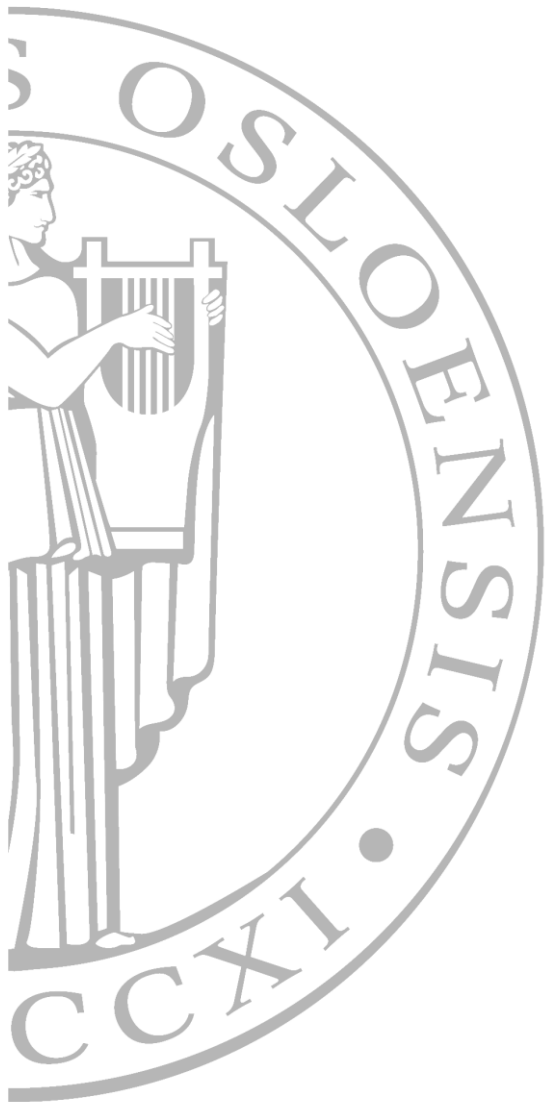


# The Vietnamese social health insurance for the near-poor A health capability approach

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Nguyen Thi Dan Thanh

Master thesis in Development Geography

*Department of Sociology and Human Geography  
University of Oslo*

May 2013

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Email: danthanh.ngn@gmail.com

Cover image: “Subscribe to social health insurance is to protect health of your family and community.” Promotion poster by the Vietnam Social Security. Downloaded from <http://www.baohiemxahoi.gov.vn/>

## Abstract

In Vietnam, the near-poor are defined as people having income up to 1.5 times above the poverty threshold. Many of them are the erstwhile poor, facing the risk of falling back into poverty. Healthcare reform is one of the main legacies of the structural transformation in Vietnam since late 1980s. Fees for healthcare have been increasing significantly. Meanwhile, income is not increasing as fast as healthcare price. The government implements social health insurance schemes, aiming to decrease healthcare cost burden for its participants. The near-poor can subscribe to the social health insurance on a subsidised premium, but are charged the same copayment rate as the non-poor.

The thesis bases its conceptual framework on Jennifer Prah Ruger's health capability approach. Under Ruger's view, social health insurance is justified as a way to keep people healthy, protecting them from the consequences of ill health, maintaining their sense of security, and promoting social justice in society.

The thesis is a qualitative research, taken the form of a poly-vocal format for the purpose of presenting the voices of the near-poor. The thesis uses semi-structured interviews as the main sources of data for analysis. During a period of ten weeks, I interviewed 22 near-poor households and three government officials in My Tho City.

The thesis offers an insight into the portrait of the near-poor in Vietnam. It discusses comprehensive reasons why the near-poor participate in social health insurance. Furthermore, it ascertains the presence of certain barriers to the access and the utilisation of the social health insurance scheme, hence assesses social justice of the scheme from the perspective of the near-poor.



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# Appreciation

I owe my deepest gratitude to my informants, who shared with me their concerns and treated me with genuine kindness. I am thankful to the local health insurance collectors, especially *chú* T. and *cô* L. They were the “light at the end of the tunnel”, who introduced me to my informants and turned my fieldwork into an enjoyable experience.

I am thankful to my supervisor, Jan Hesselberg, for approving my thesis proposal, giving me enormous freedom to develop my ideas and guiding me through completion of the project.

I would also like to thank the Department of Sociology and Human Geography, University of Oslo, for the fieldwork grant.

I wish to thank the Norwegian Centre for Human Rights, University of Oslo, for offering me the thesis scholarship. I am much obliged to Gisle Kvanvig, the project manager of the Vietnam Programme, for enlightening me with his knowledge about my country and providing me valuable contacts for my research process.

Thanks to Kåre Rønningen and the helpful staff at the Norwegian Mission Alliance in Vietnam, who provided me not only warm reception at their office, but also the key recommendation letter that pushed me through my fieldwork.

It is a great pleasure to thank NIAS, Copenhagen for giving me the SUPRA scholarship. It was a fruitful time not only for my research but also my experience in a professional academic working environment.

Warmhearted thanks to Tommaso Querini, Gisle Kvanvig, Arve Hansen, and Le Thanh Xuan Yen for your comments and insights; to Eivind Solbjell and Miranda Naish for proof-reading the English language. I appreciate your challenging feedbacks which you always enclosed with encouragements. I am, however, the only one to be blamed for any error in this thesis.

To my family and friends from every corner, *cảm ơn*/thank you! You are wonderful sources of inspiration to me.

*Grazie* my dear husband, Tommaso Querini. This new path of life with you is splendid!

I dedicate this thesis to my Mother. She makes me go further than what I dream.

Oslo, May 2013.

Nguyen Thi Dan Thanh

# Abbreviations

DOLISA	Department of Labour - Invalids and Social Affairs
GDP	Gross Domestic Product
GSO	General Statistical Office
HCFP	Healthcare Fund For The poor
ILO	International Labour Organisation
ITA	Incomplete Theorised Agreement
MOF	Ministry of Finance
MOH	Ministry of Health
MOLISA	Ministry of Labour - Invalids and Social Affairs
VND	Vietnam Dong
VSS	Vietnam Social Security
WHO	World Health Organisation

## Glossaries

Catastrophic expenditures	Catastrophic expenditures refer to large spending that threaten a households to fall into poverty. With regard to healthcare, they are indicated by the out-of-pocket payments that exceed a certain threshold of the total household spending (Priwitzer 2012).
Co-payment/cost-sharing	Co-payment/cost-sharing is a fixed amount or percentage, defined by healthcare providers, which has to be paid for healthcare services by users (Priwitzer 2012).
Health insurance fund	Health insurance fund is a financial fund generated from premium contribution and other legal sources. It is used to spend for consultation fees and treatment fees, administration fees, and other related health insurance fees.[1]
Out-of-pocket payment	Out-of-pocket payments are health expenditures paid by the patient for services that are not covered in the health insurance. Out-of-pocket payment, therefore, relies on the patient's ability to pay (OECD 2009).
Primary healthcare facility	Primary healthcare facility is the first healthcare level for the insured, indicated on the health insurance card upon registration.[1]
Social health insurance	Health insurance is a form of insurance used in the healthcare sector. Social health insurance under Vietnam's Health insurance law is not-for-profit, operated by the government, and related partners. [1]
Universal health insurance	Universal health insurance is achieved when all groups defined under the Health insurance law subscribe to health insurance.[1]
Exchange rate	1 USD = 20 500 VND (2012)

[1]Source: Vietnam's Health insurance law 2008



# 1. Introduction

## 1.1 Purposes of the thesis

This thesis addresses the issues of the Vietnamese social healthcare insurance for the near-poor. The near-poor, defined by the government as people having an income up to 1.5 times the poverty threshold (more details presented in chapter Three), are constantly vulnerable to economic-wide risks. The social healthcare insurance is a significant assistance scheme among a handful of programmes that have been implemented for this group. The near-poor have hardly been the focus of development studies in Vietnam. Most often, they have been merged into the group of the poor identified by the government, despite their distinguishing characteristics.

- ❖ The thesis aims to describe the near-poor and place them in their proper position in the healthcare reform of Vietnam.

Vietnam has made impressive progress in development. According to the World Bank's report (2012), the country has achieved and even surpassed many of the Millennium Development Goals. The poverty headcount ratio fell from nearly 60% to 15% between 2003 and 2008, following Vietnam's General Statistics Office (GSO) and the World Bank standard. The country has undertaken radical structural transformation, characterised with liberalisation both internally and externally, which has consequently led the country from a low-income to a low-middle income country since 2010. Nevertheless, poverty reduction in Vietnam is "well begun, not yet done" (World Bank 2012). Income inequality among people in the society is increasing and consequently the poverty line to identify the needy eligible for social assistance programmes is outdated.

Healthcare reform is one of the main legacies of the structural transformation. Free universal healthcare of the period before the 1986 Renovation (Doi Moi) was replaced with fee-for-services, under the inauguration of socialisation. Since then, healthcare prices have spiralled, in particular, medicine price is "unreasonably high" (Nguyen 2011). Vietnam has the highest rate of catastrophic health spending in East Asia, followed by China which applied a similar

healthcare model and is now trying to reduce its downturns (Bitran 2012).<sup>1</sup> In the absence of free healthcare, pricey healthcare treatment can impoverish everyone, but it strikes the poorer hardest. Nevertheless, the government is said to have shown a strong commitment in achieving equity in healthcare (Tran et al. 2011). The Prime Minister (PM) Decision 122 in 2013 on the National Strategy to protect, care and improve people's health for the period 2011-2020, with a vision to 2030, states that:

“Health is the most precious resource of the individual and the society, and public health service is a special social service, not for profit. The government takes commitment on innovating and improving Vietnam's healthcare system towards a Fair-Effective-Developing system, ensuring that every citizen, especially [...] vulnerable people to have access to basic and qualified healthcare.” (PM Decision 122, 2013, part 1 on perspectives. My translation)

This agrees with the perspective of the Communist Party, stating that social health insurance is an important public policy, which forms the main pillar of the social security system, contributing to and advancing a fair society, ensuring political stability.<sup>2</sup> In all, they reflect the Vietnamese Constitution: Each citizen has the right to be entitled to social security and the right to fair treatment in using health services.

- ❖ The thesis explores social justice through the case of the near-poor population in the social health insurance scheme.

Social justice refers both to an ideal, a concept and to actions aiming to create a society in which every human being is equally valued and can practise her rights with absolute fairness and respect (Faden and Power 2006). The thesis bases its philosophy in Aristotle's definition of human flourishing and Sen's capability approach, which are incorporated by Ruger (2009) in the health capability approach.

I chose to examine the issue of social justice based on several assumptions. Firstly, the near-poor population have a similar financial challenge to the poor, but receive much less support from the government, including healthcare. Secondly, most of the near-poor are informal workers. Unlike formal workers, who automatically receive healthcare insurance under the National Health insurance law, informal workers are not obliged to subscribe to social health insurance. However, even 37% of the formal workers were not enrolled in the compulsory

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<sup>1</sup> The definition of catastrophic spending has been explained in the Glossaries. The thesis considers catastrophic spending as any out-of-pocket payments that exceed 1 million VND, following data from the author's fieldwork interview.

<sup>2</sup> Document number 373/CTr-BHXH of the Vietnam Social Insurance (in Vietnamese).

scheme (Nguyen et al. 2012b). Although the non-coverage might stem from the employers' side, the figure is appalling, revealing workers' vulnerability to social shocks. Thirdly, whilst many people opt for private insurance in order to seek private clinics, especially for outpatient treatment, near-poor people appear to rely on government-based insurance as the optimal affordable health insurance.

Vietnam aims at obtaining a universal healthcare coverage within few years. The health insurance for the near-poor in Vietnam has been through several stages of adjustment, especially in enrolment rules. These incremental changes aim to attract more near-poor participants. Figures show that participation of the near-poor in the scheme appears to be low, involving less than 30% of all the near-poor in 2011<sup>3</sup>. By regulation, the scheme is compulsory, but in reality it is fundamentally voluntary based, as there is a participation fee. Is finance the key factor when the near-poor make their decisions? What are the motivations that encourage the near-poor to buy social health insurance?

- ❖ The thesis aims to determine the reasons why the near-poor participate in health insurance.

## 1.2 Thesis questions and analytical approach

The thesis focuses on two questions:

1. Why do near-poor people participate in the social health insurance scheme?
2. How has the scheme met the near-poor's needs of healthcare?

The first question aims to depict the near-poor in Vietnam and to understand their decision-making to join the social health insurance. The second question assesses social justice in health or health equity from the perspective of healthcare needs.

Following a World Bank report (edited by Hsiao and Shaw 2007), the thesis defines social health insurance on three specific characteristics. Firstly, it is a government-based scheme, available for everyone in the contributory regime group and those under subsidy, thereby distinguishing itself from voluntary private insurance. In addition, the thesis also regards social health insurance in the context of Vietnam, consisting of a government-based voluntary scheme. This is a feature of social health insurance in developing countries, where social voluntary enrolment is a temporary solution until the government has grown economically

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<sup>3</sup> VietnamPlus. 29 October 2012.



powerful enough to cover the low-income population, hence obtains a universal health insurance status. Secondly, participants enrol by paying a premium or subsidised premium. This means that citizens are not automatically entitled to social health insurance as in universal health insurance schemes funded by general revenues, namely, for instance, the Canadian or Norwegian systems. Thirdly, legislative tools ensure the maintenance of the contribution rate and benefit package. In this regard, the 2008 health insurance law indicates that the premium will not exceed 6% of monthly income and regulates other issues concerning responsibilities of the insured and the insurers. The thesis excludes other types of health insurance, namely private insurance, community prepayment health insurance and national insurance.

The thesis is a qualitative research, using semi-structured interviews as the main source of data for analysis. The fieldwork lasted for a period of ten weeks in My Tho city, Vietnam, where all the interviews were made.

The scope of the thesis covers both urban and suburban contexts, wherein the distinguished characteristics in terms of healthcare access can be identified. The research challenges taken-for-granted images of the near-poor population, whose majority who do not join the scheme. The first focus of this thesis is to understand the reasons which encourage the near-poor to participate in health insurance. The second focus is to understand the near-poor's expectation. Lastly, the thesis considers to what extent the scheme meets their expectations.

### **1.3 Relevance in development geography**

Townsend (2009) views social security as a universalistic measure that can reduce poverty in the South more efficiently and quickly than some other devices. Does the healthcare scheme practised by the Vietnamese government ultimately aim to reduce poverty? The government uses voluntary health insurance functions as an instrument to achieve universal healthcare coverage, and as a humanistic approach to support the needy, among which are the near-poor.

Liu et al. (2012) demonstrate that universal coverage does not automatically mean health equity, but the height and depth of coverage, referring to co-sharing and benefit packages of social health insurance do. The insured may not use social health insurance services due to high co-payment as it was found in China, or due to low quality as in the case of Vietnam. Consequently, the purpose of social health insurance for poverty reduction may not be

achieved. Therefore, the case of Vietnamese near-poor deserves the attention of development policy-makers.

A deep understanding of the motivation driving the choice of the near-poor is worthy of special attention in development geography for several reasons. Firstly, many of the near-poor are informal workers, who represent a large proportion of the population in developing countries. Studies on this group offer an important contribution to development characteristics and strategies. Secondly, only the very poorest—the identified poor, are entitled to 5% co-sharing of healthcare fee; near-poor people have to co-pay 20%. Initial benefits, including a low entrance fee, may be insufficient to protect the near-poor from financial shock, and therefore may hamper their financial security and well-being. Thirdly, some forms of informal work are undertaken in hazardous working conditions, the workers therefore are likely to be in greater need of healthcare than formal workers, indicating that healthcare may be vital to the informal workers. Fourthly, there has been a growing awareness among informal workers to obtain healthcare insurance, shown via annual increases in voluntary participant rate. In contrast, the near-poor participation in the Vietnamese social health insurance is still relatively low, making an in-depth understanding of their choices and experiences an investigation of a marginal phenomenon.

The thesis also aims at giving a voice to the near-poor in Vietnam in expressing their opinions on an important public policy. To a certain extent, private opinions on social policies are not yet popular in Vietnam, though change is on the way. The thesis targets at researchers with passion about development, policy makers, aid agencies and especially the Vietnamese government. The author hopes that this work will benefit first and foremost the near-poor, as their voices are represented with respect to their authenticity and dignity.

## **1.4 Outline of the thesis**

The thesis comprises seven chapters. Chapter *One* presents the thesis' purposes and questions. It also explains why the thesis is relevant in the field of Development Geography. Social health insurance for the near-poor is a relatively recent scheme within Vietnam's comprehensive social security policy. The rationale of the near-poor to join the scheme and their satisfaction regarding the scheme are the main topics of the thesis.

Chapter *Two* presents the philosophical foundation for the analysis of the thesis topics. Aristotle's theory on human flourishings sets criteria for Amartya Sen's capability approach, a

broad normative framework for assessment of social arrangements and human well-beings. Jennifer Prah Ruger uniquely develops it into the health capability paradigm, which considers health ability, health functionings, and health agency as its main components. The paradigm provides a conceptual framework to analyse the topic issues.

Chapter *Three* describes the contextual settings of the Vietnamese healthcare system and the near-poor's characteristics. The healthcare reform has changed the way medical services are delivered in Vietnam, compared to pre-Renovation era. The socialisation gradually becomes the central feature of health policy. At the same time, the government promotes social health insurance, both through compulsory and voluntary schemes, with the ultimate goal of achieving universal health insurance coverage by 2020.

The near-poor in Vietnam is a heterogeneous group in terms of financial ability and attitudes towards social health insurance. However, they all face a risk of falling into poverty. The near-poor can buy social health insurance at a subsidised price. Nevertheless there are many barriers that account for their low participation rate.

Chapter *Four* explains in detail the methodology, including the process of making the thesis, ethical issues, limitation and credibility of the research process and findings. The thesis applies qualitative method and hermeneutic writing to examine and present the study. Semi-structure interviews are the main sources of data.

Chapter *Five* and *Six* analyses fieldwork data. The portrait of the near-poor in Vietnam will be depicted closely, and the reasons of their subscription to the social health insurance will be discussed in chapter Five. Chapter Six will analyse the experience of the near-poor with social health insurance to assess social justice in the social health insurance for the near-poor. Finally, chapter Seven summarises the findings.





## 2. Conceptual framework

In this chapter I will present approaches to health insurance demand and utilisation. The chapter starts with the neoclassical economic theory. I then turn to the main approach that I will employ for my analysis: The health capability approach.

### 2.1 The neo-classical theory

According to the neoclassical economics, health is considered as a commodity. Every individual seeks to maximise health, whereas health insurance providers generate the conditions for fulfilling it. All participants in the market are informed about the demand and supply of all goods and services and—given an efficient market—they will rationally try to obtain the best possible outcomes. In regards to health insurance, a risk-averse individual will opt for health insurance in order to reduce financial loss in case of illness (Ruger 2007).

However, whereas many other basic necessities—for instance the need for shelter or food—are similar among various individuals, health needs vary between individuals and across a person's lifespan. For example, a treatment which is beneficial for one person can be harmful for another. Uncertainty is a characteristic feature of health.

#### **Asymmetric information**

Adding to this uncertainty, there is an inherent asymmetric information in healthcare, which undermines the supposed efficiency of market-based approaches (Powers and Faden 2006). Asymmetric information is an economic term which describes the different amount of knowledge between two parties in an economic transaction. If the gap in knowledge is too wide, this can lead to a market failure, or an inefficient allocation of goods and services.

When it comes to health insurance this can refer to the unequal amount of knowledge the consumer and the supplier have regarding the consumer's health status. Following economic theories, a fair insurance premium should depend on the potential loss that the insurance company is asked to cover in case of illness. In other words, the premium is calculated based on the possibility that a person will need a medical treatment. However, the knowledge regarding individual health is not the same between the insurance company, the consumer and the medical care provider. The consumers rely on professional judgements to evaluate their needs and how to satisfy them. Even though the public access to databases and the public campaigns of information may contribute to decrease it, the asymmetric information will

never be completely overcome (Kornai and Egglestone 2001).

The asymmetry of information leads to two other forms of market failure and consequently to an excessive or insufficient coverage of medical expenses that can cause severe problems in any mechanism for health insurance.

### **Adverse selection**

Insurance companies, on their side, are usually not fully informed about the health condition of their clients and must therefore set an average premium cost. The purchasers who are potentially more willing to pay for social health insurance are the ones who have most need of treatment. However, if these clients cost more than the expected average, the insurance company will face an economic constraint and will be forced to raise the insurance premium. At this point the healthier consumers will be discouraged from choosing the scheme and will withdraw, possibly leading to the collapse of the scheme. This is a process of adverse selection (Kornai and Eggleston 2001).

By contrast, even though people generally want to preserve their health, some might think they will be spared from sickness or, if they are young and healthy, that they do not need insurance. This attitude illustrates the shortcomings of any volunteer insurance scheme.

### **Moral hazard**

After an economic transaction, one party can change her behaviour knowing that she will be protected from the consequences of sickness. This is called a moral hazard (Dembe et al. 2000). We can distinguish between ex-ante moral hazard, when there is a reduced consumption of preventive care, and ex-post moral hazard when there is an increased consumption of more expensive services after an illness has occurred (Jowett et al. 2004).

The essential nature of personal health and its importance for well-being might lead the consumer to look for the best and often more expensive solution, independently from her actual need. This form of moral hazard can also be favoured by the medical supplier who, depending on her agenda, might have incentives to encourage over-spending, or on the contrary, try to reduce the costs (Kornai and Eggleston 2001).

In short, in the case of healthcare, the consumers cannot understand the quality of the product as good as the producers: users usually do not have a clear knowledge of their insurance plan, nor can they realistically estimate future changes in their health or the effectiveness of a medicine. Their behaviour is therefore not completely rational, as neoclassical economics argues.

Despite the limitations of neoclassical theories in explaining health insurance demand, its concepts are useful in analysing national health insurance schemes. In the thesis, these concepts are employed to answer the thesis questions. More precisely, adverse selection is used to analyse the first thesis question and will be presented mostly in chapter 5. Asymmetric information and moral hazard patterns are examined to explore the efficiency of the healthcare scheme in chapter 6.

## 2.2 Sen's capability approach

The capability approach was developed by Amartya Sen, whose initial intention was to propose an alternative approach to human development, opposed to neo-liberal and utilitarian approaches. The rudimentary idea is that rather than evaluating the effectiveness of a development project on the basis of availability of commodities or income, one should consider if the intervention enabled the person to lead the desired life; the capability approach focuses on individual freedom to choose what is valued (Alkire 2005, Robeyns 2005). Alkire (2005) gives an example of a development programme urging indigenous people to take jobs to earn an income, which may bring positive outcomes in terms of poverty reduction, but might go strongly against their own values and is therefore undesired.

The capability approach is a broad, interdisciplinary, and normative framework that is used for the assessment of social arrangements, public policies and individual well-being. An evaluation of a person's well-being should consider the actual functioning and the capability to achieve higher ones (Verkerk et al. 2000, Robeyns 2005).

*Functionings* are valuable states and activities that a person enjoys, and constitute her well-being (Babic et al. 2010). According to Verkerk et al. (2000), in order to achieve functionings, a person needs *resources*. The capability approach highlights the difference between instrumental means and intrinsic ends, and between capability and functioning. In Sen's view, capabilities should be the intrinsic ends of well-being, social justice, and development (Robeyns 2005).

*Capability* is defined as the freedom and opportunities that a person has in order to achieve her functioning with given resources. By definition, a capability cannot be measured but must be seen in relation to alternative potential functionings (Verkerk et al. 2000, Ruger 2010a, Qilibash 2012). A person's capability of attaining a function depends on her own characteristics and social and political arrangements (Verkerk et al. 2000, Ruger 2010a).



### **Aristotle's human flourishing**

Nussbaum (1987) further developed the capability approach by using Aristotle's concepts which, despite their age, still have a role in contemporary debates on ethical obligations of the government. In the Greek philosopher conception, the population already possesses certain natural, untrained capabilities to function, which can flourish given the addition of certain conditions. In his famous work *Politics*, Aristotle states that the role of political organisation is to provide the additional conditions for improving the capabilities of the population. Human flourishing in Aristotle's theory of the good should be the aim of "every action and decision" (Ruger 2010a).

However, defining the term "flourishing" is difficult. To reach an agreement on what is the most choice-worthy manner of leading a life is controversial because people construct values variously according to their culture or society.

Following the work of Nussbaum (1987), in Aristotle's view, a good arrangement (organisation) leads to good functioning. For an arrangement to be good, it must address the *totality* of people, not just the affluent, and must take into account the available resources. The value of distributive arrangements cannot be assessed before taking into account the functioning they positively affect. The aim is to make people able to act and live in certain concrete ways, not just spreading things around them as if they had meaning in themselves. The final goal is to increase the capabilities of the people, not just the functioning. Within these capabilities, Aristotle stresses the importance of the capability of choice.

A process of deliberation is necessary to establish a list of key components of human flourishing. For deliberation to be effective it must be led by a person with expertise on the topic and a practical wisdom to understand what is needed and what can be realistically realised in the actual circumstances. The general and particular reasoning are both taken into account and subject to revision. Decision-making becomes therefore an iterative social process, constantly incorporating the new information available.

### **2.3 Ruger's health capability approach**

Drawing mainly from Aristotle's concept of human flourishing and Sen's capability approach, Jennifer Prah Ruger is the first to have extended these concepts to healthcare in order to create a framework to design and evaluate public health policies. I will here analyse the focal part of Ruger's approach and demonstrate how they are applied specifically to health insurance based mainly on her work (2007, 2010a, 2010b and 2010c).

### *Concept of health*

Ruger recognises that the concept of health creates irreconcilable epistemological differences when seen from different perspectives. The capabilities approach tries to offer a more integrated view by combining an objective assessment of health with ethical concerns. Therefore, even without a clear definition, we can establish a consensus driven account of health, from which to determine societal ethical obligations.

Ruger (2010a) offers a broad model of health rather than a definition, encompassing a) the biomedical definition of health as absence of disease and abnormality; b) a state of integrity— anatomic, psychological and physiologic; and c) a feeling of well-being and freedom from sickness which allows a person to cope with different life circumstances. This model defines health as multidimensional, including psychosocial aspects and therefore the individual opportunities for optimal health in relation to the social environment. Ruger views health both as instrumental for human flourishing and as an end by itself, which every society has the obligation to pursue with regard to all its citizens.

### **Health functioning and health needs**

A health functioning is an observable functioning of the body or the mind—for example the ability to walk. A person who cannot fulfil a functioning will have a health need. Individual health needs are always directly related to the functionings they can perform.

As we have discussed, in order to achieve certain functionings and to satisfy a health need, a person needs resources. In terms of healthcare, resources are, for instance, government healthcare provision, personal incomes, or qualified staff. In the absence of free public healthcare, an economically disadvantaged person may need more resources to obtain the functioning of being healthy compared to the more well-off.

### **Health capabilities**

Health capabilities are defined as the actual and potential health functionings which an individual can achieve. For example, in order to achieve the functioning of walking, a person might have the health need for rehabilitation. Her health capability includes not just walking, her actual functioning, but also the ability to run, which can be considered as a potential achievement if she receives enough care.

Ruger (2010a) emphasises that the capability is the opportunity to function well if one so chooses, thus appraising the centrality of freedom of choice, which marks the influence from Sen. In addition, health capabilities can only be seen in relationship with other potential health

capabilities and are therefore not directly measurable. On the other hand, in order to evaluate policy, one needs to measure certain health functionings such as life expectancy or disease occurrence, which also work as indicators of inequality in capabilities. The *central health capabilities*, which are crucial for survival, should be prioritised over non-central ones in health policy design. However, it is not accepted that someone should renounce her central capabilities for the sake of someone else's. There are central health capabilities such as the organ functioning, which avoid premature death and deviations from good health functioning. Whereas the central health capabilities are universal in Ruger's view, the non-central capabilities should be determined, as we will see, through a process of participated deliberation.

### **Health agency**

Health agency is the other proxy component of health capability. Health agency refers to a person's acknowledgement of health value and health as final goal. The health capability of a person is not only strongly shaped by her environment, but it also encompasses her health agency. Consequently, health agency leads a person to maintain an active role in achieving health, by means of decision-making and self-management. In other words, not just knowledge about health is necessary, but also a capability for self-regulation and decision-making, which can evolve through self-scrutiny and self-actualisation. In this sense a smoker will have to change her attitude towards smoking if she wants to pursue good health, because this habit hinders an objective optimal health functioning. In the case of children, their functionings will often depend on parent's agency. Paired with health agency, health capability underscores individual responsibility and ability to reach certain health outcomes by choosing the preferred options. Ruger (2010a) also highlights that a manner in which a certain outcome is reached is as important as the outcome itself.

### **Health capability profile**

In order to determine what the health capability actually includes, Ruger (2010b) developed a health capability profile—a list of factors influencing the individual capability to achieve good health, divided into internal and external factors. Ruger recognises that hers is a first sketch of ideas that needs to be further discussed and refined. I present below the Table 1, a simplified version of the profile with a focus on the factors that I consider as most important and most relevant for the research.

Internal factors include health functioning and what we can broadly define as health agency

(knowledge, values and goals, self-efficacy, decision-making). External factors include social norms, social capital, material circumstances, social security, public health system effectiveness and accountability. This distinction will be used in the analysis chapters to discuss the reasons why the near-poor subscribe to the social health insurance scheme and to evaluate the fairness of the scheme in terms of barriers to health capability.

**Table 1: Ruger's health capability profile**

Health capability profile	
Internal factors	External factors
<b>Health status and health functionings</b> - measures of self-reported health functioning - measures of health conditions, risk factors	<b>Social norms</b> - extent to which norms are scientifically based - extent to which health-seeking behaviours are seen positively - extent to which a health behaviour is adopted by a majority or minority of the population - society ability to recognise and counter damaging social norms
<b>Health knowledge</b> - knowledge of own health - general knowledge of health, prevention, risk factors - knowledge of costs and benefits of health behaviours - knowledge of how to acquire health information	<b>Social networks and social capital for achieving positive health outcomes</b> - emotional or instrumental support from friends and families - existence of available networks of social groups - extent to which social networks may negatively impact health
<b>Health seeking skills, self-efficacy</b> - beliefs about ability to achieve health outcomes - ability to perform health behaviours	<b>Material circumstances</b> - economic - housing - surroundings (presence of risk factors) - food security - safe water and good sanitation
<b>Health values and goals</b> - value of health - value of lifestyle - ability to recognise and counter damaging social norms	<b>Economic, political context and social security</b>
<b>Self-governance and self-management</b> - ability to manage different situations - personal responsibility regarding health - ability to draw on networks of social groups - vision, direction, planning and strategy	<b>Utilisation and access to health services</b> - ability to obtain health services when there is a perceived need - presence of barriers to access and utilisation of services
<b>Effective health decision making</b> - ability to use knowledge and resources to prevent disease - ability to identify health problems	<b>Enabling public health and healthcare systems</b> - extent to which healthcare interacts with individuals to build and enable health agency - extent to which healthcare protects health and safety of public - healthcare effectiveness and accountability
<b>Intrinsic motivation to achieve health outcomes</b>	
<b>Positive expectations about achieving health outcomes</b>	

Source: Author's modified version of Ruger's health capability profile (2010b).

## **2.4 The health capability approach and social justice**

Ruger (2010a) emphasises the moral importance in achieving social justice in health. Her account of the health capability approach is therefore based on this view of social justice. Firstly, it recognises that people have heterogeneous needs and that they might need a different amount of resources in order to achieve the same functioning. Secondly, however the importance of choice and preferences are accentuated; essential health functionings are considered universal and not cultural-specific. A safe motherhood, for example, is a valued functioning, regardless of the lack of respect women receive in many societies. So health interventions are evaluated on the basis of the health functionings they meet and the health capabilities they promote. The focus is on health capabilities, rather than just health functioning, because the former embraces the value of individual agency, choice, and responsibility. Thirdly, the health capability approach focuses on essential capabilities, namely the capability to avoid premature mortality and escapable morbidity; without these, many other capabilities in all aspects of life would be out of reach. Fourthly, the approach maintains that non-essential health capabilities should not be specified a priori but left open, because the process of decision-making should be public and with broad participation in order to reach a consensus on health policies. Fifthly, the approach suggests a balance between equity and efficiency, the latter being vital for any health policy.

### **Health equity**

The health capability approach does not guarantee the same health results for everyone, but rather focuses on enabling conditions under which threshold levels of health can be granted to everyone. Individuals and groups will have different needs in terms of treatment depending on their condition. Healthcare goods and services must be necessary and appropriate to those needs.

Ruger identifies three basic ethical theories regarding health equality: a) The equalitarian assumes that everyone should have the same access to healthcare; b) the prioritarian that the resources should focus on the ones who need it the most; whereas c) the sufficiency theory states that a certain threshold should be reached for everyone. Ruger uses the two latter in her theory, recognising that a completely equal system in health is unreachable. The state should pursue the highest possible level of health functionings (sufficiency) and granting it first to the ones with the worse functioning and the lower individual agency for reaching it (Ruger 2010a). Seen from this perspective, every disparity in health support, for example for people

with a rare sickness which requires costly treatment, becomes deeply unjust.

### **Shortfall achievement of equality**

Ruger (2010a) uses the welfare economics' notions of attainment and shortfall to judge equality in healthcare. Attainment equality refers to evaluating equality based on absolute levels of achievement. This view disregards the potential of individual health because it levels down the attainment goal to the one of the worse achiever. Shortfall achievement of equality considers equality in comparison with the actual achievement to the best average. It is consistent with the concept of health as optimal functioning because it accounts for the differences in the maximal potential of health. The shortfall model allows for scaling up inequality at the individual, group or even national and international level, depending on the focus of the analysis. There will always be space for improvement in health within this proportional, relativist approach. There will thus always be request for better health services.

For these reasons the thesis places its findings in comparison with other empirical studies, apart from indicating the existing limitations in the Vietnamese public health services for improvement policies.

### **Voices of the participants in the shared health governance**

For the capability approach to function, Ruger (2010a) applies the Incompletely Theorised Agreement framework (ITA). In classic social choice theory, Arrow has shown that it is impossible in the process of collective decision-making to guarantee both the widest possible individual choice and Pareto's principle, which states that individual arrangements should not worsen the condition of someone else. In other words, it is proved that it is unattainable to reach an agreement that would satisfy all the parties at all the theoretical levels. However, for collective decision-making to be feasible, an agreement must be reached. Ruger's work is innovative because it applies for the first time in the health field the ITA, initially conceptualised in the field of law.

In Ruger's framework, ITA is a necessary part of the social choice agreement. The ITA shows how it is possible to reach an agreement in policy-making, despite incompatible differences in higher principles, or philosophical ways of seeing the world. It can be effectively applied with regard to pluralism, health capability, and public policy.

Ruger (2010a) views shared governance as an integral element of the health paradigm. A shared health governance should include the individual, the providers, and the institutions. An individual retains primary health decision, whereas it is the physician who decides which

healthcare is appropriate and which medical treatment is necessary. The policy-makers provide facilities and a regulatory platform for the operationalisation of healthcare. The final goal of the shares governance is the healthy person. Following this view, a sufficient and satisfactory healthcare requires involvement of the three actors mentioned above. The mechanism that facilitates consensus among them is the ITA. An individual uses her health agency for self-empowerment. Individuals thus have a voice concerning benefit packages that they are entitled to as well as medical appropriateness. Nevertheless, individuals also need to maintain a cost-consciousness so that they will not misuse the healthcare provision, or in other words must avoid moral hazards.

The health capability approach promotes health policy arrangements which are mutually acceptable to people with different preferences. In addition, *resource allocation* should be based on medical necessity, rather than capability to pay, and it is therefore necessary that people renounce their non-central capabilities, such as wealth, through progressive taxation, in order to grant everyone's right to central health capabilities. Another indirect, ethical aim of universal health insurance is therefore redistribution. The out-of-pocket expenditures such as co-payment or experience-rated premiums should also be put under scrutiny, since they can hinder the possibility to receive needed healthcare. Efficiency, in terms of cost-minimisation, should always be kept in mind. Therefore, if there is a choice between two treatments which attain the same result, the cheaper should be pursued (Ruger 2010a).

### **Health insurance as guarantee for basic human flourishing**

Following Ruger (2007), health insurance is justified as a way to keep people healthy, protecting them from consequences of illnesses, and maintaining their sense of security. It is also a means to actively promote redistribution within a society. If a person is lacking necessary healthcare, this can worsen her sickness and reduce the working and/or studying capability.

*Universal health insurance* guarantees some of the basics for human flourishing. If a person is not or just partially covered by insurance, this affects her possibility to receive appropriate and good quality care. A universal healthcare insurance, in which the premium is equal, based on income, and fairly calculated on the basis of average financial risk for sickness serves as a rational and ethical choice for improving the economic security and enhancing the capability of groups and individuals.

In regards to benefit packages, Ruger (2006) argues that a standard, guaranteed package for all should be the basic principle. Following this, benefit packages must be of high quality and



applied equally to everyone. This addresses the fact that under some schemes, people receive different benefit packages, depending on their abilities to pay, and this is unethical, because the benefits have to meet the needs.

## **2.5 Critics to Ruger's capability health paradigm**

### *Critics on focus of healthcare policies*

Sen, Nussbaum, and subsequently Ruger consider both the increased capability and the final outcome as the main goal of health policy. Dogmatic, paternalistic policies ignore the moral importance of one's self-determination, even though they might achieve a positive health outcome. Powers and Faden (2011) argue that it is possible to avoid the breach of individual freedom without changing the focus of healthcare policies, which should be kept on the outcomes. If health is an ultimate end of political activity, the effective achievements, rather than the potential health of individuals, should be at the very centre of health policy.

Individuals themselves cannot change the structural conditions which are the cause of their illness. Therefore it can become misleading to give the same priority to health agency and health functionings (Powers and Faden 2011). Ruger (2011) addresses this criticism by arguing that individuals, providers and government share the responsibility to pursue the health goal, each with its own tasks. Health is not a simple matter of choice of atomised individuals.

### *Critics on technical terms and ideology*

Reinhardt (2011) focuses his critic to Ruger's book *Health and Social Justice* on its technical jargon, the vagueness of central concepts such as health agency, and the general abstractedness of the whole scholarly work. The deliberation process, which would supposedly puzzle out the problems in policy making, is an over-simplification of how hard it is actually to conduct a public debate nowadays, in a political scenario where compromise between political parties no longer is attractive.

## **Chapter summary**

Ruger's health paradigm is the chosen analytical framework for the thesis because it a) Justifies health insurance as a way to promote human flourishing; b) offers an inventive normative framework to assess healthcare inequality; and c) gives room for discussion and improvements of healthcare, especially healthcare for the disadvantaged in the society. The thesis also deploys terminologies of asymmetric information, adverse selection, and moral

hazard from the neoclassic approach to examine the thesis questions, which also fits well with Rugar's concern with economic issues. The health capability emphasises the importance of moral foundation, inspired from Aristotle's philosophy, as its principle of social justice. Following this view, health equity must be enhanced by allocating more resources to the people with less ability to sustain health on their own. A shared health governance should make sure that voices from the government, providers, and the insured are heard and considered; and aims at healthy individuals as its final goal.



“...create clear progress by implementing progress and social equity, ensuring social protection, reducing the share of households living in poverty, and improving conditions for caring for the people’s health.”  
Five-year goals, The Eleventh Party Congress 2011.

## **3. The social health insurance and the near-poor in Vietnam**

### **3.1 Prelude**

Vietnam has experienced significant pro-poor growth, with average annual per-capita GDP increase of 6.1%/year between 1993 and 2008, and poverty reduction at an average rate of 2.9%/year (World Bank 2012). Although Vietnam is a low-middle income country, the health status is said to be better compared to many countries with similar level of GDP per capita. In 2009, life expectancy at birth of Vietnamese population was 70 years for men and 75 years for women: infant mortality rate was 16‰; under-five mortality rate was 25‰. These features were similar to those of countries with GDP per capita three or four times higher than Vietnam. The majority of diseases result from unintentional injuries, cardio-vascular diseases, mental illnesses, and cancer in adults, and low respiratory infection in children (Ministry of Health and Health Partnership Group 2011).

Out-of-pocket payment in Vietnam remains the largest source of health financing: In 2005, it corresponded to 68% of all health expenditure (Nguyen et al. 2012a). Achieving a significant decline in out-of-pocket payment will take years and requires additional public financing. The cause and solution of this phenomenon may derive from the healthcare reforms, which embrace the evolution of the social health insurance. The sections below present and discuss the issues.

### **3.2 Healthcare reform in Vietnam**

At the 6<sup>th</sup> National Congress of the Communist Party in 1986, the government inaugurated Renovation (Doi Moi). This meant the demise of the planned economy. During the years of planned economy, infrastructure was inadequate; there was a shortage of food and energy; state-owned companies were unsuccessful and public services were of low quality. However, it was also a period of free public healthcare. In the rural areas, a network of brigade nurses provided basic healthcare; health workers’ incomes originated from sale of medicines. However, subsidised medicines from the Soviet Union and Eastern European countries

allowed the government to sell drugs at a cheap price (Segall et al. 2000, Ekman et al. 2008). Private medical practices were prohibited in order to serve socialist idealism, to protect patients from malpractice doctors and to preserve the good image of serious medical workers (MOH Circulation 4/1984).

The economic recession following the country's reunification in 1975 made this system unsustainable and led to radical reforms (Ekman et al. 2008). Renovation into a market economy aimed to make transformations in the economy and major social aspects included healthcare. In the early reform period the rural production brigades were dismantled, substantially reducing the access to healthcare in the rural areas.

### **Socialisation of healthcare**

1989 is seen as the official turning point of healthcare reforms in Vietnam with the introduction of influential policies (Priwitzer 2012). The collection of formal and informal fees by public providers had been reported since the beginning of 1980s; but it was only in 1989 that it became legal to charge for services and medicines. Decree 45-HDBT in 1989 officially promulgated partial fee-for-services when employing public healthcare facilities. The Ministry of Health and the Ministry of Finance were in charge of formulating the fees such that they would be affordable to the majority and suited with the country's social policies. In addition, people could choose healthcare services and facilities where and how they wished. This was significant because it enhanced flexibilities for users, and it was expected to increase the quality of services through user fees. Around this time, drugs started to be sold at market prices.

Decree 45-HDBT also introduced fee exemption to particular groups. However, Somanathan et al. (2013) note that there was no explicit subsidy to implement these supports until almost 10 years later. This list of beneficiaries has been frequently expanded, which will be detailed later.

With the economic upturn, the central government overtook the responsibility of paying for commune health workers and providing them with more benefits such as allowances and pensions. This change was very important as it kept primary health workers in public sectors. In comparison, China missed this point in its policy and consequently was faced with increasing privatisation and the moral decline of village healthcare staff (Segall et al. 2000).

In addition, private clinics, traditional medical practitioners, and drug retail sale were re-sanctioned. Many current and retired state health practitioners had their own "out-of-hours" private clinics, which very often included a pharmacy store, a practice still popular nowadays.

The transformation policies are said to be influenced by the primary healthcare systems of other socialist countries such as China and Cuba (Segall et al. 2000). Among transitional countries undertaking reforms, Russian and Eastern European countries took a rapid approach, while China took a gradual one (London 2008).

### **Critical features of socialisation**

Ramesh (2013) presents a critical overview of this transitional period, suggesting that the government's ultimate goal was to transfer the costs from the state to the households. To demonstrate, he argues that the healthcare reforms can be categorised into three overlapping phases: a) Substitution of budgetary allocation with user charges, b) expansion of social insurance, and c) promotion of decentralisation.

According to Ramesh (2013) these changes worsened rather than improved the problems of rising expenditures and declining access at the base of the Vietnamese healthcare system, because they never tackled the origin of the problem, namely the health providers' motives to maximise revenues.

Ramesh (2013) continues stating that, by being a pragmatic, temporary response to budget constraints, the users' contribution was successively formalised. In 1999, Decree 73/1999/CP on socialisation or "social mobilisation" promoted private, profit-oriented companies and organisations to take part in public services such as education and healthcare. In the meantime, the percentage of user fees in the hospital on the total of the hospital balance increased from 9% in 1994 to 30% in 1998.

Nonetheless, many just simply could not afford for treatments and medicines. By early 1990s, out-of-pocket payments accounted for over 70% of spending for healthcare. Utilisation of public health services fell dramatically in the following years. Fee-for-services had a perverse effect on the healthcare system. Ramesh (2013) claims that fee-for-services drove patients into deeper poverty and increased inequality in health outcomes. In a similar vein, a study on out-of-pocket payments by Bitran (2012), based on data from Living Standards Measurement Surveys conducted in Vietnam in 1992-1993 and 1997-1998, finds that user fees increased health inequality in health outcomes, widening the poverty gap.

The problem of health related costs for households was re-addressed by the central government through subsidy of basic medicines, further extension of free of charge treatments to certain targeted groups and direct payment to public employees. All these measures, however, failed to modify the new profit-oriented approach acquired by the healthcare

providers. From 1994 to 1996 the public hospitals revenues doubled owing to out-of-pocket revenue (Ramesh 2013).

Total health expenditure grew from 5.1% in 1995 to 7% of GDP in 2009. In real terms it increased by 9.8% annually, higher than the average growth of GDP (Ramesh 2013). In the same period the expenditure per capita tripled. It must be noted that government's spending on healthcare declined between 1995 and 2005, and then increased again (Bitran 2012). In contrast, London (2008) notes that government spending for public health was reduced after 1989 and has not increased in accordance with the recent economic growth. He adds also that in 2007, the Vietnamese government distributed around 6% of its central budget for healthcare, whereas the figures were nearly 19% in Cambodia, 17% in Thailand, and 10% in China.

The majority of hospitals in Vietnam are public, but given the exiguous contribution they receive from the state, they often rely on privately owned equipment, which has been bought by members of the staff themselves or by external agents for producing revenue. Staff pool the money as a form of social mobilisation and make the investment. Consequently, this drives them to use this equipment in order to gain bonuses. In one emblematic example, a provincial hospital hosted seven ultrasounds devices and each was used an average of 107 times a day for testing (Somanathan et al. 2012).

Another common occurrence is the prescription of expensive drugs, rather than basic ones which are covered by the insurance. Consequently in Vietnam a disproportionate 60% of social insurance fund is spent on medicines. It is also worthy to note that social health insurance fund has been in deficit and has been covered by the government budget since 2008 (Ramesh 2013)

Whilst a decentralisation process already started in the 1990s, it was through PM Decree 43/2006 that hospitals gained financial and management autonomy and were encouraged to involve private investors in profit-oriented joint ventures, hence they became subject to minimal control. Social mobilisation in Vietnam has taken the peculiar form of public services reforms to socialise the costs and mobilise private investments. Socialisation has become a central feature of health policy, justifying fee-for-services, requiring state-owned companies to do philanthropy, and promoting privatisation. While Vietnamese enthusiasts see social mobilisation as embodying mutual help and community values, it actually promotes the extraction of revenues from individuals and households to private actors working in public

facilities (London 2008). Hansen (2010) states that socialisation is better understood as marketisation or commodification in Vietnamese context. This conflicts with what is stated on government's agenda as shown in chapter 1, but it appears to be true in reality as figures show high out-of-pocket payments for healthcare. The mobilisation is more a financial than a social one and decentralisation must be seen as a reform in this direction.

### **3.3 Social health insurance in Vietnam: the way to universal health insurance coverage**

To address health inequity and disastrous healthcare spending, the government prepared the national health insurance schemes (Segall et al. 2000, Lieberman and Wagstaff 2009, Somanathan et al. 2013). Early 1990s, the World Health Organisation (WHO) started to work with Ministry of Health on healthcare planning and financing. A Plan of Action focused on health insurance, in cooperation with regional WHO and the Swedish International Development Agency. Four basic strategies were defined, namely: a) Improvement in knowledge and public education, b) extension of health insurance to various population groups, c) utilisation and cost studies, and d) improvement of management and control functions. This had an important impact on the making of the Decree of Health insurance in 1992, besides other beneficial activities including pilot studies with technical supports and staff training (Ron et al. 1998).

#### **Components of social health insurance**

##### *Compulsory social health insurance*

Vietnam's first social health insurance was the compulsory scheme implemented in 1989 for public workers. It was then extended to employees, retirees, disabled, and meritorious people. In 1992, Decree 299-HĐBT announced compulsory health insurance to workers, pensioners, employers and employees of: civic sectors, state companies, foreign or related companies with more than 10 employees and international organisations operated in Vietnam with Vietnamese workers. By 2008, the coverage was 9% of the total population, half of the eligible population. The reason for this gap may be found in the weak labour registration and enforcement measures in the private sector (Giang in Ramesh 2013). The latest compulsory scheme is aimed at children below the age of 6 and is also funded by the government.



The healthcare fund for the poor (HCFP) was introduced in 2003 through Decision 139 on healthcare funds for the poor. From 2005 it became part of the compulsory health insurance. The eligible are identified by the use of the official poverty line. It can be debated whether this measure of monetary poverty describes in full scope the poverty condition and whether a multi-dimensional measure should be used instead. Besides, people just over the threshold, the near poor for instance, are not covered by the scheme, even though their life condition is almost identical to those who are under the poverty line.

The central government pays a large part (75%) of the premium; the provincial governments take care of the rest. Few provinces have actually paid their share. By 2009 the programme covered fifteen million people, and it amounted for a 50 million USD government expense. In the long run this may become unsustainable, even with further extension of co-payment. In a recent study using propensity score matching to pre- and post-intervention data, HCFP has been shown to have positive short-term effects on out-of-pocket and catastrophic expenditure reduction and a small increase in healthcare utilisation and relative reduction of self-treatment (Han 2012).

#### *Voluntary social health insurance*

According to Decree 299/HDBT, individuals of all other categories can participate in voluntary health insurance. Until 1998, voluntary participation was restricted to group membership, for instance enrolment of 100% household members and 10% of commune residents. These restrictions were then removed by the Government Decree No.58/1998. More than 20% of the population became beneficiaries of this scheme. The policies have to be implemented across the regions (Giang 2012). The voluntary health insurance scheme is aimed at farmers, the self-employed and students. The government is committed strongly to this scheme as a way to reach universal health insurance and to increase prepayment coverage. Most of the members are students who are believed to be persuaded by their institutions to join.

There are some studies suggesting that the social health insurance has reduced the out-of-pocket expenses and increased the use of outpatient facilities. By 2010 the social health insurance covered 27% of the population on a total of 60% of insured citizens (Ramesh 2013).

#### *The Health insurance law*

In 2008, National Congress passed the law 25/2008/QH12, promulgating that: a) Social health insurance is to ensure sharing costs of contingencies among the insured; b) premium is calculated on the proportion to salary, pension, allowance or minimum salary in the formal



was at 67%. The city also said to spend VND 47 billion to support social health insurance premium for the poor and the near-poor.<sup>4</sup>

*A Multi-institutional and hierarchical operating social health insurance system*

Many institutions are involved in the social health insurance system. The Ministry of Health is responsible for formulating healthcare policies, monitoring, and evaluating social health insurance schemes. Vietnam Social Security (VSS) takes charge of implementing the schemes and managing the social health insurance fund. The Ministry of Finance allocates money to VSS. The Ministry of Labour - Invalids and Social Affairs (MOLISA) holds the role of identifying the target groups eligible for types of assistance. These institutions function together; their administrative power is decentralised to provincial and communal levels. Ministries operate at state level, under which their provincial level are present in 63 municipalities and provinces. Provincial and commune agencies are embedded as holistic parts of the Provincial People's Committees. At the primary level, the commune head and social health insurance collectors are direct informers and contacts to the population (Somanathan et al. 2013).

*Premium and benefit packages*

By 2008 social health insurance law, monthly premium is calculated up to maximum 6% of a monthly salary. The running rate in 2012 was 4.5%. Payment method varies according to groups that participants belong to. Formal workers pay one third of this premium through their monthly salary and two thirds is contributed by their employers. For informal workers and all other categories, the premium is 4.5% of national minimum income standard. Various target groups receive sponsorship up to 100%. The premium has spiralled upward over the past years due to the increase of minimal income standard.

Social health insurance participants benefit from cost reduction on seeking for public healthcare. Free healthcare is available for expenditure below the amount equivalent to 15% of minimum income standard, provided that users visit their first level of healthcare on registration. Above this amount, the insured have to co-pay 20%, 30% or 50% of the total expenses, depending on which level of healthcare (compared to registered level) they are seeking. Pensioners, people on social allowance and the poor have co-payment rate at 5%. War merits, military officers, and children under 6 are entitled to free healthcare. For treatment that requires highly technological facilities of huge cost, social health insurance

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<sup>4</sup> Da Nang Government Web Porto.

coverage is up to 40 times as much as minimum monthly income. The scheme includes many services and expensive treatments like x-rays, but the benefit package is mostly undefined and therefore patients have often to pay extra-fees (Han 2012).

**Table 2: Premiums and co-payment rate among various categories**

	Premium				Co-payment rate
Year Cat.	2008	2010/11	2012	2013	
Poor*	0%	0%	0%	0%	5% ***
<b>Near-poor</b>	50%	50% and 10% **	30%	0%	20% ***
Non-poor	100%	100%	100%	100%	20% ***

\*plus other targeted groups

\*\*only in certain provinces with the support from World Bank's health projects

\*\*\*30%, 50% or 70% for bypassing the registered facility.

Source: Author's adaptation from Health insurance law 2008, Ministry of Health's Circular No. 10/2009.

#### *The healthcare facilities available for social health insurance users*

Social health insurance facilities are provided from commune to state levels. At primary level, health stations are located at communes or in schools and companies. They are however characterised with poor facilities and limited opening hours. At district, provincial, and state levels, there are public health centres/hospitals and private multi-field clinics/hospitals—in agreement with Social Security agencies—which provide more adequate services and are capable of handling complicated treatments.

Upon registration, social health insurance participants can register for the healthcare station of their choice at commune and district and city level. If participants require healthcare at provincial or state levels, evaluations of users' health problems will be made. The first choice of healthcare facility will be indicated on users' social health insurance cards. Referral to the next healthcare facility level is decided by health workers at the first level. Bypassing the first level without following this procedure, users will bare a higher co-payment, which is 30%, 50%, or 70% at provincial and state levels. Bypassing is very common because of many reasons, apart from the fact that higher level healthcare centres provide complex treatment and people also believe that they have better quality treatment.

Social health insurance also covers prescribed medicines, which are listed and administered by Ministry of Health. This means that there is a limitation of supplies that may influence users' treatment.

### **Limitations of social health insurance in Vietnam**

One of the major concerns regarding healthcare sustainability in Vietnam is the tendency of providers to over-treat the patients, in order to gain more fee-for-services. This trend is facilitated by the lack of oversight and the decentralisation process, which provides incentive for the public hospitals to maximise revenue (Ekman et al. 2008). Alternatives to fee-for-services such as capitation have been proposed, but have not yet been put in practice (Han 2012).

Even for insured patients, out-of-pocket spending is the highest source of financing necessary healthcare. Informal payments in order to get help appear to be the norm in public hospitals. It amounts to 7% of the total expenses for standard treatments and 20% for extra-treatment (Ramesh 2013).

For the peculiarities of healthcare markets, the providers are the ones in charge to decide what to prescribe to the users, and in a fee-for-service-based system with a profit orientation the risk is that the suppliers will be encouraged to over-treat patients, increasing the financial burden on households.

Since the out-of-pocket is common to all healthcare users, independently from their insurance, healthcare services are limited to those who are able to pay. Thus, the burden of out-of-pocket payment is higher on the low-income people.

Benefit packages also raise challenges against users. Nguyen et al. (2012a) find that, in a rural community north of Ha Noi, inpatient treatment was only covered by the insurance if it was in the facility where the individual was registered. Outpatient treatment was covered in departments within hospitals, but not in commune health centres. Many reported that they did not use their insurance because it did not cover the treatment they needed at certain facilities. This also reflects the heterogeneity in applying the national policy, for my fieldwork in My Tho city reveals another reality.

### **3.4 The near-poor in Vietnam**

The near poor constitute a heterogeneous group. At the top-ends of the near-poor continuum, there are the near poor who choose to be self-reliant and buy social health insurance at full price and there are those who cannot afford even the premium.

### **A governmental targeted group for social assistance**

The near-poor discussed in this thesis belong to a governmental category. PM Decision 9/2011 defines near-poor household in rural and urban areas during the period 2011-2015 as households whose incomes range the near-poor's income ranges from 0.64 USD/person/day to 1.04 USD/person/day.

The country has been using an outdated poverty monitoring system, based on economic and consumption patterns in 1990s, whereas the economy is now four times larger (World Bank 2012). With per capital gross national income above 3000 USD from 2010, the country joins the group of low-middle income countries. The economic transition has changed characteristics of Vietnamese society dramatically. However, the current near-poor standard income is far below the 2 USD/day of the median poverty line for all developing and transition economies.

In Vietnam, the near-poor has been on the poverty reduction agenda since 2007.<sup>5</sup> However, only a few programmes cover the near-poor, namely health insurance, education, and preferential credit. The near-poor are eligible to preferential credit loan with interest at 1.3 times as much as of the poor.<sup>6</sup> High school children of near-poor parents whose income is 1.5 times more than the poverty line will have reduction of 50% on school fees.<sup>7</sup>

### **Identifying the near-poor**

Because most low income earners are in the informal sector, it is often difficult to acknowledge their monthly income. Near-poor identification is achieved through mean-tests and community participation. MOLISA is responsible for administering the process which is done yearly at the same time with monitoring poor households.<sup>8</sup> It also regulates all necessary steps to be taken. In general, the Department of Labour - Invalids and Social Affairs (DOLISA)—MOLISA's agency at provincial level, collect information about potentially near-poor's household income. After that, the officials gather people in the neighbourhood and present households that are considered for approval. Finally, a secret ballot will be taken and if a considered household receives more than 50% of positive votes, they will be recognised as a near-poor household (Fieldwork interview with a DOLISA official).

Many cities adapt different measurements and duration compared to the national ones. These cities include HCMC, Ha Noi, Binh Duong, Da Nang, Khanh Hoa, Vung Tau, Binh

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<sup>5</sup>For instance on the Prime Minister's report at The XII National Assembly 22.October.2007.

<sup>6</sup>PM Decision 15/2013

<sup>7</sup>Decree 49/2010

<sup>8</sup> MOLISA Circular No.25/2008.

Phuoc, Long An. HCMC adapts a poverty line of 1 million VND/person/month regardless of whether they live in urban or suburban areas during the period 2009-2015. Meanwhile, Ha Noi employs a poverty standard of 500 000 VND/person/month in urban areas and 330 000 VND/person/month in suburban areas for the period of 2009-2013.

In most cases, the near-poor are people emerging from poverty. Slipping back into poverty can be sudden, due to the occurrence of a catastrophic health expenditure, harvest failure or loss of a breadwinner. Even though informal social protection is not uncommon in the society, it is not always guaranteed. Formal government-based protection schemes for the near-poor are needed for sustainable poverty reduction.

### **Subsidised social health insurance for the near-poor**

The near-poor is a new category in the 2008 Health insurance law, following which they are eligible to receive subsidies on insurance premium. In addition, all members in a household are encouraged to participate through a sliding scale policy on premium, in which a reduced fee is applied for every subsequent joining members of a near-poor household. It is important to note that even though social health insurance scheme for the near-poor is compulsory, it is in reality based on the willingness to pay by the near-poor because there is still a co-sharing in the enrolment premium.

When it was started in 2008, social health insurance premium was a 50:50 co-sharing between the government and near-poor participants. Participation rate was low, with around 692 000 out of over 6 million of the near-poor population participating nationwide in 2010.<sup>9</sup> Some provinces took action with financial support from World Bank's Health support projects. They subsidised the near-poor up to 90% of the premium in 2010 and 2011. Participants doubled to about 1.6 million near-poor people in 2011.<sup>10</sup> This made a positive impact on the government policy, as the government introduced an increase up to 70% on premium for the near-poor in 2012. Furthermore, an under-revised policy is about to raise full subsidy on premium to near-poor households who have recently emerged from poverty. The support will be valid for at least one year and continue for a duration of five years. With this new policy, the government expect that 3 million of the near-poor will participate in the scheme in 2013<sup>11</sup>, which is about half of all the near-poor in Vietnam.

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<sup>9</sup>Thethao&Vanhua 01.July.2011. This figure was 800 000 in Giang (2012), referenced from VSS.

<sup>10</sup>VGPnews 06.August.2012.

<sup>11</sup>Vietnam Government Portal (VGP) news 05.December.2012.

### **Reasons to low participation**

The premium is only one among other challenges that hinder the near-poor from enrolling in the scheme. The economically disadvantaged think that health is their main concern because it is the most valuable thing that they possess. Illness and costly treatment are therefore best avoided (VASS 2011). The demand for health insurance is growing in the society (Ekman. et al. 2008).

Many of the near-poor refused to participate in the scheme, even though they only had to pay 10% of premium. In a study by Nguyen et al. (2012b) on 700 households using multi-variate model, the near-poor represented 30% of the total of uninsured. In terms of utilisation, within the insured population which actually used the insurance, the near-poor represented just 19.8%; the near poor represented 22% of the insured population who did not use the insurance when in need of medical treatment. This shows that there are barriers to the effective use of health insurance by the population.

In 2010 health insurance in Tien Giang province only registered 17 150 near-poor people, which was round 30% of all the near-poor. In Dong Thap, where only 11% of the near-poor participated, an officer from the Social Insurance explained that many of the near-poor were waiting for the new poverty threshold for which they might be reconsidered as poor and granted a free health insurance. Another reason, he added, was that health insurance collectors were not so interested in this group, because commission from each near-poor participant is very low compared to other groups.<sup>12</sup> Whereas this can be true, my experience on meeting with several health insurance collectors during fieldwork demonstrates that local health collectors are devoted social workers and make an effort to persuade the near-poor to participate in the scheme because it is beneficial for the near-poor. However, serious hindrance came from the local government side as some fail to monitor the near-poor or inform them about the scheme. In many cases, the near-poor are not aware of the existence of the scheme. Neither do some of the near-poor fully understand the provision and benefits of the scheme.

Analysis of the ability of health insurance coverage by 2014 indicates that it is extremely difficult to cover 100% of the near-poor, as well as members of agricultural households (agriculture, forestry, fisheries and salt makers) with average income, and casual workers in urban areas. In contrast, it is likely to achieve 100% health insurance coverage for the groups of: Employees of government administration and state owned enterprises, pupils, students and

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<sup>12</sup> Dan Viet news 04.08.2010.



dependents of formal workers (Vietnam Ministry of Health and Health Partnership Group 2011).

### **Chapter summary**

Free public healthcare was removed as healthcare reforms took place at the end of 1980s. User fees were initially introduced to cope with the budget constraint, yet later incorporated as an inevitable characteristic of the healthcare system, as a part of socialisation process, or in other words, part of the commodification process of healthcare. This results in high out-of-pocket payments and unequal access to healthcare, especially to the low-income. Various social health insurance schemes have been promoted to address these obstacles. The near-poor have been targeted for subsidised social health insurance premium since 2009. However, the number of the near-poor covered by social health insurance remains low, which can be explained by various reasons. The next chapter of methodology will account for the process of approaching the near-poor in this issue, as I encountered them in reality.

## 4. Methodology

This chapter accounts for the paths that I have chosen in order to conduct the research. I start with the reasons for the choice of a qualitative research and the philosophical paradigm that underlies the way the research has been conducted. Next, I explain the process of data collection, covering practicalities before and during the fieldwork. I also discuss relevant ethical issues and limitation of the research progress. Finally I demonstrate the research credibility, validity and transferability.

### 4.1 Research design and paradigm

#### Choice of qualitative method

There are three main reasons why qualitative method is appropriate for my research. Firstly, qualitative research holds a dualism in explanation of the social structure and the individual experiences and behaviours towards a structure and place (Rofe and Winchester 2010). The qualitative method is particularly beneficial for giving voices to marginalised, unheard social actors. In my thesis, they are the near-poor—*the missing class*<sup>13</sup>—whose income is just enough above the poverty line to be excluded from major poverty emancipation programme, and too far below the average income to obtain a decent life, thus holding relatively little bargaining power in the society. Secondly, I had imagine before the fieldwork that it would be difficult to recruit informants because of the low participation of near-poor people in health insurance, coupled with the difficulty in gaining access to them. This results that the size of my informant group would not be relatively small. Whereas this poses no difficulty for the purpose of my research, it may have been insufficient to demonstrate representativeness if the research were conducted in a quantitative manner. Furthermore, the research challenges the criticism that a qualitative, poly-vocal format—which this research employs—is “blind to facts” (Hughes 1990). Qualitative research allows each voice to announce a part of the fact, which is a piece of fact in itself. Voices may conflict with each other, but this does not mean they are incorrect (Thody 2006). Indeed, comparing voices will contribute to a more complete picture of the complex socially constructed facts.

This research does not aim at identifying attitude patterns towards the social health insurance scheme and drawing any generalisation based on that regarding the near-poor

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<sup>13</sup> A term coined by Newman and Chen (2007) referring to the near-poor in America.

population in the country. Instead, it focuses on individual informants: Their reasons for participating in the health insurance scheme and their experiences and opinions about the effects of the scheme on their lives. This is a feature of an intensive (or qualitative) approach.

Given that the goal is to give voices to the less powerful in society and the meta-goal to improve social justice, a participatory action research (PAR) would give a better result. However, the unavailability of a support research group and the insufficiency of secondary data on the topic hinder a PAR approach. Nevertheless, this research can be a complementary step towards a future PAR approach on the topic.

### **Hermeneutic writing**

Hermeneutics is philosophically construed as constant interpretation and improvement of knowledge; therefore, it is placed above all theory of knowledge (Rockmore 1990). According to Loftus and Trede (2009), hermeneutic writing is the art of presenting interpretations into words “for the benefit of others and for oneself”. There are two main hermeneutic traditions: philosophical hermeneutics and critical hermeneutics.

The Gadamerian tradition—critically arguing against Heidegger’s view of the hermeneutic circle—suggests a distinction between epistemology and hermeneutics, and that the problem of knowledge is solved by the transition from epistemology to hermeneutics (Rockmore 1990). It concerns meaning-making from texts, text-analogues and all human practices. Researchers bear in mind multiple problems, which are called foreshadowed problems (or pre-understanding/prejudice/tradition). In fact these problems are considered endowments for scientific thinkers and should be revealed to the audience for their assessment of how rigorous the interpretation is (Malinowski in Hammersley and Atkinson 2007, Higgs et al. 2009, Hay 2010). Another important aspect of this tradition is the openness for the text to “question” the writers themselves, enhancing deeper understanding of the object. This is a matter of objectivity. In practice they are expressed through passive voice or third personal pronouns and formal style of writing.

Habermas developed a critical perspective in philosophical hermeneutics. He argues that interpretation should be for emancipation rather than deeper understanding. He suggests that writers should be in a distanced, outsider stance towards interpretations; develop critical self-awareness or reflexivity in relation to examined objects; and keep certain scepticism and suspicions towards the given knowledge (Loftus and Trede 2009).

Both traditions value openness about self and texts. I employ both traditions in my thesis because they allow me to have a cautious mindset when understanding and presenting the

knowledge claims, including both mine and the informants'. I am open about the foreshadowed problems that I had during the research process. Also I make efforts to be transparent and clear when stating my informants' opinions versus my own.

I entered the fieldwork with certain foreshadowed problems. Firstly, I regarded the near-poor as being not better off than the poor, if not worse. Expenses on health insurance such as premiums and co-payment become a burden that would prevent the near-poor from healthcare. Secondly, I had always been hesitant to contact government officers because of the persistent bureaucracy. Several people who knew about my research also warned me that the topic was sensitive and it would be difficult for me to receive cooperation from the government. Besides, talking about politics is not commonplace in Vietnam. Scott et al. (2006) confirm this through fieldwork experiences of the three authors on development geography in different regions in Vietnam. Also, talking about sickness is sometimes regarded as a taboo in Vietnam because people are afraid a sickness would happen when they name it. These impressions worried me before entering the actual fieldwork and they added to my hesitance in contacting governmental officials and asking informants for interviews. However, this hesitance did not overwhelm me as I was constantly reflecting on the research objective and my role in the research. I have kept writing a research diary from soon after the thesis proposal was approved. I have kept a constant recorded of: New findings, reflections on the data, and possibilities of new directions for the thesis. I made constant considerations about how they fit with my interests and philosophy, my understanding, pre-interpretation of the events, and what advantages and disadvantages there are for the informants and me on conducting the thesis. The research is therefore the result of a dynamic process.

## **4.2 Data collection**

### **Interview guide and questions**

Dunn (2010) distinguishes between an interview guide or aide-mémoire and an interview schedule. While the first comprises a list of key terms relevant to the research topic, the second includes well-worded questions. Dunn (2010) suggests the latter for novice interviewers to avoid moments of mental blocks and to better compare informants' answers. I had prepared a set of carefully worded questions and intended to perform a mix of interview guides and schedules as a guide for the main themes and in case I would not be able to invent appropriate questions on the spot.

The set of questions (attached in the Appendix) was prepared as the shape of an hourglass. It comprised general easy-to-answer questions in the beginning and the end of the interview whereas the more reflective questions would be posed in between. The intention was to allow time for both the interviewer and interviewee to absorb gradually into the topic, gather information and emotion for more sensitive and complicated questions, and to cool down the interviewee's emotions by end the interview. Primary question types were inspired by Dunn (2010), those that inquire from the informants' descriptive information, storytelling, opinions on social structures, reflections on certain hypothesis and controversial issues, with a guarantee of anonymity. Primary questions serve the purpose of extracting information from the informants. They can reveal facts about experiences and ideology, feelings, reflections of the informants towards these experiences, which serves both ontological and epistemological features of the thesis focus.

I used interview guides for the very first interviews or interviews after a lapse of time (which due to problems from either recruiting informants or my own sickness). For the rest, I often posed questions spontaneously, depending on the answers from the informants. However, I always checked the interview guide towards the end of the interviews to make sure all main topics had been touched upon. I added new questions when the informants' answers implied new interesting aspects that I had not considered in advance, particularly on behavioural patterns of using health insurance.

Initially, I had three interview guides, one for near-poor users, one for near-poor participants—those who have insurance, but have not used it—and one for government officials. During the fieldwork the first two guides gradually merged and were modified to suit both participants and users as I realised there was no real distinction between the two groups: Users and participants all experienced healthcare insurance on their own or from other people. On the contrary, I realised that officials interviewed in my research were from different government departments, consequently their roles and knowledge differed from each others. I then adjusted the interview guide into two versions adapted to the interviewed officials.

### **Negotiating access to informants**

The process of finding key informants started some months before the actual fieldwork. I asked my contacts who worked in related fields and searched through online articles, hoping to find relevant research on Vietnam. Unfortunately, I could not find any key informants prior to the fieldwork.

To recruit near-poor informants, I had assumed that governmental institutions would provide me with the lists of identified the near-poor participating in social health insurance. I aimed at the city's top level institutions so that they would commend me to the lower agencies. Besides, I intended to base my fieldwork in HCMC, the most dynamic city hosting the biggest economy in Vietnam. Through Internet searching, I found that HCMC Social Insurance (SI) is responsible for issuing social health insurance cards. However, as a rule, I needed to have recommendation letters. I had earlier provided two letters from the University of Oslo and University of Social Science and Humanities (USSH) in HCMC.

#### *The "right" recommendation letter matters*

After having contacted HCMC SI and discovered that they could not provide me with the information, I was directed to the City's DOLISA, which in turn referred me to the Hunger relief and Poverty reduction Committee. The Committee informed that they had the data that I required. They, however, could not provide me with the data because my recommendation letter was issued by a foreign institute, and the Vietnamese letter did not indicate the name of the Committee. Therefore I needed either a new letter from the USSH or being approved by the Department of External Relations. When I visited the Department, however, I was told that the letter needed to be verified by the Norwegian Embassy first. Then, at the Royal Norwegian Consulate in HCMC, they informed me that my letter needed to have the stamp issued by the Norwegian Ministry of Foreign Affairs. On the other hand, it would take a few weeks to get a new letter from the USSH because the university was closed for entrance exams during that period.

#### *Changing fieldwork location*

At the same time, Gisle Kvanvig of the Vietnam Programme at the Norwegian Centre for Human Rights connected me with Kåre Rønningen of the Norwegian Mission Alliance in Vietnam. The organisation holds several on-going projects in my province of origin. The meeting with Kåre and his colleagues inspired me to conduct my research in my hometown, My Tho city. I paid some preliminary visits to some government offices in My Tho to investigate whether they could provide me with information to recruit informants. Through a friend, I was introduced to an officer from the city's DOLISA. At his office, I luckily encountered a health insurance collector of a commune. The officer and the health insurance collector were willing to assist my study, on the condition of a letter of recommendation (even so, when I later met them after having obtained the letter, they did not bother to look at it).

This was a positive sign because they were government staff who directly promoted health insurance to the near-poor and registered the near-poor participation. After some other failed attempts to approach the near-poor in HCMC, I decided finally to change my fieldwork to My Tho city. This was because of the risk of time constraint if I kept insisting on researching the near-poor in HCMC. In addition, the near-poor health insurance scheme is applied nationwide. It would not alter the focus of my research. The Norwegian Mission Alliance provided me with a new recommendation letter, listing all institutions I might need to contact for getting informants, as at this point, with all the experiences I had had, I became familiar with the system. The letter functioned as the key to several gate keepers, who were the government employees.

In other attempts to find informants, I fortunately found the list of health insurance collectors in every ward and commune of the city on the notice board of a Commune's People Committee. I phoned several collectors according to the list, explained my research purpose and how they could assist me, asked for an appointment, and then showed up in person. Some of them were hesitant. For example a lady collector told me she could not help without permission from a higher officer. I went to find the suggested person in charge, but the office was closed that morning. After more negotiations to make myself trustworthy, she offered me several near-poor contacts. In contrast, I skipped negotiation with the ones that seemed time-consuming. Some collectors gave me great support which greatly eased up my fieldwork, particularly those at commune level.

#### *Learnt lessons*

Had I known the rule of the right recommendation letter, it would have shortened the time to gain access to the informants. Before leaving for fieldwork, I contacted several people but none had mentioned anything about the "recommendation norm".

To get access to the population in question, especially those at the grass-root level, I realised that the lower the governmental level, the easier it was to get help, for example state employees at the quarter (*khu pho*) level—the level under the ward and commune level. This reversed my initial inexperienced assumption that it was best to start from the top officers. However, I discovered them accidentally after I had been to several governmental offices and talked to many people. There was a more efficient way: to get official seals—the red stamp—which showed that the researchers are approved from the top. Kurti (1999) observed a similar feature in Hungary: "Just like the socialist state bureaucracy in itself, interview had to progress from the top down." In practice it means that it is advisable for the researchers to

pre-establish a connection with a Vietnam-based institution, in my case the USSH and the Norwegian Social Alliance in HCMC.

### **The fieldwork location**

My Tho city is the capital of Tien Giang province, located on the the Mekong Delta and 70km south from HCMC. In the province, My Tho has the least poverty rate, with 3.38% poor households, compared with 52% in Tan Phu Dong, a rural district (Document obtained from fieldwork). The city consists of 11 wards and 6 communes. In Vietnam, My Tho is one among 10 cities in category II, out of five plus a special category, which includes HCMC and Ha Noi. This means that the city is the hub of the province and the region with regards to political, economical, cultural, and technological aspects and transportation, service and tourism. Non-agricultural workers should represent more than 80% of all labour and the city has a fairly adequate infrastructure.<sup>14</sup>

According to a DOLISA official in My Tho city, the local government distinguishes between two types of near-poor households: Level 1 and level 2, equivalent to 1.3 and 1.5 times the income above the poverty line, respectively. Only near-poor households of level 1 are entitled to subsidised healthcare premium. A preliminary result after a poverty monitoring in early 2012 revealed that 1 380 near-poor households or 5459 people at level 1. The highest percentage was observed in ward 2, with 6% near-poor households, followed by Tan Long ward with 5%. Other wards share similar percentages, between 1% and 3% of all households. (Unpublished data, obtained through fieldwork 2012)

In 2009, 2010, and 2011, the near-poor in My Tho paid a 10% premium, equivalent to VND40 000 (ca. 2 USD), upon choosing to participate in the scheme. This was because the state budget covered 50 %, the city budget covered 10 %, and World Bank's Mekong Health Support paid 30 % of the premium. The amount of the near-poor's registration in the social health insurance was 1 737 people in 2009, 1 399 in 2010, and 2 311 in 2011. (Unpublished data, obtained through fieldwork 2012)

### **Selecting informants**

I assigned my informants based on two criteria: a) Government-categorised near-poor people and b) participants of health insurance scheme. However, I ended up interviewing also the

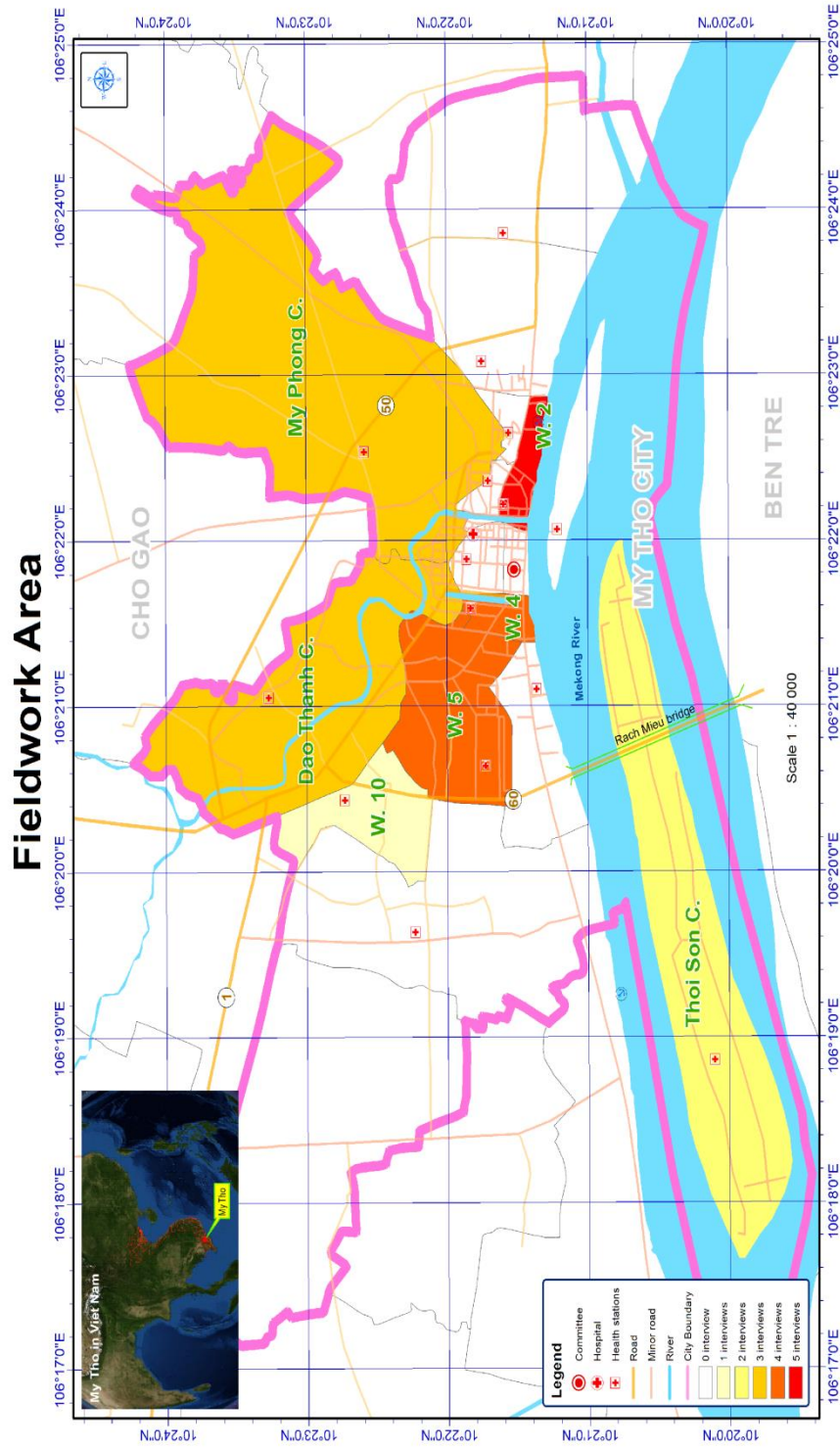
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<sup>14</sup>Government Decree 72/2001.



non-participants who did not renew their social health insurance subscription and non-near-poor who were under consideration of near-poor recognition at the point of interview.

I decided to interview the near-poor from different communes and wards because each administrative unit has its own characteristics regarding healthcare personnel, facilities, and administrative practices. As mentioned earlier, the number of near-poor people participating in health insurance was low and in many cases their dwellings were difficult to find. I had a mixed method of selecting participants. Firstly, I got some informants whom the health collectors suggested as being “acknowledgeable on the issue” and “willing to talk” (Health insurance collector in ward 2). In this way, I had “qualified informants” from the gate keepers. Secondly, I asked my informants to suggest other potential informants. This snowball method helped me to find one more informant, who was in fact a relative of the one who suggested her. Snowball was not effective in my case because most of my informants did not know anyone else who were also near-poor. I just found one more informant, who was in fact a relative to the one who suggested her. Thirdly, I followed the criterion and convenience sampling where interviewed the ones who met the two criteria plus whose houses I could find plus consented to be interviewed. This third method appeared to offer me the most valuable data because their opinions were more diverse, informative, and independent. Map 1 shows the number of interviews in each ward and commune.



**Map 1: Fieldwork Areas 2012**

Source: Fieldwork 2012, mapping data from the Geography Department, University of Social Sciences and Humanities, HCMC, Vietnam. Generated by Tuan Bui and the author.

## **Interviewing**

Semi-structured interviews were the primary data for analysis in the thesis. The benefit of using a semi-structured interview is its focus on the contents. The researcher and the informants will be in flexible positions to ask and give information based on the researcher's targets and the informants' reactions. Given the rather sensitive topic of talking about sickness and downturns of personal lives, semi-structured interviews seem to be the most suitable way of communicating. I was able to change the order of the questions when the informants turned miserable and could intervene with questions about bright sides of the informant's life. Particularly in interviews with female informants, some burst into tears when talking about the financial situation of their household. One informant was in tears when she told me that their only child was mentally ill and that the husband had, in early 2012, suffered a serious traffic accident, and that the pig which they had raised by borrowing money—with high hope that it would bring some income—had suddenly died of sickness. In a similar vein, another informant expressed that she would rather die because her sickness was a burden to the family. However, she ought to stay alive to take care of her grandchildren as a way to help her daughter.

I conducted 22 interviews with near-poor households whose members participated in the healthcare insurance scheme, two interviews with government officials and several chats with health insurance collectors (Table 3 below). The interview duration varied from fifteen minutes to two hours; they were taken at informants' houses, except one interview on a street pavement where the informant gathered almost every day to have small talks with other elderly people, and two interviews with the governmental officials at their offices. I used digital devices to record most of the interviews and noted down carefully my observation of the interview context and informant's behaviour after each interview.

## **Building rapport**

Building a good relationship with the informants will increase the ability to retrieve and receive information and the permission to use it for publishing purposes (Karnieli-Miller et al. 2009). Similarly, Baez (2002) claims that informants will answer more honestly when they trust the researcher. It took me some time during each interview to cultivate relationships of trusts, which Scott et al. (2006) also found important when doing research in Vietnam. I usually encountered the informants at their house gate. I introduced myself briefly, told them how I got to know them—often by naming the health collector who gave me the contact—and

asked whether the informants would let me interview them for about 15 to 30 minutes. If I were already inside the informant's house, I made a longer introduction and showed that I was open for them to ask questions about me. Most of the time, they wondered where I came from, and who my parents were. Some questioned whether I was a journalist or someone from the authority. I explained thoroughly that I was only a student and had connections neither with the government nor with any newspaper. In addition, I informed the informants about their rights, which I am going to elaborate on later in this chapter.

Between the two poles of interview relationship—professional interview and creative interview (Dunn 2010)—I decided to be more in favour of the latter one. As mentioned, the topics of the interviews were sensitive. I made an effort to make myself trustworthy and be sympathetic and posing questions following what was answered instead of reading them. Consequently, from the first moment of approaching until the moment I left the informant, we often developed a positive relationship.

### **4.3 Ethical concerns**

#### **Informed consent**

Informed consent requires that informants not only agree to be involved in a research, but are also informed about precisely what they are involved in (Dowling 2010). Given that the near-poor people in the setting were familiar neither with scientific research nor with an interpretative community, I gave a thorough explanation about free consent at the start of each interview. I stated clearly that I was not from any authority, so that informants would not feel obliged to participate in the interview. I also explained the research purposes, the questions I was going to ask, and the duration it would take. I emphasised that it was voluntary to participate in the interview, and that they could refuse to answer any question or cancel the interview without having to give any reason. I gave informants my contact details, in case they would need to contact me later to change or delete the interviewed data. I asked for permission to record and take photos. Only in three interviews did the informants not want to be recorded. I realised later in one of them that the person did not know what a “recorder” was. One informant called me the day after the interview and asked me to delete the photos because her son was worried that it would be used for bad purpose. Without hesitance I deleted the photos and made a second visit to her home to explain again the purpose of my research. I could feel that she was pleased and relieved.

## **Confidentiality**

One informant refused to answer when I asked for his opinion on the healthcare system. He explained that he was afraid of being given no treatment at the hospital because the government would recognise him. Some other informants were hesitant for the same reasons. They did not express it explicitly in words, but showed it through their avoidance of answering some of the interview questions.

Informants have the right to remain unidentifiable through the research. Given the rich description of participants in qualitative research, confidentiality emerges as an important concern (Kaiser 2009). Acknowledging this, I constantly informed my informants about the confidentiality concern throughout the interviews. According to Baez (2002), some critics argue that the promise of confidentiality could enhance an honest discussion from the participants. However, as discussed above, compared to confidentiality, trust plays a more crucial role in gaining honest information.

In addition, all names were presented anonymously throughout the thesis to prevent unexpected problems in case the informants would change their mind and fail to contact me, even though some informants said that it was unproblematic to have their name published. This applies also to all the third parties, who were mentioned by the informants.

Last but not least, except for the health collectors who might be familiar with some of the informants I interviewed, none of the informants' identities were revealed, even among the informants themselves. Interviews with the two governmental officials will only serve as a reference, not for analysis, so the problems of them being revealed are not considered. All the digital records, notes and transcripts are stored in a private digital account and will be deleted after the thesis defence.

## **Harm**

The humanness of qualitative research requires the participants to be protected from both physical and psychological harm (Balfour in Hadjistavropoulos and Smythe 2001). The research involved asking informants about their events of illness, financial ability for healthcare treatment, and opinions on the government's scheme. My concern before commencing the interviews was that it might trigger anxiety, sadness about their own situations, and anger towards the government. Even though a good rapport and trust may lessen these effects (Hammersley and Atkinson 2007), it could not prevent any psychological stress that the researched might develop. I had prepared for this situation in various ways, especially in the careful wording of the interview questions. I stopped some interviews when

the informants went very sad about their own situation. I changed the topics and only returned to the thesis focus when the informants appeared to have recovered from their sorrows.

#### **4.4 Limitations**

The aim during the fieldwork was to reach the saturation points of perspectives. In addition to problems of bureaucracy and finding informants' houses, I was coughing badly for several weeks due to travelling during heavy rain and accepting cold drinks offered by my informants. Consequently, I did not manage to interview as many as I had wished to. The modest number of my informants also implies that I only accessed a fraction of the near-poor population. Therefore the research findings do not represent characteristics of the whole group.

The fact that I am Vietnamese benefits communication with and interpretation of the interviewees' behaviours. However, as the thesis is written in English, the language I have used only during the last five years, it will inevitably affect the presentation of the research.

Doing fieldwork in my hometown implied also the benefits that I quickly gained trust from the informants (as all the informants related me to another person they knew). As a local insider, I experienced the same socially constructed system (the healthcare and bureaucracy system), yet I lacked the experience of my informants' background, which is the near-poor "sub-culture" (Asselin 2003). This is both an advantage and a disadvantage. The point here is that I might have bias without being aware of it, as Rose (quoted in Dwyer and Buckle 2009) puts it: "There is no neutrality. There is only greater or less awareness of one's biases." I had not realised that I asked several leading questions until I listened to my interview record. The intimacy of information that I shared with my informants plays a role here. I found myself in the situation described by Dwyer and Buckle (2009) as "the space between" an insider, in the role of a local, and an outsider, in the role of a researcher.

#### **4.5 Credibility, validity and transferability**

These criteria are important for assessing qualitative research. Credibility and transferability are regarded respectively as internal and external validity (Baxter et al. 1997, Whittemore et al. 2001). Credibility implies that the research findings can be trusted. According to Higgs et al. (2009), credibility of a research depends on it being done in a "congruent, critical, rigorous and ethically conducted manner". I have explained thoroughly in this chapter about the research process and been open about my position in the issue. For that, I have been careful in

many ways to make the research trustworthy. Above all, I always tried to be rigorous while working on the project, e.g. by cross-checking all available resources to ensure triangulation.

Validity overlaps to a certain extent with credibility in terms of truthfulness and transparency. However, it allows for creativity and flexibility of the researchers to judge the optimal approach to account for layers of bias during the research process. According to Whittmore et al. (2001), validity includes both criteria, to maintain the ideals, and techniques, to decrease threats. The main criteria include authenticity, creativity, criticality, sensitivity, explicitness, and thoroughness. Whilst many criteria can be evaluated through reflexivity and transparency, which I have explained extensively in this chapter, I discuss here the first three criteria in my thesis. During the following analysis of the data obtained through the interviews, I make an effort to retain the authentic information acquired from my informants; I explicitly state whose voices are presented and when it is my interpretation of a phenomenon. Chapter Five and Six of the thesis demonstrate this approach. In addition, the thesis takes pride in creativity, particularly in the choice of topic and the conceptual framework. Last but not least, the thesis analysis reports all voices from the informants, ensuring multi-vocality. All participants are treated with dignity and respect.

Transferability refers to the application of the thesis findings beyond their contextuality. The research is particularly conducted within the Human Geography discipline, meaning that it is strongly bound to a specific time, political setting (policy on healthcare) and people (the near-poor). Nevertheless, the near-poor is a sub-group of a larger group in the society—the low-income people. Therefore, certain experiences and their interpretations are shared. Besides, the thesis presents thoroughly the research process and gives a thick description of the findings. This enhances possibility for judgement on whether the research findings can be transferred to a larger context.

## **Chapter summary**

A qualitative method in a poly-vocal format is chosen as the most suitable approach to the thesis objective because it allows the thesis to unravel and understand the social structure on the one hand, and the individual experience of it on the other. I employ a mixture of philosophical and critical hermeneutic tradition in conducting and representing the research. For this I can demonstrate my reflexivity as an insider and outsider in the research process. Recommendation is essential to obtain information from Vietnamese authority. I am highly

concerned with ethical issues especially regarding informed consent and confidentiality for specific reasons. Sickness, language of presenting the thesis, and my place in “the space between” limit the research process. I assert that the thesis attempts to hold credibility, validity and transferability in high value, which can be judged throughout the thesis, in particular this chapter of methodology, and the two following analysis chapters, chapters Five and Six.





## **5. Why do the near-poor participate in social health insurance?**

The purpose of this chapter is to provide an insight into the near-poor and to answer the first thesis question. The health capability paradigm states that an individual's freedom to pursue good health is determined by internal factors, such as health functioning and agency, and external factors such as material conditions and social circumstances (Ruger 2010b).

The analysis begins by presenting the social and economic background of the informants and how they were categorised as near-poor. This section aims to provide a comprehensive description of a sample of the near-poor in Vietnam, which to my knowledge has never been done in any written work. The informants' opinions on the premium are depicted because it is an important concern upon buying social health insurance. Lastly, the informants' reasons to participate in the scheme are discussed.

### **5.1 Social and economic background of the near-poor informants**

#### **Household structure and types of jobs**

The household structures of my informants were heterogeneous: Single person, nuclear family, and extended family. Table 3 below lists the informants and relevant details. All households had one or more dependent members: children, the elderly or the sick who contributed little to the household income. Each household had one or more active labourer, involved in informal or formal work. I present them separately in order to emphasise that the near-poor can be found in both formal and informal sector.

The most important difference among near-poor households undertaking informal and formal work is that the latter appear able to save money from their stable income. The near-poor with informal jobs face more unstable income, thus they are relatively more exposed to financial risks. It is important to remember that catastrophic health expenditure is the main cause of poverty in Vietnam, involving more than three million people every year (Vian et al. 2012).

**Table 3: List of informants during fieldwork 2012**

Interview	Household structure	Location of interview/Residence of informants
I1	adults, children	Home, Dao Thanh
I2	adults, elderly, children	Office, Ward 2
I3	adults	Home, ward 2
I4	adults, elderly	Home, ward 2
I5	elderly, children	Home, ward 2
I6	adults	Home, ward 2
I7	adults	Home, My Phong
I8	adults, children	Home, My Phong
I9	elderly	Home, My Phong
I10	elderly	Street, ward 5
I11	adults, children	Home, ward 5
I12	adults	Home, ward 5
I13	adults	Home, ward 5
I14	adults, children	Home, ward 4
I15	adult, teenager	Home, ward 4
I16	adult, elderly, teenager, child	Home, ward 4
I17	adults	Home, Dao Thanh
I18	adults, elderly	Home, Dao Thanh
I19	adults, elderly	Home, Thoi Son
I20	adult, elderly, children	Home, Thoi Son
I21	adult, child	Home, ward 4
I24	adults, child	Home, ward 10

I22, I23, I25 were interviews with local officials.

Source: Fieldwork 2012.

#### *The near-poor with informal jobs*

The near-poor were involved in all kinds of jobs, meaning that they took up any opportunity to make ends meet, even though the remuneration was very low. Informant-10 was living alone and did not have any family linkages. The lack of family meant an increased risk of impoverishment in case of catastrophic health spending. With a work as a cook and an income of 500 000-600 000 VND each month, it appeared difficult enough to sustain a decent life in terms of food, clothes and other necessary expenses. The informant also expressed that she was worried about asking friends for financial loans because it would have been impossible for her to pay the money back.

In contrast, the household of informant-11 relied on loans to cope with extra-spending. This heightened the risk of falling into poverty if a costly treatment emerged, even though both the parents had informal work.

“I work as an undertaker and a porter. My wife makes cakes to sell. Our daughter is taking the university entrance exam, if she passes according to God’s will, we will take out a loan for her to study.” (I11)

In another case, informant-15, a retired widow, already had a study loan for one of her two sons. Since the husband, the breadwinner of the household, passed away in 2011, she earned income through various activities: Making ponchos, selling fish sauce, and undertaking menial jobs around her neighbourhood.

The household of informant-16 had six members and was one of the most indigent near-poor households I encountered in my fieldwork. Her older son worked in constructions; the daughter-in-law sold vegetables at a local market; and her grandchild was studying. The other son was mentally ill. In addition, she had an adopted child. The household could not even afford gas for cooking. In front of their house, there were drying coconut and durian shells that the ill son picked up from the local market. They used these shells for cooking. She said:

“When in need, my son has to borrow money because we do not have any savings. This week I asked him for money to buy rice. He told me to buy one kg. I have never bought five kg at a time. Every time it rains we have to bail the water out of the house. My son often eats leftover rice. He does not dare to eat anything else to save money for his son’s additional class. I do not ask for the food I want because I am worried my son would be sad.” (I16)

Some households totally lacked young labour. Instead, the only income earners were above 60 years of age. Examples of these include informants-9 and 10, who, in addition to this, were living alone. In contrast, the household of informant-5 had many young dependent members: Five grandchildren at school age, whose parents worked away from home, were taken care of by their grandparents. The grandmother made fish paste to sell with baguettes, earning about 30 000-50 000 VND a day.

The informants who resided in the countryside generated the majority of their income from seasonal work for other farmers or work in other sectors outside agriculture, rather from their own yards.

These cases indicate that the near-poor with informal jobs face highly unstable income and consequently are afraid of getting in debt. However, they also show that taking loans is unavoidable when catastrophic events happen.

*The near-poor with formal jobs*

Prior to the fieldwork, I had estimated that near-poor would be exclusively informal workers. The fieldwork disproved this pre-understanding. I had missed the fact that a household may consist of several dependent members, whose needs can drive even families with stable income into poverty. The near-poor with formal jobs who were interviewed included local government employees, factory employees or service-oriented workers, whose salaries were nearly minimum for formal work.

The household of informant-6 consisted of the mother, who was the head of the household, her son, his wife, and their two children. The head of the household was a part-time social worker, earning about 500 000 VND per month. Her son worked at a fish factory, whereas her daughter-in-law sold vegetables at the local market; their contribution was fundamental for the economy of the household.

The household of the informant-8 consisted of three adults and two young children. The main breadwinners were the father who worked as a security guard, and his daughter who worked at a clothing factory. The mother embroidered clothes at home, but due to her poor health, she could only complete one or two garments per month which could be sold for a few hundred thousand VND. The family house was built on the property of a relative. The informant said they were sometimes short of money because of the primary needs of the two young children.

Informants-2 and 21 also worked on a regular basis, earning an income of around 1 to 1.5 million VND/month, which was only sufficient for basic spending.

These cases show that the near-poor with formal jobs are struggling to maintain a decent life. Their regular incomes seem to secure the food supply and even small savings. However, they are still vulnerable on the event of catastrophic spending.

*Mixed formal- and informal-income households*

“I am retired and got a single payment for my pension. My wife works. My son also works, but it depends on the availability of jobs, which varies from one day to another. We eat on a small budget so that we can save a few hundred each month. We are trying to be flexible!” (I12)

This household of three adults relied on two active labourer's income, one of whose was unstable. The household's small saving seemingly resulted from the reduction of food intake. Nevertheless, this fund appeared to be used in case of various events such as house maintenance and celebrations, not just in case of health needs.

Interestingly, all five private formal workers interviewed had compulsory social health insurance. They are unusual compared to the relatively large population of 37% of the formal workers who did not enrol in the compulsory scheme (Nguyen et al. 2012).

Members with formal work from the mixed income households do not have to purchase social health insurance with their own budget. Even though this reduces the premium burden, it does not guarantee that these households have more resources to cover all the members, which will be discussed later.

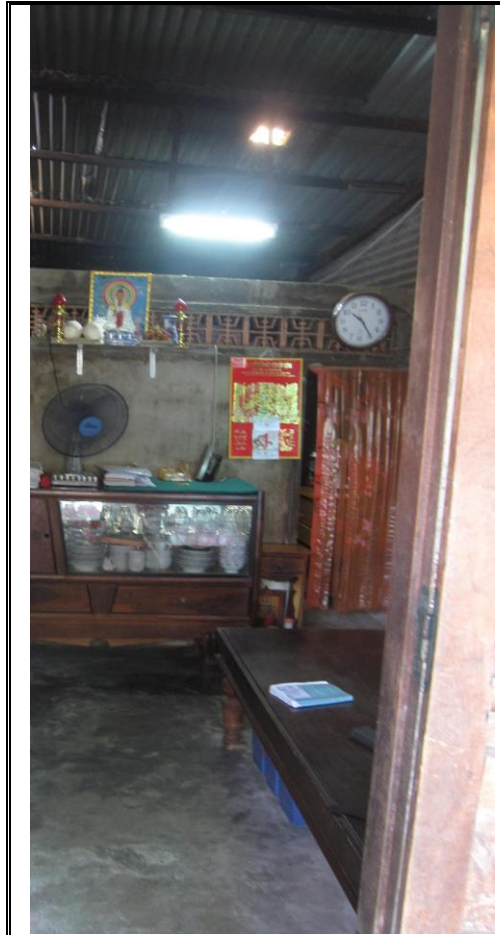
### *Living conditions*

As most of the interviews were carried out at informants' houses, I observed the condition of the houses and their facilities. Many, if not all, houses of the informants were dank and dilapidated, with old furniture and multi-purpose rooms. Some had curtained-off bathrooms, soil floors, leaf-walls and roofs. Nevertheless, some informants resided in brick-built, decently covered and furnished houses. Photos of some informants' houses are shown below.

The household of informant-3 represented a common image. Her house was modest, but rather empty. Most of the furniture was old, the wall paint was decaying. Meanwhile, the house of informant-20 revealed the most vulnerable condition. The house floor was original soil, the wall was made of leaves and you could see the holes where the rain could leak in. The informant said when it rained heavily, the house flooded easily.

Similarly, the house of informant-21 had the floor lower than the street, thus whenever there was heavy rain, it would flow into the house. Some years ago the government agreed to help her in upgrading the house, but as she changed to a new job that gave her an income above the poverty line, the government withdrew the plan. On saying goodbye to me at the gate, she touched the wall of the neighbour's house with tears, saying: "I wish my house could be like this, it does not need to be painted, just simply built of bricks."

The condition of the dwelling reveals the financial situation of a household. Due to their limited financial resources, the near-poor have little chance to upgrade their housing condition. It could be sensed from the interviews that all informants desired better living conditions, which seemed to be beyond their reach.



**Figure 2:** The house of informant-3.  
Fieldwork 2012.



**Figure 3:** The house of informant-7. Fieldwork 2012.



**Figure 4:** The house of informant-20. Fieldwork 2012.

### *Recognition as near-poor*

The recognition of a household as near-poor determines whether its members receive a discounted premium for the social health insurance. The status of being near-poor may change from one year to another, as the recognition is re-examined annually. Most of the informants had been in the poor category before they were considered as near-poor. The process of recognition as near-poor described by the informants differs from that detailed in the regulations and the information received from the DOLISA's officer, in terms of acknowledging opinions of people at local gatherings. Informant-16 perceived that the recognition was unjust and she felt hopeless to change the result.

“Previously, my household was in the poor category. Now we are in the near-poor category. I asked them why they [the authority] categorise us as near-poor, even though they know that we do not have enough rice to eat. I think that we are in a very difficult situation, but they will not consider us as poor, what can we do? Everyone knows that we are poor, but they decided themselves that we are not in the poor category any more.”  
(I16)



Similarly, informants-7 and 9 did not understand why they were moved from poor and reclassified under the near-poor category. The recognition committee often consist of officers from DOLISA and the commune chiefs, who are supposed to know every household situation in their area. At the recognition meeting, people are asked to state their opinions, yet these opinions do not appear to have any impacts. This is supported by informant-1, a former commune chief, who said in the interview that: “The process of recognising the poor has been finalised from the top. They ask for our opinions, but they do not consider them.”

Even when a reason for the category classification was given, it was perceived as unconvincing, as in the case of informant-18.

“Our household was removed from the poor category since 2000 because they looked at the family book and reasoned that there were four labourers in the household. In reality, two of them got married and lived elsewhere. Lately they made a new recognition and considered that as my household had three adults, two who cannot work and one who works seasonally, so we belong to near-poor group.” (I18)

On the contrary, some informants did not perceive the recognition process as unjust. This opinion was found among ten of the interviewed near-poor. It should be noted that these informants had experienced a shock that reduced the household income, as in the case of informant-15; or were nominated by acquaintances to move down to the near-poor categories as in the case of informant-3. The household of informant-20 was enlisted in the near-poor group for several years thanks to the local health collector:

“Some years ago while the former health collector was in charge, he said to me: “You look weak, I will list your family as a near poor household.”(I20)

This factor indicates that they were moved from a category where they had previously received no benefits, to one where they received subsidised health insurance premium. This may have positively influenced their opinions on the recognition process.

Nevertheless, according to informant-2, who was at the time a government employee, the challenge on identifying the near-poor resulted from their unstable income. Therefore the recognition might not accord with the real situation.

Liebermann and Wagstaff (2009) study the 2006 Vietnam Household Living Standard Survey and find a regional difference: Poor people living in the north are more likely to be targeted under social schemes compared to those in the Southeast and Mekong Delta. Following this, people living in Mekong Delta tend to remain in the voluntary scheme.

In general, the near-poor perceive the identification process as less fair and transparent than the government claim. This reveals a lack of accountability of the authority, which is an obstacle to increasing the health capability. An accountable recognition process for the near-poor is an important step towards social justice in healthcare. Referring each household to the right category enables certain fairness in health access. However, in order to improve the equality of the scheme, the premium cost should be incremental depending on the average income and not just depend upon dividing the citizens in wide categories such as poor, near-poor and non-poor.

Countries with more advanced bureaucracies have developed systematic methods to access the socioeconomic status of a household. Colombia's *Sistema de Identificación de Beneficiarios* (SISBEN) is a national income survey, periodically investigating assets and income of every household. Despite being costly, this system nonetheless prevents frauds by the local governments, which were typically witnessed in Thailand or the Philippines (Hsiao et al. 2007). The original SISBEN collected 62 variables including housing, family structure, labour participation, insurance, education, and recreational activities. The data is subsequently used to assess those who are eligible for subsidy. In Mexico a similar system has been applied: Upon affiliation the household-head must fill in a socio-economic scheme. The families are then classified in ten categories; the two poorest groups are completely subsidised; whereas for the others the contribution is incremental (Gallarega et al. 2010).

While the recognition process in itself is controversial, the benefits offered are also a source of debate. Near-poor people receive less social assistance compared to the poor. The economic situation and the limited government support make the near-poor very vulnerable to catastrophic health expenditure. The informants expressed that their income did not allow them to obtain decent living, let alone paying for expensive healthcare.

## **5.2 Health functioning**

Health functionings are measurable conditions of health (Ruger 2010a). I asked the informants about their health history because I assumed this would impact their decision whether to buy social health insurance. Most of my informants were between 35 and 40 years old, seven of them were over 70 years. Eight had at least one chronic ailment, among these some had several types of illness at the same time. This is consistent with the changing pattern in the Vietnamese epidemiology, with a strong increase in non-communicable chronic diseases due to the ageing of the population and changes in the lifestyle (Nguyen 2011).

Chronic diseases are especially high among the rural population and they are one of the main causes for catastrophic health expenditure (Hinh and Minh 2013). Diabetes and high blood pressure were reported from informants-2, 3, 5 and 9, in addition to other health problems such as: anaemia, chronic obstructive pulmonary disease, sciatica, osteoarthritis, chronic renal failure, high blood pressure, stomach pain, and other illnesses. The household of informant-7 had a member injured from a traffic accident and another one with mental illness. Informant-8 was diagnosed with cervical-spine degeneration, stomach ulcer and other spinal problems. She said: “When the pains come, I just wish I had a grenade to hand so that I could destroy myself.”

Poor health reduces productive time, in the sense it limits the time one can take part in an activity. Being ill, one may not be able to maintain a job and therefore loses income. Among my informants, informants-2 and 18 said that poor health prevented them from working to earn income and they could only manage minor chores at home. By contrast, informant-9, who suffered the symptoms of diabetes without any treatment, managed light jobs in a food store; and the injured member in informant-7 household undertook menial work at construction sites.

The ill near-poor have reduced health functionings which hinder them from improving their health capabilities. According to health capability paradigm, more resources should be allocated to poorer individuals with health needs in order to increase their health capabilities and their health agency.

### **5.3 Health agency: The near-poor’s choice of participating in social health insurance**

Health insurance was not a new concept to the near-poor I interviewed. All of my informants had heard about the benefits of social health insurance, both through their own experience or through stories from acquaintances. Except for informant-16 did not know about how to enrol into the scheme; informant-9 did not know how to use the insurance, her subscription was bought by her daughter; informant-10 did not know what the benefit package included. The remaining informants, especially those who experienced the treatment had a good knowledge about the scheme.

The near-poor make their decision based not only on speculation, but also on their knowledge, which is a feature of health agency. This shows that at this basic level, the local public health agencies work efficiently in making people aware of the scheme and its opportunities. However, it is important to note that this varies across areas.

## Premium

An important factor in influencing the near-poor's decision was the annual fee for social health insurance. As mentioned in chapter Four, the premium for near-poor in My Tho city increased four times from 2011 to 2012 following the termination of World Bank Health project and the increase in the national minimum salary. Consequently, these changes have posed difficulties for the near-poor.

Many informants said that they were worried because the registration fee was expensive. Informant-13 told that so far she was the only one to renew social health insurance in her neighbourhood; other households were still hesitating because they had to pay for several members, and it therefore constituted a large sum, whereas their income at the time did not provide them with enough food. This shows that the premium is a burden for near-poor households with several members.

“I think the scheme is helpful, because while other people have to pay more than 500 000 VND, I pay only a bit more than VND 100 000. But even so, I do not have enough money to pay for the premiums. Few years ago, the premium was only a few of ten thousands for a person, this year it is more than a hundred thousand.” (I20)

Similarly, informant-1 claimed that health premium was relatively large for the income of near-poor households thus it was far from being fair and equal. To allocate budget for buying social health insurance cards, informant-2 said she had to save from food money given by her son; whereas informant-20 said they had to borrow money and later pay it back by saving the remittances sent from his son and daughter. Informant-20 said they would borrow money to pay the premiums if they were short of it at the time. They might reduce food intake as in the case of informant-3 or face debt or education withdrawal. This process of impoverishment can threaten the future of a household (Segall 2002).

Informant-18 expressed that the premium was the first obstacle that discouraged his son to join. The household said they could not buy it for him, even though at the time the premium was only 40 000VND. Informants-10 and 16 expressed uncertainty about renewing their subscriptions due to the increased premium price. Having been without social health insurance since the last one expired few months earlier, informant-14 said that her family could not afford renewal yet and if they had known about the price increase, they would have saved for it. They did not receive notice from the local government in time. It is important to note that at the time of the interview no member of this household was sick. By letting the near-poor struggle alone to find strategies to pay for the premium, the government shows that they lacks of enough interaction with the citizens in order to enable their health agency

Informant-24, however, thought that the premium was reasonable, neither cheap nor expensive. Informants-2 and 7 expressed that the government had done well in providing such a reduced premium to the near-poor, considering that the country was still poor.

Nevertheless, the majority showed that they were interested in buying social health insurance; the willingness to pay for social health insurance is however different from the ability to pay (Segall 2002).

By offering a premium which is perceived as unaffordable by the majority of the near-poor, the government does not remove barriers to usage of healthcare and maintains inequity. The lack of insurance or discontinuous insurance not only gives insufficient protection but also creates barriers to receive necessary and appropriate healthcare (Ruger 2007).

### **Demand of social health insurance due to pricy healthcare services**

Fees for healthcare are increasing substantially. Meanwhile, standard salaries are not increasing as fast, making health insurance the primary solution to accessing healthcare at a reduced price. All of the informants mentioned this reason during the interview. The followed statement from informant-11 explicitly expressed that:

“I joined social health insurance to protect myself in case of being ill. Nowadays if you need to receive treatment, it costs no less than a million [VND]. With social health insurance, I would spend less if unfortunately I had a serious illness ... Without social health insurance I could not afford the costly treatment.” (I11)

This is in line with the study by Jehu-Appiah et al. (2011) on equity in Ghana’s health insurance. They found that the main reason cited for enrolment was protection against illness. This shows that the near-poor acknowledge their limited payment capability which can prevent them from using the increasing expensive healthcare. In Ruger’s paradigm, health agency is to make use of the given resources to achieve the maximum level of health functioning. This maximisation tendency is in line with the neoclassical theory on social health insurance demand. Health insurance gives the near-poor access to expensive healthcare treatment which they might not be able to afford without co-sharing from the insurance.

### **Adverse selection**

Nearly all those who were sick were equipped with social health insurance and were using coping strategies such as borrowing in order to stay into the scheme. According to Acharya et al. (2012) adverse selection is inevitable in voluntary social health insurance. On one hand, people with higher risk enrol on their own will. Many informants with poor health functioning

relied on the scheme to have regular check-ups and medications which they received free of charge or on discount. This is illustrated by the case of informant-3 as she opted for social health insurance for the treatment of diabetes:

“After having had treatment at a private clinic for a month, I was advised by the doctor to have social health insurance as this ailment [diabetes] is life-long lasting, private treatment will be very costly.” (I3)

The government promote enrolment for people with poor health in the scheme in order to prevent catastrophic health expenditure. As a consequence, Liebermann and Wagstaff (2009) find that healthcare utilisation and government expenses for inpatient and outpatient care have increased since the introduction of the social health insurance. The authors also assess whether illnesses increased the opportunity for different population categories to be enrolled in a health insurance scheme, thereby hinting at an adverse selection process. They find some positive correlation in the group of children under six years old and Decision 139<sup>15</sup> beneficiaries. The authors also find that voluntary enrolment of farmers and Decision 139 beneficiaries drove the social health insurance scheme to a deficit with no signs of improvement. However, this can be viewed positively in the sense that the individuals are able to identify their health problems (internal factor) and obtain health services (external factor). In contrast, the near-poor with good health tend to opt out of the scheme, which creates a loss for social health insurance fund and may lead to catastrophic health expenditure in case of sickness. In almost all the households of my informants the young and healthy adult members of near-poor households were without social health insurance. The common argument was that they were not likely to need it.

This attitude shows a limited value attributed to health and a lack of vision regarding one's future health and the unpredictability of events such accidents. Liebermann and Wagstaff (2009) find similar responses for not enrolling in the voluntary social health insurance scheme, even among workers in the formal sector and people under Decision 39, for whom the insurance should supposedly be mandatory. This opportunistic perspective is a short-coming of every voluntary health scheme and can only be fully tackled by gradually making social health insurance mandatory.

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<sup>15</sup>PM Decision 139/2002 on healthcare for: the poor, people economic-social regions that are in severe difficulty, and minorities on the central highland.

### **Taking benefits from the near-poor policy**

As mentioned earlier, to encourage the near-poor to join social health insurance, the government provide them with a subsidised premium and has local social health insurance collectors to popularize the scheme. This is proved to be one of crucial factors to attract the near-poor's participation. It also shows that, at least in this aspect, the government is attempting to enable individual's health agency.

Informant-13 participated through the recommendation of the social health insurance collector in her neighbourhood. Similarly, informant-5 said: "As long as they still offer subsidised premiums, we will pay them. We cannot afford the regular premium."

At the time of the interview, many informants had been buying social health insurance for more than four years, since the social health insurance scheme for the near-poor came into effect. In addition, there were newly-recognised near-poor households, such as the ones of informants-8 and 9 who have joined since 2010. Informant-3 awaited the official recognition of her household before buying the social health insurance for her two sons as well. Unlike informant-3, informant-21 was removed from being near-poor earlier that year and expressed that she was hesitant to renew her social health insurance without subsidy. It should be marked that the near-poor who were previously non-poor appreciated having subsidised premium more than the erstwhile poor. Informant-20 claimed that there was no difference in benefits between being poor or near-poor. Similarly informant-24 explained:

"Being a near-poor, I do not receive much assistance. If I say this to them [the authority], they may think that I am arrogant. It does not make any difference to be recognised or not. If I do not receive the benefit, somebody else will receive it, and that is good enough."(I24)

The helplessness expressed by this informant reflects a bureaucratic system where the appeal over a decision is not contemplated; the government appears to minimise the dissent in public opinions. Despite this, a form of social solidarity is still preserved and the well-being of someone else remains valuable.

Informant-9 reported that she had not heard any campaign about the scheme by the government and therefore lacked information in order to make a decision. The reported lack of action by the public health facilitators is an external factor affecting health capability, which is consistent with the commonly encountered barriers to subscription of social health insurance scheme (Sinha et al. 2006).

Mathauer et al. (2007) in a study on Kenyan workers perceptions regarding social health insurance found that the main barrier to subscription was the lack of knowledge regarding the

scheme, its benefits and enrolment procedure. However it is important to note that only few informants reported this problem.

Informants had therefore different accounts regarding the extent to which the public health interacted with them in order to build and enable their health agency. Most of them stated that the government did some campaigning for the scheme. However, the majority still considered the premium too high.

### **Mutual support**

Some informants recognised that participating in social health insurance was a way to contribute to their fellows in the society. They reasoned that even though they did not use their social health insurance during the year, the money was used for other people who were in need of healthcare. Informant-13 was an example. During the interview, she also gave examples of her friends who were doing the same:

“I must buy social health insurance to support those who are sick. A friend of mine whose eight family members are all healthy, all have social health insurance, but never use it. She says we contribute to the fund to support others, those who are poor. It is a mutual support. If I said that I am not sick therefore I will not buy social health insurance, then how can we create the fund?” (I13)

From a cultural perspective, the majority of Vietnamese people highly value moral principles and apply them in their lifestyles. With respect to the issue of social health insurance from the participant perspectives, solidarity emerges as the near-poor are willing to share their limited resource with others who are in difficult situations. This shows a presence of social networks and social capital among the community members, an external factor which may potentially improve their health capability, especially if used for collective action. It can also be seen as the shaping of a public moral norm regarding health insurance (Ruger 2010a).

Jowett (2003) investigates whether there exists a connection between household social capital and the probability to subscribe to voluntary health insurance. In his study, social cohesion was measured through the rating by the informant, whereas informal networks were assessed based on the source from which the informants have borrowed money. His data from the informants in Dong Thap (a province on the Mekong Delta) show that the more cohesive a community is, the less likely it is to buy social health insurance. In this case the informal networks negatively impact health capability by crowding out potential members of health insurance, thus preventing them from enrolling in a safer scheme. On the other hand, when heterogeneous networks are denser, it is more likely that the household will buy social health



insurance. The findings are therefore inconsistent and require further research in order to assess whether a form of collective action is taking place.

### **Health norms**

The described mutual support also indicates a change in the values and norms of the near poor. Informant-6, who was also the social health insurance collector in her own ward, observed the pattern change in the way people in her neighbourhood considered having social health insurance:

“Previously people would not buy social health insurance even though social health insurance sellers used up all their words to persuade. Nowadays people look around and hear from their acquaintances, who have experienced a period of sickness, and decide to follow by themselves. There is no campaign about the programs. Even people who are in short of money also try to buy social health insurance because they see the potential benefit.”(I6)

As Ruger (2010a) corroborates, external factors such social norms regarding health influence the society health outcomes. In this case, the informant described a change in the mindset of the people in the neighbourhood turning the social health insurance subscription into a social norm. This contributes to an increased health agency of this group because the people become more aware of their health necessities and with a vision for the future, voluntarily decide to subscribe to the insurance scheme. Health becomes a valuable goal and the community members activate strategies in order to attain it. I suggest however that is not yet the case for young adults, who prefer to stay out of the social health insurance, but further research is necessary.

### **Discussion**

On the process of socialisation of public healthcare, Vietnam’s social health insurance premium has been on the rise over the years. As argued in chapter three, socialisation in Vietnam has become a way for the government to relocate the financial burden onto its citizens. When it comes to the near-poor, it shows a negative effect on their participation as many are unable, hesitant to join or have to borrow money or sacrifice other consumptions in order to finance the health premium. The majority however show a willingness to subscribe due to consideration of health as a valuable goal.

Somanathan et al. (2013) comments that near-poor, like the poor people, face barriers on accessing healthcare (consequently leading to lower utilisation relative to need), which is the result of a high degree of fragmentation of pooling and revenues. The authors also find that

public subsidises in terms of hospital services has become less pro-rich during 2006-2010 and that the redistribution system has become pro-poor.

Wagstaff (2007) states that enrolment still faces problems, even when free insurance is offered. Instead, participation rates depend on multiple factors, namely income, illness history, campaign for social health insurance, perception of the quality of treatment and sometimes even ethnicity. All of these internal and external factors have a place in Ruger's health capability paradigm, under the terms of health agency, health functioning, material circumstances and health social norms.

The thesis' findings contradict results found by Acharya et al. (2012) regarding the influence of illness history on choice of insurance. After studying 34 researches on social health insurance for the poor in developing countries, including Vietnam, the authors find that initial conditions such as chronic illness, do not play any role in decision making. Meanwhile, in my research, I find that poor health condition is one of the most important reasons that urge the near-poor to buy insurance, as contrast to the healthy and young that skip social health insurance. This is consistent with other research by Liebermann and Wagstaff 2009, Nguyen 2008.

In regard to economic background, this thesis finds that the near-poor with low health functionings are likely to have social health insurance despite difficulties in paying the premium, as the cost of not having social health insurance in case of illness is certainly far beyond their ability to pay. The trend differs from the one found by Jehu-Appiah et al. (2011) in Ghana. The authors find that people who consider the social health insurance too expensive will actually not buy it, rather than sacrificing other consumptions in order to be covered. In my research, only two informants were uncertain on whether they could afford the premium.

The thesis agrees with Acharya et al. (2012) that gender of the household and demographic variables do not influence the decision upon buying social health insurance for the household members. A clear pattern observed is that dependent members such as the elderly and children at school age are more likely to be insured than the young and healthy members.

## **Chapter summary**

The chapter has presented portraits of the near-poor. Their incomes are far less than the average, they seem vulnerable towards the risk of being poor; yet they receive only minimal support from the government. However, some of the near-poor have a better economy than others. Some informants perceive that the process of identification as near-poor is unreliable

and that the near-poor benefits are insufficient. In fact the majority consider the premium for subscribing social health insurance too high for their income.

The near-poor subscribe to social health insurance to avoid costly payment, both for outpatient and inpatient healthcare. The near-poor with poor health are more likely to enrol, which lead to the problem of adverse selection. Near-poor benefits, including subsidised social health insurance premium, are among important factors for many to enrol. Several informants justified their subscription as a form of solidarity to their fellows, indicating a certain social cohesion within the population. Social health insurance is becoming a health social norm among near-poor households. More people are joining social health insurance because they have seen its potential benefits. However I suggest the social norm has not yet affected young adults. A collective action for health insurance and the young near-poor's tendency to subscribe are suggested for further research. Findings of the thesis have been compared with other studies on social health insurance.

“In the health capability paradigm, health needs map directly to health functioning, which in turn relates to health capability.”  
(Ruger 2010a, p.81)

## **6. Social justice in the social health insurance for the near-poor**

This chapter tries to answer to the second thesis question of how the social health insurance scheme has met the healthcare needs of the near-poor. Needs are considered as “material principles of justice” by Beauchamp and Childress (1994). A need becomes apparent when it is absent. Health needs, particularly rudimental health needs, are important for drafting health policy and resource allocation (Ruger 2010a). Thus, the level of social justice is assessed through the analysis of the extent to which basic health needs are met.

The chapter starts with the barriers that challenge the near-poor in utilising the social health insurance scheme. It is followed by a section on how the near-poor utilise their insured benefits. Finally voices of the near-poor are explored in line with the desired shared health governance.

### **6.1 Barriers in access and utilisation of healthcare**

#### **Long waiting time**

First of all, many of the near-poor have informal work, which implies that they do not have benefits as formal workers have. In case of illness, informal workers will not receive any compensation and they might even lose their jobs to other people. Secondly, the availability of informal work is uncertain and the informal workers have to be ready to work at any time. The same applies to informal business-owners. Their business has to run on regular routines to keep customers.

Informant-11 described one incident: “Once I was trying to have a health consultation, my boss called me to come to work. I had to drop the consultation because I needed money to feed my family.” Similarly, informant-15 told me that she could not leave home for a long time because her customers might come at any time to buy fish sauce. Informant 5—the grandmother who sold fish paste and baguettes in the morning—had to take care of her five grandchildren, apart from doing housework. Waiting for public healthcare services appeared to be impossible for her.

The problem worsened in the case of the elderly and patients with chronic or severe symptoms, at least in two manners. Firstly, their severe status made it very difficult for them to wait. “The hospital is very crowded. I would have waited to death for getting the medicine. I have a heart condition and I cannot wait as long as the young people can”, said informant-2. It is common that Vietnamese people use “death” as a metaphor to imply impossibility. The statement from informant-2 can therefore be interpreted as the impossibility of the informant to queue up for public healthcare.

Secondly, patients with chronic symptoms must have regular check-ups. Consequently, the time spent for queuing accumulates and becomes a heavy burden. It was a shared experience among many informants that they began at the earliest hours of the day when they needed to visit the hospital. For all diabetes patients who were insured and offered primary care at the City’s hospital, Tuesdays and Fridays were the only days scheduled for them. Apart from these days, they had to pay as a service-on-demand. At midnights to Tuesday and Fridays, many patients would go to the hospital to reserve a place in the queue. Informant-3 said she worried about the insecurity of travelling at night; she also had to finish all her household chores such as preparing food and washing clothes the day before. In another example, informant-19 had to travel to HCMC for check-ups, due to his special type of illness. He started about 3 a.m to make his trip and usually was about number 900th in the queue. Despite his condition which required assistance, he travelled alone to reduce the cost of the trip. With limited money the near-poor may not be able to afford food and drink at the hospital during the long hours of waiting, which informant-6 experienced.

By contrast, informant-10 opined that the waiting time was acceptable: “I just wait until my turn, it is quick enough.” Similarly, informant-24 commented that the services were “convenient” as she considered that the problem was due to the shortage of staff.

People with chronic or special illnesses should not be in a disadvantaged position with regard to appropriate healthcare in the view of Ruger (2010a). Given that they are in a condition of utmost needs, they should be prioritised more than people with milder, acute problems. Furthermore, it is peculiar that people with diffuse chronic diseases such as diabetes receives such limited time for primary care.

It has to be taken into consideration that a delay in healthcare can lead to deterioration in the health condition, need for longer inpatient treatment, and consequently higher costs for the hospitals. Weissman et al. (1991) studied the outcome of delay in five Massachusetts hospitals and found that the most disadvantaged, who had a longer waiting time, had longer

hospital stays and potentially worse outcomes. For poorer patients, cost was one of the major reasons for delaying healthcare.

Current public hospitals provide services-on-demand, operated separately from services for people with health insurance. People paying for services-on-demand often have shorter waiting time to receive consultation or treatment. Consequently, as we will see, many near-poor informants decided to pay for private clinics to avoid the queue. This reflects an unequal aspect of the Vietnamese healthcare system following the health capability paradigm's principles, which assert that access to healthcare should be equal and give priority to the ones who need it the most, independently from their ability to pay (Ruger 2010a). Due to this problem, long waiting time when seeking healthcare at public hospitals becomes a barrier to flourishing and financial stability for the near-poor.

### **Difficult bureaucracy and procedures**

Whilst some informants (for example informants-20 and 24) perceived the procedures when using the services of social health insurance as non-problematic, some (for example informants-9 and 18) considered it as a difficult and complicated process, which discouraged their use of the services.

Most of the informants, however, complained about the procedure for referral. Only doctors responsible at the primary health centres could refer the patients to the next healthcare level, but they were reported by the informants to be often absent. Their office hours at the commune/district health centres were limited because they worked also in the city hospital (I5) and they did not publish their working schedule (I12).

Secondly, doctors at the primary level refused to refer patients to the next levels either because they tried to cure the illness themselves as in the case of informant-4, or because they followed the directives from the Ministry of Health, in order to reduce the overcrowding at higher-level healthcare centres.

These create more difficulties for the near-poor patients as they need to recover good health as soon as possible to get back to work. The near-poor opted for bypassing, bearing a higher co-payment. This increases the near-poor's financial burden.

Procedural barriers have been found to be a general problem in Lao PDR (Paphassarang et al. 2002). This has an impact especially on the poorer, who are unaware of the procedures for fee-exemption and did not received help by the healthcare staff.

In Korea, a form of mandatory referral system was implemented in order to counterbalance the habit of the Korean to consult directly the hospital rather than the local ambulatory.

Patients had access to hospitals only if referred by the general physician. The policy seemed to have had an effect. However this was short-lived; and soon the Korean returned to their original patterns of utilisation, despite having to pay the complete fee for the services (Yu and Anderson 1992). Similarly, in the Thai referral system beneficiaries are required to seek the primary healthcare; or they have to pay fully for the services they need (Li et al. 2011).

### **Quality of healthcare**

The informants' perceptions on the received treatment indicate another external important barrier to the near-poor's health capability. This section discusses the quality of healthcare for outpatient/inpatient care and medical prescriptions which emerged as important issues shared by many informants.

#### *Negligent healthcare practitioners*

When it comes to outpatient care, some of the near-poor complained that doctors neither made careful check-ups nor consultations. Informant-11 said: "They asked a few questions, which was just as if I went to a pharmacy store, they did not make any examination." Sharing a similar experience, informant-13 came up with a strategy. She took laboratory tests at private clinics and presented them to the doctor. In that way, she said that she received a more thorough consultation. Not all patients could come up with this idea. Consequently, patients felt that their healthcare needs were not fully responded to. For example, informant-24 said that the doctor refused to do a complete check-up. In her own words: "I had pain all over my body ... They only examined my shoulders. I asked them to check my legs, but they refused to do it."

Informant-1 experienced another type of negligence. He reported that when he brought his son, who lacked appetite, to the commune health station, the doctor said that he should starve his son until his appetite would return. The informant said that this was unacceptable behaviour and he never sought healthcare at the commune health station again.

In her account of healthcare, Ruger (2010a) seems to take for granted that the doctors will follow the Hippocratic Oath and always seek their patients' best interest. As we can see, this is not always the case and often the patients' ability to draw on their social networks and activate strategies—like the case of informant-13—determines the quality of the healthcare received. On the provider side, in addition to an ethical stance, Ruger (2010a) suggests the use of well-established clinical guidelines, which would help prevent arbitrary prescriptions to the patients and provider-induced moral hazard. Return to the study in Lao PDR by Paphassarang

et al. (2002), participants found public services procedures complicated and the staff unfriendly towards them, and therefore the participants preferred private clinics.

### **Inequality in service provision**

This negligence issue is not uncommon in hospitals all over Vietnam, which is portrayed frequently in public media. Because patients have less trust in healthcare at commune levels and preferred healthcare centres at district or provincial levels, they add more constraints to the overcrowding of those levels. From the perspective of the patients, the healthcare system appears unequal in terms of providing its services to the citizens.

“They do their jobs better there. For example if I need a blood transfusion, in HCMC they will have my blood type, which hospitals in Tien Giang do not have.” (I19)

Having explained this, informant-19 said that he preferred to have his health check in the HCMC hospital.

Peripheral areas witness a lower quality of healthcare compared to the core. It has been recently estimated that half of the Vietnamese medical staff is located in urban centres, despite 70% of the population being rural. Among other reasons, Ramesh (2013) argues that healthcare staff do not have incentives to work or invest personally in the country’s health centres as they do in the city’s hospitals by personally buying equipment in order to produce revenues.

To counterbalance this trend, Thailand obliges new medical graduates to work in rural areas for three years, adding to the well established network of health volunteers and nurses in remote rural areas; despite this being a good policy, the shortage of medical personnel in rural areas is still an issue (Li et al. 2011).

Inequality in healthcare also occurs in healthcare staff’s reception of patients. Informant-2 criticised that the staff discriminated against insured patients and favoured patients who paid for services-on-demand. Informant-13 said, based on an experience from her acquaintance, that: “The social health insured inpatients were left to stay on their own with a few tablets, without nurses taking care of them.” Informant-18 perceived it as unjust that the first numbers on the health insurance card specify the co-payment of the card holder: “Number 02 specifies that your co-sharing is 0%, 04 is for 5% and 07 is for 20%.” In his opinion, the numbers were used by the staff to discriminate among the patients. This practice was justified by an officer I interviewed to serve for accounting purpose only (Fieldwork interview). This mismatch signals the asymmetric information between the provider and the insured and the lack of



transparency in the procedures. From the near-poor's perspective, the perception was that they were treated unfairly.

In the past, insured patients were reportedly neglected by hospitals because they were not paying enough fees (Ensor 1999). Ramesh (2013) maintains that the Vietnamese providers are focused on offering the patients services that are as expensive as possible, generating an inefficient allocation of resources and an unnecessary burden on the households. Consequently, healthcare staff overlook patients who are unable to pay.

### **Corruption**

An almost insurmountable barrier perceived by the near-poor was the corruption of healthcare staff. The fact that patients are supposed to bribe doctors and nurses for better care is not uncommon in Vietnamese society. Informant-18 talked bitterly about the issue:

“You have to put money into the pockets of the doctors, then they will take care of you, otherwise they will just ignore you. The rich can afford that, but the poor cannot.” (I18)

For the near-poor, this leads not only to discouraging their use of services covered by the insurance, but also reveals the inequity of the healthcare system. A survey in 2010 by Vian et al. (2012) find that 28% of the citizens had paid bribes in hospitals during the past year; 70% of staff interviewed by the Medical University of Hanoi admitted to have accepted or asked for bribes, or “gifts”. The authors explain that the structural reasons for corruption include overcrowding at the tertiary level, which drives the users to bribe in order to skip the queue; underfunding of public entitlements; low salaries for providers; and lack of transparency. The authors also point out a number of initiatives to counterbalance corruption in healthcare: Ha Noi National Hospital for Paediatrics has promoted anti-corruption initiatives at the participant level through a patient feedback system; users responded positively; and the data was used to identify issues for problem-solving.

A report by the World Bank (quoted in Nguyen 2008) demonstrates that in developing countries like Vietnam, informal payments to get a better and faster treatment are a norm. Consequently, people perceive that using health insurance will lead to lower quality treatment. By contrast, according to Li et al. (2011), corruption in the healthcare system is not necessarily the norm in developing countries. In Thailand, for example, it did not emerge as an issue, but monitoring must continue.

### **Out-of-pocket payment**

The near-poor rarely have large savings, as chapter Five reveals. To cope with costly co-payment of treatment, all of the informants (except informant-10) reported that they had to borrow money from their acquaintances. The example from the experience of informant-7 is a case in point. When her husband had a traffic accident, he had to go through many operations in order to regain mobility in the legs. Each time before the operation, the hospital asked her to deposit 10 million VND. She had to ask everyone she could and eventually accumulated a huge debt. If it had not been for the help of a charity fund, she “could have washed clothes for the people at the hospital to pay back the money” (I7). This informant’s inability to pay demonstrates that the near-poor can hardly afford large out-of-pocket payments by themselves.

Furthermore, the situation could lead to a stigmatisation of the near-poor, as in the case of informant-16. When her younger son was hospitalised some years ago, she could not afford to pay the fee. She had asked her acquaintances, but they disrespected her and did not lend her the money. She then had to write a commitment letter to the hospital, promising that she would pay the fee when her older son managed to borrow the amount from his boss. She said she would never forget the experience.

It is extremely unjust that treatments related to central health capabilities can be accessed only after having paid a large amount of money, despite being covered by health insurance. In this case a single major accident can lead to catastrophic health expenditure and impoverishment of the household, jeopardising the initial purposes of the social health insurance scheme.

Out-of-pocket payment is a serious issue in Vietnam, hindering necessary healthcare utilisation. It is proven to have negative effects on healthcare utilisation by the poor, as has also been found in other countries (for example in the study by Paphassarang et al. 2002), and should therefore be put under control by the government. Whereas Nguyen et al. (2012a) estimate that health insurance scheme reduced out-of-pocket payment by 18%, Lieberman and Wagstaff (2009) find a reduction of 25%. The authors indicate also a limited reduction of catastrophic health expenditure. The main reason why the insurance scheme has not dramatically reduced out-of-pocket payment is that medicine accounts for most of the expenses, together with spending on private providers. The government should therefore not only expand the coverage to more citizens but also deepen it so that the out-of-pocket payment will be reduced. However, it should be noted that Lieberman and Wagstaff (2009)

consider that health insurance covers only medicines during inpatient treatment (page 86), which differs from the information that this thesis obtains. (Chapter Three has described the benefit packages of health insurance which cover also medicine for outpatients, on the condition that these medicine are on the list of the Ministry of Health.)

The Mexican health insurance scheme, the Seguro Popular (SP), has shown some success in reducing out-of-pocket payment and catastrophic health expenditure (Galarraga et al. 2010). Before 2001, the Mexican health insurance scheme was covering only employees in the formal sector, whereas self-employed and informal workers had to attend government sponsored facilities or pay on their own for private facilities. Policy-makers were convinced to introduce a voluntary scheme for poor families to moderate the high rate of out-of-pocket payments, catastrophic health expenditures, and the highly limited access to costly healthcare. The scheme aimed at universal access to specialised healthcare and quality improvement on the supply side. It was first implemented in five states and then gradually expanded to all the 32 Mexican states, covering twelve million people. The scheme was funded by federal and state governments, but individuals contributed depending on their ability to pay, evaluated through a socio-economic questionnaire. The scheme covered 250 diseases and related drugs, prevention, ambulatory care, pregnancy and delivery, dentistry, hospitalisation, and urgent surgery. A survey for 2005–2006 concludes that the Seguro Popular had a strong protective effect on catastrophic health expenditure. With regards to out-of-pocket spending, the insured households spent less on outpatient services, whereas the effect on hospitalisation expenditures was not significant. When it came to out-of-pocket payment for medication, the protective result was ambiguous.

### **Medication**

In Vietnam, insured patients receive medical prescriptions which often include many types of medicines. Whether the amount of pills is appropriate is beyond my knowledge to discuss. The focus here is the quality of the medicine as perceived by the informants. There were two sets of contrasting opinions.

On one hand, some perceived that medicine provided under health insurance was of good quality. This experience was shared among those with chronic illnesses such as diabetes, high blood pressure, or cardiovascular problems. Informant-12 even observed a moral hazard among patients who claimed that they were sick to get medicines, which they would sell to private pharmacies for a good deal of money.

On the other hand, some complained that the prescribed medicine covered by health insurance was of poor quality. Informant-5 spoke with anger about the medication he received:

“The medicine they gave me cost 2000 VND and they are not effective ... I needed to buy the one that costs 9000 VND out-of-pocket. They do not give the medicine that is suitable to the patients. They always say that they do not have that type of medicine or do not have enough of it” (15)

This view was shared also by informant-14, who said that the prescription given by the social health insurance was worth little money. Informant-3 experienced that the medicine covered by the social health insurance did not reduce her pain as well as the medicine she bought from private pharmacies. Informant-24, less straightforward, commented with a rhetorical question: “Is the medicine of bad quality?” I interpret that she did not want to say it openly, even though she might consider the medicine were of bad quality.

Another medication issue reported by informant-5 was that the health station provided medicine only for a period of five days, even though she had high blood pressure that required medicine every day. As she had to work and the health station had limited opening hours, she often had to borrow medicine from her husband.

In Vietnam, the government allocates a disproportionate 60% of social health insurance to medicine expenditure. The Ministry of Health claims that the out-of-pocket payment share of the total health expenses for 2009 was 49%, and that the trend is decreasing (Vietnam Ministry of Health 2009). Of this, 40% is spent in self-medication whereas 60% is equally divided among public and private facilities (Ramesh 2013). The government has a weak control on medicine promotion and costs. Coupled with the incentives to sell them, over-use of medicine is not uncommon. As a result, the prices of medicine sold to patients in Vietnam are 46 times higher than the international reference for brand-name drugs and eleven times higher for generic drugs. This is even more problematic since the generic drugs are less available in public health facilities. Medicines are more expensive in public facilities than in private ones and unaffordable for the lowest-paid government workers, not to mention for informal workers (Vian et al. 2012).

The problem of medication cost is not exclusively Vietnamese. In India, households were found spending five times more for medications than for in-patient treatment (Nguyen et al. 2012). In Mexico, outpatient care and medication were the major reasons for catastrophic health expenditure (Galarraga et al. 2010).

### **Geographical barriers**

Two informants in the countryside reported that they seldom visited the healthcare centres because of the distance. One of them hired a *xe om* (motorbike taxi) when he needed to visit the health centres. It should be noted also that the roads leading to these households were muddy and slippery when it rained. This could also prevent their ability to travel and seek for healthcare.

In his study on the impacts of the social health insurance, Wagstaff (2007) does not find a significant impact on use of inpatient care for the poorest decile of the population. He speculates that the poorer are often living in remote rural areas. The costs of time-loss and for transportation are too high. Therefore it hinders the access to healthcare. This problem can be addressed by subsidising transport costs for the poor or, more controversially, paying them when they are using healthcare. In fact, the social health insurance covers transport fees for the identified poor. The government should consider expanding the support to the near-poor in rural areas, given the inequality in infrastructure development and public transport between the rural and urban areas.

## **6.2 Social health insurance utilisation by the near-poor**

With the barriers listed above, the near-poor were found to use their health insurance in various ways.

### **Chronic and serious symptoms**

The near-poor with chronic or serious illnesses used health insurance more frequently than other near-poor people without these conditions. Informant-8 visited a hospital every seven or ten days. Informant-5 said that he visited it so often that he could not count. Informant-19 travelled to the hospital in HCMC every month. Informant-3 had her diabetes check-up every month. Informant-20 frequently asked for medicine at the commune health station. The social health insurance thus played a crucial role in maintaining health functionings for these informants. Informant-8 said social health insurance saved her life because otherwise she would not be able to afford private treatment or full price. Similarly, informant-16 said she would not have sought healthcare without the social health insurance.

For the near-poor without chronic conditions, the long waiting time at public hospitals made them use social health insurance only in case of serious conditions. Informant-12 said:

“When I have serious symptoms, I will seek healthcare at private clinics first. If it then appears that I need to go to the hospital, I will use the health insurance.” (I12)

Informants-1, 2, 4, 6, 11, 15, and 18 also expressed that they intended to use the social health insurance only in case of health shocks which required hospitalisation. In other words, social health insurance was perceived by many informants as “bought to spare” for treatment of serious diseases.

These opinions reveal that social health insurance is necessary for the near-poor in case of expensive treatment. By that, it increases the near-poor’s ability to utilise the healthcare system, and therefore improves their health capability regarding chronic and serious symptoms. As we have seen, however, it does not prevent out-of-pocket spending in these situations.

In an empirical investigation of health insurance utilisation in Vietnam, Nguyen (2008), using the data of the Vietnam Household Living Standard Survey (VHLLS 2006), finds that on average, users used their insurance six out of ten times that they visited health facilities in order to get outpatient treatment; and eight out of ten times when in need of inpatient care. Specifically, the near-poor used their health insurance cards 9% less than the poorest when it comes to outpatient treatment. Nguyen (2008) suggests that this is consistent with the perception that the treatment paid with insurance is of lower quality. The near-poor in my research show a similar tendency.

### **Usage of social health insurance for acute and mild symptoms**

Few informants used social health insurance for acute and mild symptoms. Informants-10, 16, and 20, who were among the poorest of the near-poor in my fieldwork, said that they asked for medicine at their commune/ward health stations.

Informant-21 said that, even though she used social health insurance, she preferred to pay extra for the consultation as a service-on-demand to skip the long waiting queue. In other cases, informant-8 and 24 chose to bypass the primary level to seek healthcare at the district level, despite having a higher co-payment. This behaviour indicates that the near-poor rely on public healthcare, although they had to compromise their financial resources when seeking the services they needed.

Other informants compromised in other ways. Most seriously, they ignored their sickness. Informant-13 is a case in point. She did not seek any healthcare until she became too weak to maintain her daily job. Even then, she did not visit a doctor, but bought medicine at a private

pharmacy. This behaviour of self-medication was reported also by other informants, which is discussed in a section below. In a study about health seeking behaviour, Ha et al. (2002) find that in case of mild sickness or injury, 70% of the people did not seek care from any formal source. As discussed above, this can eventually decrease individual health functioning and capability.

### **Seeking healthcare at private clinics**

The near-poor with informal jobs do not have sickness compensation. They need to be healthy to maintain their jobs every day. In the words of informant-8, “Even when I have a cold or a headache, I need to seek treatment. Otherwise, just a day without working may turn into a disaster.” Many informants sought healthcare at private clinics as they provided quicker treatments and were available outside regular office hours. In some cases the informants had been long-time patients of private doctors.

“I never use my health insurance, not a single day. If I get a cold or a fever, I go to see a doctor I know. It is doctor X, her clinic is in the neighbourhood. My children have not been to a public hospital either, they do not have the time.” (I6)

Similarly, informant-2 and 24 said that they only sought private clinics when felt ill. Informant-21 said she did not any more seek healthcare with health insurance, as she had done in the previous years. It was because she changed to a new job with a schedule overlapping with the public clinics’ opening hours.

This is consistent with findings in the study by Ha et al. (2002): Patients with severe illnesses longer than four days used private clinics less than public services; and people older than 56 years were more likely to seek private care. However, it has to be stressed that these data is from a 1997 survey. The patterns of consumption have changed since the introduction of social health insurance. In addition, households with several sick members appear to use less public healthcare (Sepehri et al. 2008) and to prefer private facilities (Ha et al. 2002).

Subsidised healthcare seems inaccessible for the near-poor. Their choice might be driven by a perceived lower quality of the treatment as discussed above. The government has to improve the access and the quality of public healthcare—external factors—compared to those of private clinics, so that the patients will have more positive expectations—internal factors—to achieving health outcomes.

### **Self-medication**

It was not uncommon that the near-poor informants bought their medicine from private pharmacy stores, which were readily available and required no waiting time. This also meant that they spent out of their pocket for medication. Informant-15 said:

“When I have a light sickness, I always buy medicines at pharmacy stores. Nowadays many people visit hospitals so there are long waiting queues ... Only when I am seriously ill I will go to the hospital ... If the medicines I buy do not work, then I will visit the doctor ... My son went to see a doctor for his tonsillitis, as we did not know which medicine to buy.” (I15)

Informant-2, who had chronic heart disease, said he did not visit the hospital for medication again because the process was too long that he could not stand it; in addition to the fact that the doctors always gave him the same prescription. Therefore, he used this prescription to buy medicine at private pharmacies. “It costs a few tens of thousands [VND], but I do not have to wait”, said informant 2. As this statement indicates, self-medication was convenient because it was less time-consuming. However it was not clear whether the patients had enough knowledge in order to perform effective health decision-making with regard to appropriate drug use.

Despite some evidence that health insurance reduced self-medication (Nguyen 2008), there is a general tendency among the poor Vietnamese to rely on self-medication instead of seeking healthcare (Ekman et al. 2008). This trend involves an estimated 40% to 60% of the Vietnamese (Okumura et al. 2002).

Sick people either wait for the illness to ease by itself or self-treat with medicines (Ha et al. 2002). Khe et al. (2002) find that self-treatment was more common within the richest quintiles; and it was the most common practice even in case of severe illness.

Self-treatment has several negative consequences, in particular the risk of drug-resistant bacteria induced by an overuse of antibiotics. Okumura et al. (2002) conducted a household survey involving 505 mothers. They found an overuse of antibiotics and in some cases steroids for all kinds of symptoms, often without consulting healthcare professionals. Informant-9 in the interview was self-medicating for her diabetes. She was worried by periods of pain, yet she never sought healthcare consultation.

### **6.3 Voices of the near-poor**

Ruger’s health capability paradigm proposes a shared health governance, with the involvement of the insured participants in addition to the government and the providers. My



thesis brings forth the voices of the near-poor about a social health insurance scheme that would better serve their specific health needs.

It should be noted that some informants were hesitant to comment on how the social health insurance system should be improved. Two main reasons were given for this. Firstly, the informants thought they would be recognised by the government and would subsequently face troubles when using the public services (this issue has been discussed in chapter Four). Secondly, the informants thought their opinions would make no impact on the social health insurance system, and that all the near-poor were facing the same problems. This attitude reveals a strong feeling of exclusion of the citizens in public policy making in Vietnam.

Nevertheless, many informants raised their concerns firmly, which can be categorised under four main headlines. These concerns stemmed from *all* issues discussed throughout chapter Five and this chapter, regarding the near-poor participation in and utilisation of the social health insurance benefits. Thus, the following section will not reiterate these discussions, but conclude the issues of social justice in the social health insurance for the near-poor.

In spite of barriers in the social health insurance, the majority of the informants expressed satisfaction towards the scheme. Informant-3 and 6 said that the scheme was “very helpful” for the near-poor because it reduced the financial burden for them. It should be reminded that both the near-poor category and the subsidised scheme were relatively new phenomena. Some informants had been moved from receiving no social formal assistance to this experience, which might also influence their opinions about the scheme positively. Furthermore, other informants expressed gratitude to the government because “the government has shown a great effort in taking care of the near-poor, given that the country is still poor” (I2). Sharing a similar opinion, informant-12 commented that: “The co-payment rate is reasonable, we cannot ask the government for anything more than that.” However, he also expressed that: “For the near-poor, 20% of co-payment rate is very large and in many cases they cannot afford it, but in general we have to endure it.” These two statements appear contradictory. I interpret them as if the informant on one hand was taking into consideration the country’s economic situation and acknowledged the improvement in the government policy. On the other hand, he took the near-poor situation into account and argued from this perspective that the scheme overlooked the financial capability of the near-poor households.

### **The premium matters**

Many near-poor informants worried about the strongly increasing price of the premium. Informants-1, 12, 14, 16, and 21 argued for a reduction in the price of the healthcare premium. In addition, informant-21 desired a reduction also for the low-income population, especially those who have just risen from the near-poor group. In her opinion, this subsidy could be less than a subsidy to the near-poor, yet it would help the low-income group's ability to subscribe to the health insurance.

Informants-1 and 6 proposed that the premium should be lower for those who have been in the scheme for a long time, especially those who have not used the services, but constantly contribute to the health insurance fund for years. Ruger (2007) warns against an experience-based premium because it can promote injustice within the scheme. The premium should however always be proportional to household income.

Informant-7, 16, 19, and 20 had concerns over a free premium for the elderly from 70 years old, instead of 80 years old, as is the current policy.

In particular, informant-18, who was a war veteran, suggested an adjustment of the policy for the veterans such that they will get free healthcare card regardless of whether they could prove their war contribution.

### **The co-payment matters**

In the same vein as with informant-18 discussed above, informants-11 and 15 commented that the current rate of co-payment overestimated the near-poor's ability to pay. They suggested a total healthcare fee exemption for the near-poor, given that they have paid their contribution through the premium. Informant-8, on her part, desired a lower co-payment rate: "I would be happy if the authority could consider a reduction on co-payment, for example 15% instead of 20%, and less for people in the rural areas." In addition, informant-13 suggested that co-payment for serious illnesses such as cancer should be reduced, because these patients needed special medicines, which are often very expensive.

The case of informant-7 presented earlier showed that the near-poor had to get indebted to cover for large healthcare expenditure. Similarly, several informants said that they would take up loans from their relatives, acquaintances, or hoped for charity. A few even expressed that in that case they would not know what to do. I interpret this as an expression of their feeling about their vulnerability and insecurity, which undermine their flourishing. In a possibly extreme case, informant-13 said that: "If I had a serious illness, I would just die ... I would not be able to afford treatment." (I13)

It must also be noted that this insecurity does not only linked to the prospect of high expenses. A qualitative study with follow-up interviews by Nguyen et al. (2006) shows how catastrophic health expenditure was often the result of a series of everyday communicable illnesses, rather than one serious event. A quantitative study by Nguyen et al. (2012b) uses the capability approach to analyse how healthcare costs affect consumption and reduce other basic capabilities. The study population, almost 700 citizens of a rural commune in North Vietnam, was divided into income quartiles, and their patterns of expenses were analysed. A reduction in food consumption was observed in the poorest quartile for inpatient treatment. This can eventually lead to a worsening in health condition and functioning with regard to work and school. A similar trend was observed in the other quartiles, among those who received intensive outpatient treatments which required several outpatient visits. In addition, households experiencing at least one inpatient treatment saw a reduction in their expenses for education and farming. Therefore they lost the skills and resources for pursuing an economic stability. This reduction was most significant for the poorest quartile. The other quartiles facing inpatient treatment appeared to reduce expenses for construction and improvement of shelters, and slightly increase their food consumption.

Similar results are found in another study by Segall et al. 2002 on 656 households in four Vietnamese rural communities. The study used socio-economic and healthcare seeking survey, semi-structured interviews, and had a six years follow-up. To meet the costs of healthcare, families had to regularly sell assets, borrow money, reduce their food consumption, and withdraw their children from school in order to send them to work. This study also points out how two-thirds of poor people's healthcare expenses, both inpatient and outpatient, were on inexpensive ambulatory healthcare, but the cumulative burden was higher than unit costs for hospital treatment.

The patterns of reduction in food, shelter, or children's education are described as common throughout developing countries, where a relatively small expense for outpatient care and medication can lead to a financial catastrophe (Xu et al. 2007).

### **The healthcare service matters**

Informants-1, 2, and 13 requested fairer treatment towards insured patients and public services should be as good as private services. Health workers should pay more respect to patients. In terms of medication, informants-5 and 6 hoped that they would receive more effective medicines so that they would not need to spend out of their pockets, which were already very limited. Informants-4, 14, and 24 argued that the procedure for referral should be

made easier, so that the patients could employ fully their benefits in emergency cases in which it was impossible to consult the primary care. Last but not least, informant-3, 6, and 16 suggested that there should be more doctors at public hospitals to reduce the waiting queue.

The perception of the near-poor on quality of healthcare coincides with the poor's opinion in a report by Segall et al. (2000): "Public services were better technically, but the private services were more user friendly." Ironically, the practitioners from the public services often are the very same who run their own private clinics. The quality of the service, therefore, depends on the economic benefit, rather than the providers' skills. As argued above, one of the reasons for bribery is the low salary received by the staff.

Social justice exists at the foundation of the Vietnamese social health insurance scheme for the near-poor. It is the government's intention to encourage the near-poor to use the healthcare system and to prevent them from catastrophic health expenditure. However, the premium fee appears to be a barrier which can discourage the near-poor from participating in the scheme. Out-of-pocket payment is still a serious issue. The near-poor show that they cannot afford expensive treatment by themselves, and depend on informal loans or charity. Healthcare services are perceived as unequal by some informants, in terms of the conduct of healthcare staff and the medicines provided under the insurance scheme. These findings indicate that access to social health insurance and subsequently healthcare still depends on the ability to pay. In other words, social health insurance has not met completely the health needs of the near-poor. There is still inequality in the healthcare system.

## **Chapter summary**

This chapter has accounted for health equity in the social health insurance scheme for the near-poor. The near-poor face many barriers to their use of healthcare services, including long waiting time, bureaucracy, inappropriate conducts of the healthcare staff, poor quality of medication, high out-of-pocket payment, and geographical distance. The near-poor use social health insurance for chronic, serious illnesses and inpatient treatment. In contrast, self-medication and private healthcare seeking are popular for mild and acute symptoms. Most of the near-poor express that the social health insurance enable them to seek healthcare when they need. However, many features of the healthcare services should be improved in order to increase the near-poor's health capability.



## 7. Conclusion

Voices of the near-poor have been presented and discussed in the thesis with the purposes of: a) Portraying the near-poor and place them in their proper position in the healthcare reform in Vietnam, b) determining the reasons why the near-poor participate in social health insurance, and c) exploring social justice in the case of the near-poor population in the social health insurance scheme. Two thesis questions have been formulated to enhance the analysis. The first question concerns why the near-poor subscribe to social health insurance; the second question assesses how the scheme has met their health needs.

The thesis' conceptual framework has been based on Jennifer Prah Ruger's health capability paradigm, which justifies health insurance as a way to promote human flourishing. It has given room for discussion on equity features and improvements of healthcare, especially healthcare for the disadvantaged in the society. The thesis has also employed the terms asymmetric information, adverse selection, and moral hazard from neoclassical economics in order to examine the thesis questions, which is consistent with Ruger's concern with economic issues.

The healthcare reform has changed the manner of healthcare delivery in Vietnam. The socialisation process, manifested in the introduction of users' fee-for-services and involvement of private agents, became a central feature of health policy. It results in a tremendous increase of healthcare costs for the patients, which hinders the near-poor from using the healthcare services. The government promotes social health insurance, both compulsory and voluntary schemes, aiming for universal health insurance coverage by 2020.

The near-poor have been officially targeted for social health insurance since 2009. The near-poor in Vietnam is a heterogeneous group in terms of financial ability, but they all share a risk of falling into poverty. Until 2013, they can subscribe to the scheme on a discounted premium subsidised by the government. Even so, only 1 out of 10 near-poor people participate in social health insurance.

The thesis is a qualitative research, with the intention to represent multiple voices from the near-poor population. 22 semi-structured interviews, each lasting from 30 minutes to two hours, serve as the main sources of data for analysis. I conduct the research in light of both the philosophical and the critical hermeneutic tradition, which the process of my reflexivity

throughout the research. Ethical issues regarding informed consent and confidentiality were of particular concern, due to the consideration that the informants were novices to being researched and some of them were worried about being recognised by the government.

The thesis has inevitable limitations. The modest numbers of informants imply that the research findings may not represent characteristics of the whole near-poor population. In addition, I might have misrepresented some events mentioned in the thesis due to my relatively limited English skills. Furthermore, I might have been biased in the position of “the space between” as a local and a researcher. However, I have tried to be rigorous throughout, and transparent about all stages of the research process. The thesis drafts have been proof-read both in terms of the contents and the language; findings from other studies have also been reviewed. These attempts are to enhance triangulation of the data and the credibility, validity and transferability of the thesis findings.

In the analysis chapters, I have described extensively the near-poor. They struggle hard to sustain decent lives. They face a high risk of falling back into poverty on the occurrence of catastrophic healthcare spending. They subscribe to social health insurance in order to cushion the financial burden of their permanent or potential health needs. The near-poor, particularly those with illnesses, are determined to stay insured as long as they can. This reveals also the problem of adverse selection, which may lead to a deficit for the healthcare fund; yet it had a positive impact on the near-poor since they can receive necessary healthcare. Inclusion based on recommendation or war merits is also common. Subscription to social health insurance appears to become a health norm in the society. However, the premium fee is perceived as high for the budget of many near-poor households. In accordance with Ruger’s health capability approach, I have argued that the near-poor employ health agency maintain their health functionings and to develop their health capability.

Furthermore, the near-poor encounter multiple layers of obstacles when utilising their insurance. The barriers include long waiting time, unfair treatment by the staff, and excessive co-payment for expensive treatments. Consequently, the majority opine that the insurance is “bought to spare” for treatment of chronic or severe morbid conditions, whereas self-medication or private clinics are the first options in case of acute and mild symptoms. Nevertheless, there are also cases where the near-poor rely entirely on the insured healthcare; in contrast to cases where the near-poor are not able to employ the scheme’s benefits. These accounts reflect that the social health insurance has not met satisfactorily the near-poor’s needs of healthcare; and inequality persists in the healthcare system from the perspectives of

the near-poor.

The near-poor proposals should be considered as an impetus to devise a more equitable social health insurance scheme. Much concern is placed on reduction of premium and co-payment on the near-poor side, to a level that enhances the near-poor's capability to subscribe and utilise the system. Otherwise, as it has been seen, the near-poor may end up in poverty or give up treatment due to their limited ability to pay. In addition, actions should be taken to prevent corruption and disrespect of the insured patients among the healthcare staff. Free premium for the elderly is also desired, by lowering the eligible age to 70 years old, instead of 80 years old, as is the current policy.

My thesis agrees with Nguyen et al. (2012b), who conclude that the government scheme has met the moral obligations of social health insurance. However, the situation of the near-poor in the current healthcare system is not dissimilar to experiences of the poor population in the early period of Vietnam's healthcare reform, as was found in the study by Segall et al. (2000). As discussed in chapter Five, further research can examine the tendency among the young and healthy near-poor in joining social health insurance. Furthermore, the findings of my thesis can be employed for a further participation action research on the near-poor in the social health insurance scheme

Ruger's health capability offers a multidimensional framework within which one can discuss the health agency of the near-poor, and evaluate the social health insurance scheme. It distinguishes between internal and external factors affecting the individual's health capability; thus it provides practical means to tackle existing problems. However, the approach takes for granted certain real-life factors which in reality can account for serious pitfalls in healthcare delivery. In my thesis I have found these factors to be the financial feasibility of a universal benefit package and the healthcare staff's morality. In addition, blurred boundaries prevail between the three core concepts of the health capability paradigm—health capability, health functioning, and health agency. Therefore, while I applaud Ruger's approach to health equity, I believe that one should be highly conscious of the complexity of the reality, whenever one confronts that reality with Ruger's theoretical criteria.

My thesis has contributed to the understanding of social equity in Vietnam. In particular, it demonstrates that the near-poor is a population with specific characteristics, but that it is often under-represented in public policy and academic research. It requests that voices of near-poor to be heard in the healthcare reform discussions, and all types of reforms in a broader sense.



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# Appendix

## Interview guide, fieldwork 2012

### 1. INTRODUCTION

- 1.1 The thesis purpose, the use of interview data
- 1.2 Myself as a student
- 1.3 Informed consent, asking permission for recording, anonymity, followed-up research (later if necessary).
- 1.4 Giving my contact details to the informants

### 2. INTERVIEWEE'S BACKGROUND INFORMATION:

- 2.1 How many people are there in your household?
- 2.2 What are the jobs of household's members?
- 2.3 How much does your household earn per month?
- 2.4 How much does your household often save?
- 2.5 How long have your household been in the near-poor category? How did you know your household is in near-poor category?

### 3. SOCIAL HEALTHCARE INSURANCE

- 3.1 How long (how many years) have you been buying social health insurance?
- 3.2 Why did you buy social health insurance? (where did you get the information from: the government, your acquaintances, media? Was it your own decision or any intervention from other partite (government, organization)?
- 3.3 Was the process to get a social health insurance complex in your opinion?
- 3.4 Have you sought treatment at hospital? If yes, did you use your health insurance?

#### A. For those you have used health insurance:

- 1. Can you tell about your treatment? (what type of sickness was it? how long it lasted? Were you hospitalized? Did you have to make lots of unnecessary check-ups? Did you refuse to go on with treatment?)
- 2. Were you satisfied with the treatment?
- 3. How much was the cost (if s/he remembers)? Were you able to pay it on your own?



4. (If not, probably s/he borrowed from someone) Did you pay the loan a few months after that?
5. How was the situation of the household after a person's treatment?
6. How do you think about social health insurance in helping you to cope with illness?
7. How do you think about social health insurance in securing your out-of-pocket healthcare expenses? What would you think if there were no social health insurance or any health care scheme for you.  
Would you seek treatment for the previous illness if you had not social health insurance?
8. Would you continue to buy social health insurance?
9. Do you think healthcare insurance has secured your well-being? Do you think a 20% co-payment is a lot? And have you experienced the limit of medicine due to social health insurance's list? (*Control question, to be compared with answers from Q 5-6*)
10. What are your expectations for a (reformed) social health insurance? In the context of the cost of healthcare is increasing and making ends meet is difficult.
11. Do you want to add other opinions about social health insurance?
12. Anything you would like to ask?

#### **B. Those who have not used social health insurance**

1. Would you consider seeking treatment when you are sick? (sickness that needs treatments)
2. How much can you afford for a treatment?
3. How would you think about social health insurance in helping you to cope with illness?
4. How would you think about social health insurance in securing your out-of-pocket healthcare expenses?
5. What would you think if there were no voluntary health insurance or any health care scheme for you.
6. Would you continue to buy social health insurance?
7. Do you think healthcare insurance has secured your well-being? Do you think a 20% co-payment is a lot for you? How about the limitation of medicine? (*Control question, to be compared with answers from Q 1-2*)

8. What are your expectations for a social health insurance? In the context of the cost of healthcare is increasing and making ends meet is difficult.
9. Do you want to add any other opinions about social health insurance?
10. Anything you would like to ask?

#### **4. SOCIAL JUSTICE**

- 4.1 How well are you informed about your rights to healthcare?
- 4.2 How well are you informed about the healthcare insurance?
- 4.3 Do you think it is a fair healthcare insurance system?