GENERAL MEDICINE

Elective Report: The Healthcare System in Vietnam

by Claire Reilly

The Healthcare System in Vietnam

Introduction

As part of our elective we wanted to experience the healthcare system in Vietnam both in its urban and rural settings. In order to achieve this we spent time in a hospital in central Hanoi and visited a rural hospital and two rural clinics in villages surrounding Hanoi. Thanh Nhan Hospital a large 400 bed teaching hospital in Hanoi that serves the worker population of the city was where we spent three weeks. The other two weeks we visited the surrounding area; Mai Chau hospital four hours drive from Hanoi in a town populated by 280,000 minority Thai people, a village clinic in Hang Kia serving a poor population of around 1500 Hmong people and Van Village clinic that served a population of 2459, most of whom were Thai minority people.

Objectives

1, What are the prevent medical conditions in Vietnam and how do they differ from the UK

Doctors in the rural parts of Vietnam have to deal with more diverse conditions than an average doctor in the UK. One example of this was when a 5 year old with a tooth abscess came in and the doctor had to extract her tooth. Dentists are only available in the cities and so in more remote areas doctors also take on the role of dentists and dental care is one the common things a doctor in rural Vietnam has to deal with.

Fevers and diarrhoea were the most seen ailments in the general community particularly around the change from dry to rainy season. The water supply is not safe to drink this leads to a higher incidence of diarrhoea in Vietnam when compared to the UK. Musculoskeletal problems were common as many people did jobs involving manual labour and back pain was a common complaint in the older individuals which is similar to the UK. Due to the long days spent in the sun doing manual labour many adults came to the rural clinics complaining of fatigue and dizziness, measurement of their blood pressure found them to be hypotensive so they were initially treated with IV fluids and encouraged to rest. This is not as common a complaint in the UK as we have a more structured work day with regular breaks.

In the hospitals the incidence of trauma was high. Largely due to road traffic accidents as the traffic particularly in Hanoi is chaotic and many people ride mopeds without helmets.

Also trauma from work related injuries as health and safety standards are not a high as in Britain.

Mental health conditions were less prevalent when we discussed them with the doctors. However this may be due to a lack of understanding surrounding mental health. In the country attitudes are said to be improving but if you have a mental illness you are looked after within the family and do not tend to leave the house to socialise or interact with others. Therefore healthcare is not accessed and problems of this kind not recognised or treated. There was no psychiatric ward at any of the hospitals we went to.

2. How are healthcare services organised in Vietnam and how does provision of healthcare differ between Vietnam and the UK

Vietnam has a private healthcare system, for which insurance is not compulsory in contrast to the UK where through the NHS medical services are free to all. The government does have a complicated system to subsidise the cost of healthcare insurance for some individuals depending upon the area in which they live; the poorest areas receive the greatest subsidisation. In the two villages we visited irrespective of income, inhabitants received free treatment at their local clinics but if referred to the hospital they must pay a percentage of the healthcare costs. In more affluent areas such as Hanoi, it is assumed that all will pay for their own insurance or healthcare, government subsidy will only be provided if proof of low income is given. It was explained that many people in non-subsidised areas choose not to buy insurance and instead cover their own healthcare costs. It is also common for individuals and families to put aside part of their annual income as savings for healthcare costs in the future. Individuals are also put in charge or their medical notes as patients keep their own records and are expected to bring them with them when they access services.

Prices of healthcare also vary depending on whether you attend the city or rural hospital as an overnight stay in Mai Chau was three dollars and in Hanoi between ten and fifty. The rural areas also had equipment shortages and problems attracting staff. Therefore some of the equipment in these areas was provided by NGOs and charities for example an ultrasound machine at Hang Kia clinic. In the hospital in Mai Chau not only was much of the modern equipment provided by a Swiss NGO they also funded some international training for the doctors. In Vietnam doctors are not evenly distributed throughout the country with rural hospitals having staffing problems; in Mai Chau there was a shortfall of 30 doctors. The medical director believed this to be was due to lower wages and a lack of specialist training opportunities and limited facilities. The FPAS system in the UK ensues that all regions of the country have doctors. The rural clinics are not actually staffed by fully qualified doctors as GP surgeries are in the UK instead the staff in charge have undertaken a 3 year college or university course which placed them at a level which appeared similar to the UK physicians assistants.

In addition to western medicine practices which have become prevalent in recent times traditional medicine also has a role. Individuals come in regularly to the rural clinics for

CLAIRE REILLY

acupuncture and massage and at the hospital in Hanoi there was a herbal floor with trained herbalists there to provide both outpatient and inpatient care.

3.How could public health programmes be implemented in Vietnam to reduce disease

Vietnam actually has a number of public health care systems in place already which seem to be very effective. Immunisation programmes have 100% uptake even in remote areas because monthly vaccination days were promoted though loud speaker systems that were constructed as a the public communication system during war time. Government programmes also screen for and provide free treatment certain conditions that are prevalent. For example in Van village, every patient was screened for thyroid disease and leprosy and any suspected cases of TB or malaria were investigated. Free medication was provided for these conditions as well as HIV and mental health conditions.

Sexually transmitted infections are very common and because sex before marriage is frowned upon contraception is rarely requested amongst this group. A loss of stigma attached to accessing contraception out of wedlock through a health campaign may reduce this. A programme could also try to alter attitudes towards the type of contraception utilised. The most common form of contraception used is an IUD which is thought to be due to a public campaign in the 80's raising the profile of this method [1]. This although an effective method of contraception does not prevent sexually transmitted infections.

4. Develop my abilities to communicate with patients where there is a language barrier

In Hang Kia most spoke no Vietnamese instead using their traditional Hmong language, which has no written form. Within the clinic we required 2 translators in order to speak to the patients, from Hmong to Vietnamese and then Vietnamese to English. It was essential to maintain focus on the patient and not be distracted when the two translators were talking to each other.

In the hospital in Hanoi some doctors could speak English but not as many as I had expected therefore other forms of communication were commonly used. Gestures and drawings of parts of the body came in to play. The patients appreciated us trying to communicate and we learnt the value of non-verbal communication. The few words of Vietnamese we had mastered made a big impact as patients respected the fact that we were trying to use their native tongue, even if just for the basics of asking their name and age.

CLAIRE REILLY

References

1. _Thang N &Anh D. Accessibility and use of Contraceptives inn Vietnam'. International Family Planning Perspectives. 2002; 2 (4):214-219