

## EQUITY IN HEALTH CARE – TOWARDS THE GOAL OF IMPROVING CHILD HEALTH BY 2030

Dinh Thi Phuong Hoa

### INTRODUCTION

Equity in health care is ensuring everybody to have chance to reach the health care services. Equity also involves ethical principles at all levels within and outside of health care with the goal to optimal health for all, especially those in need, vulnerable and disadvantage subjects [1].

Children are vulnerable group and need to be prioritized attention in society. Therefore, child health care has always been put at the top priority in the strategies and policies on people's health care in our country. The comprehensive health system, covering the whole country from the central to local levels, all health care services are free for children under 6 years old [2].

Results of the implementation of the Millennium Development Goals for the period 1990 - 2015, Viet Nam was identified by the international community as a bright spot in the group of low- and middle-income countries. The under-5 mortality rate (U5MR) decreased from 58‰ (in 1990) to 22.1‰ (in 2015), very close to the target of 19,3‰.

Despite remarkable achievements in improving children's health, Viet Nam still faces

a number of challenges on the way towards to achieving of the Sustainable Development Goals (SDGs) to end, by 2030, preventable deaths of newborns and children under 5 years of age, aiming to reduce neonatal mortality. These challenges include human, financial, health service quality, etc. of which the most important is to reduce the difference in children's health status between regions as well as in economic and social conditions.

### 1. CURRENT SITUATION OF DIFFERENCES IN CHILDREN'S HEALTH STATUS ACROSS REGIONS, ETHNICITIES AND SOCIO-ECONOMIC CONDITIONS

#### *Differences in Child mortality*

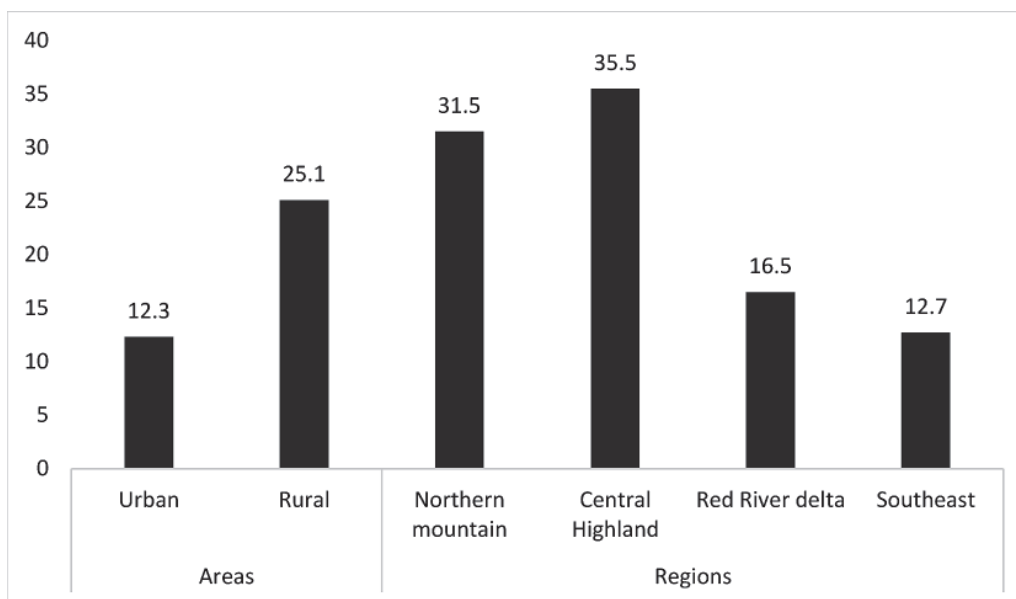
The most obvious difference in the U5MR was seen between mountainous, remote, ethnic minority areas and city, delta areas. The 2019 data showed that U5MR in rural areas was 25.1‰ – twice as high as in urban areas (12.3‰). In the northern mountainous provinces (31.5‰) and the Central Highlands (35.5‰), the level was nearly 3 times higher than in the Southeast (12.7‰) and twice as high as in the Red River Delta region (16.5‰). (Figure 1)

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*Corresponding Author: Dinh Thi Phuong Hoa*

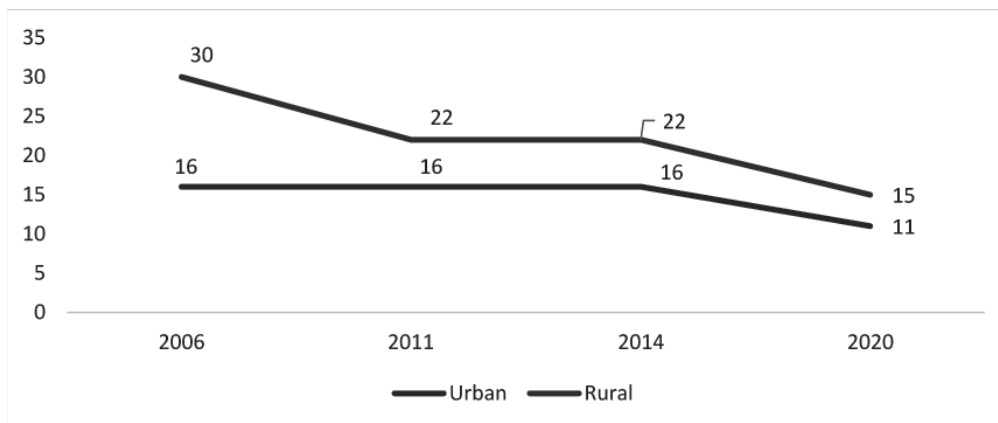
*Address: Tel: 0913075058; Email: phuonghoa55@yahoo.com*



**Figure 1. Difference in the U5MR (‰) across regions and areas**

Analysis of trends in narrowing differences over time shows that there has been an improvement for rural and urban areas. Data from MICS survey in 4 periods during 2006 - 2020 showed that the

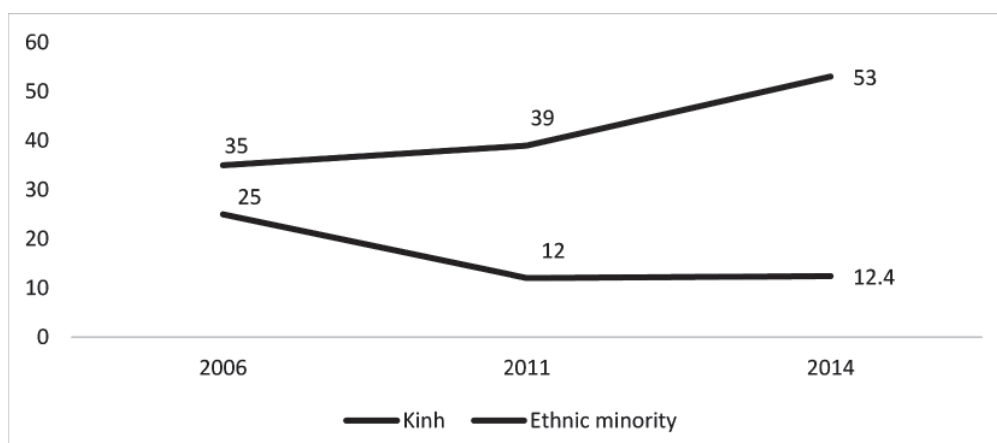
difference between urban and rural areas has decreased from 1.9 times (30 compared to 16‰) in 2006 to 1.4 times (15 compared to 11‰) in 2020 [3]. (Fig. 2)



**Figure 2. Difference in the U5MR (‰) across regions**

However, the difference between U5MR of ethnic minority children and Kinh children has not narrowed but increased markedly. The difference in 2014 was 4.3 (53 vs 12.4‰) more

than 3 times higher than in 2006 1.4 (35 vs 25‰) [4] (Figure 3). Therefore, priority interventions should focus on disadvantaged, high mountains where many ethnic minorities live [5].

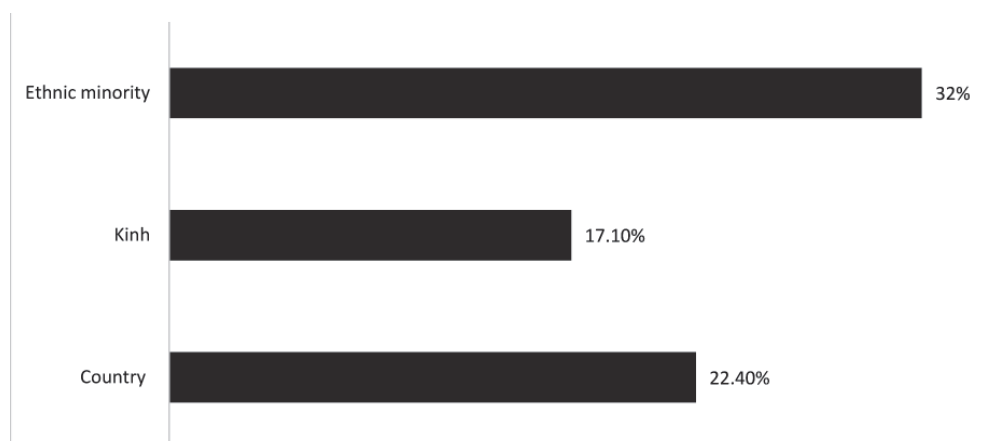


**Figure 3. Difference in the U5MR (%) between ethnic and Kinh groups**

*Differences in nutritional status*

According to data reported in the National Strategy on Nutrition for the period 2011-2020, Viet Nam achieved the target of reducing the stunting rate among children under 5 years old to 26% by the end of 2015 and 23% in năm 2020 [6]. However, according to a recent UNICEF report, Vietnam is still one of 34 countries in the World facing the burden of child malnutrition [7] and there are also large differences between

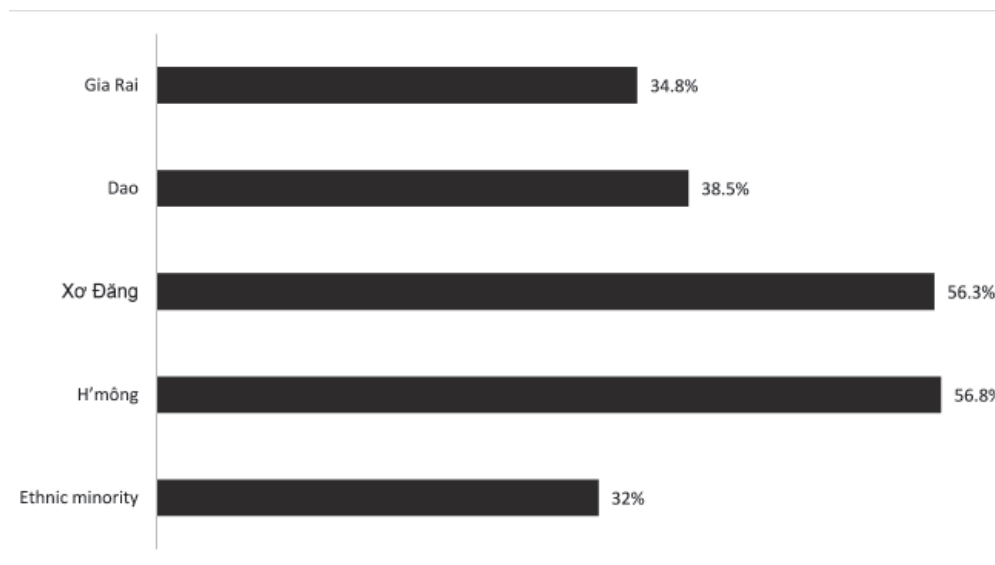
provinces and ethnic minority regions. The results of the 2010 - 2020 Nutrition Census show that the prevalence of stunting among children nationwide is 22.4%, of which the rate among ethnic minority children is 32%, nearly 2 times higher than that of children of Kinh children (17.1%) (Figure 4). It is estimated that there are 199,535 children suffering from stunting in the 10 provinces with highest prevalence and 60% among them are ethnic minority children.



**Figure 4. Stunting rate of children under five (%) by Kinh and ethnic minority groups**

The difference of stunting rate is even more pronounced among children from different ethnic groups with the highest is the H'mong

children (56,8%), Xơ Đăng (56,3%) followed by Dao children (38,5%), Gia Rai (34,8%) and người Tày (30,4%). (Figure 5)

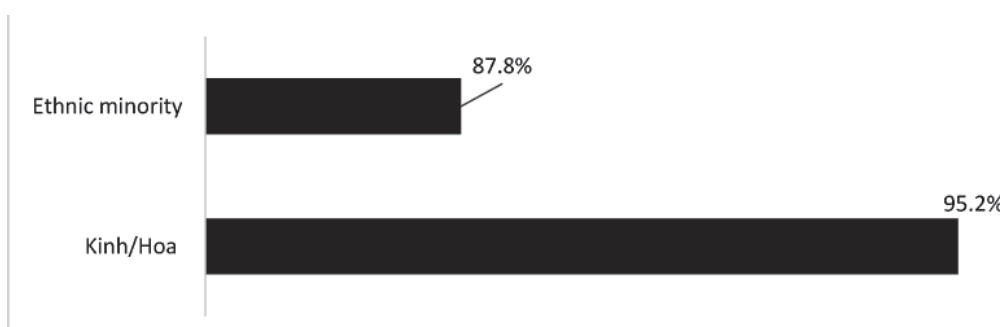


**Figure 5. Stunting rate of children under five (%) by ethnic minority groups**

*Differences in the use of preventive health services*

Expanded Immunization Program (EPI) started in our country in 1981 and over 25 years of implementation, vaccines have protected 6.7 million Vietnamese children and prevented 42,000 child deaths from dangerous diseases such as diphtheria, pertussis, polio and tetanus [8].

However, like child mortality as well as child's nutritional status, there is clear difference between ethnic minority children and Kinh children on vaccine coverage. According to data from the 2014 MICS survey, at this time, the rate of fully vaccination was very high and covered most of Kinh children (95.2%) but only 87.8 for ethnic minority children. (Figure 7)



**Figure 6. Rate of fully vaccination among children under 5 by Kinh and ethnic minority groups**

## 2. CAUSES OF INEQUITY IN CHILD HEALTH CARE

### 2.1. Economic and social conditions

As mentioned above, Viet Nam has implemented number of national policies and programs to support the poor, and disadvantaged groups in society for many years, therefore socio-economic status is not the main cause of inequity in health in Viet Nam [9]. However, since 1986, with the rapid development of the economic “Doi Moi” revolution in our country that has had a strong impact on the whole society in general and the health sector in particular in both positive and negative aspects. The positive role of economic development has made an important contribution to improving children’s health and at the same time, inequality has also increased significantly and the disadvantage is always the children in the group of unfavorable economic conditions.

The main differences in our country are between urban and rural areas; between Kinh and ethnic minority groups living in difficult mountainous areas. Ethnic minority children get less social benefits and medical care due to poor economic conditions, difficulty in accessing quality health care, some backward customs and practices, etc. Barriers of distance, cost, language, beliefs and lack of child care knowledge are the main reasons why mothers rarely use health care services for their children. Ethnicity is also considered the most important factor, having an independent relationship with child health through multivariate analysis of child and neonatal mortality trend [10,11].

### 2.2. Health care system

The health care network of the Viet Nam is a comprehensive system covering the whole country with more than 10,000 commune health stations, more than 600 district hospitals of 63 provinces/cities. The number of health workers per 1000 population according to the MOH’s

target by the year 2000 has basically been met. Essential equipment and drugs have been provided to most of the facilities for health care services according to the regulations of the Ministry of Health. However, to ensure equity in the health care services, there are still many challenges. For the child health care, there are three main problems as follows:

#### *2.2.1. Lack of human resources to care of child health at all levels*

The network of providing child health care services is limited in both resources and capacity. According to the assessment of the Institute of Strategy and Policy in 2015 [12], the average number of doctors per 10,000 people in the country reached about 8 while the number of pediatricians was only 0.25.

At district general hospital, only 42.9% of hospitals had pediatricians. A survey at 20 district hospitals in 4 northern mountainous provinces showed that only 55% of hospitals had pediatricians and 60% of hospitals have doctors trained orienting in pediatrics [13].

In the current context, the number of health workers at the grassroots level tends to move to higher levels, private hospitals or move for other jobs. Although every year there is a policy to recruit new employees, the number of new employees recruited at the district and commune level can only meet 50% and 70%, respectively of the number of employees leaving. Human resources for children are also in that situation, even less so.

At the commune level, health care for children is mainly provided by commune health workers, village health workers and village midwives. To date, there has not been a comprehensive assessment of the role of community health workers in child health care, however, according to some surveys, they mainly provide preventive services (nutrition, vaccination, etc.), have not been fully implemented yet the basic functions of the grassroots level in terms of child health care.

The services provided by village health workers and village midwives are also limited due to a lack of both quantity and quality while this human resource is an extension of grassroots health care, supporting maternal and child health care in ethnic and mountainous areas with difficult access to health services. Currently, nearly 2,500 villages in extremely difficult areas do not have village birth attendants. Since 2019, village birth attendants have not received monthly allowances [14], so many of them have quit their jobs, and the network has stagnated in some villages and communes.

Shortages of pediatricians as well as medical personnel caring for children can exacerbate children's health problems. Therefore, ensuring a sufficient number as well as improving the quality of pediatricians is a positive solution to reduce inequalities in children's health [15].

### ***2.2.2. Imbalance in the provision of child health care services between levels***

The imbalance between the upper and lower levels is most evident in the provision and use of health care services. Patient beds in upper-level hospitals are always overloaded while lower-level hospitals are not full occupied. The assessment of the Health Strategy and Policy Institute on hospital overcrowding at all levels showed that 54-65% of patients who came to the provincial and central levels for using health care services, can be treated at the lower facility levels, especially for children, this rate was even higher than 80%. The consequence of this situation is that many patients without beds at higher levels while in some district hospitals the bed occupancy is only < 60% [16]. It is very difficult to change this situation in coming years because patients tend not to use services at lower levels. They are unsatisfactory with quality and lack of trust of lower-level services, and get familiar of use high-tech services at higher levels.

Not well-controlling in running mechanism of autonomized hospitals and socialization is also a

major obstacle to reducing providing services at the lower level. At the district level, it is difficult to implement on-demand services when people's ability to pay is very limited. For children, the policy of free health care services for children under 6 years old hardly generates revenue for the hospital, so improving services provision for children is not a motivation for lower-level hospitals. Moreover, some services and drugs for children cannot be free because they are not on the list of insurance, so if patients have to pay for the services, the family will definitely choose the higher levels of their children's health care.

At commune health station (CHS) the capacity to provide services is limited, and the quality of services has not met the requirement. Commune health stations can only perform 52.2% of services according to the job descriptions by health care levels. In the field of prevention and health care management, the operation of CHSs is also low; The monitoring, supervision and follow-up activities are still limited [17].

The imbalance in service delivery is also resulted by inadequate investment in maintaining basic services and management of common health problems in children. Many health facilities are only interested in developing high-tech services, while some interventions are simple, low-cost, and highly effective such as breastfeeding, care for low-birth-weight and premature infants by Kangaroo mother care (KMC), perform essential early neonatal care (EENC), and management of common childhood illness (IMCI) have not been given enough attention. In addition, there is no effective connection with the prevention system and other related departments to intervene of accidents, injuries and poisonings, which tend to increase in children.

The lack of consistence in policies on medical examination and treatment in general as well as for children is also a significant obstacle for the choose of services at the grassroots level. The freedom to choose a medical examination place

without regulations on functions and tasks by level as well as the severity of the disease lead to children with common diseases prefer using services at higher levels while the grassroots level can handle these services.

### **2.2.3. Lack of synchronization and resources in primary health care activities**

Primary health care (PHC) is considered a development principle of the health system and the cornerstone of universal health coverage and guarantor of quality comprehensive health care for All [18]. For children, primary care was particularly emphasized in the Alma Ata Declaration of 1978 with the themes of essential care, evident based, socially acceptable and universal to all children and families in every community including the most difficult ones. It is comprehensive, continuous care from pregnancy to adulthood, including maternal care during pregnancy, child's growth and development; diarrhea management, and immunization preventing dangerous diseases [19].

For more than 40 years of Alma-Ata Declaration of 1978, it is continuing to be affirmed as the core foundation for achieving the goal of universal health coverage and equity and achieving the SDGs by 2030 by international community. The target of reducing newborn and child mortality is one of the nine goals in the SDGs' strategy to strengthen primary health care by 2030.

However, in recent years, the Government budget for health care tends to be reducing, especially for the primary health care network. Over the last 10 years, there has been almost no investment in CHSs. The budget for primary care including child care is often in short supply and interrupted. Not enough budget distribution leads to a lack of synchronization in all human resources, equipment, and drugs, so it does not guarantee health care needs.

Child health care in difficult mountainous areas are facing the challenges in both providers and users. For providers, the resource shortage

becomes more serious when the primary health care networks almost stop. Although there have been a number of priority policies on recruitment, salaries and allowances for staff working in disadvantaged areas as well as specific policies in training, fostering and benefits for staff working there, but compared with the general development of the whole country, some priority policies are still inadequate and have not yet attracted for them to work there [20]. For users, barriers in languages, customs and practices related to child health care are major obstacles to access and use health services in difficult mountainous areas.

### **3. RECOMMENDATIONS TOWARDS EQUITY IN CHILD HEALTH CARE**

- There is a need for a overall survey of children's disease patterns as well as organization of health care network to provide scientific evidence to develop the appropriate interventions for improving child health.
- Strengthening the primary health care and networks in order to minimize disparities in the provision and quality of professional and technical services in different socio-economic regions and areas.
- Renovating the model of organization and provision of primary health care services according to the family medicine approach to provide continuous and comprehensive child health care right from pregnancy, delivery and beyond. Strengthen the connection between treatment and prevention, between grassroots and upper levels.
- Encourage the participation of related departments and communities to act together for child health. Ensure children everywhere are cared for and protected from accidents, injuries or natural disasters.
- Raise awareness, change people's behavior, promote good practices on child health care of the families and the communities.

- In the short-term plan, priority should be given to child care interventions for ethnic minorities, areas with difficult economic conditions, difficult to access, and areas with high morbidity and mortality in order to narrow the gap in child health between regions.

- For upper-level hospitals, it is necessary to seriously implement the project of reducing hospital overcrowding, expanding the project of satellite hospitals with child health care by region reasonably. Strengthen the activity to support lower levels to improve the quality of services for children.

#### 4. CONCLUSION

Equity in health care in general and child health in particular is an issue in the ethical category, a basic rule that ensures human rights. For children, more than any other age groups, ensuring equity in health care is the best investment for the future of a prosperous nation with healthy citizens in both physically and mentally.

Inequality in child health care is still a burning issue in many countries around the world. Narrowing the gap between countries, regions, areas and territories is the first and foremost task of every individual, family, community and society. Vietnam has committed to the international community to reach the SDGs "Health for All" where every child is a top priority to achieve the goal "No child left behind".

#### REFERENCES

1. **W C Chang**. The meaning and goals of equity in health. *J Epidemiol Community Health* 2002; 56: 488–491.

2. **Ministry of Health**. Decision of Government number 36/2005/ND-CP. Ha No, 2005.

3. **General Statistics Office - UNICEF**. Multiple Indicator Cluster Survey (MICS2006, 2011, 2014, 2020).

4. **General Statistics Office – UNICEF**. Multiple Indicator Cluster Survey (MICS2006, 2011, 2014):

5. **General Statistics Office - UNICEF- UNFPA**. Viet Nam SDG indicators on Children and Women Survey 2020-2021. December 2021.

6. **Prime minister**. The National Nutrition Strategy for 2011-2020, with a Vision toward 2030. Decision No: 226 /QĐ-TTg.

7. **UNICEF Viet Nam – Nutrition Program**.

8. **UNICEF Viet Nam – Expanded Immunization Program**.

9. **Van de Walle D, Gunewardena D**. Sources of ethnic inequality in Viet Nam. *Journal of Development Economics* 2001; 65:177–207.

10. **Hoa DP, et al**. Persistent neonatal mortality despite improved under - five survival: a retrospective cohort study in northern Vietnam. *Acta Paediatrica* 2008;97(2): 166–70.41.

11. **Malqvist M, et al**. Ethnic inequity in neonatal survival: a case referent study in northern Vietnam. *Acta Paediatrica* 2011;100(3): 340–46.

12. **The Health Strategy and Policy Institute**. *Joint Annual Health Review 2015*. Strengthening grassroots health care towards universal health care.

13. **Ministry of Health 2019**. Support to improve maternal and newborn health care services in districts with high maternal/newborn mortality in Viet Nam.

14. **Decree 34/2019/ND-CP dated April 24, 2019** of the 34/2019/NĐ-CP of the Government.

15. **Harper BD, et al**. Where are the pediatricians? An international survey to understand the global pediatric workforce. *BMJ Pediatrics Open* 2019; 3: e000397. doi: 10.1136/bmjpo-2018-000397.

16. **The Health Strategy and Policy Institute**. Report on assessment of hospital overload at all levels. Ha Noi, Viet Nam: HSPI, 2009.



**17. Department of Medical Examination and Treatment - Ministry of Health.** Results of medical examination and treatment in 2011 and solutions to improve the quality of medical examination and treatment in 2012. Ha Noi, Viet nam 2012.

**18. World Health Organization & United Nations Children's Fund (UNICEF).** (2018). A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals. World Health Organization.

<https://apps.who.int/iris/handle/10665/328065>.  
License: CC BY-NC-SA 3.0 IGO.

**19. WHO-UNICEF.** Declaration of Alma-Ata - International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.

**20. Government.** Decree on specific policies in recruiting, training, fostering and creating sources of cadres and civil servants of ethnic minorities. Will be issued.