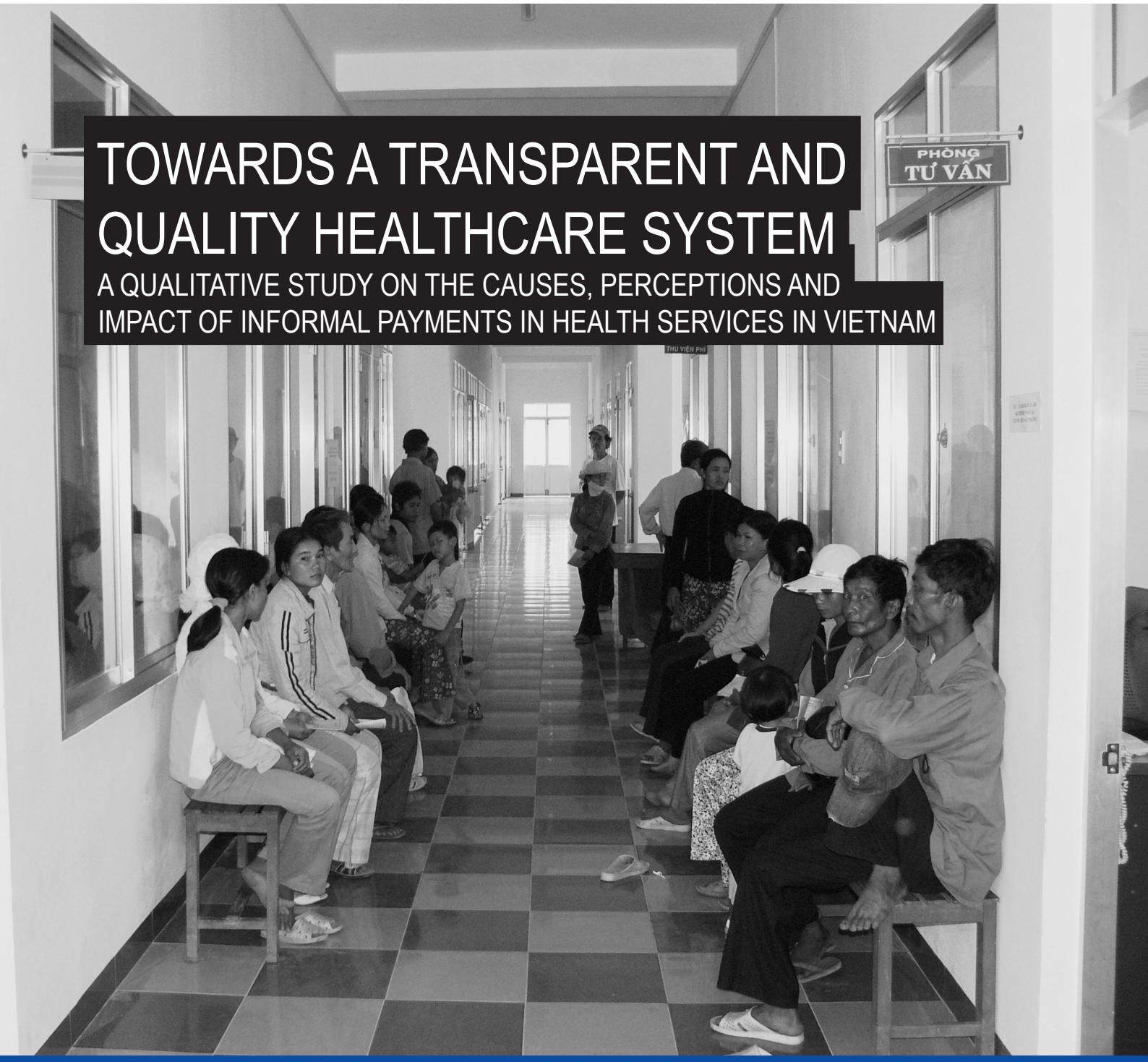
RTCCD

TOWARDS TRANSPARENCY

TOWARDS A TRANSPARENT AND QUALITY HEALTHCARE SYSTEM

A QUALITATIVE STUDY ON THE CAUSES, PERCEPTIONS AND IMPACT OF INFORMAL PAYMENTS IN HEALTH SERVICES IN VIETNAM



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the global coalition against corruption

This survey was conducted by an independent research team from the Research and Training Centre for Community Development (RTCCD) and Boston University School of Public Health (BUSPH) and finalized in collaboration with Towards Transparency (TT) and Transparency International-Secretariat (TI-S). The research team has made every attempt to accurately reflect the facts and the views that have been provided to the research team. The team, TT and TI-S take full responsibility for any errors of fact or omission, or for any inadvertent misrepresentation of material provided.

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ABBREVIATIONS

ACD	Anti-Corruption Dialogue
DANIDA	Danish International Development Agency
DoH	Department of Health
FGD	Focus group discussions
GI	Government Inspectorate
ISI	Individual semi-structured interviews
KI	Key informants
MoH	Ministry of Health
BUSPH	Boston University School of Public Health
RTCCD	Research and Training Centre for Community Development
SIDA	Swedish International Development Agency
TI	Transparency International
TT	Towards Transparency
UNDP	United Nations Development Programme
VHLSS	Vietnam Household Living Standard Survey
VUSTA	Vietnam Union of Science and Technology Associations
WB	World Bank

Photo © National Hospital of Pediatrics

FOREWORD

For almost two decades, Transparency International's work to stop corruption and promote transparency has been underpinned by the belief that corruption fuels inequality and prevents access to basic rights and services. In no sector is this more apparent than corruption in health, with international conventions regarding access to the highest standard of health as one of the most fundamental and universal rights afforded to all.

The impacts of corruption in the health sector are wide-ranging, from distorting health policies to limiting access to life-saving pharmaceuticals. In health services, petty bribery and informal payments, in particular, lead to an erosion of public trust in the public health system and rising costs for access to services which are supposed to be free. As a result, the poor are disproportionately affected, as they are less able to afford to pay bribes, which increase the costs of accessing health services, and are less able to pay for private alternatives when corruption depletes public health services.

At the same time, it is clear that widespread public engagement is a key requisite to greater and sustained progress in stopping corruption. A better understanding of the experiences and perceptions of those who play a key role in the health sector, from doctors to patients to policy makers, provides the basis for more effective anti-corruption efforts. The following report helps to understand systemic problems that have contributed to the existence and growth of informal payments in the health sector in Vietnam.

Nikola Sandoval
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EXECUTIVE SUMMARY

1. BACKGROUND

Throughout the world, the practice of informal payments in health care services undermines public policies aimed at assuring equitable, low-cost and efficient access to care.

Defined by Transparency International as the "abuse of entrusted power for private gain", corruption in Vietnam's health sector is of increasing concern to policy makers and the general public. In a recent study conducted by the World Bank,[1] 65 to 85 per cent of Vietnamese citizens perceived corruption to exist in public health services at the central and local levels. The 6th Anti-Corruption Dialogue Roundtable held in November 2009, which focused specifically on corruption in the health sector, identified three areas with high corruption risks:

1. Sectoral management systems vulnerable to procurement corruption, financial fraud, and other abuses of office;
2. Health service provision and the interaction between patients and providers, vulnerable to the extortion of informal payments from patients for services that should have been provided at lower official fees or free of charge; and
3. Health insurance systems, vulnerable to fraudulent billing and other abuses.

Informal payments to health workers has become the norm in Vietnam. However, up until now no study in Vietnam has examined the circumstances in which health workers demand and patients offer informal payments for services.

2. METHODOLOLGY

The research aims to understand the nature, pattern, perception and impact of informal payments in Vietnam. It also seeks to identify approaches to limit such practice in the country's health services.

Interviews were carried out in four geographic areas in Vietnam: Ha Noi, Son La, Dak Lak and Can Tho from August 2010 to February 2011. In each setting, two hospitals (one provincial and one district hospital) were selected. Interviews were conducted at national, province and district levels. In total, 178 people were interviewed including policy makers, health association leaders, Ministry of Health officials, hospital leaders, department managers, representatives of media agencies and international organisations, doctors, nurses, administration staff, patients, citizens who used services in the last twelve months and their caregivers.

Using an applied qualitative research approach, including individual semi-structured interview, focus group discussions and a literature review, this research focuses on the practice of informal payments including envelope, cash and in-kind payments exchanged during the process of receiving health care services. These payments are separate from any official payment for health care services approved by the government.

3. KEY FINDINGS

HISTORY

Both health service providers and users agree that the practice of making informal payments in healthcare is pervasive. A large number of study interviewees concurred that cash or envelope payments started to become common in Vietnam when the country moved towards a market economy under Doi Moi (1986), and that the practice became a significant problem from 2000 onwards.

A number of health service providers considered informal payments to be part of traditional Vietnamese practice and one that expresses the gratitude of the giver, whilst a majority of users said that payments were made to help them obtain better service.

Policy makers and health managers mentioned several factors which contribute to the increasing frequency and trend of envelope payments: the government's new health insurance policy (which partly covers the treatment fee even if the patient seeks transfer to a higher hospital level without official referral), the policy that allows hospitals to collect patient fees (Decisions 10 and 43), a poor supervision system and inadequate investigation.

FORMS OF PAYMENT

Offering cash directly and cash in envelopes are the most common ways of making informal payments to health workers. In-kind gifts (commonly in the form of fruits, candy, biscuits and etc.) are sometimes given alone but are usually given in a plastic bag which aim to hide any envelopes. In large cities, a new kind of informal payment involves "opportunities" offered by patients or their relatives to medical practitioners (to purchase goods at a lower price than the market value or the provision of free services).

Interviews with patients and health workers indicate that the form and value of cash and in-kind gifts vary by region and the seriousness of the illness. In-kind gifts typically do not cost much, and the amount of cash/envelope payments is considerably higher at central and provincial hospitals and in urban facilities compared to centres in rural areas. Informal payments, envelopes in particular, were not reported to be a problem in most district and commune level health facilities.

Informal payments differ between hospitals and also between different departments within a hospital. Payments are more likely to be presented in services where there is a high chance of fatality (e.g. surgery, emergency care, obstetrics, and pediatrics). However, informants said that administrative staff and those providing routine care, such as cleaning services or injections, are also given smaller amounts of cash at a lower frequency than doctors. Doctors and surgeons report being given larger amounts of money than nurses, assistants or orderlies. Accordingly, the forms of informal payment differ by profession - envelopes are commonly offered to doctors, cash to nurses and in-kind gifts of fruits or biscuits for administrative staff and the department as a whole.

Interestingly, pre-existing relationships between the client and health professional do not seem to affect either the amount of informal payment made, or the rate at which it is given. Even health workers report feeling embarrassed for not giving any in-kind gifts or envelopes to thank colleagues who provide treatment for their relatives.

PROCESS BEHIND PAYMENTS

The majority of patients interviewed, both in cities and rural provinces, confirm that they sought advice regarding the appropriate value of an informal payment by asking other patients, friends, neighbours and relatives, based on their past experiences with the hospital. A few patients reported that they were told by medical personnel exactly how much they should pay. Most of these cases occurred at central hospitals which are overburdened with patients.

Health personnel in higher level hospitals confirmed that most newly-graduated health workers did not accept cash, envelopes nor in-kind payments. They agreed that time is needed for a health worker to become accustomed to the practice of accepting envelope payments, usually around one to three years. One year is the estimated time for a health worker in the obstetrics or surgical departments to become accustomed to accepting envelope payments.

MOTIVATIONS FOR PAYMENT

Most service providers from central to provincial health facilities stated that informal payments (in-kind gifts and envelopes) are made after treatment, and are given voluntarily. However, a large proportion of interviewed patients reported giving money or in-kind gifts because it is the norm. Some reported experiencing poor quality care when no cash or envelopes were given before treatment or when no indication was made that doctors would be compensated for their care upon completion of treatment.

Reasons given by health providers for accepting informal payments include the need to increase their official income to meet increasing costs of living, the acceptance of envelope payments as a social norm and the desire to avoid embarrassment on behalf of the patient who offers payment.

IMPACTS

According to the health workers interviewed, the quality of care does not differ between patients regardless of whether or not informal payments have been made. However, they confirm the concerns shared by many patients that a health provider might be friendlier towards patients who offer informal payments or give them greater priority. As a result, from the perspective of health care equity, the quality of care is affected, as those who are unable to make informal payments take the risk of not being cared for in a timely fashion, given full information or experiencing comfortable hospitalization.

EFFORTS TO REDUCE INFORMAL PAYMENTS

All interviewed service providers stated that they did not see in-kind payments or envelopes given after treatment to be a problem - regardless of how big or small the amount - as long as such payments were made voluntarily by patients. All service providers interviewed criticized doctors or nurses who indirectly requested informal payments from patients. At the same time many users agreed that envelope payments should be eliminated in the health sector.

Most health workers noted that their facilities applied measures to control the practice of informal payments, including the introduction of disciplinary measures for service providers who request and accept informal payments and setting up open feedback mechanisms for service users. However, many of them said that the measures seem to be nominal and not very effective.

4. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSION 1: In-kind informal payments, usually in the form of gifts, is deeply rooted in the country's history. The practice increased during the post-war period when the national economy was in crisis, and grew into a significant social problem and shifted to 'envelop payments' when Vietnam shifted towards a market-oriented economy, encouraging the collection of user fees for public health services.

CONCLUSION 2: Reasons given for the existence of informal payments differ widely between the payer and the receiver. Most service providers stated that informal payments were given to express thanks (especially when made after treatment), whilst a majority of users said that informal payments were intended to help them obtain better and more satisfactory service.

CONCLUSION 3: Informal payments are threatening the goals of "equity, efficiency and sustainability" in the health system. It is more serious in higher level facilities where hospital capacity is significantly overstretched, and a significant portion of health expenditures must be paid by the citizens. Current efforts to date to address informal payments are mostly ineffective.

CONCLUSION 4: The model of private management mechanisms in public hospitals (collection of user fees and requiring hospitals to self-finance) is a risk factor increasing opportunities for informal payments. Additional risk factors are lack of transparency in public health service management (including human resource and financial management), economic pressures, weaknesses in system management, and the lack of investigation.

The following recommendations aim to inform future actions towards the control of informal payments in the health sector, to prevent the possibility of a consequential increase in official user fees and to strengthen anti-corruption efforts.

RECOMMENDATIONS

For Policy Makers

Giving national priority to anti-corruption control: in the health sector with pooled efforts from multi-sectoral agencies including civil society and monitored by the National Assembly.

Eliminating "private management models" in public hospitals: and instead moving towards a mixed health care system with three components (1) Public services funded by the public budget, which are completely not for profit and responsible for primary health care and preventative medicine; (2) Non-governmental health services using self-financing and possibly government subsidy which are not for profit, but for science and charity; (3) Private services, which operated following market mechanisms.

Strengthening the capacity of primary healthcare facilities: This type of investment, in addition to public education, will help to reduce overload at provincial and central hospitals, which is a key factor leading to informal payments.

For Health Facilities

Establishing an independent quality supervision system: Current health systems in Vietnam lack quality supervision conducted by a third party. Anti-corruption efforts (regulations restricting the acceptance of informal payments, punishment) will require quality and performance supervision to be undertaken by a third party independent to the health system.

Increasing both financial and non-financial remuneration for health workers: For future salary revision, payment to health workers should be at least 3 times the amount for tax exemption with variations depending on position, years of experiences and expertise. Other non-monetary approaches should also be considered for public health workers, for the short-term and for long-term.

Improving controls and sanctions including supervision, follow-up, investigation, financial punishment, and dismissal. This will help to detect and punish those who continue the practice, as raising compensation (monetary and non-monetary) alone would not be enough. It requires the efforts of not only the hospital leaders and the supervision unit, but also the proactive involvement of medical associations and the Ministry of Health's Inspectorate. Public users also can play an important role in supervising health workers' performance and regulation compliance.

For Service Users

Developing a pilot initiative to provide information, advice and counseling to the citizens: who might be asked to pay for services. These models should be set up and managed by non-profit organizations working for human rights in health care.

Transforming perceptions of service providers and users towards:

- A service-oriented Health System. To respond to consumer expectations for high-quality service, organizations in the health care industry must develop a service-oriented culture where patients are respected and receive qualified service worth the cost (paid out-of-pocket or by health insurance).
- Zero tolerance for health workers who demand for patients to make informal payments. The media can play an important role to empower the population, letting them know that they have rights to good health care service and any actions to prompt for informal payments are unacceptable. Media and community-based organizations should also inform the population that informal payments will not change a doctor's technical performance, and they do not have to pay other than the official fees.
- Limiting envelope payments in daily interactions. Government and other organizations should make a pledge to avoid all types of "envelope payments" in the course of business. There should be no envelopes used during donations, and administration procedures should be clearly outlined to public users and respected by service providers.

1. BACKGROUND AND OVERVIEW

1.1 INTRODUCTION

Transparency International defines corruption as the "abuse of entrusted power for private gain". Highlighting the relationship between the agent (e.g. government officials, private doctors) and the principal (e.g. citizens, patients), corruption occurs when the agent abuses the power entrusted in him or her by citizens, and instead acts to further his/her own private advantage. In Vietnamese, corruption is called *tham nhung.* It consists of two components:

1. *Tham* meaning excessive greedy (wanting to acquire or possess more than what one needs or deserves). Tham is a negative human characteristic, and is traditionally rejected by social norms;
2. *Nhung* meaning harassment (to irritate or torment persistently) indicating that a normal situation is made more difficult so that people have to pay in order to overcome the difficult situation.

Therefore, *tham nhung* is a clear concept, which is easily understood in Vietnamese. It is accepted that corruption may occur at individual as well as at organizational levels.[2]

Throughout the world, informal payments for health services undermine public policies aimed at assuring equitable and low-cost access to care. Many government health care systems guarantee citizens access to a predefined package of services, either free of charge or for a small fee. Yet, despite official policies, health care providers sometimes demand—or patients offer—to make informal or illegal payments outside official channels. Studies have shown that these payments increase the cost of care to patients, especially the poor, and in some instances even dissuade some people from seeking care at all.[3]

In Vietnam, corruption in the health sector has been identified as a crucial issue by the authorities and by the public at large. The media regularly reports corrupt practices in this sector, and fighting corruption in the health system has been pinpointed as one of the priorities of the Government's anti-corruption efforts, as the effects of corruption in health can be particularly harmful on people's daily life.

Research has investigated the impact of health care expenditure on household poverty. A study conducted by the Central Commission of Ideology in collaboration with the Research and Training Centre for Community Development (RTCCD), with technical support from the World Health Organization (WHO), which analyzed the 1993, 1998, 2002 and 2004 VHLSS datasets, indicated that citizens' out-of-pocket money for health care (CATA and IMPOOR indexes) increased over the years and contributed to the poverty of Vietnamese households.[4] The government has a target to reduce poverty by 2% annually but health expenditure has pulled 3.7% of the population below the poverty line between 1993-2004. This raised an urgent need for the control of informal payments.

In Vietnam, policy makers and the general public are increasingly concerned about corruption. A governance study in 2004 identified control of corruption as a key challenge to the country, while national Global Integrity surveys in 2006 and 2009 found that enforcement and monitoring of Vietnam's anti-corruption law are weak.[5] There have also been a number of studies which cover common perceptions and risks of corruption in the health sector, specifically in regards to envelope payments. These include the 2005 Vietnamese Communist Party Diagnostic survey, the 2008 Vietnam Household Living Standard Survey (VHLSS), and chapter 4 of the World Bank (WB)'s Vietnam Development Report 2010. The VHLSS 2008 results show that 85 per cent of citizens perceive slight to very serious corruption in central health services, while 65 per cent perceived corruption in local health services. The Vietnam country analysis of the 2010 Global Corruption Barometer found that, amongst the 1,000 urban citizens interviewed, just below 70 per cent of respondents had been in contact with medical services in the previous had 12 months; and amongst those 29 per cent report paying a bribe. In 2007 12 per cent of urban citizens interviewed for the 2007 Global Corruption Barometer reported paying a bribe (out of more than 75 per cent of respondents who had contact with the sector). While these studies suggest that informal payments may be a serious problem, there is a clear deficiency in quantitative and qualitative evidence-based analysis of the concrete forms and patterns of corruption in the health sector to properly inform policy actions.

1.2 HISTORY OF THE HEALTH SECTOR IN VIETNAM

The progress of Vietnam's health system can be divided into five main periods:

1. Before French colonization (Prior to 1881)
2. French colonization (1881-1954)
3. Revolution against American forces (1955-1975)
4. Towards socialism (1975-1986)
5. Economic reform (1986 to present)

Before the 20th century, Vietnamese health services were not governed by formal systems, but instead developed independently amongst practitioners, with health care based on traditional practices and experience passed from generation to generation. Health care guidelines were commonly circulated within a small fraction of the population (more than 95 per cent of the population was illiterate) and skills were normally passed to sons by their fathers (*Cha truyen con noi*), for the sake of "saving people" rather than "for profit". The performance of health care practice was thus considered as "charity, human saving" and the patient always looked to the practitioner as a benefactor. Health practitioners and teachers were two social classes who always received the respect of the citizens. Health care was highly honored. The act of "paying back" by patients was not based on material or monetary value, but "from the bottom of heart". In-kind gifts (*le*) went along side the giver's gratitude only during festivals and depended on the patient's financial situation. In general, in-kind gifts were things that were most valued by the patient's families, such as a pair of hens, a dozen of eggs, a kilo of sticky rice and etc. A physician would never refuse a gift, and the gift-giving came with genuine emotion and gratitude, right to the last day of the patient's life. These behaviors contributed to the culture that today's physicians use to explain gifts and envelope payments as described in the chapter on findings.

The modern medical framework began in Vietnam in the early 20th century by the French.[6] It included the introduction of public hospitals, a private health sector, and charity hospitals (especially for patients suffering from tuberculosis, leprosy and mental disorders). The practice of out-of-pocket payments in private health clinics was familiar, but patients' gratitude towards doctors was still honored, and the private health sector existed mostly in developed urban areas and was aimed at the upper class.

When American forces replaced the French in their domination of Southern Vietnam, a new health model followed. This new model focused on the development of a private health sector in the urban areas, and on providing health services for the army. The period is marked by the lack of public medical services and serious corruption in American aid,[7] facts which helped create a fertile environment for envelope exchange as an additional source income for physicians.

Meanwhile, the construction of a socialist health system in North Vietnam began after the Dien Bien victory in 1954.[8] At this time, a system of primary health care was developed throughout the northern provinces, with subsidized health care provided to the entire population, and the elimination of the private health sector. These changes altered the tradition of patients being grateful for healthcare. The renumeration provided to health workers from the Government generally did not differ from that afforded to other professionals, but in society, people still expressed their high appreciation to physicians. However, the habit of paying back or giving gifts to physicians also became more simple: for example, expressing gratitude and respect to physicians verbally, or giving heartfelt assistance to them when needed. This can be seen clearly in "The diary of Dang Thuy Tram,"[9] or photos of physicians' funerals, which were commonly attended by former patients.

The victory against the American forces in 1975 led to the unification of Southern areas with the Northern health model of subsidized medical treatment for all. This explains why most of the study informants reported that envelope payments in health services were rare before the country's movement to a market-oriented economy in the mid 1980s.

In the transition to a market-oriented economy after 15 years of the country's unification, Vietnam returned to favoring the role of the private sector in providing health services.[10] With the "seed of corruption" now having spread to the Northern provinces, this together with the downward trend of the socialist economy and the policy allowing hospitals to collect users' fees (which began in the late 1980s) further encouraged the risk of corruption. With the development of a private health sector, under-the-table money re-appeared and this problem spread rapidly to all sectors, including health. In-kind gifts gradually were transformed into envelopes for convenience and the confidentiality of both givers and takers (especially in the northern area).

1.3 CORRUPTION IN THE HEALTH SECTOR IN VIETNAM

General comments from donors and government officials at the 6th Anti-Corruption Dialogue (ACD) roundtable held in Hanoi on 17 November 2009 emphasized that corruption in the health sector in Vietnam appears at multiple levels, with three areas being at a higher risk of corruption. As shown in Box 1, these areas include sectoral management, health service provision and health insurance .

BOX 1. THREE AREAS OF HIGH RISK CORRUPTION IN THE HEALTH SECTOR

1. Corruption in sectoral management: this is likely to occur in procurement, bidding, human resource recruitment, position promotion and financial management.

2. Corruption in health service provision: this includes informal payments from patients to health workers, abuse of medical knowledge (e.g. forcing patients to use high-technological or unnecessary tests or treatment), and the prescription of unnecessary, expensive medicines in order to receive commissions from pharmaceutical companies.

3. Corruption in health insurance: abuse of health insurance in unnecessary medical tests or the fake billing to increase a provider's revenue from the health insurance system.

Despite the fact that informal payments paid by patients for services is recognized as a form of corruption by the health sector (see Area 2 of Box 1), it has become the norm in Vietnam. A study by Hanoi Medical School conducted in 2006-2009, reported in the ACD 2009, showed that 73 per cent of medical staff interviewed admitted that they sometimes breach medical ethics,[11] with one in ten admitting they do so "often". Another study,[12] reported that expenditures on "presents" for health workers make up 9 per cent of the total cost of an examination course (included medicine, examination, food, accommodation and presents for health workers). There is little data, however, on the prevalence of this practice or the percentage of health workers asking patients for informal payment.

The Vietnamese government and the donor community extensively discussed this issue at the 6th ACD.[13] The workshop demonstrated that there is considerable concern about the problems of lack of transparency, conflict of interest, abuse of power, and unethical behavior in the health sector.[14]

1.4 GOVERNANCE AND ANTI-CORRUPTION EFFORTS

The Vietnam National Assembly promulgated the Anti-Corruption Law on 29 November 2005 (effective from 1 June 2006; revised in 2007), embodying measures for preventing and controlling corruption, and for detecting and punishing corrupt behavior. Despite the Anti-Corruption Law being in force for more than four years, corruption remains a persistent problem. In the 'National strategy on Anti-Corruption to 2020', the Government states that "Corruption remains common, serious and complex, and is a major obstacle to the success of renovation".[15]

BOX 2. 12 FORMS OF CORRUPTION (ARTICLE 3) OF THE VIETNAM ANTI-CORRUPTION LAW

1. Embezzlement of property
2. Acceptance of bribe
3. The abuse of functions for property seizure
4. The abuse of functions for private benefit
5. The misuse of functions for private benefit
6. The abuse of functions to influence people for private benefit
7. Falsity in assignments for private benefit
8. Giving of bribe or acting as an intermediary of giving bribe by an official who is assigned to conduct a function of agency, organization, unit or locality for private benefit
9. The abuse of functions in illegal use of state property for private benefit
10. Harassment for private benefit
11. Cancellation of assignments for private benefit
12. The abuse of functions to conceal for criminals for self-interests; obstruction of justice, illegal interaction in examination, investigation, audit, surveillance, prosecution, judgment, jurisdiction for private benefit

Article 3 of the revised law identified 12 corrupt behaviors (Box 2) of which behavior No. 10 is common in health services. The law lists various types of corruption in the health sector (Box 3) but does not refer explicitly to informal payments. Article 40 defines in great detail gift giving and receiving by officials, and in particular, section 2 is applicable to informal payments in the health sector. Punishment for corrupt behavior is vaguely defined under article 69 which may enable corrupt individuals to escape punishment: "The penalty for a corruptive person will be decided based on its nature and gravity to be as ethical or financial disciplines or as a crime. If s/he is officially sentenced due to the corruptive action and the decision legally effects; s/he will have to resign from the working position"

BOX 3. ANTI-CORRUPTION IN HEALTH, ACCORDING TO THE REVISED ANTI-CORRUPTION LAW

Article 24. Integrity and Accountability in Health Sector

1. Jurisdiction, processes, procedures, approval and recovery of the professional certificate for private medical and pharmaceutical practitioners and of the conditional certificate for medical and pharmaceutical facilities shall be known.
2. The collection, management, use of state funds and properties, prices of medicines, the collection, management and uses of medical service fees and other funds according to state law by the public health management agents and health facilities shall be known.

Article 40. Giving and Accepting Gifts by Health Officials

1. The agencies, organizations and units are not allowed to use state budget and properties as gift, except for cases required by any law.
2. State officials shall not accept money, properties or any material benefits from agents, organizations, or individuals who are in associated with the assignment currently being responsible for or managed by those officials.
3. Giving and accepting gifts as a bribe or other actions for private benefit are prohibited.
4. The actions of giving and accepting gifts, and paying back the gifts by state officials shall follow the government law.

BOX 4. NINE DIALOGUES ON ANTI-CORRUPTION IN VIETNAM

Dialogue 1 on 15 August 2007: "First dialogue on Anti-Corruption", focused on two issues: 1) Functions, assignments and coordination of principal agents for anti-corruption in Vietnam; 2) Donors' participation for effective performance of these responsible agents

Dialogue 2 on 3 December 2007: "Anti-corruption in 2007", consisted of two sections: Process and Difficulties of Anti-Corruption in 2007; and Participation of Society in anti-corruption

Dialogue 3 on 3 June 2008: "Public Administrative Reform and Anti-Corruption"

Dialogue 4 on 28 November, 2008: "The role of the Media in Anti-Corruption"

Dialogue 5 on 29 May 2009: "Preventing and combating corruption in construction sector"

Dialogue 6 on 26 November 2009: "Anti-Corruption in Health sector"

Dialogue 7 on 28 May 2010: "Anti-Corruption in Education sector"

Dialogue 8 on 25 November 2010: "Anti-Corruption in Land Management"

Dialogue 9 on 25 May 2011: "Anti-corruption in Extractive Industries"

In terms of implementation, at the national level, the Government established a Central Steering Committee for Anti-corruption (CSCAC) headed by Prime Minister Nguyen Tan Dung and with 13 other members.[16] This Committee has been complemented by regional Committee on Anti-corruption in 2007, under the responsibility of the regional People's Committee. Within the Government Inspectorate a specialized Anti-Corruption Bureau (ACB) was established with the adoption of the revised Anti-Corruption Law – special anti-corruption units were also established within the Ministry of Public Security and at the People's Supreme Court.

So far the Government has organized nine formal dialogues with international donors on corruption. Each dialogue focused on corruption in a specific area (Box 4) and the 6th ACD targeted anti-corruption in the health sector. In addition, a number of activities related to anti-corruption have been launched, creating more and more discussion about and space for anti-corruption efforts: this includes different research funded by DANIDA, DFID, Finland, SIDA, TI/TT, UNDP, the WB and conducted in partnership with a number of local organizations (CECODES, DEPOCEN and etc.); and other initiatives to mobilize anti-corruption stakeholders like the Vietnam Innovation Day 2009 (VID) coordinated by the WB and the Government Inspectorate of Vietnam (now followed by the Vietnam Anti-Corruption Initiative Program – VACI in 2011) or the FACE (For A Clean Education) Club established by Hoa Sen University in Ho Chi Minh City and Ben Tre college in 2010 and etc.

At the community level, individuals and civil society groups have also contributed to the battle against corruption. For example Madame Le Hien Duc – a retired teacher – has supported countless people to bring their discontent and unfair cases to light and was given the Integrity Award from TI in 2007. In another similar case, the Elderly Union in Da Nang city supported the police to keep traffic in order and to monitor police interaction with complainants.

Against this backdrop, this research study was initiated to contribute to the follow-up activities of the 6th ACD, and shed more light on the issue of corruption in the health sector.

2. METHODOLOGY

2.1 STUDY OBJECTIVES

This research focuses on the practice of informal payments including envelopes, cash and in-kind payments exchanged during the process of receiving health services. These payments are separate from any official payment approved by the government for health care. The research team decided on a qualitative design using individual semi-structured interviews (ISI) and focus group discussions (FGD). The study ISIs and FGDs therefore focused on the interaction between patients and service providers.

Overall, the study consists of two objectives:

- To understand and map the perceptions, forms, patterns and impact of informal payments in Vietnam by asking the opinions of national policy makers, health managers, service providers, end-users and international experts working in Vietnam.
- To suggest policy implications and recommendations to limit informal payments in health services in Vietnam.

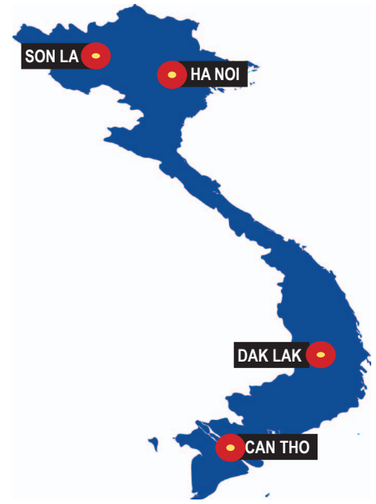
2.2 STUDY QUESTIONS AND TOOLS

The study focuses on answering specific research questions as listed below. Interview guides were developed for each audience, while desk research was conducted to review previous and existing policies and regulations associated with anti-corruption, user's fees, hospital management and health insurance.

- How has the practice of informal payments changed or grown over time in Vietnam and in the health sector specifically?
- What are the perspectives held by related parties of the impacts of informal payments on the objectives of the public health system?
- Is it necessary to control informal payments?
- What are the best approaches to address the issue of informal payments?

2.3 STUDY SETTINGS

Data collection was carried out in four geographic areas: Ha Noi (North, urban), Son La (North, rural and mountainous), Dak Lak (Central Highlands and rural) and Can Tho (South, urban site in the Mekong delta region). In each province/city, two hospitals (the provincial hospital and a district hospital) were selected (Table 1) using a modified process (see endnotes 17 and 18).



The study was kicked-off with a number of interviews with national policy makers in Hanoi (Table 2) to obtain an understanding of the big picture from a government and hospital perspective.

Initial contact by letter, followed up with phone/email contact, was made with every Department of Health (DoH) before undertaking each field trip. In each province, the consultant team had arranged a short meeting with the DoH leaders and hospital managers to introduce the study and request their support and consent. The selected DoH and hospitals generally welcomed and supported the interviews.

Directly after interviews were conducted at the hospital, the team reviewed and analysed the information collected and compared it to previous interviews, following a "constant comparison" method of qualitative analysis. Interviews continued until concepts and ideas were reiterated by new interviewees and no new concepts were being identified, i.e. until the team reached saturation of the collected information. Study preparation began in July 2010, and data collection ran from August 2010 to February 2011.

2.4 RESPONDENTS

Interviews were conducted at both national and sub-national levels. A total of 178 persons were interviewed, including 17 national level policy makers and other influential figures, 119 health workers and service users through ISIs and 42 health workers and service users through FGDs (8 with service providers and 1 with service users) at other lower levels - see Annex 1 for more detail. Among the total number of participants in the study, 68 were male and 110 were female. 40 per cent (72 out of 178) of informants were from rural areas (Son La and Dak Lak).

COMPONENT 1: PERSONAL INTERVIEWS AT NATIONAL LEVEL

Seventeen interviews were conducted with key stakeholders and specialists from policy-making agencies, ministries and health bodies. Agencies were identified based on their participation in health/anti-corruption policy drafts, policy implementations and community intervention delivery, and their commitment to the communication and education of the general population on health care and anti-corruption.

To approach the informants, a letter, issued by RTCCD and TI, was sent to 30 invited people. The letter gave a brief introduction to the study, outlined the objectives of the study, and proposed an interview time and place in a plain Vietnamese language. Key informants were contacted by phone and email afterwards to follow up on their willingness to participate in the study.

TABLE 1. STUDY SITES

AREA	HOSPITALS
HA NOI	Saint Paul[17] Hospital (central) & Thanh Nhan Hospital (local)
SON LA	Son La Provincial Hospital & Moc Chau[18] District Hospital
DAK LAK	Dak Lak Provincial Hospital & Krong Pak District Hospital
CAN THO	Can Tho Provincial Hospital & Phong Dien District Hospital

Studies were carried out in the Emergency, Out-patient Clinic, Pediatrics, Obstetrics, Surgery, Laboratory, Internal medicine, and Finance Departments of the above hospitals.

Among invited informants, two were not allowed by their organizations to participate in the study, and 11 did not respond to the invitations. In the end, 17 representatives of organizations including communist party agencies, ministries, the Office of Central Steering Committee on Anti-Corruption (*Van phong Ban Chi dao Phong chong Tham nhung Trung uong*), national hospitals, international multi-lateral organizations, medical associations, mass media, and international non-governmental organizations were interviewed (Table 2).

TABLE 2. INTERVIEWS AT NATIONAL LEVEL

TYPES OF NATIONAL KI'S	NUMBER
National policy makers	3
Ministry-level policy makers, including mass agencies	1
Mass media representatives	3
Social and medical association /hospital leaders	4
Specialists from multi-lateral international organisations	3
International experts	3
TOTAL	17

COMPONENT 2: PERSONAL INTERVIEWS AND FOCUS GROUP DISCUSSION AT SUB-NATIONAL LEVEL

Service Providers: Doctors and nurses were identified by hospital managers to participate in the interviews. For each department, the hospital manager nominated a department leader and a member of staff (doctor or nurse). During the interview with the department leader, the research team asked for permission to interview additional health workers in his/her department.

Service Users: The research team approached patients and their caregivers at the Emergency, Out-patient Clinic, Pediatrics, Obstetrics, Surgery, Laboratory and Internal medicine departments for the interviews.

In addition, those who had accessed medical services within the last twelve months were also asked to participate in the study. They were approached by the research team at cafeterias, hairdressers, in taxis, hotels and food stalls. Researchers also asked to be introduced to any acquaintances who had accessed health services in the past twelve months.

Participation in the 9 FGDs and 119 ISIs at the sub-national level were voluntary. The research team clearly explained to potential participants the rationale, purpose and objectives of the study, and its significance to the health system and development of Vietnam. Participants were then asked if they would be willing to participate in the study.

2.5 INFORMATION ANALYSIS

Interviews were either tape-recorded or transcribed by hand. An independent team transcribed all information, and the most informative transcripts were fully translated in English using a professional translation service. Translation into English facilitated the report-writing process, and allowed English-speaking collaborators to participate in the analysis. Transcripts were identified by an ID code that was assigned before the interview. No names of respondents were written or identified in the transcripts.

Since the analysis of data was to be conducted in Vietnamese, transcripts in Vietnamese were imported to the copyrighted NVivo 7.0 software for analysis. Coding was based on interview guide topics, with other codes developed as concepts emerged from the data. Themes are summarized in Annex 3.

Responses between different types of respondents (health leaders, providers and users) are explored within each thematic area. Key issues are prioritized based on the frequency with which they were referred to and discussed by respondents. Contradictory perspectives are also highlighted in the report. The research team has carefully sought to avoid the inclusion of any identifying information for respondents to ensure confidentiality.

3. KEY FINDINGS

3.1 HISTORY OF INFORMAL PAYMENTS IN VIETNAM'S HEALTH SECTOR

The term "informal payment" is primarily used in written Vietnamese, while the terms *qua tang* (in-kind gifts), *tien boi duong* (small cash directly) or *phong bi* (envelopes) are more commonly used in spoken Vietnamese.

According to respondents, it is hard to pinpoint exactly when envelope payments started to appear in Vietnam but in-kind informal payments, which was explained as 'in-kind gifts' by both patients and care givers, is deeply rooted in the country's history. Behavioural changes in giving and receiving informal payment can be divided into three phases:

- War Time and Subsidy Era;
- Doi Moi until 2000;
- From 2000 until Present.

WAR TIME[19] AND SUBSIDY ECONOMY[20]

Many central-level informants agreed that envelope payments (offering of small amounts of money in envelopes or directly) to health workers did not exist during war-time (before 1975) and during the subsidisation period (1976-1986). However, giving in-kind gifts to health workers did exist and acquaintances of health workers may be more likely to receive free tablets of common medicine (such as anti-flu, pain relief, antibiotics) than non-acquaintances. According to health-sector informants, the gifts were given voluntarily and were usually small consumables (e.g. a rooster, rice, jack fruit, grape fruit, eggs, etc.).

"Thirty years ago, no one had to pay anything to get services. It was a public service." (IDI-CEN-15)

"In the time of subsidisation when everyone was poor, the doctors and patients acted as their true role which was allocated by the social functions for each, farmers do farming, and doctors do treatment. The salary which the government paid me came from the taxes paid by the farmers and workers. In other words, I was fed by the citizens. Consequently, I must serve them when they become sick. It was fair….. I still remember a case. I cut his ulcer stomach. Several months later, he came to the hospital and invited me to his home town. Taking his invitation, some of my friends and I cycled ten kilometers to his home town. When we arrived at his home, it turned dark. His family set a mat in the front yard, presented a pot of sticky rice, a cuisine with pork paws and pig's tripe. It was the story of 1978-1979. No sign of envelope payment existed. The people loved their doctor so much and they gave me a kilogram of sticky rice, or some oranges, or a hen or a home-made wine whenever Tet came. I thought those were the best gifts ever. Patients, they were too good to me and I was thrilled" (IDI-CEN-12)

"In 82-83, there was a phenomenon that patients wanted to thank doctors by inviting them out for a coffee or smoking cigarette together. In my district hospital, patients showed their appreciation in diversified approaches. They invited doctors to their family's wedding or funeral party. If I was busy and could not come, they would send me some food. It was very emotional and I could feel their heart from my heart" (IDI-CEN-16)

"Informal payments did exist in the history. It started from the patient's gratitude and appreciation to doctors. I remembered when I was small; I was very annoyed when my mom or my dad held a chicken to present to the doctor. At that time envelope payments did not occur...I think that giving gifts to health workers is beyond giving and receiving. It is the story of culture. Vietnamese just give the gifts when they feel close or appreciated." (IDI-CEN-13)

FROM DOI MOI[21] TO 2000

There were a range of different perspectives among respondents regarding this period. A large number of respondents agreed that cash or envelope payment started to become common in Vietnam when the country started to open towards a market economy under Doi Moi. Meanwhile, other respondent did not consider Doi Moi to be the key cause for the trend towards the envelope payments and instead pointed to the government's policy allowing hospitals to collect patient fees (*Quy dinh thu mot phan vien phi y te*) and the health insurance policy as the main reasons behind this trend (Box 5). According to this policy, patients must pay a proportion of service fees to the hospital in order to access services at any level they wished. This is in contrast to the subsidy era when health service fees were all covered by the national budget and patients needed to access primary health care services before being referred to higher health facilities for serious conditions. In the opinion of a number of respondents, this policy led to an overload of patients in central and provincial hospitals, requiring patients to offer envelope payments in order to catch the attention of health workers and obtain better care.

"By 1995 I started to notice the envelope payments. From 86 to 95, after the reform of Vietnam, I didn't notice them, so it is hard to say exactly when it started." (IDI-CEN-10)

"The health problem in Vietnam lies in the unmet need. The need is always higher than the supply. In the subsidy period, people had to use relationship or in-kind gifts, not envelopes or cash. But under the market economy, the envelope takes the role." (IDI-CEN-8)

"I think envelope payment started from 87, from Doi Moi or from the health insurance policy." (IDI-CEN-14).

"The shift [from in-kind gifts to envelope payment] started from the collection of service fees. Since then, there is no clear boundary of treatment facility levels. This is very dangerous. In the past, the levels of treatment facilities (phan tuyen dieu tri) *was strictly followed. If a district doctor referred a patient to provincial hospital when the referral was unnecessary [could be treated at district hospital], there would be a review meeting in the whole district and provincial system. So the referral system helps to avoid the overcrowding in higher health facilities."* (IDI-CEN-12)

BOX 5: DECISIONS ON OUT OF POCKET PAYMENT FOR HEALTH SERVICES AND HEALTH INSURANCE

Decision 45-HDBT issued in 1989: to allow health services to collect service fees from patients to improve the quality of treatment. 60 per cent of the total fees collected is for supplies for treatment, 35 per cent for health workers' salary and 5 per cent for management fee to the MoH. Patients required to pay health service fees include: people requesting special services, people suffering from work accidents, traffic accidents, drinking and fighting damages and people not on the social protection scheme.

In 1992: health insurance was introduced in Vietnam. Patients were required to follow the primary health service and get referrals to access higher level care.

Decree 95-CP issued in 1994: revised Decision 45-HDBT, which added health insurance targets.

Decision 33-CP issued in 1995: revised article 6, clause 1, reallocating 70 per cent of the total fees collected for supplies for treatment and 30 per cent for health workers' salary.

Decision 10-CP issued in 2002: to allow state-owned agencies (including hospitals) to become self-financed and independent in their human resource management. As a result, hospitals could increase income in exchange for receiving more patients. Hospitals were also allowed to collaborate with medical equipment companies and private services to use materials and income from machine/test use would be divided accordingly between hospitals and companies. Thus more patients are recommended to take tests or use laboratory services, potentially leading to over-crowding.

Decision 43-CP issued in 2006: revised Decision 10-CP to enlarge certain aspects of self-financing.

FROM 2000 TO PRESENT

Comments by former health facility managers and national policy makers suggest that envelope payments increased significantly during this period. Around this time, public and private health services were combined and central and provincial hospitals overloading made access difficult for patients. In the context of dynamic economics, the basic needs of adequate food and clothing have increased to eating well and dressing fashionably. Riding bicycles has given way to driving motorcycles and cars, and thus the whole country has turned towards more consumerist behaviors. Citizens needed more money to sustain higher living standard and health workers were no exception. Thus patients transformed in-kind gifts into cash or envelopes for the convenience of both the giver and the receiver.

"The period when envelope payments came into being was when health workers were allowed to open private clinics. Citizens approached doctors at private clinics and asked for help to connect with services at public hospitals. Envelope payments became a phenomenon when the needs of the whole society increased, when people wanted motorbikes" (IDI-CEN-16)

"Before 1985, there was no envelope payment…..From 1997 or 2000, everything messed up" (IDI-CEN-11)

"Please imagine one day without envelope. For example, you are given five envelopes a day; each envelope has 50 thousands VND. The money is easily kept in your wallet. If five envelopes are replaced by five packs of biscuits, can you eat them up? Additionally, to have five packs, the giver needed to go to the supermarket, buy the goods, put them into the bags; it is a series of many activities compared to putting money into an envelope. Having envelopes, everything becomes more simple and convenient for all. The envelope is comparable to a quid of betel. In the past, "A quid of betel and areca-nut starts the conversation". Now, "An envelope starts the conversation." (IDI-CEN-13)

TABLE 3. DENSITY OF PHYSICIANS AND NURSES/ MIDWIVES PER 10,000 PERSONS (2010 STATISTICS)

COUNTRY	PHYSICIANS	NURSES AND MIDWIVES
VIETNAM	6	8
CHINA	14	10
JAPAN	21	95
UNITED STATES	27	98

Source: World Health Organization, World Report 2010

Informal payment is of particular concern for provincial hospitals and central hospitals where patient overload is present.[23] In a comparison with a range of countries across the world (Table 9) the density of doctors and nurses per 10,000 people is lower in Vietnam. Hospital overload and poor supervision are more likely to be the main reason for the rise in envelope payments in Vietnam.

According to the MoH, overload of hospital capacity in 2008 reached 150 per cent at central hospitals, 125 per cent at provincial hospitals and 115 per cent at district hospitals. Bach Mai hospital (the leading central hospital in internal medicine in Hanoi) was overloaded by up to 200 per cent of its capacity and the K hospital (the leading central hospital in cancer treatment) was even higher at 300 per cent. Two to three patients in one bed has become common in recent years. Up to 75 per cent of patients went directly from commune to central hospitals without referrals from district and provincial hospitals.[24] The prolonged situation of overloading at central and provincial hospitals led to the gradual reduction of treatment quality. Overloading has been observed in both in-patient and out-patient services. The rate of health workers assigned to each bed is very low, around 0.57-1.09 health workers/ bed while the standard in Vietnam set by the MoH is 1.45-1.55 health workers/bed. The average time spent on each patient is about 3-5 minutes.[25] There is no clear answer to when informal payments, particularly cash/ envelopes payments, started in Vietnam but it is clear that with health services struggling to meet demands at all levels, patients commonly encounter shortcomings in their attendance by health worker and their quality of care.

Thus, it can be said that the practice of giving envelopes appeared when the socialist health care in Vietnam moved to a mixed system and developed rapidly as a result of weakness in systematic management in a resource-constrained economy, and was perpetuated by wide-spread corruption that existed at the time. These factors meant that the health system was more likely to become market-oriented, and with the development of the private health sector, all components of the society have deepened in gaining private benefits (health staff), or organizational benefits (health facilities) instead of community benefits. As a result, levels of corruption in general and envelope payment in health services in particular were more likely to grow.

3.2 FORMS AND VALUE OF INFORMAL PAYMENTS

According to health workers and service users interviewed, informal payments in recent years has taken a number of different forms, with its name and true meaning corresponding to the giver's intention. However, informal payments can generally be categorized into three types:

- Gifts (in-kind payments)
- Cash
- "Opportunities"

GIFTS (IN-KIND PAYMENTS)

Most patients interviewed in Hanoi stated that they did not give gifts alone but presented gifts with an envelope. The gifts (commonly fruits, candy, biscuits, etc.) were put into a plastic bag which aimed to hide the envelope. Some patients who reported having established relationships with health workers and knowing the taste of the doctors, said they sometimes presented brand-name lipsticks, outfits or shoes. Other presents included cell phones, LCD televisions or imported milk for the doctor's baby. Regardless of the cost of the in-kind present, they still considered it as a 'gift'. A small proportion of patients coming from the provinces to Hanoi for treatment presented home-made products as gifts, for example new-harvest peanuts, garlic, corn, oranges, or fermented sausages. Most of them went out to the market and bought fruits to thank health workers.

CASH OR ENVELOPE

Cash alone or cash in envelopes are the most common form of informal payments to health workers. A doctor of a surgery department in Hanoi stated that *"100 per cent patients thank health workers by envelopes, and only a few of them enclosed envelopes with a bottle of wine or a box of biscuits"* (IDI-CEN-13). Another doctors said *"As I know, about 40-50 per cent patients thank doctors by money. Others do not. How can students, workers and rural patients have money to present doctors?"* (IDI-HN-DO-1).

Many Vietnamese terms have been used to replace the term "informal payments" or "envelope payments", even though these two terms have still been intermittently used. The other common names of informal payments (Table 3) are used to intentionally hide the true purpose of the givers, and to make the providers feel at ease when they accept it, as illustrated in this quote *"You should mention that this money is to reimburse the doctor's effort (Vietnamese: tien boi duong), don't tell any little thing about "bribe" (Vietnamese: hoi lo), otherwise you will get a scolding from the health workers"* (PCASE-SL-12)

TABLE 4. TERMS USED IN THE CONTEXT OF CASH PAYMENTS IN HEALTH SERVICES

VIETNAMESE TERM	TRANSLATION IN ENGLISH	SITUATIONS WHEN THIS TERM IS APPLIED
1. tien cam on	Money to express thanks	Given after service, when service is well done
2. chut qua cho chau	Small gift for doctor's children	Given after service, when service is well done
3. tien uong nuoc/ tien an trua/ tien an bat pho	Money for drinks/ lunch/ "pho"	Given after service, when service is well done
4. tien quan tam	Money to pay more attention to patients	Most commonly given at check-in time (before service)
5. tien boi duong	Money to reimburse the doctor's efforts	Given in addition to official fees, but not hidden. Intention is to thank
6. tien dut	Bribe	Given before service. Intention is to speed up service or to have a better quality of care
7. tien quan he	Money to create a warmer relationship	Given to speed up service
8. phong bi (in the North)/ phong bao (in the Central)/ bao tho (in the South)	An envelope	General terms for informal payments, implies the transaction of the informal payments, or the payments itself

People in the north of Vietnam use all types of wording mentioned in Table 4 to describe the payment of money to health workers, while in the Central and the South, people commonly used four terms: 1,3,5 and 8.

"OPPORTUNITIES"

This is a new means of expressing thanks which has recently started in large cities. Instead of thanking health workers with in-kind gifts or money, some patients try to establish relationships with doctors, explore doctor's needs and concerns and offer opportunities in the future. For example, patients can offer doctors the chance to purchase an apartment at a corporate price which most people could not access, help to buy imported formula for the doctor's infant, or help to enroll the doctor's children into good schools. Only doctors with special expertise, such as outstanding surgeons, obstetricians or In Vitro Fertilization doctors, are likely to be offered such privileges.

"Giving gifts or money, it is old style and it is the behavior of persons who do not know how to set up a relationship. Me, I would thank without any gift or money, but ask for the doctor's telephone. Of course I must exchange conversations with the doctor whenever I can to let him know that I can offer services that he needs. When I have a chance to buy an apartment at a corporate price, I would telephone doctor and pass him the opportunity. That is money and a lot of money, which is not visible. All hands are clean but I know for sure that if any member of my family or friends need healthcare services I can call him. If he could not do it by himself, he would connect us to his colleagues" (PCASE-HN-17)

"Money is not our concern. We don't want to receive their envelopes. If they help me to enroll my son into a selected school, I would appreciate more and I like it that way" (FDG-HN-DO-1)

VALUES OF INFORMAL PAYMENT

Policy makers and hospital leaders interviewed were very interested to know the amount patients pay informally when using health services. The research team raised this question to all informants interviewed including doctors, nurses, administrative staff, service users at different departments and citizens who have used public health services in the last 12 months.

In order to assess how much informal payments cost, it is necessary to understand the salary scheme in Vietnam. Under the current salary scheme, a teacher after ten years of graduation is paid 2-3 million Vietnam dong (VND) a month (around USD 100-150). A newly graduated doctor (after nine years of training) is paid a salary of VND 1.8 million a month (around USD 90) not including bonuses. After 10 years of working, most doctors are paid VND 4-5 million per month (around USD 200-250) including salary, a per diem for night shifts and a monthly bonus (for example, from the payroll of a deputy of the surgery department in a Hanoi-based hospital in 2010, the total income from the hospital is VND 4.2 million a month).[26] A chief nurse in the Obstetrics department in Hanoi is paid a total of VND 3.4 million (USD 170) a month after 15 years of experiences. The salary of health workers in rural areas is almost the same as those in urban areas, however, those in rural areas do not have monthly bonus and instead only have a small bonus at the end of the year.

As one hospital department head described, it appears that *"The practice of informal payment pervades from national to local levels, but its scope varies"* (IDI-CEN-13). There are many factors that were associated with the level of informal payments expected, requested or given. They are service location, type of service acquired, type of medical personnel, and provider-patient relationship.

Service Location and Type of Services. Both health providers and patients agreed that the cost of gifts are not exceptionally high and do not differ widely between regions. However the amount of cash/envelope payments is clearly greater at higher level hospitals (central and provincial), and in urban facilities (Table 5).

Almost all service providers and service users stated that cash/envelope payments and gifts are made in situations where there is a high chance of mortality. The monetary value of informal payments is highest for complex or difficult services such as emergency, surgery (orthopedic and aesthetic-related surgery), obstetrics, pediatrics or cardiovascular diseases and the amount given appears to be a substantial proportion of or even larger than the monthly salary. In other departments, especially in internal medicine, the cash/envelope payment are of lower cash value than in other potentially life-saving departments.

"If you used the outpatient services, I think the practice of informal payments will not be as common as when you use the in-patient ones." (PCASE-HN-5)

"[The amount of cash paid] is based on the patient's illness gravity. Severe, 1 million VND [50 USD]. Less severe, 500,000 VND [25 USD]. But 1 million VND is cost norm" (PCASE-HN-2)

"I gave 300,000 VND [15 USD] to the doctor when the delivery was completed. When the baby was bathed, I gave 20,000 VND [1 USD], when they came to take care of the mother, 20,000 VND [1 USD]. I also paid 100,000 VND [5 USD] to have a better place in the ward." (PCASE-HN-8)

TABLE 5. RANGES OF CASH/ENVELOP PAYMENT AMOUNTS BY HEALTH FACILITIES AND TYPE OF SERVICES

TYPES OF SERVICES	DISTRICT HOSPITAL	PROVINCIAL HOSPITAL	CENTRAL HOSPITAL
Surgery	50,000-500,000 VND (2.50 - 25 USD)	200,000-2,000,000 VND (10 - 100 USD)	500,000-5,000,000 VND (25 - 250 USD) Several tens of millions (several thousands US dollars) the highest reported case was in Ho Chi Minh City
	400,000-500,000 VND average (20 - 25 USD average)	500,000-1,000,000 VND average (25 - 50 USD average)	1,000,000-3,000,000 VND average (50 - 150 USD average)
Obstetrics	100,000-600,000 VND (5-30 USD) 200,000-500,000 VND average) (10-25 USD average)	200,000 - 3,000,000 VND (10-150 USD) 500,000-1,000,000 VND average (25-50 USD average)	1,000,000-2,000,000 VND (50-100 USD) 1,000,000 VND average (50 USD average)
Emergency & Recovery	No Data	No Data	200,000-300,000 VND (10-15 USD)
Laundry and cleaning	No Data	No Data	5,000-20,000 (.25 – 1 USD)

Type of Medical Personnel. During the interviews the research team asked the direct question of "who are often being given gifts, cash or/and envelopes?" Both service providers and users stated that whoever provides the surgery or emergency care, or directly communicates with or provides routine care for the patients (i.e. cleaning services, injection or medication administration, etc.), are in a better position to receive informal payments from patients or families. However, doctors or surgeons have normally been given larger amounts of money than nurses, assistants or orderlies. While envelopes are generally given to doctors, cash is given directly to nurses and administrative staff, and gifts of fruits or biscuits are given to departments in general.

"The cost norm is 2–5 million VND [100–250 USD] for doctors, 50,000–100,000 VND [2–5 USD] for nurses. I pay doctors once per 10 days, nurses once per 1 week."(PCASE-HN-11)

"Doctors are most often offered envelopes. The patients consider that the doctor is the person who decides whether their illness will be treated or not. Nurses always follow the doctor's medical instruction, that's all. They [the patients] want to work with the "leaders" (IDI-HN-NU-6)

"The members of a surgery team, the health workers involved in treatment for the severely ill patients, obstetric and pediatric doctors are mostly being given the envelope payments" (IDI-SL-AD-5)

However, in the obstetric department opportunities for informal payments between nurses and doctors are either equal, or nurses sometimes are better positioned than doctors to receive small cash when providing daily care. This situation was reported in both big cities and provincial hospitals.

Hospital doctors, nurses, and patients in big cities confirmed that there are other hospital employees who might receive cash from patients, for example, test administrators, cleaning and laundry personnel, orderlies, the leaders approving paperwork and etc. However, this research found that such practice is uncommon in rural hospitals, and that informal payments do not appear to be made to these staff in district hospitals.

"An acquaintance of mine told me that when she was in hospital, she had to prepare small notes in her pocket to give the staff. If she wanted to borrow a chamber-pot or a set of uniform, she had to pay a note. She also paid the person who administered injections, and people who operated equipment. She had to pay many people as they worked in shifts, it was thus very costly. Moreover, she paid not only the surgeon, but also the other personnel of the surgery team" (IDI-CEN-11)

TABLE 6. RANGES OF CASH/ENVELOPE PAYMENT TO HEALTH WORKERS

TYPES OF MEDICAL PERSONNEL	DISTRICT HOSPITAL	PROVINCIAL HOSPITAL	CENTRAL HOSPITAL
Doctors	200,000 VND (10 USD)	50,000-1,000,000 VND (2-50 USD)	100,000-2,000,000 VND (5-100 USD)
		200,000 VND average (10 USD average)	500,000-1,000,000 VND average (25-50 USD average)
Nurses	10,000-50,000 VND (0.50-2.50 USD)	10,000-100,000 VND (0.50-5 USD)	10,000-100,000 VND (0.50-5 USD)
	20,000 VND average (1 USD average)	20,000-50,000 VND average (1-2.50 USD average)	50,000 VND average (2.50 USD average)
Orderly	No Data	5,000 VND (.25 USD)	20,000 VND (1 USD)
Administrators (test administers, guardians, health insurance staff, cleaning personnel)	No Data	No Data	20,000 VND (1 USD)

Relationship with Providers. Both service providers and patients interviewed in this study reported that having a pre-existing relationship does not reduce the amount a patient pays in informal payments, or affect the likelihood that the patient will make an informal payment. However, introduction or instruction by an acquaintance can enable a patient to obtain privileges such as faster care, better attitude from medical personnel, more advice and consultancy from attending physicians, clearer instruction on examination or treatment procedures, more information about better medicine and technology, or more convenient visits from relatives while hospitalized, compared to what "non-acquainted or non-introduced" peers may receive. Rather than giving an informal payment, a patient who is acquainted with the provider might sometimes give gifts or in-kind payments. A small number of patients did not give anything to their acquaintances or treating doctors. If the payment is money, the acquainted health worker may take the informal payment on behalf of the actual recipients (i.e. the providers who actually cared for the patient). If the acquainted person is not the patient's family relative, s/he also may be paid in cash or in-kind payments, (although usually through in-kind payments). In addition, some providers said that they themselves had become givers many times, when their family members or relatives needed medical care.

"Having a pre-existing relationship sometimes prevents the patients from giving an envelope. Some people pay [the acquainted person], some do not" (IDI-HN-DO-3)

"Years ago, my 2-year-old son required surgery. I had a pre-existing relationship with a doctor at that hospital. But I was worried before the surgery when I had not given money to the surgeon. I did not know if my son would have enough care. After the surgery, I actively solicited the doctor to accept the money. I just felt a peace in mind from that moment." (IDI-CEN-26)

"The poor people give more often than the educated people. We, the medical personnel, also give often. When I have a relative who is cared at the other departments, I usually give an envelope or an in-kind gift to thank the colleagues after his/her discharge." (IDI-SL-NU-5)

Both central policy makers and rural patients who were interviewed while using provincial and district hospital services stated that from their experience, cash/envelope payments were more common in provincial and central services than in commune and district services. This is thought to be because providers in more rural areas are reluctant to directly demand payments from patients with whom they are acquainted. In commune health stations, since services do not have as many patients waiting, the need for patients to exchange money to ensure they have the health worker's attention is not as widespread.

3.3 PROCESS BEHIND PAYMENTS

INFORMAL PAYMENT: DEMANDED OR GIVEN VOLUNTARILY?

Service Providers' Perspectives

Most services providers from central to provincial and district health facilities stated that informal payments (gifts and envelopes) are given voluntarily by the patient. Only in a few cases did respondents state that, health workers, mostly nurses or administrative staff, explicitly request small amounts of cash from patients. A doctor told a story about a patient which has remained in his mind for a long time. He sees it as evidence that giving something to thank health workers is a cultural habit of Vietnamese people and entirely voluntary behavior.

"Some years ago, I did an appendicitis operation for an 8-year-old girl. Her mother was very beautiful. The mother had intentionally been avoiding meeting me, I did not know why. Three months later, she came back and gave me 300 thousands VND. She said "That day you made the operation for my daughter; I had to borrow money to pay for the hospital fees. Now I have money I would like to give to thank you". She is poor, yet she brought 300,000 VND to say thank to me. She cried saying those words. I accepted the money, then gave it back to her and said "I received your money, but I want to present it to your child". Then she continued crying, and she told me her life story. She is a sex worker. Watching a person who cried this way, who had a good feeling of gratitude this way, I inferred that many people feel a need to give an envelope to express their appreciation. It is the need of the whole society. It is not bad." (IDI-CEN-13)

"Most doctors do not require envelope payments. However the Vietnamese people have a habit of thanking helpers by something and the Vietnamese people also has a proverb: "the first money is the wise money". That leads to the common situation of envelope payments in the health service now." (IDI-CEN-1)

"Even if the health workers do not require it, the patients feel they have to give the payments to make them feel safe. We tell them that it [the envelope payment] is not necessary, they insist on giving, that is like a psychological therapy for them." (IDI-SL-DO-1)

However, a number of former doctors who worked in the health sector for decades and as health managers of hospitals also revealed that in a minority of cases, some medical personnel might withhold care until the informal payment was made. Most doctors confirmed that they and their colleagues gave the same quality of care to every patient whether they made informal payments or not.

Service Users' Perspectives

Among those who acknowledged giving informal payments to health workers,[27] there are three contrasting perspectives: voluntary payments, neutral payments and those demanded by health workers. A small proportion of patients, both in central hospitals and rural-area hospitals, admitted that the payment was made from their heart and it is normally given after the medical personnel have performed their duties. A similar perception also exists among both urban and rural service users.

"It's true gratitude. The woman has been followed-up during 9 months of her pregnancy. Now she has a safe delivery, all family members are happy and they would love to thank the doctor." (FGD-HN-CI-1)

"I think I should thank them by a little money as they have provided good care to me. I was hospitalized under the health insurance so the official payment would be very little. So I gave 300,000 VND [15 USD] to the team." (PCASE-HN-8).

About half of the patients interviewed, both urban and rural service users, said that they gave money or in-kind gifts because it is the common behavior of others. Under this situation, it is not ranked as voluntary nor demanded – even if there is clearly a dimension of social pressure "pushing" people to follow these common behaviors.

Finally, up to one third of patients reported that providers sometimes extort payments in subtle ways. They may behave in ways which are meant to prompt an extra payment from patients/family; they may, for example, give a more painful injection, or adopt a less gentle attitude. Most of these comments came from patients at provincial, city and central hospitals. In such situations, the action of 'asking' for a payment is more hidden, complicated and may be difficult for outsiders to witness. It invisibly causes a sense of fear on the part of the patients whenever they are in need of health care. As a result, patients have unwillingly given the informal payments.

"They have never directly asked for money. They do a very strong and painful injection to signal or prompt the payment. While if you have paid, the injection is gentle, and the medicine may be better….A number of health workers acts badly if they don't get an envelope payment from the patient." (IDI-CEN-11)

"*When handling over a baby to the family, the nurse tells them "The delivery has had a good outcome, we have been working hard for the whole night". The family thinks "They have been working hard, we should give them money"… or the nurse says "I have asked him to do the surgery for your woman. He is the best doctor here. He did not require, but [you would better] give him money. You can give me the envelope, I will pass it to him later". The nurses have taken advantage of their position to pass on the money, and sometimes they keep the money [which was received on behalf of the doctor] for themselves."* (IDI-DL-DO-1)

HOW PATIENTS DETERMINE WHAT TO PAY

All interviewed service providers confirmed that from their experience, they never tell patients how much to pay nor do patients ask them how much they should pay. However, a few patients said that medical personnel had told them exactly how much they should pay. Most of these cases occurred in the central hospitals which are extremely overloaded with patients. The majority of all interviewed patients, both in cities and rural provinces, confirmed that they estimated how much to pay by asking other patients, friends, neighbours, and relatives based on their past experiences using the health services at the hospital. Although they might receive several suggestions, the actual payment is ultimately also made based on their ability to pay.

"After the surgery, they asked "who accompanies Ms….". I came to meet them at their own working place [inside the hospital]. They told me something about my wife's illness and surgery outcome. Yet, they did not mention any word about the envelope payment. I gave them 300 thousands VND [15 USD] and said "my family would like to give a little to reimburse your effort". I gave it to a surgeon. He asked "is it for the principal surgeon or for the whole team?" Actually, I had two envelopes in my pocket, I thought I would give an envelope of 300 thousands VND for the principal surgeon, and the other one of 200 thousands VND [10 USD] for the assistants. Then I gave him the other envelope of 200 thousands VND and said "Yes, this is for the others". So I paid 500 thousands VND [25 USD] in total. This was less than the others had paid, because I thought my wife's problem is not very severe. Her operation was not very complicated and I am not very rich. A majority of the people in the ward paid an amount of money 2 times higher than I did; several people paid 3 times higher (1.5 millions VND [75 USD])." (PCASE-HN-1)

"My acquaintance informed me. She told me that «This doctor is good, give him 300 thousands [15 USD], and 50 thousands [2.50 USD] for the nurse who cared for you». I was also advised to directly give them the money" (PCASE-HN-5).

"I saw a lady asking "How much to thank them?" There were 6 or 7 people in the ward gathered to counsel her. They said "we had experiences. You cannot bring money alone inside the doctor's room. Now go out and buy 2-3 kgs of fruits and put 200,000 – 500,000 VND [10 – 25 USD] into an envelope". So she did. She entered the doctor's room. I did not know what she said but she looked happy when coming out of the room" (PCASE-SL-12).

Several health workers and patients of both rural and urban areas said that intermediaries work in central hospitals, providing patients with instructions for how to easily approach the doctors, and acting as an intermediary between the doctor and the patient. Brokers may be someone in official positions as part of the health system (i.e, staff in the facilities), or someone outside the system.

"In fact, I recognized that the practice of informal payments is more hidden when it happens at the lower level health facilities, whereas it is more frankly mentioned at the higher level hospitals. The latter is the most convenient for two sides; otherwise it requires the involvement of an intermediary. In this case, it means that the patient has to pay more, and the money for true recipient is embezzled." (IDI-SL-AD-5)

Table 7 summarizes some of the ways that providers convey to patients the need to make an informal payment, both indirectly and directly.

TABLE 7. HOW PROVIDERS CONVEY THAT PATIENTS NEED TO PAY, ACCORDING TO PUBLIC INFORMANTS[28]

BEHAVIOUR	EXAMPLE
Staff emphasize the hard work involved in taking care of the patient	"She described how hard they work in the night to help the pregnant women have a safe birth." (IDI-DL-DO-1)
Directly request payment	"When her [respondent's sister-in-law] operation finished, the doctor directly suggested that "It's well done, you should give "thanks" to the doctor." (PCASE-HN-5)
Act in an unfriendly manner with the patient	"The nurse ignored her when she asked for a bed wrap" (IDI-DL-AD-3 shared from her cousin's experience)"
Ask "Who is with the patient?"	"After the surgery, they asked "who accompanies Ms.…". I came to meet them at their own place." (PCASE-HN-1)
Withhold or delay care	"When I took my student, who had a bad motorbike accident and smashed his jaw and face, and the doctor had to be paid before the surgery would be done even though he had a student health care card. Ask "Did the health workers give any sign that a payment needed to be paid?" Everything stalled, he was there for a week before the surgery was done. It was supposed to be done several times before but it kept getting cancelled with no reason." (IDI-CEN-29)
Staff indicate that there is no medicine, or this is a special medicine, so the patient must buy his/her own at a indicated pharmacy/ address	"The doctor prescribed a number of medicines, and he said that they are not available at the hospital pharmacy. You go to the [name of pharmacy] opposite the hospital entrance" (PCASE-HN-6)

TRANSACTION MECHANISM

Table 8 summarizes the various forms of transactions patients commonly adopt for giving informal payments. The quotes are from patients and caregivers; most providers confirmed that these strategies are used by patients and gave additional examples.

TABLE 8. HOW PATIENTS GIVE INFORMAL PAYMENTS, ACCORDING TO BOTH PROVIDER AND PATIENT INFORMANTS

MEANS	PLACE	EXAMPLE
Keep money in patient's record booklet, test document or facial tissue	Everywhere	"I put money in a facial tissue or soft toilet paper and put into nurse's pocket" (PCASE-SL-12)
Slip money into health worker's pocket	Doctor's working place, ward, corridor, canteen	"I followed her, we pretended shaking hands, and I slipped money into her pocket." (PCASE-SL-2)
Give directly in a face-to-face meeting	Doctor's working place, corridor	"The patient met me to ask about their illness and treatment methods. Then he gave me money directly" (IDI-DL-DO-4)
Leave money on the table where doctor is sitting	Doctor's working place	"I left the envelope intentionally next to the notebook in which doctor was taking notes." (PCASE-HN-6)
Leave money in baby clothes	Maternal room after delivery	"If you have the delivery at the X hospital, you should pay if your newborn baby is bathed by leaving money in the folds of baby's clothes" (PCASE-HN-5)
Enclose money in a fruit pack	Administration place, doctor's working place	"Before being discharged, they bought fruits, candies and biscuits for all staff of the department. They enclosed an envelope in the fruit pack." (IDI-HN-DO-4)
Visit doctor's home	Doctor's home	"The relative of severely ill patients came to my house to give an envelope" (IDI-HN-DO-1)
Use a number of family members to give simultaneously (to give money at any cost)	Chasing the intended recipient at every place where s/he works	"In the morning of the day my operation was arranged, my husband and I tried to meet the surgeon to give money (each of us kept one envelope, we went separate ways) because I wanted my operation to go well. My surgeon refused to meet us and she shouted at me on the phone, when I tried to call her. Finally, that morning we failed to give her money [but they gave later when the operation finished]" (PCASE-HN-7)
Use an intermediary (an acquaintance)	Don't know	"Sometimes, you cannot approach doctor, you must use a "bridge" (IDI-CEN-12)

DEVELOPING THE HABIT OF ACCEPTING ENVELOPE/CASH PAYMENT

This question is of keen interest to policy makers and health managers who want to understand in greater detail the process for a new health worker to get used to regular informal payment practices. This would help to design targeted policies to try to prevent such practices before they are readily accepted by health worker. Most doctors and nurses interviewed smiled when the research team asked this question. Only some spontaneously gave the reply.

Both doctors and nurses in Hanoi, Can Tho and provincial hospitals confirmed that most newly-graduated health workers accepted neither cash nor envelope payment nor in-kind payments. They agreed that a certain amount of time is needed for a health worker to become accustomed to the practice of accepting envelope payments. This period of time is estimated to be between one to three years. Three years is the time it takes for a newly-graduated health worker to complete their internship or short-term contract and be granted their long-term staff contract. During those three years, her/his professional skills are also developed and she/he has the chance to observe the behaviours of experienced health workers. One year is the required time for a health worker in obstetrics or surgical departments to become accustomed to accepting envelope payments.

BEING A DOCTOR, I DON'T KNOW HOW LONG I CAN KEEP MYSELF CLEAN?

I am a young doctor...I attended a provincial gifted high school, and was then directly selected to the University of Medicine and Pharmacy in Ho Chi Minh city. After graduation, I passed the exam for residency....

For me, the salary is a burden, but I'm not brave enough to leave this working environment. Perhaps I love it. I graduated in 2005. I didn't have a salary during the 3-year residency and I was granted a scholarship of 240,000 VND from the University as a monthly stipend and grants worth between 480,000 and 560,000 VND from the hospitals where I practiced, depending on what each hospital could afford to pay. Besides these two allowances, I received 400,000 VND per month for doing night duty at the hospital (2 nights a week) and 500,000 VND per month for attending surgeries. On holidays, I received a bonus worth about as much as one fourth of that received by most hospital staff. I have just described all the income I received during my residency - less than 2 million VND (100 USD) per month in total. This income alone was not enough for meals, accommodation, tuition and other costs, so for three years until I turned 28, I also required financial support from my family...

I have described my income in detail so that everybody understands the difficulties that we as young doctors have to encounter working in a public health setting. At 30 years old, working in this city where the cost of living is high, is this salary enough or not? This salary is just enough to pay for accommodation and living expenses. I spend all of what I earn each month so I don't have any savings. Most medical students would dream of going through their studies the way that I did, but if you look towards the rates of pay as a doctor, I think many of them would hesitate. All of my peers in other professions, to some extent, have little or great success in their career and can help their family, whereas I'm helped by my family whenever I have difficulties, for example to pay for foreign language tuition and fees for post graduation. When I meet my friends, I always feel inferior and sad because of my income.

Frankly, to be paid even that salary, I have to work all of my time, laboring all day in the hospital from early morning to late afternoon: examining, prescribing, operating and supporting operation. Also, I'm under heavy pressure from administrative and insurance procedures and risks of review and insurance liability if I make mistakes such as prescribing medicines outside of the official list or not following official procedures. In my role as a lecturer, I am kept busy guiding intern students. With this much work, I end up having to do some at home in the evening.

I truly love the job, thus I have continued doing it with this salary to this point now. But sometimes I feel really hurt when I hear my mother says: "Studying all these years, 30 years old, still asking for money from your mother".

Many people say that in medicine there is no lack of ways to earn money. That's right, working accepting informal payments in public health settings is one example, but let me tell you, not everyone can do that. We're taught and educated for implementing the good things; I have not dared to receive any envelopes from patients although I have often been tempted. I have also had invitations to earn a better income elsewhere. Oh dear, maybe I'm not good at increasing my own income, but I don't resign myself to do that within the public system in ways my conscience does not allow [by accepting informal payments from patients]. I have lived with the salary that the State pays me, not by any additional amount besides the "grants" from my own family. Let me share with you my feeling after studying 12 years at general school and nearly 10 years at university and after it. If I didn't love the job, as a young doctor now, with the escalating pressure of this environment and society, I don't know how long I would be able to remain true to my morals and while still continuing work at public health facilities and "live by medical ethics"?

If there's a day when I get married, give birth to a child, surely financial pressure will weigh heavily on my shoulders. If I lose my moral standards at that time, would that be purely my own fault....

A Doctor of the University of Medicine and Pharmacy in Ho Chi Minh city

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3.4 MOTIVATION FOR INFORMAL PAYMENT

WHY PATIENTS GIVE INFORMAL PAYMENT

There have been a number of reasons for giving informal payment listed by interviewed patients. The following reasons are the most commonly mentioned:

Desire for better service

Patients sometimes felt that they, as a whole, are responsible for the practice of informal payments. In giving informal payments to health providers for better service, they have "trained" the providers to expect informal payments from them. Some provider respondents agreed with this perception. Over time, informal payments in central, city and provincial hospitals have become the rule for all rather than the exception.

"The patients and relatives have trained the doctors to expect informal payments. It is similar to the students' parents who have trained the teachers to expect gifts." (PCASE-HN-2)

"But if the patients had not actively solicited doctors for more attention, faster or better care by giving them money, doctors will not be used to it. The doctors do not require an envelope payment" (IDI-DL-AD-3)

Health providers also perceive that patients willingly give payments so that they will get better attention and care (anything from "a little smile" or showing kindness, spending more time with patient, providing more or better medications, conducting more attentive surgery or medical care, receiving greater medical consultation before discharge, having qualified doctors, shorter treatment duration). In fact, some providers said that when they or their relatives need care at health facilities different from their regular facility or at higher level facilities they also make informal payments to ensure the best possible treatment. Such statements coming from health providers familiar with common medical practices, indirectly demonstrates that informal payments have an impact on the quality of care received.

"In fact, if my relative needs to have a surgery at a higher level hospital, I may give money because I am afraid that s/he is still treated differently." (IDI-SL-NU-1)

To gain access to care

"Because you must pay or you will not be seen or receive any care" - A rather large number of patients reported that they have experienced this situation first-hand, or heard it from a relative, friend or colleague. However, many health providers completely denied this practice, and the very few health providers who would admit to its existence would only refer to "health workers" in very general words which did not clearly identify the type of provider (certain health workers – *nhan vien y te nao do*, someone – *ai do*, somewhere – *dau do*). Whether this perception is true or not, it is of great concern to the government and the MoH as this is the first perception of patients. It implies that the trust of users in the quality and equity of public health services has been degenerated. Once trust is broken it is extremely difficult to repair and can never be restored to its original state.

"I was the taxi driver to transfer a patient having pleural effusion to enter the emergency unit of a central hospital. When the patient was there, the doctors did nothing. I had reminded the patient's relative to give them an envelope and the emergency aid was performed at that time." (PCASE-SL-12)

To ensure the availability of supplies

Some patients reported that they have paid to be sure that supplies are available. The payment exchanged was mainly made to hospital personnel such as the orderly, nurses or cleaning personnel who can provide the supplies. The amount of payment is not big, ranging from 5,000-20,000 VND [0.25 – 1 USD], but it sometimes causes an emotional discomfort to patients and relatives.

"If you do not give 5 thousands VND to the orderly, your hospital uniform has no belt." (IDI-CEN-12)

To ensure one's own security.

The patient normally makes informal payments to encourage health providers to provide better care. With many health services carrying a wide range of risks and dangers, a number of respondents (central, provider and public citizens) confirmed that payment was driven by the belief that it is risky not to pay.

"I know that the payment does not make a better quality of care. But if I am in the hospital next time, I am going to pay. Who on earth knows what they [medical personnel] will do, if they treat badly, I will die for sure" (PCASE-HN-1).

To avoid shame

It is raised by some policy makers and patients that patients gave envelopes because they may feel ashamed in front of peers who have paid. Poor people might be worried about not exchanging money. This is a great concern as this kind of thought might develop into a social norm which nurtures an unhealthy health system and enlarges wider social discontent. A service which carries an official financial payment but also induces a feeling of shame for not giving additional "thanking" payments is inherently unfair.

"When a patient has not paid while the roommates did, he feels ashamed that he has not made an adequate care for the doctor." (IDI-CEN-14)

To ensure a transfer to higher level

A Son La provider added one more reason for patients to give informal payments is "to be transferred as expected". The respondent said that some patients, who wanted to be transferred to the higher level health facilities although it was not required by the gravity of the illness, paid to achieve this.

"A patient wanted to be transferred to a hospital in Hanoi but it was not a compulsory requirement based on their illness. Her economic status was fairly good and she seemed to have a pre-existing relationship with a hospital leader. She might have paid (both in-kind gift and money) to the leader. Soon after, we received a call from the hospital leader to direct the transfer for the patient." (IDI-SL-NU-5)

WHY HEALTH PROVIDERS ACCEPT INFORMAL PAYMENTS

When asked "why service providers accept in-kind gifts", all interviewed health workers in cities and rural provinces, both hospital managers and staff, admitted that they accepted in-kind gifts, which were given voluntarily by the patients, and in-kind gifts, which were for all health workers in the department. When asked "why service providers accept envelopes or cash" the research team often received a reverse question "do you know how much a doctor gets paid a month?" Below are the reasons given by health workers for the accepting cash or envelopes.

To increase income to meet changing economic pressures or to have a higher standard of living

This reason was stated by both central and provincial health service providers. The fast growth of the national economy and modernised social development has been affecting lifestyles. The availability of material goods is changing the way people live and as a result, a number of health personnel accept the informal payments from patients in order to earn extra income in addition to the low salary paid by the government. As mentioned above, a doctor after 10 years of practice is given a total income (paid by the hospital) of 4-5 million dong [200-250 USD] a month. Meanwhile, a bank officer after 10 years of working is paid 25-30 million dong [1,250–1,500 USD] a month (for example, payroll of a Bank for Investment and Development of Vietnam officer in 2010 earned a total 30 million VND, including 15 million VND of salary and 15 million VND of monthly bonuses). Although there has been no updated official information on the monthly average expenditure per capita at current prices (in 2010), recent discussion in online forums on salary and inflation in Vietnam recently suggest that at least 10 million VND (500 USD) per month is a needed for a family (parents with two children) in the city (without contributing to any savings).

Hospital leaders also understand that the current salary scheme for health workers is too low[29] to keep health workers happy in their daily work, thus they ignore small violations to allow health workers to earn extra income for their livelihood. Allowing some departments in the public hospitals to operate as on-request services or to set up a separate area for on-request service has been one method to increase the official salary of health workers. This brought about a different approach to public hospitals – a trend towards private hospital style management. This unclear financial management situation provides a rich environment for corrupt practices in the health sector, and particularly envelope payments in health services to flourish.

In the current socio-political context, although economic development is visible throughout various aspects of society the government salary scheme has not caught up with the current market mechanism. In comparison to other countries, health workers in Vietnam are very poorly paid (Table 9). Thus the situation of being over-worked and under-paid gradually declines health worker's enthusiasm and their professional conscience.

"There are people who think that to work for the health care sector; they should be more equitably rewarded. People [the provider] said they "would like to have an electric rice cooker", or "I want to have this, I want to have that." So they need to get more money. They cannot get more money from the hospital; therefore they get it from patients." (IDI-CEN-11)

"Honestly, I have felt shameful to accept an envelope. But it [the acceptance] is compulsory. I am unable to feed myself if I do not receive it." (IDI-DL-DO-4)

"Giving and accepting envelope payments is becoming a habit. If we uniquely look at it, that doctor's behavior [accepting money] is evil. However, when we look at it in the light of the realistic circumstances, we will realise that it is acceptable." (IDI-CEN-13)

TABLE 9. SALARY PAYMENT FOR HEALTH PERSONNEL WITH 10 YEARS OF EXPERIENCES ACROSS COUNTRIES IN 2010

COUNTRY (POSITION)	MEAN SALARY PER YEAR IN 2010	CUT-OFF POINT FOR TAX PAYMENT PER YEAR	IN COMPARISON TO TAX PAYMENT LEVEL
United States (Doctor in emergency room)	181,350 USD	47,240 USD	3.8 times
Vietnam (Doctor in emergency room)	56,4 million VND	48 million VND	1.2 times
Australia (Nurse)	90,000 AUD	28,000 AUD	3.2 times
Vietnam (Nurse)	44,4 million VND	48 million VND	0.9 times

At the same time, if one does the math, a number of medical practitioners (particularly surgeons, obstetricians and other specialized doctors, and also nurses and etc) attain a very high standard of living and become quite wealthy, as a result of informal payments. De facto doctors, especially in urban areas, are perceived as rich and the examination for students to enter medical schools is one of the most competitive and selective – meaning that young people see clear benefits and incentives in becoming health workers.

Envelope is a social norm

A small number of doctors and nurses, who have friendly relationships with interviewers, responded frankly that informal payments have became common as health workers follow one another to take money. They thought that if other health workers can take envelopes or cash, why don't they. They also stated that although hospital leaders (whose actions serve as an example for other health staff) do not take envelopes from patients, they do accept envelopes from pharmaceutical companies, construction commission, and additional contracts. In addition, the whole society operates under the envelope mechanism. To enroll a child into a good selected school, an envelope payment is needed. To foster a quick public administration for land certificate, envelopes are needed. Health workers also need envelope payments to pay for other sectors during their daily life.

"The route for a child being enrolled at a good school, the family has to distribute all kind of envelopes. In the society, envelope is needed to complete the public administration procedure. Envelopes are everywhere, with such a low salary, how can health workers find enough money to put into envelope to pay for others in their life." (IDI-HN-DO-7)

"[Health] Leaders also receive envelopes from pharmaceutical companies, construction, procurement etc. The money I received from patients is just a small amount which is nothing in comparison to the amount leaders get." (IDI-HN-AD-5).

To expand the provider's own social capital

Some interviewed treatment doctors and department leaders said that a provider-patient relationship benefits both sides, tangibly or intangibly, financially or non-financially. For health providers, if they accept the informal payment from a patient, it implies a provider's commitment in guaranteeing a better service, but at the same time that a good relationship between the provider and that patient will be established. Giving and accepting in-kind gifts or cash/envelope payment is a process that involves conversations and a doctor can explore patient or patient family's power and capacity which might be helpful to the doctor sometime in the future. It means the provider's own social capital is being expanded over time and the patient social capital in health services is enlarged as well.

"A doctor has two benefits in relation to accepting envelope payments: the extra income and social relationship. It [the latter] is difficult to estimate in terms of its monetary value. The patient may not give me 1 million VND, but they are willing to provide me an opportunity to earn 100 millions VND. I still have respect from society towards my profession." (IDI-CEN-13)

To avoid embarrassment on behalf of the patient

This justification is given when health providers genuinely believe that patients want to make payments voluntarily. Several doctors revealed that they see an obvious improvement in the emotional well-being of patients when they accept the money they offered.

"I was offered an envelope payment of 10,000 VND [0.50 USD]. It is a small amount of money. If I refused to accept it, I would make them feel less secure. Actually, accepting the payment will not badly affect the patient [perhaps patient's economy-related situation], but [it helps] their emotional well-being. I accept, they are excited." (IDI-SL-DO-1)

RESEARCHERS PERSPECTIVES

Today, the practice of 'presenting something to doctors' (bieu bac si) or 'envelopes to doctors' (di phong bi bac si) have become commonly used terms amongst Vietnamese people and pressing issues for society. In the past, thanking doctors was motivated from the bottom of the heart. Those who could afford to do so presented in-kind gifts. Those who could not would just drop in to say "thank you". In the past decade, such acts have come to be perceived as "odd". It is now considered embarrassing to be seen "thanking empty handed," thus patients and their families try to find something material to give to doctors. This feeling is not only widespread amongst ordinary patients but also health workers themselves, who report feeling embarrassed if they thank colleagues who provide treatment for their relatives without giving any gifts or envelopes.

In the past, gifts were given as gestures and any in-kind gift, regardless of value, were highly appreciated by the recipient. Since then, as a result of a number of social, economic and systemic factors, the role of thanking gifts have been transformed so that today envelope payments are instead perceived by patients as necessary to obtain quality services. This transformation has been driven by a number of factors, including a non-transparent health system, increased competition amongst patients in access to health services, a strong focus on material benefits and a law system which remains unfinished and law enforcement which is not yet fully formed. Consequently, the purpose of giving envelopes in the context described is extremely different from that of "thanking" or "redemption" of a doctor before, as it becomes much more difficult for "envelope giving" to be justified as a nice cultural gesture.

3.5 IMPACT OF INFORMAL PAYMENTS

INFORMAL PAYMENTS AND QUALITY OF CARE

Belief of Providers

Do informal payments help to improve the quality of care? This question has been raised to all health service providers, including both doctors and nurses, from central hospitals to provincial and district hospitals. The answer given by most respondents is no. According to health workers, the quality of care (in the health worker's perspective, quality of care means the way they perform technical practice) does not differ from patients regardless of any informal payment exchanged. Although there have been no studies in Vietnam to date comparing the quality of services provided to patients who do and do not give informal payments, all health workers interviewed stated that an envelope, regardless of how thick it might be, cannot change a normal doctor into a more experienced doctor. All of the surgeons interviewed assured us that they had no thoughts about envelope payments when the time came to performing surgery.

However, patients who did make informal payments might be approached in a friendlier manner or given priority in services. According to both doctors and nurses, envelopes might bring "gentle counseling" to patients, i.e. spending more time with the patient, having a better interpersonal attitude, giving attention after surgery, etc. Although these factors may not seem to affect the technical quality of care, giving post-operative care and using effective methods of communication with patients are basic elements of care. Indirectly, health workers are admitting that people offering envelopes or in-kind gifts might receive a higher quality of care.

From a health care equity perspective, the quality of care is affected as the turn of a patient in urgent need is taken by another patient who has power or money. When treatment priority is not based on the severity of the illness but is slightly modified by power or money, there is no health care equity and the quality of life of a patient (health outcome) is affected, leading to the difference in quality of care.

"A payment of 3 millions VND does not change a "level C" [low professional skill] doctor to a "level A" one. Payment cannot help to upgrade his diagnosis skills to be better. The quality of care is encompassed by two factors: clinical or technical quality and service quality. Money cannot pay for clinical quality as I mentioned above. Money also cannot pay for service quality, such as basic hygienic conditions, because it depends on the basic situation of the hospital. Money can pay for a better provider's attitude, but it is just a part of it. You have the better attitude of a certain medical workers, but when the shift is turned, can you ensure that the other workers behave well on you? You can not chase them all. Many well-educated people understand the facts that I have talked about, but they continue giving informal payments." (IDI-CEN-14)

"Giving or not giving envelopes cannot change the quality of care. We cannot reduce the amount of medicine prescribed to patients, we cannot use low-quality thread for wound sewing, we cannot use unsterilized gloves or gown in the surgery room, we cannot cut the unnecessary part because the patient does not give envelope or money. The only difference between giving envelopes and not giving envelopes is that patients giving envelopes are given more care after surgery. When I worked for the surgery department, patients with envelopes are moved up in the queue for surgery. However, for the poor and health workers' relatives, we care more regardless of the envelope payment." (IDI-SL-NU-5).

However, one specific concern pointed out by a retired health manager is that informal payments has contributed to the increase of caesarian births in Vietnam as doctor is more likely to receive envelopes when a caesarian birth is conducted.

"The doctors did not allow many patients to have a normal delivery, but required caesarian and then did not share the money with the nurses, but are keeping the money on their own. Finally, the most disadvantaged people are patients. They are told they must have the surgery, in spite of the fact that it is not necessarily medically required" (IDI-CEN-12)

Belief of Patients

Do patient think that informal payment improves the quality of care? Most of interviewed patients in city and provincial hospitals, especially at emergency, obstetrics and surgery units, stated that they have heard that patients would not be given proper care or friendly counseling if an informal payment was not made in advance. Some experienced being ignored when not giving envelopes or cash.

"Yes, it is different. If not giving an envelope, they would not provide good care, they perform the care in quick way, they shout at patients, they hit a patient's thigh if they move it (the case of a pregnant woman who sits up while having contractions for baby)" (PCASE-SL-2).

"I have not experienced that [not giving envelope/cash and being given poor quality of care]. However, some people told me that if not giving envelopes, doctors will not provide good care." (PCASE-SL-9).

"The patient who does not pay will not be carefully watched with concern. Also, they will suffer from unwelcome attitude and pain during the injection of nurses. If you pay, you will get the bed wrap or uniform exchange immediately. A poor person does not pay; he must be waiting for 1 week to have sheets changed." (PCASE-HN-11)

"My brother got into an accident and he was transferred to X hospital. He had not received any care, not even washing the blood patches from his face, in almost 1 day due to lack of payment. After the payment was made, the care was performed and the attitude of medical personnel was totally different. They were more interested in us and more welcoming." (IDI-HN-NU-5)

In contrast, in Dak Lak province, giving informal payments does not appear to be a common practice in either district or provincial health facilities. Many hospitalized patients and citizens who have used health services in the last 12 months in this province confirmed that they did not give envelope payments to health workers either before or after the treatment and they did not feel any discrimination in health workers' behaviours. Most informants interviewed in district hospitals in four study settings also reported that they did not present cash or envelopes when using the district health facilities and did not perceive any difference in care from health workers. In contrast, most patients in Hanoi and Can Tho said that they sensed behavioral differences when they didn't pay when using the central and provincial health facilities.

"In central or provincial hospital, if we do not give money, they will not change bed sheet. However in this hospital [district], the nurses change bed sheets once a day, their attitude is good. In the provincial hospital, they asked me to pay money in advance before setting the surgery date while in this hospital [district], I asked the ultrasound doctor for an order for receipt to pay hospital fee, he told me gently 'Why you are bothered about paying money. Let me read a thorough ultrasound for your wife first, seeing if she needs an urgent surgery or not. If yes, we will set a date for her surgery. Then you can come to the admission room for paying money. Calm down. Don't worry'. His attitude was very nice." (PCASE-CT-12)

NEGATIVE IMPACT OF INFORMAL PAYMENT

The research team asked health workers, health managers and policy makers to comment on "what negative impacts might informal payments create for health services in Vietnam". Below are the themes analysed from their responses.

Erosion of professional image, respect and trust

Many providers and most of the interviewed national policy makers claimed that informal payments negatively erode the patient's belief, respect and trust in the health system. They felt that the presence of informal payment taints the hospital's prestige and professional image with a black spot. Consequently, it often makes the public hesitant to choose using health care services at these hospitals.

"The practice of exchanging informal payment, either in advance or after performing duties, makes the public misunderstand that it is obligatory to give informal payments during the public health service procedures. It obviously negatively affects the prestige and image of the hospital in the eyes of the citizens." (IDI-DL-DO-1)

"The teachers or professors who have accepted the informal payments during their life cannot teach their students about medical ethics. The students' medical ethics, whose profession is not good and determination is not high and firm, will be easily breached." (IDI-CEN-26)

Create internal conflicts in the department

Several doctor respondents moreover complain that the informal payment is sometimes responsible for conflicts amongst colleagues within a hospital or a department.

"… It [the envelope payment] badly affected the sentiment amongst colleagues, and people treat [other colleagues] dishonestly. Nurses say bad things about doctors, midwives talk badly about doctors." (IDI-CEN-12)

Inequity in health care

A number of policy makers and representatives of funding agencies thought that informal payments create inequity in health care for poor and vulnerable people. This is against the objective of equity in health care for all set by the Vietnamese government.

"So what I saw is that the system is particularly unfair to poor people, this is one of the key dynamics. Poor people usually don't know that they can complain. Poor people are usually shy, compared to say a rich doctor or someone rich in the city, or province or even districts. Poor people often aren't aware of their rights, so usually what happens, and I'm not talking about all health care providers, but unfortunately some health care providers, they take advantage of the situation. They target poor people, they threaten and they scare them in order to get as much money as possible, because even poor people, through family and friends can usually mobilize a certain amount of money, even if in the future they have to pay it back." (IDI-CEN-19)

"From the management angle, informal payment has an impact on quality of care… Arranging patients for surgery is an example. With an envelope, a patient might get priority to get surgery. The quality of care is not changed, from the technical performance [the way doctor conduct the surgery to a patient]; however, the quality of life of this patient is changed considerably. For patients who need urgent surgery but are delayed due to some patients with envelopes, their quality of life might be reduced due to delay in surgery" (IDI-CEN-16)

In addition, patient ignorance also contributes to the problem. With poor knowledge of hospital fees and patient rights, and having no confidence of obtaining a satisfying resolution if they report violations, patients have to accept a health worker's rough treatment in silence. Well-off patients can use money to gain priority, leading to a wide-spread fear among the remaining patients that they will not be cared for. Over time, if a large proportion of patients use envelope payments to compete with one another, the poor are most likely to receive lower quality of care. This point was reflected in a statement made by an informant on the negative impact of informal payments on the arrangement of surgery schedule for a patient, as stated above in (IDI-CEN-16).

3.6 APPLIED EFFORTS TO ADDRESS INFORMAL PAYMENTS

Health providers were asked about the efforts made by their facilities to control informal payments. Most of them said that their facilities have applied a number of measures to recognize and control the practice of informal payments. However, many of them said that the measures seem to be nominal and not very effective.

"The press, mass media, citizens, and the MoH have had many discussions on how to limit the envelope payment, but it seems that no effective solutions has been launched to bring a significant change for the society" (IDI-CEN-1)

Ethical Disciplines and Financial Punishment

As observed by the research team, all of the hospitals visited have hung a board of written hospital regulations on medical practices, which includes providers' behavior practices, to provide information to staff and clients (Figure 1). All providers stated that they know the Hippocratic Oath, Uncle Ho's slogan "Medical staff as a kind mother" (*Luong y nhu tu mau)*, and 12 medical ethics code required by the MoH. The MoH medical ethics code consist of an article "Any words and physical behaviors of the health workers to request and accept the informal payment/envelope payments from patients are not allowed".

Health providers reported that ethical disciplinary action such as reprimand (*len an*), downgrading ethical rankings (*ha bac hanh kiem*)[30], demotion, and financial punishment (reducing annual bonuses or the share of service-based revenues and etc.) (*thu 3 loi ich*), may be applied to any health staff who accept money from patients. However, very few of them could describe any specific cases of an individual who suffered from that punishment, as many said that the informal payments are not common practice in their hospitals, or it is hard for the practice of informal payment to be detected because it is usually hidden.

FIGURE 1. POSTER ON HOSPITAL'S REQUIREMENTS FOR STAFF BEHAVIOUR TOWARDS PATIENTS AND THEIR FAMILIES

Open Feedback Mechanism

All hospitals have boxes for patients to submit complaints and suggestions, set-up hotlines to the hospital board and organized inspectorate committee (including hospital and department leaders). In some hospitals, the A4-sized warning that "It is prohibited for patients to put money into examination booklets" or "Patients should only pay money at the administration and financial department and ask for receipts" (Figure 2). In Dak Lak hospitals, in particular, the hospitals hold weekly patients' meeting to remind both providers and clients about not offering or accepting informal payments.

However, it appears that such mechanisms are not being used by patients when they encounter unacceptable behaviors of health workers. Some patients interviewed said that they have seen the comment boxes but have never used them.

"The hospital has big posters displayed where notices "No envelope payments", but it is for nothing" (IDI-HN-AD-2)

"The boxes for patients to submit complaints and suggestions are seen by all people, but it has not been used. The same goes for the hotlines. People do not call because they think that the problem [giving and accepting envelope payments] would not be solved by the hospital. They normally call the press's hotlines." (IDI-CEN-25)

Expansion of Service Accessibility

Allowing some departments (usually the outpatient/examination and internal medicine department) to operate after working hours as an on-request service (where the patient is expected to pay a slightly higher fee in comparison to the public fee to use the service after 5pm) or set up a separate area for on-request service (where patients pay higher fees in comparison to the public fee but are able to access to quicker care all day) is the approach which many hospitals in Hanoi, Can Tho and some provinces have applied. The patients' accessibility to health services are enlarged because the hospitals have prolonged working hours and made other forms of services available (out-reach, special care). The expansion of working hours has allowed the patients to reduce their waiting time, consequently reducing also their need to access faster examination. In regard to the opening of home-based services, the providers confirmed that it helped to increase the health providers' official income, meaning they have less need for the informal payments from patients. In turn, the income of health workers is reported to increase by about 30%.

FIGURE 2. WARNING FOR PATIENTS NOT TO PUT CASH INTO THE EXAMINATION BOOKLET

"The hospital has three extra working hours (opens at 7am, closes at 6pm, and keeps opening during noon), as a result, the waiting list of patients has been reduced quickly. Additionally, the patients' automatic ticket applied contributes to reducing the state of patient's offering money to providers to be the first in line." (IDI-CEN-25)

"Our hospital offers the home-based examination service for wealthy people, and provides the special care service for needy patients. For instance, there are better-off families who can not arrange any member to take care for their ill relatives; therefore, they use the special care service. Some people do not want to use their health insurance; they select on-request service. They do not care much about money, but quality of the provided services. So, why should we not provide the services to raise the income for our staff? When our staff can earn money officially, they will not care about the informal payments." (IDI-HN-DO-4)

3.7 IS IT NECESSARY TO CONTROL INFORMAL PAYMENTS?

The research team approached interviewees from a neutral perspective by asking them "what do they think of informal payments in health services in Vietnam and is it necessary to control the situation?"

Service Providers

Health service providers said they did not see in-kind gifts or envelope given by patients after treatment as a problem, as long as they were voluntarily offered by the patient. At the same time, they criticised the inappropriate behaviours which some doctors or nurses used to indirectly ask for informal payments (i.e. delaying care, providing painful care, ignoring patient's requirement, etc.) and also the way patients or their caregivers for money are directly approached for money. Most of the service providers interviewed also did not support the behaviour of taking the in-kind gifts or envelopes before the completion of treatment as it feels like a transaction.

"It is okay to accept the payment from a patient whose extra payment is affordable, who feels satisfied with the provider's attitude, who receives the long-term care for their chronic disease, who has a good treatment outcome." (IDI-HN-NU-2)

"When the patient felt that they are saved, or when they have a perfect birth outcome, it is not bad to offer a payment to the doctor. At that moment, the patient gives it [the informal payment] with their true gratitude." (IDI-DL-NU-7)

"In my opinion, it is totally if the patient thanks the doctor for a good treatment for his illness at the discharge time. But if the health worker does not care for the patient if the patient does not pay. This is entirely unacceptable." (IDI-SL-DO-1)

Some doctors doing surgical work said that they do not want to take the patient's money, even after treatment completion, as it weighs on their professional conscience. However, the MoH must pay them high enough to sufficiently care for their families.

"I would prefer to be given flowers or fruits as an honor gift from patients. I appreciate more a bunch of flowers which costs 100-200 thousands VND than an envelope of 500 thousands VND. I am totally against the envelope payment because it makes health care like a business." (IDI-DL-DO-1)

Policy Makers

Five policy makers from top government agencies and the MoH and three leaders of medical associations (also policy makers) stated that a well-functioning health system should not feature envelope payments as the norm. However, they cited that the salary of health workers is low compared to other professions, thus they are not strongly opposed to gifts or envelope payment after services.

"Accepting monetary payment is entirely prohibited….However, I think it is a vicious cycle...although they have studied for six years [at medical university], and undergone an additional 3-4 years of training [as intern doctors], with high expectations of the quality of their work, their salary is not sufficiently high, so they would find an extra amount for livelihood." (IDI-CEN-1).

"The most important factor is the time of informal payment transaction. If it is given to press or drive someone to do something for the benefit of the giver or if the health worker puts pressure on the patient to give something to them, it is negative and we should prohibit it. However, if it is given, regardless if it is in-kind gifts or money, after the treatment is completed and patient is discharged, I think it is the thanking gift in a pure meaning and I do not oppose that kind of informal payment. Nowadays, when using health services, service users have habit to give envelopes and it has become a phenomenon. It is absolutely not good at all." (IDI-CEN-9).

Service Users

Most patients and caregivers said that it is good for all patients if envelope payments are not given in the clinical settings. Like service providers, patients are not concerned about curbing thanking in-kind gifts.

"I recognize that the Vietnamese are kind of scramble…. All want quick service, all want being prioritised; thus they give money. In my opinion, this problem must be worked out and eliminated. However, it requires a systematic change in the whole country. The tenet of equality must be respected. All are equal under the public service, regardless acquaintance relationship or rich/poor." (PCASE-HN-10)

4. CONCLUSIONS AND POLICY RECOMMENDATIONS

4.1 KEY CONCLUSIONS

This research helps to understand systemic problems that have contributed to the existence and growth of informal payments in the health sector. By providing insights into corruption in the health sector, this study leads to the following conclusions and recommendations for policy change:

CONCLUSION 1: In-kind informal payments, usually in the form of gifts, is deeply rooted in the country's history. The practice increased during the post-war period when the national economy was in crisis, and grew into a significant social problem and shifted to 'envelope payments' when Vietnam moved towards a market-oriented economy, encouraging the collection of user fees for public health services.

CONCLUSION 2: All policy makers, health managers, providers and users interviewed agreed on the existing pervasiveness of informal payments in health services, but gave different explanations to the causes. Most health providers stated that informal payments were given to express thanks (especially when it is made after treatment), while a majority of users said that they were made to help them obtain better and more satisfactory service.

CONCLUSION 3: Informal payments are threatening the goal of "equity, efficiency and sustainability" in the health system. It is more serious at higher levels where hospital overload is an issue and has become a noticeable part of the health expenditure that must be paid by the citizens. Applied efforts to address informal payments in the health sector are mostly ineffective.

CONCLUSION 4: The model of private management mechanisms in public hospitals (collecting user fees, requiring hospitals to self-finance) is a risk factor increasing opportunities for informal payments. Additional risk factors include lack of transparency in public health service management, such as human resource and financial management, increasing economic pressures, weaknesses in system management, and lack of investigation.

Envelope payments in the Vietnamese health sector has been an increasingly pervasive problem in the last 20 years, while efforts to control this practice are either nominal or fail to target the real causes. The behavior of thanking with money or in-kind gifts has become widespread as patients feel a pressure to conform to the norm. "Get used to it" (*Song chung voi lu*) was a common response given by citizens and health managers when asked about this unwanted and unethical practice. It is particularly difficult for health leaders to find solutions for the control of informal payments as envelopes are widely used in society to make public administration procedures go smoothly and are also commonly given as gifts in social events (funerals, weddings, visiting sick persons, congratulating newborn babies and etc). The growth of the practice of informal payments signifies that previous approaches have failed. It appears clear that a new approach is required, which looks deep into the cause of corruption in the health sector, particularly to its links with the shortcomings of systemic and infrastructural resources and management practices within the Vietnamese health system, in order to change behaviours and attitudes to informal payments in the health sector.

4.2 POLICY RECOMMENDATIONS

The following recommendations aim to inform future actions towards the control of informal payments in the health sector, to prevent the possibility of a consequent increase in official user fees, and to strengthen anti-corruption efforts in society.

FOR POLICY MAKERS

Giving national priority to anti-corruption control in the health sector with pooled efforts from multi-sectoral agencies including civil society and managed by the National Assembly.

Eliminating "private management models" in public hospitals and instead move towards a mixed health care system having three components: (1) Public services using public budget, which are completely not for profit and responsible for primary health care and preventative medicine; (2) People-founded health services using self-financing and possibly government subsidies, which are not for profit, but for science and charity; (3) Private services, which operate following market mechanism.

Strengthening the capacity of primary healthcare facilities. This type of investment, in addition to public education, will help to reduce overload at provincial and central hospitals, which is a key factor leading to informal payments.

FOR HEALTH FACILITIES

Improving controls and sanctions including supervision, follow-up, investigation, financial punishment, and dismissal. This will help to detect and punish those who continue the practice, as raising compensation (monetary and non-monetary) alone would not be enough. It requires the efforts of not only the hospital leaders and the supervision unit, but also the proactive involvement of medical associations and the Ministry of Health's Inspectorate. Public users also can play an important role in supervising health workers' performance and regulation compliance.

Establishing an independent quality supervision system: The current health system in Vietnam lacks quality supervision conducted by a third party. Anti-corruption efforts (regulations, say NO to envelope, punishments and etc) will only be effective once quality and performance supervisions are made by a third party independent to the health system.

Developing a pilot initiative to provide information, advice and counseling to citizens who are vulnerable to being asked for informal payments. These models should be set up and managed by non-profit organizations working for human rights in health care.

TABLE 10. TYPOLOGY OF INCENTIVES

FINANCIAL	A. Pay B. Other direct financial benefits • Pensions • Illness/ health/ accident/ life insurance • Clothing / accomodation allowance • Travel allowance • Child care allowance C. Indirect Financial benefits • Subsidized meals/ clothing / accomodation • Subsidized transport • Child care subsidy/ creche provision
NON-FINANCIAL	• Holiday/ vacation • Flexible working hours • Access to/ support for training and education • Sabbatical, study leave • Planned career breaks • Occupational health/ counselling • Recreational facilities

Source: Buchan, J. (2000) Health Sector Reform and Human Resources: Lessons from the United Kingdom. *Health Policy and Planning* September 2000,15(3):319-25.

Increasing salaries for health workers. If no effective intervention takes place to ensure that proper salaries are paid to health workers, informal payments are simply likely to be replaced by "official" payments (e.g., an increase in users' fees). This will lead to an increase in public hospital fees in a similar way to the trend that exists in other public services (eg. electricity, petroleum). For the future salary revision, payment to health workers should be at least 3 times of the amount for tax exemption with variations depending on position, years of experiences and expertise.

Improving non-financial renumeration for health workers. A number of studies[31] have indicated that motivation systems (both monetary and non-monetary) can increase health workers performance if they are well implemented (Table 10). Other non-monetary approaches should also be considered for public health workers. For the short-term this could include free health care insurance for health worker's family, annual short-course training/education, recreational facilities in hospitals, free good meals during work and etc. For the long-term this could include subsidized public transportation and subsidized accommodation if salaries are not significantly improved.

FOR WIDER SOCIETY

Transforming perceptions of service providers and users

- Health systems should be service-oriented. To respond to consumer expectations for high-quality service, organizations in the health care industry must develop a service-oriented culture where patients get respect and qualified service worth the cost (paid by out-of-pocket money or health insurance).
- Harassment by health workers demanding patients make informal payment should not be tolerated. Media can play an important role to empower the population, letting them know that they have rights to good health care service and any actions to prompt for informal payment are unacceptable. Media and community-based organizations also should inform the population that informal payments will not change a doctor's technical performance, and they do not have to pay other than the official fees.
- Envelope payments should be limited in daily interactions. Government and other organizations should make a pledge to avoid all types of "envelope payments" in the course of business. There should be no envelopes used during donations,[32] and administration procedures should be clearly outlined to public users and respected by service providers. In addition, websites where service users can share information or experiences about their informal payment (such as the website "I paid a bribe" initiated by Indian anti-corruption activists[33]) can not only help transform the acceptance of such practices but can also provide the government with quantitative and qualitative insights into corruption in particular sectors from service users.

ENDNOTES

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2. Tran Tuan, *Realities in health service delivery: Perspectives from Vietnamese health professionals*. Discussion paper presented at the workshop on "Corruption perception and impact on poverty in the health sector in Viet Nam: How to improve transparency and accountability". Hanoi, Vietnam (17 November 2009).

3. Kelly Miller and Taryn Vian, Chapter 6: Strategy for Reducing Informal Payments, p. 55-66 in *Anti-corruption in the Health Sector: Strategies for Transparency and Accountability* in Taryn Vian, William Savedoff, and Harald Mathisen (eds) (Kumarian Press: Sterling, VA, 2010).

4. Hung PM et al. *Health care system development: Household catastrophic health care expenditure & improverishment in Vietnam 1993-2004.* (2007)

5. Taryn Vian, Derick W. Brinkerhoff, Frank G. Feeley, Matthieu Salomon, Nguyen Thi Kieu Vien. "Confronting corruption in the health sector of Vietnam: Patterns and prospects". Under review.

6. Tran Tuan, *Historical Development of Primary Health Care in Vietnam: Lessons for the Future,* Harvard School of Public Health; Takemi Program in International Health; Research Paper No. 102 (1995).

7. Ibid.

8. Tran Tuan, *Community-based evidence about the health care system in rural Vietnam*. PhD thesis. Call No. THESIS 2920, Auchmuty Library, the University of Newcastle. Chapter 2 page 30. (2004).

9. Random House Inc., 2008.

10. Tran Tuan, 2005.

11. Ten common behaviors of medical ethics being violated by health workers: make it difficult for patients, asking for informal payment, prescribe expensive medicine for commission with pharmaceutical companies, refer patients from public service to own private clinic, lack of responsibility in daily performance, do not pay enough respects to patients, do not concentrate enough in performance, lack of tactful behavior in communication with patients and their caregivers, do no explain full situation of patient and counsel the family, and provide treatment plan that beyond the own capacity.

12. VUSTA, *Public Opinion on the Draft Law on Examination and Treatment version 15: A Report to the National Assembly* (VUSTA and RTCCD: Vietnam, 2009).

13. In 2007 Prime Minister Nguyen Tan Dung assigned the Government Inspectorate (GI) to regularly organise a biannual ACDs in Vietnam with the international donors community. ACDs have become a strategic entry point where interested donors, Vietnamese institutions and other stakeholders can discuss corruption issues of concern to all sides, as well as how the international community can cooperate with Vietnam to combat corruption effectively and in a coordinated manner. Sweden acts as the lead donor and coordinator to organise the ACDs with GI. Nine ACDs have been organised and have addressed various issues, including public administrative reform, the role of the media, construction, health, education and land management sectors.

14. Transparency International, Embassy of Sweden, et al. *Corruption perceptions and impacts on poverty in the health sector in Viet Nam: How to improve transparency and accountability*. Report of the donors roundtable – 6th anticorruption dialogue in Vietnam. Hanoi, Vietnam (17 November 2009).

15. CECODES and Formin Finland FI, *Anti-Corruption in Vietnam: The Situation after Two years of Implementation of the Law* (Vietnam, 2008).

16. Vice Prime Minister, Inspector General, Minister of Security, President of People's Supreme Procuracy, Presiding Judge of People's Supreme Court, Minister of Culture and Information, Vice Chairman of Central Commission of Examination, Vice Chairman of Central Commission of Home Affairs, Vice Minister of National Defense, 3 Deputy Office Managers of Government, Standing Commissioner.

17. At first, Bach Mai hospital in Ha Noi was selected as a study setting for the fieldwork data collection, however the hospital officially refused to be involved in the study. Saint Paul hospital was selected to be a substitute.

18. The Moc Chau hospital was the alternative one for Muong La hospital. The change had been made following the suggestion from Provincial Department of Health. It was advised that Moc Chau is a district which is developing faster and faster, and is becoming a new central hub of the province.

19. The wartime here refers to the period from 1945 – 1975. In this period, community values and the tenets of country re-union de facto prevailed over individual values. Devotion and sacrifice were important values.

20. Subsidy economy is widely known as nen kinh te bao cap (Vietnamese). This period lasted from 1975 to 1986. It was a time of great hardship. The whole country had a planned economy. The economy remained challenged by small-scale production, low labor productivity, unemployment, material and technological shortfalls, and insufficient food and consumer goods. In each enterprise, there was a health worker, either doctor or nurse who acted as a primary health facility. In the community, the commune health station was effectively a primary health facility which met almost all the healthcare needs of villagers. Only patients with severe diseases were transferred to higher health facilities. There was not yet an overload of district and provincial hospitals.

21. Doi Moi (English: Renovation) is the name given to the economic reforms initiated in Vietnam in 1986 with the goal of creating a "socialist-oriented market economy". The state plays a decisive role in the economy but private enterprise and cooperatives play a significant role in commodity production. By the late 1990s, the success of the business and agricultural reforms ushered in under Doi Moi was evident. More than 30,000 private businesses had been created, and the economy was growing at an annual rate of more than 7 per cent, and poverty was nearly halved (Haughton, D., J. Haughton, 2001). Under this period, hospitals and primary health facilities were given rights to collect some fees. More State budget was invested for health facilities at provincial and central levels. The spontaneous movement of patients from primary health facilities to provincial and central health facilities became visible, leading to an increasing overloading of these higher-level hospitals and the diminished capacity of primary healthcare facilities at commune level.

22. Decision 07/2003-PL-UBTVQH11 allows health workers to operate private services, including treatment, vaccination, pharmacy, traditional medicine, and medical equipment. According to this law, after the working hours, health worker can provide treatment services to patients at his/her own clinics.

23. In current Vietnam, a nurse has to take care for patients in 3 wards a day (total 20-25 normal patients or 10 surgery patients). In Australia, a nurse is expected to take care for either 6 normal patients or 1-2 surgery patients a day.

24. Nguyen Thi Xuyen and Le Quang Cuong, *Overload in central-level hospitals: situation and causes* (Ministry of Health: Hanoi, Vietnam 2008).

25. Cuong, L. Q., T. T. M. Oanh, et al., *Overload situation in hospitals in Hanoi and Ho Chi Minh city: situations and recommendations* (Health Strategy and Policy Institute: Hanoi, Vietnam, 2009)

26. These amount included 3.4 million salary, 290 thousands night shift per diem, 220 thousands lunch support, 90 thousands night shift dinner, 200 thousands surgery fee.

27. Here it seems important to keep in mind the findings of the Vietnam 2010 Global Corruption Barometer mentioned above where 29% of the urban citizens interviewed, who had contact with medical services in the previous had 12 months, declared that they had to pay bribes. See Towards Transparency and Transparency International, *Global Corruption Barometer 2010: Vietnam Country Analysis* (Vietnam, 2011). In 2007 only about 12% of the urban citizens interviewed for the 2007 Global Corruption Barometer gave the same answer.

28. Adapted from Vian T., Gryboski K., Sinoimeri Z., Hall Clifford R. *Informal Payments in the Public Health Sector in Albania: A Qualitative Study.* Final Report. Bethesda, MD: The Partners for Health Reformplus Project (Abt Associates, Inc. July 2004)

29. According to the national census in 2009 conducted by the General Statistics Office, on average a personnel working in health sector earned 2.8 million dong a month, while the finance personnel earned 7.3 million, mining personnel 5.6 millions, transportation and electricity personnel earned 4.5 millions. Payment for personnel in health sector is at the 11th of the total 18 sectors in Vietnam. Payment for agriculture and education is behind the payment for health personnel.

30. Both children in schools, students in colleges/universities and staff working in state-own enterprises/ bodies are eligible to the ethical ranking which has 3 levels: A=good, B=average or C=bad. For the working staff, if they are ranked as bad ethics, their annual bonus might be deducted or cut. Level A: the monthly bonus accounts for 50% of the basic salary (bonus equals to 700,000 VND = $US 35). Level B: two thirds of the level A bonus. Level C: half of level A bonus.

31. Adams, O. and V. Hicks, *Pay and Non-pay Incentives, Performance and Motivation*. Prepared for WHO's December 2000 Global Health Workforce StrategyGroup, Geneva, World Health Organization; and Ojokuku, R. M. and A. O. Salami, "Contextual influences of health workers motivations on performance in University of Ilorin Teaching Hospital," American Journal of Scientific and Industrial Research, vol 2(2) (2011), p.216-223.

32. Putting money into envelope before slotting it into the charity/ donation box

33. http://www.ipaidabribe.com/. Around mid 2011, a similar website appeared in Vietnam, see http://toidahoilo.net/.

ANNEX 1: INFORMANTS DETAILS

TABLE 11. LIST OF SURVEYED PROVINCES AND NUMBER OF INTERVIEWS

TYPE OF KI'S	NUMBER
National informants	17
Provincial informants	90
District informants	45
Public informants	26
TYPE OF INTERVIEWS	**NUMBER**
ISI	136 (17 + 119)
FGD	9
Number of FGD informants	42

TABLE 12. ISI IN HANOI AND IN OTHER THREE PROVINCES

(N=119)

TYPE OF INFORMANT	PLACE WHERE INFORMANTS WERE APPROACHED FOR INTERVIEWS				
	HOSPITALS IN HANOI	PROVINCIAL HOSPITALS	DISTRICT HOSPITALS	IN THE COMMUNITY	TOTAL
Health Managers		5	3		8
Doctors	7	9	7		23
Nurses	9	10	8		27
Administrators	5	1	2		8
Service users and care takers	3	19	11	20	53
TOTAL	24	44	31	20	119

TABLE 13. FGD IN HANOI AND IN OTHER THREE PROVINCES

(N=9 (42) [# OF FGD (# OF PARTICIPATED INFORMANTS)]

TYPE OF INFORMANT	PLACE WHERE INFORMANTS WERE APPROACHED FOR INTERVIEWS				
	HOSPITALS IN HANOI	PROVINCIAL HOSPITALS	DISTRICT HOSPITALS	IN THE COMMUNITY	TOTAL
Health Managers					
Doctors	1 (4)	1 (7)	1 (4)		3 (15)
Nurses	1 (3)	2 (8)	2 (10)		5 (21)
Administrators					
Service users and care takers				1 (6)	1 (6)
TOTAL	2 (7)	3 (15)	3 (14)	1 (6)	9 (42)

ANNEX 2: CODING THEMES

TABLE 14. LIST OF SURVEYED PROVINCES AND NUMBER OF INTERVIEWS

CODE #	SHORT DESCRIPTION	LONG DESCRIPTION OR CONTENT
A	Background	Job, length of time worked, other demographic information
B	Meaning	Typology of different sorts of informal payment
B1	Names	Words used in Vietnamese and how they are different from each other, what they mean to the informant (envelope payment vs. cash vs. bag vs. gift—include specific terms in Vietnamese as well as English approximate translation)
B2	Cash/in-kind	Whether payment is cash or in-kind
C	History	Comparison of changes over time. Description of situation today vs. in past. Historical roots and significant events.
D	Why?	Why do payments happen? Why do providers accept or decline? Why do people give / not give? What are the urban/rural patterns?
D1	Why happen	Why do payments happen?
D2	Why accept	Why do providers accept or decline?
D3	Why give	Why do people give /not give?
D4	Pattern	What are the urban/rural patterns?
D5	Where common	Where does in the health system the IP happen most commonly?
E	Process of payment	Description of how payments occur during service delivery
E1	When give	When the patients give informal payments?
E2	Who	Who asks for, collects or receives payment?
E3	How	Mechanisms of collection or transfer of informal payments
E4	Price	Detailed price information How much (what was price?) Source of price information (how is price known?) Price variation by factors (type of facility, type of service, status or income of patient, relationship to provider, level of provider, other factors) Negotiation (evidence that people negotiate? Or pay over time?
E5	Timing	Timing (given before, after, during)
E6	Non-pay	Non-pay situations (when would you pay vs. not pay? Can you still get care if you don't pay?)
E7	Uses of the payment	How is informal payment used by providers (to increase salary of physician, to buy supplies for the facility or care giving process). Are informal payments shared with other providers?
E8	Demanded/voluntary	Do people feel obliged or have a choice in this practice? If obliged, is it morally or socially obliged? or forced by provider?
E9	User perspectives	In user's opinion, in which context the payment is acceptable or not?
E10	Provider perspectives	In provider's opinion, in which context the payment is acceptable or not?
F	Effects of payment	
F1	Benefits/advantages	Perceived positive effects that may be anticipated when offering/accepting informal payments (show appreciation, reward positive outcome of service such as a safe delivery, get faster service, quality of service is better, makes one feel better, warming up of relationship between provider and patient)
F2	Disadvantages/negative effects	Perceived negative effects or bad consequences of informal payments (people can't get treated, avoid seeking care, seek care late, have to sell assets to get money to pay, have to borrow money, feel angry, uncertain, frightened. Providers feel loss of respect, less professional.)
F3	Status differences, equity or power issues	Unequal power relationship, no enforcement, patient doesn't know rights
G	Reforms	What should be done about informal payment
G1	Information known about reform	What people reported is already being done about informal payments, reports they know about, organizations or individuals who are active in reform
G2	Opinions about reform	What people think could or should be done (e.g. increase availability of private medical service options, increasing salaries of medical staff, changing cultural beliefs, etc.)
G3	Agents of change	Who people think should be responsible for reform, involved in reform decisions

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