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THE RELATION BETWEEN HEALTH INEQUALITY AND LOW HEALTH UTILIZATION:

THE CASE OF VIETNAM

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Introduction

Vietnam is known for its remarkable economic and human development in the last 30 years. From one of the poorest nations in the world, the country successfully transformed to a lower-to-middle income country in 2010. Besides economic growth, Vietnam has also witnessed impressive human development as the country's Human Development Index (HDI) value increased by 45.9 percent between 1990 and 2018 (UNDP, 2019). However, despite the huge and stable growth in the economy and human development, the country records low utilization of health services, especially among poor demographics. This study examines the impacts of health inequalities, political, economic, and social determinants on health utilization.

To begin, I present a comprehensive review of relevant literature on health inequalities, state-led development, economic growth and human development inter-links, and the biopsychosocial model. In addition, an overview of the country is provided to understand Vietnam's current situation. Then, I will discuss the problems of and the link between health inequalities and low health utilization in Vietnam. Lastly, the research concludes by providing some suggestions as solution to the problem.

Literature Review

To fully understand health inequalities and its impacts on health utilization, it is important to define them. Also, this section situates health development under the lens of state-led development, economic growth (EG), and human development (HD) connection and the biopsychosocial model.

Health Inequalities

According to WHO (2017), health inequalities are the differences in health status or the distribution of health determinants. Health inequalities can be divided into two cases, unavoidable health inequalities and health inequities. In the first case, health inequalities are caused by biological variations, free choice, other external or environmental conditions. In the second case, health inequalities are attributable to the uneven distribution of health determinants. In this case, health inequalities lead to health inequities which are preventable. The problem of health inequalities should be viewed on both macro and micro levels since the contributors vary from national to individual levels. Therefore, to understand and reduce health inequalities and its impacts on health utilization, health development should study and address problems at different levels.

State-led Development

"Governments can create conditions for good and equitable health through careful use of social and economic policy and regulation" (WHO, 2008). Dréze and Sen (1991) highlights the impact of political systems and political choice on wellbeing in their study on famine. They claim that the inefficiency in political-economic institutions was the main cause of food shortages, "suffering and death," not the lack of food itself. Their study emphasizes the impact and significance of politics on human development. Additionally, chapter three of the study, "Challenges in health and development: From global to community perspectives", discusses the connection and issues between health and "state and human security, macroeconomic performance and population health" (Johnson, 2011, pg. 77). According to Johnson (2011), the state plays a crucial role in development. State adoption of development "influences the availability and quality of health inputs" no matter if it directs its efforts toward human or economic development (pg. 84). In fact, the government's approach to development policies affects health care provision and resources for health. Johnson (2011) raises four questions about the balance between economic growth, fiscal sustainability, welfare programs, and health care: 1) "who is responsible for financing and delivering health care;" 2) "how much of the population should have access to health care;" 3) "what services and supports are considered vital to health:" and 4) "who regulates care." Therefore, a government's development adoption has tremendous health impacts on its people.

State-led development is used to discuss the incoherencies and constraints of Vietnam's policies that relate to health inequalities in the country. The four questions about the balance between economic growth, fiscal sustainability, welfare programs, and health care are used to examine the link between inefficient policy and health inequalities that discourages health utilization.

Economic Growth and Human Development

The connection between economic growth (EG) and human development (HD) is critically important to development. The Stewart, Ranis, and Samman (2018) article examines the two "distinct casual chains" of HD and EG: one runs from EG to HD; the other runs from HD to EG. In the first chain, EG provides the resources that support improvements in HD. For example, strong economic growth leads to an increase in GNP and contributes to HD through household and government activity. However, the difference in the allocation of the same GNP can lead to different HD results. In the second chain, HD improvements enhance economic agents' performance by raising the capacities. For instance, improvements in health and nutrition for the poor increase labor productivity. The article also categorizes country performance into four classifications: virtuous, vicious, HD-lopsided, and EG-lopsided. Countries in the virtuous cycle case demonstrate that good HD enhances growth, which leads to good HD and EG achievements. In the vicious cycle case, poor performance in HD tends to negatively affect EG performance, which in turn depresses HD achievements. The authors explain the HD-lopsidedness as "strong HD/weak EG" and EG-lopsidedness as "weak HD/strong EG" (pg.208). The case of lopsidedness is said to be due to the weak linkage between HD and EG.

The relationship between economic growth and human development has been one of the most debated topics. As a matter of fact, the connection between wealth and health is one of the most documented findings (Wang & Arah, 2017). There is a belief that "wealthier nations are healthier nations" (Pritchett & Summers, 1996). However, there are many cases that cast doubt on that belief. For example, Kerala state in India demonstrate high literacy rate, and low morbidity and mortality rate despite having a poor income population. It is thanks to the local government direct most part of its revenue on education followed by health. The Kerala model contrasts the "wealthier nations are healthier nations" belief as it proves that exceptional human development can be achieved without high individual and national income. It also emphasizes the fact that ensuring good education and healthcare for all people can benefit a region's or nation's economy (Kannan, Thankappan, Ramankutty & Aravindan, 1991). Hence, the connection between HD and EG provides insights into the factors in Vietnam's HD-EG cycle that lead to health inequalities and low health utilization, as well as the need to eliminate health inequalities to support the country's development.

The Biopsychosocial Model

The biopsychosocial model states that the cause, manifestation, and outcome of health are determined by biological characteristics, behavioral factors, and social conditions (Engel, 1977). The advantages of this model are its high awareness and inclusiveness of diverse causes, risks, and perspectives attributable to wellbeing and illness. Under the lens of this model, social and behavioral factors play a major role in human health.

Social determinants of health are significant factors that affect an individual's health. These include socioeconomic status, education, physical environment, culture, nutrition, social context, and health care systems. These determinants emphasize the importance of quality of life, livelihoods, and sustainability in health development. Moreover, they determine people's perception of health, health care, and the impact of social and physical environments on health. Hence, it is fundamental to examine social determinants of health by the learning "place". Foucault's (1978) article points out the historical and geographical elements have great effects on the consciousness of disease. It is important to review how "place" affects health and people's experience in social and physical environments. The lack of development in social determinants causes community to be vulnerable. Vulnerable communities are those unable to access health care services even when these are available, highly exposed to risk factors, and are often excluded from development strategies (Chinai 2011). Therefore, social determinants can shape health development and health outcomes in a powerful way.

Behavioral factors, such as lifestyle and health beliefs, also play a role in health outcomes. Many studies point out that "specific behaviors are associated with increased risk of specific diseases and related conditions" (Institute of Medicine, 2001). For example, tobacco use has been linked to cardiovascular disease and cancer. Moreover, health beliefs are important to encourage behavior change that leads to better health outcomes. In other words, an individual must believe he/she can take action to prevent, screen for, or control a disease or condition. So, behavioral factors are crucial to improve health outcomes. The Biopsychosocial Model is applied to determine the social conditions and behavioral factors that prevent health utilization in Vietnam.

Vietnam: A Country Overview

Historical context

Vietnam is a country with a 4000-year history. Due to colonialism, it has a long past of affiliating with invading dominant countries and adapting to those dominant civilization's ideas, institutions, and technology to Vietnamese purposes. Three colonial powers had the most impact on the country: China, France and the U.S. Vietnam suffered from a thousand-year occupation period by China, which had

influenced most of Vietnam's cultures. "The French arrived in Vietnam initially as missionaries in the seventeenth century and established colonial control of Vietnam in 1887 with the formation of La Fédération Indochinoise" (Lam, 2016). With about 100 years colonized by France, Vietnamese culture was heavily impacted by the French culture, especially in language. In 1954, after the French withdrew from Vietnam, the country was partitioned into North and South, with the U.S. heavily in support of the South. After three decades of war, the country was unified in 1975. Then, the country had embarked on a withering socialist subsidy economy before beginning its socio-economic development with the 1986 reform "Doi Moi" (Innovation). In the past 30 years, Vietnam's development record is remarkable as it has transformed from one of the world's poorest nations to a lower-middle-income country.

Political structure

The Socialist Republic of Vietnam is a one-party Communist state. Since the early 1980s, Vietnam has constantly improved its diplomatic and political status, establishing an "open door policy" which focused on forming diplomatic relations and strategic partnerships with other countries as part of its "Doi Moi" socio-economic reforms. In 2000, policies were introduced to encourage medium and small-scale enterprises. These policies have boosted entrepreneurial characteristics for the country's economy and human development. Globalization has also urged Vietnam to enhance its political and social situation. For example, the Trans-Pacific Partnership Agreement stipulates that its members focus on good governance and human rights improvements. In addition, Vietnam Corruption Perceptions Index (CPI) had maintained a constant score, 31 out of 100 points, from 2012 to 2015. In 2017, the country scored 35 out of 100 point in the 2017 CPI 2017 ranking, ranking 107 out of 180 countries (Towards Transparency). The slight increase indicates a positive signal for Vietnam's anti- corruption efforts in recent years**.** However, The Country Policy and Institutional Assessment (CPIA) on transparency, accountability, and corruption in the public sector rating (1 = low, 6=high) of Vietnam has been at 3 from 2008 to 2015 (World Bank). Thus, **c**orruption in the public sector is still perceived as highly severe in Vietnam**.** Nonetheless, the Vietnamese government has been working to heighten transparency, especially to its citizens. For instance, the country records a high level of citizens' trust in the government in how it handles the COVID-19 pandemic. Hutt (2020) states that during uncertain times, Vietnam government is greatly transparent with the public in terms of communications. As a matter of fact, with a population of about 90 million, the country reports a low number of COVID-19 cases and deaths. Hence, transparency is a key factor if Vietnam is driving for state-led development.

Vietnam's political system creates both opportunities and constraints for health development. The establishment ASEAN Economic Community (AEC) in 2015 supported the expanding and exporting of medical services (Pham, 2016). Additionally, AEC also allows freedom of movement for skilled workers of the following occupations engineering, nursing, architecture, medicine, dentistry, tourism, surveying, and accountancy in the South East Asia region thanks to Mutual Recognition Agreements (MRAs) (Koty, 2018). This is an opportunity for Vietnam to attract high-skilled medical workers to help the country grow its medical services holistically. Vietnam Pharmaceuticals & Healthcare Report - Q4 2016 reports that the government resists aligning "lawfully with international standards which deters multinational sector expansion" and neglect health infrastructural and resource development (2016). Moreover, domestic and international investors consider legal policies one of the biggest concerns when venturing further in the country's market. For example, the limitations of the Law on Medical Examination and Treatment 2009 (i.e., requiring obtaining investment or business license from Ministry of Health without further specific guidance) and "the lack of a circular guiding Decree No.63/2015/ND-CP, ('policies towards redundant employees due to the restructuring of state-owned single member limited companies'), on the Public-Private Partnership (PPP) model" are two of numerous issues worrying foreign private investors (Bich Thuy, 2020). In Vietnam, corruption in the health sector is a serious problem for both the government and

citizens due to the "uncertainty, asymmetry of information between health officials and patients, and conflicts of interest between health officials and private companies" (Transparency International). Therefore, the government needs to utilize the opportunities effectively to solve these constraints and improve its health sector.

Economic structure

Vietnam is a lower-middle-income country. It has witnessed substantial changes in the policy and business environment following its accession to the World Trade Organization (WTO) in early 2007. A WTO membership creates enormous opportunities for Vietnam's economic growth and poverty reduction. For example, foreign direct investment (FDI) in Vietnam tripled in 2007 compared to 2006 (Ahmed, 2018). Vietnam's economic performance has also rapidly developed. Its GDP increased from $31.2 billion in 1991 to $164.1 billion in 2016, alongside a stable growth rate, reaching an all-time high of 9.3 percent in 1996 and about 6 percent in other years. The country's GDP per capita increased from $464.2 in 1991 to $1770.3 in 2016. From 1991 to 2001, Vietnam's GDP per capita growth rate fluctuated from 4 percent in 1991 to 7.6 percent in 1996, then decreased to 4.8 percent in 2001. From 2006 to 2016, its GDP per capita growth rate experienced a slight decrease from 5.8 percent in 2006 to 5.1 percent in 2011, and 5.07 percent in 2016. Vietnam GDP per capita PPP increased from 3,687 USD to 5,955.3 USD between 2006 and 2016. Furthermore, Vietnam experienced structural changes, in which the country experienced a decline in the agriculture sector. World Bank's data from 2010 to 2016 shows that agriculture accounted for 18.1 percent of Vietnam's GDP in 2016, a decline from 21 percent of GDP in 2010. The country's industry sector also experienced a slight drop, 36.7 percent in 2010 to 36.4 percent in 2016. Meanwhile, Vietnam service sector has slowly gained its share, which was 44 percent in 2016. Therefore, the country is shifting towards a service economy.

Vietnam's remarkable economic growth has created resources for health development. There have been better trainings for health staff along with improved health facilities and services. For example, the country enacted the National Cancer Control Plan in 2008 whose goal was to better the quantity and quality of medical staff in cancer control and treatment facilities. The plan has attracted considerable investment and results, an increase in radiotherapy equipment, oncologists, oncology nurses, and radiation therapists (Tran, Pham, Dao & Tran, 2017). On the contrary, rapid economic growth has led to income inequality barring health utilization. Moreover, the country's economic freedom score is still low. In the 2018 Index of Economic Freedom, Vietnam's score of 53.1 ranks 141st out of 180 countries. As a result, the country has not been able to achieve higher levels of foreign direct investment in health.

Vietnam's infrastructure

Vietnam is one of Asia's biggest spenders on infrastructure. In 2016, its public and private sector investment in infrastructure averaged 5.7 percent of GDP (Asian Development Bank). Vietnam's infrastructural development is considered one of the fastest in the region. According to ADB, the country is investing in building transport networks, boosting power supply sources, and upgrading water and sanitation facilities. The Asian Development Bank has estimated that Vietnam's infrastructure needs will cost $480 billion between now to 2030. In 2020, one of the highlight prospects for private domestic and overseas ventures in Vietnam is the EU-Vietnam Free Trade Agreement (EVFTA). The EVFTA not only opens a door for European products to enter Vietnam's market, but also presents a chance for foreign investment in infrastructure, specifically the healthcare sector (Bich Thuy, 2020). However, Vietnam is experiencing numerous infrastructure shortfalls. According to the latest global competitiveness rankings of the World Economic Forum, infrastructure is the biggest drag on Vietnam's national competitiveness. Moreover, only 20 percent of the country's national roads are paved. Water and waste treatment systems remains inadequate in the main cities as urbanization continues apace.

The growth in infrastructure also impacts healthcare facilities in Vietnam. Healthcare infrastructures are divided into public and private sectors. Public hospitals are categorized into central (47 hospitals), provincial (419 hospitals), and district-level (684 hospitals). There are 182 private hospitals, mostly located in urban areas of the country (WHO, 2020). As a matter of fact, there is a rising inequality between these two sectors. According to Nguyen and Wilson (2017), private clinics and facilities outnumber public ones in both infrastructures and services offered. So, even though people live near public health facilities, they tend to seek care at a private health facility. However, as private healthcare only offers for those have the financial capacity to pay for the services, it creates an access gap as poor population cannot afford private quality healthcare. Furthermore, public and private investment is breeding some renovations in Vietnam's healthcare infrastructure. In the 2011-2016 period, "the number of public and private hospital beds grew at a Compound annual growth rate (CAGR) of 3.4 percent and 17.7 percent respectively, while the number of public and private hospitals grew at a CAGR of 0.8 percent and 6.8 percent respectively" (Das, 2018). Even though it is reported that foreign investors are interested in the Vietnamese healthcare market, health infrastructure in Vietnam is still a problem. Despite the growth in the number of hospital beds, the country has not solved the issues of high bed occupancy rate, surpassing the 80 percent threshold occupancy rate recommended by the WHO (2020). Overcrowded hospitals continue to be a major issue in the country, to the extent that Vietnamese would seek medical treatment abroad, resulting in $2 billion overseas annual spending (Das, 2018). Additionally, there is a huge gap between the quality of medical equipment or medical staff in the provincial level and national level hospitals (PWC, 2015, p.2&3). In conclusion, Vietnamese health care infrastructure cannot keep up with the demand for medical services.

Social structure

Vietnam has a diverse and culture-clothed society that comprises 54 official ethnic groups. The majority ethnic group is the Kinh, and the smallest group is the O Du. Among minority groups, the Tay has the largest population with an estimated 1.85 million members (UNFPA, 2019). There are three cultural dimensions that need to be addressed in economic and human development, which are collectivism, high power distance index, and social stratification. Vietnam is a collectivistic society. According to Hofstede's cultural metrics, people of collectivist culture tend to exert themselves for the betterment of their group, family, or country. The power distance index indicates how people belonging to some specific culture view power relationships between people. Hofstede states that people of high-power-distance culture tend to view themselves as part of a hierarchy. Vietnam scores high on this dimension (70 out of 120) which means that the people accept a hierarchical order. Social stratification is still visible in Vietnam, where the rapid economic development and urbanization has extended the gap between different income levels. Social stratification results in inequalities in access to health care, education, and other services.

As they can affect health outcomes, it is important to understand the cultures' impacts on people's perception and behaviors. It is significant to understand that health inequalities are associated with ethnicity and culture. Since Vietnam's health development is still lacking in culture profile for each ethnicity group, the cultural difference between health workers and patients leads to ineffective health communication and poor health outcomes. As a result, health development should consider the social structure to eliminate health inequalities.

Human Development Index

Between 1990 and 2018, Viet Nam's HDI value increased from 0.477 to 0.693, a rise of 45.9 percent (Human Development Report, UNDP, 2019). The HDI value of 0.693 puts Vietnam in the medium human development category. However, the country's actual HDI in 2018 is lower when taking into consideration of inequality value, like human inequality coefficient, inequality in life expectancy at birth, inequality in education and inequality in income. So, Vietnam's HDI in 2018 decreases to 0.580 due to the discount for inequality, 16.3 percent, including human inequality coefficient (16.2 percent), inequality in life

expectancy at birth (12.9 percent), inequality in education (17.6 percent) and inequality in income (18.1 percent) (Human Development Report, UNDP, 2019). During the 1990-2015 period, Vietnam's GDP per capita PPP increased from 1,501 to 5,668, or about 277.6 percent. Hence, the country's performance of HD-EG chain belongs to the virtuous cycle of HD-EG as it experiences an increase in both HDI and economy (Stewart, Ranis, & Samman, 2018). With its citizen gets by with an average of $5000 in national average, Vietnam's standard of living is put into medium group. This number indicates that people have better access to goods and services, which can improve their quality of life. WHO statistical profile indicates that life expectancy at birth for both sexes in Vietnam increased by 2 years throughout 2000-2012, from 73.3 to 76. Also, from 2002 to 2015, Vietnam's infant mortality rate decreased by an estimated 2-3 deaths each year. The country's data showed that infant mortality decreased from 22 in 2002 to 19.1 in 2008, and the most recent rate was 17.6 in 2015. Lastly, according to WHO Maternal Mortality in 1990-2015 report, the maternal mortality rate in Vietnam had declined from 139 in 1990 to 81 in 2000 and then, 54 in 2015. Also, in 2015, the adult literacy rate increased to 94.5 percent. In terms of gender equality, Viet Nam has a gender inequality index value of 0.314, ranking it at 68 out of 162 countries, and its gender development index value of 1.003, placing the country into Group 1which includes "countries have high equality in HDI achievements between women and men," in 2018(Human Development Report, UNDP, 2019).

However, it is difficult to explain the country's good human development performance despite its low expenditure on health and low health utilization. Vietnam's public health expenditure was 3.8 percent of GDP in 2014. The public expenditure on health was accounted for only 14.2 percent of total government expenditure (World Bank, 2014). Tran, Nguyen, Nong, and Nguyen (2016) reports low health service use is mostly severe in "difficult-to-reach areas". The research finds that "more than 20 % of respondents reported that they had self-medication without consultation to health workers" (Tran, Nguyen, Nong, &Nguyen, 2016). Inaccessibility to general healthcare services is common barrier among this group as 29 percent of the participants' state that it is difficult for them to access health service (Tran, Nguyen, Nong, &Nguyen, 2016). Therefore, despite the increase in HDI, Vietnam does not invest enough in its health sector which causes inequalities in healthcare access and low health utilization.

Discussion

Health inequalities are caused by various factors. In this case, there are three major contributors to health inequalities: 1) lack of governmental support; 2) unequal income distribution; and 3) social determinants.

Lack of governmental support

As discussed in the country's profile above, the Vietnam health sector faces many incoherencies and constraints due to some existing policies. The country experienced policy shifts in the period between the late 1980s and early 1990s, including the liberalization of its healthcare and pharmaceutical industries. However, according to Vietnam Pharmaceuticals & Healthcare Report - Q4 2016 reports, the government resists aligning "lawfully with international standards deterring multinational sector expansion" and neglect health infrastructural and resource development (2016). Moreover, during the country's socio-economic reforms, the healthcare sector was neglected (World Bank 2001; Glewwe *et al.*2004). According to Johnson (2011), state adoption of development "influences the availability and quality of health inputs" no matter if it directs its efforts toward human or economic development (pg. 84). It is clear that in the reform period, the Vietnamese government focused more on economic growth than human development. However, recently, the Vietnamese government has directed more of its efforts towards improving people's life quality, especially in health conditions, through the National Targeted Programs (NTP). The NTP focuses on five themes: 1) Private Sector Development, 2) Social Development and Protection, 3) Human Development and Gender, 4) Urban and Rural Development, and 5) Environment and Natural Resource Management (World Bank, 2020). Among the themes, Social Development and Protection specifically contributes to the economic and social improvements of ethnic minority groups in

Vietnam. Dimensions, such as education, health, housing, sanitation, and water, are also emphasized in this program (UNDP, 2020). On the other hand, even though Vietnam adopted universal health coverage, out-of-pocket health expenditure still accounted for 63 percent of health expenditure (World Bank, 2018). Healthcare fund for the poor (HCFP) was established under Decision 139/2002/QD-TTg (Socialist Republic of Vietnam 2002). It is a part of Program 135, Vietnam's Sustainable Poverty Reduction Support Program (NTPSP). HCFP aims to provide financial support for people living in poverty-stricken and disadvantaged communities so that they can obtain free access to healthcare (Le, Groot, Tomini &Tomini, 2019). The fund indicates that the country is focusing on health financing reform. However, Wagstaff (2010) states that although HCFP has reduced out-of-pocket spending, it has had no impact on the use of services. Moreover, user fees at public healthcare facilities and out-of-pocket payments for healthcare services are major barriers to access. Additionally, according to Le et.al (2019), HCFP has unintended negative effects on labor supply in the targeted areas and among targeted groups. The research found that the HCFP negatively impacts labor supply among the insurance covered groups. It observes a labor distortion among people who are living in poverty in rural areas who receive HCFP in 2006 compared to in 2004. "Interestingly, the effects are mainly driven by the non-poor recipients living in rural areas, raising the question of the targeting strategy of the program" (Le, Groot, Tomini &Tomini, 2019). As a result, HCFP may create more disadvantages than benefits for the poor recipients' healthcare utilization. Consequently, the lack of governmental support and policy reform causes various issues that discourage people to seek for healthcare because of the shortage of financial support, poor-quality health infrastructure, health facility accessibility, and other unintended impacts. Policymakers should better target vulnerable groups to ensure equity.

Unequal income distribution

In the 28-year period (1990-2018), Vietnam has witnessed a significant improvement in human and economic development. This indicates that Vietnam's human and economic development has moved completely to the virtuous cycle. However, as mentioned in the country's profile, social stratification is one of the consequences of rapid economic development and urbanization, especially the inequalities in access to healthcare, education, and other services. Also, despite the exceptional economic growth, Vietnam public health expenditure remains low. In the past 10 years, public health expenditure (% of GDP) has fluctuated. In 2009, public health expenditure accounted for 2.6 percent of GDP. It had increased to 3 percent in 2010 but decreased to 2.8 percent in 2011. As a result, poor health infrastructure has not yet been addressed. The low and unstable health expenditure create financial barriers health services. The inadequacy of health financing is attributable to "inefficiencies and disparity in allocation of healthcare service […] between rural and urban areas" (Piabuo & Tieguhong, 2017). Also, FDI has played a significant role in accelerating the country's socio-economic development, Vietnam's Ministry of Planning and Investment has collaborated with the World Bank to develop a new five-year FDI strategy for 2018-2023. The strategy aims to attract investment in high-tech industries and enhance the quality of investment. Moreover, a free flow of capital and investment in the AEC is an opportunity to improve the overall well-being of the country and its citizens. Additionally, foreign companies have been interested in Vietnam's healthcare market. Such investments will create more international-standard medical services in Vietnam (Pham, 2016). On the contrary, these investments are mostly in big cities, provincial cities, and large municipalities, meaning they can contribute more to the current health inequities in Vietnam. According to Ranis (2000), EG provides the resources to improve HD. On the other hand, the limitations in EG can affect HD. Thus, the unequal income distribution causes health inequalities, especially uneven and preventable health inequities.

Furthermore, unequal income among the population can cause health inequities. Sepehri (2005) examined the economic groups' health utilization in Vietnam, showing that compared to the poorest 20 percent, the richest 20 percent of the population visits public hospitals nearly four and half times more frequently. In addition, inpatient admission rates for non-poor households are greater than in poor households. Therefore, there is a correlation between the income gap and health inequalities.

Social Conditions

The biopsychosocial model states that biological characteristics, behavioral factors, and social conditions have huge impacts on health outcomes. Behavioral factors and social determinants can powerfully shape people's consciousness about wellbeing and disease. In Vietnam, looking from a micro-perspective, despite the significant increase in HDI, from 0.477 (1990) to 0.693 (2018), human development levels are still unequal between different communities in the society. The vulnerable communities are the poor population, elders in rural areas, and minor ethnic groups. Among these groups, ethnic minorities face the highest degree of social vulnerability due to geographical locations, social exclusion due to cultural and linguistic barriers, limited access to agricultural resources, education and health facilities, and low migration rates.

Firstly, most ethnic minority groups in Vietnam are living in two regions, the Northern Mountains and Central Highlands, and most minorities remain rural residents (The World Bank, 2009). The locations contribute to the disparities in education, infrastructure, and public services as most investments in development are at the city or provincial level. Moreover, geographical isolation leads to limited market access. Also, minority groups use physical marketplaces less than the Kinh ethnic group which leads to market vulnerabilities among minorities, including price fluctuations and opportunistic middlemen. Furthermore, most ethnic minority farmers have little awareness of market demands and market prices. Country social analysis: ethnicity and development in Vietnam: Summary report (2009) states that despite the improvement in infrastructure for trading and markets in highland areas, there is a lack of attention on cultural and social issues in these areas, especially the fact that "trading and business in minority areas is not dominated by [ethnic minority communities]." Vietnam poverty assessment (2012) highlights a rising concern about increasing inequality in income or expenditures in the country. The inequality is considerably visible in the rural sector. Also, minorities are over-represented in income inequality study as the report demonstrates that the ratio of incomes earned by the bottom 20 percent of minorities relative to the bottom 20 percent of majorities (bottom 20 percent of minorities/ bottom 20 percent of majorities) has increased from 1.4 in 2004 to 2.1 in 2010. In other words, ethnic minority individuals are earning more in 2010 compared to 2004. Furthermore, according to the International Work Group for Indigenous Affairs (IWGIA) (2019), in 2015, the poverty rate registered for ethnic minorities was 23.1 percent, about triple the national poverty rate, 7 percent (IWGIA, 2019). The article "Vietnam continues to reduce poverty, according to WB report" (2018) states that ethnic minorities account for 72 percent of Vietnam's poor. As minor ethnic communities mostly concentrate in rural and mountainous areas, they are more vulnerable to poverty and development's inequities. Poverty increases the health equity gap between minor and major ethnic groups as financial burdens prevent ethnic minorities from seeking and using healthcare services. Therefore, it leads to low health utilization among people in minority ethnic groups.

Secondly, cultural and language differences between ethnic minorities and Kinh is one of the factors that contribute to vulnerabilities. Malqvist et al. (2013) highlights that traditions and patriarchal structures within these groups often lead to harmful health behaviors and gender inequality. In addition, WHO (2009) reports that ethnic minority women are often placed in a "subordinate position." In other words, men play a dominant role in the household which gives them the capacity to make decisions on behalf of other family members. For example, some women are denied access to necessary maternal care due to

cultural practices of another member of the family, who is responsible for decision-making (WHO, 1999). Cultural factors are also barriers to economic transactions. For example, there are norms against charging interest on loans from kin and neighbors. Some minorities view the ability to earn income as a "socially unfavorable trait" (WHO, 2009). However, WHO report (2009) points out that the government often ignores the essential heterogeneity of these groups by enforcing homogenous development interventions. Since most of the policies attempt to improve minorities' living conditions use majority groups as the standards, they tend to fail. Furthermore, the Malqvist (2013) journal states that there is discrimination from health workers towards minority groups due to cultural differences. The lack of health information in ethnic languages also causes difficulties in increasing health utilization for people from ethnic minorities. They are less likely to be reached out or provided with comprehensible health information, such as vaccination. The diphtheria outbreak in Kon Tum Province, Vietnam, in July 2020 is one of the examples of the lack of materials in ethnic languages to improve ethnic minorities' health literacy. The outbreak emerged because the affected communities were not vaccinated for the disease. According to VTV's interview, the low vaccinated rate is because most people from ethnic minority groups are not educated about the disease or vaccination by local government (VTV, 2020). Having poor access to information via communications channel is another barrier for people from minor ethnic groups. According to Nguyen et.al (2019), people living in mountainous areas are more likely to receive health information from radio or television, at 74.1 percent, than health worker, at 26.9 percent. Therefore, the information provided in digital channels or other sources may not effectively reach people there. For example, during the COVID-19 epidemic, minor ethnic communities have faced more challenges than the Kinh ethnic in updating official information and guidelines of the pandemic. Although Vietnam Ministry of Health provides handwashing guidelines in various ethnic languages (Thai, E De, H'mong, Tay, Dao, etc.) on its YouTube channel, the materials may not be able to reach these groups due to limited internet and technology access. Hence, cultural factors, especially language, are crucial in working towards better health and development in Vietnam.

Thirdly, due to their concentrated locations, these groups have limited access to high-quality lands that can support agricultural activities. Despite support policies, such as Land Reform and Aid for Poor Families 134/2004/QĐ-TTG, ethnic minorities still face a lot of challenges in purchasing and owning lands for personal purposes (Ministry of Justice, 2004). The land rights and land uses change from public-managed to private-owned in 2006. However, the incoherency in policy transition has caused numerous problems in land ownership for both public and private lands. There are two key issues with the current land policy. First, most of the lands vital to minor ethnic groups' livelihoods are designated as forestland, although the groups have used these lands for agriculture for a long time. IWGIA finds that, in 2015, "only 26 percent of the total area of forest land was allocated to households and 2 percent of that land was allocated to communities for management" (2019). However, the quality of the land assigned to the households was low. So, it is hard to generate income from the assigned lands. Second, the role of communities in land governance is being ignored. Individuals can receive collective land certificates, "but they cannot make decisions about the use and assignment of land within communities" (Luong & Genotiva, 2010). As a result, there are uncertainty and insecurity for many minor ethnic households without solving the unequal distribution of land. Additionally, mountainous areas pose a great challenge in terms of utilization and management. These areas also often face major natural hazardous risks, such as landslides, seasonal floods, and mudflow. In addition, the migration of the Kinh to minority regions in the past 50 years has reduced land availability among ethnic minority communities. Consequently, landlessness has increased in these areas which is one of the reasons for the high poverty rate among minority groups. Another critical barrier to achieving high development is less access to quality education, especially for the poor and women. "Vietnam poverty assessment: well begun, not yet done - Vietnam's remarkable progress on poverty reduction and the emerging challenges" (2010) highlights the gaps in education between ethnic

minorities and Kinh majorities. The report records that 44.2 percent of the extreme poor minorities have not completed primary school, while the record is 21.7 for the extreme poor Kinh ethnicity. Also, 38.6 percent of poor minorities have not completed primary school compared to 16.4 percent of poor Kinh majorities. Financial burdens, shortage of education facilities, and traditions are three main causes of the high illiterate and dropout rates among minorities. Additionally, according to the World Bank (2014), Vietnam's public health expenditure was 3.8 percent of GDP. The public expenditure on health accounted for only 14.2 percent of total government expenditure (World Bank, 2014). As a result, the shortage of financial resources leads to a shortage of facilities and medical staff, particularly in rural areas. Local and federal government should address this issue by developing more quality healthcare facilities to solve people's inaccessibility to healthcare.

The last factor that contributes to the vulnerabilities of ethnic minorities is the lack of resources to support migration. In Vietnam, internal migration is due to the shortage of access to educational and occupational opportunities. The lack of infrastructure discussed above is also one of the main reasons that forces the vulnerable communities to migrate to other locations. As a matter of fact, migration is often seen as an opportunity to improve life quality given the fact that migration people have to face many challenges such as getting access to local education, health systems. However, migration is hardly an option to ethnic minorities because of cultural differences, absence of protective policies, missing of migration information sources, low financial aid, or inability to meet labor skill requirement. According to Coxhead, Nguyen and Vu (2015), the migration rate of ethnic minorities is 2.75 for work purposes and 1.35 for non-work purposes. It is estimated twice lower than Kinh and Hoa people's migration rate, 4.58 for work purposes and 3.63 for non-work purposes.

In conclusion, it is important to note that health inequalities among ethnic minorities are due to social determinants and behavioral factors. Ethnic minorities are exposed to many vulnerabilities in both economic and health development. These are due to political, economic, and social factors. Policy development often overlooks this vulnerable group's perspectives, concerns, and demands. Thus, it is important to bridge the inequitable gap between minorities and majorities so that Vietnam can achieve more desirable outcomes in economic and human development.

From Health Inequalities to Low Health Utilization

In Vietnam, both cases of health inequalities, unavoidable health inequalities and health inequities, exist. In the first case, most Vietnamese believe in self-medication. In other words, they rarely seek healthcare services, instead they wait for the illness to go away. Household Utilization and Expenditure on Private and Public Health Services in Vietnam reports that "more than 70 percent of all the sick people did not seek care from any formal sources" (Nguyen et al, 2002). Moreover, Adam Wagstaff (2007)'s research on impacts of healthcare funds for the poor (HCFP) "reports descriptive statistics for the outcomes studied for both the full sample and those eligible for HCFP". The data indicate that even though a Vietnamese record, on average, one outpatient consultation a year, only 30 percent recorded one or more outpatient visits in the 12 months before the survey; additionally, 7 percent recorded an inpatient spell. This health behavior contributes to health inequalities in the society in which individuals whose health services have better health outcomes.

In the second case, the political, economic, and social determinants account for unequal health distribution in Vietnam. Firstly, political constraint and lack of support create barriers for vulnerable communities (i.e., ethnic minorities) to receive fair health access. The constraint and incoherency in policies contribute to the uncertainty for public and private investors who want to venture further in the health sector at the communal level. An example is the uneven investment distribution between different health facilities. Wagstaff (2007) points out that "there is a strong bias in reimbursements towards higher-level facilities and inpatient care." He states that in 2004, 40 percent of the HCFP budget went to provincial

hospitals, 34 percent to district hospitals, and 20 percent to communal health facilities. The difference in distribution of investment in health facilities prevent people from seeking healthcare and high-quality health services due to the absence or inefficiency of available healthcare services. Despite the increase in healthcare facilities in recent years, the national and local government still neglect health development in vulnerable areas. Moreover, support program, like HCFP, observes numerous shortcomings, such as targeting strategy and health access. These disadvantages generate a negative two-way impact where good healthcare cannot be provided to the people and, simultaneously, people do not come to healthcare whenever they need it. Plus, the political determinant contributes to the inequity between different demographics among which poor ethnic minorities are the most vulnerable. Thus, the government at all levels should play a more transparent and efficient role in solving the existing health inequalities in Vietnam. Secondly, the majority of minor ethnic people in Vietnam are living in destitution, despite the country's rapid economic development and effort to reduce poverty. The country is slowly shifting to a service economy and experiencing a decline in the agriculture sector, with an estimated decline of 3.1 percent from 2010 to 2016 (World Bank, 2017). This is a disadvantage to ethnic minorities who depend mostly on agriculture to generate income and do not receive enough educational or vocational support. Moreover, as aforementioned, the shortage of land rights and low mitigation rate can contribute to the unequal income inequality in minor ethnic people. As indicated, the richest 20 percent of the population visited public hospitals nearly four and a half times more frequently than the poorest 20 percent Sepehri (2005). It is undeniable that there is a correlation between the income gap and low health utilization. Finance is one of the key factors that determine one's decision to obtain health services. Therefore, to increase the health utilization of ethnic minorities, Vietnam has to solve the income inequalities. Lastly, there are social factors, such as cultural appropriateness of services, language barriers, and cultural differences that affect the health inequality gap in Vietnam. Lingual and cultural differences are rarely taken into consideration when development interventions are conducted for minor ethnic groups (WHO, 2009). They contribute to health illiteracy which is one of the major problems in health development. Also, the reproductive and sexual health services are culturally sensitive topics that require culturally sensitive approaches from healthcare workers. However, cultural appropriateness of health services is not commonly discussed and approached in Vietnam. Discrimination from healthcare workers towards minority groups is another factor that prevents minor ethnic individuals from receiving health services. Therefore, to encourage minor ethnic people to utilize healthcare services, Vietnam has to develop its healthcare to cater to the cultures and needs of minor ethnic communities. Consequently, there is a correlation between low health utilization and unavoidable health inequalities and unjust health inequities in the country. Health inequalities are caused by various factors at both macro and micro levels. It is important to determine the causes of health inequalities. Health inequalities in Vietnam are not only affecting people's perception and choices in utilizing healthcare services, but also prevent them from keeping up with people's health services' demand due to uneven health facilities and health worker's distribution. Health inequalities can lead to health illiteracy which negatively impacts people's self-efficacy. As a result, people are not motivated to seek healthcare which adds to low health utilization.

Evaluations and Recommendations

Despite the challenges, there are some opportunities for health development for ethnic minorities in Vietnam. For example, Resolution No. 20-NQ/TW states that WHO will support the Vietnamese government in moving forward to the universal health coverage agenda (WHO, 2020). The effort to become more inclusive in the health sector of the government by creating health materials in ethnic languages should also be acknowledged. Lastly, the increase in public and private investments in healthcare infrastructure can bring more opportunities in health development to rural and mountainous areas.

With the findings above, the recommendation is that the government cannot focus on only one determinant. To thrive in the healthcare sector, Vietnam needs to address political, economic, and social determinants in healthcare. Also, the government has to emphasize its role as a vital actor in health development. Moreover, it is necessary to reform Vietnam health finance. Lastly, social issues and cultural factors need to be highlighted to improve health literacy and develop effective communication between health workers and minor ethnic people.

Conclusion

In conclusion, Vietnam health system has been improved significantly recently. However, the health inequalities in the country still exists because of the lack of governmental support, unequal land and income distribution, and other social determinants. Low health utilization is linked to these inequalities due to three reasons: 1) lack of self-efficacy due to health illiteracy, 2) inability to use health services because of its uneven distribution, and 3) shortage of federal, provincial, and communal aids. Although, many argues that economic growth can provide the country infrastructural and financial resources to enhance its development, focusing on only economy can lead to social inequalities which harm people. The fact of only using or prioritizing gross domestic production (GDP) to measure the development of the society is not suitable. Both economic growth and human development should interchangeably benefit each other. As a result, human development, especially health development, is the first and foremost priority. In order to achieve greater human development, Vietnam should not neglect health development, especially for vulnerable groups like ethnic minorities.

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