

## THINK PIECES

### Medical stratification in Vietnam

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#### Abstract

Market transition in Vietnam is known to have fueled health disparities, but racialized and nationality-linked aspects of the country's medical stratification have received less attention, despite the growing presence of foreigners using the health system. Field experiences reveal the country's increasing health and medical inequity – legible in the social, linguistic, economic, and physical distinctions between public health stations staffed by government employees and the private clinics serving mostly expatriates. Ethnographic interviews and experiences of receiving care in both public and private facilities inform my argument that the privatization of Vietnam's health sector produces racialized, classed, and citizenship-linked forms of medical profit, privilege, segregation, and risk – trends visible both in recent debates over US health policy and recent episodes of pandemic disease outbreak.

#### Keywords

inequity, medical stratification, nationality, race

#### Travel medicine

The retooling of Vietnam's health-care system along neoliberal lines in the 1980s and '90s has created an upper stratum that is virtually inaccessible to all but the wealthiest patients – a startling about-face from the country's previous emphasis on universal access to preventive care. This new medical elite draws from the nation's growing middle class, but increasingly also from the tourist economy: though Vietnam is not much remarked on as a destination for medical tourism like Thailand, Malaysia, and Singapore, its private providers serve an expanding pool of foreign patients: Over the last ten years, the number of tourists annually has risen from 10 to 34 percent per annum and now hovers around 7.5 million international passengers, equivalent to nearly 9 percent of the

national population of 88.78 million (Ministry of Culture 2014), and current estimates suggest some 75,000 foreigners are living and working in Vietnam on a more permanent basis (Linh 2012). Though the website of the Medical Tourism Association (2013) acknowledges Vietnam as ‘the underdog in the medical tourism industry’, it urges readers not to ‘underestimate the quality of care that private Vietnamese hospitals<sup>1</sup> provide’ and touts the popularity of ‘extremely affordable’ cosmetic, bariatric, and dental procedures.

As a foreigner planning research in Vietnam, I was inserted into this elite health care stratum even before I arrived. When I traveled to Hồ Chí Minh City for the first time, I received immunizations for typhoid, tetanus, and hepatitis A, a prescription for short-course antibiotics, and the recommendation to purchase Florastor, Purell, a steri-pen, and a bed net imbibed in permethrin – items whose cost would rival the annual out-of-pocket health expenditure of most lower-income Vietnamese persons. I did buy high-SPF sunscreen and saturate my clothes with insect repellent, and found that even those minimal preparations had an uncomfortably colonial flavor.<sup>2</sup> For anthropologists from the Global North conducting field research in the Global South, perhaps it is impossible to shed certain legacies of empire.

The paranoid tenor of these measures followed me to the field, where I found I was often nervous about whether I would return home with a dissertation topic, empty hands, or malaria. Not having realized the importance of the telephone in Vietnamese professional culture, I spent a lot of time at internet cafés emailing requests for meetings. Work progressed slowly. I slept restlessly and often woke up disoriented. One night I had heart palpitations, numb hands, and chills, and walked across town to the International SOS Clinic for the comfort of a biomedical opinion (diagnosis: too much coffee).

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<sup>1</sup> Data regarding service provision by private hospitals are not captured by national health statistics, as non-state institutions are not required to cooperate with the public health sector or report their patient treatment data to the Ministry of Health. Tellingly, a recent report on service delivery has a blank space where the total number of private clinics in Vietnam should be (World Health Organization and Ministry of Health 2012, 3).

<sup>2</sup> Indeed, contemporary travel medicine has its roots in military medicine and the requisites of European colonial expansion; this legacy has more recently, as Sarah Davies (2008) suggests, assumed a biopolitical flavor as Western states move to securitize contagious diseases such as HIV and SARS, framing them as existential threats to the global order.

This was the somewhat inauspicious beginning of my study of the Vietnamese health-care system's response to the threat of epidemic disease. During sixteen months of medical anthropological field research on cholera and public health in Hanoi, Vietnam, I often used the capital's health services myself. The contradictions between the promises and failures of Vietnam's national health capacity fascinated me, and I found these themes clearly manifest in the contrast between private and public health facilities. For example, the International SOS Clinic, which boasts 'over 700 locations in 76 countries worldwide', had dedicated surgical facilities, medevac services, multilingual staff (English, French, German, Italian, Japanese, Korean, Spanish, and Thai), an on-site pharmacy, and short waits. By contrast, when I visited a prominent public hospital, I was unnerved to see a pile of discarded facemasks lying outside the entrance: a sign of the popularity of a low-cost, less effective attempt at prophylaxis. Outside the hospital, a shabby monolith, sick people waited on backless benches in the heat. My meeting was next door at a newly built research unit funded by a British global health charity; it boasted laboratory facilities but no patient care capacity. The uneasy juxtaposition of high-tech health securitization and public health risks seemed to crystallize ominously on a visit to a medical university where I happened across a pile of shattered glass, syringes, gloves, and blood on the ground. No one was around, leaving the impression of an accident without a cleanup protocol. Contrasts such as these also opened a political and intellectual dilemma: What could an American responsibly say about the proudly touted achievements of medicine in Vietnam, and how might one understand them in counterpoint to the better-hidden failures?

### **Anxious states**

In the colonial period, the sort of malaise that I experienced was not uncommon among Europeans in Indochina, who were prone to a nervous, unsettled affect termed '*le cafard*'.<sup>3</sup> This affective complex revolved around the dread of sickness, poisoning, and death. Medicine of the period held that the causes of this syndrome included 'colonial anemia ... excessive heat and humidity, the intensity of the light, sudden barometric fluctuations, and changes in the electrical field' (Vann 2005, 104). *Le cafard* is an interesting entry in the annals of tropical medicine, in part because it is

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<sup>3</sup> This term, whose literal translation is 'cockroach', was first used by Charles Baudelaire in *Les Fleurs du Mal* (1917) to denote depression or melancholy. '*Le cafard*' in Indochina parallels the paradoxical sense of 'vulnerability and tenderness' among senior American officers in the Philippines that Warwick Anderson (1997, 1343–44) describes in his analysis of 'tropical neurasthenia' and 'brain fag'. See Arnold (1993) for a discussion of the role of health fears in structuring medical interventions in colonial India.

essentially a folk illness or culture-bound syndrome. Imagining the white physique as fragile despite the social power it embodied, *le cafard* revealed the repressed knowledge of colonialism's potentially precarious and vulnerable future. Its humoral model of causality, blaming symptoms on the climate, sidestepped the role that sublimated cultural anxieties, social dislocation, and bad conscience might have played in structuring a tense, melancholic, or misanthropic affect. Indeed, as the historian Michael Vann points out, 'by medicalizing this psychological state, the discourse of this condition exculpated the colonial from rude, reckless, or violent behavior' rather than properly identifying it as the byproduct of racism and disproportionate privilege (2005, 105).

In retrospect, I speculate that I, like the French with their tropical horrors, was suffering from a somatized form of bad conscience – albeit one grounded in left-wing ambivalence and not imperial unease. Unlike the French, however, I was aware that my anxiety was exacerbated by being American in a country to which the United States had recently laid waste. Though my Vietnamese friends would joke with me about the points of etiquette that distinguished 'good' Westerners, I was never sure there was a good way to be an American. In Vietnamese, the word '*mạng*' references 'life', as in the Greek concept of *ζωή*. It also means 'network' – a homonym underscoring the degree to which life is understood as social and related to intersubjective connection and exchange. The beneficiaries of inequity in a stratified society also suffer, especially if they are prone to shame about benefiting at the expense of others. This prompts me to ask, if only rhetorically for now: How can medical anthropologists – often themselves members of elite foreign groups – establish an ethical orientation towards segregationist and neocolonial tendencies in their field sites?

### **Dead American**

In 2009, I returned to Vietnam on a Fulbright fellowship. The first official function I attended was an orientation where attachés from the US Foreign Service Office presented on security, health, economics, and politics. It was an experience that called up what I had believed were bygone notions of American sovereignty, insofar as we were made to understand that our lives, like those of the French *colons*, were precious yet fragile. The health staffer warned us about Japanese encephalitis, sex workers, rabies, air quality, and heatstroke. Most memorably, we were told that traffic accidents were the leading cause of death for foreigners as well as locals: a case in point was a couple that had gotten in a bad road accident. Not wishing to receive a blood transfusion in-country, the man insisted on being airlifted to Thailand and died en route. The woman, unconscious and unable to

refuse care, was transfused in a Vietnamese hospital and survived. The casualty's final paperwork might have stated two causes of death: Vietnam's chaotic, economic-boom-driven road traffic (#modernity), and the refusal of local health care (#racism). At the same time that this story focused on one exceptional foreign death instead of the fifteen to eighteen thousand Vietnamese traffic fatalities that had occurred annually in recent years (Ngo et al. 2012), it was thus also legible as a cautionary tale about medical stratification. Insisting on the privilege of health care superior to that accessed by the general population, we might have gathered, was potentially a serious mistake.<sup>4</sup>

As my research progressed, it seemed more possible that this fatal attempt to bypass local trauma care was not just an object lesson on the risk of refusing critically necessary services as a foreigner; it also underscored the sense of uncertainty and peril that members of all social classes experienced in their efforts to stay healthy and safe in a transitional society. Many people I interviewed assessed the risks of the health-care system as real. A senior researcher at the national epidemiological institute told me that blood donors in Vietnam were frequently poor individuals who drank large amounts of water to increase their ability to donate for pay. 'Under the microscope, you can see the blood is thin', she said (personal communication, 20 December 2009). Further, she said, donated blood was pooled in a single storage system before being screened for infectious diseases. An informational session hosted by International SOS in Hanoi recommended transfusion in Bangkok or Singapore over Vietnam. Banking one's own blood for emergency auto-transfusion was also an option: the ultimate gesture of insulating oneself from local conditions, facilities, and the bodily substances of others (field notes, 26 January 2010). This hypothetical blood-loss emergency brings the type of post-market-transition biopolitics currently prevalent in Vietnam into clearer view, revealing both that access to survival varies with class and 'race'/nationality, and that a stratified medical system is prepared to extract profits that vary with the needs, assets, and also fears of those who seek its care. The case of an American willing to risk his life and spare no expense in order to secure a safe transfusion should also encourage us to wonder about the economic pressures that require people to dilute their blood to sell it more frequently. As Walter Benjamin (1968, 257) noted: 'The tradition of the oppressed teaches us that the "state of emergency" in which we live is not the exception but the rule'.

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<sup>4</sup> This hypervaluation of American lives in Vietnam has more recent historic resonance: Christina Schwenkel (2009) has critiqued the racial exceptionalism that underscored the disparities between American and Vietnamese lives and living standards during the Second Indochina War.

That said, it was not only elites and foreigners who had their suspicions about the nation's medical services. There was ambient paranoia about public facilities of all kinds, a trope I have elsewhere termed the 'tainted commons' (Lincoln 2014). When I interviewed low-income families in Hanoi about their health-care preferences, although some reported using public health facilities, others said that the health stations (*trạm y tế*) that had been established as the building block of the socialist medical system were frightening (*sợ*), and the doctors unskilled (*không giỏi*); in the case of a serious concern, many expressed a preference to use private clinics, and used them when they could afford to.

Analyses of the nation's health-care system have worried about the diminution of utilization, quality, and capacity at health stations for decades (Gellert 1995; Segall 2002). During my field research, I visited twenty-two ward health stations (*trạm y tế phường*) in four different districts (*quận*) of Hanoi; their facilities were typically simple and spare. While some had a number of separate consulting rooms, others were so small that there was no room for a private conversation. Health stations are at least theoretically equipped to provide a range of services: nutritional consultation, prenatal care and well-baby visits, pharmaceutical dispensing, preventive health screenings, and the diagnosis and treatment of common health problems. However, only 65.9 percent of health stations have a medical doctor (Ministry of Health and Health Partnership Group 2009, 15), with fewer doctors in rural areas.<sup>5</sup> The number of patients treated is typically low. As a health administrator at the national epidemiological institute told me, 'People in the city don't use the *trạm y tế* except for, maybe, vaccinations' (personal communication, 25 February 2010).

The preference for private care was evident in an interview I conducted with a poor Hanoian couple whose son had been diagnosed with AIDS; the husband worked as a porter, earning VND 1.2M (US\$60) per month. His wife was disabled and produced handicrafts at home. They lived in a small attic apartment in an alley (*ngõ*) and received a nominal amount of financial support from the state: VND 750,000 (US\$37.50) at the Lunar New Year. When I asked them where they sought health

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<sup>5</sup> As early as the mid-1990s, this disparity was reported to translate into disparities of care when ill: 'The poor are more likely to use a commune health clinic when ill, with a 10% chance of being treated by a trained physician, in contrast to the more affluent, who obtain treatment in hospitals and will be seen by a physician 90% of the time' (Gellert 1995, 1499).

care, they stated their preference for hospital and private venues, including those where doctors were moonlighting from public-sector appointments:

- ML Do you ever get health services at the ward health station?  
Bác Loan Not at all. The ward health station is very poor (*nghèo*).  
Bác Thanh It's not that they're poor, but when you're sick, they aren't there. You have to go to the hospital.  
ML Do you ever go to a private clinic or hospital?  
Bác Thanh Yes, of course. We often go to private clinics. We go to the doctor in Vân Hồ. There are a lot of doctors there. In the Nguyễn Công Trứ area there's even a district with shared offices (*khó nhà tập thể*) with doctors from the Army Hospital. There are many good doctors there.  
(Male and female respondents, 66 and 63 years old, Phố Huế ward, Hai Bà Trưng district, Hanoi, 28 April 2010)

Statements like this worried me. Other interview respondents had showed me the high bills they'd received and the packets of costly medications they had been prescribed at private clinics. Once I'd taken a respondent's drug list to a social worker to make inquiries on her behalf; he informed me that while generic versions were readily available, nothing constrained the practice of writing expensive prescriptions for poor patients and their families.

### **Moral hazards**

Population health is a complexly determined outcome that is shaped by the distribution of goods and status in society as much as by the provision of hospital services and curative medicine. However, patterns of caregiving at hospitals also reflect broader trends in the social determinants of health, and some key features of social disarray in post-socialist Vietnam are visible at Bạch Mai Hospital in Hanoi, the nation's largest public hospital.

'We don't have enough room for patients', said my neurologist friend at Bạch Mai hospital. 'There are sometimes four, five in a bed'. Its overcrowding reflects the impact of cost-recovery policies and the enervation of health-care providers at lower administrative levels. Overcrowding also illuminates the low capacity of the private sector to provide inpatient care: according to a recent report, the private sector's 7,124 hospital beds represent only 3.6 percent of the nation's total (World Health Organization and Ministry of Health 2012, 3). My friend was accustomed to sixty-hour weeks of patient care and sleeping in his office, and he was not the only one sleeping without a bed: a news

article about the oncology ward at Bạch Mai (Lê and Anh 2009) featured images of patients' families sleeping in the hallway near biohazard containers.<sup>6</sup> As the American medical attaché of the US Department for Health and Human Services in Hanoi told me, the nation's hospitals are overcrowded due to the common fear of incompetence at lower levels of the health-care system and the expectation that urban hospitals would be better equipped (personal communication, Michael Iademarco, 13 October 2009).

The term 'moral hazard' in health policy references the tendency of consumers to use health care unnecessarily when others cover the cost, but it could be *détourned* to describe situations where patients are forced to seek more expensive forms of care in order to secure their well-being. This is the situation in Vietnam, where one of the effects of market transition was the removal of bureaucratic obstacles to self-referral in the health-care system. Whereas access to health services was previously administered by the subsidy system, the sector now privileges cost recovery, and one's ability to pay is now the only permission needed for seeking hospital care or specialist services. This practice is called 'transferring up' (*truyền lên*). According to Ministry of Health data, two million patients, or some 40 percent of patients treated annually, self-refer to central hospitals for check-ups and treatment; as a result, the largest municipal hospitals run at 200% of their capacity or more (Thanh 2008). The situation of hospital medicine reveals a great paradox in Vietnam's post-transition health sector: as a result of their commercialization and reputation for providing superior care, hospitals are overcrowded and incubate health risk.

### **Blaming patients**

My conversations with foreigners, visits to foreign-oriented and public health-care facilities, and review of a well-trafficked expatriate advice-sharing website<sup>7</sup> suggest that foreigners are disinclined

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<sup>6</sup> Family members do the work that nurses would do in other hospital systems, in part, as a health economist told me, because nursing care cannot be monetized: 'Why pay for nurses when you can have the families care for patients? That's money out of your pocket. Doctors prescribe drugs and tests and bring in money' (personal communication, 7 July 2010).

<sup>7</sup> *The New Hanoian* (tnh.xemzi.com) is a 'community-produced local reviews and answers guide' that contains a health section with listings and user reviews of alternative practitioners, dental care, doctors, hospitals and clinics, labs, mental health services, optometry, pharmacies, and physiotherapy (<http://tnhvietnam.xemzi.com/en/c/1/cat/36/health-care-hanoi#2/36>, accessed 3 July 2014). It recently has been supplanted by Hanoi Massive, a Facebook group with 15,023 members (<https://www.facebook.com/groups/pantsgatewillneverdie/>, accessed 3 July 2014).



to use commune health stations that serve the Vietnamese population in their respective administrative catchment area – that is, a foreign NGO worker residing at a villa in Tây Hồ district would be unlikely to use the Quảng An ward *trạm y tế* that served their Vietnamese neighbors. This is, at least in part, an artifact of the insulated, segregated world in which foreigners exist in Vietnam, which does not often require (or allow) them to exit a green zone demarcated by class, ‘race’, and nationality. My foreign acquaintances in Hanoi were inclined to use private clinics and hospitals, and sometimes traveled to Thailand or Singapore for more complex procedures. Given their tendency to be wealthy but poorly acculturated, transferring up is all but inevitable for foreigners, so much so that ‘transferring’ might not be quite accurate.

These patterns of health-care use, especially by contrast to the compressed health-care options that lower-income men and women described to me, reveal Vietnam’s significant and growing degree of medical stratification. This trend is also legible in the social, linguistic, economic, and physical distinctions between public health stations staffed by government employees and the air-conditioned private clinics serving mostly expatriates. As a foreign researcher, I had the ability to use preferable health care venues if I wished, and could – barring serious accidents – avoid the ‘frightening’ facilities funded by the state. My choices and those of other foreign nationals mirrored the local ethos of transferring up – as people in Vietnam sometimes say, ‘same same but different’.

Both laypeople and health-sector experts in Vietnam have a tendency to assume a disapproving tone when discussing the general population’s efforts to ‘transfer up’, as if their refusal to stay put were the source of the health sector’s chaos. While medical tourism and its local equivalents are virtually always framed as normative, the similarly agentive pursuit of life and health by the poor is framed as antisocial and disorderly. Stigmatizing poorer patients as ‘matter out of place’ would be merely distasteful if it were paralleled by an equivalent scorn for the medical needs and preferences of wealthy and foreign groups. As it stands, overcrowding driven by self-referral, the mutual reinforcement of bad economic and physical health among the poor, and wealthy patients avoiding non-elite medical venues are all foreseeable consequences of a health-care system increasingly organized by economic and commercial imperatives.

## **Conclusion**

I have begun to suggest some pathways for the study of race-, class-, and citizenship-linked forms of medical stratification as they manifest at ‘home’, in ‘the field’, and the spaces in between. In the post-socialist setting of my case study, medical stratification furnishes an opportunity to examine what Nguyễn-võ (2008) terms ‘the ironies of freedom’ as they translate into inequity of health access between foreign visitors and citizens as well as between wealthy and poor. The freedom of choice exercised by Vietnamese patients, especially lower-income ones, is cited as a driving factor in the diminution of quality in hospital care nationwide, while the freedom of the market to distribute health care differentially is freer in Vietnam than it has been since the colonial period.

Of course, similar patterns of stratification can be observed in the United States: for example, even as the state has embarked on an allegedly socialistic program to equalize access to health insurance, the Affordable Care Act of 2010 addresses the social determinants of population health disparities in only piecemeal fashion (Leong and Roberts 2013). It also leaves millions of non-citizen residents uncovered; as Didier Fassin has noted, undocumented immigrants today constitute ‘the last frontier of welfare’ (2009). The classed, racialized, and citizenship-linked politics of health disparities are more grimly visible in the recent Ebola outbreak in West Africa, where the high-profile rescue of two virus-infected American aid workers alongside the death of thousands of African patients supplied an eloquently globalized illustration of Ruth Gilmore’s (2007, 28) definition of racism as ‘the state-sanctioned or extralegal production and exploitation of group-differentiated vulnerability to premature death’. The racialized construction of this disease event and the concomitant projection of pathology onto both racial others and stateless citizens were also evident in a recent statement by a member of the US House of Representatives implying that child refugees entering the US from Central America might be carrying the virus (Murphy 2014).

As this case study suggests, medical stratification in Vietnam is an increasingly significant concern for domestic health outcomes. More broadly, however, such patterns at and across multiple geographic scales – local, translocal, global – press for the development of new knowledge and critique to address the interfaces of economic, racial, and citizenship-based forms of health privilege and exclusion, and the contribution of these forces to emergent dynamics in global public health.

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