Can I afford free treatment?: Perceived consequences of health care provider choices among people with tuberculosis in Ho Chi Minh City, Vietnam

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Abstract

Vietnam has a well-organised National TB Control Programme (NTP) with outstanding treatment results. Excellent prospect of cure is provided free of charge. Still, some people prefer to pay for their TB treatment themselves in private clinics. This is a potential threat to TB control since no notification of cases treated in the private sector occurs, and there is no control of the effectiveness of treatment provided in private clinics. Using a qualitative approach within a grounded theory framework, this study explores health-seeking behaviour among people with TB, applying a specific focus on reasons for choices of private versus public health care providers. The study identifies a number of characteristics of private TB care, which both seem attractive to patients and at the same time contrast sharply with the structure of the NTP strategy. These include flexible diagnostic procedures, no administrative procedures to establish eligibility for treatment, flexible choices of drug regimens, non-supervised treatment (no DOT), no tracing of defaulters in the household, no official registration of TB cases and thus less threat to personal integrity. A possibility to demand individualised service through the use of fee-for-service payments directly to physicians also seems attractive to many patients. A number of the components of the NTP strategy that have been put in place in order to secure optimal public health outcomes are lacking in the private sector. A dilemma for TB control is that this seems to be an important reason for why many people with TB opt for private providers where quality of care is virtually uncontrolled. The global threat of TB has led to calls for forceful measures to control TB. However, based on the findings in this study it is argued that the use of rigid approaches to TB control that do not encompass a strong component of responsiveness towards the needs of individuals may be counterproductive for public health.

Keywords: Tuberculosis control; Private health care; Health-seeking behaviour; DOT; Vietnam

Background

As a response to the global threat of tuberculosis (TB), the World Health Organization (WHO) urges governments to commit themselves to establish comprehensive TB control strategies. In particular, the importance of well functioning systems for case management and monitoring of treatment is stressed. Use of short-course chemotherapy (SCC) delivered as directly observed therapy (DOT) is seen as a crucial component of such a strategy (Kochi, 1997; Efferen, 1997; Crofton, 1994; Morse, 1996). Observational studies showing a better treatment outcome with DOT compared to non-supervised treatment are plentiful.
TB treatment in private clinics (Lönnroth, Thuong, Linh, 1998; Ngoan, Ho & Arnadottir, 1997). This NTP are cured. Less than 5% default during the first 2 months of treatment. In Vietnam, TB is officially managed mainly within the National TB Control Programme (NTP) that applies the DOT policy — short-course (DOT-S) treatment is available free of charge. This excellent prospect of cure from a potentially lethal disease is available free of charge.

Still, some people in Vietnam prefer to pay for their TB treatment in private clinics (Lönnroth, Thuong, Linh & Diwan, 1999; Netter & Wolffers, 1999). Gertler and Litvack (1998) have estimated that 84% of the total health expenditure in Vietnam is from private sources and that 49% of all health care delivery is in the private sector. However, there are no official statistics of how many TB patients are treated in the private sector. We have previously shown that quality of both case detection and case management by private physicians in Vietnam are insufficient (Lönnroth et al., 1998, 1999).

Monitoring of case-management and treatment outcome for TB in the private health care sector is nonexistent or very limited in most low- and middle-income countries. The few studies that have examined quality of TB care in the private sector in these countries have found poor case management (Uplekar & Shepard, 1991; Uplekar & Rangan, 1993; Uplekar et al., 1996; Singla, Sharma, Singla & Jain, 1998). Widespread use of private providers who apply sub-optimal treatment strategies for TB may have severe negative effects on spread of the disease as well as on development of multi resistant strains of TB (Nunn & Felten, 1994; Editorial, 1997). This may be one reason for the remaining high incidence of TB in Vietnam despite excellent treatment results within the TB programme (Bosman & Gebhard, 1997).

What, then, are the reasons for some people in Vietnam to opt for private health care providers and spend large amounts of money when effective TB treatment is available free of charge?

Studies from other low- and middle-income countries have identified a number of possible reasons why many people with TB turn to private providers, including: limited outreach and perceived low quality of the government run services; perceived adverse attitudes among staff in public health care facilities; convenient location and short waiting times in private clinics; possibility of credit payments in private clinics; and higher degree of privacy in private clinics (WHO, 1997b). The social stigma still attached to TB in most cultures may make people unwilling to have themselves officially registered as “TB cases”, with the risk of exposing their illness to neighbours, employers and authorities (Johansson, Diwan, Huong & Ahlberg, 1996; Long, Johansson, Diwan & Winkvist, 1999; Aljunid, 1995; Swan & Zwi, 1997; Liefooghe, Baliddawa, Kipruto, Vermeire & De Munynck, 1997; Jaramillo, 1998; Rubel & Garro, 1992). Similar mechanisms are believed to make private providers more popular than public health care services for people with STDs (Ward, Mertens & Thomas, 1997; Msiska et al., 1997). Illegal immigrants have been found to be reluctant to seek care for TB within public health care facilities fearing that their immigration status might be revealed (Ash, Leake & Gelberg, 1994; Ash, Leake, Anderson & Gelberg, 1998).

In all times and in most societies there have been good reasons for people with TB to keep their disease secret. This has not only been due to a strong social stigma. The history of TB control is full of forceful strategies to safeguard public health. Legislated isolation and compulsory confinement in sanatoriums have been an important part of the strategy before chemotherapy was available. In most countries, modern regulation of infectious disease control still includes clear components of legislated means for forceful treatment or confinement of people who do not voluntarily agree to be treated. In TB control, a person with TB has historically been seen as a source of contagion, a threat to public health, a subject that needs to be controlled (Rothman, 1993). In this control paradigm there is an inherent conflict between individuals’ perceived needs and civil rights on the one hand and public health objectives on the other.
the other (Campion, 1999; Porter & Ogden, 1997; Annas, 1993). “Modern” TB control, including the DOT strategy, may be seen as a natural continuation of the classical TB control philosophy. The underlying assumption has not changed: since individuals’ health is not merely their own concern, the health authorities should make sure that they comply with the treatment for the best of society.

In a previous study (Lönnroth et al., 1998) we interviewed private and non-private physicians regarding their attitudes towards private and public TB care in Vietnam. We found that many physicians believed that patients preferred the private providers’ flexible approach with regards to diagnostic procedures as well as choice of treatment regimen. The strict standardised approach of the NTP in Vietnam, including DOT, was perceived as complex, bureaucratic, time consuming and sometimes a threat to individuals’ privacy. The sometimes complicated diagnostic procedures as well as the supervised treatment used in the NTP were believed by physicians not only to make some people default during treatment but also to be a reason why some people avoid the NTP altogether, or default after the diagnosis has been made but before treatment has started. The latter type of defaulting, which is at least 5% of all smear positive cases diagnosed in the NTP in HCMC (Lönnroth et al., 2000), does not show in the official NTP statistics.

The aim of the present study was to further investigate peoples’ health seeking behaviour with regard to choices between private or public providers of ambulatory TB treatment. We have studied attitudes towards private providers and the NTP, respectively, among people with TB. More specifically, we have analysed perceived consequences of various health provider choices in order to identify provider characteristics that are of importance for patients when making health provider choices.

Methods

Setting — structure of TB care in HCMC

The study was carried out in Ho Chi Minh City (HCMC), the largest city in Vietnam with 5 million permanent official residents. In contrast to the generally agriculture-dominated economy in Vietnam, HCMC is dominated by trade and industry.

In HCMC, three dominant types of ambulatory TB care have been identified: treatment in the NTP, treatment by self-employed private physicians, and treatment in the semi-private “evening clinic” at the regional TB hospital (the only TB hospital in HCMC).

The NTP applies DOTS administered through 21 District TB-Units (DTU) and provides treatment free of charge. The self-employed private physicians (private lung specialists, GPs and other specialists) do not use supervised treatment and provide treatment on a fee-for-service basis where the patient pays the whole cost of treatment. There are about 3200 self-employed private physicians in HCMC. 45 of them are licensed to treat TB. It is not known what proportion of other private physicians treat TB. At the “evening clinic” in the regional TB hospital patients also pay the full price of investigation and drugs on a fee-for-service basis. Physicians employed at the TB hospital work in the clinic “off-hours” and get paid per patient treated. The clinic may be regarded as a semi-private clinic. It is not fully private since the premises are state owned and a small part of the profit goes to the TB hospital. The main characteristics with regard to payment mechanisms of these providers of TB care are displayed in Table 1.

Ambulatory treatment may also be provided to a limited extent by other providers such as private assistant physicians or nurses, directly at private pharmacies, by military health services, by not-for-profit private health facilities and by public health facilities not linked to the NTP. These less common providers are not considered in the present study.

Within HCMC the structure of DOTS differ from district to district. However, there are some common characteristics. A basic requirement before free treatment is initiated is that the patients need to agree to attend the DTU daily during the initial two months of treatment for DOT. For this, a written agreement has often been used in combination with a financial deposit from the patient which will not be returned if the patient defaults from treatment. This was abolished in some districts in 1998. Those who do not agree with these regulations are not registered for free treatment in the programme.

If treatment has been started and patient then defaults he/she will be traced in the household with assistance of staff at the most peripheral level of the Vietnamese health care system, the Commune Health Stations (CHS). In order to enable tracing of patients, only patients who have a permanent address and can present proof that they are permanent residents in HCMC are eligible for treatment in the NTP. People who are temporarily in HCMC should, if they are diagnosed with TB, receive treatment through the NTP in their home province. The TB programme provides a financial incentive to the health workers as they are paid for each TB case detected and successfully treated (approximately 1.5 $US per case during 1998).

In order to avoid treatment of false positive TB cases the diagnostic procedures in the NTP are standardised and thorough. Sputum smear is the core diagnostic tool (WHO, 1994). If the patient has a positive sputum smear
on the first occasion, then the diagnosis is usually swift. However, the diagnosis of smear negative TB may take up to two months to make due to a need for repeated tests and examinations (Lönnroth et al., 1998).

In contrast to the standardised approach in the NTP, private physicians and the evening clinic at the TB hospital apply flexible diagnostic criteria, flexible treatment regimens, and flexible methods to monitor treatment.

Sample

Non-probability sampling was used to identify in total 26 persons with diagnosed TB. Only people who were currently under treatment for TB were included. There was an aim to include people who were treated by all main providers of TB care: seven were identified in the TB hospitals in-patient wards, six in the “evening clinic”, eight at the DTUs, and five in private clinics. Fourteen males and 12 females were interviewed. The mean age of the interviewees was 40 years. Four people did not want to participate in the study.

All interviewees had been in contact with more than one provider for the current illness episode. Seventeen of the interviewees had been treated with anti-TB drugs by more than one provider. Responses by interviewees therefore relate not only to the provider at which the interviews were conducted.

Data collection

Interviews were carried out in Vietnamese by the second author. Six interviews were carried out by the first author assisted by a translator who translated from Vietnamese to English. A flexible interview guide was used. The questions primarily tried to capture the decision-making process behind various health service choices with a clear focus on choices of provider of ambulatory treatment. The questions concerned (1) the health seeking sequence, (2) reason for each health provider choice, (3) reasons for changing from one provider to another, (4) perceptions and experiences of the various health care providers’ competence and attitudes, and (5) perceptions and experiences of quality of services, waiting time and cost. All interviews were tape-recorded and additional hand-written notes were taken when needed. Interviews carried out in Vietnamese were translated into English and transcribed by the second author. All respondents were interviewed at the health service they were currently attending. The interviews took place in an undisturbed place where the health worker in the health facility could not hear the interview. The average interview length was 1.5 h (range: 0.5–3 h). A first round of interviews were carried out between October and December 1997, and the second round were carried out during September 1998.

Analysis

The analysis has been inspired by Strauss and Corbin’s interpretation of Grounded Theory (Strauss & Corbin, 1990; Hallberg, 1998). The initial coding was predominantly open. However, some substantive codes were mirroring predetermined themes in the interviews.

Health provider choices as a result of prioritising perceived consequences was the core category in the selective coding, i.e. the central story was one of making judgements about consequences of particular health provider choices and to make a choice depending on current priorities with regards to these perceived consequences. One group of sub-categories reflected different dimensions of perceived consequences. These categories were: perceived chance of cure, perceived possibility to contain cost, influence on privacy, convenience, and perceived risk of “social welfare stigma”.

These dimensions were assessed in relation to specific provider characteristics in order to analyse what provider characteristics were of importance for the respondents health service choices. The specific provider characteristics represent a second group of sub-categories. These were: use of protocols vs. flexible case management; treatment in a public vs. private arena; and free treatment vs. fee-for-service payment directly by
patients. Based on the qualitative analysis we developed a matrix of perceived “qualitative associations” between the three identified variables of provider characteristics and the five dimensions of perceived consequences of provider choices. This matrix is shown in Fig. 1.

The analysis has not attempted to rank consequences of health provider choices in order of importance. Instead, the aim of the final analysis has been to find dominant perceptions of how different provider characteristics are related to certain dimensions of quality of care from the patients’ point of view.

**Findings**

Most respondents had interpreted the first symptoms of their illness as signs of a benign respiratory infection, and a common initial action was to turn to a pharmacy or a local private physician where it was generally believed to be easy to get a quick remedy for such an illness.

All respondents had been in contact with more than one provider for the current illness episode. Seventeen (65%) had been treated with anti-TB drugs by more than one provider. Of these, 11 had switched from treatment at a private physician to another provider (seven of these had switched to the TB hospital’s “evening clinic” and four to a DTU), two had switched from the evening clinic to a private physician, and four had switched from a DTU (of which three had switched to the “evening clinic and one to a private physician”).

The common story for all respondents was that they sooner or later had learnt or suspected that they had TB and were faced with a more complicated decision of which health care provider to opt for. Comments by the respondents indicated that they had developed clear perceptions during the course of their illness concerning potential health consequences as well as potential economic and social consequences of different health provider choices.

A general impression was that many respondents had become well informed both about TB and about the various health care facilities providing TB care. Apparent ignorance of the risks of TB or the importance of long-term treatment was not found in any interview. Many of the respondents reported that they had been well informed before they had become ill. Information through TV, radio and newspaper about TB and about the NTP was referred to spontaneously by many respondents.

For most respondents health seeking seemed to be a well-informed act. However, this act was not isolated to the individual. Advice from relatives and friends was central in many respondents’ descriptions of how health care choices had been made. The significance of health provider reputation in many of the stories told showed how tightly individual perceptions were woven into a web of notions about various health care providers in the extended family, among peers and in the community. However, it was difficult to assess to what extent others than the ill person were directly involved in deciding which provider to opt for.

**Qualified help for a feared disease**

A core determinant of the choice of provider was perceived effectiveness of treatment provided and the possibility to be cured. Respondents reflected on TB as a feared disease with a stigma of unavoidable suffering and death, a serious disease that requires help from a qualified health care provider. The regional TB hospital or “famous” private specialists were generally seen as the ultimate providers of TB treatment.

P¹: You know, even if I say private doctor it’s the same as the one in the TB-programme. It’s the same person, only he works off-hours privately. So I have confidence in him.

I: If it had been a general private doctor, would you have gone to him?

P: No! I wouldn’t dare for the whole world! If it was somebody else, he wouldn’t be specialised in this disease and then I wouldn’t dare to trust him. My God, this is treating a disease, not fixing a car.

(27 year old female.)

While the complexity of the diagnostic procedures and the perceived bureaucracy involved in securing eligibility for free treatment was seen as a negative aspect of the NTP by many, there were predominantly positive attitudes towards the standardised treatment in the NTP. No respondent mentioned a negative attitude towards the daily attendance for DOT. On the contrary, most of them viewed it as a sign of professionalism and care for the patients that they were monitored daily. The same attitudes were identified with regards to the use of a standardised treatment regimen. Particularly, patients that had experienced maltreatment or incomplete monitoring of the treatment in the private sector welcomed the structured approach and the use of “protocols” in the NTP as well as for in-patient care at the TB hospital.

I: Then a private doctor would be as good?

P: No, no, not at all. I think that with the private doctors, you don’t know what you get. It’s very uncertain and not secure. Here, at the public facility, they have regulations and rules and then everything is in order.

(40 year old male.)

¹P = patient, I = interviewer.
Drug quality seems to be a very important component of perceptions concerning effectiveness of treatment. Respondents had various notions about the quality of drugs at different providers. A few thought the drug quality was better in the private sector whereas other perceived the drugs in the NTP to be of higher standard and more thoroughly controlled. Generally, foreign drugs were thought to be of higher quality than Vietnamese drugs. As is discussed below, there was however, a general suspiciousness towards both drugs and other goods that were provided free of charge.

**Time is money**

Reported cost of treatment at the ‘‘evening clinic’’ and by private physicians varied. It ranged between 200,000 and 1,000,000 Vietnamese Dong\(^2\) per month. This was a heavy financial burden for many and some reported having to borrow money from friends and relatives to finance private treatment. Some said they had no choice but the free treatment in the NTP. For a few, private treatments had been interrupted due to financial reasons, which had forced them to transfer to the NTP.

However, reported cost of treatment was related not only to fees and drug costs. A very dominant theme in the interviews was the aspect of time. Nearly all respondents reflected on the importance to avoid time-consuming components of health care contacts, and thus avoiding loss of time from work. To go to a local private pharmacy was generally perceived to be the least-time-consuming health care action. When more qualified help was required, private physicians were generally perceived to provide a service which required much less time input than at the NTP or other public health care facilities.

Respondents reported several components of the NTP strategy that were perceived as very time consuming. The diagnostic procedure with repeated visits and long waiting time at each visit was one. The paperwork involved in initiating the treatment another. For those who were receiving DOT, the time consumed for this was reported by nearly all as a heavy burden.

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\(^2\)1 US $–13,000 Vietnamese Dong 1999.
sometimes to the extent that people had to stop working. It was very clear that the treatment in the NTP is not “free”, the cost of travel and time lost may be even larger than the cost of drugs and fees in the private sector.

You know, I’m very poor. To get here (to the DTU) everyday, the injections and the medicines don’t cost anything but the transport to come here costs 10 000 Dong every day, and I’ve been here 3 months so only the transport has cost me 900 000 Dong so far. You know, miss, I don’t have money but I still have to try to hold on. (…) I saw that when I went privately, my illness didn’t seem to decrease while when I go here, it seems to diminish but they tell me to come all the time and…. it’s tiring. My illness is so severe so I have to go several months so I get a bit fed up. Fed up of coming and going, every day coming and going. And it’s far as well. You know, once, I owed the cyclo-driver money for 8 days before I paid. But I still try to go and don’t dare to stop taking medicines even for one day. You can even ask the cyclo-driver yourself, even him, he begged me but I try to go and not quit. He said “I’ll take you there and you can owe me money, because if you stopped, the bacteria will get stronger” so I got so scared and I went. (…) I do feel better and therefore I continue. Because to be honest, I don’t have money and I considered stopping. Injections for so long, several months… But then I told myself to make an effort and continue. I thought I’d ask for medicines to take at home. But I’m afraid they won’t let me, that I’ll have to come. So I do feel very sad. I do wish that they’ll let me take the medicines home to have it there. (64 year old female.)

If I get treatment here (at the evening clinic), I can continue to work. I will pay for the treatment but I will have a little money left. If I go to the countryside (the DTU in the home province), I will have free treatment but I have to quit working and I will have no money. (22 year old female.)

Some people had been coming to a DTU for weeks, taking repeated tests without getting a final diagnosis or a good explanation for the different tests. Some had defaulted from the diagnostic procedure since they got tired of waiting for results, doing repeated rounds of smears and not being well informed about the rational for the complexity of the diagnostic procedures.

Then they made me pay this and that fee and they told me to go home and wait. They made me do sputum smear, and then blood test, and then they told me to pay a deposit fee of 50 000 dong and then I had to wait. (…) With that money I could have gone directly to a private doctor to get a prescription of medicines to take and to get well without any fuss. (…) They wasted four days for me and finally, I got fed up so I left everything, my money and all, and didn’t come back. You see, I tell you the truth. If there is, I say it, if there is not, I wouldn’t say it. Like today, if I get treatment… But if nothing happens today and I have to wait another day, I will not have any other option than to die slowly without treatment. There is still some strength in me and I will work until I can’t anymore. What else can I do?? I wait and wait and when will I ever get the results? I am very impatient to see if there is TB. If there is, I am not sure whether to go to the local unit to get the medicines, even if it’s free. Because consider yourself to come and wait to get the medicines, and wait and wait and a whole day will have passed and that’s a working day with income that is lost!

Interviewer’s observation at the end of the interview: The patient later learned that he had positive smear but he would have to be transferred to another TB unit in his home district and that this procedure would take a few more days. Also, it would mean a longer travel distance for him. He got very upset and stormed out of the room, declaring that he would go to a private doctor. (36 years old male.)

Mutual fear in a public arena

The DTUs and to some extent the regional TB hospital were described as places crowded with severely ill people. Contact with others with TB was a negative aspect of attending those facilities. Fear of having “more disease” transmitted that would worsen an already bad situation was reported by a few respondents, who thus related a health care encounter in a public arena with the risk of the disease being worsened. Others seemed to avoid these facilities simply because they became ill at ease when seeing severely sick people.

P: When I got there (to the TB hospital), I trembled and was so afraid I thought I’d die. Seeing this kind of diseases scares me to death!
I: Why?
P: My God! When I see all those ill people. Of course they were being treated but seeing their faces, it scared me.
I: Were you scared of getting transmitted?
P: Of course I was! My God, in my situation, if I get more diseases by somebody else then…(shaking head). God! When I first learnt I had TB, I was so
They feel more responsible towards the patients. Because they have chosen not to put themselves in the situation of the chaotic and bad conditions of the hospital by going “off hours”.

(38 year old male.)

If we talk about the real meaning of the medical profession, then it’s different. But here, we are talking from the perspective of a social reality. That is different. Because if we reason according to Hippocrates, then it’s idealistic isn’t it? So with the private doctors, both sides will profit. Because if he treats you with care and enthusiasm, then you’ll have to repay him exactly according to his efforts and work. (…) The centre of the human being, in their mentality, that’s the “I”. When born, the “I” is the first thing that matters. Those great persons, who forget themselves for others, they don’t count. That’s a rule. And it applies to everything. There are non-logical things sometimes. For example, the salary of a minister is 1 200 000d. That’s unbelievable. That’s what a student spends in a month. It’s too little. And all governmental salaries are like that. And it makes the employees lose their motivation. It doesn’t matter what they do. So they have to start by changing that.

(23 year old male.)

The local units, they are… (laughing and shaking the head), of course they have a role to play in the government’s plans in the fight against the TB, but it’s clear that they have to work because it’s a job and not because of a sense of responsibility. (…) They only tell you to come, you do the investigations they tell you what to do and you give them the results of it and you are not allowed to ask too many questions, and there’ll be explanations. It’s clear that; you can’t ask questions, you’re only allowed to come, sign the commitment documents, then receive the medicine and that’s all. Not a word of advice or care.

(26 year old male.)

There was a common suspicion towards the value of any good without a price, provided without a financial transaction taking place. The good in the TB care market is not only an effective TB treatment, but also positive attitudes among staff, and flexibility with regards to how case management should be organised in order to make the treatment convenient to patients. Nearly all who had health care insurance (only valid at certain public health care facilities) still preferred to pay for treatment at private providers. The fact that no cash payment is involved, and that no money goes directly to health staff was seen to be an important factor for why quality of care for people with health insurance was perceived as poorer than for those who paid health care fees in public or private facilities.
There are hospitals where they are not that attentive towards patients having health insurance compared with the patients paying cash, because when it comes to issues concerning money and the state is involved, people say in a popular way: “it goes around in a circle” (“lau lac”). So no one wants it. Also, the majority of the working people, or others everywhere... you’ll see that whenever, so to speak, money is changing hands to and fro, things will work more smoothly. So it’s difficult to talk about it. (27 year old male.)

Of course, it’s not as good as if there is money changing hands. Then, of course, the feeling is different and one get better received. (27 year old female.)

Social welfare stigma

For many, the state financed care provided within the NTP had a status of social welfare programme for the poor who had no opportunity to access care at the regional TB hospital or private specialists. Few respondents mentioned the fact that treatment was free of charge in the NTP without adding negative comments which indicated a stigma attached to the state-run TB control institution. The word “free” seem to have negative connotations, often leading to associations of poor-quality services for the most disadvantaged people in the society. Many indicated that they would not like to be associated with such an institution. Furthermore, being a receiver of “social welfare” may be perceived as becoming morally indebted. Particularly for people who can afford to pay, the act of receiving free treatment may be seen as unrightfully using a system for the poor.

I: I thought it was good that it’s free?
P: Well, good and good. It is good for the patients considering the financial side of it. Of course. But psychologically, it’s not very nice, not very considerate towards the people. So it’s only those with circumstances that make them not able to seek help at the hospitals who accept it. (26 year old male.)

Free? No thank you. Free, I never touch free. (…) Generally speaking, we live in a free market society and doctors are people like us. If we think we can afford it, we go to the evening clinic. Then, there are people who don’t have the means, who have difficulties; we should give something for the poor and save the usual clinics for them. (38 year old male.)

“Feeding the disease”

Though positive aspects of financial incentives in the private sector dominated in the interviews, the negative aspects were also obvious to many. Many respondents had notions of how a provider’s aim to make a profit may lead to induced demand and overproduction of care. Some reported that they were worried that private providers would take unnecessary tests and prescribe unnecessary drugs.

Sometimes, you feel dizzy, or sick or you have a head-ache, and you hear about others who’ve had the same problem and who’d been treated for days by the same doctor. Those are the doctors who feed the disease. That is, they keep the disease so the patient has to come back all the time. (…) Sometimes, I go to a doctor, there are so many others there and we all get injections after injections. I see lots of people I know but after a while, I wonder whether he feeds the diseases or not… (35 year old female.)

A model of the relationship between provider characteristics and patients’ perceived consequences of health provider choices

Among respondents in this study, health care provider choices seem to be based on explicit or implicit priorities with regards to perceived health consequences, economic consequences and social consequences. Five dimensions along which these perceived consequences could be understood have been identified. These are shown as column headings in Fig. 1.

Health provider choices seem to be related to perceptions of how different provider characteristics are related to positive and negative consequences along these dimensions. Three particularly important variables of provider characteristics, which seem to be closely linked to the patients’ health provider choices, have been identified, namely: case-management strategy, setting, and payment mechanisms. These variables take on the following dichotomised values for the NTP and self-employed private physicians, respectively: use of protocols vs. flexible case management; treatment in a public vs. private arena; and free treatment vs. fee-for-service payment directly by patients. The semi-private evening clinic can be placed somewhere between the two other types of providers for each variable. This categorisation of provider characteristics is illustrated in the left-hand side of Fig. 1.

Respondents emphasised different dimensions of provider choice consequences. However, a pattern of perceived positive and negative influences of the
different provider characteristics has been identified that was rather consistent across respondents’ stories. Perceived associations between the three identified variables of provider characteristics and the five dimensions of perceived consequences of provider choices are shown in Fig. 1.

In summary, there were only two clearly positive aspects of the NTP from the interviewees perspective: that use of strict protocols was associated with perceived higher chance of cure and that treatment free of charge was associated with perceived better chance to contain costs. In contrast, there were many perceived positive aspects of private TB care, particularly with regards to consequences related to privacy, convenience and possibility to avoid ‘‘social welfare stigma’’.

Discussion

The NTP’s approach of highly standardised free treatment delivered in a public arena has few clearly positive characteristics from the point of view of the respondents in this study. That the treatment is free of charge is of crucial importance for those who have no means to pay for their treatment. On the other hand, the complex diagnostic procedures as well as the use of DOT were perceived as expensive components of the NTP strategy with estimated costs sometimes exceeding estimated costs of treatment in the private sector.

A perceived positive effect of the use of a standardised approach was that regulated treatment following protocols was thought to improve the chance of getting cured. On the other hand, the fact that treatment was “free’’ in itself led many to question its quality. A further negative component of the NTP with regards to the risk of being cured was the fear of having ‘‘more disease’’ transmitted when in contact with other TB patients in a public arena.

Threatened privacy was a perceived negative consequence of opting for the NTP for most respondents. Inconvenience, including long waiting time, repeated visits, etc., as well as lack of attentiveness and responsiveness by the health care staff were other perceived negative consequences. The government run DTUs that provide fully subsidised treatment were generally perceived to have a role to play for the poor and the disadvantaged. However, attending such a service seem to be associated with a feeling of being a receiver of social welfare, adding an additional stigma to the social stigma already attached to being a carrier of TB in Vietnam (Johansson et al., 1996, 1999; Long et al., 1999).

Several characteristics of private or semi-private providers, which contrast sharply with the NTP strategy, seem to make these providers attractive to people with TB. In the presented model, more characteristics of private providers than of the NTP are associated with perceived positive consequences. This may lead to a conclusion that private providers are generally preferred to the NTP. However, it should be emphasised that the relative importance of the different dimensions of consequences of provider choices is not considered in the presented model. When focusing on chance of cure and estimated cost, which are likely to be the most important dimensions, the pattern of perceived positive and negative impact of different provider choices is not easily interpreted. Furthermore, it may well be that priority setting for an individual involves a central judgement along a single dimension such as chance of being cured which dominates the decision-making process.

The aim of this study has not been to determine which provider alternative is generally most attractive to people with TB. Instead, the analysis has aimed at identifying provider characteristics that are important for patients when making health provider choices and it thus points to components of the NTP that could be altered to make it more attractive to patients.

Strict protocols vs. flexible case management

There are good reasons for using strict diagnostic procedures and standardised treatment regimens in the NTP (WHO, 1994, WHO, 1997a). However, when protocols become too rigid and do not encompass a dimension of responsiveness towards needs of individuals, they may deter patients. The findings in this study suggest that it is particularly important to attempt to reduce bureaucracy and the time-consuming components of TB care. One of the most time-consuming components of the NTP strategy is the application of DOT. The NTP needs to consider whether the positive treatment outcomes due to universal and compulsory DOTS outweigh the potential negative effects it may have on health seeking. It has been shown that if the DOT strategy itself discourages between 4 and 10% of patients from enrolling in a treatment programme, the overall effectiveness of the DOT strategy will be less than that of self-administered treatment (Heymann, Sell & Brewer, 1998).

The issue of public health objectives vs. individual privacy and civil rights is often salient in the TB control debate (Porter & Ogden, 1997; Annas, 1993; Rothman, 1993; Campion, 1999). One might expect that some people dislike compulsory DOT because they feel their privacy being affected negatively by having to be observed when taking their medicine. The findings in this study do not support that this is the case in HCMC. On the contrary, positive attitudes towards the observed treatment as such were reported by a few respondents. The reported reasons for dislike of DOT were related to time and travel and were all linked to dimensions of
cost, loss of income and inconvenience rather than to threatened privacy. Though this study indicates that introducing self-administered treatment might increase some peoples’ willingness to attend the NTP, the study also points to a need to administer DOT in a way that makes it less time consuming and causes less inconvenience for patients.

The tracing of defaulters is another component of the control strategy with potentially negative effects on willingness to attend the NTP. This study indicates that it is important to parallel such an approach with attempts to change attitudes towards TB in the community, in order to reduce fear of stigmatisation.

A third component with a clear public health logic, also based on strict protocols, is the procedure for diagnosis and securing eligibility for treatment in the NTP. If the reasons for the complexity of these procedures are not explained carefully to patients they may be left with feelings of neglect or refusal which may lead to patients defaulting during the diagnostic procedures as well as to a reputation of unnecessary bureaucracy in the NTP.

Zwarenstein et al. (1998) discuss a potentially alienating effect of an authoritarian TB control approach that may lead to depersonalised care and disempowered patients. It seems extremely important to promote empowerment of patients, particularly when a strategy is used which transfers much of the responsibility for the treatment success from the patient to the health worker.

Netterop and Wolflers (1999) report that training courses for health care staff in the NTP in Vietnam focus too little on health education for patients. It is of vital importance that the health care staff in the NTP have skills in communicating to patients the rational for the various components of the TB control strategy and the NTP needs to revise its’ training course curriculum accordingly.

Public vs. private arena

Fear of being exposed as a TB patient in public is possibly a strong discouraging factor for attending the NTP. Physical appearance and structure of DTUs, improved communication by staff to patients, as well as more sensitive approaches when tracing patients in the household may reduce this fear. However, a more effective long-term strategy may be to try to influence attitudes towards TB in the community.

Treatment free of charge vs. user charges

This study suggests that patients feel they are in a better position to negotiate and demand good service when cash payments take place. Fee-for-service payments directly by patients has elsewhere been described as a mechanism that creates flexible and individualised care which corresponds closely to patients’ demands (Whyte, 1992; Silverman, 1984). Acknowledgement of these positive aspects of privately financed health care may go hand in hand with a general suspicion towards “free” health care, where there are no clear financial mechanisms available for patients to influence provider behaviour.

It is often held that user charges are effective tools to decrease demand for health services (Saltman & Figueras, 1997). On the other hand, user charges can also be seen as tools to influence quality of care in government run health services (Griffin, 1992) particularly if used in combination with decentralised budget responsibility (Sahn & Bernier, 1995). It may be hypothesised that utilisation of the NTP services may increase among parts of the population if user charges were introduced. This would, however, exclude the poorest, if no fee exemptions were made. With equity in access at stake this is probably a dangerous way to go. Instead, the NTP need to face the challenge to make people change attitudes towards its’ subsidised services.

The findings in this study point to a perceived division of roles between the NTP and the private sector with a focus for the NTP on “welfare treatment” for the poor. This, in turn, seems to be linked to a lack of confidence in the NTP services. The treatment outcome in the NTP is excellent. However, with regards to perceived quality from the patients’ point of view, it may well be that the quality of care provided in the NTP is poor. It is also quite possible that this dimension of quality could be improved if user charges and different financial incentives to the staff were introduced. These are common arguments for privatisation and introduction of market mechanisms in health care. A problem is that introducing more market mechanisms will introduce more market failures, and the net effect for public health may be very negative (Swan & Zwi, 1997; World Bank, 1993; Musgrove, 1996; Griffin, 1989), particularly if the government lacks sufficient means for controlling private markets as is often the case in low- and middle-income countries (Bennett, 1997; Hsiao, 1995).

If the NTP in Vietnam is to be sustainable based on national resources a potential dilemma is that willingness to contribute to a state-run service like the NTP through taxes or health insurance may be limited among the growing Vietnamese middle class because of perceptions of such a service as being social welfare for the poor. It may be that the Vietnamese health care system is already in a vicious circle of deteriorated trust in state-run health care where those who can afford it opt out and purchase health care on the private market. Allocation of more public resources to state-run health services while actively trying to change people’s attitude to subsidised health care may be the only way out of such a vicious circle.
Limitations of the study

This study includes a small non-random sample of people with TB in one urban area in Vietnam. All interviewees but one were under treatment at the time of the interview. Generalisation of the findings to people with TB in Vietnam in general should therefore be done with caution. Interviewing a person in the health service in which the person is currently under treatment may lead to bias in the responses regarding this particular health service. However, we found that the different interviewees had rather similar attitudes towards a particular provider regardless of place of interview.

Conclusions

People with TB in HCMC associate the structure of the NTP with a high chance of cure and with a possibility to contain cost. However, when other aspects of quality of care are considered, the NTP appears less attractive than private or semi-private providers. We have shown in other studies that about half of all persons with TB in HCMC initially opt for a private provider and that about 30–40% of all TB treatment is provided by private or semi-private providers. Thus, the perceived positive aspects of private TB care outweighs the perceived positive aspects of the NTP for many patients.

There is an obvious and strong public health logic to the NTP strategy in Vietnam. The state finances health care that is for the benefit of all. The treatment regimens used are the most cost effective from society’s viewpoint. Supervised treatment that is believed to give better treatment outcomes than non-supervised treatment has been implemented widely. Strict diagnostic procedures and criteria are being used, primarily based on sputum smears, which minimises the risk of treating false positive cases while still detecting the most contagious cases with smear-positive TB. When putting public health in focus, the NTP strategy seems to deliver the most rational care for TB.

But people do not choose health care providers based on public health concerns, they make decisions based on their individual perceived needs. From the findings in this study it could be argued that a too narrow focus on public health objectives within national TB control programmes may be counterproductive for the control of TB. A crucial point for the planning of an effective TB control programme is to take account of individuals’ perceived needs as well as public health objectives.

We believe that National TB Control Programmes could take a number of measures to make its’ services more attractive to people, without having to compromise a clear public health focus, and we recommend National TB Control Programmes to consider

- to make DOT as little time consuming and bureaucratic for patients as possible.
- to make a strong effort to explain carefully for patients the rationale for DOT, complex diagnostic procedures and any administrative procedures used in the diagnosis and monitoring of treatment.
- to structure outpatient departments and TB clinics in a way that promotes privacy for patients.
- to educate health staff in how to perform the tasks outlined above.
- to structure health education in a way that it not only decreases the stigma of tuberculosis in the community but also decreases possible stigma of government run and subsidised programmes.

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References


