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State Healthcare and National Integration:
The Case of Vietnam's Central Highlands since 1975

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[*Abstract*]

This study examines the multifaceted role of state healthcare as an instrument of national integration in the Central Highlands of Vietnam in the immediate years since the unification of the country in 1975. The research focuses on elucidating how the state intervened in the healthcare system to realize its governance objectives and ethnic integration in this strategic frontier region. The article adopts a political-historical research method through archival analysis, primarily drawing on primary documents preserved at the National Archives Center III. The key findings indicate that Vietnam's healthcare policy toward the upland regions served a dual purpose: to extend administrative presence and to foster social cohesion through a humanitarian welfare mechanism. Based on these findings, the study proposes a post-Scottian reading of the highlands, characterized by a strategic integration of state control and welfare. This research suggests that healthcare service should be considered as an effective instrument for the state to build trust and foster stability and sustainable integration in the multi-ethnic regions.

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Ⅰ. Introduction

In the history of Southeast Asia, the process of consolidating and expanding state power has frequently encountered resistance in frontier regions, where ethnic minority communities adopted social and economic strategies to evade centralized control (Scott 2009). This challenge necessitated the development of sophisticated governance tools by the state, often associated with military measures and direct coercion (Ferguson & Gupta 2002; Mitchell 1991).

In Vietnam, following the national unification in 1975, the state implemented incremental steps to integrate the ethnic minority communities of the Central Highlands in South Central Vietnam into the newly established socialist administrative system. This region, then comprising the provinces of Đắk Lắk, Gia Lai, Kon Tum, and Lâm Đồng, accounts for approximately 16.2% of the country's total land area and shares a long border with Laos and Cambodia (Ministry of Health 1981b). It features a unique topography characterized by a series of tiered, relatively flat volcanic plateaus covered in exceptionally rich red basaltic soil ideal for developing perennial crops, such as coffee, pepper, rubber, cashew, and tea. The area is home to a large number of distinct ethnic groups, notably the Jrai, Êđê, Ba Na, K'ho, M'nong who possess their own diverse belief systems, indigenous medical knowledge, and varied historical experiences in their relationship with the central state (Hickey 1993; Trần 2024). In addition, the Central Highlands represents a strategic hub for national security, defense, and the economy. Therefore, the post-1975 reconstruction of unified Vietnam demanded a specialized governance strategy capable of replacing old power structures and fostering trust among the highland populations.

In the wake of the nation-building process, state healthcare

emerged as a strategic imperative. Healthcare served not only as a provider of essential services, demonstrating the state's welfare role, but also as a subtle mechanism for exercising "biopower" (Foucault 1978) and constructing national cohesion (Anderson 1991) through unified administrative and health standards. The expansion of the healthcare infrastructure, the training of indigenous personnel, and the standardization of traditional medicine integrated the highland communities into the trajectory of national governance and consciousness.

This study focuses on the first decade since the country was unified in 1975. Earnest attempts were made by the newly unified Vietnamese state to consolidate its legitimacy and control over the whole country, especially the upland regions. After a decade of intensified implementation, the healthcare initiatives of the Vietnamese government yielded empirical evidence of humanitarian efforts and national integration. Within this framework, healthcare transcended its role as a provider of essential services to become a sophisticated instrument for exercising "biopower" and forging national connections.

While previous scholarship has highlighted the significance of social policies in the highlands (Michaud 2009; Salemink 2003), research on healthcare in Vietnam's Central Highlands still demonstrates significant theoretical and empirical gaps. First, there is a lack of an integrated strategic model. Public health studies tend to bifurcate into two directions: one emphasizing the state's imposition of power to exploit or control populations and resources (Scott 1998, 2009; Zingerli 2003: 4; Foucault 1978), and the other focusing on the state's humanitarian and welfare efforts (Li 2007). The fundamental gap lies in the absence of a model capable of explaining and illustrating the strategic integration of these two elements within the Vietnamese state's management framework. Second, there is a deficiency of policy-level evidence. Current analyses often rely on field observations or ethnographic studies of local impacts, with few works examining the state's primary intentions and policies through primary archival evidence.

This study deploys a top-down approach, focusing on the

state's strategic policies and practices. This methodology facilitates the identification of the systematic nature and prioritization of healthcare strategies at the central level, while avoiding the reduction of policy to disconnected local actions. To address these research gaps, the primary objective of this article is to analyze: How did the Vietnamese state utilize healthcare policy to function both as a welfare mechanism and as a political instrument to promote national integration in post-war Central Highlands?

By reinforcing a post-Scottian approach, this research asserts that healthcare is an effective "soft" governance tool for building trust and national cohesion in multi-ethnic regions (alongside other vital instruments such as education, economy, and media). The theoretical framework is constructed upon a synthesis of governance functions that transcend the dichotomy between control and welfare, including the theory of "legibility" in the highlands, biopolitics, and nation-building. The primary aim is to analyze the role of state healthcare as a tool for integrating the Central Highlands, supported by primary archival evidence.

The article offers significant theoretical and empirical contributions. It reinforces the post-Scottian reading by providing empirical evidence that state strategy is not merely technocratic control (Scott 1998) but a strategic integration of technocratic control and welfare care (Li 2007). Healthcare serves as a clear example of this duality. By exposing unpublished primary archival records from the Prime Minister's Office and the Ministry of Health preserved at the National Archives Center III,[1] this study confirms the systematic, proactive, and central-level nature of the healthcare strategy—an aspect that field studies cannot fully capture. This enriches the historical record of post-1975 Vietnam. In addition, the article provides important policy implications, asserting that healthcare investment is an effective "soft" governance tool for building trust, stability, and national attachment in multi-ethnic

[1] Primary documents cited in this study are preserved at the National Archives Center III (NAC III) in Hanoi, Vietnam. In-text citations follow the standard author-date format (e.g., Ministry of Health 1981). Full archival details, including the specific inventory number (No.) within the fond of the issuing agency, are provided in the References list.

areas.

The paper is organized into four main sections. Following this introduction, Section II discusses the theoretical approach regarding state healthcare and the project of nation-building. Section III examines state healthcare in the Central Highlands after 1975, presenting empirical findings from archival sources and contrasting them with the theoretical framework. Finally, Section IV provides the conclusion, synthesizing the main arguments and proposing directions for future research.

Ⅱ. Theoretical Approach: State Healthcare and the Nation-Building Project

This study does not examine healthcare solely through the lens of medical techniques or public services. Instead, it situates healthcare within the trajectory of nation-building processes and the governance of frontier spaces. To analyze how state healthcare functioned as an integration tool in the Central Highlands after 1975, the theoretical framework is built upon three primary pillars: spatial governance and "legibility" in the highlands, biopolitics, and nation-building and "imagined communities".

2.1. Spatial Governance and "Legibility" in the Highlands

In the process of nation-building, the control of geographical spaces and populations in frontier regions has always posed a major challenge for any central government. After 1975, in the Central Highlands, the Vietnamese state confronted a territory that was not only topographically formidable but also ethnically diverse and heavily scarred by the remnants of war. To decode how state healthcare became a tool for territorial occupation, James C. Scott's theory of "legibility" provides a crucial analytical lens.

Highland areas like Vietnam's Central Highlands, characterized by Scott as Zomia, are home to ethnic minority communities that frequently engage in mobility or dispersal. These very activities hinder fundamental state management functions, such as taxation,

census-taking, and political control. Scott terms this condition "illegibility" (Scott 2009: 1-2, 77). To render society more "legible," the state imposes standardization instruments. This research indicates that state healthcare served as one of key mechanisms to transform the Central Highlands from "a zone of resistance" into "a zone of integration." Far more than a mere welfare initiative, the construction of the grassroots health network drove a process of "spatial flattening," wherein the state leveraged administrative mechanisms and public services to transcend geographical barriers and dissolve the historical asymmetry of state presence between the lowlands and the mountainous peripheries. Immediately following unification, the Vietnamese state prioritized extending its administrative footprint into the Central Highlands through healthcare infrastructure, notwithstanding severely limited resources. By the early 1980s, the state had successfully institutionalized health stations in 98% of the region's communes (Ministry of Health 1978), effectively establishing a dense administrative coordinate system in the peripheries. Each health station functioned as a vital node in the power grid. This was the site where highland residents were identified and categorized through medical records, vaccination cards, and epidemiological reports. The process of transforming an individual from an "illegible highlander" into "a patient in a file" constituted the initial step in creating legibility for the state. This administrative technique transformed a dispersed population into a recognizable and controllable subject (Rose 1999: 31-32; Scott 2009: 82, 219).

Spatial management is further elucidated through Andrew Hardy's theory of "internal frontiers" (2003). Andrew Hardy argues that the highlands are not merely geographical boundaries but political spaces that must be integrated into the nation's moral and administrative map. After 1975, the Central Highlands ceased to be a separating buffer zone and became an "internal frontier" necessitating connection. Healthcare played a pivotal role in this endeavor. The construction of district hospitals and commune health stations was the method by which the state materialized its sovereignty over the territory. The physical presence of public service facilities in remote areas served as tangible evidence of state

power overcoming geographical barriers.

Furthermore, the mobilization and distribution of health personnel during this period introduced not only medical expertise but also "state discourse" (Central Highlands Institute of Hygiene and Epidemiology 1977; Ministry of Health 1983). These individuals acted as observers and reporters, providing direct information from the grassroots to the central level. Healthcare during this period operated under a three-tier model (province-district-commune), demonstrating a systematic effort toward spatial coverage. The state managed not only diseases but also the patterns of human movement and settlement by strategically positioning health facilities in conjunction with sedentary settlement clusters (Ministry of Health 1976; Central Highlands Institute of Hygiene and Epidemiology 1977).

According to Timothy Mitchell (1991), the state is not an abstract entity but an effect produced through daily practices. In the Central Highlands, healthcare produced this effect with significant resonance. The establishment of a commune health station simultaneously introduced standards for hygiene and lifestyle (Ministry of Health 1984). The legibility created by healthcare allowed the state to implement subsequent integration steps, such as land management and migration. Without a healthcare network to ensure the well-being of migrants and control epidemics among the indigenous population, the Central Highlands could hardly have achieved sustainable stability. Therefore, "legibility" achieved through healthcare served as the informational infrastructure for the state to transform the Central Highlands from a remote, alien frontier into "a readable" and integral part of the unified national map.

2.2. Biopolitics

While the network of health stations explains the spatial framework through Scott's concept of legibility, biopolitics clarifies how the state acted upon living bodies and populations. After 1975, healthcare in Vietnam's Central Highlands was not just a technical service, but a method of population governance through the

optimization of health and life (Foucault 1978). According to Michel Foucault (1978), modern power has shifted from the right to "take life or let live" to the power to "foster life and monitor death" (Foucault 1978: 136-138).

In the Central Highlands, the presence of the Vietnamese State was materialized through large-scale biopolitical programs. Through expanded immunization campaigns and malaria control, the State began to intervene in the "biological capital" of indigenous ethnic communities. Additionally, the application of modern medical models created new behavioral norms. New perspectives on personal hygiene, family planning, and the elimination of spiritual healing methods (Ministry of Health 1981b) contributed to reshaping residents' lifestyles along the trajectory of national modernization (Salemink 2003; Bùi, Trần, and Bùi 2006). Archival reports on infection rates and hospital beds served as tools for the State to monitor the health of the entire "national populace."

Tania Murray Li expanded this concept through the term "The Will to Improve." She argues that development projects are often presented through technical and humanitarian lenses, which "depoliticizes" state intervention (Li 2007: 5, 7). In the Central Highlands, healthcare was deployed as a form of "humanitarian power." The state-built hospitals and health stations focused on treating complex diseases such as leprosy, tuberculosis, and dermatology. These activities are perceived by residents as care and welfare rather than political imposition (Abrams 1988: 58, 76). According to Li (2007), when medical techniques yield practical results, such as reducing mortality or healing illnesses, people develop loyalty and acceptance toward the State's governance system (Li 2007: 68, 254). Healthcare thus became "a common language" to bridge the gap between the lowland government and highland compatriots.

A unique feature of biopolitics in Vietnam, distinct from crude assimilation models, was the combination of traditional medicine and indigenous herbal remedies with modern medicine, as seen in the case of Ngọc Linh ginseng (Ministry of Health 1979a). The research and use of traditional indigenous medicine (Thuốc Nam) at

district health stations showed that the state did not just bring "Western medicine" to the highlands but also sought to integrate indigenous cultural elements into the national health system. Plans to train physicians and doctors from ethnic minorities (university nominations for highland students, for instance) were strategic moves to create an intermediary intellectual class. These individuals acted as links connecting the state's biopower with local language and culture, ensuring the integration process occurred smoothly and sustainably (Ministry of Health 1977; Ministry of Health 1978).

Thus, through the approaches of Foucault and Li, the state integrated the frontier not only by mapping territory but also by deeply penetrating Central Highlands society through healthcare. This provided the foundation for creating "biological citizens"—individuals who are healthy and closely attached to the national welfare system.

2.3. Nation-Building

At the highest level, healthcare serves as a moral symbol to bind distinct ethnic groups into a unified national identity. According to Benedict Anderson, a nation is an "imagined community" bonded through a shared discourse (Anderson 1991: 6, 26). Within this framework, individuals who may never know one another still feel a sense of connection through common symbols and narratives (Anderson 1991: 6, 26). After 1975, the Vietnamese state utilized healthcare as a medium to construct this imagination.

Symbols of care were established. Healthcare discourse often emphasized the concern of the Communist Party of Vietnam and the state for ethnic minority compatriots through various instructions and resolutions. The image of the dedicated physician from the lowlands tirelessly caring for highland patients became a moral symbol. The nation was then defined as a family, where members (ethnic groups) care for one another. Furthermore, when the State set collective health goals for the entire population through expanded immunization and malaria prevention campaigns, the health of an individual in a remote Central Highlands village became directly linked to the strength and future of the whole

nation. This created “a national healthcare discourse.” Illness was no longer an individual issue, but a matter of the unified nation’s destiny.

In the Central Highlands, after years of being fractured by war, healthcare acted as the “glue” for connection. The robust deployment of the healthcare network was a strategy to “reconnect” space and people, helping to dissolve old boundaries. This connectivity was not just a top-down imposition but also involved negotiation and adaptation by local communities. Through tangible welfare services, as people accepted state healthcare, they simultaneously participated in the nation's social and administrative networks. From this, residents formed loyalty and a sense of belonging.

Thus, state healthcare in the Central Highlands after 1975 is studied across three dimensions: Horizontal (Spatial): Expanding sovereignty and creating legibility through the grassroots health network. Vertical (Power): Governing life and improving residents' livelihoods through biopolitics. Depth (Socio-psychological): Constructing loyalty and national identity through medical welfare. This combination allows the authors to evaluate healthcare as a comprehensive integration tool, where state power is exercised subtly through the intersection of administrative control and welfare care.

Ⅲ. State Healthcare in the Central Highlands after 1975: Practices of Integration and Theoretical Comparison

Archival records at the National Archives Center III, specifically the Prime Minister’s Office and the Ministry of Health reports, reflect a systematic and urgent effort by the central government to establish a medical presence in the Central Highlands after the unification. This was a period of transition from a healthcare system characterized by colonial legacies, war-time fragmentation, and division, toward a universal and community-oriented health network

3.1. Establishing "Legibility" through the Grassroots Health Network

Vietnam's Central Highlands is a territory inherently characterized by self-governing social structures and complex topography. According to James C. Scott, the state requires technocratic tools to render local entities, which are originally "opaque", into "legible" ones (2009: 41, 74, 191). During the 1975-1985 period, the Vietnamese state deployed a healthcare strategy in the Central Highlands not merely as a humanitarian activity, but as an instrument for the governance of this frontier region. By establishing administrative healthcare coverage, the state conducted systematic measurement, statistics, and surveillance of the population. This was a crucial task aimed at transforming the region from "a zone of resistance" into "a zone of integration."

The establishment of the state's presence was evidenced by the rapid expansion of the health network at both the commune and district levels. The state exerted significant effort to bring public services as close to the people as possible. According to data from the 1977 Personnel Organization Department report (Ministry of Health 1977), the entire Central Highlands region had 301 communes, 239 of which had rapidly established health stations. In Đắk Lắk province alone, by 1978, 94 communes had established health stations, achieving a rate of 86% with an average of 6 hospital beds and 5 health workers per commune (Ministry of Health 1977). By 1983, the state's presence through healthcare had reached a very high level of coverage. Approximately 98% of communes and wards in the Central Highlands provinces were equipped with health stations (Ministry of Health 1983). This coverage serves as clear evidence for the "administrativization" of the living space of ethnic minorities, where each health station became a coordinate of state management on the ground.

The healthcare system was consolidated under a three-tier model. At the district level, by the early 1980s, 100% of districts in the Central Highlands had established their own hospitals, hygiene and epidemiology teams for malaria control, and pharmacies (Ministry of Health 1983). Additionally, each district was equipped with 1 to 2 mobile health teams (Ministry of Health 1983). The

provincial level maintained large-scale general hospitals with 260 to 600 beds and specialized stations (Ministry of Health 1983). In 1976, the Central Highlands Institute of Hygiene and Epidemiology was established in Buôn Ma Thuột with an area of 4,680. This institute served as the central hub for investigating and researching disease patterns and proposing epidemic prevention measures for the entire region (State Planning Committee 1979).

Furthermore, "legibility" was reinforced by converting life phenomena into statistical data and national hygiene standards. The state conducted epidemiological statistics, an activity aimed at transforming fragmented reports into concrete figures for management. For instance, in Đắk Lắk, the mortality rate from the plague was strictly monitored, dropping from 113 cases (1976) to 29 cases (1977) (Ministry of Health 1978). The rate of malaria parasites in the blood was also targeted for reduction from 4% (1980) to 2.8% (1985) (Ministry of Health 1984). The "Five Definitive Objectives" movement was a state measure to impose new living standards in the Central Highlands. By 1982, on average, 1.6 families shared 1 latrine (compared to 1.8 families in 1980) and 3.7 families shared 1 water well (Ministry of Health 1983). Practices such as "eating cooked food, drinking boiled water" and moving livestock pens away from houses became administrative indicators to evaluate the development of villages (Ministry of Health 1983).

In new economic zones and sedentary settlement areas, healthcare was prioritized to protect the migrant labor force and stabilize local ethnic minorities (Ministry of Health 1976). The expansion of the healthcare network also carried a silent but vital mission: ensuring national security. This activity helped the State control the flow of people and limit the influence of reactionary forces, particularly in Đắk Lắk (Central Highlands Institute of Hygiene and Epidemiology 1977). The "mobile to villages" medical examination network received focused attention to detect diseases and manage health in remote areas, ensuring no gaps in medical governance (Ministry of Health 1983; Ministry of Health 1984). These teams acted as "extended arms," helping the state penetrate into remote areas and former resistance bases to control epidemiology and understand the population situation.

To demonstrate the effort to "flatten" the healthcare gap between the highlands and lowlands, indicators of hospital beds and personnel at the commune level were closely monitored. By 1982, the quantitative ratio of hospital beds reached 13.5 beds per 10,000 people at the district level, and the average number of health workers for the whole Central Highlands was 5 per 10,000 people (Ministry of Health 1983). The state managed not only diseases but also how people moved and resided in connection with population clusters. This biological and health legibility gradually blurred the boundary between the "lowlands" and "highlands." The Central Highlands gradually became an inseparable part of the unified national governance structure (Hickey 1982: 17-18; Sikor, Nghiêm, Sowerwine, & Romm 2011: 1-2, 24).

In summary, the "legibility" of the health system in the Central Highlands during this period carried a dual meaning: it was both a welfare infrastructure to bridge regional gaps and a monitoring apparatus that helped the state "see" and "reach" the most remote villages. Consequently, the Central Highlands gradually emerged from its status as "a gray zone" of power to become a unified spatial entity within the political map of post-war Vietnam.

3.2. Biopower and the Strategic Development of Medical Human Resources

While the network of health facilities (Section 3.1) served as the "hardware" for spatial coverage, then the medical personnel functioned as the "software" operating the state's biopower. According to Foucault, this power does not stop at territorial management but involves a direct impact on the population's bodies to optimize life (1978: 142-143). In the Central Highlands, archival records reveal a methodical personnel strategy aimed at "localizing" state power through two pathways: large-scale personnel mobilization and the training of indigenous health doctors.

Regarding the large-scale personnel shift, the state rapidly executed movements toward the highlands. This penetration was not merely technical but also political: each health worker represented national civilization and discipline. As early as 1976, the Ministry of

Health proposed mobilizing 250 cadres (including 100 doctors) to implement the "new plan" in the Central Highlands (Ministry of Health 1976). For long-term planning during the 1981–1985 period, the Ministry of Health allocated 60-70 doctors and 20 university-level pharmacists to the region annually[2] (Ministry of Health 1984). By 1982, the average reached 5 physicians/doctors per 10,000 people (Ministry of Health 1983). This force functioned as "a technocratic group" imposing modern scientific protocols upon a space previously reliant on folk healing experiences. However, this workforce experienced frequent fluctuations; cadres from the North often requested transfers after 5-7 years due to hardships and low remuneration (Ministry of Health 1977; Ministry of Health 1993). Shortages of pharmaceutical managers and deputy heads of health services were common across all three provinces (Ministry of Health 1977).

To ensure sustainable resolution of these shortages, the State prioritized training ethnic minorities to eliminate language and custom barriers. In the first three years after liberation (1975-1977), Đắk Lắk trained 607 intermediate and primary-level cadres, 25% of whom were ethnic minorities (Ministry of Health 1978). For long-term stability, the State established the Faculty of Medicine at Tay Nguyen University (with a capacity of 600-1,000 students) as the core for training doctors for the entire region (Ministry of Health 1984). Implementing the strategy to "universalize" basic medical knowledge, between 1980 and 1982, the number of nurses increased sharply from 59 to 1,444 (a 24-fold increase), while midwives grew from 41 to 181 (a 4-fold increase) (Ministry of Health 1983). The prioritization of using the offspring of Êđê, Jrai, and Ba Na ethnic groups (Ministry of Health 1983; Government Committee on Organization and Personnel 2000) carried profound political significance. When a village youth donned the white blouse, it signified a change in identity: from an individual living by custom, they became "a link" to the national health system. They brought the State's language back to explain it to the community. From

[2] The entire cohort of medical graduates from the Faculty of Medicine and Pharmacy at Tay Nguyen University was allocated to the region and supplemented by additional graduates from Hue University of Medicine.

there, new “biological citizens” were created, closely attached to Central governance (Rose 1999: 48-51).

Biopower in the Central Highlands was also specifically implemented through the standardization of health behaviors and the management of biological indicators. This was the process by which the State directly intervened in the bodies of the population to optimize life and bind them to the national welfare system. In the Central Highlands, the “Five Definitive Objectives”[3] movement was the tool to change the lifestyle of indigenous residents. The movement included building latrines, wells, and bathrooms, and practicing hygiene for disease prevention (Ministry of Health 1984; Ministry of Health 1987; Piao 2014). By 1982, hygiene indicators had penetrated deeper into daily life: on average, 1.6 families had 1 latrine (compared to 1.8 families in 1980) and 3.7 families had 1 well (Ministry of Health 1983). Implementing this movement helped the State intervene in the living spaces and hygiene habits of the villages.

Moreover, the State concentrated resources on addressing the “four major diseases” in the Central Highlands: malaria, plague, intestinal diseases, and goiter (Ministry of Health 1983). Empirical reports demonstrate the effectiveness of this intervention. In Đắk Lắk, the death toll from the plague decreased from 113 in 1976 to 29 in 1977 (Ministry of Health 1978). The state applied different policies for various population groups to optimize demographic resources in the strategic Central Highlands. For the ethnic Kinh people and new economic zones, the goal was to lower the natural population growth rate to 1.9%-2.2%. For ethnic minorities, the state did not emphasize birth reduction but focused on “combating infant mortality” and reducing pre-birth deaths to improve the quality of the lineage (Ministry of Health 1983; Ministry of Health 1984). This work helped build the people's trust in the State's role as a health

[3] The "Five Definitive Objectives" Campaign (Phong trào 5 dứt điểm) comprised five objectives: (1) constructing sanitation structures and managing epidemic prevention through vaccination; (2) cultivating and utilizing traditional herbal medicine; (3) advancing family planning; (4) developing local healthcare networks; and (5) strengthening primary healthcare management (Resolution 55-HĐBT dated April 2, 1984, of the Council of Ministers on immediate healthcare tasks).

protector. Reports consistently indicate that the local people were more responsive to vaccinations and malaria prevention drugs than before, and there were a growing number of ethnic minority women coming to healthcare centers for check-ups and childbirth (Ministry of Health 1983). The synchronous implementation of the "Five Definitive Objectives" movement and population management transformed healthcare into a subtle governance tool, where power was exercised through the intersection of administrative control and welfare care (Rose 1999: 75-76; Ong 2006: 78-79).

3.3. "Will to Improve" and Cultural Integration through Traditional Medicine

While the expansion of the network (3.1) and the management of human resources (3.2) represent the state's "hard power," then the preservation and development of traditional medicine in the Central Highlands after 1975 manifest a subtle "will to improve." According to Tania Murray Li, development projects often seek to integrate local elements to mitigate resistance and enhance legitimacy (2007: 15-16). In the Central Highlands, records from National Archives Center III reveal that the State did not entirely dismiss indigenous knowledge; instead, it sought to "scientize" and incorporate it into the national healthcare stream (Ladinsky, Volk, and Robinson 1987). This was a strategy of profound cultural and economic integration, transforming local resources into national assets and reducing dependence on imported pharmaceuticals during a period of crisis (Ministry of Health 1981a; Ministry of Health 1983).

The Vietnamese state early on recognized the immense potential of the Central Highlands ecosystem, particularly the medicinal plant species linked to local indigenous knowledge. Consequently, the State proactively investigated and transitioned the management of precious medicinal materials from natural harvesting to planned cultivation and production (Hoàng and Lê 1998). In Gia Lai-Kon Tum, investigations estimated the natural reserves of Ngọc Linh ginseng at approximately 60 tons of fresh roots (Ministry of Health 1979a). To ensure conservation and sustainable exploitation, the state advocated for transforming natural ginseng forests into cultivated ones. In 1978, a research farm was

established, and 1 hectare was experimentally planted using wild ginseng seeds under the supervision of agricultural engineers (Ministry of Health 1979a). This process involved the participation of research institutes and universities (such as the University of Hồ Chí Minh City) in clinical trials and formulation, preparing for large-scale production (Ministry of Health 1979a). This demonstrates the state's significant efforts to integrate modern science with local medicinal excellence to create a common value for the national health system (Ministry of Health 1987).

Furthermore, traditional medicine was identified as one of the five pillars of the "Five Definitive Objectives" movement. Thus, the opening of traditional medicine clinics in hospitals and the establishment of herbal gardens at communal health stations were carried out[4] (Ministry of Health 1983). By 1985, the target was for 50% of communes to have traditional herbalists and for each commune to have at least one staff member specialized in herbal medicine and acupuncture (Ministry of Health 1983; Ministry of Health 1984). In Đắk Lắk province, medicinal resource surveys showed that over 80% of communes possessed medicinal sources, with more than 700 types of medicinal plants identified. The output of medicinal materials supplied to the Central Government rose sharply from 272 tons in 1980 to a value equivalent to 2.3 million VND in 1982 (Central Highlands Institute of Hygiene and Epidemiology 1977; Ministry of Health 1983). These figures prove that healthcare became a vital bridge integrating the highland economy into the national medicinal market (Hoàng and Lê 1998)

In the context of an extreme shortage of imported antibiotics (inventory was approximately 500,000 vials of Penicillin compared to a quarterly demand of 20 million vials [Ministry of Health 1981a]), Central Highlands medicinal materials took on strategic significance

[4] The "Project for the Strengthening and Development of the Healthcare System in the Central Highlands Provinces" mandated the consolidation of a traditional medicine network spanning all administrative levels, from provincial centers to grassroots health stations. Structurally, the policy focused on establishing district-level clinics and standardizing therapies like acupuncture and herbal remedies, while operationally seeking to extract, document, and preserve the indigenous medical knowledge safeguarded by local ethnic minority communities (Ministry of Health 1983).

for health security (Aso 2024; Mai and Dhont 2025). The state set a target for the Central Highlands provinces to self-supply 60-80% of common medicines (for flu, coughs, intestinal, and skin diseases) (Ministry of Health 1984; Ministry of Health 1987). Medicinal materials did not only serve local needs but also contributed significantly to the central budget. In Đắk Lắk, the value of medicinal materials contributed to the Central Government increased from 559,000 VND (1980) to 2,345,000 VND (1982) (Ministry of Health 1983). According to the plan, by 1985, the Central Highlands provinces were to supply the Central Government with 650 tons of medicinal materials, featuring key items, such as *Coix lacryma-jobi* (240 tons), *Amomum villosum, Codonopsis pilosula*, and *Strychnos nux-vomica* (Ministry of Health 1984). To ensure sustainability, the State adjusted procurement prices for 22 medicinal items, both naturally harvested and cultivated, ensuring reasonable prices relative to the labor efforts of local workers (Ministry of Health 1979b).

From a cultural perspective, rather than forcing people to completely abandon traditional methods, medical staff were instructed to combine them with Western medicine. This helped indigenous people feel that their knowledge was respected, thereby making it easier for them to accept the presence of state health stations (WHO 1978; Ladinsky et al. 1987). The exploitation of traditional medicine in the Central Highlands, therefore, carried three levels of integration: (1) economically, transforming forest resources into national commodities and linking the interests of residents with state plans; (2) politically, using indigenous knowledge as “a cultural touchpoint” to establish trust between the government and the people; (3) discursively, affirming that national healthcare is a harmony between modernity and ethnic identity, contributing to the consolidation of great national unity.

The development of traditional medicine in the Central Highlands was not merely a substitute for the lack of Western medicine, but part of a “will to improve” aimed at harmonizing national modernity with local cultural identity (Salemink 2003). Through this, the Central Highlands villages were not just recipients of healthcare but became a crucial link in the country's medicinal

economy. The state initially succeeded in incorporating the quintessence of the highlands into the general governance system, transforming traditional knowledge into a part of the nation's post-war strength.

Ⅳ. Conclusion

Research on state-governed healthcare in the Central Highlands during the post-1975 period demonstrates that healthcare was not merely a social welfare service; it functioned as a pivotal technocratic tool in the process of national integration and the consolidation of the Vietnamese state's administrative authority in the frontier regions (Ministry of Health 1983).

First, based on empirical evidence, this study proposes a refinement to Scott's theory of "legibility." He typically emphasizes that states make highland societies "legible" primarily for the purposes of surveillance, control, and taxation. However, archival data from the Central Highlands reveals another dimension: legibility for the purpose of public welfare. The establishment of a healthcare network covering 98% of communes by 1983, along with the identification of patients through medical records and vaccination books, transformed the elusive and "non-legible" realities of the highlands into specific beneficiaries of state welfare. This medical-administrative coordinate system enabled the State to mobilize doctors from the lowlands and provide timely medical supplies to suppress epidemics (Ministry of Health 1978; Ministry of Health 1984). Consequently, "legibility" here served as an information infrastructure for the state to fulfill its role as a health protector, rather than acting as a mere instrument of power imposition.

Second, the study asserts that healthcare served as a subtle mechanism for the Vietnamese state to exercise biopower. Driven by the "will to improve" (Li), the state fostered social cohesion. The human resource development strategy, specifically the 24-fold increase in nursing staff between 1980 and 1982, with priority given to the youth of Êđê, Jrai, and Ba Na ethnicities, created an

intermediary intellectual group. These nursing staff carried medical skills and the "language of the state" back to their communities. They facilitated the translation of modern hygiene standards into village life as seamlessly as possible.

Third, the research supports the vision of "a flat plateau," where the boundaries between the highlands and lowlands were progressively blurred through healthcare connectivity. The integration of traditional medicine and the zoning of medicinal herb regions, such as Ngọc Linh ginseng, indicates that the state did not pursue a crude model of integration but rather engaged in "a cultural negotiation." The scientific systematization of indigenous knowledge integrated the Central Highlands into the unified nation.

Theoretically, this article reinforces a post-Scottian reading, affirming that highland governance is a strategic integration of technocratic control and welfare care. Empirically, the utilization of primary archival records from the National Archives Center III exposes the systematic nature and the Government's prioritization of the Central Highlands region within the challenging context of post-war reconstruction. In terms of policy implications, the study confirms that healthcare, as a socio-political institution, is an important soft tool for building trust and long-term stability in multi-ethnic regions.

Future research could further analyze the role of healthcare as a space for cultural interaction to promote sustainable national harmony. Specifically, it is necessary to evaluate the extent to which the integration of indigenous knowledge into the national governance system influences outcomes. Further attention should be paid to removing psychological barriers and enhancing the participation of ethnic minorities in socio-political life. Additionally, surveying cross-cultural healthcare models may serve as a solution to mitigate potential conflicts in highland areas. Such studies will provide further vital implications for national unity policies in the contemporary context.

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