





WORKING TOWARD A HEALTHY VIETNAM

KEY POLICY MESSAGES FROM THE VASS-SSRC PROJECT

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TABLE OF CONTENTS

The Vietnamese health sector is at a crossroads. Thirty years ago, it was almost entirely government run, and health outcomes were impressive given Vietnam's low per capita income. Then, with the emergence of *doi moi* in the late 1980s and its shift to market-based reforms, the health care system experienced the same process of fiscal decentralization as the Vietnamese economy. Starved of public funds, public health facilities began deteriorating. The private health sector and out-of-pocket health spending by individuals grew. Health disparities between the rich and poor increased substantially.

Since the mid-1990s, the government has been developing new policy tools, such as user fees, health insurance, and health care funds for the poor. While this has improved health care financing, health infrastructure at the grassroots level still remains inadequate.

I. THE VASS-SSRC PROJECT

In 2006, the Vietnam Program of the Social Science Research Council (SSRC) was commissioned to evaluate the Viet Nam Population Health Program run by The Atlantic Philanthropies (AP), a limited life foundation. Working with the Vietnam Academy of Social Sciences (VASS), the SSRC designed a longitudinal study and began collecting data prior to Atlantic's interventions, through the intervention period, and beyond to determine the degree to which the health of the target population improves.

The overarching objective of this research project was to understand household health practices and health-seeking behavior, especially among economically and socially disadvantaged groups. We provided ongoing feedback to Atlantic to inform their work and that of other donors in Vietnam, and consulted with local health officials on the replication of successful models and the management of health care improvements. Research findings were disseminated throughout the duration of the project with periodic reports, publications, policy convenings, and workshops.

WAITING AREA AT AP-SUPPORTED CHC IN KHANH HOA

II. METHODOLOGY

Drawing upon data collected to explore a host of issues—health-seeking behavior, individual perceptions of health, the attitudes and performance of health providers, and the state of health infrastructure—at the commune and district levels, the VASS-SSRC project analyzes how individuals make decisions about their health care and what their perceptions of health providers are.

The project focuses on three provinces that together provide a solid baseline sample: Thai Nguyen, Khanh Hoa, and Vinh Long. Although all three provinces differ significantly in terms of geography and ethnic composition, they are broadly similar in terms of per capita income and income growth. According to the 2009 census, ethnic minorities constituted 27% of the total population in Thai Nguyen and 2.6–5.3% in the other two provinces. Khanh Hoa is the richest of the three provinces, but differences in income and income growth across all three provinces are not very large. In 2008, compared to Khanh Hoa, monthly per capita income was only 6.9% lower in Vinh Long and 12% lower in Thai Nguyen. Between 2008 and 2014, after adjustment for inflation, per capita income grew 45% in Khanh Hoa, 38% in Thai Nguyen, and 28% in Vinh Long.

Much of the project analysis relied on a multipurpose, population-based household survey conducted in two waves: 2008–09 and 2013-14, as well as a case study of commune health centers (CHCs) and other health care providers in 12 communes in 2013-14 and in four communes in 2016. In each province, two districts were chosen for the survey, and two communes were then randomly selected within each district. Survey data were supplemented with interviews conducted with households, health facility personnel, and patients to add context and nuance. The 2008-09 study established a baseline for evaluating how the health care system has worked and how it could work better, while the 2013-14 resurvey looked at changes that had occurred over the five years.

It was during the period 2004-13 that AP supported programs to strengthen primary health care through (i) funding new and upgraded CHC buildings and essential medical equipment for all CHCs in eight provinces, and (ii) piloting clinical, maternal, and health care delivery service models. The service models were considered basic components of a community health system, and five were piloted in the surveyed CHCs. They included: (i) laboratory testing capacity and high-tech equipment, such as ultrasound machines and diabetes testing equipment; (ii) developing and computerizing health information management system capacity; (iii) family medicine doctor training; (iv) social marketing and a franchise model for changing staff attitudes and increasing the use of reproductive health/family planning services at CHCs; and (v) improving health for mothers and newborns through a Household-to-Hospital-Continuum-of-Care model that provided training and equipment to enable provision of quality essential and emergency services at CHCs and public hospitals, behavior change communication to increase awareness, outreach to households to promote safe motherhood practices, and construction of newborn units at district and provincial hospitals. Because most of the AP interventions were introduced in some, but not all, of the survey communes during the period between the two household surveys, it is possible to conduct a rigorous evaluation of the AP interventions.

The VASS-SSRC methodology is distinctive for several reasons. First, as noted above, the longitudinal nature of the data collection, in which we combine data from pre- and post-intervention surveys, is rare in Vietnam. It allows us to evaluate the impact of the AP interventions. Second, our comprehensive approach, in which we examine issues through multiple perspectives and multiple quantitative and qualitative research methods, is crucial to understanding the process of economic development and social change. Third and finally, ours is the only study in Vietnam that enables us to look at the grassroots level of the commune—something that studies based on large data sets (such as the Vietnam Health Survey and the Vietnam Living Standards Surveys) are unable to accomplish.

III. KEY POLICY MESSAGES

This policy brief is not intended to substitute for a full reading of the many reports that the VASS-SSRC project has produced, all of which include rich data collected to explore health issues at the commune level. These reports also draw upon other recent research on the Vietnamese health sector in order to highlight the main areas where donors and the government will need to focus in the coming years in order to improve and reduce disparities in health outcomes.

What we have summarized here are policy messages for reducing disparities in health outcomes by increasing the usage of health care facilities by all and by getting more women to seek out prenatal care and assisted births.

RAISING THE USE AND EFFECTIVENESS OF COMMUNE HEALTH CENTERS

Vietnam has strived to make CHCs the first line of defense for the primary health care needs of its people. Over time, the utilization of CHCs has been declining steadily in Vietnam, as it has in many other developing countries, owing to rising incomes, increased availability of private health providers, and better roads and transport options that enable patients to bypass CHCs and directly access district and provincial hospitals. However, our data show that disadvantaged populations (viz., the poor, the less educated, ethnic minorities, and the elderly) have continued to rely more heavily on CHCs than on other health care providers. This is actually a desirable trend insofar as it allows the government to focus its health spending on the underprivileged sections of the population.

That said, communes with better-treated CHCs (in terms of investments in CHCs' physical infrastructure, high-tech equipment, and staff expertise, as well specific reproductive health and maternal and child health programs) saw a stronger improvement in antenatal care behavior of pregnant mothers and better self-reported health than communes with less-treated CHCs. The latter finding was true for men and women, the poor and the non-poor, as well as minority and Kinh populations.

But there was also a significant variation in the CHC utilization rate among the better-treated CHCs. Investment in infrastructure and programs alone are not enough to raise CHC utilization rates; CHC leadership and management matters a great deal as well. For instance, CHCs with

visionary leaders who set up centrally-pooled income funds to hire additional staff members, to improve CHC physical infrastructure, to provide significant additional income to its staff, and to increase staff members' morale attracted many more patients, including from other communes, than CHCs that did not establish such innovative management practices. Health staff in the better-managed CHCs did not have their own private practices on the side, as is common elsewhere, and provided a strong backup for one another in the provision of health care services to CHC clients.

There is an important lesson here for public policy. The successful CHCs—those that solved organizational, morale, and service quality problems that other CHCs faced—were those whose leadership was willing to take risks and find ways around strict government rules and regulations. This highlights the importance of government policy allowing CHC heads greater autonomy and flexibility in running their units.

Likewise, our study suggests the need for more differentiation among CHCs, based on their proximity to urban centers and the availability of other health care providers. Greater differentiation among CHCs would be helpful, including possible revision of long-established national benchmarks for CHCs. For example, birth delivery, which Vietnamese health authorities consider an important part of standard CHC services, may be less relevant today, excepting in remote and very poor communes. Resources spent on birth delivery equipment and personnel at urban ward and rural lowland CHCs could be saved and shifted to remote CHCs in poor mountainous regions, where people rely on CHCs to a much greater extent owing to fewer private health provider options, more difficult transportation systems, and generally lower income levels.

⇒ GETTING HEALTH INFORMATION TO RURAL AREAS

Notwithstanding the great importance of CHCs in the Vietnamese health context, the fact is that CHCs are not the exclusive provider of health services in rural areas, even among the poor. Thus, public policies that focus only on CHC improvements cannot address the major health problems facing the country. Policy will have to draw in other, non-public providers. For example, pharmacies have emerged as important sources of health information and services in the country. Many Vietnamese resort to self-treatment for their health symptoms and obtain antibiotics directly without prescription from drug stores, despite the requirement of prescription for the sale of antibiotics. The overuse and abuse of antibiotics has led to an alarming rise in antimicrobial resistance in the country. **It is vital that the Ministry of Health promote and expand outreach education programs on drug safety and drug protocols.**

⇒ RAISING THE EFFECTIVENESS OF THE HEALTH INSURANCE SYSTEM

Increased health insurance coverage has been one of the most impressive developments in the Vietnamese health sector in the last two decades. Health insurance has tried to be more responsive to users' needs and adopted the policy of allowing people with health insurance to visit any public health care provider at the district level, as of 2016, and at the provincial level, as of 2020. Under this new health insurance policy, the better-treated CHCs

with good leadership and management in our study are able to attract more clients from surrounding communities, while many others with similar investments have lost patients. This further highlights the importance of strong leadership and management and of incentives for management innovation so that investments in infrastructure, high-technology equipment, staff expertise and programs can be better utilized. In addition, **effective implementation of the family medicine model for CHC will increase the likelihood that other CHC investments are used well.**

⇒ IMPROVING ELDERLY CARE

Since the 1980s, Vietnam has made progress in diminishing the burden of childhood diseases and infant mortality, but it has not made commensurate progress in improving old-age health. Vietnam's elderly population is growing at a faster rate than the world average. As the country's population ages rapidly in the coming years (as a result of its highly successful fertility transition), it will need to focus more attention on the health problems of the elderly who often suffer from chronic health problems, or are at risk of suffering from long-term unhealthy habits, such as drinking and smoking. The **monitoring of the elderly's chronic health problems has benefitted from the high-technology equipment provided to many CHCs** (electrocardiogram machines, blood and urine test equipment) and the increasing percentage of elderly on health insurance. **But the use of high-technology equipment has varied significantly, since CHC personnel has not always been well trained in using them, and since the efficiency in usage needs to be improved with a good back-up system** among CHC staff.

⇒ UTILIZING THE POWER OF HEALTH INFORMATION CAMPAIGNS

The increased use of helmets by all socioeconomic and demographic groups—a major behavioral change—is a good example of the power of health information campaigns. Information campaigns have also contributed to better antenatal care behavior among pregnant women. **Policymakers can learn from this experience and create health information campaigns to discourage unhealthy behaviors, such as tobacco and alcohol addiction and the overuse/abuse of antibiotics.**

EXAM AT AP-SUPPORTED CHC IN KHANH HOA

IMPROVING ANTENATAL CARE AND UTILIZATION

While the period 2009-13 saw the utilization of antenatal health services (as measured both by the proportion of pregnant women who had at least four antenatal checkups during their pregnancy as well as the proportion that took iron supplements for more than three months) increase sharply in the studied communes, the increase was significantly greater in communes with AP interventions than in the control communes. This highlights the significance of the AP interventions in both raising awareness of the importance of antenatal care and making it worthwhile for women to make a trip to the improved commune health facilities that now offered higher quality care.

That said, there remain large differences in utilization of antenatal services across socioeconomic groups. Younger, more-educated and higher-income mothers report more antenatal checkups than older, less-educated, and lower-income mothers. Rates of antenatal service utilization are lower among ethnic minority mothers, especially those living in remote areas.

In part, this happens because some antenatal services are not always provided free of charge. For instance, iron tablets are not routinely and uniformly provided for free in all communes, because the local budget that covers iron supplementation is limited and often runs out well before the close of the fiscal year. This highlights the need to focus on providing adequate budgets for antenatal services designed for vulnerable women, especially those living in remote areas and belonging to ethnic minority groups. Greater reliance on village health workers to increase awareness and encourage pregnant women to have four or more antenatal care checkups and take iron supplements is also called for.

⇒ REDUCING THE PROPORTION OF LOW BIRTH-WEIGHT BABIES

Low birth weight is an important leading indicator of early childhood health. Decreasing the proportion of low-birthweight babies remains a challenge in Vietnam. In some of the studied provinces, as many as 15% of babies born are low-weight babies, while in other provinces, the proportion is 5%. **Understanding why the rate of low-weight births remains so high in some provinces while it has been reduced in other provinces, even those with a high ethnic minority composition, can help us find a solution for this significant health issue.**

⇒ OUTREACH BEYOND THE HEALTH-CARE SYSTEM

Much policy is focused on improving services for those who use the system. **However, it is even more important for policy to reach out to those not using the health-care system.** Ensuring that qualified health workers assist births is an important challenge. For example, 17% of births in Khanh Hoa are at home, and qualified health workers assisted with about 14% of these. One out of every five births takes place at home in Khanh Son district. Drawing these mothers into the institutional delivery system will be difficult, so outreach will be very important. Qualitative data from our surveys show that AP

and other donors' reproductive health programs with an outreach component provided many pregnant women with essential knowledge of antenatal and postnatal care.

⇒ STANDARDIZING PRENATAL TESTS

Large numbers of pregnant women are taking advantage of prenatal checkups, which is an important improvement. However, the content of these checkups varies widely and most often does not include many of the seven tests that the World Health Organization considers standard for prenatal checkups. Half of the battle is getting women to see these checkups as important and to go for them; the other half is making sure that the content of the checkups is up to standard. Data suggest that **women are deciding whether to get prenatal checkups based on the availability of ultrasound tests at the commune health center.** This has implications for policy implementation with respect to the content of checkups and for the potential importance of information campaigns and policies related to ultrasound usage.

HEALTH INSURANCE MEDICINE CHEST AT AP-SUPPORTED CHC IN KHANH HOA

IV. IMPLICATIONS AND FUTURE WORK

Our study shows that the one area where many CHCs fall short is in the implementation of categorical, vertical programs (such as the Control of Diarrheal Diseases, Tuberculosis Control, Control of Acute Respiratory Infections, Malnutrition Control, and HIV/AIDS Control). **A large proportion of the CHCs do not always implement the essential disease control programs, even in cases where the CHC is well-staffed and stocked with drugs and medical equipment.** This is surprising because Vietnam has invested heavily in developing highly effective health programs. These programs have been very successful, and their integration into the primary health care system has been a high priority of the government for years. Any CHC improvement program needs to address this important issue of integration of vertical programs into the primary health care system.

Finally, we would like to reiterate that this policy brief and the reports that have already been released under this project are just the beginning. There are Vietnamese health-care issues that call out for further investigation, and we want to make sure that the rich data we have collected are fully put to use by the broader research and policy community in order to inform important policy choices facing the country in the years ahead.

Looking forward, we see the need for developing sustainable local research capacity in Vietnam. This will set the stage for sound, evidence-based policymaking by central, provincial, and local governments and by the range of stakeholders involved in the primary health system. The VASS-SSRC project was just one small step in this direction.

AP-SUPPORTED COMMUNE IN KHANH HOA