COMMUNITY-BASED EVIDENCE ABOUT THE HEALTH CARE SYSTEM IN RURAL VIETNAM

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I hereby certify that the work embodied in this thesis is the result of original research and has not been submitted for a higher degree to any other University or Institution.

(Signed) _____

Tran Tuan

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Thesis Summary

COMMUNITY-BASED EVIDENCE ABOUT THE HEALTH CARE SYSTEM IN RURAL VIETNAM

This thesis contributes further evidence for policy-making on health care system reform in Vietnam. The author aims to provide insights into the provincial rural health system ten years after health sector reform was launched, through assessing availability of health care services, patterns of access of health care services when people are ill, and the costs of care and the performance of public and private providers.

The following questions are addressed:

1. Which health care providers, i.e., public or private, are dominant in providing curative services to rural people when they are ill?
2. How much inequality exists between the poor and the non-poor in access to health care services in general, and public health care services in particular, when they are ill? Which factors explain the gap in use of services between the poor and the non-poor?
3. What policy and strategies should Vietnam consider implementing in order to reach the goals of better equity and quality of care for rural populations?

These research questions were addressed using community-based survey data collected in 2001 from Hung Yen province, in which three components of the system -- user, provider, and community context -- are described and linked together in analysis. In addition, a supplementary health care provider survey collected in 1999 in three other provinces (Thai Binh, Binh Thuan, An Giang) is used to provide evidence about the availability of healthcare services in general and of private health care providers.

The thesis is divided into two parts with a total of 9 chapters. Part A (chapters 1-4) provides background for the research questions raised about the commune health care system in rural Vietnam, the framework used in evaluating this health care system, and the data sources used in this thesis. Part B consists of five chapters (chapters 5-9) that

presents research results on various dimensions of the rural health care system. It also provides conclusions on the health care system in rural Vietnam, and proposes policies and strategies for strengthening this system toward equity and efficiency.

Chapter 1 presents the research rationale and objectives. It examine the international context of health sytem research, the Vietnamese context of health sector reform since the 'Doi Moi', and the current trend of health sector reform, and the previous research done so far related to health system reform in Vietnam. The research questions addressed by the thesis are presented at the end of this chapter.

Chapter 2 describes the historical development of rural health care system in Vietnam. It startes with an overview of social changes in the rural Vietnam including revolution and wars and both the positive and negative impacts on the health of rural populations. The evolution of the rural health care system is then outlined, from the single national provider system (public) to the reforms of 1989 where a public-private model for rural health care was introduced.

Chapter 3 provides frameworks for analysis of availability, health accessibility, quality and efficiency of the rural health care system, and inequality of healthcare service utilization. It starts with a statement about the concept of health care system used in this thesis. Then five theoretical models for assessing the health care systems (health service utilization model, triangular model, model for improve quality of care, health care services as an open system, and the World Bank's framework for assessing the performance of the health sector in serving the poor) are presented. The strategy of using these frameworks to assess the rural health system in Vietnam is explained. The link between the research questions and methodology used was described.

Chapter 4 provides detailed descriptions of the two data sources and analysis strategies used to address the thesis research questions. The design and data collection methods of the health care provider surveys and household surveys in the four provinces are presented, followed by the specific strategy of using information from each database for the thesis objectives. The chapter ends with a presentation of the overall strategy of data analysis.

Chapter 5 assesses availability of the commune health care system in rural areas of Vietnam with empirical data from all the four provinces. The findings show that both public and private health care providers are available in rural Vietnam, with a slight dominance of private services. There were commune health centers (CHCs) in all communes with at least one private physician in the majority of the communes. The average number of private providers ranged from 2.7 to 7.7 per 10,000 population in the four provinces. Many of them practiced without formal registration and under limited government supervision.

Chapter 6 estimates perceived need of care by measuring the burden of non-fatal health problems with data from 3,498 people of 900 households randomly selected in Hung Yen province. Compared to the better off, the poor suffered significantly more long-term health ailments (an excess of 78 cases per thousand population) and more short-term morbidity (an excess of 112 cases per thousand population). The study found that the gap in household wealth index contributed approximately 55% of the explained gap in prevalence of long-term health conditions, equivalent to the gap of 60 cases per thousand population, and also 55% of the explained gap in short-term morbidity, equivalent to the gap of 38 cases per thousand population between the two groups based on the Oaxaca decomposition (D=0). Gaps in education, gender, health insurance, and occupation played a minor role in explaining the wealth-related inequalities in non-fatal health burden.

Chapter 7 describes patterns of use of health care services when people are ill by type of providers, by type of illnesses, and by poverty ranking level. Findings in this chapter reveal a high level of self-medication, greater access to private than public services, and less use of public services or any health care services by the poor in comparison to the better off. Self-funded purchases of drugs for self-medication and use of private curative services were even common in those with health insurance. A single private provider contact for treatment of illness costs on average 2.6% of the total annual expenditure per capita, and self-medication with drugs purchased at private health care facilities costs 1.0% of total annual expenditure per capita, similarly these at district hospitals and commune heath centers were similar. Finally, the percentage of ill people with no

access to any health care providers during their illness episode was high, regardless of their wealth or health insurance status.

Chapter 8 compares the quality of private and public health services using a framework proposed by the World Bank for evaluating the quality of health care in developing countries. Results from this chapter show that technical quality of care was poorer in the private sector than among public providers while costs for patients were similar in private and public facilities, and client satisfaction was similar in public and private facilities.

Chapter 9 summarizes the results from Chapters 5-8 to identify the main characteristics of the rural health system with a view to system sustainability and proposes policies and strategies for strengthening the quality of the public health care sector and improving its equity and efficiency. The main features of the current rural health care system in Vietnam identified from the community-based evidence found in this research are: (1) primary health care services are available and there is equality in physical access; (2) financial resources for the CHC system are diversified with Government resources the key contributors; (3) private health care providers for outpatient services, public providers for inpatient services; (4) quality of treatment services is below the national standard; (5) public services are available but under utilized; (6) the rural health care system is not a pro-poor system; (7) direct payment is the main component of total health care expenditure; and (8) the economic relationship of the rural health care system is a user-provider model rather than a health care triangular model.

Nine recommendations to strengthen the rural health care system were then developed based on a critical view of the objectives of the Vietnam health sector reform for the period 2001-2010 supported by evidence found in this research. This chapter ends with a section to remind readers about the limitations of this study and then proposes future research with specific questions covering three main dimensions of health care system reform in Vietnam (accessibility, quality of care, and overall management). A study with a sentinel site approach to follow-up the impact of the social and health sector reform policies is also proposed to help the government make timely adjustments to their policies to protect the poor.

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