



What Makes for an Effective Commune Health Center? Assessment of Major Elements



TO BUILD AND SUSTAIN CAPACITY FOR PRODUCING AND USING
SOCIAL RESEARCH FOR EVALUATION AND DECISION MAKING IN
VIET NAM'S HEALTH SECTOR - PHASE 2

Grant Number: 21293

Grant Period: July 1, 2012 to August 31, 2018

Grant purpose: To help inform the work of The Atlantic Philanthropies and its grantees through an evaluation of the Population Health Programme in Viet Nam, and to build indigenous social research capacity for program evaluation and decision making through the evaluation.

7 January 2019

Authors:

Associate Professor Le Thanh Sang. PhD

Nguyen Thi Nhung. MA. PhD Candidate

Southern Institute of Social Sciences, Vietnam Academy of Social Sciences

Grantee: Social Science Research Council

One Pierrepoint Plaza, 15th Floor

Brooklyn, NY 11201 USA

Telephone: (00) 1 (212) 377-2700

Fax: (00) 1 (212) 377-2727

Web: www.ssrc.org

Acknowledgements

This report is based on the main findings from a large-scale longitudinal study of rural health care in Vietnam from 2008 to 2016. Funded by The Atlantic Philanthropies (AP), a limited life foundation, the study was jointly conducted by the Social Science Research Council (SSRC) and the Vietnamese Academy of Social Sciences (VASS), and at arm's length from AP.

The research project was jointly designed by SSRC international advisors (Professors Anil Deolalikar, Judith Tanur, Hy V. Luong, and David Featherman, Dr. Mary McDonnell, Ms. Van Bich Thi Tran, and Ms. Nina R. McCoy); VASS team leaders (Professor Đặng Nguyễn Anh, Professor Nguyễn Hữu Minh, Associate Professor Vũ Mạnh Lợi, and Associate Professor Lê Thanh Sang); and Dr. Lê Minh Giang of Hanoi Medical University. Data collection was carried out by the case study team from the Southern Institute of Social Sciences (SISS) (with Associate Professor Lê Thanh Sang and Ms. Nguyen Thi Nhung as field supervisors), as well as by many other researchers from SISS, the Institute of Sociology, and the Institute for Gender and Family Studies, among other units.

This report was co-written by Associate Professor Lê Thanh Sang and Ms. Nguyễn Thị Nhung based on their analyses of the longitudinal study data and main findings of the Case Study Team, which included the co-authors and Ms. Nguyễn Thị Minh Châu, Ms. Nguyễn Đặng Minh Thảo, Mr. Nguyễn Ngọc Toại, Mr. Trần Khánh Hưng, and Ms. Trần Thanh Hồng Lan. To complete this report, we have worked closely with Professor Hy V. Luong and Dr. Mary Byrne McDonnell and received precious advice and detailed comments. We are extremely grateful for this valuable help. This report has also benefited from comments from Professors Anil Deolalikar, Judith Tanur, Đặng Nguyễn Anh, and Nguyễn Hữu Minh, Associate Professor Vũ Mạnh Lợi, Ms. Van Bich Thi Tran, and Ms. Đào Thị Khánh Hòa.

We are grateful to Ms. Van Bich Thi Tran and Ms. Le Anh Phuong for their assistance in translating our report from Vietnamese into English and to SSRC Program Associate Alethea Cook for editing the text and figures.

The research project received strong support from AP's Strategic Learning and Evaluation program executives, as well as from Dr. Lê Nhân Phương, AP's former country director for Vietnam, and Dr. Nguyễn Trọng Hậu, the former program executive for the primary health care grants.

Finally, we owe our Vietnamese informants and respondents in the Thai Nguyen, Khanh Hoa, and Vinh Long provinces a great debt for their willingness to share with us valuable information on their lives and their families. The research would not have been possible without their understanding and the support of the commune health center heads and staff and local officials in the twelve commune sites over the years.

What Makes for an Effective Commune Health Center?

Assessment of Major Elements

Associate Professor Le Thanh Sang and Ms. Nguyen Thi Nhung

I. Introduction

This paper aims to develop the basic components of effective commune health center (CHC) models for different rural areas in Vietnam. These CHC models need to adapt to local socioeconomic contexts, health care demands of local people, demographic and migration trends, and changes in health and health insurance policies aimed at improving the quality of CHCs. To date, CHCs have made great achievements in health care for rural people, but the quality of health care services in many CHCs is still limited due to unsynchronized and outstretched investments and ineffective use of invested resources. Changes in health and health insurance policies in recent years have led to a decrease in client numbers—both those with and without health insurance—for many CHCs, and to an increase for some CHCs. Although there is a clear distinction in the ability to attract clients among CHCs, the assessment of CHCs based on the Ministry of Health’s National Benchmarks for Commune Health to 2020 (hereafter “National Benchmarks”) does not differentiate between high quality and poor quality CHCs. Therefore, an evaluation of the major components of a well-functioning CHC is necessary. It is useful to develop a toolkit for assessing CHCs in different contexts, and to identify elements of best practices within CHCs for replication. The development of appropriate CHC models and the means by which to increase investment effectiveness in CHCs without increasing the budget are meaningful policy issues.

Our analysis is based on findings from a case study of 12 communes¹ in six districts within Thai Nguyen (TN), Khanh Hoa (KH), and Vinh Long (VL) provinces from 2012-2016. The case study was conducted by the Southern Institute of Social Sciences (SISS) research team as part of the Social Science Research Council (SSRC) and Vietnam Academy of Social Sciences (VASS) Provincial Population Health Study (hereafter “the Study”). In each commune, at least one experienced researcher observed CHC activities for a week, interviewed their staff and clients, and gathered administrative data. Other researchers examined demographic and socio-economic aspects and health care policies at the commune, district, and provincial levels, and interviewed local authorities and collected secondary data. Although the case study of 12 communes is not representative of all CHCs nationwide, the in-depth study allows us to gain a comprehensive understanding of the elements of an effective CHC and the impact of interventions to improve access to and the quality of health care.

In addition, a new policy went into effect in January 2016 allowing people with health insurance to obtain a medical exam or treatment at any CHC or district hospital within their own province (*chính sách thông tuyến* or “one line” policy). In order to assess the impact of this policy on CHC usage, the research team returned to four CHCs in Thai Nguyen and Vinh Long provinces (TN3, TN4, VL3, and VL4), and interviewed by phone the leader of one CHC in Khanh Hoa province (KH1) in September 2016. The supplemental information helped us to consolidate previous findings on the need to develop effective CHC models based on good practices.

¹ Of the 12 surveyed communes, six met the National Benchmarks: TN4, KH1, KH2, VL3, VL1, and VL2. Communes that failed to achieve these benchmarks include TN3, TN1, TN2, KH3, KH4, and VL4.

The paper consists of three main sections. First, we assess two good practices at VL3 and KH1 CHCs based on the major components in the toolkit for evaluation (see Appendix 1). Next, we point out the limitations of the classification of CHCs based on the National Benchmarks for commune health care, which do not encourage the improvement of CHC quality. Finally, we make policy recommendations aimed at developing major components of CHC models and investment orientations for CHC models appropriate to different rural areas. This is supported by qualitative evidence from the Study.

II. Good practices at VL3 and KH1 CHCs

1. The case of VL3 CHC in Vinh Long province

First, we offer VL3 CHC as a model that has attracted a large number of clients over time, and as one of the CHCs that increased its number of clients after implementation of the “one line” policy, instead of losing clients like most CHCs. “Since implementation, there has been on average an increase of 200 patients per month. It has not increased as much as it could because some people are still accustomed to going where their health insurance is registered. As such, it is projected that in the future, VL3 CHC will have an increase in clients.”²

Human resource advantage

Like other CHCs, human resources in VL3 CHC met the National Benchmarks. However, due to its central location for land and water transportation and proximity to a market, VL3 CHC is convenient for residents to seek healthcare services. Therefore, the number of residents who came to VL3 CHC was about two to ten times higher than that of many other CHCs. The difference in the number may actually be higher because some CHCs inflated the number of patient visits. While some CHCs inaccurately reported more visits to meet targets, VL3 CHC did not need to inflate their numbers and had more than the number of visits they reported.³ The demand for services led to the CHC contracting five additional workers.⁴ This helped enhance the CHC’s medical examination and treatment capacity and other functions.

² Interview with CHC head, VL3 CHC, December 2016.

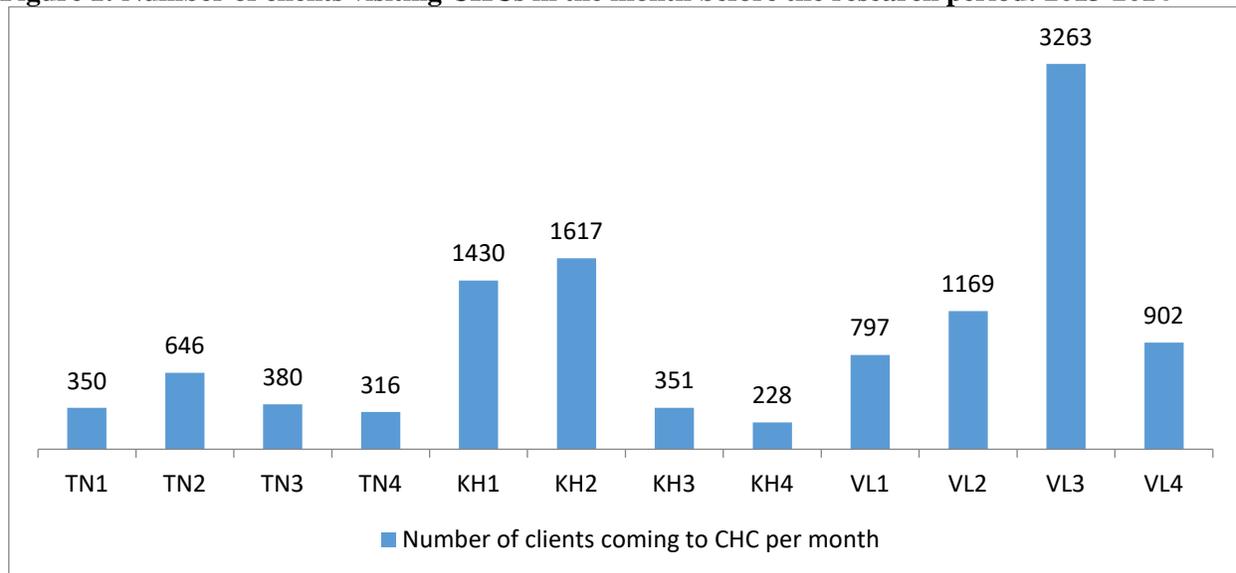
³ During a week of observation in each CHC, the research team discovered that some CHCs reported false figures because so few patients came for examination and treatment. By contrast, many patients went to VL3 CHC for examination and treatment, but the CHC head did not want to fully report their patient numbers, which were high due to public-private activities and their own innovations.

⁴The five contracts included: (1) A private dentist to provide tooth extraction tools at the CHC, which he self-financed. The CHC neither paid nor took fees from contracted staff for the expansion of healthcare services at the CHC. In return, contracted staff, when not busy with clients, helped CHC staff do paperwork (e.g. recording exam and treatment information in notebooks, especially for referrals); (2) A person with a certificate in accounting to record health insurance prescriptions on the computer and to work as a bookkeeper for the CHC, while she studied pharmacy at an elementary level; (3) A health worker to be in charge of medicine sales for the CHC medicine cabinet (the CHC had its own medicine sales business and its own business permit); and (4) Two health workers to help with examination and treatment and making stiches. Furthermore, the contracted staff also performed other work, like village healthcare (with payment for being the village healthcare workers). This was convenient for the CHC because these people were involved in the health sector, so they more readily understood health-related issues and were able to perform other work, like implementing the National Targeted Health Care Programs. Regular permanent staff were expected to carry out these activities, but the CHC allowed contracted staff to share the workload to gain additional income and to reduce the workload for permanent staff, who had many patients at the CHC for exams, treatment, and other healthcare services.

Although VL3 commune does not have a doctor trained in family medicine, such as in KH1 commune (see below), it currently has two doctors. This has also helped to improve its quality of service. People in rural areas prefer a CHC with a doctor so they do not have to go to the district level, which is usually farther away and has longer waiting times. That VL3 CHC had two doctors ensured that residents have a suitable alternative to stay with their CHC and not seek care at the ever more crowded district hospital, due to the “one line” policy that allowed unrestricted access from all communes. Moreover, people from outside the commune, free now to go to any CHC, have increasingly sought care from doctors at VL3 CHC instead of going farther and having to wait longer at the district level.

VL3 CHC also has two female staff members with specialization in obstetrics and gynecology, including a midwife who holds a bachelor’s degree and is able to perform ultrasound exams. The CHC has a special room for obstetric and gynecological exams that is fully equipped and has two ultrasound machines. The availability of an ultrasound exam attracts many clients, including female clients from outside the commune.

Figure 1: Number of clients visiting CHCs in the month before the research period: 2013-2014



Source: CHC reports

Diversification of health services and a public-private service model

The head of VL3 CHC said that due to barriers in health insurance paperwork and regulations, many CHCs did not want to provide services covered by insurance or, in order to receive salaries from the state, only offered the minimum required. In contrast, VL3 CHC provided not only medical examination and treatment covered by health insurance, but also those that were not. Examination and treatment provided to insured and uninsured patients at VL3 CHC attracted many additional patients.⁵ There were also clients seeking traditional medicine services (especially acupuncture), bandaging of injuries, obstetrics-gynecology exams, ultrasound examinations, and medicine.

⁵ For each health insurance examination, the health insurance district office paid CHC 4,000 VND (less than 20 US cents) per person.

The decisive factor to the CHC's success in attracting more clients was that the CHC head dared to diversify services and combine public and private services in organizing examination and treatment activities. Partnering private with public healthcare services was necessary to meet client needs and added to the CHC's prestige, thus attracting even more clients. For example, the CHC contracted with a private specialist in traditional medicine to provide services like acupuncture and massage and traditional medicine. It became the most effective among the 12 studied in using traditional medicine and equipment, and attracted many patients. The head also distributed the workload and income from pay-on-demand services fairly among the staff. It was the CHC head, not upper level managers, who made all of the decisions, including on financial matters. The volume of clients generated a remarkably high income for VL3 CHC,⁶ from which they could pay contracted workers.

Leadership is dynamic and takes responsibility for problems of the CHC

The success at VL3 CHC shows that the qualities of a leader are also critical. A CHC leader should dare to be an entrepreneur, take responsibility, and be highly devoted to functions of the CHC. The head of VL3 CHC stated, "We have to know how to take care of ourselves, because if we waited for help, we would be sitting until we died." The head found and paid an accountant, as a contracted worker, to solve problems that many other CHCs complained about, such as settling the monthly balance sheets with the health insurance office and preparing financial reports for higher authorities. He contracted with a private provider to offer dental services at the CHC, aiming not for income, but to expand the services available to attract more clients. This was a renovation at the CHC level in a context in which the CHC had decent infrastructure but limited healthcare services, so few clients came to it.

Organized all health workers to provide income-generating health services within the CHC, and not outside of the CHC

One of the factors that brought success to VL3 CHC was that no CHC staff was involved in private healthcare services outside of the CHC; instead, they focused on work at the CHC. In contrast, many staff at other CHCs had their own private healthcare services, including medicine sales, injection provision, and fluid transfusion. Doing so, they lacked enthusiasm in examining and treating regular patients with health insurance and performing preventive and other related work. At KH2 CHC, each staff member sold medicine from their own supply at work and, outside of work, provided private services at the patient's home. Staff at TN1 CHC sold their own medicine during work and even cut down their work hours to provide services privately. A large number of clients complained about this practice. In TN2 CHC, the CHC head had her own clinic right in front of the CHC and directed clients to go there instead of the CHC, and usually used CHC equipment for her own private services. These self-interested practices resulted in low quality of examination and treatment, and a loss of patients seeking care at the CHC. The high volume of patients seeking examination and treatment at VL3 CHC showed that it is possible for a CHC to attract many clients, both with and without health insurance, if there is a good organizational model in place.

⁶ This additional income, considered relatively high by healthcare staff here, was not made known to higher authorities and outsiders.

The interventions, especially the Marie Stopes International (MSI) program, have improved the attitude of health workers towards patients

In addition to these qualities, the CHC head and staff were mindful of their behavior toward patients and always conscious of client service. Staff practiced in ways that left patients satisfied and happy to return, and patients also told others to use the CHC services. This include strict adherence to the work schedule, punctuality, and having a happy, harmonious, and enthusiastic attitude. One health personnel said, “We also heard some people say that at other CHCs the doctor is harsh [rude], so we learn from this experience. I told the staff that regardless of what the patients say, we must be cheerful and soft spoken.”⁷ For example, they will courteously say, “Auntie, wait a little,” instead of “Mrs., sit here and wait a bit.”

The MSI program was launched at VL3 CHC between January 2011 and April 2012, and included not only professional training, but also training on client reception and patient communication for all health workers within CHCs, including the head, doctors and physician’s assistants, midwives, nurses, and pharmacy staff. This provided synchronization of professional work in the organization. The head of the CHC said, “The program is very good—patient and friendly. They train themselves with skills, such as how to receive and communicate with patients, how to provide emergency care, including first aid, washing hands ... then there are some good games for staff to participate in collective activities.” Although Vinh Long has 109 CHCs, when the Study provinces were checked on gynecological examinations, VL3 CHC was a model in good performance. On a daily basis, the obstetrics and gynecology room in VL3 CHC also attracted more patients from neighboring communes.

Have a good distribution of responsibilities and benefits and encouraging staff morale

VL3 CHC also epitomizes a fair distribution of workload and income that made staff feel good and motivated to work actively as a team. Payment was commensurate with efforts and not because they were permanent staff. If they worked more, they received more money. If they did less work, they received less money. In one specific case, the CHC head made it clear that for each ultrasound performed, the patient would pay 20,000 VND. Of this amount, the staff who performed it would receive 5,000 VND and 15,000 VND would be contributed to the CHC’s common income pool. The CHC head’s fair and transparent management style and distribution of extra income served as an important factor in incentivizing good performance. Because the staff was motivated to serve clients, they made effective use of their knowledge and professional skills. They also utilized education, counseling, and communication skills that they gained from the MSI Sisterhood Program in working with clients at VL3 CHC, especially in their attitudes and interaction with the patients.

2. The case of KH1 CHC in Khanh Hoa province

Even though the number of clients who went to KH1 CHC was much smaller compared to that at VL3 CHC⁸ and there were no additional contract workers, KH1 CHC had a good leader and a team of high-quality, devoted staff. The staff only provided examination and treatment services at the CHC, and there was also a policy in place for expanding services at the CHC beyond those offered by the CHC and during office hours, so they achieved much higher efficiency than many other

⁷ Interview with CHC staff, VL3 CHC, May 12, 2016.

⁸ Our fieldwork research in 2011 and 2014 at KH1 CHC showed that the figures provided were reliable. They did not fake the number of patient visits, and as one of the few good CHCs, had a large and stable number of clients.

Study CHCs. In August 2013, the Minister of Health visited KH1 CHC and declared it to be a model CHC. Similar to VL3 CHC, after the “one line” policy was implemented in January 2016, KH1 CHC also increased its number of clients.

Human resource advantage

At the time of the Study, human resources for healthcare, like doctors and physician’s assistants were seriously limited and this significantly impacted the quality of healthcare of the whole district of Ninh Hòa. However, KH1 CHC was one of the four CHCs where there was a family doctor. Dr. L. graduated as a general practitioner in 2002, pursuing in-service tertiary education while working as a physician’s assistant at the CHC. After completing a two-year family doctor training program conducted in Ninh Hòa district and funded by The Atlantic Philanthropies (AP), this staff member graduated in 2009 with a level I specialization. He also took a dental course for a year and completed a three-month ultrasound training course funded by AP in 2011 in Ho Chi Minh City. The doctor’s high qualifications, training, and skills were a big advantage for the CHC and attracted many patients within the commune and from neighboring communes. Residents from other communes also bought and registered their health insurance at KH1 CHC, due to the presence of a good doctor and because they could obtain quality examination and treatment at the CHC and avoid long waits at the district levels.

KH1 CHC had a midwife and an obstetric-pediatric physician’s assistant whose expertise in obstetrics was second to none in the area. The CHC attracted many pregnant women who went there for child delivery due to the skills and reputation of these professionals. The research team heard many praises about these professionals from local residents, colleagues, and authorities.

Figure 2: Number of obstetric-gynecological clients at KH1 CHC in 2008, 2012, and the first six months of 2013

Services	Payment	2008	2012	First 6 months of 2013
Child delivery at CHC (person)	Fees	144	161 ^(*)	47 ^(**)
Gynecological exam (visit)	Free	910	708	289
Pre-natal exam (visit)	Free	611	643	67
Counseling (visit)	Free	1036	936	206
Home visits for pregnant women	Free	132	156	39

() 37 of them had health insurance; (**) 23 of them had health insurance*

Source: KH1 CHC

Compared to 2008, the number of people who came for child delivery at KH1 CHC in 2012 increased. Also, since early 2012, the CHC began to receive mothers with health insurance to come for child delivery at the CHC. Those without health insurance commonly had to pay between 800,000 and 1,000,000 VND for each delivery, including medicine and service fees. However, in the first six months of 2013, the number of child deliveries at the CHC decreased. According to CHC staff, this may have been caused by the tendency to have fewer children, a preference for hospitals, and health insurance not paying for deliveries at the CHC. Despite this, compared to the other CHCs, more residents delivered their babies at KH1 CHC. For some CHCs, no birth deliveries have been performed in recent years.

Diversification of health services and a public-private service model

KH1 CHC provided not only health insurance examination and treatment, but also non-health-insurance examination and treatment. At the time of the Study, healthcare services at KH1 CHC consisted of (1) obstetrics, (2) medicine cabinet (Bamako medicine cabinet), (3) examination and treatment services (including injections, fluid transfusion), (4) making stitches, and (5) providing diagnosis and testing with high-tech equipment, such as ultrasound and electrocardiogram. KH1 CHC provided 24/7 healthcare services—well beyond the typical eight office hours. Of the 27 CHCs in Ninh Hoa district, KH1 CHC was one of the few successful CHCs in providing private or pay-on-demand services at the CHC. This success at KH1 CHC has been acknowledged by authorities at upper levels who would like to expand this model, because it increased CHC staff income. This in turn encouraged staff to work harder and incentivized them stay with the CHC, especially when there was a lack of good doctors and physician’s assistants in the healthcare industry.⁹

The combined public-private healthcare services at the CHC increased the prestige of the CHC and attracted more clients. As stated by the head of KH1 CHC, many CHCs did not want to provide examination and treatment for health insurance patients due to challenges in paperwork and health insurance regulations, and thus provided them at a limited rate to earn state salaries. However, with private services at KH1 CHC, this CHC still effectively conducted health insurance examination and treatment to attract clients to come for expanded services.

Leadership is dynamic and takes responsibility for problems of the CHC

The head of KH1 CHC had been awarded a “Physician of Excellence” title by the State and established fame as an excellent midwife physician’s assistant in the area. In addition to managing the CHC as its head and performing her professional work, she held several leadership positions in the commune. She was a Commune Party member, Commune People’s Council member, and member of the Executive Board of the commune Women’s Union. With these many roles, she advocated for favorable conditions for the CHC in building plans, objectives, and activities for commune healthcare, as well as making recommendations and performing specific responsibilities of the CHC to meet local people’s needs for health protection and care. The head of this CHC proudly said that she can speak to different constituents.

Organized all health workers to provide income-generating health services within the CHC, and not outside of the CHC

As in VL3 CHC, one of the crucial factors that contributed to the successful examination and treatment activities at KH1 CHC was that staff did not provide private services outside of the CHC, but instead all focused on services at the CHC. Even though the head of KH1 CHC had a private

⁹ The research team worked with two leaders of the Ninh Hoa District Healthcare Center and they both thought highly of the success of private services at KH1 CHC. Because of the new construction and expansion of healthcare at district and provincial public hospitals, many upper-level facilities were ready to recruit good doctors and physician’s assistants, especially those who graduated from the family doctor program. This made it hard for CHCs to keep their staff if they did not provide on-demand or private services at the CHC to supplement low salaries and income and limited promotion opportunities. At present, most doctors who graduated from the family doctor program in Khanh Hoa did not work at a CHC, and instead worked in upper level hospitals. Those interviewed highly assessed the quality and the usefulness of the family doctor training program, but the challenge is that CHCs could not attract or retain these doctors to work on a long-term basis.

healthcare clinic funded by Blue Star,¹⁰ very few clients went there, because the head spent her work hours at the CHC and wanted clients to come to the CHC. The head's and staff's devotion and collective interest made this CHC different from other CHCs, where leaders and staff prioritized individual interests at the CHC's expense and were satisfied with being average.

The interventions, especially the Marie Stopes International (MSI) program, have improved the attitude of health workers towards patients

With the above-mentioned favorable factors, KH1 CHC was often chosen to implement pilot healthcare programs. For instance, it was selected as a CHC to receive new physical infrastructure in the initial period and chosen to be the first CHC for the MSI program, for both the family doctor program and a pilot program for high-tech equipment (all funded by AP). The investments created favorable conditions for the CHC and were largely successful, despite some hard-to-control factors, like health insurance policies.

The MSI program, implemented at KH1 CHC from September 2007 to December 2009, was assessed by the Khanh Hoa healthcare department authorities as one of the most successful among one-third of CHCs in Khánh Hòa province that still maintained their activities after project completion. Reproductive healthcare services, such as normal birth delivery, prenatal exam, gynecological exam and treatment, abortion, and healthcare counseling at KH1 CHC attracted a large number of patients. This program provided training to healthcare staff and CHC heads on necessary knowledge and skills related to the individuals' roles. One CHC staff said, "MSI provided training in various aspects of professional knowledge and skills, management, education, publicity, office layout, etc." Based on upgraded professional knowledge and skills, as well as skills taught by MSI in education, counseling, and communication with clients, staff employed more gentle attitudes and behavior with clients, and attracted a remarkable number of patients.

Have a good distribution of responsibilities and benefits and encouraging staff morale

Fairness and transparency in the management of work and in the distribution of increased benefits of CHCs are important factors in the positive effects of health workers. All staff in the clinic work in harmony. While each staff member performs within their own area of expertise, the profit from private services is included in the CHC general fund and, at the end of the month, is divided equally to the staff. For a CHC that offers a wide range of services, including childbirth, medical examination, treatment (e.g. infusion, pharmacy, etc.), and outpatient services (e.g. electrocardiography, ultrasound, etc.), monthly staff income tends to increase for well-performing staff, thus increasing staff morale. Most importantly, the head of the CHC knew how to divide the work and income fairly, so the CHC staff worked very actively.

3. Performance of CHCs after the implementation of the "one line" policy

The "one line" policy went into effect on January 1, 2016, allowing those with health insurance to seek medical examination and treatment at any CHC and district level public hospital in the same province. Dan Tri Newspaper reported on May 1, 2017:

¹⁰Blue Star Organization (<http://bluestar.org.vn/>) is a network for reproductive healthcare and family planning working since 2008. Marie Stopes International (MSI) is one of the funding organizations for these activities in many provinces and cities in Vietnam.

After implementation of the policy, medical exams and consultations at CHCs were greatly reduced. In 2015, there were 32.7 million patient visits for medical examination and treatment in CHCs, but in 2016, only about 30.5 million. Within the country, 38 provinces saw decreases in patient visits to CHCs ranging from 10% to 30%. This has led to an increase in health care costs for medical examination and treatment at the higher level. However, the cost of medical examination and treatment at the commune level has not gone down. Due to the “one line” policy, many people prefer to visit higher levels.¹¹

As such, following the implementation of the “one line” policy, service quality at CHCs must be improved in order to attract patients to reduce overcrowding and health care costs at higher levels.

In our September 2016 supplemental survey, which was done in person at four CHCs in Thai Nguyen and Vinh Long and by phone with KH1 CHC in Khanh Hoa, we saw that for a few CHCs, the number of patients increased significantly, but in many, it decreased. More specifically, among the five CHCs studied, three CHCs saw a reduced number of patients (TN3, TN4, and VL4). Two CHCs (VL3 and KH1) saw an increased number of patients after the “one line” policy was implemented. This raises the question of whether it is the policy itself, the quality of service in each CHC—including infrastructure, equipment, medicine, skilled medical personnel, and attitudes of medical staff—or the geographical conditions of each CHC that attract different patients. Our answer is that the quality of services in each CHC will attract patients, despite the change in policy.

III. Reappraisal of the National Benchmarks

1. Reasons to reappraise the National Benchmarks

Presently, CHCs in Vietnam are assessed on the basis of the National Benchmarks for Commune Health. However, the National Benchmarks were constructed to “assess activities for health protection, care, and enhancement for residents of all communes, wards, and districts (hereinafter all referred to as ‘commune’), rather than simply to assess CHC activities.”¹² The CHC and CHC staff are central to, but are not the exclusive focus of, the benchmarks. This has led to a situation in which some benchmarks may be irrelevant or unnecessary in assessing certain CHC activities. Furthermore, the benchmarks focus mainly on measuring infrastructure and physical materials and thus do not truly reflect the quality of CHC activities. The indicators and scoring of the benchmarks have not adequately emphasized **the function of examination and treatment and the quality of this function** at CHCs. Some assessments are mainly based on **subjective remarks or those that are hard to prove**, so they have not yet become useful tools that can help to screen and identify differences across CHCs. Besides, the National Benchmarks have not paid due attention to population and socioeconomic trends in rural areas, which may influence disease and healthcare behavior patterns of different population groups, as well as impact the role of CHCs in the healthcare system, especially in the context of rapidly growing private healthcare services.

¹¹ Voice of Vietnam. Thông tuyến bảo hiểm y tế: Nơi chật cứng, chỗ hiu hắt bệnh nhân (Health insurance: a tight place, a flickering place for patients.) Dan Tri Newspaper, 2017. <https://dantri.com.vn/viec-lam/thong-tuyen-bao-hiem-y-te-noi-chat-cung-cho-hiu-hat-benh-nhan-20170510110335756.htm>.

¹² Decision No. 4667/QĐ-BYT dated 7/11/2014 of the Ministry of Health: Directions for Implementation.

In the meantime, our case study shows that despite being ranked the same under the National Benchmarks, CHCs varied greatly in quality. While many CHCs had few patients, others were dynamic and attracted numerous patients, including those beyond their own communes. Yet, thus far, high performing CHCs' successes have not been acknowledged and assessed as a possible model for expansion. Furthermore, trends in rural socioeconomic change should also be considered in building benchmarks to assess the adaptability of CHCs to new conditions. Trends in aging populations and rural-urban migration can increase the rate of elderly people in rural areas, because the elderly have less mobility than young people to migrate to urban areas. CHCs should prepare for suitable health protection, care, and improvement for aging populations in rural communities. Economic development trends and rapidly growing private healthcare services have not only created more choices for residents with decent income, but have also made the poor, ethnic minority populations, and other vulnerable populations more dependent on CHCs and government support.

Recognizing the need to enhance examination and treatment quality at CHCs and other healthcare providers, the Ministry of Health issued Decision No. 4276/QĐ-BYT on October 14, 2015 approving the National Action Program to Enhance the Management of Exam and Treatment Quality until 2025. Some important contents of this Decision include: (a) Building the Benchmarks for exam and treatment quality at CHCs and general clinics, (b) Designing policies to incentivize quality improvement of healthcare providers and staff, and (c) Building a quality management system and integrating quality management into activities of healthcare providers. This has also created the objective need to reassess, adjust, and supplement some indicators in the National Benchmarks for commune health.

In addition, the health insurance policy that went into effect on January 1, 2016, pursuant to the 2014 Law Amending and Supplementing the Law on Health Insurance, stipulates that the insured has the right to be examined and treated at the CHC, polyclinic, or district hospital in their home province. In the past, generally the insured was limited to going to only to the CHC where they reside and must be referred to the next level of care, or were allowed to be registered and seek care first at the district level, but would not get full health insurance benefits for seeking care at the CHC. Increased portability of health insurance significantly reduced the number of people who visited CHCs and increased the usage of higher-level health facilities. To stem this and the higher costs for the state health insurance agency, it is necessary to increase the quality of medical examination and treatment at CHCs.

Recently, the Ministry of Health¹³ and the People's Committee of Ho Chi Minh City,¹⁴ in conjunction with the Viet Anh Health Joint Stock Company, decided to permit Ward 11 CHC in District 3 to provide health services for people based on the family doctor model from May 19, 2017 onward, while still maintaining regular CHC functions. The CHC is equipped with necessary equipment and staffed with a team of doctors and consultants, receives technical support from major hospitals, and operates in a way that is convenient for patients. The public-private model of

¹³According to Decision No. 1568/QĐ-BYT dated 27/4/2017 of the Ministry of Health approving the plan for expanding and developing the family doctor's clinic in Vietnam for the period 2016-2020. Within this decision, CHCs are authorized to operate based on the principles of family medicine.

¹⁴ According to Decision No. 186 /QĐ-UBND dated 17/4/2014 approving the development plan of health sector in Ho Chi Minh City up to 2020 with a vision to 2025.

service at the CHC has attracted many clients, including health insurance clients, because clients receive quality services without having to travel long distances and wait for a long time.¹⁵ This model is being piloted prior to scaling it up to the whole city and in the future, to the whole country. This demonstrates that improving the quality of healthcare at the CHC is very important.

2. Some limitations of the National Benchmarks for CHC activities

Some benchmarks are not suitable or are unnecessary in assessing CHC activities

The National Benchmarks for commune health activities consist of 10 benchmarks¹⁶ with 46 indicators, and a total of 100 points. Because the purpose of the benchmarks is to assess all activities for health protection, care, and enhancement for people in the whole commune, there are some benchmarks that go beyond the scope of CHC activities. These benchmarks depend on many other factors and most are beyond the control of the CHC, such as indicator 22 (Benchmark 5) on residents' participation rate in health insurance in the commune, indicator 24 (Benchmark 6) on the proportion of households in the commune using hygienic water, and indicator 25 (Benchmark 6) on the proportion of households in the commune using hygienic toilets.

Despite being directly related to CHCs, some other benchmarks mainly depend on local state management offices at commune and district levels. In these cases, the CHC is a “beneficiary” and the CHC head is only responsible for implementing state policies at the CHC. These benchmarks, for example, include indicator 6 (Benchmark 2) on full implementation of Government policies for CHC staff, village health workers, and other medical staff; and indicator 21 (Benchmark 5) on the provision of sufficient and timely funding for regular expenses to CHCs and on CHCs conducting financial management as required.

The structure and scoring of the benchmarks are not yet appropriate to CHC functions

The CHC has eight major functions and responsibilities, as specified in the National Benchmarks for commune health.¹⁷ However, the benchmark structure and scoring are not suitable to the importance of these functions. Within the 10 benchmarks, CHC activities are the main focus in benchmarks 6, 7, and 8, but the total points for them is 44 out of 100 total benchmark points:

- Indicator 29 on medical examination and treatment function at CHCs (5 points)
- Indicators 23 and 28 on disease prevention and control (7 points)
- Indicators 29 and 33 on exam and treatment and hospital referral (6 points)
- Targets 34 to 40 on mother and child care (13 points)

¹⁵ Thanh Son. Trạm y tế đạt chuẩn, người dân hưởng lợi (The CHC meets standards, the people enjoy the benefits.) Saigon Giai Phong Online, 23 May 2017. <http://www.sggp.org.vn/tram-y-te-dat-chuan-nguoi-dan-huong-loi-446277.html>.

¹⁶ The ten National Benchmarks include: Benchmark 1: Direct, manage healthcare activities; Benchmark 2 : Healthcare human resources; Benchmark 3: CHC infrastructure; Benchmark 4: Equipment, medicine, and other facilities; Benchmark 5: Planning-Finance; Benchmark 6: Preventive Medicine, prevention, and control of HIV/AIDS, environment hygiene and food safety; Benchmark 7: Exam and treatment, rehabilitation and traditional medicine; Benchmark 8: Maternal and child healthcare; Benchmark 9: Population-Family planning; and Benchmark 10: Communication-health education.

¹⁷ CHC functions and responsibilities were adjusted into nine contents in Circular No. 33/2015/TT-BYT dated 27/10/2015 of the Minister of Health, but the functions remain basically the same.

CHC examination and treatment activities can score a maximum of five points, even though the CHC has the function of conducting 1,091 technical services (6.3% of a total of 17,217).¹⁸ Maternal and child health services utilize almost all CHC resources, especially human resources, but total only 26 points. The scoring does not adequately reflect the importance of these activities, and thus fails to encourage CHCs to improve examination and treatment quality and to thereby attract more clients.

On the other hand, more weight is given to benchmark 3 on essential infrastructure (11 points) and benchmark 4 on equipment and medicine (9 points), and since most CHCs have achieved or will soon achieve them, the building and equipment indicators lose their significance as a measure. They include:

- Indicator 8 on CHC land and construction size that meets local residents' needs for healthcare
- Indicator 9 on CHC construction according to criteria in CHC design and construction, and on a sufficient number of rooms with adequate size to fulfill designated functions and responsibilities
- Indicator 10 on the CHC main building graded to be at least level IV
- Indicator 18 on a CHC bookshelf with at least 15 sets of professional books¹⁹

Findings from our case study showed that nine out of the 12 studied CHCs were newly built in the last five years and they fully met National Benchmarks on infrastructure. Only three CHCs were not newly built and their main buildings were of lower quality with fewer rooms, but this had little impact on CHC activities because the working capacity in most CHCs was low. Likewise, equipment for CHCs was widely supplemented in recent years, and this was planned to happen in all CHCs in the near future. Of the 12 studied CHCs, all 12 CHCs were equipped with dental chairs, 11 with a traditional medicine tool set, 10 with electrocardiogram (ECG) machines, and six with ultrasound machines. Medical equipment for village medical workers was also fully provided, as stipulated. All CHCs had sufficient record books and statistics forms as required; sufficient, timely, and precise reports on statistics; and charts and updated statistics on present situations. Although we cannot exclude the necessity of physical facilities in maintaining CHC activities, the points for these benchmarks should be reduced to make them more comparable to other benchmarks, especially the one about exam and treatment, which totals only five points.

Some measures are not yet specific, are subjective, and are hard to measure

Some measures are overly general or they do not focus on assessing quality, which indicates the National Benchmarks' failure to assess the quality of CHC activities. For example, examination and treatment is a crucial function of CHCs but it is only briefly mentioned, framed as a general percentage of technical services that are permitted in Indicator 29²⁰ (Benchmark 7): "CHC has the capacity to conduct $\geq 70\%$ technical services as indicated in designated functions and

¹⁸ Specified in the list of technical services for different healthcare levels, issued with Decision No. 23/2005/QĐ-BYT dated 30/8/2005 of the Minister of Health.

¹⁹ Presently, it was not difficult to have 15 professional books and any CHC could have this, not to mention of availability of Internet making it possible for CHCs to access abundant update professional materials.

²⁰ Refer to Decision No. 23/2005/QĐ-BYT on the list of technical services for CHCs which includes 1,091 out of 17,217 technical services.

responsibilities; ensuring the implementation of common first aid and emergency activities as required by Ministry of Health regulations.” Similarly, it is very difficult to assess and categorize CHCs based on general measures in many other indicators, such as Indicators 26, 13, and 14:

- Indicator 26 (Benchmark 6) on good implementation of food safety activities and timely control of food poisoning cases happening in the commune
- Indicator 13 (Benchmark 4) on having sufficient equipment to successfully carry out designated responsibilities and on having medical staff capable of using provided medical equipment
- Indicator 14 (Benchmark 4) on having sufficient medicine for treatment, anti-shock medicine and common medicine for first aids, and having medicine management conducted as stipulated

In reality, the quantity and quality of services provided by CHCs vary and they cannot be assessed and categorized by these general measures. The lack of specific measures can result in an assessment that is based on subjective remarks and can be influenced by local desires to be acknowledged as having achieved the National Benchmarks.

Our case study findings showed that medicine inventories were different among CHCs in the provinces. Many responses from local resident interviews indicated a lack of medicine at varying degrees in most CHCs, especially by the end of each month. However, this was difficult to clearly ascertain at the CHCs. It was even harder to precisely assess CHC participation and responsibility levels in activities related to food safety and food poisoning.

Our research also showed that there was no current accurate data about health insurance in the communes because people obtain their health insurance from many different sources, and neither the CHC nor the commune authorities had these figures. CHCs only knew the number of residents with health insurance registered for primary examination and treatment at the CHC, whereas many residents received health insurance from their offices or social organizations, and thus did not register for examination and treatment at local CHCs. Additionally, some residents had more than one health insurance registration. Health insurance data collected by different sources often overlapped, yet on the whole, are insufficient because data was not available from all sources. Some CHCs even produced faked health insurance statistics to achieve National Benchmarks. In a work meeting between the Director of the District Healthcare Center and CHC heads, with the participation of our research team, the director said that in many other places, CHCs achieved National Benchmarks because they had false health insurance statistics. Therefore he directed CHC heads to do the same to achieve this indicator (Indicator 22, Benchmark 5).

Self-reporting and incomplete and inaccurate record-keeping also mark another shortcoming of the benchmarks: the statistics upon which scoring is done are sometimes false. We had heard that many CHCs manufactured false figures to achieve some yearly targets in the National Benchmarks. Within the Study, we gained direct information from the surveyed CHC healthcare staff that their figures were higher than the actual number of patient visits. Observations by the research team during one week at each CHC showed that in some CHCs, only a few patients came daily, especially in mountainous areas (i.e. KH4 CHC) as well as in midlands and plains (i.e. TN1 CHC), or they mainly came for hospital referral (i.e. TN3 CHC).

In the period 2011-2020, having the basic is appropriate. In the next stage, [the National Benchmarks] should be more detailed and must go deeper in terms of quality as well as the subsequent need to reduce the portion, judged on the basis of the material, and it should increase the points for quality, because later we will need to increase the professional quality and the quality of service, in order to assess CHCs in the next stage.”

- Director, District Health Center, Thai Nguyen (June 2016 Interview)

Based on the best practices within high performing CHCs and the shortcomings of the existing National Benchmarks, we have developed additional indicators and conceptualize three different models for organizing, equipping, and staffing the CHC to better achieve quality in providing preventive and clinical medical services.

IV. Three models for the effective commune health center

During the 2015 Policy Roundtable that SSRC and VASS organized to discuss the results and policy implications from the Study, participants were asked the question: “Is it necessary to diversify the CHC model to suit the local situation and the needs of local residents?” Many participants answered in the affirmative, in support of flexibility and a diversified model. We now discuss the criteria and indicators for assessing different CHC models, based on three zones or regions. The criteria for classifying the three zones are different than those used in the National Benchmarks, because we also consider the residents’ living standards and availability of alternative providers.

Characteristics of the CHCs in each Zone:

CHCs in Zone 1:

- Delta
- Near the hospital or medical center
- Residents are relatively well off
- Many private service establishments
- Convenient transportation

CHCs in Zone 2:

- Same as for Zone 1, but 10 km from the hospital or medical center

CHCs in Zone 3:

- Highlands, mountainous
- Ethnic minority groups
- Residents are relatively poor
- Few private health services
- Inconvenient transportation

We have developed an assessment tool for CHCs with 28 indicators, which is attached as Appendix 1. The indicators are grouped into ten categories or dimensions: infrastructure, equipment, technical training, drugs, human resources, leadership, organizational structures, staff attitude and behavior, focus on older people, the poor, and ethnic minorities, and quality of care. The scoring for some indicators, especially the ones for equipment (2.2, 2.4, and 2.5) and human resources (5.1, 5.2, and 5.3), will vary, based on the zone in which the CHC is located. The scoring for indicators such as infrastructure, leadership, and staff attitude and behavior will not be dependent on zones, and all CHCs should meet these standards. Each indicator has a total of 10 points. All 10 points are awarded if the CHC meets the indicators and no point is given if the CHC does not meet it. Where the indicator is not applicable, a zero is recorded. For example, for a CHC in Zone 1, where a doctor is not required (indicator 5.2), the CHC will receive a “0.” For CHCs in Zones 1 and 2 who do not have ethnic minorities in their population (criterion 5.4), they will receive a score of “0.” We will demonstrate how this assessment can be applied by discussing the indicators that are applicable to nearly all CHCs.

1. Infrastructure

1.1. Quality of building

The CHC building and its appearance is one of the most important factors. Surveyed CHC staff stated that having a new building instills confidence and trust among the people in the health facility and the health workers, and it also motivates them. The two-story design in AP-supported CHCs has been adopted by the Ministry of Health (MOH) as being one suitable model. Single-story buildings, like VL3 CHC, also meet standards if they have a sufficient number of rooms for professional activities.

1.2. Number of rooms

An effective CHC has a total of at least 14 rooms for the different functions and services required by the MOH. Almost all health care workers were satisfied with this size and said it was appropriate.

1.3. Fresh water

The CHC should have a source of clean water.

1.4. Traditional medicine or herbal garden

The requirement of a garden or pots with plants and herbs that can be used in traditional medicine is the same as Indicator 30 of the National Benchmarks. CHCs have implemented this well and traditional folk remedies are considered useful. One CHC doctor said, “Nowadays many people are also interested in being treated with traditional medicine. I planted the garden in order to maintain a number of medicines.”²¹

2. Equipment

2.1 Essential medical equipment

Essential equipment for medical examination and treatment and health education and communication, as required by the MOH, should be in all CHCs in all three zones.

²¹ Interview with CHC head, TN4 CHC, May 9, 2016.

2.2. Dental equipment

Many AP-supported CHCs were equipped with dental chairs and instruments, but so far, very few have successfully utilized that equipment. Our research suggests that CHCs currently lack staff with qualifications in dentistry. Therefore, for CHCs to be properly equipped with dental instruments, they need investment in training for staff in dental care, such as performing a tooth extraction or a basic dental treatment. Moreover, not all CHCs need to provide dental care and the provider can be non-CHC staff. Zone 1 is close to the district center, so people can easily use the dental services there. Thus, investments should be in Zones 2 and 3. For example, VL3 CHC is in Zone 2 and has a very successful dental service, provided by a private dentist who has a contract with the CHC and charges patients directly.

2.3. Traditional medicine equipment

The demand for traditional medicine in health care is popular, especially among the elderly and those with chronic diseases who are dissatisfied with the use of western medicine. All CHCs should have equipment to provide traditional medicine treatment. Currently, although all surveyed CHCs were equipped with traditional medicine equipment, few successfully used them, because the CHC staff either lacked traditional medicine expertise (VL1, VL4, TN2, TN1, and TN4) or the CHCs did not have a traditional medicine practitioner (KH1, KH2, KH3, KH4, and TN3).

2.4. High-tech equipment

Although they had specialized or high-tech equipment, such as ultrasound, ECG, and biochemical tests (VL4, VL2, VL1, and TN4), many CHCs did not use them or underutilized them. One health worker said, “In fact the ultrasound at the CHC is ineffective. First there are many outside providers of ultrasound services. The CHC’s machine is black and white, and people do not like black and white images. They like 4D or 3D images, so very few asked for an ultrasound exam. It has not attracted many clients.”²² The staff also added that local residents did not trust the skills of doctors at the CHC level performing ultrasounds, because they had only studied how to do so for three months.²³ A few CHCs in Zone 2, however, have successfully utilized ultrasound machines (VL3 and KH1). Thus, equipping CHCs with high-tech equipment has only been successful in CHCs in Zone 2, such as VL3 and KH1, with the conditions to attract patients for diagnostic services.

2.5. Obstetrics and gynecology equipment

The residents in Zones 1 and 2 do not rely on CHCs for birth delivery services and have a preference for giving birth at a public hospital. Due to the low birth rate in rural areas, the improved economic conditions, and convenience of good roads, expecting women in the surveyed CHCs have chosen higher level health facilities for better services and added security. Thus, it is not advisable to invest in equipment for birth delivery nor in budgeting for such services.

3. Technical training

3.1. Staff are trained sufficiently to use all equipment

Health workers must also have adequate training to use their equipment. Our survey found that only a few CHCs have been successful in having staff trained to use the dental, traditional medicine, and high-tech equipment. Specifically, traditional medicine equipment, ultrasound,

²² Interview with CHC staff, September 2016.

²³ Field notes, May 4, 2014.

ECG machine, and biochemical test machines were provided to CHCs, but they had little success in using them because there were no trained human resources. In KH4 CHC, UNICEF-funded obstetric equipment received in 1986 remained in their packaging, unused. Investments in equipment must be coupled with training. One health worker said, “Once the equipment is in place, every year there needs to be training to learn different aspects.” Using herself as an example, she said that she studied how to operate the oxygen machine nearly 20 years ago. If she had not been retrained as part of the AP-funded project, she would have lost all knowledge. Therefore, training needs to be provided on a regular basis, and knowledge needs to be updated.²⁴

3.2. Staff can competently utilize all equipment

The quality and frequency of the training must also ensure that staff have the confidence to apply their training to effectively use the equipment. This helps to avoid waste, improve professional skills, and attract more patients. Lack of confidence in the skills of health workers adversely impacts patients’ decisions to visit a CHC. In our Study, many households said that they did not go to CHC for this reason. Household ID 131 (TN3 commune) commented, “To tell the truth, I don’t have much trust in the CHC. Many times the examination is not accurate so I don’t want to go there. They lack equipment and the staff have a low level of qualifications. It is not accurate so I rarely go there for medical exam.” Household ID 137 (TN2 commune) stated, “The skill level of the doctor is not high and the medical staff at the facility is not good. Now, there is only a private ultrasound machine at the house of the head of the CHC. If you are seriously ill, you have to go to them for private treatment.” A private medical provider also commented, “Professional qualifications have changed much and require new knowledge, but many staff are old and have limitations, and their knowledge does not meet the needs of patients. Many times there are many patients who come and need their assistance, but the level of their expertise is not enough to advise the patients.”²⁵

4. Drugs

4.1. Essential drugs for the CHCs are always available

The quality and quantity of drugs at a CHC also affects the number of patients who go to the CHC. Many of the surveyed CHCs were stocked with a few drugs. The case study group observed TN1 CHC for seven days and recorded the following:

In looking at the drugs that patients receive, there is nothing out of the ordinary. Sometimes we joke with each other that we can be a doctor (in the sense that the medical examinations and medicines are so simple). Most of the respondents who answered the exit survey were satisfied. However, when we asked more closely, many people said that they were satisfied with the attitude of the staff and not with the drugs at the CHC being available and good. They said that it takes a long time to feel better from taking the medicine at the CHC. The drugs given to adults and children were for common diseases like headache, sore throat, cough ... and the medicine they receive is usually Tatanol and two Fabamox 500 pills, if available for vestibular disorders or blood pressure related illnesses. For children’s common diseases are fever, cough, sore throat, inflammation of the tonsils ... the drugs

²⁴ Interview with CHC staff, September 2016.

²⁵ Interview with CHC staff, September 2016.

usually received is 10 packets of Cefakid²⁶ and one box (10 packs) of Mexcold²⁷ (Paracetamol 150 mg).²⁸

Household ID 232 (TN1 commune) said, “People with children under age six who use health insurance all had the same complaint about medicine, because any time they go to ask for medicine, they get 10 pills of antibiotics and 10 pills of fever-reducing meds. Other than that, there is nothing else. Whether you have a serious or light illness, it is the same.”

All CHCs within a province have a list of essential drugs for the commune level that is released by the province, which is relatively similar and includes about 400 drug items. Upon observation, we see that every CHC received a different amount of drugs, even among CHCs in the same district. The types and quantity of medicine at the CHCs also vary from province to province. Our findings indicate that the differences are due to four main reasons. First, one MOH regulation authorizes some drugs to be dispensed only when the CHC has a doctor. Second, the supply is made available through the district hospital drug procurement process. One staff member said, “What we have is based on what the hospital was able to procure and give to us. In general we do not get 100% of drugs listed as essential meds. We send up our requisition for medicine that we need, but we have to accept that some meds will not be provided.”²⁹ Third, how proactive the CHC is in obtaining and selling medicine from other sources, including from self-funded supplies. Fourth, the type and quality of the examination and treatment are unequal across CHCs, which leads to a lack of drugs for CHCs. For example, when interviewing VL3 CHC staff, staff stated that they did not have the medicine they needed because it was not utilized by any other CHC, and their hospital would not bid for the drug for just one CHC.

4.2. Drugs to be prescribed by CHC doctors are available

Due to the shortage of drugs at the CHC, the doctor’s prescriptions are very limited. Many CHCs have had a doctor for many years, but the doctor has not been able to prescribe certain drugs because they are not available, despite being on the list of authorized drugs for CHCs. Addressing the shortage of medication is necessary in order to increase the number of patients. Several CHC staff interviews stated that because of limited medicine covered by health insurance, the CHC function is perfunctory (*cam chung*). One KH1 CHC staff member said, “The health insurance agency does not want the CHC to do so much medical examination and treatment and expend so much, so many CHCs don’t like to work, don’t like to provide medical examination and treatment covered by health insurance.”³⁰ The head of VL3 CHC said, “The health insurance agency does not tightly limit the drugs, but if there are many patients, the health insurance agency does not like this.”

²⁶ This drug is used to treat respiratory tract infections, such as acute and chronic bronchitis and super coagulant bronchiectasis and nasopharyngeal infections, such as otitis media, mastoiditis, sinusitis, tonsillitis, and sore throat.

²⁷ This drug is used to relieve headache, tooth ache, muscle aches, menstrual pain, rheumatic fever, and fever.

²⁸ Observation of patient visit, case study team member, June 19, 2013.

²⁹ Interview with CHC staff, September 2016.

³⁰ Field notes of researcher NTN, August 27, 2013.

5. Human resources

5.1. Having a sufficient number of CHC staff

The National Benchmarks require a sufficient number of employees with professional titles for the work of the CHC that is approved by competent authorities. The number of staff is based on the local population and topography (towns, plains, and mountains). Our indicators distribute human resources by zone, with less staff in towns due to near non-usage of CHCs for clinical and birth delivery services.

For CHCs in Zone 1, it is not necessary for them to have a doctor because the residents mainly choose private services and upper level hospitals, especially district hospitals. A central-level government official at the November 2015 Policy Roundtable acknowledged that CHCs in the town (*thi tran*) lie in their reporting on patient visits because people in towns do not visit the CHCs for medical examination and treatment.

The CHCs in Zones 1 and 2 do not need to provide birth delivery services, and should not receive investment in human resources and equipment nor use operational funds to provide birth delivery services. Due to current low birth rates in rural areas, considerable economic improvements, and more accessible roads, people tend to seek better services at hospitals. Therefore, CHCs near and in towns have only performed disease prevention and other public health functions. Because fewer people come for medical examination and treatment, the human resources need is less than in the other two zones. In contrast, CHCs in Zone 3 are in great need of doctors with OB/GYN qualifications and the birth rate among ethnic minorities remains high. Knowledge of reproductive health among ethnic minority people is limited and, for them, access to higher level health services is inconvenient and expensive. The staff that would have otherwise been allocated to CHCs in Zone 1, especially doctors and physician's assistants in obstetrics, could be redirected to CHCs in other zones that are short of doctors. To attract them to work and stay long-term in more rural and remote CHCs in Zone 3, preferential policies should be applied, such as increased allowances and assistance and high quality training.

5.2. Having at least one permanent doctor

One of the standards in the National Benchmarks is that any CHC must have a doctor working on a regular basis, which can mean working at least two half-days per week based on a fixed schedule. Our assessment tool requires doctors to be distributed based on zones. For the reasons discussed in Section 5.1, CHCs in Zone 1 do not need a doctor. Most CHCs in Zones 2 and 3 need a doctor working on a regular basis. Currently, the CHCs in Zone 1 have a sufficient number of doctors but few patients, while the CHCs in Zone 3 lack doctors and should be prioritized in getting them.

In reality, it is difficult to get doctors to stay long-term in Zone 3. Specifically, due to their location in a mountainous district, KH3 and KH4 have suffered from a serious shortage of doctors for many years. Although there is extra remuneration for doctors in this area, it is still inadequate. Part of the problem is that the doctor shortage is widespread. Another reason is that even if doctors go to mountainous areas and can earn higher income through providing after-hours private healthcare services,³¹ they tend to leave after a short duration because there is little opportunity for

³¹ Doctors in poor areas often only have their salary because the residents are poorer and cannot pay for private services or because most are poor or near poor and qualified for health insurance, so they do not use private services. The salary at a CHC for a college graduate is 1.8 to 2.4 million VND per month (less than 100 USD), which is very

advancement or professional development. In addition, although there are many policies to train physicians on site in these areas, when the training is complete, doctors may quit their job and find work in the delta.³² The mountainous district also made an effort to recruit ethnic minority children to attend a doctor training program, but failed due to limited capacity among the children and a lack of funding to meet the actual needs of the sector.³³ Providing training on the job is also difficult, because with already so few doctors working, they cannot be absent for long duration for training. Securing a permanent doctor is a vicious circle that the district health center cannot escape. More supportive policies are required to meet the demand for human resources and capacity building in CHCs.

5.3. Staff are trained regularly

Regular training to improve skills and update professional knowledge is necessary for all three zones. Particularly in Zone 3, CHCs need to develop a long-term plan for training high-quality human resources at the provincial level and for spending the necessary resources for this priority area.

5.4. Staff understand and communicate in minority languages

In Zone 3, there are many ethnic minority groups, especially in the mountains. They usually have little understanding of the Vietnamese language, so they encounter some difficulties when seeking medical examination and treatment. It is therefore necessary to have ethnic minority health staff or health workers who can communicate in ethnic minority languages. The study results showed a significant difference between the more successful KH4 CHC and the less successful KH3 CHC.

low compared to the general cost of living. In the KH 3 and KH4 communes, the majority of the population are ethnic minorities, have health insurance, and receive care at almost no charge. At the time of the Study, the supplemental pay for working in this area on average about 100,000 VND/month. They pay for being on duty at night was 15,000 VND/day per person at the district level and 10,000 VND/day at the commune level. The surgery allowance is only 10,000 VND per shift. Recently, there have been more realistic policy changes. On October 29, 2015, the Ministry of Health and Ministry of Finance issued Joint Circular No. 37/2015/TTLT-BYT-BTC regulating uniform health insurance service prices among hospitals of the same rank in the whole country. Accordingly, CHCs are entitled to the rates of hospital services of class IV. Price includes direct and special allowance made from 01/3/2016 and the price includes direct costs, special allowances, and wages made from 01/7/2016. With the above calculation, the price of health care services and the price of technical and laboratory services have increased significantly, including services that can be provided at CHCs. For example, the price of medical examination for hospital class IV is 7,000 VND/visit from 01/3/2016 and 29,000 VND/visit from 01/7/2016, compared to 4,000 VND/visit at the time of the Study. The ultrasound price is 30,000 VND/visit from 01/3/2016 and 49,000 VND/visit from 01/7/2016, compared to 20,000 VND/visit previously collected by CHCs. On the one hand, these new regulations will enable health facilities, including the CHC, to work better and improve health workers' income. On the other hand, they will increase health insurance premiums and increase the burden for those who buy health insurance without partial or total subsidies.

³² Doctors can easily apply for jobs in the delta area because hospitals in the delta are currently in serious shortage of doctors. Leaving a job is also simple and there is no binding mechanism. The cost of training for doctors is low (about 40 million VND or less than \$2000 USD/doctor). Doctors are willing to reimburse this cost in order to be free to work elsewhere for higher income. Interview with Deputy Director of the Khanh Son District Hospital.

³³ In 2009, the provincial People's Committee contracted with Hue Medical University to recruit students from areas which lack doctors and pharmacists. The number of candidates for this training was eight for physicians and two for pharmacists, of which 50% were ethnic minorities. The aim was to assign the graduates to the CHCs in the district in order to reach 100% of CHCs with doctors in the year. Although there are no official statistics on how many students have left school, only 3-4 students remain in the program. The ethnic minority students have dropped out, since they could not keep up with their studies and there was no money for living expenses. Interview with Deputy Director of the Khanh Son District Hospital.

KH3 CHC has a few non-ethnic minority health staff who know ethnic minority languages. KH3 CHC has both health workers who are ethnic Vietnamese who know ethnic minority languages and ethnic minority health workers, and it is more successful relative to CHCs without ethnic minority health workers or with only health workers who can speak ethnic minority languages.

They need to provide assistance for training and coaching, providing them expertise and processes to implement, as well as upgraded equipment. Thus, the grassroots treatment facility helps reduce costs and avoid overload at the upper level. People always want to go to a specialist or to higher level because more and more they will get better service, but that it will be more expensive, costly to themselves and costly both their budget, from which it will give rise to inequality.

- Director of Center for Diabetes Mellitus, Thai Nguyen (June 2016 Interview)

6. Leadership

6.1. The CHC head is an exemplary leader and is highly respected by staff

This indicator does not relate to quantity; it is entirely qualitative. To act as a good head of a CHC, there must be a convergence of many factors, such as enthusiasm, dynamism, and the knowledge and ability to create more income for employees. One employee said that a CHC head, “Must be enthusiastic, have the ability to mobilize, to know where to do business to increase the income of staff. The CHC leader without a sense of responsibility ... cannot do anything. But someone who is enthusiastic but does not know how to discharge his responsibility, cannot solve anything either. Now that the age is dynamic, for example, now they can provide meds outside of health insurance, the leader also has to find ways to supplement the basic functions, to increase the health of the patients, and increase salary/benefits of the staff.”³⁴ One senior official said that, “The top down direction is only a part; the rest is the CHC. If you want to build the CHC, want to build the brand, having quality is a matter of survival for them. If after this time people are required to calculate the proceeds, service, and salary, at that time it had a huge impact. Hospital must now serve well. There are clients who come to use the service and they are the ones who pay to raise this hospital. But when the state will not subsidize anymore, there will be changes. There will be competition among CHCs. If the CHC does not improve it will not attract clients; from that you will not get money.”³⁵

6. 2. Providing paid services collectively at the CHC

An income-generating service model that includes services not provided by the State nor by health insurance can be deployed successfully for CHCs in Zone 2. Specifically, VL3 CHC already provides employee incentives in the form of additional income from providing on-demand services paid directly by patients to the CHC. The combination of public and private services is essential in order to increase clients. Private services will increase prestige for CHCs and attract more clients. A manager at a district health center said, “CHCs can do some medical services for additional income, but if they do not care about that area, then they would be worried and would

³⁴ Interview with CHC staff, September 2016.

³⁵ Interview with Director of District Health Center, Thai Nguyen, June 2016.

not feel reassured. Sometime they sit at the CHC and worry about working outside. But at a CHC that does good work and has ensured that staff are paid enough to live on, the staff don't need to trouble themselves with working outside.”³⁶

6.3. Increasing and distributing income fairly among staff

Generating and dividing income is not an easy task for the head of a CHC. To create a common pool of income for the CHC in the context of health insurance, the CHC head must attract more clients to the CHC by organizing health care activities on the basis of public-private partnership at the CHC. In addition to being a good manager and having a good mind, the head has to find ways to bring in extra income for the staff and pay for the CHC operations.

I also wish the best doctors can do so to have a job, the second one also has income to raise children with this salary. Tomorrow there will be other demands. I also worry so much, but I have many things to think about. Dividing income and work evenly to the staff is part of the art of management for the head of the CHC. This requires the head of the CHC to be honest, transparent, and not self-serving. The person who decides the financial allocation is the head of the CHC and not a superior.

- CHC health staff

CHCs could benefit from greater autonomy in deciding how to raise and spend their revenues and to develop additional services and ensure the quality of the services they offer, in order to secure client satisfaction. Currently the CHCs that provide additional services do not report them to higher levels in their monthly reports. VL3 CHC reports a much smaller amount of revenues earned from services beyond those provided as “public” and has the highest revenue from “private or on-demand services” among all the CHCs. Neither the full amount nor actual number of patients are reported to superiors. The research team observed the CHC staff reporting fewer patients than the actual number, and the staff also know that is not the actual number.

7. Organizational structure

7.1. Encouraging public-private models in the CHC

Partnering public and private services is a model that we believe should be encouraged for all CHCs in all three zones. This model has already been widely applied at higher level hospitals. However, for CHCs, we consider Zone 2 to be the most feasible for implementation. Zone 2 has favorable conditions under which to develop CHCs as a comprehensive grassroots-level health facility that can meet the health care needs of all local people and alleviate the burden on higher level facilities. Our Study shows that the CHC with the highest quality of service, VL3 CHC, has demonstrated that public-private partnership is successful. Therefore, it is unreasonable to not promote and allow the model to replicate in areas with similar characteristics. Private-public partnership can garner a number of simultaneous benefits, such as (1) promoting effective use of the investments in facilities, equipment, and human resources at the CHC; (2) improving professional skills and income for health workers, and thereby enhancing staff morale, attitudes, and service quality; (3) better meeting the health care needs of local people and improving the role of the CHC in protecting people's health, especially for the poor, ethnic minorities, and rural

³⁶ Interview with Director of Ninh Hoa City Health Center, Khanh Hoa, October 2011.

elderly; and (4) mobilizing external resources for the CHC and reducing pressure on higher level health facilities. The success has been recognized by some officials, such as the director of a district health center quoted below.

Public-private partnership is absolutely right, because the current model of the CHC is that the state pays for the medical staff salary, but there are CHCs that attract patients and CHCs that do not attract patients. This depends on the capacity and the organization's operations of the CHC. There are CHCs that have made clear delegation of work and publicly disclose the income of the CHC. Everyone considers the CHC as if it was their home. They work together and enjoy the successes together, and there is a reasonable division.

- Director, District Health Center, Thai Nguyen, May 2016

In addition, we can learn about this and another model for CHCs being piloted in Ho Chi Minh City. The socialization of Commune and Ward Level CHCs project is the first private polyclinic within a CHC in Vietnam. The Socialization of CHC model provides primary health care, medical examination covered by health insurance, and health checkups, and creates an adjacent level of care that helps relieve strain on the higher levels by promoting the principle of family medicine to train family doctors. The Model of a Satellite Clinic within the CHC project has created favorable conditions for people to access good quality health services at the closest facility, also contributing to a reduction in overburdening at higher level hospitals.

7.2. Fulfilling preventive health care function

All CHCs must fully perform the function of preventive care and preventing disease, through implementing mandated public health programs, such as providing immunization, prevention and control of epidemic, and providing health checkups to beneficiaries entitled to such policies.

7.3. Fulfilling primary health care function

CHCs in Zones 2 and 3 must fully provide first level medical examination and treatment, medical examinations covered by health insurance, and health checkups. As discussed earlier, CHCs in Zone 1 do not need to be publicly supported to carry out the primary health function because they are too close to the district health centers. In our research, the CHC in the town of Mang Thit did not perform medical examination and treatment because it was too close to the district hospital.

8. Staff attitude and behavior

8.1. Working sufficiently eight hours per day and having staff on duty 24 hours per day

Having staff work on time and for the full number of administrative hours at the CHC is very important. This means maintaining a strict and professional working style. In reality, our research shows that many CHCs have not maintained strict hours, to their patients' dissatisfaction. Household ID 206 (KH4) expressed dissatisfaction with the service attitude of health workers, stating, "The CHC has very few patients but the patients have to wait a long time, sometimes waiting an entire morning without any certainty of being seen. Must wait a long time for the doctor to arrive." Household ID 154 (KH4) said, "I had to wait the entire morning for the person who issued medication to arrive. Is there anyone working at that time? They are

supposed to start work at 7:00, 7:30 am, but at that time, I have to wait until 9:00 or 10:00 am. The CHC here is close by, so that helps, but it does not meet my needs.”

In addition to working the full administrative hours, requiring off-hours, on-call duty for three types of CHC staff would be adequate to ensure full coverage. Currently, the National Benchmarks only requires one staff member to be on duty, and the staff member must be able to provide medical examination and treatment. This has been a problem for CHCs in Khanh Hoa and Thai Nguyen provinces that have only two staff who can do so and must take turns performing off-duty assignments. Being on duty all night in shifts compromises their availability during the day to carry out medical examination and treatment. One of the CHC health staff stated, “One person at the station is just a form, because in the case of a doctor or physician’s assistant, it is not a problem, but when it is a nurse on call, nothing can be handled. For this reason, people rarely come to the CHC in emergency cases outside the normal hours.”³⁷ Unlike these provinces, Vinh Long CHCs assign on-call duty to three positions—doctor or physician’s assistant, nurse, and midwife—and have been successful in doing so.

8.2. Treating patients graciously and politely

In addition to having professional qualification, everyone requires that there be trust, so must change how patients are greeted, welcomed, respected. [If] they feel welcome and respected they will come.

- CHC staff (September 2016 Interview)

How staff treat patients is important. There is much evidence that the number of clients coming to CHCs is reduced due to poor client service attitude. The comments from these two interviews expressed an assessment that is shared by many other households that we surveyed and interviewed. Household ID 292 (TN1) said, “I think that because their economic condition is better [the CHC staff] think they are better than the locals. Sometimes I ask about an illness, or we have to buy drugs, but their attitude is not good. So if you want the truth, our mindset is that we do not like to go the CHC.” Household ID 131 (TN1) said, “Every time I go there, she [CHC staff member] is not enthusiastic, so I rarely go. The female staff is not concerned. For example, when I went to buy drugs or for a medical examination, the ladies are sitting at the computer or doing something. They said, ‘Wait.’ Then there are times when the ladies play badminton or are sitting chatting. Sometimes they just make me sit and wait. It is very time consuming. So I would rather just buy medicine somewhere else because it is faster and then I can get home and go to work.”

9. Focus on older people, the poor, and ethnic minorities

Our research³⁸ found that older people, ethnic minorities, and the poor are more likely to visit the CHC than younger people, people of Kinh/Hoa ethnicity, and the non-poor. Particular attention should be paid to the elderly and the poor in Zones 2 and 3, and ethnic minority groups in

³⁷ Interview with health worker, TN4 CHC, June 2013.

³⁸ Le, Sang Thanh and Nguyen, Nhung Thi. (2011). “Impacts of the Atlantic Philanthropies’ Interventions on Commune Health Centers in Rural Vietnam: A Comparative Perspective.” *Journal of Preventive Medicine*.

Zone 3, because they are the most dependent on CHCs. Our research indicates that for the elderly, when they are sick, having examination and treatment at the health care center nearest their house is a priority in choosing a provider. Presently in Vietnam, households have few children (2-3 children for households in rural areas), and children often work outside of the home or far from home. Thus, they are not in a position to help their elderly parents should they need to go for medical examination and treatment at the district, provincial, or higher level. Therefore, the CHC is the first choice among facilities for health care for the elderly.

In an interview with Household ID 38, two ill members of an elderly couple (husband age 69 and wife age 73), said: “At the start, they said to go to the CHC. We did but the CHC could not treat us so we asked for a referral. If [the health facility] is near the house, the grandchildren can take us. But Hanoi is very far away, and we do not have money and our house is in a state of disrepair The children are married and have left only us two—old man and woman. We are poor in not having enough people.” For low-income groups, the need for CHCs to provide health insurance services is very necessary, because it will reduce expenses such as travel and accommodation at higher public health facilities. Household 161 (in VL2 commune) said: “I also worked for hire and have little money to buy food and send my children to school. I am so short of funds. What money I have I can use to buy health insurance, but if I buy insurance, I do not have money to send my children to school every day. I also would not have money to buy food every day. I go to the CHC for an exam. Last month I was coughing and had nasal discharge. The CHC staff said I had sinusitis and I took the meds from then until now. I took the medicine for five days and the headache went away.” For ethnic minorities living in remote areas, they have fewer conditions to access better health care and there are often no private providers, so it is essential to invest in medical equipment and human resources to meet their needs.

10. Quality of care

10.1. Evaluation by clients

We need to see the satisfaction of clients when using services at the CHC, and for this, it is necessary to add the people’s evaluation as a benchmark. This will be more objective and we can thereby evaluate the service quality of the CHC. Assessing the services used at the CHC and satisfaction must have direct methods of evaluation, such as household surveys. In addition, there will be a toolkit to manage the numbers, but not too heavy on the quantitative metrics, but we should attach more importance to assessing quality.¹

- Director, District Health Center, Thai Nguyen (May 2016 Interview)

Bringing clients’ evaluation to the CHC is essential for CHCs in all three zones. The necessity of this benchmark is expressed by the director of one district health center above.

10.2. Supervision by superiors (higher levels)

Besides the district health center’s inspection, the CHCs currently perform peer checks. Based on our observations, the way the different levels and the CHCs carry this out is inappropriate. The upper level simply gives orders and the lower level receives them. CHCs are not creative, proactive, nor productive. One health worker stated, “Frankly now the heads of CHCs attend

meetings and have no ideas. They just know that's all; they only follow targets set and not dare to see any ideas." There is often false reporting of patient number and activities, and staff dare to not report because top-down directives must always be accepted as true. The reason for not reporting real data is that currently the mechanism for accounting the revenues and expenditures at the upper level is complex. All CHCs want to have control over their earnings, but the mechanism for this does not currently exist.

In summary, the effective CHC models bring various benefits to relevant stakeholders. The government can properly allocate limited resources to where they are needed and promote high-performing CHCs. The CHC can effectively use the investments in its building, equipment, and human resources, especially doctors. Using models of public-private partnership, CHCs can attract outside investment through "socialization" where possible. Besides common services for clients with health insurance, the provision of charged services for clients with and without health insurance at CHCs can incentivize workers by offering an increase in income and motivate CHCs and grassroots health to improve service quality. There are some challenges, including a lack of motivation for change, satisfaction with having a public salary for doing minimal work, conservative thoughts, or concerns about the increase of expenses or the neglect of preventive health functions and duties. The lack of CHC leaders with enthusiasm and capacity is another key challenge for change. However, an adjustment of personnel, equipment, and other resources in accordance with the specific requirements of each CHC model should not increase the cost. The government should invest more in remote areas and targeted populations, but public-private partnerships can help to mobilize outside resources for health services at CHCs. Finally, the evaluation of good practices based on major components and the step-by-step replication of good models will help to reduce risks.

APPENDIX 1: COMMUNE HEALTH CENTERS ASSESSMENT TOOL

This assessment tool is for evaluating the quality of commune health centers (CHCs), based on (1) relevant indicators in the existing National Benchmarks for Commune Level Health Care to 2020 and (2) emerging trends in the ageing population, changing patterns of illness from acute to chronic conditions, improved living standards, and an increase in the number of private providers in the past two decades. Each indicator has an equal weight of 10 points. Each CHC is assigned a total score.

Dimension	Indicator	Weight	Normal CHC	Note for special CHCs		
				Nearby hospital (<5km)	Far from hospital (>10km)	With minority (>20% pop)
1. Infrastructure	1.1. Quality of building (solid)	10				
	1.2. Number of rooms (14 or more)	10				
	1.3. Fresh water	10				
	1.4. Traditional medicine or herbal garden	10				
2. Equipment	2.1. Essential medical equipment	10				
	2.2. Dental equipment	10				
	2.3. Traditional medicine equipment	10				
	2.4. High-tech equipment	10		Limited		
	2.5. Obstetrics and gynecology equipment	10		Not Required		
3. Technical training	3.1. Staff are trained sufficiently to use all equipment	10				
	3.2. Staff can competently utilize all equipment	10				
4. Drugs	4.1. Essential drugs for the CHCs are always available	10				
	4.2. Drugs to be prescribed by CHC doctors are available	10				
5. Human resources	5.1. Having a sufficient number of CHC staff (≥ 7)	10				
	5.2. Having at least one permanent doctor	10				
	5.3. Staff are trained regularly	10				
	5.4. Staff understand and communicate in minority languages	10				Required
6. Leadership	6.1. CHC head is an exemplary leader and is highly respected by staff	10				
	6.2. Providing paid services collectively at the CHC	10				
	6.3. Increasing and distributing income fairly among staff	10				
7. Organizational structure	7.1. Encouraging public-private models in the CHC	10				
	7.2. Fulfilling preventive health care function	10				
	7.3. Fulfilling primary health care function	10				
8. Staff attitude and behavior	8.1. Working sufficiently 8 hours/day and having staff on duty 24 hours/day	10				
	8.2. Treating patients graciously and politely	10				
9. Focus on older people, the poor, and ethnic minorities	9. Focus on older people, the poor, and ethnic minorities	10				
10. Quality of care	10.1. Evaluation by clients	10				
	10.2. Supervision by superiors (higher levels)	10				