Chapter 1

INTRODUCTION

1.1 Rationale

The ultimate goal of health policy is to improve the health of population. The good quality of health services provided to population is one of the key factors to attain that goal. Quality of care has become a critical issue for providers, funders, and consumers. (Friedman 1995, quoting O'Leary and Walker,1994). The providers are increasingly interested in having more information about their performance. The patients and funders want to know more about the quality of care available. Therefore, the evaluation of quality of health care is essential for the health system. In the industry sector, the focus on quality is pervasive in all sectors of the economy. According to Juran (1993), the 21st century will be the "Century of Quality". It will embody better ways of defining, measuring, and improving the quality of health care (Friedman, 1995).

On the other hand, quality of care plays an important role among major determinants of the utilization of health services. If the patients are not satisfied with services received from health providers health service utilization will be lower. In other words, the low utilization of health services, to some certain extent, reflects the poor quality of care.

The low utilization of health facilities is a major concern in Vietnam. The data provided by the Ministry of Health of Vietnam (see Table 1.1) showed a decrease in utilization of health services during the period 1986-1990 in terms of the annual number of consultations, the annual number of inpatient admissions as well as the annual number of hospital days /person. There was a wide variation across provinces and regions. In an evaluation of the health sector cooperation program between Vietnam and Sweden conducted by SIDA (1992), the low utilization of health facilities in Vietnam was mentioned as the main problem in Health care delivery in Vietnam recent years. The average of bed occupancy rates for hospitals were less than 50%. Annual per capita contact rates with the health services averaged between 0.3 and 0.5 for the overall population with wide

Table 1.1 Trends in health service utilisation (1986 - 1990)

Indicators	1986	1987	1988	1989	1990
Number of consultations	130,480	129,718	114,999	77,293	66,904
Number of IP admissions	6,431	6,510	6,270	5,107	4,515
Number of hospital day/person	52,616	53,444	49,281	37,581	34,307
Average duration for the treatment of 1 IP (day/person)	8.1	8.2	7.8	7.4	7.3
Average No of day beds occupied/month (day/bed/month)	29	28.5	26.5	22.9	20.8
Average No of consultations per person per year	2.31	2.07	1.8	1.2	1.0

Source: Ministry of Health, Vietnam, 1990 quoted by Guldner M. (1995)

variations across provinces and regions. The main factor behind the low utilization of health facilities was the poor quality and the long distance required for travel to the facilities, especially people living in mountainous and remote areas.

The problem of poor quality of care is very common in developing countries. In Vietnam, it is a major concern for health system. Quality improvement of medical care is one of 8 priorities in health programs of MOH for the period 1990-1995 in Vietnam (MOH,1990). The shortage of financial resources for health is considered as the major reason of this problem. Due to the limited health budget, hospitals have been deteriorating, health equipment is becoming obsolete, and drug supply is insufficient. In a survey of health providers conducted by MOH in 1991 in 3 provinces, the majority (91.1%) of providers cited low salaries, inadequate equipment (87.6%) and inadequate drugs and medical supplies (82.6%) as problems affecting the quality of health services.

In terms of health care financing issues, like many other countries, the Vietnam health system greatly depends on the State's subsidies. Expenditure for the health system comes from the 4 following sources: Government budget, user charges, health insurance and external aid. Vietnam is a developing country ranked among low income countries with per capita income of US$300. The government budget allocated for health is limited and insufficient to meet the increasing health care demand. In 1995, health expenditure per capita was about US$3, still very low compared with the average health expenditure per capita in low income countries of US$12 (Health Statistics Year Book, MOH, 1995).

Facing with financing constraint for improving quality of health care system, the Government has paid attention to measures for mobilizing additional sources of funds. The introduction of health insurance is considered as a measure to improve the quality of care by providing more resources and motivation to health care providers (Abel-Smith,1992). Therefore, besides a user charge policy the health insurance system has been introduced to provide new resources for health care financing following the aim for " Health for all by the year 2000".

Some pilot health insurance schemes have been carried out at province level since 1989 and since the end of 1992, the Ministerial Council Decree No 299/HDBT

on Health Insurance has officially been implemented nationwide. Two major components of the health insurance system are voluntary health insurance and compulsory health insurance for serving government servants and industrial workers. A system of health insurance offices has now been established in all 53 provinces and in some sectors. About 7 million people had been covered by health insurance by the year 1995 including 5 million compulsory members and 2 million voluntary members (mainly school children's insurance).

In the context of health insurance, quality of care is major concern for all parties involved: health insurance buyer, health facilities and health insurance agency. Health insurance buyers are obliged to pay premiums and entitled to medical services. The holder of a health insurance card when receiving health care services does not need to worry about the costs but only about the quality of care. In their vital interest, the insured persons should fight for the quality of care. The health facilities which contract with health insurance agencies to provide health care services are responsible for the quality of health care. From the perspective of the health insurance agency, quality assurance is an important function in order to attract the health insurance buyers (Abel Smith , 1990). One of the main policy objectives of health care financing reform in general as well as health insurance in Vietnam is to improve the efficiency and quality of health care syste (Bui Nguyet Nga and Bui Duc Khanh, 1994).

After 4 years of operation, besides the considerable achievements of health insurance activities in health care delivery, there are some arguments about its effectiveness: one of the most critical issues is the quality of care under the health insurance scheme. The quality of the health care provided to the insured person is still questionable issue. Many insured patients had said they have been treated as second class patients in the sense that of quality of care received is worse than that of non-insured patients. They complained that the doctors usually prescribed cheap and low effective drugs, order too few laboratory investigations etc. Meanwhile health insurance officers commented about the possibility of bankruptcy because the expenses for medical costs outweighed the revenues collected. A lot of evaluations on performance and effects of the health insurance scheme were made but none of them was concerned about the quality of care issue.

Therefore, in this study the evaluation of quality of care under the health insurance scheme will focus on answering the following questions. Firstly, is there a difference between quality of care of patients with health insurance and patients without health insurance? Secondly, if the difference exists, what are factors associated with that difference?

Haiphong was the earliest province to establish the health insurance scheme for the whole province in 1992. Haiphong health insurance activities have been considered as the most well operated so far. In 1995, the health insurance scheme covered 35% of the population in Haiphong while in the whole country the coverage of health insurance was only 10%. This study was located at Viet-Tiep Hospital, the provincial hospital of that city.

1.2 Objectives of the study

(1) This study was carried out with the main objective is to compare quality of care between insured and non-insured patient.

(2) The secondary objective is to study the factors affecting the quality of care of insured and non-insured patients such as medical costs, payment mechanisms.

1.3 The scope of the study

This study was implemented at Viet-Tiep Hospital. The data were collected within the year 1996 and related to four types of diseases selected. The quality of care was assessed by using selected indicators of process and outcome. This study was carried out with the hypothesis that there is not a difference between compulsory health insured patients and voluntary health insured patients.

1.4 The structure of the thesis

This thesis consists six chapters. Chapter 1 is the introduction, summary of rationale, objectives, scope and structure of the research. The background of Vietnam and Haiphong in terms of the socio-economic situation and the health care issues are presented in Chapter 2. Since this thesis is a case study at Viet-Tiep Hospital, this chapter also provides an introduction of that hospital. Chapter 3 is the literature review section, reviewing principles and practice of health insurance, the payment

methods under the health insurance scheme, the definition and assessment of quality of care. Previous studies concerned about quality of care under health insurance schemes are reviewed. Chapter 4 focuses on research methodology of the study, including conceptual framework, data collection, outcome measurement and data analysis. The results of study are presented in Chapter 5. Finally, conclusions and recommendations are presented in Chapter 6.