International Family Medicine

An International Consultation: The Development of Family Medicine in Vietnam

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An effective international consultation on health system reform can be approached using the five-step process of establishing goals, conducting a needs assessment, defining objectives, developing methods, and designing evaluation strategies. This structure provided guidance to a consultation we provided to the Ministry of Health, Socialist Republic of Vietnam (SRV) to review its current health care delivery system. The consultation examined all levels of health care delivery and medical education. The SRV has an extensive, but poorly staffed, "commune health center" system. There is a widespread perception that the quality of medical care is low in these health centers. People leave their communities to obtain health care elsewhere at more-specialized levels and more-expensive sites. Our consultation included an analysis of the potential effect of creating a primary health care delivery system based on the model of family medicine. In addition to consulting, part of the time spent in Vietnam was used to advocate for changes in the system to allow for movement toward a primary health care delivery system. The consultation culminated in the creation of the specialty of family medicine and in the establishment of the medical education system to train family physicians.

(Fam Med 2004;35(5):352-6.)

The declaration of Alma-Ata in 1978 charges "the world community to protect and promote the health of all the people of the world," with the conclusion that "primary health care is the key to attaining this target."[1] In the 25 years since the declaration was made, much effort has been put into the development of new approaches to primary health care systems. As health planners worldwide have been searching for well-functioning, high-quality, and cost-effective health care systems, they have looked to family medicine as one model for the provision of primary health care.

The six principles of family medicine—continuity, comprehensiveness, coordination, community, prevention, and family[2]—have been of particular interest to ministers of health around the world. This interest has led to a growing number of countries that either have established training programs in family medicine[3,4] or are contemplating this development. There have, however, been few reports of international consultations and assistance programs to aid in the establishment of family medicine.[5-7]

There also remains a paucity of information on how an effective international consultation on health system reform should be conducted. Recent efforts have included work by the World Health Organization (WHO), the World Organization of Family Doctors (WONCA), and the American Academy of Family Physicians (AAFP). A collaborative work of WHO and WONCA, "Improving Health Systems: The Contribution of Family Medicine," describes strategies to organize programs to meet the need of primary health care education.[8] In response to a need expressed by international consultants from the United States, the AAFP has created the International Family Practice Assistance Program (IFPDAP), modeled on its successful Residency Assistance Program. The IFPDAP advisory board has developed tools and hosted workshops to prepare consultants for their role in the development of family medicine around the globe.

In 1996, the Ministry of Health (MOH) in the Socialist Republic of Vietnam (SRV) approached the Division of International Family Medicine Education (DIFME) of the Department of Family Medicine at

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Maine Medical Center (MMC) to provide consultation on the reorganization of its primary health care delivery system. In 1994, the vice-director of the MOH Health Strategy and Policy Institute (HSPI) published an article[9] reporting the status of health care in Vietnam, focusing on the need for reform in primary health care. Through the subsequent year, the director of DIFME and the vice-director of HSPI shared information about health care delivery and education in Vietnam and about primary health care delivery and education around the world. This resulted in the Vietnamese MOH's request for HSPI to develop a plan to propose change. DIFME and HSPI received grant funding from a US foundation to support a 5-year project. This paper describes the resulting process provided by the consultants to the MOH for the evaluation of changes in Vietnam's national primary health care system.

Methods

This consultation followed a five-step approach:

Goal

The first step in this consultation was defining a goal. The goal, as collaboratively defined by client and consultant, was to explore the feasibility of introducing family medicine as the core specialty for primary care in Vietnam.

Needs Assessment

Needs assessment was the second step. The needs assessment explored strengths, weaknesses, opportunities, and threats, otherwise known as a SWOT analysis. The consultants involved key stakeholders (Table 1) in the process, including those from health care delivery, training, and political administration, as well as the recipients of health care to determine the current shortfall in preparation of medical manpower for competent general practice and to learn how health care was provided, financed, and legislated.

Objectives

The third step was to translate the needs assessment into objectives, thus determining the work and evaluation of the project. The objectives for this consultation were to (1) review the health care delivery system, focusing on primary health care, (2) examine the training of primary care physicians, and (3) make recommendations to the MOH about changes in primary health care education and delivery and submit a proposal for a project model to the MOH for the development of family medicine as a specialty in Vietnam.

Methods

Methods for the consultations included meetings and formal interviews with key stakeholders, in-person and e-mail discussions, library and Internet searching, and observations. The consultants made five trips to Vietnam over a 5-year period. In addition, a team of Vietnamese collaborators conducted a work-study tour in the United States and the Philippines. The methods concluded with a verbal and written report of findings and recommendations to the MOH.

Table 1

Stakeholders Interviewed and Observed in Three Regions of the Country During the Needs Assessment

Hanoi
Director: Health Strategy and Policy Institute
Vice minister of health
Vice minister of education
Dean, department chairs:Hanoi Medical University
Director, service chiefs: Bach Mai Hospital
Director, Board of Directors: Hanoi City Health Services
Physicians: Urban district health center
Patients: Rural commune health center
Ho Chi Minh City
Dean, department chairs:HCMC School of Medicine and Pharmacy
Director, service chiefs: Cho Ray Hospital
Physicians: Urban district health center
Medical school outpatient clinics
Private health center
Thai Nguyen
Dean, department chairs: Thai Nguyen Medical College
Director, service chiefs: Bach Thai Provincial Hospital
Physicians: Thai Nguyen district health center
Patients: Rural commune health center
Director, Board of Directors: Thai Nguyen City Health Services

Regional and international leaders were brought on to the consulting team in 1998 to facilitate information gathering and increase expertise. These included the president and the Asia-Pacific regional vice president of Wonca. In 1999, the consulting team further expanded its resources by adding a behavioral medicine scientist to provide expertise about family systems and an educational specialist to address curricular changes that would be new to the Vietnamese medical education system.

Evaluation

Evaluation was the final step in the process. The success of the consultation was measured by evaluating the achievement of each of the three objectives. To achieve the first two objectives, the consultants needed access to all levels of the health care and medical education systems to ascertain the organizational structure and function and the willingness of stakeholders to consider changes in the delivery of primary care. To evaluate the final objective, we noted whether our recommendations were accepted and acted on by Vietnamese officials.

Results

DIFME conducted the needs assessment during three visits to Vietnam in 1997–1998. The needs assessment began in Hanoi in the Northern region and expanded to both Ho Chi Minh City in the Southern region and a rural province in the Northern region. Each of the first three trips included meetings with key stakeholders (Table 1). Most of the individuals interviewed indicated a strong desire to improve primary health care delivery but expressed concerns about family medicine training and had questions about the acceptance of family physicians by the community.

SWOT Analysis

Some of the strengths identified in the existing Vietnamese health care system were government funding with coverage for all of Vietnam, an organized hospital system providing various levels of care, a strong cultural family orientation, and a turn in the political climate to welcome international consultation. Weaknesses included few physicians in the rural health care sites, lack of continuity between levels of care, lack of trust by patients in primary health care providers, a small proportion of gross domestic product (GDP) spent on medical care, and outdated teaching methods. Opportunities included an ability to devise a new educational system to upgrade primary care training and status and receptiveness to a new paradigm for looking at mental health/psychosocial needs. Perceived threats included cultural differences between regions, a changing political and economic environment, and an economically disadvantaged country. Results of each visit were reported to the MOH verbally and in writing.

Chronology of Events

In 1998, a Vietnamese team made a work-study tour to the United States and the Philippines. The tour's goal was for the team to understand undergraduate and postgraduate training in family medicine by studying a regional model at the University of the Philippines and US models at Brown University and MMC. The Vietnamese team had the opportunity to meet with medical and behavioral faculty and discussed family medicine development with officers of WONCA, AAFP, and the American Board of Family Practice (ABFP). It was during this tour that our Vietnamese colleagues began to understand family medicine and to see how its principles are put into practice.

In 1999, the expanded consultative team provided a 5-day workshop on the education, principles, and practice of family medicine to government officials and more than 40 educators from three medical schools in Vietnam. These seminars were important to create a broad coalition of support and an understanding of a different paradigm in medical training. During these sessions, the participants wrote a mission statement for family medicine and created a 2-year postgraduate training outline, which were both eventually accepted by the MOH. The full effect of the workshop was apparent at the end of the consultation, when the consultative team delivered its report and recommendations for a new approach to primary care education and delivery, meeting its third objective.

During the final visit to Vietnam in 2000, the fourth objective was completed. The consultants and stakeholders made a recommendation that the SRV create educational programs in family medicine—a specialty that would be the cornerstone for the delivery of primary health care to the people of Vietnam. A list of goals (Table 2) was then drafted for a project that would develop, implement, and evaluate a postgraduate training network for family physicians. The MOH accepted the recommendations and declared family medicine as the newest specialty in Vietnam.

Evaluation and Information Obtained

Evaluation of the first objective of the consultation revealed success in developing an overall review of the current health care system. The following paragraphs outline what we learned.

There was a solid organizational structure to meet the health care needs across the country but a lack of physician providers and minimal patient confidence in the primary health care system, particularly in rural areas. The SRV, a country of more than 77 million people with 80% of the population in rural areas, does better than many other countries in its region on some health indicators but not all. The infant mortality rate of 35/1,000 and life expectancy at birth of 69 years are comparable with those of other nations, but the prevalence of malnutrition and preventable communicable disease are still comparatively high.[10] Even though public health expenditures represent only 1% and private health expenditures 4% of the GDP, there has been a strong po-

Table 2

Goals Developed With Stakeholders and Accepted by the Ministry of Health for a Long-term Project to Develop Family Medicine in the Socialist Republic of Vietnam

- Establish and maintain departments of family medicine
- Complete curriculum development
- Upgrade community training sites
- Conduct faculty development
- Link US and Vietnamese family medicine departments
- Establish national oversight committee
- Develop and administer entrance examinations
- Implementation of 2-year training program
- Develop and administer certifying examinations
- Evaluate transition to community-based practice

litical commitment to provide health care to all in Vietnam (Personal communication, Professor Le Ngoc Trong, vice minister of health, SRV, March 2000).

In the 1950s, this commitment to health care for all led to the development of a medical network of 10,000 commune health centers across the country. The MOH trained a cadre of health care workers for each of these centers over the next 2 decades. Attempts to introduce generalist physicians into these health centers have met with limited success. Many of the barriers experienced by other countries to bring physicians to rural areas exist in Vietnam. As a result, midwives, nurses, and assistant physicians have primarily staffed the commune health centers. One decade ago, only 15% of the commune health centers were staffed with physicians. Currently, general doctors staff 40% of the commune health centers. These physicians, however, have no postgraduate training or continuing medical education requirements and are perceived as being poorly trained.[11] The development of a "first-degree" specialty of family medicine seeks to address this problem by offering advanced training to generalist physicians.

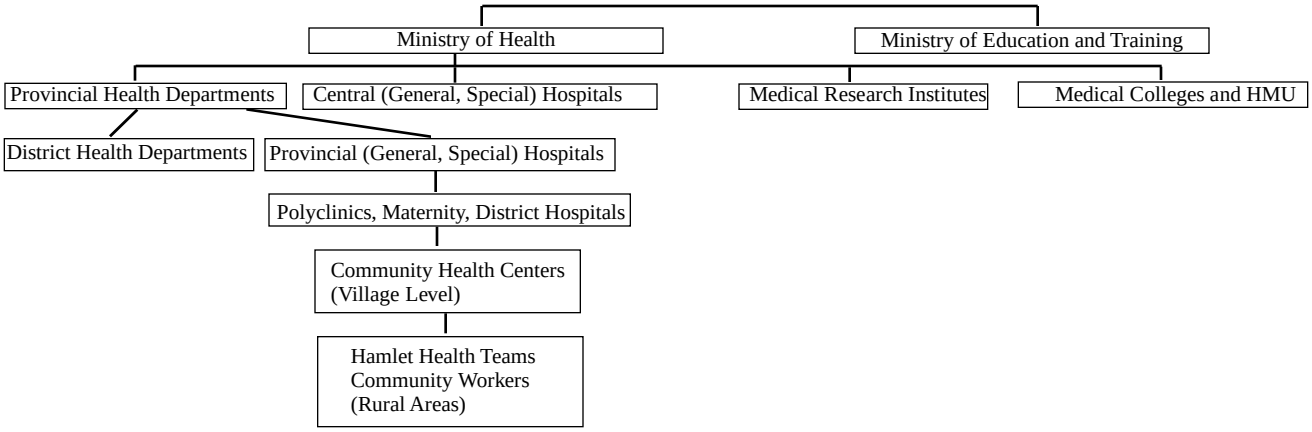
The public health care delivery system provided by the government in Vietnam is hierarchical (Figure 1). The intended first point of patient entry is the commune health center. Referrals are then made from the commune health care center to the next levels of care at the district, provincial, and central levels. Following the advent in 1986 of private health care, patients expect increasingly higher quality in their medical care and are less likely to follow the expected avenues of health care delivery. In a 1991 survey in Cu Chi, a rural province in the Southern region, only 10% of the population sought services from the commune health centers, 15%–20% sought services directly from the hospitals, and 40% sought services in the private sector. The rest chose health care services at the district level. In urban areas, a more-affluent family can go to a private physician or a hospital clinic, where there is a 90% chance of being seen by a physician.[12]

The second objective was to examine the medical education system. What we learned is that Vietnam's current system is based on the French system of medical education.[13] Candidates are eligible to enter 6 years of medical school directly after high school. Medical training consists of classroom academics, then rotations within the hospital. Little time is spent in outpatient care. Two years of postgraduate training is required for the first-degree specialties, which include internal medicine, pediatrics, surgery, obstetrics and gynecology, and now family medicine. Following this certification and 2 to 3 years of practice, a first-degree specialist may then be eligible for additional training as a second-degree specialist. This certification of advanced training is needed for a physician to become a subspecialist within his or her discipline.

The final objective was to develop guidelines for a project that could make the needed changes in the pri-

Figure 1

Health Care Delivery System of Vietnam



HMU—Hanoi Medical University

Most community health centers are poorly staffed, and patients go directly to the district or provincial levels for higher-quality health care.

mary health care delivery system. Its success was measured in three ways. The first was in the recognition by WHO and WONCA that this project represents an exemplary design for this type of consultation[8] and the second was the determination by the president of WONCA that it would "not only succeed but become a model for other developing countries."[14] The most important measure of success was the fact that the MOH accepted the recommendation that family medicine be the model for the new primary health care delivery system for the SRV.

Discussion

Several lessons were learned while performing this consultation. As in performing any consultation, the consultants must remain flexible, persistent, and patient. Careful attention, sensitivity, and prior study of the host culture and economic and political realities as well as the educational and health systems are vital to establishing relationships that go beyond simple business communication. Academic fellowships organized by the DIFME at US family medicine departments for core Vietnamese faculty leadership from each of the three medical schools was started from the first days of the project. This produced a cadre of highly committed leaders at each school who became effective advocates for and partners in the early advocacy stage. Stakeholders must be integrated into the process and become inside advocates for change to engender local ownership of the project as early as possible. These short-term faculty fellowships will continue throughout the life of the pilot project.

The importance of flexibility and persistence cannot be emphasized enough. Plans can change overnight, and buy-in can be slow. In our experience, meetings during the first consultative visit were difficult to arrange, and attendance and seniority of participants were low. Twelve physician educators attended initial informational sessions. However, by the end, there were more than 100 participants for workshops, including authorities from various ministries of the government, practicing physicians, and medical school deans, their faculty, and students.

Conclusions

Training for family physicians has begun in Vietnam, but there are still challenges to be faced. Outdated teaching methods are still being used, ambulatory teaching is minimal, and the biopsychosocial model is not well understood. Broad-based faculty development has been requested but hasn't begun. As consultants, we will observe the implementation respectfully and listen for readiness for further training.

Our consultation has resulted in a new paradigm for the delivery of primary care in Vietnam. Family physicians with postgraduate training will begin practicing in 2004. Will their training be adequate to meet their needs? Will there be more- and better-qualified physicians in rural areas? Will patients trust family physicians? Ultimately, will family physicians have a positive effect on national health indicators? We will patiently wait and see.

Acknowledgment: Financial support was received through a grant from the McKnight Foundation, Minneapolis.

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References

1. WHO/UNICEF. Primary health care. Report of the International Conference on Primary Health Care, Alma-Ata, USSR, September 6–12, 1978. (Health for All Series, no. 1). Geneva, Switzerland: World Health Organization, 1978
2. Shahady EJ. Principles of family medicine: an overview. In: Sloane P, Slatt L, Curtis P, eds. Essentials of family medicine, second edition. Baltimore: Williams and Wilkins, 1993:3-8.
3. Gilbert T, Culpepper L. World survey of family practice and general practice. In: Proceedings of the International Conference on the Education of Family Physicians, October 26–28, Bethesda, Md. Bethesda, Md: National Institutes of Health, 1993:16.
4. Montegut A. The Russian-American Family Medicine Project. In: Proceedings of the International Conference on the Education of Family Physicians, October 26–28, Bethesda, Md. Bethesda, Md: National Institutes of Health, 1993:16.
5. WONCA News 2003;29(4):6-7.
6. Haq C, Ventres W, Hunt V, et al. Where there is no family doctor: the development of family practice around the world. Acad Med 1995;70(5):370-80.
7. Morikawa M. Primary care training in Kosovo. Fam Med 2003;35 (6):440-4.
8. World Health Organization. Making medical practice and education more relevant to people's needs: the contribution of the family doctor. an update. Geneva, Switzerland: World Health Organization, 1999.
9. Dung PH. Challenges in health personnel development in Vietnam. Changing Medical Education and Medical Practice 1995;7:30-1.
10. World Health Organization. World health report 2000. www.who.int/whr/2000/en/report.htm. Accessed December 2000.
11. Gellert GA. The influence of market economics on primary health care in Vietnam. JAMA 1995;273(19):1498-502.
12. Socialist Republic of Vietnam Ministry of Health. Strategic orientation for people's health care and protection in the period of 1996–2000 and Vietnam's national drug policy. Hanoi: Socialist Republic of Vietnam, 1996.
13. Singer I. The Medical Education Project in Vietnam. JAMA 1975;234 (13):1405-6.
14. WONCA News 2000;26(3):2.