THE QUALITY OF HEALTH CARE SERVICES AT THE GRASSROOTS LEVEL IN VIET NAM EXTREMELY DIFFICULT SOCIO – ECONOMIC AREAS

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Abstract

Using the 5Qs model of Zinedl (2000a), our research evaluates the quality of grassroots health services in extremely difficult socio-economic areas in Vietnam. It used descriptive statistics to analyze and evaluate the components that make up the quality of health services. Analysis and evaluations in this paper were conducted through a survey of 200 households living in the areas of Program 135. The results indicated that the five components of the quality of health services at the grassroots level: (1)Q5 - Quality of atmosphere, (2) Q4 - Quality of interaction, (3)Q 1 - Quality of Object, (4)Q2 - Quality of process, (5)Q3 - Quality of infrastructure

Keywords *- the quality of service, quality of health care service, grassroots levels, extremely difficult socio-economic conditions areas.*

I. INTRODUCTION

Health care services are a special type of service and have distinct characteristics such as intangibility, heterogeneity, and concurrency that make identification and measurement of quality difficult. They are invisible and can not be felt, viewed, counted, or measured as tangible goods. Therefore, it is difficult to identify and measure the quality of health services compared to other fields. However, the quality of health services depends on the service process and the interaction between clients and service providers (Mc Laughlin CP, Kaluzny AD, 2006).

The health sector is facing environmental pressures such as demographic change and population aging, as well as the development of new technologies and approaches and the need for higher quality services to maintain competition (Ingram and Desombre, 1999; Andaleeb, 1998). Quality of service and customer satisfaction for the quality of health services is the major concern for health organizations.

In the health system of countries, hospitals, or health care facilities at grassroots are important places in the care and protection of the health of the people. According to WHO, the hospital is a complex working environment organization. Because advances in many aspects of society have made people better aware of their rights. They are increasingly asking for hospital systems better, so the hospital's responsibilities are more and more complex, so the complexity increases, and the roles and responsibilities of hospital staff also become more severe.

Nowadays, with the development of the health sector, the quality of healthcare services can be upgraded, the spirit of service will be more and more cared for, and the major tasks of the entire personal worker, the employee in the medical base are responding of customer needs.

According to the No. 900 / QD-TTG Decision dated 20/6/2017, Vietnam currently has 2,139 communes with special difficulties, border communes, and safe communes in 46 provinces eligibility for the Program 135, the period 2017 - 2020. The Viet Nam Government has had a number of priorities in improving the quality of health services at the grassroots level in extremely difficult socio-economic areas, such as free of charge in granting health insurance cards, having policies to support physicians and medical Volunteers… However, people in this area still hard to access health care services. The main reason is the shortage of human resources, especially specialized qualifications doctors (according to the Ministry of Health, 62 poor districts lack about 600 doctors in 15 specialties).

Therefore, to improve the quality of healthcare service, health facilities at the grassroots need to come up with appropriate solutions and policies base on customers' needs.

II. FRAMEWORK

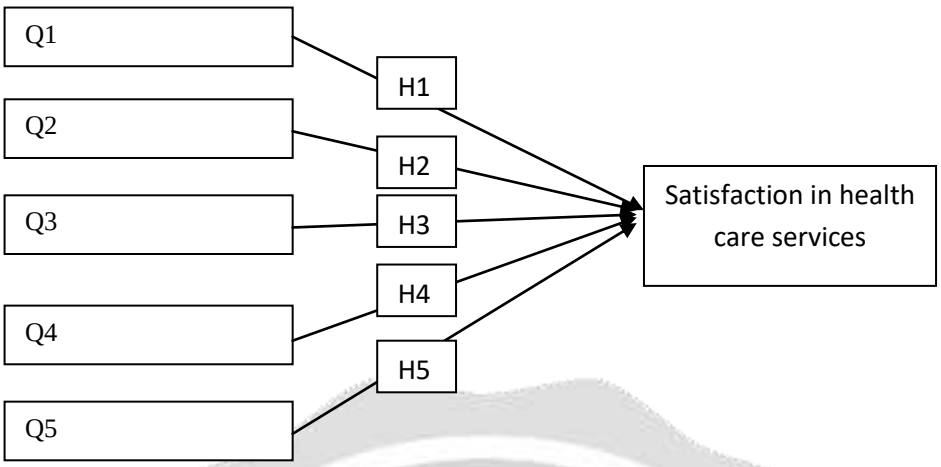

Figure 1: Research Model
Sources: Zinedl(2000a)

Now, there are many kinds of research about the model of the quality of the general service and the healthcare service such as:

SERVQUAL service quality scale (Parasuraman et al., 1988) measures service quality based on the perception of service users themselves. For any service, the service quality perceived by customers consists of five components:

1. Reliability: the ability to deliver the right services and on time at the first time.

Responsiveness: the desire and willingness of the staff to provide services to the customers.

Competence: the expertise to perform the service, such as the ability to serve when staffs interact with customers, employees directly perform services, research capabilities to capture necessary relevant information for serving customers.

Understanding customer: The ability to understand customer and customer's needs by understanding the customer's requirements, knowing characteristics of customers, and identifying their regular customers.

Tangibles: Represented by the appearance, costumes of the service personnel, the equipment supporting the services.

Zinedl (2000a) expanded the SERVQUAL technical quality and functional models into five quality frameworks for health services (5Qs), including (1) Q1 - Quality of Object; (2) Q2 - Quality of process; (3)Q3 - Quality of infrastructure; (4) Q4 - Quality of interaction; (5) Q5 - Quality of atmosphere.

III. METHODS

In this paper, we use descriptive statistics to analyze and evaluate the components of health service quality at grassroots in extremely difficult socio-economic areas, including (1) Quality of Object; (2) Quality of process; (3) Quality of infrastructure; (4) Quality of interaction; (5) Quality of atmosphere.

Primary data was collected by questionnaire, random surveys of 200 households in extremely difficult socio-economic areas in January 2018. In 200 questionnaires, 19 were rejected because of the lacked information, and 181 valid votes were used as data for the content to be analyzed in this paper.

The secondary data using is taken from household living condition surveys conducted by the General Statistics Office of Vietnam, including the results of (1) Accessibility to health care services; (2) Quality of health facilities; (3) Quality of human resources in the health sector from 2010 to 2018; (4) Results of finance, human resources in the health sector from 2012 to 2018 of Ministry of Health. The main objective of each survey is to provide detailed information on health care utilization and expenditures, sources of payment, health status, health insurance, demographic characteristics, income, and expenditures of a representative sample of Vietnamese people, which are divided into areas with/without special socio-economic conditions (under Program 135 and non-135 regions). Each survey collected data from a sample of selected households randomly in different provinces across the country. The sample size surveyed by the General Statistics Office (GSO) is 9400 households in 2018. Details of the survey results are available in the VHLSS datasheet and the General Health Sector Report from 2012 to 2018.

IV. RESULTS

4.1. An overview of the quality of health care services in Vietnam

4.1.1. Accessibility to health care services

Health insurance is an important element to access people's health care. After 10 years of validation, the Law on Health Insurance of Vietnam has made many changes in social life, but the actual implementation still has many inadequacies. Many poor people, ethnic minority people have not been accessed to health care services of health insurance.

Since 2002, the Prime Minister has issued Decision 139 to support health care for the poor through a fee exemption card or health insurance card. In 2006, this policy was implemented by Decree 63 of the Health Insurance Regulation and in 2008, the coverage ratio for the poor households was determined to be relatively high. In 2008, the health insurance law came into existence, and the poor, EM people, and people living in extremely difficult socio-economic regions were exempted from health insurance premiums. As of the year 2018, the total number of people covered by health insurance is 71.6 million, reaching a coverage rate of 76.7% of the population, an increase of 34 million compared to 2010 - the time when the Law on Health Insurance is not effective (Table 1) (General Statistics Office of Vietnam, 2018). The initial registration of medical examination and treatment was carried out by the law, which contributed to reducing the burden on upper-level hospitals, enabling health insurance participants to select health care registration locations initial fit. At the same time, creating favorable conditions for access to health services of health insurance cardholders, especially for the poor, near-poor, people living in ethnic minority areas or areas with special socio-economic conditions, was difficult. Although the proportion of people without health insurance has declined significantly compared to 2004 (General Statistics Office of Vietnam, 2018), the target group is involved, with the number of poor and near-poor households participating in health insurance, is 19 million, which has a considerable impact on the access to health services of the target group.

Table 1. The estimated principal source of health insurance, 2018

	Number of people (millions)	***Population (%)***
1. The population have the health insurance card	71,6	76,7
2. The population does not have the health insurance card	21,8	23,3
Total	93,4	100

Sources: General Statistics Office of Vietnam, 2018

4.1.2. Quality of facilities

The distribution of health facilities as well as human resources in the health sector in our country is still not reasonable today. Most clinics with good facilities and highly qualified medical staff are concentrated at the central level, in major cities, and urban areas. Meanwhile, the majority of the poor people in our country live in rural, mountainous, remote, and isolated areas. Therefore, access to health care and quality health care of the poor in these areas is quite difficult.

Table 2. Percentage of communes having health facilities by far and remote areas in 2018

Unit: %

Type of medical facility	***Communes under program 135***	***Communes is not under program 135***
Commune Health Station	99,2	99,7
Regional General Clinic	12,8	9,2
District Hospital	2,6	4,4

Sources: General Statistics Office of Vietnam, 2018

Comparison between poor communes (under Program 135) and non-poor communes (not included in Program 135) and between communes in remote and far-off communes showed that the proportion of establishments Communes in communes not covered by Program 135 were often higher than Program 135 communes and were also higher in remote communes. Also, in the poor communes, only a small number of health stations, district hospitals, or provincial hospitals account for a very small proportion and almost none (Table 2) (GSO, 2018).

4.1.3. Quality of health workforce

Regarding the structure of health resources, there are also differences between levels. Of which, the provincial level focuses the most numerous doctors, at the district level, the number of the nurses and midwives

are the largest proportion, while at the commune level the majority is the physician. This also shows the difference in the level of health staff at all levels.

Table 3. Percentage of health workforce by professional level and by 2018

Unit: %

	Total	***After university***	***University***	***College, Intermediate***	***Arithmetics***
General structure	**100**	2.3	21.9	45.3	30.5
Spreading (%)					
Center	11.5	44.8	19.0	13.8	0.3
Province	37.0	48.7	40.1	31.8	41.8
District	31.2	6.4	29.4	29.6	36.6
Commune	20.3	0.1	11.5	24.9	21.3
Total	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**

Sources: Yearbook of Health 2018

Most of the trained health workers (post-graduate) concentrated at the central level (44.8%) and the provincial level (48.7%). At the district and commune levels, the health workforce is primarily college, secondary and primary (66.2% at the district level and 46.2% at commune level) (Table 3) (Yearbook of Health, 2018). Thus, with the differences in the allocation of the health workforce in Vietnam, the accessibility to quality health services for the poor, people in remote areas is very low.

4.2. Evaluation of the quality of health services at grassroots in extremely difficult socio-economic areas

4.2.1 Indicators of evaluating the quality of health services at grassroots in extremely difficult socio-economic areas

The paper adopted the 5Qs model for health services at grassroots in extremely difficult socio-economic areas. Therefore, the targets in the 5Qs model have been adjusted to suit reality.

Q1 - Quality of Object, including:

Q11. Sense of wellbeing that you felt in the hospital

Q12. The ability of the hospital to treat you the way you expected

Q13. Sense of security from physical harm you felt in the hospital

Q2 (Quality of process), including:

Q21. Waiting time for medication

Q22. Waiting time for tests

Q23. Speed and ease of admissions

Q3(Quality of infrastructure):

Q31. Skills of the nurses attending you

Q32. The skill of those performing your tests

Q33. The skill of the physicians attending you

Q4 (Quality of interaction)

Q41. Adequacy of explanation about your treatment

Q42. Adequacy of instruction on release from the hospital

Q5 (Quality of atmosphere)

Q51. Responsiveness of nurses to your needs

Q52. Clarity of information about your condition

Q53. Politeness of the physicians.

4.2.2 Evaluation of the quality of health services at grassroots in extremely difficult socio-economic areas

Basing on data in Table 4, the quality of health services at grassroots in extremely difficult socio-economic areas is shown as follows:

Q1 (Quality of Object) - The technical quality (what customer receives)

Q1 reflects the technical quality of the health facility, relating to the treatment procedure being performed and the accuracy of the drugs and regimen for the patient.

Respondents did not appreciate Q1 indicators. Approximately 50% of respondents rated poorly to Q11 and Q12 (feeling satisfied and ability of treatment as the patient's desire). Especially, Q12 was rated bad, only 25% of respondents rated average and 26% of respondents rated good to very good. Q11 reflects the patient's satisfaction as well as overall treatment in the hospital was not well appreciated by the patients, nearly one-third of respondents said that this factor of health facilities is very bad.

As such, most patients do not trust the treatment process that health facilities at grassroots in extremely difficult socio-economic areas implement.

Q2 (Quality of processs) – the functional quality: how the health care provider provides the core service

Q2 reflects the quality of the treatment process and patient care from the time they arrive at the hospital to admission. In Q21, there are only less than 4% of patients satisfied with a very good rating, more than 10% rated it good, while 42% rated badly. The tiredness of patients in waiting time for medication and examination is very common in the health facilities at grassroots. With local characteristics, many people who have relationships with health staff are often interrupted, giving priority to medication and examinations. This will affect the waiting time for medication and examination of the others.

Q3 - Quality of infrastructure

Infrastructure in health facilities is the most important factor affecting the treatment process and the patient's satisfaction. The infrastructure is related to the capacity, skills, attitudes, motivation, and assurance of health staff. Without this factor, it seriously affects the quality of health care service or medical facility will provide poor quality of care.

The skills of doctors, nurses, and technicians involved in the examination and treatment process are critical to the quality of care service. In the health facilities in extremely difficult socio-economic areas, these factors are reduced to three factors Q31, Q32, Q33. Health staffs in this area are both shortly and weakly, which is why more than 52% of respondents rated Q31 as bad and very bad, only 15% rated Q31 as well.

Q4 - Quality of interaction

Quality of interaction measures quality of information exchange, payment of hospital fees, and other interactions in the course of medical examination and treatment. Patient's satisfaction depends on the doctors' explanations during the treatment and instructions after discharging. Although the explanations during treatment (Q41) were not appreciated, the doctor's recommendations after discharging (Q42) were generally above the average.

Q5 - Quality of atmosphere

Quality of atmosphere refers to the relation between the health staff and the patients, the health staffs' attitude to the patients. Many patients evaluate that the health staff neither do meet their needs nor public the patient's condition. Particularly the polite attitude of doctors and nurses to the patient, 47% evaluated badly and very bad.

Table 5. The average score in 5Qs model

Các chỉ tiêu (Indicators)	Điểm bình quân (Average score)
Q1	2,71
Q2	2,70
Q3	2,67
Q4	2,71
Q5	2,74
Mean score for the total quality	2,71

Sources: Synthesize the data of the authors

Survey results indicated that to improve the quality of health services, the quality of the process (Q2) and the quality of the infrastructure (Q3) should be impacted.

Table 4. Evaluating the quality of health care services at the grassroots level in extremely difficult socio-economic conditions areas

	1 V. bad	2 Bad	3 Average	4 Good	5 V. Good	n	1 V. bad (%)	2 Bad (%)	3 Average (%)	4 Good (%)	5 V. Good (%)
Q1											
Q11	56	28	73	15	9	181	30.94	15.47	40.33	8.29	4.97
Q12	37	49	46	30	19	181	20.44	27.07	25.41	16.57	10.50
Q13	20	33	65	50	13	181	11.05	18.23	35.91	27.62	7.18
Q2											
Q21	21	55	79	19	7	181	11.60	30.39	43.65	10.50	3.87
Q22	30	39	80	15	17	181	16.57	21.55	44.20	8.29	9.39
Q23	25	41	84	18	13	181	13.81	22.65	46.41	9.94	7.18
Q3											
Q31	55	40	58	18	10	181	30.39	22.10	32.04	9.94	5.52
Q32	32	42	67	25	15	181	17.68	23.20	37.02	13.81	8.29
Q33	22	26	96	21	16	181	12.15	14.36	53.04	11.60	8.84
Q4											
Q41	46	43	59	15	18	181	25.41	23.76	32.60	8.29	9.94
Q42	10	45	91	25	10	181	5.52	24.86	50.28	13.81	5.52
Q5											
Q51	20	56	72	19	14	181	11.05	30.94	39.78	10.50	7.73
Q52	21	42	77	21	20	181	11.60	23.20	42.54	11.60	11.05
Q53	39	46	62	15	19	181	21.55	25.41	34.25	8.29	10.50

Sources: The results of the authors' Survey

IV. CONCLUSION

The role of grassroots health care quality in the development of the health sector in general and in regions with extremely difficult socio-economic conditions, in particular, has been clearly recognized. The coverage of basic health care services in Vietnam in recent years has made significant progress, attracting the attention of the Party, State, and health organizations, in which strong development of grassroots medical facilities.

The article "The quality of health care services at the grassroots level in Vietnam extremely difficult socio-economic areas" tries to clarify the following issues:

- Summary of the theoretical framework according to the 5Qs model in health care service quality assessment research.

- Apply the 5Qs model to assess the quality of health care services at the grassroots level in Viet Nam extremely difficult socio-economic conditions.

This article focuses on health care service quality components and quality measurement. Hospitals and health managers should find a way to measure the performance of health workers as well as the cost-effectiveness of healthcare.

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