

IDENTIFYING FACTORS DISCOURAGING AND RETAINING MEDICAL DOCTORS TO WORK IN UNDERSERVED AREAS OF VIETNAM

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Background

The health system of Vietnam is organized in four tiers: central, provincial, district and commune levels. Each commune has a Commune Health Center (CHC), which makes the health system a large coverage at commune level. The policy "one commune - one CHC" is very important for the Vietnamese Health system since 76% of people are living in rural areas. In fact, the CHCs have important role at grassroots level in providing primary health care services and they are the first health institution recognizing early health issues. CHCs are also the most appropriate places to implement and experience all health policies and strategy as well. Some health indices of Vietnamese improved due to this wide CHC network. To strengthen the CHC capacity and motivate the human resource, Vietnam Government issued Decision No 58/TTg in February 1994 with special regulations and policies for CHC health staffs. The most popular measure concerning education and training was to upgrade the local assistant doctors into medical one. Financing incentives were also used as motivating procedure. The target of 80% of Commune Health Centers have at least one medical doctor has been considered as one of the most important targets of the Vietnam Health Care Policy for people in the period 2001 – 2010 in order to get more equity and efficiency for the poor living in remote underserved areas.

In the Direction No 06 issued on January 22, 2002, an expanded education program was prioritized for the local minor health workers to reach the above mentioned target by 2010.

At provincial level, every province tries to develop their own regulations attracting medical doctors to work in rural areas. A lot of assistant doctors have the chance to follow up the 4-year upgrade course into medical doctors. Some financing incentives have been offered as different kind of allowances the rate of which varies by province. The coverage of CHC having MD has been improved, attaining 67.4% in 2007, while it was only 23.4% in 1997.

However, the underserved and remote communes in the West North, East North, and South Central Coast still suffer from serious shortage of medical doctors. The coverage of the MDs in CHC of these areas was only 24.3%; 55.2% and 52.3% respectively. On the other side, most of prioritized minor MDs and a part of local assistant doctors getting medical doctor diploma

after four-year course did not return to the CHC where they have got the special priority in MD education program.

The rate of CHC having MD was only 67.4% in 2007, far from the target of 80% by 2010, whereas the number of physicians giving up their work in the public health sector has been increasing by year. This tendency is widening not only in the public health institutions in the urban, but in the rural health ones as well.

The possible “push - pull” factors operating on new medical graduates’ reluctance to join the public sector were mentioned in Tan Tun Sein report. The push factors are: i) social class background of most of the medical students being from well-off urban families, ii) dislike of HRH management practices in the public sector especially the financial incentive, iii) does not want to work at peripheral areas and iv) prefers to migrate abroad. The pull factors are: i) prefers to do private business which may not be related to the medical training received, ii) increased opportunities in private sector medical care services located in big cities, and where salaries are high, and iii) prefers to join an international NGO where salary is higher than in the public sector [1].

The root factors urging medical doctors to give up their work in public health sector and go abroad were identified by Rezvi Sheriff as inadequate financial remuneration, inadequate facilities for clinical work and continuing professional development, inadequate facilities for wellbeing and social support and unsatisfactory work environment [2].

In Vietnam, the work conditions and professional activities of CHC medical doctors were described in some researches as poor facilities, drug insufficiency, low work effectiveness, etc. [3, 4].

The factors discouraging CHC staffs to work in rural areas of Vietnam were identified in the survey of Marjolein D. et al (2005). These factors are low income and allowance, difficult transportation, no updated information and lack of knowledge and heavy work without plan [5].

However, discourage factors of CHC staffs may not be the same as of MDs. In addition, the voice of the most concerning stakeholders including CHC medical doctors, policy makers and newly graduate MDs on this problem seems not to be enough sounded.

In order to get evidence-based data for developing proper policy encouraging medical doctors to work in rural areas, particularly in remote underserved mountain areas, the aim of this research is to identify the factor discouraging MDs to work in CHC and factors that are strong enough to keep them at CHC with better work performance.

Conceptual framework

Shortage of MDs in rural areas is one of HRH issues of Vietnam. Solving this problem requires a comprehensive database as evidence-base information for policy development and thus, a cross-sectional qualitative and quantitative survey was conducted in three poor provinces as Tuyen Quang, Quang Nam and Hau Giang. Two first provinces are located in mountain areas. The third is in Mekong River Delta where the transportation is mainly by boats. The semi-structured questionnaires were developed to get information concerning MD work conditions, their in-service education and training and their work satisfaction. Six commune MD group discussions were also organized. The deep interviews were given to the managers at provincial, district and commune levels to get their opinions on feasibility of existing regulations and policy for rural MDs. Forty two MDs working in 6 underserved districts of above mentioned provinces have participated in this survey. The infrastructure and work conditions of the 18 CHC locating in these 6 districts were randomly chosen for observation and analysis as well.

Besides, a special workshop was designed and carried out with the title **“Political options for implementing the national strategy encouraging medical doctors to work in rural areas”**. All participants of this workshop were managers - policymakers from concerning ministries such as Ministry of Health, Ministry of Home Affair, representatives - directors/vice directors of 8 Provincial Health Departments (as representatives of 8 regions of the country). The director board of four medical schools educating MDs in the areas where this survey was conducted was also invited as participants. The aim of the workshop was to identify the factors that are strong enough to retain MDS to work in CHC. All participants were provided information of MD’s group discussions and results of their questionnaires before conducting group discussion. The experiences of Asian countries in motivation and retention of MDs in rural areas were also shared for the participants. Each proposed factor was ranked by participants with highest mark is 5 and lowest is 1 and then summarized. Five factors with highest marks were identified as final ones.

Two major questions in this survey were: 1/ to identify the factors discouraging and 2/ to identify factors retaining MDS to work in CHC. The obtained results will be used as evidence - base information for policy makers in developing comprehensive strategy attracting MDs to rural areas.

Results and Discussion

Profile of the CHC medical doctors

Most of MDs are local population in which 40% were born in the same commune where they are working in and 43% were born in the district which their commune belongs to. Their average age is 41 and working experience is 12 years. Most of MDs working in the mountain areas in Tuyen Quang and Quang Nam province belong to ethnic minorities and 30/42 of them (71.2%) were the CHC director. More than 90 % of MDs were upgraded from assistant doctors and 71.4% are general physicians. One

third of MDs have to work overtime in average 3 – 5 hours outside at the commune as private doctors to earn more income.

Work conditions and in-service education and training

All observed in this survey CHC have electricity and telephone line. CHC houses were built for 20 – 30 years ago, that are too old and small. Water resource is mainly taken from deep wells with pump and simple filter system. Two of 18 CHC still use water from mountain slit directly.

CHC equipments are poor and old, the most popular ones are stethoscope, sphygmomanometer, and some instruments for gynecology, obstetrics and child delivery. Some other instruments such as electric acupuncture instrument and aerosol apparatus were given by National Project 135 for the underserved CHC. However, they have not been used properly because of the lack of specially trained health workers for these instruments. Every CHC was equipped one cool chain for keeping vaccines. Unfortunately, they were kept in the boxes due to its high electricity expenditure. In general, CHC equipments and drugs were insufficient and adequate only 20 – 30% of standardized equipment list for CHC.

Poor equipment conditions did not allow the medical doctors to provide as much services as they can. A MD group discussion illustrates information about it as follow:

“We may perform only about 50% of our ability since we don’t have enough equipments for our work, particularly for the diagnosis in village”.

Table 1. In-service education and training of commune MDs

No	Number of attended in-service education course	Number of MDs	Percent
1	0	18	43
2	1	16	38
3	2-3	6	14,2
4	≥ 4	2	4,8
Total		42	100

Though commune medical doctors have 12 working years in average, but 18 among 42 of them have no chance to get any in-service education and training course. Only 38% have attended one training course (See Table 1). Commune MDs have little in-service education, therefore, they have to retrain and strengthen their knowledge by self-education such as reading their own books, although most of them are old and out-of-date or sharing experiences with colleges (See Tab. 2). The other chance of self-education of commune MDs is sharing experiences with colleges during their monthly

meeting at District Health Center.

Table 2. The self-education ways of commune MDs

No	The self-education ways	Number of MDs	Percent
1	Reading books in library	2	4,8
2	Reading own books	35	83,3
3	Sharing experiences with colleges at meetings	14	33,3
4	Others (phone/ask colleges)	3	7

Commune MDs have little chance to attend workshops or conferences. Majority of them have participated workshops only at district level (See Table. 3).

Table 3. Workshop participation of commune MDs

No	Workshop/Conference level	Number of attended MDs	Percent (%)
1	Abroad	0	0
2	National	1	7,1
3	Provincial	2	14,2
4	District	11	78,5
Total		14/ 42	33,4

Opportunity of career development and public awards

The key CHC functions are giving primary health care and preventive services. It makes commune MDs have less opportunity to use knowledge that they gained in medical school. In addition, 71.4% of commune MDs are general physicians, they don't have enough and updated knowledge on preventive medicine.

To write different kinds of report, including CHC monthly, quarterly, biquarterly and annual reports, reports of 10 national target programs as EIP, ARI, etc., commune MDs have to spend a lot of time for this tired work and it was considered as their big burden. In addition, commune MDs have to do different kind of work because of the lack of health staffs. Sometime, they have to do simple operations that other health staffs can do simply

because the community trust in them. It was a big spiritual award for MDs, especially in village. However, they felt their future is “blocked” within their village. In some districts, there was staff changing within the district to renewing the human resource. In fact, it seems not to be so much better. Commune MDs stay in their commune without promotion for long time and they are discouraged,

The inequity between MDs was mentioned during their group discussions. For whom who did not return to their village after university graduation and stay in urban for their work, they have a lot of chance to get better jobs in term of work conditions, upgrading knowledge (following master and then Ph.D courses) and salary as well, whereas the commune MDs have very few chances as urban MDs have, except living in their own house.

Factors discouraging MDs to work in CHC

Results of MDs questionnaires showed that the main factors discouraging them to work in CHC are: 1/ poor opportunities for career advancement and continuing education (80.6%), 2/ poor regulation system concerning graduate medical doctor (74.2%), 3/ poor work conditions (71%), low salary scale and allowance (64.5%), 4/ heavy work load (42%), 5/ little social recognition (35.5%) (See Fig.1).

The following opinion of one group discussion illustrated above figures:

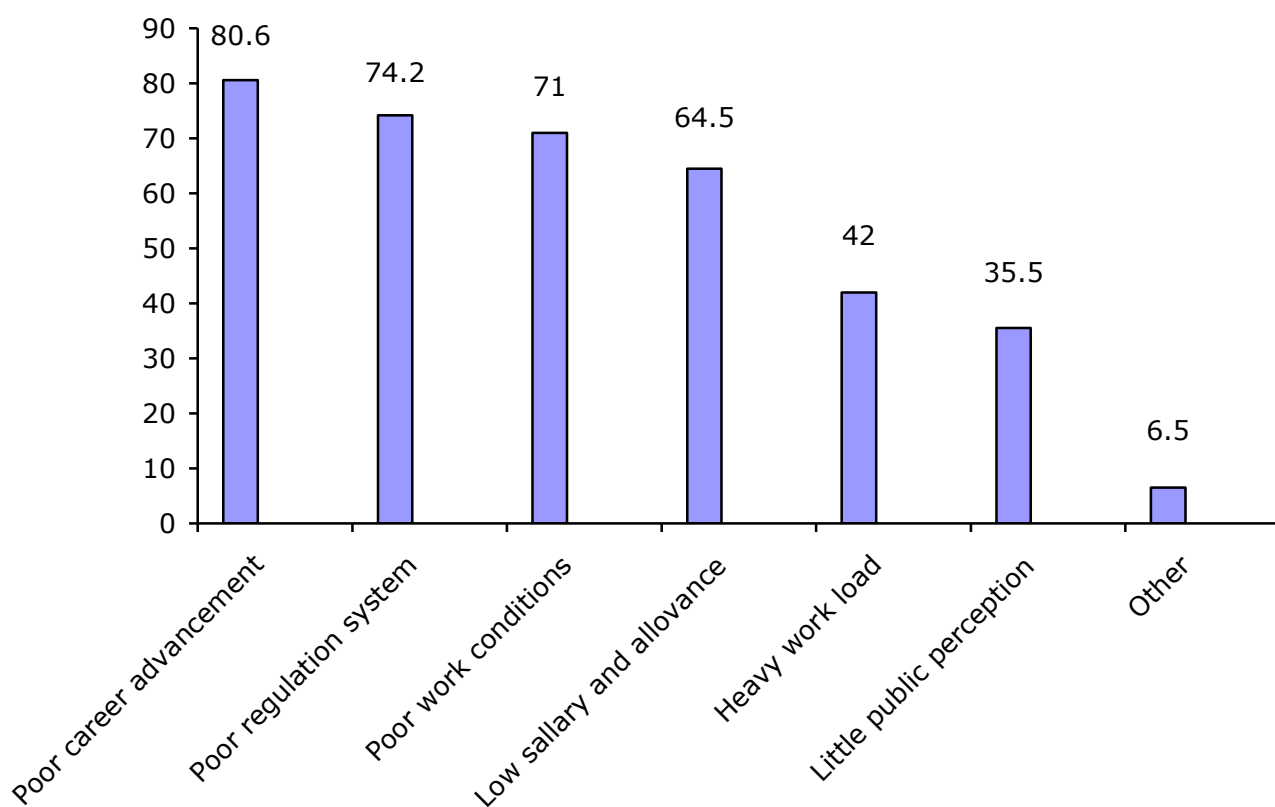


Fig. 1. Main factors discouraging commune MDs to work in CHC

"I am a medical doctor working in CHC. If I worked in a district clinic, I'll have more chance to diagnose patients, and my knowledge could be much better. But I am working here in village, my knowledge therefore in deterioration. I forget a lot. I am so sorry because my knowledge couldn't be used as I have".

Factors retaining MDs in CHC

At the workshop, the real situations of CHC and factors discouraging MDs to work in CHC were actively discussed by all participants. The experiences of Asian countries in solving this problem were also introduced to them. Finally, five factors with highest marks were selected as prerequisite conditions to mobilize and retain medical doctors to work in CHC. It can be seen as important measures in getting the national target 80% of CHC having MDs. These factors are indicated in Tab. 4.

Table 4. Factors retaining MDs in CHC

No	Necessary factors retaining MDs in CHC	Total marks
1	Good enough working conditions as infrastructure, equipments, transportation	71
2	Appropriate regulations: salary, regional and professional subsidize, allowance, etc.	71
3	Legal regulations: the service in public health sector must be institutionalized as compulsory duty for all graduate MDs. Its service duration, MDs interests and penalties must be defined as well,	53
4	Career advancement: in-service education and training, opportunity to share and exchange experiences, enlargement of technical grade for CHC	33
5	Professional and social promotion as career advancement, position in society, public recognition	14

Good enough working conditions were the most essential for commune MDs. Working as hard as they can is their happiness, conscience and morale. They are worried when they have to move patients to the district hospital because lack of equipments, while patients have to pass a difficult way to reach

there.

Second factor discouraging commune MDs was financial. Low income was the reason why one third of them have to work overtime. Their physical and mental health will be exhausted soon after long working time, and naturally they can not contribute their capacity to the work in CHC as expected. Low service quality in CHC is the consequence of low income. Improving income with better salary scale and allowance/subsidize is important condition attract commune MDs to underserved regions.

Sharing experiences from the Asian countries, many managers paid their attention on compulsory service system for MDs in public health sector. Like other developing country, Vietnam government has to subsidize lot of money for tuition fee for students in public universities, particularly medical one. By the other words, medical students are in debt of the government and working in certain time in public health sector can be seen as their duty. Compulsory service also can be considered as an effective measure of equity among graduate MDs. However, this compulsory service system is not used in Vietnam and therefore, is not highly ranked as the two first factors.

The fourth factor related to MD in-service education and training by manager's ranking. However, for the MDs themselves, it is their most discourage factor that might be have higher priority (See Fig.1).

The fifth factor related to the MDs professional and career advancement, namely promotion at work, public awards, etc.

Thailand had carried out many public recognition awards for the MDs who worked in rural areas for long time and devoted their life to people health in the commune. It was important strategy of Thailand's success in HRM [6, 7].

Some factors considered as reasons urged Sri-Lanka graduate MDS to migrate abroad were mentioned in Sheriff's work (2005). It was poor financial remuneration, not in keeping with rise in cost of living, inequities in salary scales, inadequate facilities for personal wellbeing and social support, unsatisfactory working environment and poor management [2].

Sending graduate MDs to rural, particularly in remote areas is difficult problem for developing countries. Myanmar had three – years oblige service in public health sector. However, the so called "push-pull" factors have influenced on young MD and the government has not completely solved this hard issue [1].

Carrying a survey in 9 CHC, Trinh Van Hung and his colleges (2001) found that only 1/9 of commune MDs satisfied with their work in CHC and all of them (9/9) have desire to get more opportunities in upgrading their knowledge and their CHC must be more invested with new equipment and budget as well [3].

The factors considered as obstacles for MDs to get higher working efficiency

were mentioned in the survey of Le Van Them and his colleges (2005), namely poor infrastructure and equipment (62%) and drug deficiency (25%). Being recognized as CHC permanent staffs was also a important factor retaining MDs in commune [4].

The financial and non-financial factors for job motivation of rural health workers in the North of Vietnam were defined by Marjolein Dieleman (2003) [5]. In general, most of factors discouraging the health workers in his survey were also the same as in our work. However, the opportunity to get career development was not emphasized in his work, but it was most important for the commune MDs in our survey. It can be explained by knowledge difference between simple health workers and MDs.

Lessons learnt

The shortage of MDs in rural and remote areas can not be solved without comprehensive strategy basing on good evidence-based information of stakeholders. Our work was a base-line research and one important step of strategy development. The findings were obtained basing on the consensus opinions of the most important stakeholders – commune MDs, policymakers and managers of all levels. These findings indicate that financial incentives were not all for the MDs in rural areas. Their first needs are opportunities for career advancement and continuing in-service education. Legal regulation system is also considered as an important factor keeping equity in HRM. In addition, morale and spiritual awards could not be overlooked. Since discouraging and retaining factors are the two sides of one issue, the strategy for MDs in rural areas must be developed considering all these factors.

In fact, a lot of regulations concerning shortage of MDs in rural areas have been developed and implemented for long time in Vietnam. However, the key MDs interests were paid not enough attention. Moreover, when the government budget is limited, the compulsory service in solving MD's shortage like the way as the other countries did must be considered soon in Vietnam. In addition, the policy "one CHC – one MD" is a political willing in the market economy period, therefore, requires an appropriate strategy. It means the MD interests and penalties must be considered well. In general, little interest and weak/lack legislation system for the MDs can be considered as reasons of MD shortage in CHC of Vietnam.

Proposals for region or global actions

As in other developing country, the tuition fee for the medical students in Vietnam is quite low so that the government has to subsidize most part. However, there is not any regulation concerning oblige service in the public health system for the graduate medical doctors. The graduate medical students can work everywhere they want. The consequences are obvious: severe shortage of medical doctor not only at commune, but also at district

and soon at provincial health institutions. Underserved areas remained underserved on qualify medical doctors, which caused inequity and inefficiency in health system. The ways to solve the problem may not only to improve work conditions at CHC, but also apply the compulsory service in public health system in a certain period like other developing countries did such as Thailand, Indonesia, Sri-Lanka, etc.

REFERENCES

1. Than Tun Sein, M.M.W., Nilar Tin. *Human Resource for health in Myanmar*. in *Workshop on Asian Action Learning Network on HRH 2005*. Bangkok, Thailand, 3-5 August 2005.
2. Sheriff, R. *Migration of HRH within and out of Sri-Lanca - Report and Analysis*. . in *Workshop on Asian Action Learning Network on HRH*. 2005. Bangkok, Thailand, 3-5 August 2005.
3. Trinh Van Hung, P.H.D., *Real situation of commune medical doctors in Pho Yen district, Thai Nguyen province*. Practical Medicine, 2001.
4. Lai Van Them, D.N.P., et al, *Professional activities of CHC medical doctors in Hai Duong province in 2005*. Hanoi Medical University Annual Research Work. , 2006.
5. Marjolein Dieleman, P.V.C., Le Vu Anh and Tim Martineau, *Identifying factors for job motivation of rural health workers in North Viet Nam*. Human Resources for Health 2003, 1:10.
6. *Human Resource for Health. Overcoming the crisis. Joint Learning Initiative*. Global Equity Initiative. Cambridge, Massachusetts. 2004
7. Thinakorn Noree, H.C., Veerasak Mongkolporn. *Abudant for the few, shortage for the majority: The inequitable distribution for doctors in Thailand*. in *Workshop on Asian Action Learning Network on HRH*. 3-5 August 2005, Bangkok, Thailand. 2005.