

First, Treat the System

*The Atlantic Philanthropies' Effort to Promote Health and Equity in Viet Nam
by Investing in a Healthier, More Equitable System of Policy, Practice, and Care*

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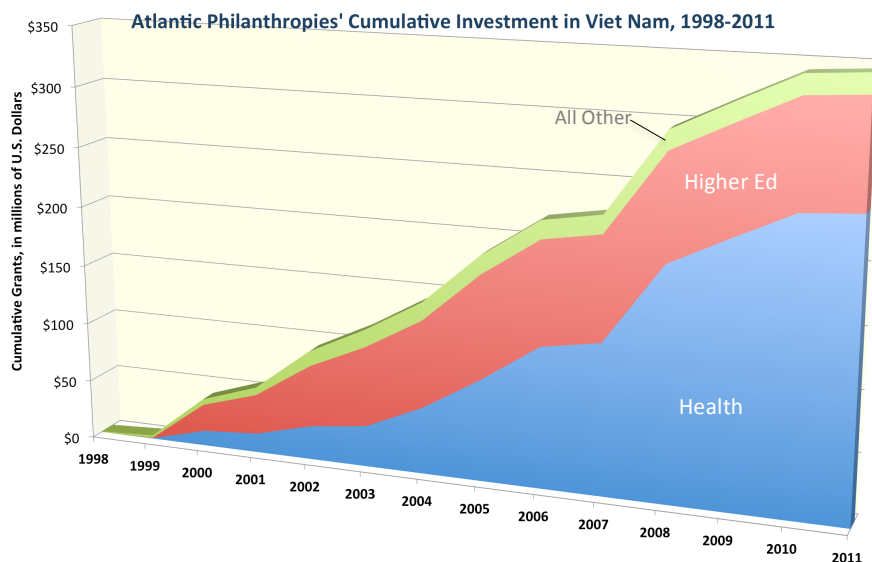
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Executive Summary

SINCE 1998, The Atlantic Philanthropies has invested nearly \$350 million (7 trillion Viet Nam Dong) in improving higher education, public health, and primary health care in Viet Nam. With particular intensity since 2003, the Foundation has concentrated its attention and resources on the latter two goals: helping Viet Nam develop a more complete and more equitable primary health care system, and instilling a culture of public health in policy and practice nationwide.

Along the way, Atlantic has found allies and directed its own resources at every level of the country's health care system: at elite national institutions and central-



government policy, at key regional hospitals and increasingly powerful provincial health departments, and most expansively, at Viet Nam's frontline community clinics, called Commune Health Centers, or CHCs. The centers are meant to be the main source of

primary care, especially for poor, rural, and minority Vietnamese who are not well served by the country's burgeoning system of private health-insurance. But since the late 1980s, as Viet Nam has restructured and decentralized much of its economy and many of its government services, the CHCs have suffered, and many have become dilapidated, thinly staffed, and starved for supplies and equipment. As conditions deteriorated, staff morale and patient confidence eroded as well.

The decline of the CHCs has created spillover problems for the rest of the health-care system — particularly for severely overcrowded district and provincial hospitals, where patients often turn up with conditions that should properly have been prevented or treated at the commune level. The results have been not only inefficient but inequitable, as standards of care for uninsured people have fallen further and further behind those available for patients with private coverage. Yet although the problems are systemic, the government's response has tended to be mostly episodic and piecemeal — dozens of mostly worthwhile reforms, each with

separate rules and performance standards, falling one after another onto already overwhelmed — and often undertrained — local health workers.

Atlantic's approach has been to address the system as a whole, helping to develop better facilities and methods of primary health care delivery at the front lines and working in partnership with innovators at the provincial and national levels to sustain and replicate the best approaches. The governing theory of this effort has been that a well-designed, integrated reform of primary health care at the most basic level, demonstrated in a handful of enterprising, reform-minded provinces, would create a template of reform that could be promoted from province to province and adopted by the central government as national policy. Beginning in two provinces, Khanh Hoa and Da Nang, the Foundation joined forces with the Da Nang-based East Meets West Foundation and with visionary government officials to spark the renovation of (by now) hundreds of CHCs. Atlantic has contributed to the cost of information technology, equipment, medicines, and other supplies, with growing commitments from the Vietnamese government to preserve and expand these investments. And the Foundation has drawn on outstanding international programs and institutions to train physicians and health workers, help design improved forms of care, and raise standards of practice in certain critical areas, such as reproductive health, maternal and child health, and family medicine.

By 2008, results in the first two sites were promising enough that Atlantic expanded the program to three more provinces, all with somewhat more challenging circumstances. By this time, provincial governments were matching the Foundation's grants in at least equal amounts, thus both doubling the amount of available money and ensuring substantial government investment in the model. A further expansion began in 2010, this time involving provinces poor enough that major funding from the national government would be necessary. As with support from provincial authorities, the financial commitment by Viet Nam's central government reflects a degree of political and monetary endorsement that bodes well for further replication.

Atlantic has also worked with national leaders and policymakers to strengthen several of the country's most influential medical and public health institutions. One of its earliest and longest stream of investments has been in the Ha Noi School of Public Health, a strategically important center of learning and leadership in a country that had, as recently as a decade ago, almost no public health system and little experience of public health as a professional discipline. By 2007, less than a decade after the school had conferred its first Master's degree in public health, researchers were reporting that "there are few other schools that can rival the quality of the teaching and training at HSPH." Leaders in several of the country's best medical schools have built distinguished programs in public health at their own institutions, often with Atlantic's help. On parallel tracks, Atlantic grants also supported Viet Nam's early cadre of public-health leaders in forming the Viet Nam Public Health Association. Among its early successes, the association used Atlantic

support to fuel a national public-health collaboration to prevent highway injuries by successfully promoting a helmet requirement for motorbike riders.

Another pivotal institution to receive major support from Atlantic was the National Hospital of Pediatrics, which has strengthened both research and standards of practice in children's health. Here, too, major central-government funding has followed Atlantic's initial investment, with a public commitment of \$52 million for expansion and upgrading of the hospital complex — an amount nearly four times the size of Atlantic's total contribution. Other support for leading national and regional institutions has gone to the National Institute of Hygiene and Epidemiology and to several key provincial hospitals across the country.

In all these lines of investment, Atlantic has sought to distribute its interventions carefully among the many centers of influence, power, and creativity that make up a well-functioning system. It has directed its support toward both institutions and practitioners, seeking, in the words of Atlantic's Viet Nam Country Director, Dr. Le Nhan Phuong, "to instill a culture [of public health and primary health care] at the major institutions, while at the same time multiplying the number of people out in the field who share that culture and can put it into practice." It has focused on both the top and bottom of Viet Nam's policy hierarchy, seeking out reform-minded officials and acting as a resource for them, not only in broad policy formation and institution-building, but in frontline implementation, testing, and replication. It has invested in both hard and soft development — not only new and upgraded buildings and equipment, but also new skills, new methods, and new approaches to care among the practitioners working inside the buildings. It has brokered creative partnerships linking leaders and experts in Viet Nam with those outside the country, especially from Australia and the United States. And it has managed to forge relationships of trust and collegiality with government officials while simultaneously pressing them for change and helping Vietnamese civil society to do the same.

With the full program still less than a decade old as this is written, it is impossible to say whether these efforts will live up to all the hopes that Atlantic — and its many Vietnamese partners — hold for them. There is no question, however, that more than a dozen prominent institutions and hundreds of CHCs are now providing more and better care, in better surroundings, and with better trained personnel, than was even imaginable before the start of the Foundation's involvement in Viet Nam. Innovators among Viet Nam's public agencies and voluntary organizations have gained national stature and credibility, and increasingly have come to work together, forming networks of research, experimentation, and advocacy that range far beyond Atlantic's direct involvement. A series of evaluations now under way will determine whether these various, separate advancements are likely to blend together, over time, into a more effective, more equitable, and more adaptable system of public health and primary health care for all 80 million Vietnamese people and their communities.

First, Treat the System

The Atlantic Philanthropies' Effort to Promote Health and Equity in Viet Nam by Investing in a Healthier, More Equitable System of Policy, Practice, and Care

WHEN The Atlantic Philanthropies' founder, Charles F. Feeney, made his first visit to Viet Nam as a philanthropist in October 1998, the country was in its 12th year of a massive political and administrative overhaul known as *doi moi*, roughly translated as "change and renovation." Little by little, the 1986 restructuring was replacing Viet Nam's centrally planned economy and regulated society with a more dispersed, open, and market-oriented system that would shift the foundations of daily life for all 80 million of its citizens. The *doi moi* process continues to this day, with effects that by now are visible everywhere, including an explosion of private manufacturing and commerce, rapid GDP growth, and near-ubiquitous small enterprise in storefronts, in markets, on farms, and along roadsides.

Though far from a total free-market liberalization, by 1998 *doi moi* had already swept away many elements of Viet Nam's former command economy and established a hybrid system of private and public enterprise, decentralized management, broad new opportunities for private ownership and investment, and greater reliance on the private sector as an engine of economic growth. Among the elements of Vietnamese life transformed by the changes were the country's vast rural areas, where collective farming gave way to private land-use rights and freedom to buy and sell products. Another was its health care sector, where a system of private insurance was quickly replacing publicly funded care, leaving only an antiquated system of public clinics and hospitals to provide for poor families and isolated or minority communities. Across these and many other aspects of economic and social life, a once-rigid power monopoly based in Ha Noi was being broken up and distributed among provincial capitals and the district and communal structures beneath them.¹

Among the unintended side-effects of *doi moi* was a decline in the already-rudimentary quality of health care for poor and rural Vietnamese, as the sector shifted unevenly to the new political and market reforms. Budget constraints,

¹ Tim Thompson and Joel Prater, "Economic Renovation in Vietnam," California State University–Chico, Fall 1998, accessed at <http://www.csuchico.edu/~cheinz/syllabi/asst001/fall98/thompson/doimoi.htm>

administrative upheaval, and the introduction of an unfamiliar mix of public and private payments slowed progress on longstanding problems in poor areas, such as malnutrition and infectious diseases. By the end of the 1990s, health care claimed less than 1 percent of the national government's budget (compared with 37 percent in China, 14 percent in Thailand, and 6 percent in Malaysia) and total health care spending had become overwhelmingly private, with the government furnishing no more than one dollar out of every five spent on care. Chronic shortages of hospital beds and of adequately trained health-care workers, especially nurses and midwives, often led to substandard care, particularly in remote areas and among patients who couldn't afford private insurance.

Private-pay clinics and hospital wings accounted for most of the new capacity being developed in Viet Nam's health-care sector, leaving those who depended on government support to seek care in the increasingly cramped, outdated, and understaffed remnants of the old government system.² The dissolution of agricultural cooperatives, which had been the main source of revenue for health care in rural villages, had left the communal health centers with depleted budgets and few means of paying for basic equipment, medicines, staff training, or building maintenance. Primary care in poor, remote, and rural clinics was so meager that families traveled for hours or days to seek help in overcrowded district and provincial hospitals — often for illnesses that would have been routine or preventable if adequate primary care and public health information had been available nearer to home. Under-funding of basic public infrastructure like sanitation and water purification, part of a broader lack of attention to public health and disease prevention, sent periodic waves of preventable diseases into hospital wards and outpatient clinics.

Partly as a result, patients in acute-care institutions were commonly jammed two or more to a bed or made do with chairs or floor space. Obsolete and overworked equipment broke down regularly. Facilities crumbled from overuse and deficient maintenance; plumbing and electricity periodically failed; sanitation suffered. Even without the crush of preventable cases, the hospital infrastructure was barely adequate: In the late 1990s Viet Nam had just 14.8 hospital beds per 10,000 people, well below average among Asian nations (comparable figures for China, Thailand, and Malaysia were 24, 19, and 20 beds, respectively).³

Early projects and emerging opportunities

Among the first examples of these conditions to greet Chuck Feeney in his 1998 visit was the massive bottleneck at Da Nang General Hospital — overflowing with both a rapidly growing urban population and throngs of rural and minority patients from Viet Nam's impoverished central region. Mr. Feeney had come to Viet Nam in the

² "Country Profile: Vietnam," Library of Congress, Federal Research Division, December 2005, p. 7, accessed at <http://lcweb2.loc.gov/frd/cs/profiles/Vietnam.pdf>. Comparison figures for China, India, and Thailand come from the corresponding Country Profile for each of those countries.

³ "Country Profile: Vietnam," p. 7, plus "Malaysia – Health," Encyclopedia of the Nations, accessed at <http://www.nationsencyclopedia.com/Asia-and-Oceania/Malaysia-HEALTH.html>.

early stages of a partnership between Atlantic and the East Meets West Foundation, a nongovernmental organization that had developed health and educational facilities and operated small programs in Da Nang and elsewhere in Viet Nam. The organization, founded by a Vietnamese American who had returned to her home in Da Nang, was highly regarded but struggling with a budget chronically on the verge of insolvency. Mr. Feeney offered East Meets West a financial lifeline — six figures at first, but soon seven figures and more, growing year by year — to build or renovate libraries, university dormitories, and, in the first year, two major new facilities at Da Nang Hospital: a burn center and a new pediatrics department.

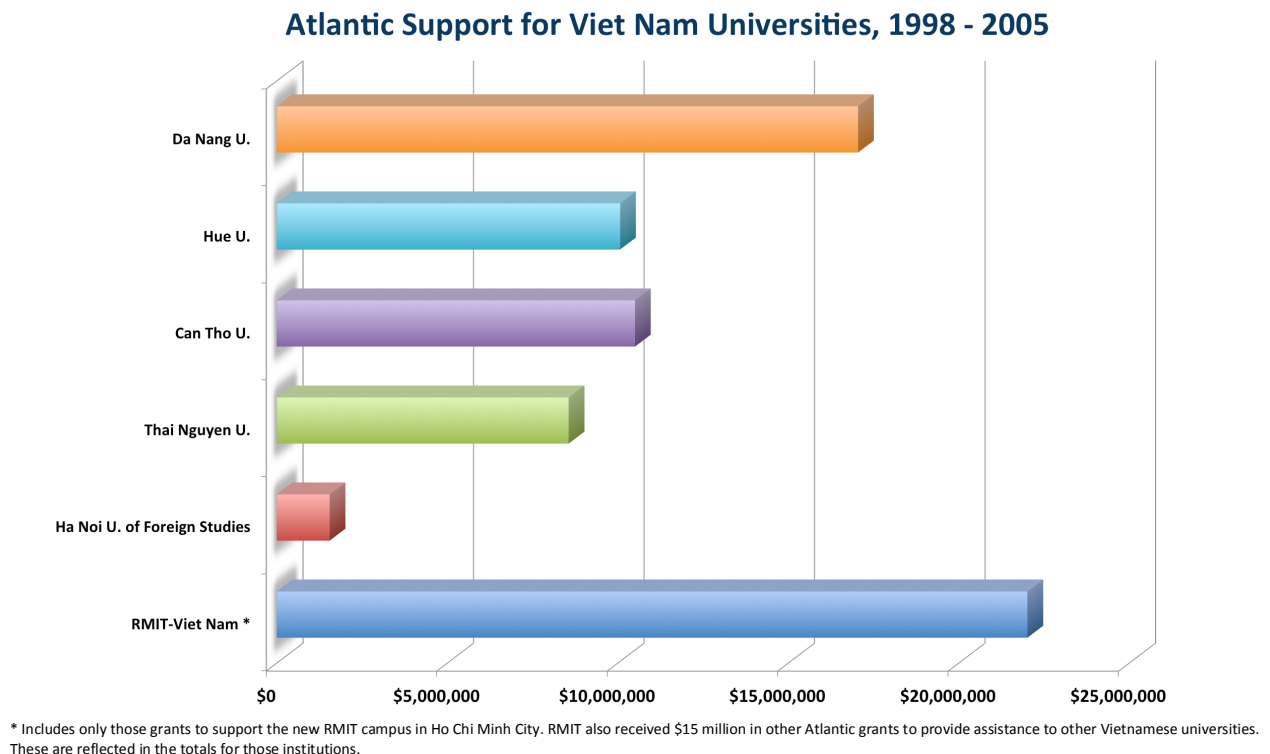
The choice of initial projects was partly serendipitous. East Meets West happened to have a base in Da Nang; the hospital happened to make a timely appeal for the burn and pediatrics wings; Mr. Feeney had a keen understanding of facility development and a personal dedication to health and higher education. Da Nang, like much of the rest of Viet Nam, encompassed a series of needy and overburdened institutions with talented leaders, plus a cadre of government managers eager for help and — at least in some cases — for new ways of solving problems. For Da Nang's central hospital, in the first five years Atlantic invested well over \$8 million in the renovation of the pediatric, intensive care, and OB/GYN departments, and construction of new facilities for internal medicine, emergency care, waste treatment, and the morgue, among other things. Fifty miles to the north, in Hue, Atlantic invested more than \$5 million to build new Pediatrics and Cardiovascular centers at Hue Central Hospital, beginning a relationship that would eventually grow to \$10 million and more.

For several years, Mr. Feeney's interest was drawn at least as much to higher education as to health. While in Da Nang on his first visit, he paid a call to the city's university where, according to Atlantic CEO Christopher G. Oechsli, who was then an Atlantic programme executive, Mr. Feeney was shown an unfinished library building for which the university had run out of money. "The idea of completing that building became the first major grant that Atlantic made in Viet Nam," Mr. Oechsli recalls. "It had an awful design. Contemporary Vietnamese design at the time had a light well down the center of the building, which Chuck thought was a waste of space. He worked with the Vietnamese government to completely redesign the building."⁴ The library provided the first step in what would become a \$17 million stream of investments in Da Nang university between 1998 and 2005, with virtually all of the construction overseen by East Meets West and with extensive curriculum and other technical support funded by Atlantic through universities in Australia, the United States, and elsewhere.

As Mr. Feeney and Atlantic staff members traveled more extensively around Viet Nam in these years, further investments went to universities in nearby Hue and in the Mekong province of Can Tho (roughly \$10 million each), in the northeastern province of Thai Nguyen (\$8.5 million) and in the largest and most dramatic case, in the creation of Viet Nam's first privately owned university, a branch of the Royal

⁴ Interview with Mr. Oechsli, 11 August 2009.

Melbourne Institute of Technology in Ho Chi Minh City (\$22 million). Many of these investments included the creation of Learning Resource Centers — an expanded model of university libraries incorporating computer and telecommunication centers, meeting and conference facilities, language labs, and other accommodations for advanced learning, teamwork, and research. For Atlantic’s first six years in Viet Nam, nearly 60 percent of its grants supported higher education, mostly for university facilities like Learning Resource Centers, dormitories, classrooms, and athletic centers.



But beginning in 2004, the balance began to shift toward health-care grants, for two main reasons. First, it was becoming clear that unlike Viet Nam’s university sector, which was vigorous but undercapitalized, its health-care system lacked many basic elements that would be essential to improving the health of the population. Universities could be strengthened with new or upgraded facilities, more modern equipment, more extensive library collections, or any combination of these. The health of the Vietnamese people, however, would need something more fundamental: a strong and well-managed system of primary health care, supported by a culture of public health (which was then barely emerging in Viet Nam as a field of study and practice), and buttressed by a network of leading medical institutions.

The second reason for the shift in emphasis was that Atlantic in 2003 was beginning to revamp and refocus its entire program portfolio as it prepared for its final 15 to 20 years of operation. As it contemplated the end of the Foundation’s intended life

in 2020, the Board had chosen to concentrate its resources on fewer areas of activity and to pursue major, transformative changes in the time remaining. In Viet Nam, those criteria clearly pointed to an all-out effort on public health and revitalizing the national health-care system, with an emphasis on primary care. Within a year, the shift in that direction had begun.

Starting with anchor institutions

In a 2002 presentation to the Atlantic Trustees, Chris Oechsli reflected on the Foundation's experience in Viet Nam thus far, and on the feeble infrastructure of primary care on which the health of most of the country's people depended. Although the Foundation had had considerable success improving individual hospitals and supporting some water and sanitation upgrades in the Da Nang and Hue areas — success that was soon to be affirmed by an outside evaluation⁵ — these institutions were still functioning in an overall national health system that placed too little emphasis on prevention, public health, and primary care. The result was that whenever Atlantic managed to improve facilities and equipment in a major provincial hospital like those in Da Nang and Hue, overcrowding grew even worse, “as the number of patients have increased dramatically with the improvements in the quality of the facilities and services.”⁶

The problem, Mr. Oechsli concluded, was not merely that some facilities were substandard and needed renovation, but that they were caring for patients whose conditions should properly have been treated at lower levels of the health-care system, or might have been prevented entirely. The country needed outstanding institutions, public-health professionals, health-care workers, and health-information programs that could galvanize a culture of prevention, health promotion, and early care. That kind of leadership, he reasoned, could lead over time to practices that would reduce the incidence of injuries, complications of child-bearing, early childhood illnesses, the spread of communicable diseases, and other treatable or preventable conditions that were needlessly flooding overcrowded hospitals. The government, though broadly aware of the gaps in health-care delivery and committed to raising its level of health spending, seemed at a loss to tackle such problems at a systemic level. A significant, standard-setting investment in public health and primary and family care, Mr. Oechsli suggested to Atlantic's Board, could significantly affect the government's “allocation of resources and degree of support for the capacity of health systems” nationwide. To bring about a healthier population, he argued in effect, it was necessary first to treat the system.⁷

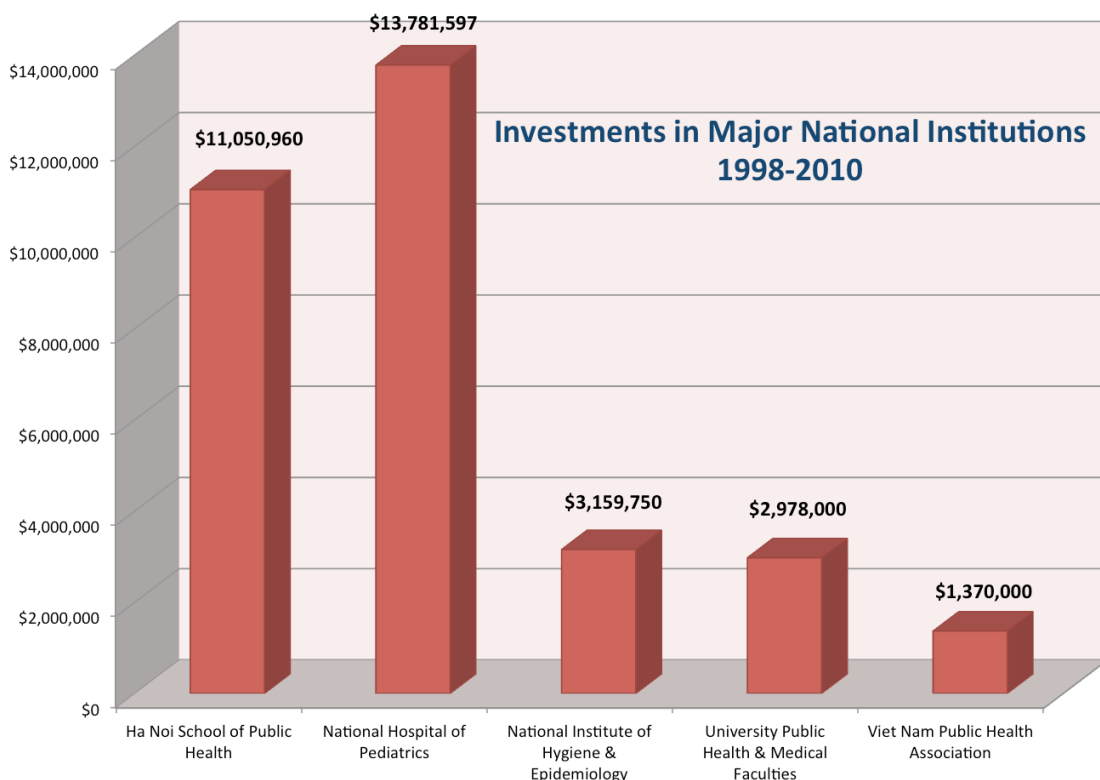
Already, a year earlier, the Foundation had taken some first steps in working with the government to develop an infrastructure of public health in Viet Nam. It had begun channeling technical and financial support to the Ha Noi School of Public

⁵ Thomas T. Kane, “Assessment of the Atlantic Philanthropies' Support for the Health Sector in Viet Nam: 1998-2003: Final Report,” The Atlantic Philanthropies, 10 May 2004.

⁶ *Ibid.*, pp. 7-8.

⁷ Christopher G. Oechsli, “Public Health and Biomedical Research: A Preliminary Assessment of Opportunities for Impact,” unpublished presentation notes, July 2002, p. 2.

Health, an institution that had just that year been named a free-standing national university. The school had only recently evolved from its previous mission as a training academy for health administrators, and had conferred its first Master's degrees in public health in 1999. Building on earlier efforts by the Rockefeller Foundation and other international donors, Atlantic tapped its contacts at universities in Australia and the United States to help the School of Public Health enrich its curriculum and recruit faculty. In 2002 it made an initial grant of \$500,000 to begin operating the school's newly created research and advocacy centers and implement its expanded curricula. With intensive technical assistance from Queensland University of Technology, paid for by Atlantic, the school was about to launch its first four-year program leading to a Bachelor in Public Health degree.⁸ In the vision that Chris Oechsli was outlining for the Atlantic Board, expanding and elevating the stature of the Ha Noi School of Public Health would be a key first step in helping Viet Nam begin to re-engineer its fundamental approach to health and health care nationwide.



Just over a year after Mr. Oechsli's presentation, the Atlantic Board approved a program, budgeted at roughly \$20 million a year, to build the field of population health in Viet Nam, part of a Foundation-wide initiative that also included work in South Africa and Cuba. In Viet Nam, the program's first commitment was to strengthening "key institutions in Population Health," beginning with the Ha Noi

⁸ Mary Byrne McDonnell and Van Bich Thi Tran, "Final Report: Phase One Strategic Learning and Assessment of the Atlantic Philanthropies' Population Health Programme, Viet Nam — Annex F: Context Paper Related to the Ha Noi School of Public Health, Ha Noi, Viet Nam," Social Science Research Council, June, 2007, p. 15.

School of Public Health and adding what would become a significant, extended investment in the National Hospital for Pediatrics. The latter was to be the cornerstone of “a substantial phased grantmaking strategy in pediatric health in Viet Nam,” beginning with an effort to build the hospital into an internationally recognized Center of Excellence and a standard-setter for pediatric care throughout the country.⁹ Together, these two institutions alone would receive a total of \$25 million in Atlantic support as of 2010, including more than \$15 million in construction projects carried out by the East Meets West Foundation.

Of the two institutions, the Hospital for Pediatrics claimed the plurality of the dollars, but that is largely because its needs were more narrowly concentrated on facilities and equipment — capital requirements that carry a hefty price tag. The success of that investment was confirmed a few years later, when Viet Nam’s central government allocated \$52 million of public money— nearly four times Atlantic’s total commitment — to complete construction of the hospital campus. Atlantic also invested heavily in buildings and technology at the School of Public Health, but there the effort put at least as great an emphasis on curriculum development, faculty training, organizational development, fundraising, and public education and advocacy, all of which are less costly than construction and heavy equipment, though their long-term dividends can be at least as great.

In 2007 — roughly half a dozen years into Atlantic’s partnership with the Ha Noi School of Public Health— the Social Science Research Council reported that “there are few other schools that can rival the quality of the teaching and training at HSPH,” despite many lingering weaknesses and challenges. Among the latter was the continuing difficulty of recruiting faculty in an environment where the discipline of public health is still relatively unfamiliar. The school continues to face what SSRC described as a chronic “country-wide shortage of Master’s and Ph.D. trained public health professionals from which to draw faculty.”¹⁰ Even so, by 2007 the field was growing in both scope and stature, with distinguished faculties of public health also beginning to take shape at regional medical schools in Ha Noi, Hue, and Ho Chi Minh City — all of which were by then also receiving support from Atlantic.

One Atlantic-supported program at the Ha Noi School of Public Health, its Center for Injury Policy and Prevention Research, was becoming especially well-regarded at the time of the Social Science Research Council’s report. The Center, SSRC noted, “is a good example of a program that can bring the HSPH into the spotlight and help to raise its profile with the Government, institutional peers and the public. Whether or not all the rest of the HSPH is developed enough to be considered international standard, the CIPPR is one of the programs that is already recognized internationally. There is absolutely nothing like it in Viet Nam and there will be great value in developing it further.”¹¹ The success of the injury center was

⁹ “Population Health Strategy Revisited,” memorandum to the Board of Trustees, the Atlantic Philanthropies, 6-7 December 2004, p. 5.

¹⁰ McDonnell and Thi Tran, *op. cit.*, p. 8.

¹¹ *Ibid.*, p. 29.

important not only in its own right, but also as a component of a broader Atlantic push for injury prevention, which would eventually total close to \$20 million for grantees such as the Asia Injury Prevention Foundation, the Alliance for Safe Children, and UNICEF, besides the Ha Noi School of Public Health.

The most visible success of that effort — though certainly not its only accomplishment — was a sustained campaign leading to the enactment of a 2007 law requiring all motorcycle and motorbike drivers and passengers to wear helmets. Among the many preventable conditions contributing to overcrowding in Viet Nam's hospitals — particularly in critical departments such as emergency, surgery, and intensive care — were thousands of severe and often deadly injuries from traffic accidents on roadways teeming with motorbikes. To reduce both the human cost and the strain on Viet Nam's health-care system, Atlantic supported research into the social and economic benefits of a helmet requirement, funded both grassroots and high-level advocacy campaigns for the legislation, and even invested, through the Asia Injury Prevention Foundation, in a new industry to manufacture lightweight, attractive helmets, something that had been unknown in Viet Nam until the mid-2000s.¹²

Alongside its investment in training and education, Atlantic also set out to build a cohesive field of practice in public health with a 2003 grant to launch a new Viet Nam Public Health Association, through which, in the words of an Atlantic grant recommendation, “public health, as a profession, [could] speak with a single voice that represents the professionals of the field.”¹³ The first movements toward such an association had actually surfaced in the early stages of the Atlantic-funded research on injury prevention. When that effort began, participants from public health programs around the country found themselves working together, often for the first time, and their interactions formed the first links in what would become a national network. By 2007, the Association reported that it had grown to 5,000 members; had operations at the national, provincial, and district levels nationwide; and was raising nearly 60 percent of its revenue from sources beyond Atlantic. The Foundation responded to this progress with renewed support in 2008 totaling more than \$1 million over three years.

A further commitment to a major national institution came in 2006, with support for a strengthened blood-borne viral analysis capacity at the National Institute of Hygiene and Epidemiology. As the International Association of National Public Health Institutes points out, Viet Nam is “a geographical hot spot for emerging infectious diseases such as SARS and avian influenza. Tuberculosis, dengue, hemorrhagic fever, viral encephalitis, diarrhea, measles, and cholera remain major public health problems. The prevalence of HIV/AIDS is increasing throughout the

¹² Mary Byrne McDonnell, Van Bich Thi Tran, and Nina R. McCoy, “Helmet Day! — Lessons Learned on Viet Nam's Road to Healthy Behavior,” Social Science Research Council, May 2010.

¹³ Le Nhan Phuong, “Ha Noi School of Public Health: In Support of the Start-Up for the Viet Nam Public Health Association,” memorandum to the Board of Trustees, the Atlantic Philanthropies, 29 July 2003, p. 1.

country.”¹⁴ In 2006, Atlantic provided support to University College Dublin, already a major grantee in Ireland, to provide direct technical support in building the Institute’s capacity and expanding the national public-health arsenal against viral diseases.

Along the way, Atlantic also continued to support improvements to major hospitals in the provinces where it was working. One prominent example was Hue Central Hospital, where the Foundation’s seminal investment in a new Cardiovascular Center helped place the institution in the forefront of leading-edge heart surgery in Viet Nam. In early 2011, surgeons from the hospital’s cardiovascular faculty performed what the hospital’s director, Dr. Bui Duc Phu, described as “the first-ever heart transplant to be performed by local doctors without the support of foreign experts.”¹⁵ Soon thereafter, the Austrian government awarded a €17 million grant to Hue Central Hospital for further development.

Strengthening the national primary health care system

Alongside the creation of national centers of excellence, the second core element of Atlantic’s strategy for public health was working with Viet Nam’s provincial health departments “to develop an integrated model of health care ranging from rural communities to urban hospitals.”¹⁶ The strategy’s premise was that elevating overall standards of training and practice, developing leading national institutions, and building a better-networked and better-trained work force in public health and medical care would not, by themselves alleviate the central problem in Viet Nam’s congested health-care system. That problem, in simple terms, was that too little basic primary care was being delivered at the bottom of the health-care hierarchy, at underfunded local clinics called Commune Health Centers or CHCs. Because of shortcomings at the local level, many people either went without care altogether or postponed treatment until problems became acute — at which point, they had to make the long journey to jammed district or provincial hospitals. Not surprisingly, the poorer or more distant a community was, and the lower the incidence of private health insurance, the less likely were its residents to receive essential care. The result, as a newspaper in Ho Chi Minh City reported in 2005, was that an international study had named Viet Nam “one of the most inequitable health-care systems in the world, ranking 187th out of 191 countries.”¹⁷

These conditions were not the result of widespread indifference or ineptitude among CHC employees. In fact, given the physical disrepair and the chronic shortages of staff, medicine, and equipment at many CHCs, the commitment of local

¹⁴ “Vietnam: National Institute of Hygiene and Epidemiology (NIHE) — Institute Profile,” accessed 28 June 2011 at http://www.ianphi.org/member-countries/country.cfm/count_id/6C9C1329-123F-73FE-8906979C977B63DC.

¹⁵ “First-Ever Heart Transplant Successfully Conducted in Hue,” Viet Nam News, 4 March 2011, accessed online at <http://vietnamnews.vn/vn/Social-Issues/208966/First-ever-heart-transplant-successfully-conducted-in-Hue.html>.

¹⁶ “Population Health Strategy Revisited,” p. 5.

¹⁷ “Equality in Health Care: Viet Nam Ranked 187/191” (translated), *Tuoi Tre* Newspaper, April 2005, quoted in “Population Health Capacity-Building Through Improving Provincial Community Health Care Systems,” internal memorandum, the Atlantic Philanthropies, July 2005, p. 1.

physicians and health-care workers often seemed little short of heroic. Nonetheless, crumbling buildings, broken or obsolete equipment, thinly stocked supply and pharmacy cabinets, and in some places barely sanitary conditions severely limited the quality of service that even the most skilled and dedicated staff could provide. More subtly, the atmosphere of decay and neglect in many CHCs was a drain on both staff morale and patient confidence, causing the best employees to transfer elsewhere if an opportunity arose, and encouraging patients to bypass their CHCs altogether when seeking anything but the simplest forms of treatment. Taken as a whole, the results suggested a system whose foundations had all but collapsed, leaving many people without adequate care and putting the system's upper levels under greater and greater strain.

Nor was the Vietnamese government unaware of the problems. In fact, the Ministry of Health had instituted a flurry of reforms and new programs over the years, though usually in piecemeal and uneven fashion. As the Population Council explained in a 2005 report to Atlantic, government efforts to improve local health care had resulted in “near-universal child immunization coverage, compliance with safe delivery practice guidelines, and high levels of contraceptive use.” But the various government initiatives generally took the form of separate, “vertical programs [that] typically have their own independent targets and goals, and reporting requirements and forms. CHC staff must coordinate the requirements of an average of about 20 national health programs, each with unique reporting and task requirements, ... promulgated in top-down, target-driven directives that are inconsistent with local priorities, needs, and capabilities.”¹⁸ In short, although the government was eager to improve particular conditions, it seemed unable to grapple with primary health care as a whole system, and re-engineer the way that system worked.

Atlantic's response was to design new models of primary health care at the commune level, demonstrate them in one or two provinces, assess the demonstrations, and work with the government to replicate the successes more widely. The new models would integrate facility improvements, more modern equipment, better staff training, and more aggressive promotion of healthy living and prevention of illness and injury. They would embody the international principles of the Primary Health Care movement — an approach formally embraced in a 1978 U.N. declaration calling for universal access to care, community participation, development of the health-care workforce, and a general public policy organized around social equity and health for all.¹⁹ As an early consultant had warned, however, “a comprehensive program of public health sector reform can be very expensive,” and would surely be beyond the Foundation's means. But working with just a few well-run, receptive provincial health departments — a level of

¹⁸ “Synthesis Report: Pre-Intervention Assessments of Primary Health Care and Prevention Services at the Commune Level in Khanh Hoa and Da Nang Provinces,” the Population Council, 30 June 2005, p. 9.

¹⁹ For a fuller description of how Atlantic has applied these principles in Viet Nam, see Trinh H. Tuan, *The Atlantic Philanthropies and the Effort to Develop the Primary Health Care System in Viet Nam (Reviewing-Learning-Discussing Series)*. Ha Noi: The Atlantic Philanthropies (Viet Nam) Ltd., 2011.

government that had become more powerful under Viet Nam's recent administrative reforms — could create a template for a new approach to primary and preventive care, which could then be replicated elsewhere.

These considerations added up to an overall theory that was to guide the rest of the Foundation's work on primary health care in Viet Nam: Working with reformist health officials in the national and provincial governments, Atlantic projects could demonstrate ways of integrating the various elements of better primary care into a true system, in which the parts reinforce one another and result not only in more efficient service delivery, but fundamentally better care and a healthier, more informed population. This would eventually call for several large-scale demonstrations, with escalating public-sector investment, in at least half a dozen provinces with varying kinds of need. But it would not require "a comprehensive program of public health sector reform" by Atlantic alone. Rather, given the Ministry of Health's evident commitment to improving primary care, it would be enough to enlist active government partnership in a few places where a model could be thoroughly tested and proven, and where a strong case could then be built for nationwide replication.

Atlantic chose as a starting point the south-central coastal province of Khanh Hoa, a mostly rural area that, despite some pockets of wealth, contains many poor farming villages, including minority communities, flood-prone coastal farmlands, and remote mountain areas ill-served by the current system. Even more important, the director of its health department, Dr. Truong Tan Minh, is a leading physician and public health expert highly regarded as astute, creative, and committed to reform. For all these reasons, it was a logical place to build a model that could then be replicated elsewhere. Given that Atlantic was already deeply involved in Da Nang's health care system and had a good working relationship with local officials, that city soon became the demonstration's second province. (Like Viet Nam's other largest cities, Da Nang is a province unto itself.)

Dr. Le Nhan Phuong, who succeeded Chris Oechsli as director of Atlantic's Population Health Programme in 2005, explains the choice of these two jurisdictions as an attempt both to start small and also to build on strength: "Initially, what we needed to do was test the model and see whether it would succeed. To do that, we had to look for places that had the factors that would make that possible: good leadership, good people, good system, a commitment to the main purposes of the grant. It doesn't help anyone if we go first to the most needy area, the most difficult one, and then fail. We wanted to make sure the idea works, first, in a reasonably well-functioning place. Da Nang wasn't a place of especially concentrated poverty, but it was part of the disadvantaged central region. And we had a partner there, so that was something to build on. ... Khanh Hoa, likewise, is certainly not the neediest province, but it has areas of real hardship. And we had

great confidence in the leadership there, and a relationship we felt we could develop.”²⁰

Between 2004 and 2007 — a period Atlantic now regards as Phase I of its primary health care demonstration initiative in Viet Nam — the Foundation invested more than \$6.5 million in the planning, reconstruction, and enrichment of services in scores of CHCs in the two provinces. Another \$1 million helped modernize the information technology linking CHCs to the rest of the provincial health system. In Khanh Hoa, which spans nearly 5,200 square kilometers (2,000 square miles) of mostly rural terrain, Dr. Minh started relatively small, by designating seven CHCs “whose condition is so critical that a complete rebuilding of the CHC is necessary.”²¹ Drawing from an aggregate two-year grant of \$400,000 in 2004, Atlantic provided for a new facility in each of the seven sites, built and equipped to new standards that Viet Nam’s Ministry of Health had adopted in 2002, along with specific design adaptations for the particular geography and climate of each community, such as flood-proofing and protection against land erosion. Remarkably, such adaptations to the physical surroundings had been unprecedented in CHC construction. Facilities would be built for a 20-year lifespan, up to four times the life expectancy of the buildings being replaced. In turn, the province committed to providing the staffing, training, and maintenance to ensure that the services in each CHC would likewise meet the Health Department’s standards and would continue operating at that level.



An old Commune Health Center and a renovated one, both in Khanh Hoa Province.

(Photos: Le Nhan Phuong)

The results were strong enough that, less than two years later, Atlantic followed with a \$4.2 million investment to convert 62 Khanh Hoa CHCs over the next four years. But this time, the construction costs would not be borne by the Foundation alone. In what would become an escalating joint-funding arrangement, the Khanh Hoa provincial government committed one-third of the total cost of construction and renovation, \$2.1 million, in addition to its commitment to improve the CHCs’ staffing

²⁰ Interview with Dr. Phuong, 23 June 2011.

²¹ Le Nhan Phuong, “Khanh Hoa Provincial Health Department: In Support of Improving the Commune-Level Health System,” internal memorandum, the Atlantic Philanthropies, 28 July 2003.

and services once construction was complete. Over the ensuing years, because of the province's expanding confidence in the initiative and desire for expansion, "they actually ended up putting in more than what they got from us, at the end of the day," Dr. Phuong calculates.²²

Still, the challenges in reaching this point were not limited to constructing well-designed buildings, providing up-to-date equipment and supplies, and enlisting government support. From its earliest experience with creating new facilities, the Foundation had learned that a key part of the mission would also be to change the way development is pursued and the way buildings are managed in Viet Nam. Part of the problem, as the East Meets West Foundation had reported early on, was that Vietnamese managers had little or no budget for ongoing maintenance of structures or equipment, nor even much of an awareness of preventive maintenance and timely replacement as a way of preserving value. Atlantic projects consequently involved both a requirement for maintenance budgeting and a close working partnership with building managers, who could observe the structure and its component systems as they were being created and were trained to keep them in good working order.

But there was a subtler and more sensitive challenge as well: As in many societies accustomed to centralized political control over the economy, Viet Nam was grappling with habits of routine corruption that both undermined development and discouraged outside investment. Acknowledging the problem, in the early 2000s the government had launched a series of annual Anti-Corruption Roundtables with international donors to find solutions. One of these roundtables, in November 2009, specifically focused on corruption in the health sector and its effects on poverty. Among the participants' conclusions was that genuine reform would demand a long-term effort on multiple fronts "to support, promote, and build small-scale improvements while also increasing advocacy for high-level support and leadership for reforms. ... Government officials and development partners should focus on curbing opportunities, reducing incentives for corruption, and analyzing and rebutting the rationalizations or excuses."²³

Atlantic saw its place in that effort as beginning, in the first instance, with the partners it chose. "From the beginning," says Dr. Phuong, "we really worked hard at identifying places that have both the needs and the capacity for change. We also look for leaders with integrity and honesty, folks that we feel we can work with. And in our admittedly subjective way, we have been rather successful." Second, the Foundation expanded its Viet Nam-based staff and retained a series of local engineering and consulting firms to monitor construction and keep watch on resources. The intent was not only to prevent losses, but to demonstrate techniques by which "leaders with integrity and honesty" could police their jurisdictions on a

²² Interview with Dr. Phuong, 23 June 2011.

²³ Taryn Vian, "Corruption Perceptions and Impact on Poverty in the Health Sector in Viet Nam: How to Improve Transparency and Accountability — Report of the Donors' Roundtable, Sixth Anti-Corruption Dialogue in Viet Nam," Boston University School of Public Health, 20 April 2010, p. 18.

wider scale. In each case, the Provincial Health Department — which was the official grantee and carried out all these projects with Atlantic support — worked alongside consultants and Foundation staff to create processes for effective monitoring and accountability, mandating that participating districts and communes have their own monitoring units as well. “With multiple checks-and-balances,” Dr. Phuong observes, “it makes it very difficult for people to skim from the budget.”²⁴ Provincial leaders, armed with this experience, in turn become better advocates for similar reform among their peers and at higher government levels.

Investing in skills and professional practice

Atlantic’s support for the primary care system in Khanh Hoa and Da Nang was not limited to building facilities and equipment or to improving methods of construction and maintenance. The strategy depended at least as much on upgrading the quality of care provided in the CHCs — and making them more effective at promoting health and preventing illness and injury — as on producing a better environment for staff and patients. As a 2011 report by Boston University’s Family Medicine Global Health Collaboration pointed out, “The typical general doctor staffing a commune health center has the minimum of undergraduate medical school training, based primarily on didactic, theory-based lectures. These general doctors entered into clinical practice without any significant clinical experience or post-graduate training. Many patients recognize this lack of skill, and [consequently] bypass the local CHC in favor of visiting the nearest district or provincial hospital.”²⁵ Viet Nam’s national Ministry of Health in 2001 had authorized two-year postgraduate training programs in family medicine to be set up at four major regional hospitals, but at the time of Atlantic’s first efforts in Da Nang and Khanh Hoa, these were relatively new. To complete their certification, physicians would have to leave their communities to study at one of the urban universities, and not unexpectedly, many never returned once they had their credential.

In 2006, Atlantic made a grant of \$3 million to Boston University²⁶ to start a work-study training program in which physicians in rural Khanh Hoa CHCs could study family medicine through Hue College of Medicine and Pharmacy. The program was designed to help them earn their family medicine certificate while remaining in active practice in their communes. The Hue medical college created a new Family Practice Department, led and staffed by physicians specially trained at Boston University and Queensland University of Technology, and began publishing new textbooks in family medicine. Within five years the program had trained 89 doctors in its first class and enrolled 22 more in the second. Graduates overwhelmingly reported increased knowledge and competence in follow-up surveys, and firsthand evaluators found “observable improvements in the quality of primary care practiced

²⁴ E-mail from Dr. Phuong, 3 August 2011.

²⁵ Jeffrey F. Markuns, M.D., et al., “Improving the Primary Health Care System at the Rural Commune Level Through Development of an Innovative Medical Education Program: Project Summary and Evaluation,” Boston University Family Medicine Global Health Collaboration, January 2011, p. 5.

²⁶ The grant was initially made to Maine Medical Center, but was transferred to Boston University when key staff moved to that institution.

daily with patients. ... Specifically, trained physicians showed statistically significant improvements in communication skills and comprehensiveness of care.”²⁷ The province soon started offering training opportunities for other members of the CHC staff, to create a team approach to family medicine at the CHCs. Partly because of markedly upgraded conditions and rising morale at new or renovated CHCs, and partly due to strong support from the provincial health service, “the vast majority [of trained physicians] have remained at their posts in the commune health centers.”²⁸

At about the same time as the grant to Boston University, Atlantic also awarded another \$2.6 million to two other international organizations to raise the level of care in two specialty fields: reproductive health, and care for mothers and young children. Although Viet Nam had made considerable progress in reducing maternal and infant mortality overall, rural families still lagged well behind their urban counterparts. The mortality rate among rural infants and children was double that in cities, and among ethnic minority groups, the rate was two to three times that among Viet Nam’s Kinh majority. “The major challenge in the coming years,” Dr. Phuong concluded in an internal Atlantic analysis, “will be to demonstrate and ramp up effective provincial-led models for improved maternal and newborn health.”²⁹

Deficiencies in rural CHCs’ services for pregnant women and their children were particularly harmful, given that it was rarely realistic for families in sparsely populated farming villages to receive consistent, ongoing care at distant hospitals. In reality, many received little or no care at all, or ended up at district or provincial hospitals only when their problems had become severe. Consequently, a 2005 grant to Save the Children–U.S. set out to work with the Da Nang and Khanh Hoa provincial health services to create a better planned, more rational continuum for maternal and newborn health care across the whole province, from individual households to rural CHCs to district hospitals to the major provincial institutions.

With Atlantic support, Save the Children helped Khanh Hoa and Da Nang to train designated specialists who could extend detailed training in maternal and newborn health to every CHC in their territories. As the trainers gained more experience and expertise, they would in turn begin training other trainers, thus expanding the circle of knowledge. Meanwhile, provincial health services agreed to pay for continued training beyond the term of the demonstration, thus ensuring that the new expertise would be permanent.

On a parallel track, Atlantic sought to build on a series of recent commitments by the Vietnamese government to bolster economic development in rural areas by improving family planning and healthy childbearing. The intertwining goals of three new government initiatives — on population, reproductive health, and the

²⁷ Markuns et al., *op. cit.*, p. 21.

²⁸ *Ibid.*, p. 34.

²⁹ Le Nhan Phuong, “Save the Children (US): Improving Maternal and Newborn Health in Viet Nam,” internal grant recommendation, the Atlantic Philanthropies, 24 September 2007.

advancement of women — included lowering infant and maternal mortality rates, promoting safe sex and awareness of sexually transmitted diseases, and helping people make informed reproductive choices. But as often happened with other government initiatives for rural areas, national policies and even dedicated funding had been slow to translate into measurable progress. Given the limited facilities, equipment, and technical skills in many rural CHCs, combined with the difficulties of communication and transportation across broad areas, clinic staff often lacked the expertise and basic materials — or even a clear understanding of the issues — to satisfy the new goals. Even when staff had the necessary skills and commitment, rural residents were sometimes unaware of the need to seek this kind of care or were reluctant to turn to the bare-bones environment of a typical CHC for such sensitive matters. What was needed was, in effect, a new model of standard practice for reproductive health in rural communes, taking account of the sensitivity of the issues; the technical demands of education, diagnosis, and care; and the need for inviting, professional surroundings that would put patients at ease and encourage them to keep coming back.

With a grant to Marie Stopes International–Viet Nam, Atlantic supported the creation of a franchise network in which participating CHCs developed outreach programs, dedicated counseling areas, and tested methods of patient care, all to a specified standard of quality, to earn a joint certification from Marie Stopes and the Vietnamese government. For the participating CHC, earning the franchise in effect conferred a brand, or seal of approval, that testified to a high level of care comparable or superior to what patients would receive in a district or provincial hospital. The results — measured both in objective quality of care and in patient utilization and satisfaction — were so strong that the provincial health services committed to expanding them and supporting their ongoing operating costs after the end of Atlantic’s demonstration period.

In improving patient care, just as in building and equipping clinics, the Foundation has had to confront habits of petty corruption that have undermined efficiency and quality throughout Viet Nam’s health system. The Atlantic-sponsored training and certification programs have dealt with this issue to varying degrees, and government efforts to improve pay and working conditions for physicians and health workers are also making some progress. The Foundation’s investment in better information systems to link provincial, district, and commune-level facilities also makes it easier to monitor the use of resources — a process that leaders in the participating provinces have welcomed. The requirement that cash-strapped districts and communes must contribute some of their own resources (not always money, but often personnel, land, or other in-kind support) to every project also gives them a direct stake in policing abuse. But at the commune level, where contact between workers and community members is direct and constant, the effort to make patients and families more informed participants in primary care may be the most powerful anti-corruption strategy of all. “There is real local ownership of these projects,” Dr. Phuong wrote in 2011. “The health station represents a community property that is for the good of the whole, so it is taken quite seriously by the

people. This is *their* facility, not Atlantic's. ... It is the community that will hold the staff, and thereby the government, accountable for the health of the people."³⁰

By the end of 2007, the combined effect of these various interventions — improved facilities and equipment, new technology, expanded community involvement, staff training, a more rational continuum of care between CHCs and hospitals, and the spreading franchises for reproductive health — were paying increasingly visible dividends. To illustrate the scope of the achievement, Dr. Phuong described a single CHC in rural Khanh Hoa, now operating in a new building, designed and equipped with Atlantic support, with up-to-date technology, well trained staff, and a certified reproductive health program. Referring to the staff director, he pointed out that “once she had the nice building, she now had more people coming in. And they’re delivering more service, and the services are better and getting better outcomes. So now she’s saying, ‘We need A, B, and C to meet this increased demand and maintain this level of quality.’ And she has been forceful about advocating that to the [provincial] directors. To me, that’s the change. Not so much the building that we built, although it all started with that. But the change is empowering the staff to address the director and say, ‘This is what we have in mind, and this is what we need to do for the health of the people.’ And that’s how progress will come.”³¹

Expanding to areas of deeper need

Having started in the familiar surroundings of mostly urban Da Nang, and in the innovative environment of Khanh Hoa’s enterprising Health Department, Atlantic’s initiative was ready to expand to more challenging territory. “Once we had established the model in two relatively strong places,” Dr. Phuong explains, “we could begin moving into more difficult places — in the deeper Mekong Delta region, in the Northern Mountains, and the Central Highlands — where the system in place was maybe not as strong. But having the experience we now had [in Da Nang and Khanh Hoa] allowed us to make adjustments and also to give better advice to the new provinces, and to recognize up front some of the challenges and obstacles that we had to be prepared to deal with.”³²

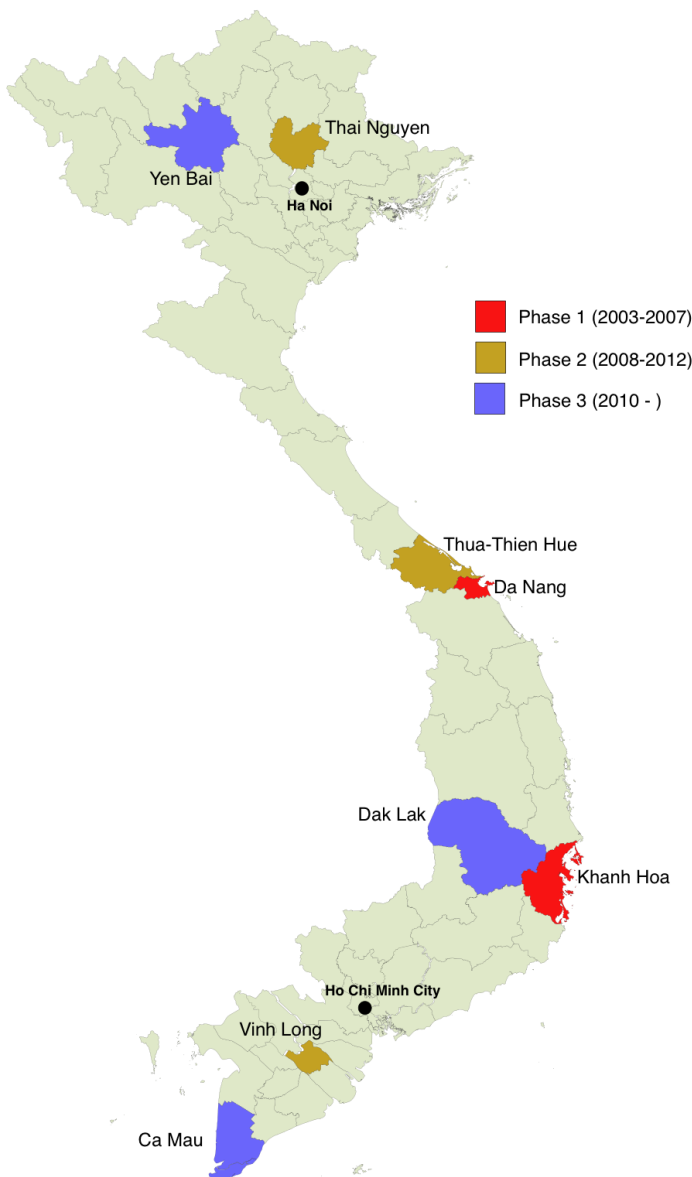
Atlantic opened its second phase of the primary health care initiative with a combined \$23.5 million in new funding between 2007 and 2008. It expanded to Thai Nguyen in the mountainous region north of Ha Noi; and to Vinh Long in the Mekong Delta region of southernmost Viet Nam, both of which are home to extensive ethnic-minority populations in poor, hard-to-reach communities far from the centers of wealth and public services. In both provinces the poverty is deeper and more extensive than in Da Nang or Khanh Hoa, the rural villages are more dispersed and sometimes harder to reach, and public agencies and officials are less well connected to central government authority and resources. A third expansion site was Thua Thien Hue, in the central region just north of Da Nang. Though not quite as

³⁰ E-mail from Dr. Phuong, 3 August 2011.

³¹ Interview with Dr. Phuong, 24 August 2010.

³² Interview with Dr. Phuong, 23 June 2011.

disadvantaged as the other two new provinces, it had been, like Da Nang, a site of considerable Atlantic investment already, and leading health officials there had become both enthusiastic Atlantic allies and committed voices for national reform. As in the first two locations, Atlantic's capital investment in renovating and equipping CHCs (now matched dollar-for-dollar by the provincial governments) was accompanied by parallel training and technical support from Save the Children, Boston University, Marie Stopes, and others.



Continued success in the first five provinces has led, most recently, to yet another expansion that began in 2010, with a \$14 million replication — half funded by Atlantic, half by the government — in Ca Mau, at the Mekong Delta region's extreme southern tip. Two more initiatives of similar size completed the list of demonstration sites in 2011: in the Central Highlands province of Dak Lak and in Yen Bai, in the northern mountains. All three are isolated, both geographically and politically, with topographical barriers that make it especially difficult for residents to travel to distant cities for health care. And all are home to large numbers of Viet Nam's poor, historically neglected ethnic minorities, for whom language and culture pose further obstacles to receiving care outside their communities.

These final three sites, Dr. Phuong notes, are so

disadvantaged that it would be nearly impossible to carry out the demonstration without direct support from Viet Nam's central government. Obtaining that support was a critical test of the theory behind the first two phases of primary health care grants: that a limited number of successful demonstrations, carefully built up, documented, and expanded, would eventually attract the official endorsement of the

national Ministry of Health and become the model for primary care nationwide. “These are three provinces that are really needy,” he explains. “They are still not the poorest of the poor, but they are located in very high-need regions, with sizable populations in really severe poverty. And they are the strongest provinces in those three needy regions. So with them, the next phase is to work directly with the central government to unlock federal money to go into primary health care, and bring the government along so that in future they can take over this kind of work. Up to now, we’ve been working with somewhat better-off provinces, because they had the money. It’s always difficult to get central government money, because there’s just not that much of it out there. But recently the government has made it a point to invest more in health, and a couple years ago it began to issue bonds for health care. So we look at that as an opportunity to advocate for money specifically targeted for primary health care, rather than just building more hospitals.”

Early signs are positive: the national government has earmarked some of the bond proceeds to match Atlantic funding, and most significantly, it has targeted that funding specifically to the demonstration sites. “Instead of spreading that money evenly among 64 provinces, which would be the usual thing, they’ve prioritized it. They’ve said, essentially, ‘We’ll use some of it to match your investment and see if we can, together, do this for a selected number of provinces. Then if this works well, we’ll consider doing more of it on our own in the future.’”³³

Other branches of Atlantic’s work in Viet Nam have been of shorter duration or narrower focus, though all have been closely related to the program’s two primary pillars. For example, an initiative to improve eye care concluded in 2009 with construction of the Da Nang Eye Hospital and a major ophthalmology department at Hue Central Hospital, along with grants to the Fred Hollows Foundation to strengthen treatment of preventable eye diseases in several other centers around the country. Following the logic of other lines of work, Atlantic approached the need for vision care at two critical levels: raising the level of care and expertise at outstanding regional institutions, and improving the ability of local physicians and centers to monitor and prevent diseases before they end up, often too late, at overburdened hospitals.

Atlantic has also supported parallel work to improve public policy and citizen advocacy on health issues, building on successful experiences like the helmet law campaign and on the growing strength of the Viet Nam Public Health Association. Some of this work has made important contributions toward tobacco-control laws and cigarette taxes, more concerted national policy on preventing childhood injuries, and on deepening knowledge and expertise across the health-care system on HIV/AIDS and other sexually transmitted illnesses.

The combination of promising demonstration projects and persuasive public advocacy appears to be bearing fruit in an increasingly collegial, creative, and

³³ Interview with Dr. Phuong, 23 June 2011.

ambitious response from national policymakers. “I never expected the government to be as cooperative as they have been recently, in terms of being willing to sit down and talk to us about co-funding and long-term issues,” Dr. Phuong concludes. “I think part of it is that we’re helping the government to achieve many of its own social goals. Rapid growth here has produced a lot of income inequality, and the government understands that under those conditions, stability in the country depends on delivering benefits for the lower rungs of the economic ladder. I think the government sees us as helping them figure out how to achieve that.”³⁴

Lessons, inferences, and principles

“Rather than providing narrowly targeted inputs,” evaluators from the Social Science Research Council wrote in a 2007 report, “Atlantic has taken a *systems approach*” (emphasis added).³⁵ The attempt to reform whole systems of policy or practice is a common goal in strategic philanthropy, though more often than not it has been an elusive one. The difficulty of changing sprawling, complex, entrenched networks of public and private agencies, bodies of law and regulation, webs of economic relationships, and patterns of personal and professional conduct has proven too great for many foundation programs in many fields, even when the resources dedicated to the task have been (by foundation standards) very large. Yet Atlantic’s work in Viet Nam has appeared, thus far, to have broken through some of the natural barriers of complexity, inertia, and corruption that hold back many system-reform efforts, to achieve what appear to be fundamental and lasting changes in the Vietnamese health system in the interest of both the population and practitioners. That has been due, according to the SSRC researchers, partly to “the intensity and density of the support, the focus on a limited number of institutions, and the level within the health system being targeted.”³⁶

It is important to preface this observation — and the discussion of causes and implications that follows — with a strong caveat. With barely a decade of effort so far, and with impact evaluations still in progress, it is too soon to say whether these seemingly positive changes have made a permanent difference, much less whether they will ripple outward into a thoroughgoing reform of the system. Among other difficulties in analyzing the specific effects of Atlantic’s approach is that the economy and public policy of Viet Nam are changing rapidly overall, far beyond the health sector. The pace of change has been so great that even many government insiders have found it hard to keep up, or even, in some cases, to discern clear logical connections linking the various reforms into a coherent whole. Navigating within this constant flux is a challenge not only for Atlantic, but for its many Vietnamese partners, grantees, and co-funders. As the SSRC evaluators wrote in 2007,

³⁴ Interview with Dr. Phuong, 24 August 2010.

³⁵ McDonnell and Thi Tran, “Final Report, Phase One Strategic Learning and Assessment of the Atlantic Philanthropies Population Health Programme, Viet Nam,” Social Science Research Council, 9 July 2007, p. 4.

³⁶ *Ibid.*

Defining the appropriate mix of private and public care and ensuring sustainable health care financing are urgent issues, and there are considerable opportunities for Atlantic to be engaged and make a major difference. ... [However], there are potential risks associated with government policies that are in transition and evolving as the State 'learns while doing.' This is exacerbated by the apparent little control that the Ministry of Health and the provincial health services and lower levels have over multi-faceted structural changes to the health system that are largely engineered outside the health sector. ... If a policy does not work, it is discarded, but the replacement is rarely based on sound studies, leading to further changes as soon as shortcomings are revealed.³⁷

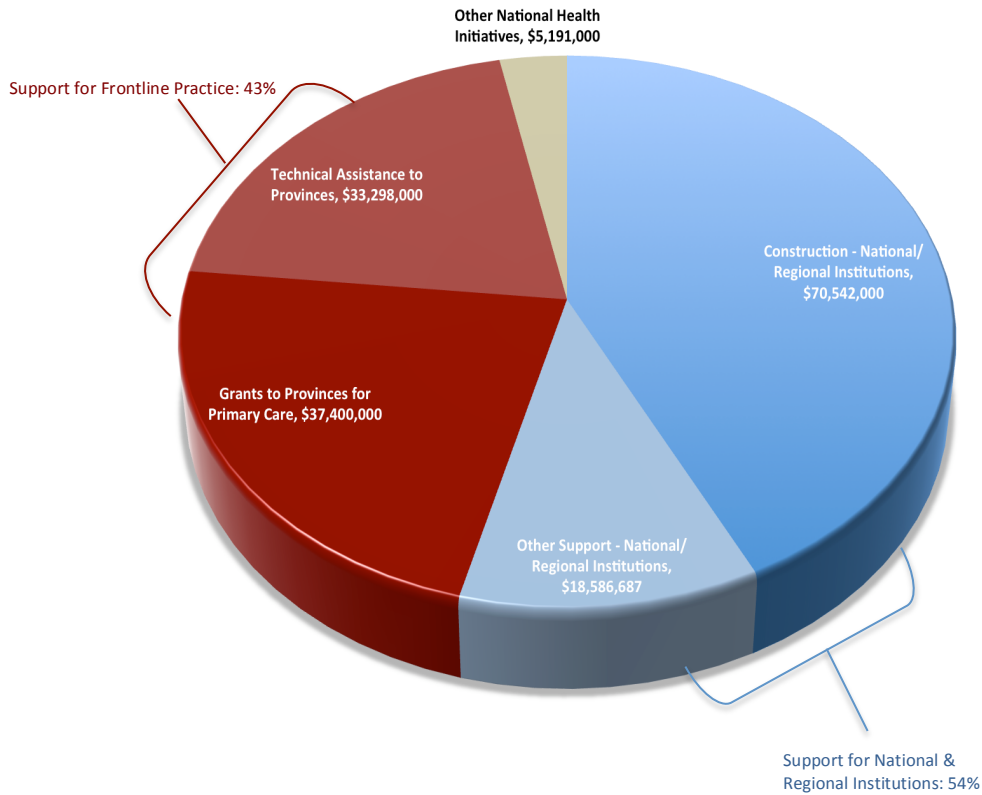
Amid the sweep of political and economic change in Viet Nam, the opportunity for "sound studies," or even for the development of common standards of analysis and evaluation, has been limited. Citing a "lack of provincial or national definitions or criteria or even common definitions among Atlantic grantees for determining cost-effectiveness," the SSRC noted the difficulty of comparing models and choosing one over another. "Cost-effectiveness and sustainability are terms used by the government, donors, and grantees," the evaluators point out, "but without clear definitions and with some indication that different definitions are at work."

Many of these obstacles can and probably will be addressed over time, by some combination of outside donors, perhaps including Atlantic, and most of all the government itself. Yet within the limits of current knowledge, and based on what is still a brief but sizable stream of Atlantic investments thus far, it is possible to form some impressions of why the Foundation's approach to reforming the Vietnamese health care system seems to be showing progress, why Atlantic staff finds the results encouraging, and why the usual obstacles and impediments to philanthropic system-reform efforts may not prove fatal in this case.

Overall, preliminary reports by grantees and outside observers focus on Atlantic's determination to intervene in just a few, carefully chosen places, but within those places to address several complementary facets of the system in ways that could produce a far-reaching change in policy, practice, and attitudes. Given that earlier sections of this report have already focused on some of the Foundation's chosen points of intervention — specific institutions, locations, and jurisdictional levels — the best way to conclude may be to highlight the facets of the system that Atlantic is trying to combine and balance in each of these interventions, and how those combinations may elevate an assortment of disparate grants into an integrated, broad-based attempt to alter an entire field.

³⁷ *Ibid.*, pp. 4 and 8.

Support to National & Regional Institutions vs. Provincial-Level Care



1. Institutions and workforce. The attempt to raise the profile of public health and to instill the international principles of Primary Health Care in Viet Nam has taken place both at the level of institution-building — creating preeminent centers of training and research that embody high standards of practice — and at the level of individual physicians, public-health specialists, policymakers, and health-care workers. Some grantees, such as the Ha Noi School of Public Health or the National Hospital of Pediatrics, do both: they house top-level experts and research programs, and they help expand and promote their disciplines by populating the field with well-trained graduates. Atlantic support for other training centers, including public health faculties in major cities and the family practice program at Hue College of Medicine, extend the principle farther afield, by both training more practitioners and elevating public health and family medicine within the country's leading centers of knowledge. Further down the health hierarchy, training for the staff of CHCs by such grantees as Save the Children and Marie Stopes is combined with efforts to bolster the CHCs themselves, with better facilities and more effective policy and support from provincial and district governments. The governing principle, as Dr. Phuong puts it, is “to instill a culture at the major institutions, while at the same time

multiplying the number of people out in the field who share that culture and can put it into practice.”

2. Top and bottom. Closely related to the first point, but important in its own right, has been Atlantic’s careful effort to form alliances both among elite decision-makers and frontline (or lower-level) operators and managers. The most obvious reason for concentrating on both ends of the political/administrative hierarchy is that, in a government-controlled but decentralizing health system, significant power rests in both places. Viet Nam’s whole government is gradually apportioning more authority to lower levels of the federal structure, though the full extent of this transfer of power remains unsettled. No matter how it turns out, many decisions about top priorities and major resources — and, crucially, authority over the civil service system, which includes nearly all health workers — will remain concentrated in the capital. Any significant change in the overall delivery of health care, as the general public experiences it, will have to take place at each major level of government. For example, as the SSRC evaluators noted, an articulated national priority on primary health care, which the central government promulgated in 2002, has been slow to produce measurable results, largely because neither national policy nor local capacity has been sufficiently galvanized to turn the priority into a reality. “Even the [Ministry of Health] leadership has bemoaned that reality has not matched rhetoric,” SSRC reported in 2007. “State investments continue to be skewed toward tertiary care, and subsidies show that the rich benefit more from State subsidies than the poor.”³⁸

Even in Da Nang and Khanh Hoa, two central partners in Atlantic’s primary-care efforts, SSRC reported that as of 2004, two years after the national directive on primary care took effect, “in Da Nang, 2 percent of the health budget is spent at the commune level, while 80 percent is spent on curative care. Khanh Hoa spent 82 percent on curative care in 2004, 5.7 percent on preventive care, and 2.46 percent on maternal child and family planning.”³⁹ Based on the provinces’ work with Atlantic, among other things, these figures have most likely improved by now. But if so, it is partly because of a concerted combination of advocacy and direct support at the national, provincial, district, and commune levels, all focused on accomplishing goals that the government officially shares, but that it seemed unable to reach on its own. Making a better match between “reality and rhetoric” will require not only more effective leadership at the top, but more resources, creativity, and diligence at the front lines. In the poorer provinces, more resources from the top will be indispensable for delivering better services in individual communities. For all these reasons, Atlantic has built its alliances at both ends.

3. Facilities and program. From its earliest grants in Viet Nam, Atlantic has taken care to establish standards of quality in both the way services are delivered and in the physical conditions that surround them. In the case of buildings and equipment,

³⁸ McDonnell and Thi Tran, “Final Report,” Annex J, p. 25.

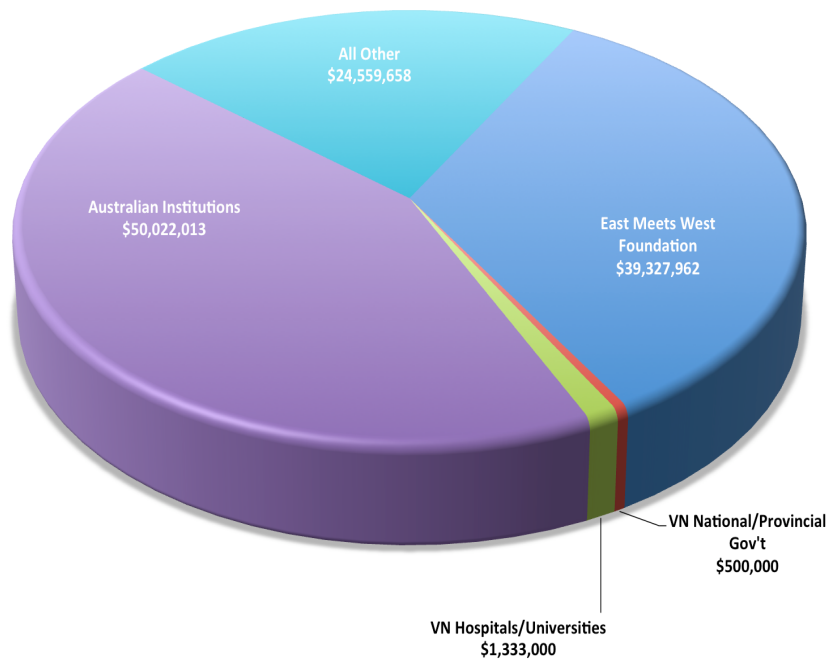
³⁹ *Ibid.*

the Foundation has not only upgraded facilities and built new ones, but it has created and promoted models of superior construction and maintenance designed to prolong the useful life of the buildings and ensure a better working environment inside. Compared with the Spartan surroundings of most Vietnamese health care — especially in poor villages, but even in many elite urban institutions — the sturdy, well-designed facilities of Atlantic-supported projects are meant to make a statement about the importance, quality, and stature of the work being done in them. The result appears to be a noticeable esprit-de-corps among the staff and greater confidence among patients, both of which are essential for elevating the quality and quantity of basic care. “Atlantic’s total investments,” SSRC writes, “are integrated to impact at various points in the provincial system, rather than being narrowly targeted to, for example, constructing buildings alone, rather than providing equipment, training, or information-management capacity.”

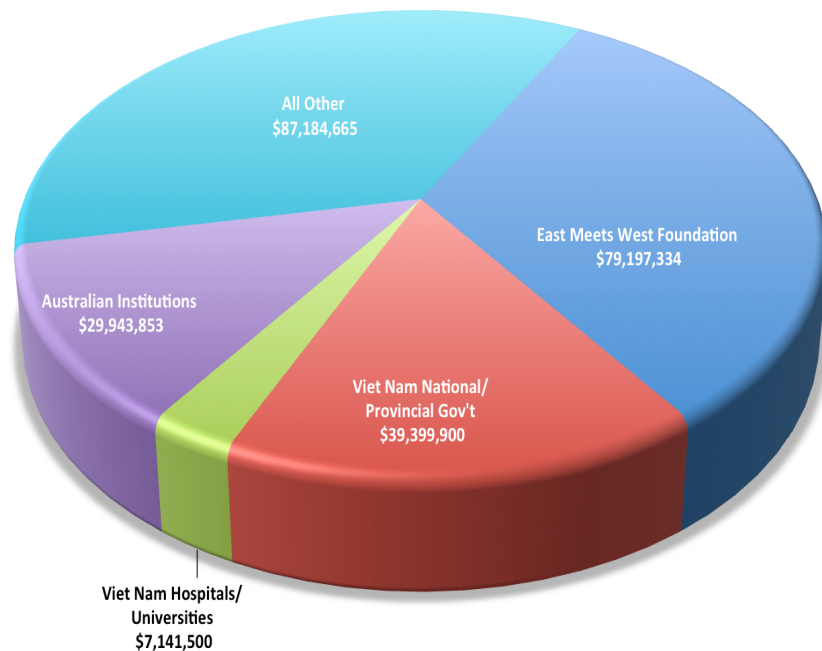
4. Outside and inside. Particularly in its early years — but still, to a lesser extent, today — Atlantic borrowed heavily from the expertise of its grantees and allies in other countries, particularly Australia, the United States, and Ireland, in bringing models, technology, training, and research to Viet Nam. In some respects, this was simple necessity: Viet Nam was still struggling to build capacity that other countries had in surplus. So harnessing some of that surplus for Viet Nam’s benefit was the most efficient way to introduce new ideas and techniques. A prominent example of the benefits of this approach is in the development of the curriculum and faculty at the Ha Noi School of Public Health. There, the Rockefeller Foundation had begun bringing international support to the school in the mid-1990s, and Atlantic expanded and deepened the school’s international support by forging a partnership with Queensland University of Technology, which is now being expanded to public health departments in other universities.

The full list of international partners is long and broad. Much of Atlantic’s early investment in improving vision care in Viet Nam flowed through the Australia-based Fred Hollows Foundation. American universities including Harvard, Johns Hopkins, University of Washington, and Boston University provided technical help in particular areas of public health and medical practice. Pathfinder International, whose origins are in the United States, provided extensive professional training and curricular development. Australia’s Royal Children’s Hospital was central to Atlantic’s support for the National Hospital of Pediatrics and other Vietnamese institutions. University College Dublin was the main vehicle for Atlantic’s support of the National Institute of Hygiene and Epidemiology. And various other technical support relationships involved Australia’s Universities of Auckland, Melbourne, New South Wales, and Queensland.

Early Grantees, 1998-2003



Later Grantees, 2004-2010



Over time, however, as these relationships produced greater expertise and organizational strength at Vietnamese institutions, the need for outside advice and training diminished. Judging from the flow of Atlantic grants, the learning curve was

steep, and Vietnamese grantees began fairly quickly to receive more and more support directly. But that was possible, as Dr. Phuong points out, “mainly because we had time to build the capacity of the grantees, and frankly the relationships of trust with them, so that they could take the helm of these projects themselves.”

5. Advocacy and partnership. More than in most other places where Atlantic works, partnership with the government in Viet Nam is an indispensable factor in determining whether the Foundation’s achievements will persevere and spread once Atlantic has departed the scene. Consequently, co-funding with government agencies is now the norm throughout the program, and nearly all new activities are developed jointly with government officials. And yet most of the program is in fact designed to change the way government works and shift more public funding toward public health, primary care, poor and minority families, and underserved communities. Playing both the role of partner and of reformer is a delicate matter in Viet Nam, where unchallenged central authority has long been the norm, but where public officials are now adjusting — often uneasily — to a broader distribution of power. Consequently Atlantic, like many international donors, has followed the approach of demonstration and evaluation, encouraging government institutions and agencies to examine new ideas in practice, weigh the results, and then consider replication. To raise the odds that the results will be understood and will make a real difference in the way decisions are made, Atlantic has also funded various forms of technical assistance directed toward the government itself. One example is a series of grants to engage the University of Queensland in a multiyear partnership with the Ministry of Health to improve the way government uses health data and research in making policy choices. A similar partnership with Australia’s Menzies Research Institute is helping the Ministry to develop a nationwide surveillance system for non-communicable diseases.

At the same time, some grants have gone directly to the Ministry of Health to help it absorb this assistance and put it into practice. In recent years, Atlantic has also funded voluntary organizations to raise awareness of public health, prevention, and primary care among the population at large. These grants have included support for the Viet Nam Public Health Association, the Viet Nam Committee on Smoking and Health, and the Women’s Union of Viet Nam (to promote community health care for the elderly), as well as a variety of international aid and technical-support groups. Compared with the aggressive forms of advocacy common in more pluralist, multiparty societies, this approach might seem highly subtle and indirect. Yet in a country still emerging from decades of central control, and in a health sector in the midst of sweeping changes and uncertainty, it represents a carefully calibrated balance between working with government as a trusted ally and confidante and prodding public officials — respectfully but persistently — to see their responsibilities in fundamentally new ways.

This approach is consistent with a wider trend among Viet Nam’s international donors, toward both increasing partnership with government and increasing advocacy for change. A 2007 report by the Stockholm School of Economics found

that donors who have taken this approach have managed not only to widen the scope of policy reform, but to create a dynamic of independent advocacy long lacking in Viet Nam's centralized culture. The report's conclusion succinctly describes Atlantic's fundamental approach to public health and primary health care in Viet Nam, and the reasons for optimism about its longer-term success:

The donor community has clearly played a role in the diffusion of new practices, and many of the changes started in aid-funded programs but have gradually spread to other areas. The role of Viet Nam's foreign development partners has been to introduce ideas, exert some pressures for change, but also provide an arena where the government has been able to test new ideas and refine its thinking on development policy. To some extent, it can be argued that the donor community has taken on the roles played by civil society and a political opposition in parliamentary democracies. Although Viet Nam still has a long way to go in its transition from central planning to a more market-oriented system with a strong civil-society representation in policymaking, it can be argued that the trends are favorable, and that relations with the donor community are contributing positively to Viet Nam's development.⁴⁰

⁴⁰ Le Thanh Forsberg and Ari Kokko, "The Role of Donors in Vietnamese Development Planning," working paper 238, Stockholm School of Economics, June 2007, p. 26.