JOURNAL OF SCIENCE, Hue University, N^0 61, 2010

ALIGNING RESEARCH WITH POLICY: THE EVIDENCE FOR HEALTH POLICY IN VIET NAM (VINE) PROJECT

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SUMMARY

The increasing call for evidence-based policy making assumes a linear, positivist relation between the processes of knowledge creation, agenda setting and policy development. Yet the complexity of the policy process, and the very different value constructs of research mean that valuable research data has little value unless it is strategically mediated into the policy process.

The Evidence for Health Policy in Viet Nam (VINE) Project is a collaborative research project between the University of Queensland and the Health Strategy and Policy Institute and key Medical Universities in Viet Nam. It has been designed specifically to provide evidence to health policy makers, using a sequential structure that develops local skills, improves data collection, and sequentially builds knowledge that will inform policy decisions and priority resource allocation.

This paper will outline the logics of the research design, and explore the issues that now confront the research team as they seek to make this data available to policy makers. These issues will be explored in terms of the key stakeholders and the relationships between them, the context of policy making in a one party socialist state in transition, the content of currently proposed policy and the construction of the research data, and the complex relationships between these over time.

The increasing call for evidence-based policy making assumes a linear, positivist relation between the processes of knowledge creation, agenda setting and policy development. Yet the complexity of the policy process, and the very different value constructs and timelines for research mean that valuable research data has little value unless some form of translation and integration into policy frameworks occurs.

The Evidence for Health Policy in Viet Nam (VINE) Project is a collaborative research project between the University of Queensland and the Ministry of Health (MOH) through the Health Strategy and Policy Institute and key Medical Universities in Viet Nam – Hanoi Medical University, Hanoi School of Public Health, Hue University

of Medicine and Pharmacy, HCMC University of Medicine and Pharmacy, Thai Nguyen Medical University and Can Tho Medical University. The project has been designed specifically to provide evidence to health policy makers, using a sequential structure that develops local skills, improves data collection, and sequentially builds knowledge that will inform policy decisions and priority resource allocation.

The core commitment of the project was the development of a Burden of Disease (BOD) analysis for Viet Nam, an analysis that enables policy makers to compare the impact of health issues in Viet Nam both in terms of their mortality, but also in terms of the effects of morbidity on productivity. The technique converts these to a single metric--the Disability Adjusted Life Year (DALY)—and allows comparisons to be made for conditions as radically different in aetiology, causality or patterns of expression as mental illness, injury or infectious disease.

To construct a Burden of Disease Analysis requires accurate death and cause of death data; to interpret its findings into policy options needs some indication of the most cost-effective interventions, determined through cost-effectiveness analyses (CEA). These three components of the VINE project are linked to each other sequentially: the BOD analysis cannot be undertaken until the mortality and cause of death data is available; with their commitment to cost effectiveness, the CEA need a completed BOD analysis if they are to address interventions for the major burdens of disease in Viet Nam. The fourth component of the study, the policy analysis, seeks to make sense of the transition from evidence into policy.

What is clear, in this fourth and final year of the study, is that though both the research agenda and the policy agenda share a rhetoric around their objectives—to reduce the social, economic and personal burden of disease in Viet Nam—their values, structures and processes mean that they have very different understandings of health in the context of government policy. This paper will outline some of these challenges that need to be addressed if the research is likely to be influential in policy processes in Viet Nam.

The challenge of chronology

Both research and policy have their own chronologies – their own distinct time-lines. For research, the issues needing to be researched need to be identified, the literature examined, a proposal developed, funding secured, research teams recruited and trained, ethics approval obtained, the data collected, analyzed and presented in an accessible form. The path to peer reviewed publication may add months, sometimes years. For policy, issues may be ‘on the agenda’ for prolonged periods, but to use Kingdon’s (1984) model, it is only when the problem stream, the policy stream and the politics stream come together that action is possible. The *problem* stream recognises an issue that ‘needs’ to be addressed. The *policy* stream provides analysis of the problem,

and proposes solutions; health systems evidence is integral to this step. The *politics* stream ensures the support of popular or political groups to guarantee policy implementation. The conjunction of these three streams provides a limited window of time for evidence to play an influential role: timing the availability of the evidence for action is critical.

For any of our research to be credible, we have had to establish confident mortality and cause of death data: this has been collected using two different samples—the first based on the Government Statistics Office Annual Population Survey. While the data were useful, the process was not economically sustainable, and a second survey was constructed using specific sentinel survey sites. Comparisons between the two were necessary before we could be confident of the quality of the data: the match was encouragingly close, but it has taken three years to produce a baseline from which we can confidently offer the MOH an understanding of the major causes of death in Viet Nam, and begin to map out the factors that contribute to these.

The central research product of the VINE project, its BOD study has only recently been completed – further analysis will be completed this year. But early evidence suggested that motor vehicle injury would be significant, and economic studies commenced early, for the first time, estimating the financial cost of head injuries to families. Work calculating the willingness to pay for helmets was under peer review when the legislation was implemented–that data was reworked around quality, providing some insight into what motor cyclists would pay for a helmet of reliable quality. Retrospective lessons do, however, have use in the policy cycle—the analysis of the state-owned media has allowed us to understand better the complex political processes that underpin legislative change, and to identify with greater clarity why this legislation was successful, when previous attempts at change failed.

In terms of tobacco control, one of the key contributors to Viet Nam's BOD, delays in the legislative process have allowed us to complete several key cost-effectiveness analyses, demonstrating the relative yields for the interventions proposed, and providing the state with clear evidence of the cumulative impact of each strategy. Yet policy tensions within government, which derives substantial economic benefit from the industry, mean that evidence alone may not drive the needed changes to meet Viet Nam's commitment to the Framework Convention on Tobacco Control.

Early work on alcohol, particularly in relation to its linkage to motor vehicle injury, is alarming—yet alcohol policy is in its very early development, and the paucity of data available to date, the multi-sectoral responses needed and the lack of public awareness of the enormity of its contribution to BOD means that the research timelines are well ahead of both the 'problem' and 'politics' streams: our role will be to raise the profile of alcohol control in both these areas.

The challenge of priority

The VINE project, in particular, is direct in its claims on priority setting. Its purpose is to provide government with an instrument that allows comparison between health issues, and to identify where resource allocation should be directed. The CEA component provides economic justification and guidance for this process. Yet the political process has a complex approach to priority setting, for which objective evidence is only one component. The intersection between tobacco and alcohol and broader socio-economic issues, for example, is complex. Public perceptions of government responsibilities for health often crystallize around services, and the perceived quality of those services, rather than outcomes for specific conditions. We are aware that mental health will feature highly in the BOD profile – expressed in alcohol related disease in men and anxiety and depression in women. Yet the health system is poorly prepared to deal with these areas, and the establishment of appropriate mental health services—not only in Viet Nam, but also in Australia—lags decades behind other health services.

We recognize that as researchers, if we are doing our work appropriately, we will both respond to the needs of the MOH for evidence, but also challenge its priorities with new evidence. The point of the BOD study is to bring to attention those conditions whose contributions are under-estimated, such as mental health, tobacco related disease, stroke; and to put into perspective issues such as HIV/AIDS that may better resourced for a variety of reasons, than their contribution to the BOD would justify.

The challenge of persuasion

Recognizing the significance of a health issue to the national BOD is only a beginning point: the mobilizing of population responses to that issue is a more complex and demanding task. Stroke appears to be one of the highest in terms of total BOD in Viet Nam. The dilemma is that while diagnosis and management of hypertension in individuals is an important strategy for secondary prevention, the strategies for primary prevention require changes across the whole population, with marginal changes across the whole population bringing significant yields in terms of the overall impact of stroke. Yet arguing for dietary change, including salt reduction for the whole of the nation, will require ‘selling’ and a complex process of regulation and dissemination, without the benefit of a tangible and direct focus as was possible with mandatory helmet legislation.

Passive smoking measures face similar constraints in terms of enforcement: the direct linkage between behavior and consequence is not as clearly apparent in the public mind, and the multiple arguments against this infringement on individual ‘rights’ will be exploited. One of the difficult tasks in documenting the policy process around tobacco control has been access to those arms of government who are responsible for the industry itself. The political process in Viet Nam is complex: the fact that it is a one

party, socialist state does not imply homogeneity. Party, Government, Ministries, Mass Organizations, Municipalities and Provinces, state owned press and implementing agencies may express differing perspectives on the same issues, and within each of these, strong 'silo' structures may protect specific interests that influence policy positions. Those most readily accessible to health researchers are those who may be already sympathetic to the messages that we offer. The task of the researcher is not complete with the production of the data: its availability and presentation to policy stakeholders is vital, and alliances with policy stakeholders must be continued into implementation.

The challenge of adequate evidence

Over the life of this project, despite the extraordinary quantum of evidence that has already been made available, on mortality, cause of death, on tobacco, alcohol, injury, cardiovascular disease, sexual and reproductive health, we are aware that there is always demand for further evidence. In some cases, we are aware that the issue is not the quality or quantity of evidence—much good policy is made on the basis of 'good enough' but inadequate evidence—but that there is resistance in policy to the messages that we are communicating. It is particularly difficult to present the cumulative burden of tobacco, to convince governments that the current high consumption will continue to impact on health outcomes for a generation, and that action now is to secure change over 20 to 30 years. The early evidence we have on the links between alcohol and injury is 'enough' to demand action, but in a context that has no 'problem' support from a population that does not regard this as an issue, and a 'political' stream that does not see it yet as a priority. The issues of mental health will be made clear, but the 'policy' stream—the necessary infrastructure of mental health services—is still massively underdeveloped. Though we can argue that addressing this issue will have tangible economic benefits through regained productivity, the process of progressively developing services will be incremental, and the policy pressures need to be maintained.

The challenge of sustainability

But the critical issue that this project faces will be sustainability, the capacity for local uptake of the analyses that have been conducted and the application of the evidence to the policy process. The mortality component of the study has effectively been implemented by a coalition of medical universities in Viet Nam. They have the skills to implement this research, and the challenge now is to institutionalize the process of data collection into the local activities of the Ministry of Health, shifting the roles of the universities to analysis, training and supervision. Having undertaken the primary Burden of Disease analysis, Hanoi School of Public Health staff have the capacity to update the models, and with a modicum of collegial support, to repeat the study at strategic intervals. The CEA and policy analyses have exposed staff in several institutions to the processes, though the need to construct each analysis afresh means

that the process of developing the skills for independent research will need ongoing support. As external partners to the research process, the staff of the School of Population Health at the University of Queensland recognize that this has only been possible as a collaboration—and that deep access to the policy process is only available through our Vietnamese colleagues.

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