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INTRODUCTION

The social security system in Vietnam is in the process of changing and developing. Although there are still many difficulties, the State still allocates a significant amount for the development of this system. This also reflects the great care of the State for social policies, especially the policies for vulnerable and disadvantaged groups.

Ministry of Labour, Invalids and Social Affairs (1999, p. 20)

European and Western scholars have discussed for a long time which factors (international, economic, political, institutional, historical, cultural) explain how welfare is provided through welfare states. Since Esping-Andersen’s publication of *The Three Worlds of Welfare Capitalism* (1993) the debate on what affects welfare outcomes in a country has somewhat shifted away from finding one single explanatory factor to establishing regime typologies. Latest welfare regime typologies have included the newly industrialized economies in East Asia,¹ and even more recently low income countries such as Vietnam. As welfare regimes and social policy has been in a state of flux almost everywhere, the discussion about welfare regimes in East Asia is intense and passionate. For the last fifty years many countries in the region have seen a rapid socio-economic modernization — in some cases even a political transition towards democracy. The question is thus whether East Asian countries with increasing levels of wealth would develop similar welfare regimes as the ones developed in the Western world, develop their own genuine systems or no systems at all.

The same question also applies to Vietnam, which has been in a tremendous modernization and transition process for the last twenty years. Large economic and societal restructurings have changed the relationship between the public and private economic sector, workers have become more
mobile — migration has increased both within Vietnam and to other countries; the arrival of international companies and donors has exposed the political elite, but also the whole society, to new ideas in terms of categories such as the family, the elderly, the work place, and social protection.

The Communist Party of Vietnam (CPV) and the government have indicated their commitment towards improving people’s income as well as the overall welfare of society.\(^2\) The government has thus started implementing several social protection measures such as a health insurance scheme for poor people (Health Care Fund for the Poor), a voluntary health and social insurance (targeted towards the rural population) and an unemployment insurance (targeted towards former state employees). Despite these efforts, the actual welfare outcomes are somewhat contradictory. While the country now has a poverty incidence of under sixteen per cent from almost sixty per cent in 1993 (VASS 2006, p. 20), Vietnam is plagued by raising levels of inequality. Catastrophic health expenditures\(^3\) are estimated to affect as much as ten per cent of all households in Vietnam jeopardizing the remarkable reduction of poverty in Vietnam (Xu et al. 2003, p. 113). The central question is thus twofold:

- Why are attempts of the CPV and government for more health equity so easily diluted?
- Under which conditions can positive welfare outcomes nevertheless be achieved?

### 1.1 A POLICY NETWORK ANALYSIS OF AN INFORMAL SECURITY REGIME OF HEALTH PROTECTION

The presented analysis attempts to clarify why positive welfare outcomes in Vietnam are so difficult to achieve even though the government and the Communist Party of Vietnam have emphasized their support for raising equality in the health care system. The work will draw from the concept of an informal security regime, network analysis and belief systems to explain the welfare outcomes in Vietnam.

While the analytical categories of welfare in developing countries are similar to Western welfare regimes, the concept of an informal security regime gives emphasis to the specific differences to welfare regimes in the Western world. There are profound distinctions in the socio-economic setting between a Western welfare regime and an informal security regime in a developing country. Formalized work in developing countries such as in Vietnam is not as widespread as in the Western world; other forms of livelihood such
as peasant agriculture, petty trade, etc. are more common forms of work. In consequence, stratification normally does not only occur along lines of capitalists exploiting workers; other forms of exclusion coexist such as along lines of ethnicity, gender and religion. Furthermore, a very strong divide normally exists between rural and urban areas in terms of socio-economic development.

Tax systems in developing countries are usually weak. Hence, financial means for financing social services are small. Often governments use user fees\(^4\) to compensate for the lack of tax income. However, user fees can easily exacerbate inequality since they reduce the utilization of health care by the poor. Fee exemptions and other good — but poorly designed — intentions often fail to counteract increasing inequalities. The opening process of the health care sector to private actors thus frequently weakens the ability of the government to implement and supervise health care reforms. Furthermore, the lack of regulatory power does not allow the government to compensate for the market. Additionally, the government is not fully able to provide a conducive context for private actors. As a consequence, private actors do not necessarily relieve the financial and administrative pressure from the public health care system; instead the private health sector deprives the public sector of financial means and human resources.

Even if a national government is in favour of more equity in health, the structural problems of an informal security regime make it difficult to bring about positive welfare outcomes. Furthermore, political projects stemming from a generally pro-poor oriented national government are frequently also driven by a second set of ideas or beliefs: efficiency gains, growth, competitiveness and integration into the world market. Welfare outcomes therefore also have to be understood as a struggle of decision-makers for social equality on the one and economic growth on the other hand. This struggle takes place in a highly fragmented provider and regulatory network. Welfare outcomes are normally not only the result of state initiatives, but involve a broad provider and regulatory network including various public and private actors. Those different actors do not necessarily work in consistence with national set goals. Hence, lack of harmonization of policies and structures can only slowly be changed through a long-ranging process of policy learning and clarification over how to translate core into secondary beliefs.

This work will concentrate on the case study of Vietnam to interpret and understand the logics of policymaking in the specific policy field of health protection reform. To concentrate on the aspect of health protection enables a certain depth of focus which a comparison of several cases or an analysis of the whole social system of Vietnam would not have allowed. It will provide a
certain explanatory richness elaborating further the concepts and assumptions made about the welfare mix and the role the state, the market and society plays in the comparative literature.

Rather than being caught in the exceptionalism of the case of Vietnam, the results from the policy analysis of the health protection system will be linked to the theoretical discussion — seeing it as a chance to apply and test models developed in academic research with a broad comparative approach. The findings of the analysis thus will make reference to the broader debate on welfare regimes in developing and (South) East Asian countries (cf. Aspalter 2006; Gough and Wood 2004a; Gough 2001, 2004a/b; Ramesh and Asher 2000; Rudra 2007). Here special attention will be given to the discussion whether there exists a genuine East Asian welfare regime characterized by high regulatory power, little investment in social insurance, but high investment in productive aspects of social policy such as education and health care (see also chapter 2.1.2).

The case of Vietnam is especially interesting since the socio-economic and political setting of the welfare regime is quite different from the East Asian countries which have been included so far in the existing typologies such as Singapore, South Korea, Taiwan or Hong Kong. First of all Vietnam's political system has a strong political dual structure of a Communist Party on the one hand and a national government on the other. The relationship between both actors can be seen as similar in their interests at some points, but conflict-riddled at others.

East Asian countries have often been described as having had a strong regulatory and interventionist role during their rapid socio-economic transition. The transition process in Vietnam however takes place in an environment in which the policymaking process is exceedingly fragmented. Important changes have occurred bottom-up. Hence, financing and implementation of policies are highly decentralized. Investment in human capital (education, training and primary health care) has been low. Instead, the government has relied heavily on private expenditures.

Furthermore, Vietnam has entered the world market as an economic latecomer. It is debatable whether the strategy of the newly industrialized countries — an outward oriented export-driven development strategy with little focus on domestic consumption — will bring similar results for Vietnam in terms of income and welfare. In contrast to other East Asian countries, Vietnam's Communist legacies manifest themselves in comparatively high payments in the social insurance and social assistance system such as pensions for meritorious people, war veterans and hero mothers. However, the reforms which have taken place in the last couple of years have changed some of the
social policy initiatives profoundly. Vietnam therefore provides an interesting case for a social policy analysis in a transition process from plan to market.

The conclusions of the study in terms of regime typologies might lead to slightly different results if one would look at other aspects of social policy in Vietnam such as labour markets, education or the social insurance system including pensions or occupational safety. However, since health can be seen as a central aspect of human capital formation (which is one of the major aspects of an East Asian welfare regime), it already is relatively indicative of the overall logic (or lack of logic) of the Vietnamese welfare regime. Furthermore, as Esping-Andersen (1999, p. 88) has pointed out, almost no regime type is pure in the sense that all benefits and programmes follow exactly the same logic. As Kasza (2002, pp. 274–78) has highlighted: parallelism in policy development is the exception rather than the rule — especially since the implementation of programmes and the group of public and societal actors differ depending on which welfare policy one analyses. However, I would agree with Esping-Andersen (1999, p. 86) that one aspect of a welfare policy can already tell a great deal about how a state adapts to massive social and economic change and which structural problems and actor constellations are in place.

1.2 ASSUMPTIONS ABOUT SOCIAL POLICY, WELFARE STATE AND WELFARE REGIME

The assumptions made about welfare states — which are not even agreed on in the analysis of established Western welfare states — have to be questioned even more in developing countries, where the capacity of the state to tax and redistribute is only weakly developed (Gough and Wood 2004, p. 3).

As Titmuss has argued, “we must not jump to the conclusion that social policy … is necessarily beneficient [sic] or welfare-oriented in the sense of providing more welfare and more benefits for the poor” (1974, p. 26). In contrast, social policy can foster and multiply inequalities — both in developing as well as in developed countries. Depending on the political system, social rights can be at times only vaguely developed (Gough 2004b, p. 182). In authoritarian regimes, the rationale for social policy is often legitimacy among certain important groups in society such as civil servants. Hence, social policy is provided not based on social rights and entitlements but rather on means-tests and is highly stigmatized (Croissant 2004). Keeping these excesses of social policy and welfare regimes in mind, welfare in this book is understood in a positive sense, as procedures or social efforts designed to promote the basic material and social well-being of people in need.
Narrow definitions of social policy only include welfare provided by state actors and their involvement in social assistance and social insurance programmes (including social health insurance). Following Heclo, social policy in this analysis is not restrained to political programmes by national actors. In fact, social programmes are only one way how policy is expressed (Heclo 1974, p. 4). An analysis of social policy also takes into account what is done through a policy as much as what is not done.

Social services can come in different forms: through actual services, cash and in-kind. Social policy extends besides social insurance and assistance programmes to issues such as labour market policy and group specific policies for families and children as well as (community based) micro-credit and insurance programmes (see ADB 2003). It also includes housing and education policy. Areas which are closely affiliated to social policy and therefore deserve recognition are competition policy, fiscal policy, consumer protection and environmental policy.

Social policy — both in developed and in developing countries — has to be thought of wider than just being related to state actions. A rough distinction will be made between privately provided social policy (through the family, community or the market) and public social policy (state institutions). Social policy is implemented by a variety of actors, i.e. the public sphere is not confined to the nation-state, but may extend downwards through regions, localities and associations to “clubs” and communities, and upwards to trans-national and global actors (Gough 2004a, p. 22). Social services can be provided for by the national government, the community, households and individuals, and international actors such as International Non-Governmental Organizations (INGOs) and donors. However, most often the state remains to play a key role in either the provision or the regulation of social services.

Social policy is financed through several mechanisms: direct and indirect taxes (value-added tax, excise tax), compulsory insurance contributions, voluntary contributions, medical savings account, out-of-pocket payments, loans, grants and donations. Normally, systems combine multiple sources of financing. Due to weak tax collection systems and the absence of adequate numbers of workers in the formal sector, out-of-pocket-payments in developing countries often make up for the bulk of funding (Bhatia and Mossialos 2004, pp. 185–86).

Following the distinction of Gough and Wood (2004), the term welfare state regime will be used to describe (Western) developed welfare states and their interaction with private actors. In contrast to welfare state regimes, the categories of informal security regimes and insecurity regimes will define social policy in a developing-country context to emphasize the fact that health
services are often provided by non-state, transnational and informal (non- or weakly monitored) private actors (Abu Sharkh and Gough 2010, p. 28). Welfare regime\textsuperscript{12} will be used as the broadest term — which includes both welfare state regimes on the one hand and informal security and insecurity regimes on the other hand. The exact meaning of welfare is dependent on a societal process of negotiation or subjective feelings of wellbeing.

The welfare outcomes can be analysed by looking at the way in which the welfare system “shapes inequalities, interests and power in society and in this way reproduces the welfare regime through time” (Gough 2001, p. 167). Health outcome is defined as the outcome in the health status of an individual, group or population which is attributable to planned or unintended interventions. Interventions may include government policies and consequent programmes, laws and regulations, or health services and programmes, including health promotion programmes, but also the actions of private actors. It may also include the intended or unintended health outcomes of government policies in sectors other than health (cf. WHO 1998).

Positive welfare outcomes show high levels of equity in access to affordable health care services — both in the sector of prevention and curative care. Equity in health care means equal access to social services based on the principle of need, not on that of ethnic or class affiliation, dependence on the market or a certain occupational group (WHO 2000, p. 7).\textsuperscript{13} While equal access to health care alone cannot overcome all socio-economic differences inside a society and might not counteract all negative aspects related to the costs and immediate loss of income due to absence from work, it can reduce private out-of-pocket payments and catastrophic health expenditures. It thereby increases the level of human security,\textsuperscript{14} decreases exposure and vulnerability and prevents major stratification effects through the health care system (Diderichsen et al. 2001, pp. 14–16).

Following Devereux and Sabates-Wheeler (2004), social protection will be defined as protection provided by “public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of the marginalized; with the overall objective of reducing the economic and social vulnerability of poor, vulnerable and marginalized groups”. Social (health) protection thus is defined as the absence of poverty and the protection against livelihood risks and socio-economic and political marginalization. Social protection as social policy can be provided both by public and private actors.\textsuperscript{15}

The term social security is often used by the ILO to describe the state provision of protection — especially in the area of social insurance (mainly contributory schemes), social assistance (tax-financed benefits provided only
to those with low incomes) and universal benefits (tax-financed benefits, provided without being income- or means-tested) (ILO 2000). In this book, however, the terms social security, health security and security in general are used in the sense of human security and therefore interchangeable with social and health protection, which allows for the fulfilment of basic material needs and a minimum level of protection against livelihood risks.

The factors that can contribute to health achievements and failures go well beyond the public health care system, and include many influences, varying from genetical propensities, individual incomes, food habits and life styles, on the one hand, to the epidemiological environment and work condition, on the other (Sen 2002, p. 660). At the individual level, health will always be unequally distributed (Peter and Evans 2001, p. 27). Therefore, this study is not so much an analysis of health indicators such as infant mortality or incidences of certain sicknesses and individual levels of inequality. Instead, this work concentrates on the political and institutional rationale of health care in Vietnam, access criteria and the utilization of services as well as the underlying power relations related to health care. Following Kreckel health inequality is defined as asymmetric relations between human beings and unequal access to health care, which influences the long-term living conditions of individuals, groups or whole societies (2004, p. 19).

Positive welfare outcomes in the sector of education, social assistance, housing, and health can be achieved by equal access to services independent of gender, race, ethnicity, and local origin. Concerning health in developing countries, special attention is given to the relationship between health and poverty. Equal access in health care should break through the vicious circle in which poverty enhances ill health and ill health causes impoverishment. Primary health care services (including not only the direct services, but support for food and transportation) should be provided in order to minimize catastrophic expenditures in health. The reliance of the public health care system on private out-of-pocket payments should be kept as minimal as possible.

1.3 STATE OF RESEARCH

The literature on social policy is immense. Beginning in the 1940s and 1950s there are several waves of analysis, which mainly focused on the Western capitalist and democratic countries. At first, research focused primarily on economic growth correlating with demographic change. It was argued that these developments would eventually lead to convergence of social policy in different countries (Wilensky 1975, 1976). Later analysis focused more on
the differences among welfare states. Authors explained the divergence by distinctions in ideology (see Wilensky 1975), the influence of the working class and power resources (Gough 1979; Korpi 1983), historical-institutional and path dependency concepts (P. Pierson 2000; Thelen 1999).

Esping-Andersen in his later writings was one of the first authors who looked beyond single explanatory factors, and concentrated on identifying interaction effects (Esping-Andersen 1993, p. 29). He therefore started to analyse the broader welfare mix of the state, the private sector and households in producing livelihoods and distributing welfare (Gough 2001, p. 169). The outcome was a regime typology, which more systematically than before was able to analyse welfare states comparatively.

For a long time, Japan remained the only Asian country which was included in the comparison of welfare states (Wilensky 1975; Vogel 1979; Esping-Andersen 1997a; Goodman 1998). Vogel (1979, p. 189) was the first author itemizing certain (East Asian) characteristics by looking at the example of Japan. According to Vogel, the family (including relatives beyond the nuclear family) and the workplace are the main bearer of welfare, while the state has a rather low profile. This characterization was later extended to the newly industrializing countries in East Asia (South Korea, Singapore, Taiwan and Hong Kong) and resulted in a debate whether a genuine East Asian welfare regime exists (Goodman and Peng 1996; Esping-Andersen 1997a).

Neoliberals tend to stress that East Asian states have high levels of welfare despite low levels of government expenditure. The quality of the East Asian welfare state is therefore often measured by its ability to function as a “regulator which enforces welfare programmes without providing direct finance” (White 1998, p. 13). A strong emphasis on education is also seen as typically East Asian. Furthermore, it is stressed that social policy is often a political means to stability and legitimacy:

Welfare programmes were … introduced as part of a broad political strategy to build legitimacy for authoritarian regimes (in Taiwan and South Korea), as part of a programme of sponsored democratization (in Hong Kong), or to forestall opposition challenges (in Japan in the early 1970s). As a result of these and other differences, individual welfare systems have their distinct characteristics: for example, the large-scale public housing programmes in Hong Kong and Singapore, and the Central Provident Fund (CPF) in Singapore, which reflects their status as city-states with migrant population. (White and Goodman 1998, p. 14)

As Goodman and Peng argue the lack of interest in the region can be attributed to language barriers and overall disinterest in the subject, but also
to the fact that social policy in the region was often used for ideological reasons to justify a lean state (1996, p. 192).

The Confucianist culture and family values (respect and care towards parents, sick and the elderly, mostly carried out by women in their role as mothers, sisters, wives and daughters-in-law) were used as an excuse to avoid the establishment of national social programmes. Family values did not make national programmes redundant. Quite the contrary: the lack of national programmes fostered family or company-based occupational welfare (Esping-Andersen 1996a, p. 21). The other factor which contributed to the neglect of the region was that most researchers concentrated on social insurance systems rather than on broader social policy initiatives including the development of human capital and land reforms. This brought scholars to the conclusion that East Asia was a social policy-free zone (Croissant 2004; Chang 2004).

More recent research focuses on a broader definition of social policy and thus has come to quite different results. Holliday and Gough have classified East Asian states as productivist welfare regimes (Holliday 2000; Gough 2001) — that is regimes prioritizing productive aspects of social policy such as education (in the case of Japan and Korea especially on secondary education) and health over social insurance systems. The sustainability of productivist welfare systems relies heavily on economic growth. The private provision of social protection has thus become challenged in the context of the Asian financial crisis (Chan 2001; Croissant 2004). The democratization of countries in East Asia has also brought about changes in the notion and extent of social policy and social rights (Cook and Kwon 2007). Especially, South Korea and Taiwan seem to have taken a much more universalistic approach than countries such as Malaysia and Singapore (Holliday 2000). Many of the authors working on welfare regimes in East Asia have thus taken the road to building sub-categories of the productivist regime without however challenging the basic concept.

Individual attempts to analyse welfare regimes in East Asia have been compiled for many countries in the region such as Japan (Vogel 1979; Goodman 1998; Uzuhashi 2003; Takayama 2003), South Korea (Joo 1999; Kwon 2002, 2004; Son 2003), Hong Kong (Jones 1990; Chan 2001; Lee 2005), Taiwan (Aspalter 2001), Singapore (Ramesh 2000b), Indonesia (Ramesh and Asher 2000; Ramesh 2000a), Malaysia (Ramesh 2000a), the Philippines (Reese 2005), and Thailand (Schramm 2000, 2002a/b). Publications on social policy and welfare regime development on China, with which Vietnam is often compared due to its Communist legacy, can also be found. Many authors look at how the Communist path dependence has influenced the present social policy in China. Few however have tried to
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link their results to the broader discussion of welfare regimes and comparative politics (White 1998; Aspalter 2001a/b; Cook 2002; Guan 2005; Leung 2006; Chan 2008). 

Comparing Vietnam and Eastern Europe shows some path dependent remnants: a high number of State-Owned Enterprises (SOEs) and comparatively high expenditures in the sector of health and social insurance. A broader look at Post-Communist states also brings some useful insights into the concept of statehood: Transitional Communist states are neither consolidated nor can they be described as coherent and unitary. They are at the crossroads between states which are disengaged from society — demands coined by patrimonial networks and personal relationships — and legal rational structures, popular sovereignty, and adherence to international norms. What can be drawn from a comparative analysis with Eastern European countries is that an analysis of the specific nature of statehood can bring major insights into social policy in transition processes (Grzymala-Busse and Luong 2002, p. 532). However, in general the countries in Eastern Europe are very different from Vietnam in terms of their economic, social and political transition, which makes the comparison quite difficult.

As Son (2003) has argued there is a strong neglect of national variations in social policy programme development in the different East Asian countries. The same can also be said about Southeast Asia. Articles such as the one by Hort and Kuhnle stay on the surface of social policy development (mainly by listing government regulations and stating pledges) and lack — as the two authors admit themselves — an analysis of country-specific variations and policy which goes beyond the rhetoric of governments (Hort and Kuhnle 2000).

Cook and Kwon (2007) are one of the first authors to have challenged the fact if East Asian welfare regimes can be analysed within a regional context, which is extremely heterogeneous in socio-economic, political, and cultural regards. In his analysis of Korea, Malaysia, Thailand, the Philippines and Indonesia, Gough (2001) was the first author who explicitly dealt with the assumptions Esping-Andersen made about welfare regimes in Western countries. He highlighted several factors, which are genuine to the experience of non-Western countries such as their history of colonialism, stronger economic dependency on the international economy, lower levels of industrialization and formalized income, and weaker class organization. More recent typologies (Gough and Wood 2004; Gough and McGregor 2007; Rudra 2007) look deeper into the differences between developed and developing countries. These typologies seem more promising for analyzing a late-coming industrializing nation as Vietnam than the productivist model
which generalizes all East Asian countries and overemphasizes the ability of the central government to provide and regulate social services.

Very little has been written so far on the Vietnamese welfare regime. Cook and Kwon (2007) briefly analyse the transition of the welfare regime of Vietnam from one mainly based on the community and the collective to one moving towards individual private provision of social services. London (2007, 2008) looks into what he calls the Vietnamese “market-Leninist regime”, in which the Communist Party of Vietnam (CPV) adopts “market institutions and employs market-based strategies of accumulation while retaining Leninist principles of political organization” (London 2008, p. 116). He concludes that the CPV uses redistributive and accumulative reassertions in order to bolster its subjective legitimacy. However, he does not go into details about the different layers of statehood nor does he follow a comparative approach (London 2008, p. 115). Much of the other literature on social policy in Vietnam is written from a technical perspective or primarily as policy advice on how to improve the social system. In general, very few references in these policy papers are made to the theoretical discussion on welfare regimes.31

1.4 THEORETICAL ASSUMPTIONS AND STRUCTURE OF THE ARGUMENT

The theoretical assumptions for the study are drawn from a variety of theoretical approaches including Esping-Andersen’s (1993) supposition of welfare regimes and the adaptation of Gough and Wood (2004) to developing countries (informal security regimes, insecurity regimes). Regime typologies offer an understanding of the way policymaking and policy outcomes have to be thought of in a state in society approach. The effects of public social policy cannot be understood without analyzing its relation to private actors such as the family, the voluntary sector, market participants, etc. The state is understood as being both, a powerful and clearly bounded unified organization at some point, but also a fragmented entity strongly entangled with private actors and social forces at other times (Migdal 2001, p. 22). The regime typology helps to schematize some of the problems in terms of actors and structures affiliated with welfare development in a developing country context.

However, what is missing from the regime approach is that it lacks proper tools with which to more specifically analyse the different actors involved in the political process and their interaction. Furthermore, the concept is static in the sense that it does not explain how change in regimes can happen. This study therefore combines regime analysis with the concepts of network
analysis and policy learning (Heclo 1974; Hall 1993; Sabatier 1988, 1993). Only few authors have come up with this solution even though it promises to give in-depth insights into policymaking and political change in a certain political area.

In describing and analyzing social policy legislation and implementation in an environment of informal security, this analysis will highlight under which conditions positive change towards a more universal and equal social system can be achieved. The study is based on the assumption that in a setting of informal security which is characterized by a high fragmentation of political decision-making, welfare outcomes cannot only be explained (and ultimately changed) by the actions of a government, but by three factors which are interwoven:

- the socioeconomic setting in which reforms are embedded;
- the public private provider mix; and
- the negotiations inside a regulatory policy network of different societal, political actors and — to a certain extent — international actors.

The analysis will therefore be divided into the following categories, which also structure the study:

- **Socio-economic setting in Vietnam (chapter 3):**
  The transition in Vietnam from plan to market has been characterized by privatization, spontaneous decentralization and deregulation. Furthermore, formalization of work remains low, and has — through the very process of privatization — even increased. This has augmented the already existent inability of the central government to fully implement its decisions. This failure to alter outcomes has enhanced inequality, since the state is not able to compensate for the shortcomings of the market. For a Communist government this lack of steering capacity is a worrying situation given the fact that the government assumed office with the explicit goal of eradicating poverty, exclusion and domination.

- **Public provider network (chapter 4):**
  In chapter 4 the existing public schemes of health protection will be analysed. Here the historical development from the seizure of power by the Communist Party up until the official reform process shows some of the problems the central government faces. The analysis demonstrates that the central government has only a loose grip on health care in the fast modernization process; its steering capacity is weakened by local players,
the marketization of health care and the way in which a decentralization process has taken place spontaneously from the bottom-up. Some of the reform efforts, which the government has initiated with the support of the Ministry of Health (MOH) in the area of health insurance and health assistance, are thus difficult to implement.

• Private provider network (chapter 5):
The family remains the most important social safety net since public programmes are only slightly effective. Private initiatives in the sector of health have long outnumbered the activities of the public sector. One of the most worrying developments in the private sector is how the public sector has privatized from within. Moonlighting and job sharing are common phenomenon among health care staff. The advent of private pharmaceutical companies has improved the availability of medicine, but has also increased self-medication and the costs for accessing health care services. The private voluntary sector including the international donor community and national and international NGOs has somewhat relieved the public health care system. However, while the former are highly fragmented, the later are often marginalized in the political process.

• Regulatory policy network analysis (chapter 6):
On the basis of core beliefs, the major actors inside the regulatory policy network agree that poverty should be eradicated and equality should be increased. On the level of secondary beliefs however, actors dispute on how fast these goals should be achieved — especially since the second core idea — that of economic growth — brings about much public legitimacy to the CPV. Hence, discussions revolve around which resources should be focused on projects enhancing health equity and which ones should focus on efficiency, growth and financial sustainability. The regulatory policy network analysis reveals the bargaining system of decision-making in Vietnam, which is highly fragmented, decentralized and characterized by a high level of informal decision-making. The assumption with regard to the policy network is that positive change can emerge from policy learning: this includes more regular interaction of the relevant actors inside the policy network. This enlarges a common understanding of the policy subject. It also allows pivotal actors to strengthen their analytical and bargaining power. Policy brokers or so-called Party champions can be helpful in finding a compromize for both sides.
1.5 TIMEFRAME INVESTIGATED

While the main timeframe investigated is 1989 to 2008, it should be clear that major changes have already occurred since the end of the 1970s. The year 1989 marks an important official turning point in terms of health protection in Vietnam. In this year the Vietnamese government introduced user fees for the public health care system and allowed private practitioners and pharmacies to operate. Health insurance was introduced three years later in 1992 to further overcome financial restraints of the state. Special focus will also be placed on the period 2002 to 2008, when important decisions related to the future of health insurance were made. Some of the major policy changes have been introduced through the Health Care Fund for the Poor (HCFP) (introduced in 2002) and during the drafting of a law on health insurance (2005 to 2008).

As Sabatier argues, it is necessary to analyse a period of a decade or more for a policy analysis. This allows at least one cycle of formulation, implementation and reformulation and some insights into the success and failure of policy (Sabatier 1988). It strengthens the conclusions, as short-term variations are not so easily misinterpreted. In contrast, more emphasis can be put on the overall direction of the policy process.

1.6 OPERATIONALIZATION

In order to get insights into the case study of the policy network of health protection in Vietnam, several methods were combined (methodological triangulation). The methods used (expert interviews, participatory observation, document/data analysis, personal email correspondence) proved to be especially valuable in capturing the concrete political practice of members of the policy network. All mentioned methods helped to reconstruct the informal rules of inclusion and exclusion of ideas and beliefs as well as to disclose the contradictions inherent in the informal security regime.

Expert Interviews

Fieldwork for this study took place between March to July 2007 and between November 2007 and January 2008. Forty-one semi-structured interviews were conducted in Hanoi and Ho Chi Minh City. Through this qualitative method important members of the policy network could be identified. Furthermore, policy actors and their decision-making processes could be analysed. Interview partners from the policy network included current and former members of
the relevant ministries related to social policy such as the Ministry of Labour, Invalids and Social Affairs (MOLISA), the Ministry of Health (MOH), the Ministry of Finance (MOF) as well as members of the organizations inside the Communist Party important for the overall direction of health policy in Vietnam. Interviews were also conducted with members of the Vietnam Social Security (VSS), which manages the health insurance fund, as well as a member of the National Assembly. Furthermore, meetings were arranged with members of research institutes, which are affiliated with the MOH, as well as various donors and consultants.

For the interviews a semi-structured format based on an interview guideline was used (see Annex 1). Some of the interviews were recorded on tape. Mostly, especially in the case of Vietnamese interview partners, recording was not used in order to create a more informal environment for the interview. All interviews were transcribed afterwards. At the beginning of each interview the purpose of the interview was explained.

The objective of the interviews was to get first hand information on issues affiliated with the hypothesis of the study — identification of the policy network, the interplay between different actors inside the policy network (public and private, national and local). Furthermore, the interviews were used to analyse the intentions, attitudes and evaluations of members of the policy network as well as to find out the long-term societal belief system. Another aspect was to identify structural problems responsible for the weak welfare outcomes in Vietnam such as the economic setting and the social environment in which policy takes place.

The semi-structured interview technique was applied as it is rather seldom that one can find individual opinions and statements about political strategies and institutional attitudes in Vietnamese journals, newspaper articles and official documents. It is therefore especially difficult to extract opposing opinions inside the policy network about the past, present and future of the social system in Vietnam relying only on secondary sources. The information gained in the interviews was often more concrete and comprehensive than that found in any newspaper and journal articles — which is not to say that they were not helpful in other aspects of the study.

The open ended form of interviews put few limits on the available response options and allowed interviewees to raise issues, which had not been considered so far. There was no coding scheme used. However, citations were grouped into thematic categories which related to the main questions which were established in the interview guideline.

All interview partners were contacted via email or telephone. International donors were often very open and talkative about their experience. Meanwhile
Vietnamese partners — especially members of the Central Committee and the Commissions — were often more difficult to get in touch with. After a while, a snowball effect took hold, in which one interview partner was able to open doors to other interviewees. Vietnamese interviewees were open and critical on technical issues and in broad categories also about other ministries and other views. They often maintained a low profile the moment one tried to dig deeper into criticism of individuals and actual beliefs. Vietnamese interviewees, who had had contacts with Germans before, mostly since they had studied in Germany, were more open in general and more often willing to meet more than once.

In most cases interview questions were not sent to the interviewees a priori but asked on site. The questions to the interview partners were adapted to the individual position and situation of the respondent. Most interviews were conducted in English. Only three were conducted in Vietnamese and translated through an interpreter. Some were also in German. The interviews in general took between thirty and sixty minutes, in exceptional cases ninety minutes. For the reason of confidentiality, the interviewees are treated anonymously in the study.

**Participatory Observation**

Further insights were gained in participant observation through the attendance at conferences, workshops and study tours. During my research visits I was able to participate in two workshops by the German development agency InWent with the VSS on model calculations for a compulsory health insurance system and training for employees of the VSS in May and December 2007. The two workshops allowed me to work closely with members of the VSS and gain insights into problems of data quality in Vietnam, political will and economic and administrative restraints of health insurance. In June 2008, I accompanied a study tour organized by the GTZ Poverty Reduction Project for several members of the Department of Social Protection inside MOLISA to Germany. The study tour was conducted to inform the group of state employees about social protection mechanisms for low income earners. This trip provided useful conversations with members of national and local representatives of the department of social protection inside MOLISA. Furthermore, I was able to comment as an advisor to the GTZ Poverty Reduction Project on the Vietnam Development Report 2008 on “Social Protection” allowing me to work closely with international donors, who operate in Vietnam. I gained a closer look at opinions inside the donor community related to the establishment of a health insurance scheme.
Document and Data Analysis

Apart from interviews, documentary research was a second major source of information. Legal documents and statistical data were collected to the extent that they were accessible either via the internet website of the General Statistics Office of Vietnam, the ministerial websites, publications available in Vietnam or via libraries in Germany. Substantial amounts of data were also drawn from donor publications. Additional information was gathered through the regular analysis of the English press in Vietnam, such as the *Viet Nam News*, *Viet Nam Net*, *Thanh Nien Daily*, as well as some blogs.

The two research visits in Vietnam were used to collect information in libraries of the University of Hanoi and in NGO resource centres. Additionally, all secondary literature on the subject of social protection and welfare regime in theory and specifically on Vietnam was screened. Prior to and after the fieldwork, a careful literature review was conducted and regularly updated.

Personal Email Correspondence

Some of the information has also been gathered through personal email correspondence before and after the field trips. Information from this source was only used when personal meetings could not be arranged in Vietnam or if some follow up information was needed.

Data Limitations

As will be seen throughout the chapters, there is often no single truth about statistics in Vietnam. Current data limitations — especially the issues of accuracy, reliability and comparability — are a severe restraint to both academics and policymakers. One of the major statistical source in Vietnam are the Vietnam Living Standard Surveys — VLSS (1992/93 and 1997/98), which are conducted by the General Statistics Office (GSO). Both surveys were funded by the United Nations Development Programme (UNDP) and the Swedish International Development Agency (SIDA), and technically assisted by the World Bank. The household questionnaires include topics such as education, health migration, fertility, agriculture.

As Fritzen and Brassard (2005, pp. 40–41) have highlighted much of the problem with data in Vietnam stems from the fact that more specialized databases are missing and the Vietnam Living Standard Surveys (conducted in 1992/93 and again in 1997/98) and the Vietnam Household Living Standard Surveys since 2002 are highly overused. Knowles highlights: “[a]ccuracy suffers
because many health workers do not have enough time and motivation to ensure that their statistics are complete and accurate and, in some cases, they have incentives to misreport data on the level of services provided” (Knowles et al. 2008).

Sample sizes often remain too small to precisely estimate poverty at lower levels than provinces. Poverty maps allow estimates of poverty rates at the district and commune, but can be easily contested due to the rapid change in economic growth and massive rural-urban migration (World Bank 2008a, p. 6), a problem with which probably everyone who works in a developing country has to live with.

Another challenge is that some social and political issues have not been covered yet in the data. So far no reliable and longitudinal data on domestic migration exists. Similarly, there is no national database which gives insights into the characteristics and operation of the rural land-use rights market (Fritzen and Brassard 2005, pp. 40, 44).

In order to minimize restraints related to data reliability, it will be indicated when several opinions on numbers and figures exist.

### 1.7 SPELLING AND CITATION

Some Vietnamese terms are written in spelling with diacritics, especially when newspaper articles are cited in Vietnamese or when more than one English expression exists for a Vietnamese institution. Đỗ mơi is simplified to Đội Mới, Hà Nội to Hanoi, Việt Nam to Vietnam etc. Viet Nam is only used when it is part of the official name of a newspaper or organization. Vietnamese names are cited and alphabetized by the full name starting with the family name, which is the first name in order, i.e. Nguyễn Khắc Vien (1975).

### Notes

1. A distinction will be made between East Asia and Southeast Asia. The term East Asia refers to the countries of Japan, China, Taiwan, Hong Kong, North and South Korea, and all countries in Southeast Asia. Southeast Asia consists of Burma (Myanmar), Cambodia, Laos, Thailand, Vietnam and Malaysia, Brunei, East Timor, Indonesia, Malaysia, the Philippines, and Singapore. The newly industrialized countries in East Asia — Hong Kong, Singapore, South Korea and Taiwan — are also referred to as the four Asian Tigers.

2. The slogan of the Communist Party of Vietnam (CPV) illustrates this policy agenda: “accelerating national industrialization and modernization for a prosperous people, a strong country, an equitable, democratic and civilized

Catastrophic health expenditures are often used to indicate the risk of people in a given society to sink into poverty. Catastrophic health expenditures normally refer to the number of households with out-of-pocket-payments exceeding some pre-specified threshold of total, non-food, or non-subsistence consumption, expenditure or income. Household out-of-pocket-payments are payments borne by a patient directly without the benefit of insurance (OECD 2000, p. 155). Payments include consultation fees, purchase of medications, and hospital bills. Wagstaff and Doorslaer (2003) consider out-of-pocket-payments being catastrophic when exceeding a ten per cent threshold of total household expenditure. Xu et al. (2003) describe out-of-pocket-payments as being catastrophic when they exceed more than forty per cent of a household’s non-subsistence spending.

User fees are charges for goods or services of public or private providers of health care (Gottret/Schieber 2006: 231).

I would agree with Lees (2006, p. 1098) that single-country scholars should be aware of the danger of constructing tautological explanations based on the assumption of cultural exceptionalism.

One of the characteristics of informal security regimes is exactly the lack of a certain organizational logic, stemming among other factors from the way in which the state is not able to alter market, community and family relations. The state is not able to regulate other actors in the welfare mix, decision-making is highly fragmented and consensus is thereby more difficult to achieve (Gough 2004, pp. 28–30).

As Weale (1985) has argued, welfare states in the OECD world pursue very different objectives. The whole idea of welfare regimes is that societies make different public choices about the level of equality and redistribution in society.

According to Esping-Andersen “[S]ocial policy is supposed to address problems of stratification, but it also produces it. Equality has always been what welfare states were supposed to produce, yet the image of equality has always remained vague.” (1993, p. 3). In his later works he added: “We should not confuse the welfare state with equality […]. Welfare states, in fact, pursue different conceptions of equality” (Esping-Andersen 1996b, pp. 261–62). Latin America is a typical example how social services can be highly regressive. Cf. Huber et al. (2009).

Wellbeing is a term almost as vague as welfare (cf. the discussion in Gough and McGregor 2007). In my understanding, the concept of wellbeing does not only include the notion of material wellbeing, but extends to concepts of social inclusion, i.e. access to social services, equal opportunities in terms of health and education and most importantly a say in decision-making processes for social
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policy. The notion of wellbeing is dependent on subjective evaluations, which can change over time.

As Ramesh (2004, pp. 116–52) has demonstrated housing policy has been very important in some of the East Asian cases, where rapid urbanization and population growth promoted a strong demand for affordable housing.

There is no consensus whether to include education into the analysis of social policy, however most authors refrain from doing so. I would agree with Iversen/Stephens (2008: 602) that the design of education policy is closely related to an economic development model and social protection — having profound impact on the distribution of income and the level of vulnerability a person faces inside a society.

Reference is made here to the definition of a welfare regime by Esping-Andersen as “the combined, interdependent way in which welfare is produced and allocated between state, market and family” (Esping-Andersen 1999, pp. 34–35). I will use this definition as a starting point for the elaboration of my own theoretical framework in chapter 2.

Inequality, by implication, means asymmetric power relations between human beings and unequal access to public goods. Those asymmetries influence the long-term living conditions of individuals, groups or societies (Kreckel 2004, p. 19).

Human security in this book is not only understood as freedom from fear, but in a broad term as “a condition of existence in which basic material needs are met, and in which human dignity, including meaningful participation in the life of the community, can be realised” (Thomas 2001, p. 161).

For an overview on definitions on social protection see Devereux/Sabates-Wheeler (2004). See also ADB (2003) and ILO (1984; 2000).

Health expenditures are catastrophic when a household must sacrifice immense parts of its current consumption and/or faces negative long-term welfare consequences due to borrowing or depleting assets to pay for health care. There is no consensus over the exact threshold of catastrophic expenditures. Authors have concluded several thresholds varying from five per cent (Berki 1986) to forty per cent of total household income (cf. Xu et al. 2003). For terms often used in the text see also the glossary in Annex 8.

See Titmuss (1958), Cutright (1965), Aaron (1967) generally on social policy; see Zöllner (1959) on Germany; Woodrofe (1962) and George (1968) on Great Britain; Kuhnle (1978) on Nordic welfare states.

Wilensky (1975, p. 27) analysis of sixty countries brought him to the conclusion that their social systems converge through economic growth: “[E]conomic growth makes countries with contrasting cultural and political traditions more alike in their strategy for constructing the floor below no one sinks”.

In his early writings (see for example Esping-Andersen 1985), Esping-Andersen’s approach was quite close to the power resource theory such as followed by Korpi (1983). Esping-Andersen first analysed how political power resources of the
working-class affect the distributional and institutional characteristics of welfare-state development. His later writings are still rooted in a perspective of class conflicts but are somehow broader by looking not only into the power resources of the working class, but in general asking “under what conditions the class divisions and social inequalities produced by capitalism … [can, comment K.P.] be undone by parliamentary democracy” (Esping-Andersen 1993, p. 11).

20 Vogel (1979) for example emphasized that the Japanese welfare state was able to provide security without granting entitlements (title of chapter 8: security without entitlement).

21 Holliday (2000) further differentiates the productivist welfare regime into a facilitative regime such as in Hong Kong in which the state only play a facilitating role, a developmental universalist which emphasizes the universal provision of social services such as in Japan, Taiwan and South Korea, and a productivist-particularist in which individual provision of social services is prevalent such as in the case of Singapore.

22 For further information see Snodgrass (1998); Stevenson (1998) demonstrates that the original endowments of educational capital in East Asia was not better than in other regions and even worse than in Latin America were pupils had 3.0 years of education compared to 2.3 in East Asia. However, in the 1960s, East Asian countries started to have higher than average enrolment rates compared to their income at the primary and secondary level.

23 This discussion is very linked to the debate about the East Asian developmental state, which was able to achieve high growth rates combined with low levels of inequality by proper education systems, well targeted subsidies, and outward-oriented export-led growth, as well as the strategic and selective intervention into the market and thereby a counter concept to free market ideologies (Johnson 1982 on Japan; Amsden 1989 on Korea; White and Wade 1984; Wade 1990; Önis 1991 for an overview on the debate; Thompson 1996; Goodman, White and Kwon 1998 for the connection between the East Asian developmental and welfare state debate; for the newer discussion see Radice 2008).


25 Holliday (2000) differentiates between facilitative (Hong Kong), developmental-particularist (Singapore), and developmental-universalist (Korea and Taiwan) productivist welfare regimes; Park and Jung (2008) use a hierarchical cluster analysis to differentiate between three groups which include some Southeast Asian countries: Japan, Korea, Taiwan, Thailand, and the Philippines, (2) Hong Kong and Singapore, and (3) Malaysia and Indonesia.
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26 Besides this literature which makes reference to the broader discussion on welfare regimes and welfare regime theories, there are a number of publications which are of more technical or descriptive nature such as Low (2004) on Singapore or Ku (2007) on South Korea.

27 One of the major differences is the socioeconomic and industrial structure of Vietnam in contrast to Eastern Europe. While Vietnam’s share in agriculture in the late 1980s was as high as fifty per cent of GDP (or around sixty-five per cent of the total labour force), countries such as Poland, Hungary or Czechoslovakia had shares around fifteen per cent of GDP and much higher shares in industrial production (CIA 1990). Private health spending on average was between 9 (Czech Republic) and 35.5 (Romania) per cent of total health spending in 1996 (Haggard/Kaufman 2008: 213) in contrast to around 70 per cent in Vietnam in 2000 (WHO 2008). The high number of private health expenditure shows how much more privatized the Vietnamese system is. Another difference is the political landscape. Democratic transitions in Eastern European countries since the breakdown of the USSR have been much more profound compared to the small-scale political liberalization process in Vietnam (Haggard and Kaufman 2008, p. 305; for Vietnam see for example Hansson 2003).

28 The Human Development Index (HDI) in 2005 varied enormously between Japan (0.953), Viet Nam (0.733) or countries such as Cambodia (0.598) or East Timor (0.514) (UNDP 2008).

29 According to the Economist Intelligence Unit’s (2008) Index of Democracy 2008, on a scale from 1 to 0, Japan scores 8.25, Laos only 2.1, North Korea with 0.86.

30 In terms of religion, the region of East Asia is influenced by Confucian (China, South Korea, Japan, Vietnam) Buddhist (Thailand, Vietnam, Laos, Myanmar), Muslim (Indonesia, Malaysia, Brunei), and Catholic (East Timor), and Animist influences. In addition, a vast range of languages (Malay, Mandarin, Thai, Korean) and ethnic groups (Tai, Austronesian, Burmese, Mon-Khmer, etc.) exist.


32 Kai Hon Ng (2007) has worked on policy networks in Hong Kong, specifically on the government policy on civic education between 1970 and 2000. Son is one of the few which uses a historical-institutional approach to better understand the extension of the entitlement to health insurance to the non-wage earning population in Korea and Taiwan. She uses this approach to better highlight the impact of the political system (especially presidentialism) and the importance of culture and belief systems of both countries on social policy (Son 2003).
For further information on the advantage of a qualitative method mix in policy analysis see Schneider/Janning (2006) and Behrens (2003).

In the VLSS 1992/93, a total of 4,800 households in 150 rural and urban communities have been surveyed. In the VLSS 1997/98, 1,200 more households were added. Of those over 6,000 households in total, 4305 households had been surveyed already in the first VLSS. Questions were added such as on social subsidies, government poverty alleviation and assistance from non-governmental organizations (Cox 2004, footnote 1, footnote 12, 575). Out of the 4,800 households of the 1992/1993 VLSS, only 495 (roughly ten per cent) were not interviewed again for the 1997/1998 survey. Due to the small sample size and the low frequency of implementation every five years, the information gathered was often contested. Since 2002 therefore, every two years Households Living Standards Surveys (VHLSS) are published. The VHLSS 2002 contained 30,000 households.

For further basic information on the sample, size, data processing, etc. of the VLSS 1997/98 see World Bank (2001c).

For an assessment of the information system in health see MOH (2006).