The Vietnamese Health Care System in Change

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The Vietnamese Health Care System in Change

A Policy Network Analysis of a Southeast Asian Welfare Regime

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ABBREVIATIONS

ADB	Asian Development Bank
CBO	Community-Based Organization
CEM	Committee for Ethnic Minorities
CEP	Capital Aid Fund for the Employment of the Poor
CHC	Commune Health Centre
CHW	Commune Health Worker
COMECON	Council for Mutual Economic Relations
CPV	Communist Party of Vietnam
CRD	Centre for Rural Development
DAV	Drug Administration of Vietnam
DFID	Department for International Development
DOF	Department for Finance
DOH	Department of Health
DOLISA	Department of Labour, Invalids and Social Affairs
DOPF	Department of Planning and Finance
DOTS	Directly Observed Treatment Strategy
ECVN	Evangelical Church of Vietnam
EPI	Expanded Programme of Immunization
FDI	Foreign Direct Investment
FES	Friedrich-Ebert-Stiftung (Friedrich Ebert Foundation)
GDP	Gross Domestic Product
GSO	General Statistical Office
GTZ	Gesellschaft für Technische Zusammenarbeit (German Technical Cooperation)

HCFP	Health Care Fund for the Poor
HDI	Human Development Index
HEPR	Hunger Eradication and Poverty Reduction
HI	Health Insurance
HIF	Health Insurance Fund
HMIS	Health Management Information System
HPG	Health Partnership Group
HSPI	Health Strategy and Policy Institute
HSS	Health System Strengthening
ICC	Inter-Agency Coordinating Committee
IDA	International Development Agency
IDU	Injection Drug Use/User
IFC	International Finance Corporation
ILO	International Labour Organization
IMR	Infant Mortality Rate
INGO	International Non-Governmental Organization
JAHR	Joint Annual Health Review
n.d.	no date
IOS	Institute of Sociology
ISEAS	Institute for Southeast Asian Studies
KfW	Kreditanstalt für Wiederaufbau
MCH	Maternal and Child Health
MIGA	Multilateral Investment Guarantee Agency
MMR	Maternal Mortality Rate
MOET	Ministry of Education and Training
MOF	Ministry of Finance
MOFA	Ministry of Foreign Affairs
MOH	Ministry of Health
MOHA	Ministry of Home Affairs
MOLISA	Ministry of Labour, Invalids and Social Affairs
MPI	Ministry of Planning and Investment
MTEF	Medium-Term Expenditure Framework
NGO	Non-Governmental Organization
NHSP	National Health Support Project
NIHE	National Institute of Hygiene and Epidemiology
NIMPE	National Institute of Malariology, Parasitology and Entomology
NPE	National Programme on Employment
NPHEPR	National Programme on Hunger Eradication and Poverty Reduction

NSE	Non-State Enterprises
NTP	National Targeted Programme
NTP-PR	National Target Programme on Poverty Reduction
ODA	Official Development Assistance
OECD	Organization for Economic Cooperation and Development
PAA	Post Assessment Activity
PCF	People's Credit Fund
PFPP	Population and Family Planning Project
PHC	Primary Health Care
PIT	Personal Income Tax
PMT	Project Management Team
PPMT	Provincial Project Management Team
PSMS	Provincial Secondary Medical School
RDSC	Rural Development Service Centre
RP	Retirement Pension
RTCCD	Research and Training Centre for Community Development
SARS	Severe Acute Respiratory Syndrome
SBV	State Bank of Vietnam
SGFRR	Social Guarantee Fund for Regular Relief
SI	Social Insurance
SIDA	Swedish International Cooperation Agency
SME	Small and Medium Sized Enterprise
SOE	State-Owned Enterprise
STD	Sexual Transmitted Diseases
TB	Tuberculosis
TEW	Toward Ethnic Women
TU	Trade Union
TYM Fund	Tao Yeu May Fund
UBCV	Unified Buddhist Church of Vietnam
UN	United Nations
U5MR	Under Five Mortality Rate
UNDP	United Nations Development Programme
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
USSR	Union of Soviet Socialist Republics
VBARD	Vietnam Bank for Agriculture and Rural Development

VBP	Vietnam Bank for the Poor
VBSP	Vietnam Bank for Social Policy
VCCI	Vietnam Chamber of Commerce and Industry
VFA	Vietnam Farmers' Association
VHLSS	Vietnam Household Living Standards Survey
VHWs	Village Health Workers
VLSS	Vietnam Living Standards Survey
VND	Vietnamese Dong
VNHS	Vietnam National Health Survey
VNDP	Vietnamese National Drug Policy
VPA	Vietnam Peasants' Association
VSI	Vietnam Social Insurance
VSSA	Vietnam Social Security Agency
VUSTA	Vietnam Scientists and Technicians Associations
VWU	Vietnam Women's Union
WB	World Bank
WG	Working Group
WTO	World Trade Organization

FOREWORD

Health policy and health insurance systems have come under scrutiny all around the globe. From the debate of the U.S. American health care system and global health initiatives such as the Millennium Development Goals to that of privatization and reform of health services in post-socialist countries, discussions on health care provision and financing have been ongoing and heated.

This book is the first macro-study systematically analysing the evolution of the Vietnamese health care system since the beginning of the reform process in the mid-1980s. The book is a valuable contribution to the welfare regime debate since it extends theorizing on welfare systems from a basically OECD-perspective to the domain of developing countries. It thereby examines changing state-society relations in an erstwhile socialist country. It supplements the bulk of literature on industrialized countries with an empirically rich and theoretically reflected study of an important developing country.

The theoretical framework is based on the concept of informal security, network analysis and belief systems to explain the welfare outcomes in Vietnam. The book departs from two central questions: Why are attempts of the Communist Party of Vietnam and the Vietnamese government for more equitable health services so easily diluted? And under what conditions can positive welfare outcomes nevertheless be achieved?

Kerstin Priwitzer argues here that Esping-Anderson's famous welfare regime concept provides an excellent starting point, but does not fit well the conditions of developing countries where social security systems are highly informal and non-state based. For analysing Vietnam's informal security

regime, she develops an analytical framework which distinguishes several analytical categories. One is the socio-economic setting in which Vietnam's health system is embedded, the second is the provider network (public and private) and the third the so-called regulatory network which captures the interactions among actors in the health sector. Change in health policies is brought about by policy learning.

The research questions reflect a key problem of Vietnam's transition from a centrally planned state economy into a market economy with socialist orientation: the tensions that emerge between equity, on the one hand, and growth and efficiency, on the other. The reform politics (*Doi Moi*) introduced in 1986 arrested the country's economic downward trend and ushered in a more market-based economic policy. Today Vietnam has caught up with the third generation of Asian tiger economies, which transformed East and Southeast Asia into the world's most vibrant economic powerhouse. Yet, economic transformation based on world market integration had its price: It was paralleled by growing regional and social disparities and it exhibited the pathologies which usually trouble transitional societies. Although poverty rates declined, economic growth bypassed women, minorities and rural people living in the highlands.

In the wake of eroding state resources, a creeping privatization of health services began well before *Doi Moi*. In the inevitable process of a progressive commodification and privatization of social services, major segments of the population got increasingly excluded from access to health and other welfare services previously provided by the state free of charge or at least at subsidized cost. People, in order to reduce personal insecurity, mainly relied on private institutions such as family, kin and friends. While access to private sources of health care provided a modicum of security, it heightened inequality. Poor people without access to public health services usually could normally not rely on a more resourceful private social security net. Individualization as a concomitant of rapid modernization and a highly fragmented public provider network even exacerbated this situation, confirming alarmist calls by international organizations, NGOs and the media about the increasingly exclusionary and discriminating tendencies of the Vietnamese social system.

NGOs and international donors made noteworthy contributions, especially in financial and technical terms. Especially international organizations became a major source of ideas from which the government benefited. The drawback, however, was that most domestic private health service providers operated under a rather precarious and rigid legal framework and often had to contend with a state suspicious of nongovernmental activities.

In the book, the Kerstin Priwitzer departs from the observation that even a Leninist state is not necessarily a monolithic state. In fact, a continuous and accelerating perforation of the Vietnamese state could be observed with the advent of *Doi Moi*. Part of this perforation was an asymmetric decentralization from which large and rich provinces benefited most, whereas remote, rural and upland provinces were left behind. Another facet of this transformation of the state towards a system of governance was the pluralization of health actors — ranging from the relevant government ministries to the local agencies, to legislative bodies including an increasingly assertive National Assembly, and a plethora of private sector entities. It suggests that there is an increasing interaction between these actors which produces learning effects for the government. The latter can be seen in the gradually improving translation of core beliefs on the health (and social) system into operational secondary beliefs, all bottlenecks notwithstanding.

The book places the Vietnamese example of health care reform in a comparative perspective. It combines insights into the Vietnamese health care system with international theoretical discussions. It is thereby a valuable source of information not only for scholars interested in Vietnam, but for development specialists and epistemic communities in Southeast Asia and beyond, too. It also advances the ongoing discussion about welfare regimes in developing countries and the opportunities and flaws of transferring concepts of social protection developed in the Western world to non-Western, newly capitalist systems.

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January 2011

PREFACE AND ACKNOWLEDGEMENTS

The idea of this book derives from my Master thesis, which I wrote on civil organizations in Vietnam. While writing my thesis I realized what enormous impact non-governmental private actors have on every policy area in Vietnam. I also realized that to talk about the state did not make much sense, since Vietnam's political system was far from being monolithic. I became interested in understanding reform processes in health policy, a policy area which I found especially important in terms of equity and social cohesion inside a society.

This thesis could not have been completed without the help of many people. I would therefore like to acknowledge my gratitude to all those who have supported me in my work during the last years.

First of all I want to thank Professor Dr Jürgen Rüland for accepting me as a doctoral student, for his support and guidance throughout the whole process of research and writing. Furthermore I thank Dr Jörg Wischermann who inspired this work, for his helpful advice and encouragement.

I am grateful to Professor Dr Heribert Weiland for encouraging my work and providing me with a work place at the Arnold Bergstraesser Institute (ABI) in Freiburg. I am deeply indebted to all my friends and colleagues at the ABI. The ABI has provided me with a stimulating research and working atmosphere in which I have found motivation to finish my Ph.D. I would like to especially thank my friends and colleagues Angela Herrmann, Christl Kessler, Ingrid Wehr, Steffi Gerum, Jan Völkel, Clemens Jürgenmeyer, Martin Adelmann and Reinhard Kössler for their encouragement and critical analysis

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Despite of all the help I received I am of course still solely responsible for all mistakes and shortcomings of the book.

Kerstin Priwitzer
January 2011

GLOSSARY

Adverse selection	Adverse selection refers to a market process (often within the insurance sector) in which information asymmetries exists between two parties. An insurance company for example does not know who is a smoker, a diabetic, or HIV/Aids patient and who is not. Hence, the fee is normally higher for both customers. This could lower the usage of health care services among poor or chronically ill people. A voluntary health insurance system also risks only attracting poor people and threatening off rich people, thereby undermining the financial means of a fund.
Catastrophic health expenditures	Catastrophic health expenditures are often used to indicate the risk of people in a given society to sink into poverty. They are normally measured by 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. Wagstaff/Doorslear (2007) 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.

Co-payment	Co-payment is a fixed amount or percentage which has to be paid for a health care service privately (OECD 2000: 155).
Equity in health care	Equity in health care means that health care resources are allocated according to need, not ability to pay (WHO 2000: 7).
Health	A state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity (WHO 2006 [1948]).
Health outcome	Health outcome is the health status of an individual, group or population which is attributable to planned or unintended interventions. Interventions may include government policies and consequent programs, laws and regulations, or health services and programs, including health promotion programs, 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).
Health sector	The health sector consists of organized public and private health services (including health promotion, disease prevention, diagnostic, treatment and care services), the policies and activities of health departments and ministries, health related non-government organizations and community groups, and professional associations (WHO 1998).
Household out-of-pocket-payments/ expenditures	Household out-of-pocket-payments are payments borne by a patient directly without the benefit of insurance (OECD 2000: 155). Payments include gratuities and in-kind payments made to health practitioners and to suppliers of pharmaceuticals, therapeutic appliances and other goods and services, whose primary intent is to contribute to the restoration or the enhancement of the health status of individuals or population groups (WHO 2006: 160). The higher the out-of-pocket-

	payments, the more likely it is for a person to face catastrophic health expenditures and thus poverty.
Indirect payments for health care	Indirect payments for health care are payments not directly linked to individual's consumption of health services such as general taxes, payments made to mandatory or voluntary health insurance schemes, or payments made to local health cooperatives (Gottret/ Schieber 2006: 232).
Moral hazard	The term moral hazard refers to the possibility that the redistribution of risk (such as insurance which transfers risk from the insured to the insurer) changes people's behavior. A car driver could get less diligent, since the damage on his or her car would be covered by an insurance firm. The same is sometimes said about health systems, where universal coverage would increase demand for health care.
Primary health care	Primary health care is essential health care made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable. The primary health care system is normally the first level of contact of individuals, households and communities with the health care system. It combines promotive, preventive, curative and rehabilitative services (WHO 1978, Article VI and VII).
Private expenditure on health	Private expenditure on health refers to privately funded part of expenditure on health activities provided by individuals, the for-profit and non-profit sector (WHO 2006: 159).
Public expenditure on health	Public expenditure on health refers to expenditure on health care incurred by public funds. Public funds are state, regional and local government bodies and social security schemes. Public capital formation on health includes publicly-financed investment in health

	facilities plus capital transfers to the private sector for hospital construction and equipment (OECD 2001).
Purchaser provider split	The separation of purchaser and provider in government-funded health systems enables competition to develop between providers. Competition is seen as a means to drive technical efficiencies by providers.
Rider	A life insurance rider provides additional coverage for something specifically not covered with a primary policy. The rider is added to the primary policy for which the policyholder pays an extra amount.
Social health insurance	Social health insurance is an insurance programme which meets at least one of the following three conditions: participation in the programme is compulsory either by law or by the conditions of employment; the programme is operated on behalf of a group and restricted to group members; or an employer makes a contribution to the programme on behalf of an employee.
Social insurance	The technique of pooling risks and finances in autonomous funds.
Social protection	The set of policies and programs designed to reduce poverty and vulnerability by promoting efficient labour markets, diminishing people's exposure to risks, and enhancing their capacity to protect themselves against hazards and interruption or loss of income. Social protection can be defined to include social security (social insurance), social services, social assistance, and social safety net schemes for government and private sector employees, the poor, and the disadvantaged and vulnerable groups.
Social security	The ILO defines Social Security as the protection which society provides for its members through a series of public measures.

Total expenditure on health	Total health expenditure (THE) has been defined as the sum of general government expenditure on health (commonly called public expenditure on health), and private expenditure on health (WHO 2006: 159).
Universal health insurance	A national plan providing health insurance or services to all citizens, or to all residents.
User fees	User fees are charges for goods or services in the health sector either by public or private providers (Gottret/ Schieber 2006: 231).