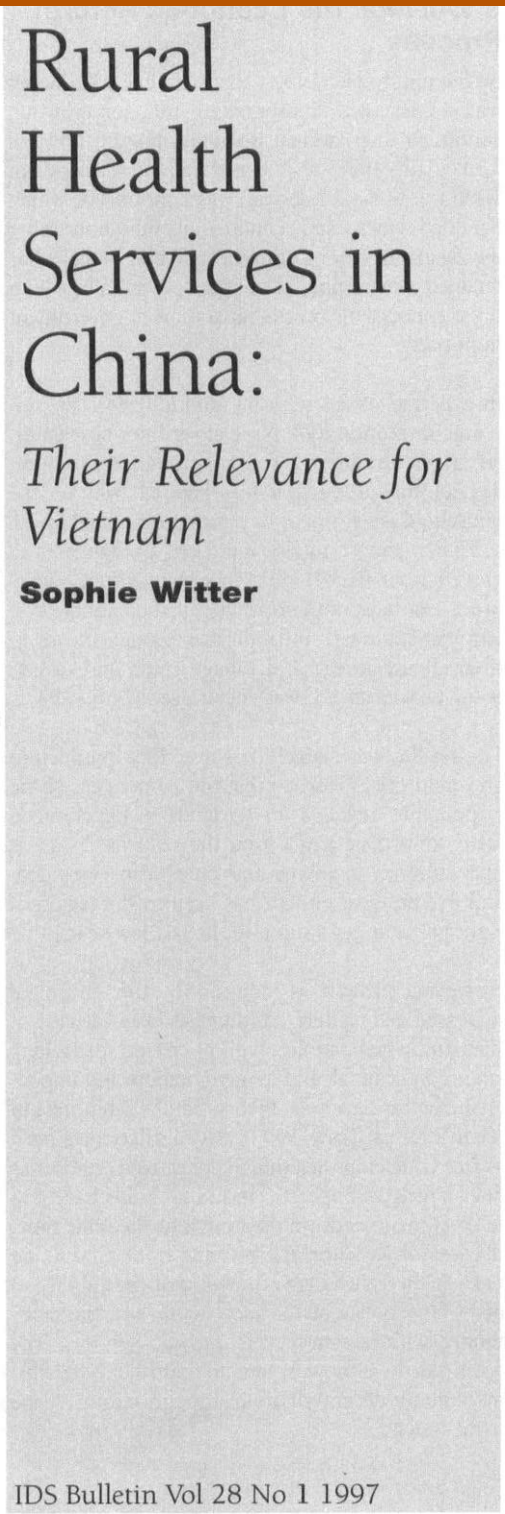
1 Introduction

Vietnam relates to China in a way typical of former colonies which have had to struggle for independence: it distrusts and rejects China at the same time as being highly influenced by developments there. China is in fact the most obvious image of what the future could hold for the health sector in Vietnam. Their development prior to recent reforms was run along similar lines; the reform process shares many features; and many of the problems currently being experienced in China are also found in Vietnam. Vietnam would therefore be wise to study the current situation in rural areas of China and take from them both positive and negative lessons about how to manage ongoing changes in its own health sector.

2 The Health Situation in Vietnam Prior to Reform

After independence (in 1954 in the north, 1975 in the south), the emphasis in Vietnam was on developing an infrastructure to provide basic health care and training up health workers to meet norms of numbers of doctors per population. This was carried out at the same time as land reform and other policies which ensured a relatively equitable distribution of resources in society. Access to health services at commune health centres was provided for around 90 per cent of the population and preventive activities were given prominence through the mobilisation campaigns of the Communist Party and related social organisations. Consequently, Vietnam's health indicators were better than expected given its low GNP per capita (UNICEF 1994).

We have to be wary, in Vietnam as well as in China, of 'golden ageing the past'. The primary health care system at that time was underfunded, in terms of equipment and supplies in particular; many of its staff were undertrained or poorly trained; the services were probably of poor quality and unresponsive to patient needs, although patient expectations were also lower. The lack of independent data from the period prior to the mid-1980s means that the myth of a perfectly functioning PHC system is hard to disprove, but a myth it nevertheless almost certainly is (Vogel, 1987).



3 *Doi Moi:* the Economic Reform Process

By the mid to late 1980s, the Vietnamese economy was in crisis, with output falling, inflation growing, continued international isolation, and aid from its former ally, the Soviet Union, about to cease. In 1986 the policy of *doi moi* was announced, which heralded widespread economic liberalisation under the aegis of the Communist Party, which has retained a monopoly of political power, albeit with some concessions on the separation of government from party.

In a period of a few years around 1990, an economic revolution took place along lines now familiar in a number of transitional economies. Agricultural production was handed back to the household level; prices of most commodities freed; subsidies almost totally removed; exchange rates moved from fixed to floating; state-owned enterprises lost most of their privileges; the banking system was reformed; inflation was brought down to single figure levels; and foreign trade and investment, as well as aid, was encouraged (IMF 1994).

The results were largely positive. Rice production grew and prices rose, so that the 70 per cent of the population engaged in agriculture experienced some immediate gains from the reforms. Business opportunities in towns and cities also expanded, and overall GNP growth has been in the region of eight per cent per annum in the last few years.

However, growth is commonly the cause of increased inequalities, and this has been the case in Vietnam, where families with poor land, or lacking labour and capital, and living in remote and impoverished areas have seen their situation deteriorate in relative terms (Long 1993). Social safety nets such as free education, health and collective social funds have largely disappeared and households have had to meet their needs on their own. At the same time, the loss of its automatic revenue from production has left the central government with less ability to determine policy at the local level, and the communes with less money to provide services. The government is now trying to partly reverse this involuntary decentralisation through reform of the fiscal system.

4 Reform in the Health Sector

The three main changes in health policy which resulted from *doi moi* were the legitimisation of private practice; the liberalisation of pharmaceutical production and sales; and the introduction of fees for curative services in the public sector (albeit at low level, below costs). A difference from China is that there has been no structural reform of the health system, which remains integrated and largely financed by public money.

One important consequence of changes in health policy has been a drop of about 50 per cent in the use of public facilities since 1989. This presumably reflects the increased prices of the public sector, its poor quality, and the existence of alternatives. The most striking trend has been towards self-prescription, which is now the course taken by two-thirds of people experiencing illness, according to World Bank figures (World Bank 1995). The private sector has also been growing, especially in cities, but almost entirely in the form of public servants carrying out private services in or after hours. The confusion of public and private sectors, found in China, is therefore also a feature of the health market in Vietnam today.

Although state funding for health has been maintained, in real terms, private expenditure on health has increased greatly and now constitutes around 85 per cent of the expenditure on health (World Bank 1995). Most of this money is spent on drugs though, rather than contributing to cost recovery in the public sector through fees. The lowest level of health worker prior to reform, the brigade nurses, who were funded by the cooperatives, have now all but disappeared and the commune health staff, previously paid for by the communes, are now being taken onto the state pay-roll as many communes are no longer able to support them (Guldner and Rifkin 1993).

5 Challenges in the Health Sector

There are many challenges facing the health sector in Vietnam at present. The majority are shared with China, although there are some notable differences.

Underfunding: Although state funding has held up, as mentioned, the system was underfunded before in most areas – salaries, supplies, capital costs and maintenance – and that problem has been

exacerbated by the price rises and increase in expectations under *doi moi*. Cost recovery is limited because fees are low and the ability of the rural population to pay for health is restricted. A programme is underway to develop health insurance in rural areas, but it will face problems because of low income levels, the need for effective exemption mechanisms, and the lack of trusted local collective bodies to administer the scheme (Ensor 1995). Successful experiments with rural health insurance in China would be of particular interest to policy makers in Vietnam.

Access: Services which used to be free are now fee-paying, and although the fees are low, the burden illness imposes on families is now much greater than before, especially when taking into account informal payments to staff and the cost of drugs. Access has therefore become an issue, which will only get worse as costs in the health sector rise (Tipping *et al.* 1994). The growth in self-prescription can be seen as an attempt to minimise costs by families, with possible negative consequences for their health as a result of inappropriate treatment. Expenditure in the public sector is also biased towards the higher level referral services, with only five per cent of the health budget being spent at commune level where most of the poor live (World Bank 1995).

Overextended infrastructure: The combination of large infrastructure of buildings and staff, low utilisation and low overall funding is a relatively common scenario in transitional economies. It results in a service which exists but does not have the funds to operate and consequently loses the confidence of the public. Moreover, if, as in China, staff and other costs rise with general economic growth, the problem will be exacerbated, with staff costs absorbing the whole of the public health budget (salaries are remarkably low at present, but this too has adverse consequences). In recognition of this, the Ministry of Health in Hanoi has called for staff reductions at all levels of the health service. However, the bureaucratic culture and lack of alternative employment has meant that these reductions have not been forthcoming so far. A shift from training to retraining is also required, as is a change in staff mix from doctors to nurses and administrators (Abbatt 1989).

Drugs overuse: As in China, growth in consumption of drugs in a largely unregulated market is creating a threat to cost-effective health care. The challenge is four-fold: to educate the public on the potential danger of overuse of drugs; to re-train staff in appropriate prescribing practices; to ensure that staff do not have financial incentives to over-prescribe (e.g. getting income from commune revolving drug funds); and to have effective regulation of the private pharmacies, which have sprung up since 1990. All four strategies have to be pursued if the policy is to be successful.

Preventive activities: Unlike in China, these services are still provided free, at least in theory, and coverage rates remain relatively high. However, these national programmes are currently quite heavily supported by foreign donors, and in the longer term funding needs to be secured for them from local resources, if the achievement is to be sustained.

Management issues: Management systems in the health sector have not adapted sufficiently to the new conditions. Funding at the province and district level is still calculated according to norms, and although the basis for those norms has changed from beds to population, there is still too little flexibility for local managers to shift expenditure from one category to another, without the agreement of the national level. At the same time as being overcentralised in this respect, local levels are more independent financially, which means that it can be hard to implement central policies, to gather information about activities, etc. It is perhaps not uncommon to find this paradox in transitional economies: that they are both too anarchic and too controlled at once.

6 Lessons from Recent Reforms in China

It is clear from the above brief description that there are many similarities between the situation in China and that in Vietnam. There are also some salient differences, such as the formal autonomy which has been granted to service providers in China, the degree to which they support themselves by charging fees to patients, the fact that preventive services are charged for, and the problem of cost escalation and its connection with salary levels and the incentives to invest in high technology equipment in China. These differences may, however, merely reflect the lag in growth between China and

Vietnam: if the Vietnamese economy continues to grow at its current level, it is likely to face exactly the same issues unless it takes deliberate policy decisions to pursue an alternative strategy. China now can serve as a mirror into Vietnam's future. What are the lessons which it might reflect?

China's experiments with **health financing** are of key interest, particularly the difficulty of maintaining coverage in rural areas and controlling costs. China's experience supports the view that the combination of voluntary health insurance and fee-for-service payments tends to lead to cost escalation and an increase in higher level curative activities (Bogg *et al.* 1996).

Decentralisation in China has taken the form of giving health providers in the public sector greater autonomy in raising funds and managing themselves. This can be likened to hospital trusts in the UK, which have remained in the public sector but been given budgetary autonomy. The theory behind this change is that competition between providers will provide benefits in the form of more efficiency (i.e. lower costs) and, in the case of China where fees were introduced, increased mobilisation of private resources.

In practice, though, China has experienced cost escalation rather than cost cutting. This is in part due to government policy on staff salaries, which have risen in line with growth in the fastest developing parts of China, and also its controls on prices for basic health care, which have encouraged health facilities to invest in higher technology which is more profitable. Using staffing levels to allocate government funds is also not the best way to encourage increased efficiency amongst providers. However, even if norms are changed and the labour market made more flexible and price controls (which aimed at ensuring access) replaced with exemption mechanisms and/or social funds, it is still possible that introducing competition between provider units would result in non-price competition, which increases rather than decreases costs. This has been observed in countries like the US, especially when health insurance is the dominant method of financing. The competition between providers not only increases costs but may reinforce trends towards less effective health care (such as over-prescribing or overuse of diagnostic tests, which may be popular, rather than basic preventive activities, which would reduce demand for the providers' services).

In terms of **resource mobilisation**, China's health providers appear to have been successful in raising an average of 75 per cent of their budget from private sources (see article by Chen Jie in this Bulletin). However, as stated, these resources may not be used in the most effective way to maximise health gains. The level of fees is also creating a major barrier **to access**, with substantial evidence that peasants cannot afford to seek treatment and that treatment is a serious source of indebtedness and financial hardship (see articles by Yu *et al.* and Lie *et al.* in this Bulletin.

China's experience also identifies some further potential problems of decentralisation, notably the lack of incentives to pass information from one level to the next, to supervise the lower level services and provide support to them, and generally to coordinate services to meet the needs of the population. This is particularly true when there is no strong **purchasing agency**, with the financial muscle to identify health needs and plan and purchase appropriate services. In this situation, the system fragments into all level of providers competing to provide the profitable services, which may well not be the more cost-effective ones.

The question which this raises is whether some of the benefits which were sought through decentralisation might not be better realised within an integrated system in countries like Vietnam. Increased efficiency, for example, could be achieved by changing the system for paying providers, introducing target payments and payments based on staff productivity. Given the inequalities between regions in terms of wealth, there is also a strong argument for **national funding mechanisms**, such as an earmarked tax, rather than fees for service or local voluntary health insurance schemes, which do not allow cross subsidisation between provinces and a larger pooling of risks and which are likely to leave a substantial part of the population uncovered. The difference in health budgets between rich provinces like Ho Chi Minh City and the northern central region is already remarkable: up to three times as much is spent per capita (Smithson 1993). These differences are likely to increase rather than decrease in the future, as China illustrates.

The story of health in China in recent years also points to the importance of **political commitment**. It appears that at one stage, health came high on the political agenda, but it has now been 'privatised away' as an issue of lesser concern. In Vietnam, the Communist Party seems to be committed to maintaining the social gains of its previous era. It may be that this forms a part of its nationalist appeal and hence general political legitimacy. If so, it is likely that more priority will be paid to solving some of the problems listed above. As in China, though, there is a widespread disenchantment with collective activities amongst working people, as a result of the recent history, and maintaining the credibility of the public sector will require a range of reforms.

7 Conclusion

The experiment which has been going on in health in China is of interest to many developing countries, but especially countries in transition from a communist system. Of these, Vietnam is arguably the one which most closely resembles China in terms of its past, its culture, and the present problems in the health sector (at least if the comparison is made with poor rural areas in China). I have therefore argued that China presents a most useful mirror of the future for Vietnam, which only recently embarked on reforms along similar lines to those started by China in the early 1980s.

Vietnamese policy makers would do well to watch most health developments in China over the next few years. Of particular interest would be: any successful models of rural health insurance which maintain coverage in poor areas; measures which succeed in limiting drug consumption; measures which successfully control costs, especially of staff; new funding sources for preventive services; incentives to provide cost-effective care; the upgrading of semi-trained staff; and any changes in fiscal relations between different levels of government.

The importance of planning ahead on the basis of national priorities is reinforced by the way in which interest groups get entrenched once a policy such as decentralisation has been carried out; it then becomes much harder to make changes such as promoting coordination between different parts of the health system. On the basis of China's experience, one might question the wisdom of decentralisation as it has been implemented there, arguing rather in favour of management reform within an integrated system in Vietnam, so that government can set priorities and local managers have more flexibility within those parameters.

References

Abbatt, F., 1989, 'An analysis of health and health manpower in Vietnam', Hanoi: report for SIDA/Ministry of Health

Bogg, L., Dong, H.J., Wang, K.L., Cai, W.W. and Diwan, Vinod, 1996, 'The cost of coverage: rural health insurance in China', **Health Policy and Planning**, Vol 11, No. 3: 238-252

Ensor, T., 1995, 'Introducing health insurance in Vietnam', **Health Policy and Planning**, Vol 10 No 2: 154-163

Guldner, M. and Rifkin, S., 1993, 'Sustainability in the health sector: Vietnam case study', London: report for Save the Children Fund UK

IMF, 1994, 'Vietnam', **IMF Economic Reviews** 13, Washington, DC: IMF

Long, N.G., 1993, 'Reform and rural development: impact on class, sectoral and regional inequalities', in W.S. Turley and M. Selden, (eds), **Reinventing Vietnamese Socialism: Doi Moi in Comparative Perspective**, Boulder, CO: Westview

Tipping, G., Truong, D., Nguyen, T. and Segall, M., 1994, 'Quality of public health services and household health care decisions in rural communes of Vietnam', **IDS Research Report** 27, Brighton: IDS

Smithson, P., 1993, 'Health financing and sustainability in Vietnam', London: report for Save the Children Fund UK

UNICEF, 1994, **Situation Analysis of Women and Children in Vietnam**, Hanoi: Unicef

Vogel, U., 1987, 'Some reflections on primary health care experiences in Vietnam, 1945-1985', dissertation, University College of Swansea

World Bank, 1995, **Vietnam: Poverty Assessment and Strategy**, Washington DC: World Bank