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The Political Economy of Healthcare Commercialization in Vietnam

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The Political Economy of Healthcare: Commercialization in Vietnam

Le Thanh Forsberg*

Abstract

Three million people are pushed down to poverty in Vietnam each year as direct and indirect consequences of ill-health and medical costs. The current economic situation with extremely high inflation and an absence of a functional social safety net may set many more households on the road to poverty.

Vietnam is at a crossroads. The basic systems put in place now in terms of public services and development-financing solutions will fundamentally shape the development and economic structure for decades to come. Against this backdrop, the Vietnamese health sector is facing fundamental challenges in terms of access, quality, financing and effectiveness of healthcare services. Rapid commercialization in healthcare services has shifted a large part of fiscal burden of healthcare from the state onto individuals. While some health indicators are improving and public investment in healthcare services is increased, Vietnam meets serious problems in making healthcare equitably accessible and affordable to a large segment of the population.

This paper aims at addressing the impacts of commercialization in healthcare services and its policy challenges to healthcare in Vietnam. Drawing on existing analyses and outcomes of field studies in the health sector, the author suggests that changes in health financing and institutions governing access to healthcare services are needed to reduce individual financial burdens, increase access to services and improve quality and effectiveness of healthcare. These changes are associated with the Vietnamese political economy at large, notably with the role of the state and its relations to social welfare services and market institutions. Structural changes may require a central political and economic reconsideration of the health sector in the development, in which healthcare can be considered a welfare investment in growth, rather than economic burdens.

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1. Introduction

Health sector reforms in developing countries since the 1980s have brought about significant changes. While acknowledging the improvements in health provisions and outcomes, there are problems arising from the trend to increased marketisation of the health sector. A growing body of literature has shown socio-economic consequences of health sector reforms in which health finance strategies have put focus on direct out-of-pocket payments, promoting user fees for public sector health provision and an increasing role of private for-profit health services.[1]

The major concern here is not only economic burdens of household illness and healthcare utilisation from increasing medical expenses and income losses due to ill-health, but also the inequitable access to quality healthcare that relates to ability to pay.

To a greater extent, making welfare provision and basic social services equitably accessible and affordable is increasingly a challenge to many developing countries. Reducing financing burdens, increasing access to healthcare services and improving quality of healthcare are prominent issues. However, there are significant differences in the health system financing solutions among countries, especially to which extent governments fund public healthcare services, which determines financial accessibility of service users.

In the context of Vietnam, health sector reform has taken place since the late 1980s. A marketization of healthcare provision has been introduced for health financing, which includes increase of public user fees and autonomy of public hospitals, expansion of the private health sector and introduction of a new insurance mechanism.[2] This process, embracing a rapid commercialization of services in public hospitals, has shifted a large part of the fiscal burden of healthcare from the state onto individuals. High levels of out-of-pocket financing in combination with informal fees and service provider-induced incentive structures have contributed to inflated drug and healthcare service costs, and challenged the implementation of an equity-efficiency orientation as well as effectiveness and quality in healthcare provision.[3] Despite continuous improvements in health outcomes, Vietnam is facing fundamental challenges to make healthcare equitably accessible and affordable, especially to the lower-income groups. Health inequalities are increasingly evident and more people are having problems coping with the costs of basic social services.[4]

This paper aims at addressing impacts of rapid commercialization in healthcare services and the resulting institutional challenges to health sector development in Vietnam. The analysis pays particular attention to the political economy and institutional context of health sector reforms during the last two decades, and its impacts on the commercialization process. The purpose is to better understand the policy challenges to the health financing and systems governing access to healthcare services. Two questions are important to address: Under what conditions is the commercialization taking place, and what are the major institutional challenges of the healthcare system?

2. The Health Sector at the Arrival of Marketization

Prior to the market-oriented economic reform in 1986, Vietnam had extremely limited economic resources. Still, the country posted remarkable health outcomes with much lower infant and maternal mortality rates and longer life expectancy than many better–off countries.[5] Vietnam's health system was entirely state-financed up to the 1980s and had a large health network from central level down to communes. Of particular importance were a strong network of commune health centres (CHCs), built from the 1950s to provide free access to comprehensive basic healthcare as a universal right to the entire population.[6] This was a part of the state's strong commitments to social equity and the development of basic social services to all, which played a significant role in creating functional and equitable basic primary care systems.[7]

However, poor economic performance in the post-war period posed major challenges to the health sector as Vietnam entered economic crises caused by failed economic policies, international economic sanctions, the end of Soviet aid and a price inflation of over 700%. This resulted in severe state budget constraints and social spending cuts. Primary health care at communal-based centres entered a crisis with shortages of resource allocations, degraded facilities, and downsized medical staff as salaries could not be paid.[8] The 1986 Doi Moi economic renovation policies were launched introducing market liberalization and privatization of trade and agriculture. It brought an end to the cooperative system that was behind the success of communal primary care networks. Welfare provision was redefined and health sector reforms began. In 1989, the public health sector began charging service fees and drug sales were privatised. Private practices were legalised and commercialization of services spread rapidly.

As a result, the quality of healthcare provision and access to services began to deteriorate. Aggregate utilization rates dropped 50% from roughly two to one consultation per person per year between 1987 and 1990.[9] While healthcare provision became better in many aspects and for some social groups, significant differences in healthcare utilisation emerged as healthcare provision became based predominantly on ability to pay. Health data for 1990-1998 shows that the government health funds were mainly reserved for the higher-tier curative services and less equitably distributed, especially regarding inpatient care. The richest quintile of the population captured more than 50% of tertiary care resources and slightly less than 50% of district hospital care resources, while the poorest quintile used only 2% and 5% of the resources respectively.[10]

The fiscal constraints and budget cuts led to public funds being prioritized to curative care services at provincial and central levels, while investments in public local services declined. Hinders to access to and availability of services at CHCs due to the lack of medical staff, services and quality of care were reasons driving patients to private clinics, primarily owned by public hospital staff. Public health staff began to operate private practices during off-hours and charging informally for care, and prescribing drugs of unknown quality without quality supervision by health authorities. With no systems of quality control or patient's medical report system, or a mechanism to control health care costs, medical service costs became excessively high and uncontrollable.[11] Insufficient investment in commune-level primary care began to undermine the ability of the poorer and rural groups to access quality care and treatments.

3. The Economics of Healthcare Commercialization

3.1. Health Financing

Commercialization of healthcare led to a sharp increase in direct out-of-pocket expenditures and the private health sector expanded rapidly. State health financing decreased in relation to a sharp increase of the private share of total health spending, and remained stagnant as percentage of GDP for about two decades after the economic reforms in 1986. Unlike education in state expenditure priorities during the first two decades of reform, state health spending captured only a small share of roughly 5% of the total state budget, fluctuating between 1 – 2 per cent of GDP.[12]

As a direct effect of the introduction of service user fees, the share of out-of-pocket (OOP) payments in total health financing increased from an estimated 59% in 1989 and 71% in 1993 to 80.5% in 1998.[13] It is expected that OOP payments will decrease after new insurance mechanisms are put in place and the available schemes increase. According to the current official figures from the MoH, the level of OOP has fallen to 52%, though other sources put the level at 75%, a much more credible figure.[14] In either case, it suggests that Vietnam has among Asia's highest levels of private health financing together with Bangladesh, China and India.[15]

Current public health spending has begun to pick up a higher share of Vietnam total health expenditures. According to the Ministry of Health's review (2010), both state financing and total health

spending share of GDP have increased; the total public health financing in 2010 accounted for 37.8 %, of which the state share was 10.2%, and the total health financing was at 6.4% of GDP.[16] However, about 70% of the funds go to curative care at the central and provincial levels and to those service providers, at the expense of primary care and preventive services in rural areas and at the commune level. Of total state health expenditures, 60% is mainly to cover medical staff salaries, allowances and their social insurance while 37% is allocated to health sector development, of which 46% and 51% are respectively allocated to national and provincial levels. Only 3% of the central state spending is allocated to district and communal healthcare. This trend shows that public spending and resource allocation have been inequitably distributed. It is highly concentrated to curative care and in-patient services at higher-tier hospital levels.

Despite an increase in state and public health financing, the high level of OOP payments and medical costs in relations to income has caused major concerns over the social and economic consequences to an increasingly larger segment of the population. While service availability and quality have been improved at the higher-tier healthcare services, giving the richest 20% of the population an increase in hospital utilization, the poorest 20% has indeed reduced their share of hospital utilization. A report on health financing by the MoH (2008) showed that Vietnam has the highest percentage of households affected by catastrophic health expenditures among 59 countries included in a multi-country analysis. It is on average five times larger than other developing countries when it comes to incidences of catastrophic payments relative to 40% of the annual non-food consumption. Furthermore, health service costs soared up to 75% of the monthly non-food per capita expenditure of a poor household.[17]

In times of illness, there is no option for low-income families but to try to find money for needed treatments. This is harder for poor families being hit by catastrophic illness incidents since they have to ask for loans with high interest rates or sell capital goods or livestock, grasp money from the food budget or even withdraw children from school. The reduced access to health care has also forced people into self-medication or to avoid seeing a doctor for non-acute problems, which may both endanger their health and others due to disease resistance or transmissions. Lack of access to medical services also forces more people to private drug vendors who tend to sell drugs without prescriptions and more drugs than needed, or even give irrational combinations of drugs or sell fake medicines.[18]

Health expenditures cause a considerable burden for Vietnamese households and set many households on the road to poverty. Van Doorslaer et al. (2007) show that numbers of individuals pushed into poverty by OOP payments are greatest in countries such as Vietnam, China, India and Bangladesh. Vietnam continues to have the highest incidence of catastrophic payments in Asia.[19] Today, about forty million Vietnamese are still living under $2 a day. Coupled with high social service costs especially in medical services and a lack of social security, economic shock from ill health is pushing about three million people per year below the poverty line.[20]

3.2. Health Insurance

The health insurance system is another acute problem. Health insurance was introduced in 1992 to cover some target groups such as government officials, state employees and staff of foreign invested companies, and those considered indigents such as war heroes, war invalids and their children. The national health insurance scheme covered 12% of the population in 1997 and increased to an estimated 60.5% in 2010, with the government aiming at 80% in 2014.[21] Today, about 34 million Vietnamese are uninsured and at high risk of falling into poverty when encountering major medical expenses. The 53 million insured can in principle benefit from their health insurance. However, because of the insurance refund structure and the way healthcare services are run, the poor and the exempted groups still find services inaccessible without informal fees to doctors, nurses, midwives or other health staff. Expanding insurance coverage is planned to reduce OOP payments, but most studies have found only a modest effect.[22] The design of current insurance schemes has made the

poor paying hospital fees for the rich and extracts insurance refunds from poor provinces to wealthier cities.[23] It is state officials and urban elites that are the main beneficiaries of the insurance refunds as insurance coverage and refunds are to cover mainly high-class curative care and in-patient services in urban and centralized hospitals.[24]

The health insurance refund system is facing major challenges in containing costs, involving dysfunctional rules and informal arrangements in which corruption incurs. There is hardly any effective mechanism to record, report or measure service costs and adverse insurance selections. Neither can they control doctors in their prescriptions and consultations involving duplication and falsification of doctors' medical records to claim refunds and medical reimbursements.[25] Furthermore, pharmaceutical companies can lobby, or often pay bribes, to make sure that their drugs are included on insurance lists. Once on the lists, they often increase drug prices by at least 30% over the market prices and encourage doctors to overprescribe expensive medications and laboratory tests. Medication accounts for 45-60% of all hospital costs.[26] Such distortion increases the cost incurred by the Vietnam National Health Insurance Fund (VHIF). Technical input and high-tech medical equipment also form a major part of health insurance expenses. Unsurprisingly, the VHIF is running at loss and facing the risk of bankruptcy.[27] The current performance of the health insurance system implies that the government may find it difficult to extend insurance provision to an increasingly vulnerable population at the currently high medical costs.

3.3. Informal Fees and Corruption

Although informal fees are misrepresented in official health reports, they account for a significant proportion of hospital fees and constitute a major source of revenue for public hospitals and medical staff.[28] More acutely, corruption in the healthcare system is endemic.[29] Together, informal fees and corruption can add serious economic burdens of healthcare costs to individuals, especially considering the already relatively high level of OOP payments. Uncontrollable informal fee arrangements exist at all levels of healthcare services in the form of bribes or paying commissions to cover the service costs and salary deficiencies of medical staff.[30] A study in 2005 showed that informal payments to health care providers accounted for as much as 36% of hospital fees and 19.6% of total hospital bills for patients receiving "better" quality inpatient care through 'envelope' payments.[31]

Corruption exists in both grant and petty forms.[32] According to these studies, corruption ranges from commissions to doctors from drug sales, personal gains from health insurance refunds by medical staff, corruption practices from privatization of public hospitals, licensing, management decisions overseeing medical facility establishments, health properties, to personnel recruitments. Envelope payments and commissions to medical staff, or requiring patients to overprescribe tests and medicines are huge problems.[33]

The kickback systems from pharmaceutical companies to doctors and health professionals for prescriptions have generated far higher prices on medicines, especially in public hospitals.[34] According to media investigations, the majority of medicines available in pharmacies are 200-300% higher priced than import prices. In pharmacies attached to central hospitals, such as the national paediatric hospitals, parents of sick children were forced to buy medicines at 60% higher prices than private pharmacies outside the hospital, where prices of medicines were already seven times the import price.[35] Doctors can be offered up to 30% of the total incomes pharmaceutical companies get from prescriptions.[36] Weak controls and the lack of fair market regulations in the pharmaceutical market has made imported medicine distributors more offensive in rewarding commissions to doctors for drug prescriptions, distorting procurement and licensing procedures in order to ensure market entry and shares.[37]

This has not only burdened households, but also become a destructive arrangement for service quality and management. A research by the Medical University of Hanoi in 2009 shows that

70% of medical staff interviewed admitted that they have often breached medical ethics and asked patients to pay bribes.[38] People's perception of corruption is also widespread. Based on the Vietnam Household Living Standard Survey (VHLSS Governance Module 2008), 85% of respondents stated that they perceived slight to very serious corruption in central health services, while 65% perceived corruption in local health services.[39]

Vasavakul (2009) shows a highly corrupted health sector in Vietnam where services and health workers are concentrated to the wealthier social groups. Unhealthy incentive systems are increasingly the causes of unequal access to health care, imbalanced health care services and medical staff withholding services from those who cannot afford to pay. Since doctors and health specialists engage in a dual-system working in public hospitals and their home clinics to maximize their private gains, service quality and performance standards are distorted. Systematic connections between public hospitals and private medical equipment companies and between doctors and pharmacists have spiked medical expenses, adding severe economic burdens to the sick and the poor.[40]

4. The Politics of Healthcare Commercialization

4.1. The Myth of Socialization in Healthcare Provision

To cover the cost in the public sector, commercialization of the healthcare services, ironically labelled 'socialization', began in the forms health financing through user fees, a high level of out-of-pocket payments and patient self-selective service mechanisms called "elective services". [41] In the context of the Vietnamese political ideology and rhetoric, the term 'socialization'[42] calls for mass mobilization and contribution of all social forces to invest in and share the cost of social services, primarily in education and healthcare, in order to relax the state from fiscal burdens. In reality, 'socialization' actually means a process of marketization of social services through commercialization of social services including privatization of certain aspects of public health provisions.[43] All are to fit in a market-oriented but socialist economy. Hence, when 'socialization' is mentioned in the Vietnamese context, it actually means a marketization process. Marketization here does not refer to a conventional Western market economy concept. It refers to a system of partial privatization and commercialisation of public ownership of public goods and services, which allows the state stakeholders to play a dominant role on both informal and formal markets.[44]

The myth of 'socialization' derives from the transformation from a centrally planned economic system to a socialist-oriented market economy. In this context, development has been about economic growth by all means focusing on the country's industrialization and modernization process. Accordingly, all resources were prioritized for economic growth through investment in production and manufacturing, ahead of social development and environment.[45] Hence, focus since reforms in 1986 has been on industrialization while transferring state financial responsibility of social services to households. Preoccupied with economic growth, social welfare services are seen as burdens and economic costs rather than a comprehensive component of development. This is politically convenient driving 'socialization' to capitalize and privatize public services.

In practice, "marketization" of the health sector has constituted one of the main components of the myth of Vietnamese socialization. One clear example is the Ministry of Health (MoH). The MoH manages and allocates the government's funds to several components of the health sector development. Meanwhile, the MoH owns and administers dozens of state companies in pharmaceuticals and medical equipment. VINAPHARM, for example, is Vietnam's biggest pharmaceutical corporation directly under the MoH. VINAPHARM has dozens of daughter companies and owns all pharmaceutical producing units in public ownership. Critically, it does not only hold a monopoly position in the domestic market of production, trading and distributing drugs and medical equipment, but also operates hotel and restaurant services, real estate, food retails, and commercial leasing of offices and warehouses.[46] The army and security forces, as well as dozens of other state

corporations such as Electricity of Vietnam and telecom companies have their own hospitals offering quality healthcare services to their own staff, family members and state officials. Hence, health sector development and policies have been influenced by these relationships between the government and state corporate groups to make healthcare provisions increasingly beneficial to state official and their elites.[47] A result of this political economy is a shortage of fiscal funds to social services and 'socialization' was invented to shift the fiscal burdens from the state onto individuals.

Without a good contextual understanding of the political economic environment in which institutional rules and incentive structures are shaped, it is difficult to understand why commercialization of healthcare services in public hospitals has been rapidly driven and unregulated in Vietnam. Acknowledging implications of the increasing role played by the public hospitals and service providers as informal and formal actors in the market in the public health sector, the incentive structures are clearly provider-induced.

With rapid commercialization under way since 1997 under the coverage of 'socialization', Decree 43 was introduced in 2006 to intensify 'socialization' of health services through fee-for-service mechanisms and the encouragement of private financing of health services. London (2008) has argued that the political assertion behind the commercialization process has created incentives to place private interests before public health.[48] It has encouraged public hospitals to become profit-centres and transform into businesses or non-public institutions. Public hospital managers and medical staff are encouraged to co-invest in public hospital high-tech equipment and facilities to offer quality side-service charges, both formal and informal. This mechanism encourages service quality and access differentiations based predominantly on ability to pay. It also reduces health insurance and hospital fee exemptions to some targeted social groups to be only nominal. In reality, it is all the formal and informal fees paid by individuals that matters.

4.2. Decentralization of Service Management

Aimed at improving effectiveness in the use of state budget allocation and planning and reducing public health institutions' dependence on central budget allocations, the government launched decentralization in the health sector in 2002 by Decree 10. It sets the legal frame for fiscal autonomization of public hospitals aiming at financial self-sufficiency. Accordingly, decentralization has given public hospitals power in determining allocation of investment funds, quality of services, fee collections, staff recruitments, staff salaries and prescription drug sales. Given the small share of state budget allocation to healthcare and a significant source of hospitals' revenues from service user fees, the incentives facing public hospital managers favour fee policies and medical investments to the services that can generate most revenues.[49] Decentralization thus may intensify commercialization and the incentives of public health institutions to place profit and private gains before public interests. This risk is high as central regulations to health provision, service quality and cost control is already weak.[50]

Reviews of decentralization in the health sector show that the incentives to generate revenue through fee collection and drug sales have raised the number of consultations doctors perform on their patients.[51] Furthermore, under the 'socialization' policy to increase private investment in the public health sector, there is pressure for these private investments to generate profits.[52] Combined with fiscal autonomy and management decentralization, public hospitals are encouraged to seek investments in high-cost services such as diagnostic testing and clinical imaging to cover operating costs and boost medical staff's income. Strong incentives to improve income levels have distorted quality care, the moral and professional relations to patients and contributed to the increase of medical costs. Both prescriptions and diagnoses are quantitative oriented. As a result, overuse of diagnostic tests, over-prescription of expensive drugs, and duplication of doctor consultations has become common.[53]

The decentralization is also considered to have expanded the overall healthcare expenditures and shifted distribution of resources from lower to higher levels, from rural to urban areas, from primary and preventive care to curative services, and from planning care to market forces.[54] Fiscal decentralization without central regulations may add problems to financing disparities in social services and geographical inequity of in healthcare as the poorer regions have already problems to sustain public funds for healthcare.[55] Distribution of public expenditures among provinces is hardly pro-poor and lacks incentives to promote social development. Also, public investment has been mainly disbursed to benefit wealthy cities and social groups.[56] Lack of social and economic investments in rural areas where 70 per cent of the population still live has not only created disparities in regional development and a wider gap between rural and urban parts, but also runs a risk of pushing low-income groups including rural farmers, the urban poor and near-poor into the trap of poverty. While the central government has made attempts to transfer public expenditures to poor groups via national social-targeted programs, resource allocation and management of public spending at local levels have often turned the poor down as very little actually reaches them.[57] Despite the fact that ODA and government social spending have been pro-poor, less than seven per cent of these funds went to the poorest quintile.[58]

Decentralization was expected to promote local accountability and innovation, systematic citizen involvement in setting the goals, design and financing for health care, and in monitoring service provision. However, evidence shows that decentralization to provincial control of health services has reduced access to services for the poor.[59] Drastic decentralization without quality governance and supervision becomes problematic. The structural changes brought by the decentralization means that authoritative power is shifted away from the MoH. With less authoritative power and lack of monitoring and evaluation instruments to assess healthcare provisions and service delivery, the MoH is left with formal health sectoral policies without much control over policy implementation or to develop mechanisms to hold local government, service units, and workforce accountable.[60]

4.3. Challenges of Healthcare Commercialization

There are increasing adverse consequences of commercializing healthcare in Vietnam. The first effect is seen in the expanding healthcare costs and high levels of out-of-pocket payments that mainly burden on individual households. The economic burdens related to direct high medical treatments and financial costs as well as indirect income loss due to illness are threatening millions of people, especially the rural poor and urban near-poor.

The second impact is the distortion of the equity of healthcare provisions and service quality. Healthcare provisions are based predominantly on ability to pay and have shifted from strong primary care and preventive services to curative services and inpatient care at the central level and wealthier cities. Lucrative economic and commercial incentives pull doctors and healthcare providers to move from rural and poor urban areas to major urban hospitals that serve state officials, local elites and relatively wealthier sections of society. The majority of well-trained medical staff is found in central public hospitals. Service quality is deteriorating, as many bypass local health centres and end up in overcrowded central hospitals, creating a serious challenge for these hospitals. Three to five patients sharing a single bed in in-patient and intensive care are common situations in most central specialized hospitals in Hanoi. Degraded medical facilities and lack of quality health staff are serious problems in public care centres. Ensuring access to and utilization of healthcare becomes more difficult for the rural poor and low-income groups whom are more likely to use outpatient services at communal health centres, where inadequate staffing and medical facilities are already huge problems. Hindered from getting access to local health services, the poor suffer further economic burdens when sickness occurs as they have to fund transportation to urban and central hospitals, or seek local and costly private health services.[61]

The third aspect derives from the implications of low state health financing. While it intensifies the commercializing of healthcare and health financing through public-private investments in high-end curative services, it reduces investments in healthcare provision in general. Lack of public investment funds and efficient state budget allocations to primary care and preventive services at rural and communal level have indeed impacted the structure of quality as well as access to medical services to the poorer segments of the populations.

One of the major institutional challenges of healthcare commercialization is defined by the impacts of 'socialization' and decentralization processes in the health sector. This dual process has indeed intensified adverse incentives in the service provider systems because it redefines the role of informal and formal markets by public service actors whose private interests have distorted public health provision. The impacts are evident in the institutional design of insurance coverage and refunds, allocation of public investment funds, fee-for-service mechanisms to ensure provision based on ability to pay, and public hospitals as profit-centres.

Allowing commercialization of healthcare services based on fee-for-service principles so as to relieve the state's fiscal burdens has distorted the incentives facing healthcare providers. Inefficient allocation of public funds, focused on curative services at the central levels, and at the expense of primary care and preventive services at communal levels, has created regional disparities and distorted service quality. Corruption and insufficient investment in commune-level health services have undermined the ability of the low-income segments of the population to access quality treatments due to individual financial burdens. The design of the health insurance and service systems favours high-income social groups, targets service provider-induced subsidies, prioritises high-cost curative services and promotes quantity rather than quality care. The institutional design of the healthcare systems has pushed public hospital managers, medical staff and pharmaceutical companies to promote a rapid commercialization of services without regulations. As a result, healthcare provisions have become costly, inaccessible and inequitable to increasingly vulnerable groups, especially to the rural poor. Hence, the question is how to possibly achieve social equity and system-wide efficiency as well as cost effectiveness of healthcare.

Finally, the decentralization is without regulation, cost controls and quality assurance governance, and actual institutions governing access to healthcare services. The current institutional set-up and decentralization indicate that sound institutional changes will need to address the incentive structures and the health sector stewardship of the MoH. The MoH may need to politically capture a better role as health regulator to stream-line national health objectives, safeguarding access to medicines and care, setting up quality assurance systems for drug supplies, evidence-based medicine and resulted-oriented performance while promoting local governance and accountability.

Greater concerns are now given to the health service quality and unequal access to health care, the increasing evidences of service provider moral hazard and unethical clinical practices as well as the heavy burdens of hospital costs on patients. Informal fees and institutional arrangements with corruption and perverse incentives are major obstacles for radical health sector reforms and poverty alleviation at large. They make all government efforts in health financial support to vulnerable groups or the rural poor of fee exemption or reduction and health insurance only nominal. Without ability to pay high costs of formal and these informal fees, these institutional obstacles make the quality and effectiveness of healthcare as well as social equity and access to services very difficult to reach.

Throughout the health system and service delivery, there is no adequate and effective database for medical records of treatment or drug prescriptions. Where something exists, there is no mechanism to validate the quality.[62] Thus, problems in the information system of the health sector are part of the reason why corruption and abuse of power can be widespread in the service delivery. To have validated quality health statistics remains a challenge for any effective analysis of the problems or meaningful policy decisions by health policy planners in Vietnam.

5. Policy Challenges of Health Sector Development in Vietnam: Final Reflections

In the context of the Vietnamese health sector reform, positive changes have taken place but major obstacles are lying ahead as the economic and institutional consequences of rapid commercialisation are critical. After more than two decades of market-oriented economic reform, the health sector has been transformed from a highly equitable system with strong networks of primary care and preventive services at grassroots level to a system focusing on curative care and commercialization of services. In many aspects, health provision is better than it was in the 1980s. Notably, treatment standards have improved and more choices are available. Official health indicators on issues such as life expectancy, child mortality and incidence of tuberculosis are improving. However, the main beneficiaries of the commercialization continue to be affluent social groups. While allowing the rising middle-class and high-income groups to enjoy better care of high standard treatments, commercialization has shifted a large part of the fiscal burden of healthcare from the state onto individuals and deteriorated the quality and effectiveness in healthcare provision.

Today, huge challenges are facing the Vietnamese government in reducing financial burdens, increasing access to services and quality of healthcare provisions by the lower-income groups, and improving quality and effectiveness of healthcare. The current underinvestment in healthcare provision to primary and preventive care has caused a general decline in the standard of healthcare available to large parts of the population, especially in communal primary care and rural areas. The state-led socialization of healthcare for financing is not reducing financial burdens of households, but adding extra economic shocks to individuals due to increasing medical costs and high levels of out-of-pocket payments. Public healthcare financing of direct provision user fee revenues has made Vietnam the country with the highest incidence numbers of catastrophic payments and greatest numbers of individuals pushed into poverty by OOP payments in Asia together with India and China. Expensive medical costs and economic consequences of ill-health have put heavy burdens on the household economy and set many million Vietnamese on the road to poverty. More people are having problems coping with the costs of basic social services. Inequitable access and the growing economic burden on households may lead to social and political instability.

The current and projected economic situation with high inflation implies that Vietnam will struggle to change the situation significantly in the next five to ten years. The government will struggle to increase both current and capital healthcare expenditures. This may also mean that the trend towards out of pocket and informal payments will continue, and the government will find it difficult to extend insurance provision to an increasingly vulnerable population.

The major policy challenges to the health sector in Vietnam are placed on the political economy and its institutional capability to reform. Lack of institutional capacity and firm regulations, and ineffective allocation of public funds has distorted the health sector. Without major reforms to remove negative incentives available to service providers and a reduction in informal and corrupt procedures in healthcare services and insurance refund system, Vietnam will struggle to develop a more efficient, affordable and equitable healthcare system. These reforms are all more necessary because healthcare costs will only increase with economic development and increased demand for effective, accessible and quality services. To a greater extent, there is a need for institutional restructure of economic incentives and ideological readjustment of the role of the state in the delivery of public services with the health sector as a case in point.

Low state spending in healthcare is common among developing countries. However, the experience in the Vietnamese healthcare illustrates an essential point to any developing countries' health sector reforms: the importance of public-financed healthcare and the implications of having low public expenditures on healthcare. In the context of the Vietnamese political economy, healthcare has rather been considered a low priority in relation to central growth targets and other core economic and military sectors. Hence, the state has left public investments in basic social services to

commercialization and high out-of-pocket financing to cover healthcare costs. Accordingly, the welfare state has been transformed from a highly committed state in the delivery of public services to a more state-sponsored commercialized market, using the term 'socialization' to maximise the dependence on market forces and individual household responsibilities. Today, socialization in the public services has gone far beyond its rhetorically socialist ideology of the state to provide social justice and economic prosperities.

Structural changes may require a central political and economic reconsideration of the health sector's role in development, in which healthcare can be considered a welfare investment in growth, rather than an economic burden. Development in the health sector is threatening to deteriorate Vietnam's achievements in poverty reduction and to eliminate sound conditions for the country to sustain its economic growth. It has been proven that health sector development is an essential part of a comprehensive approach to economic development and that poor health outcomes disrupt long-term economic growth. Accordingly, high economic growth is not enough to end poverty. Functioning political institutions and a welfare state focusing on public-financed healthcare is crucial as poor health outcomes have a direct connection to why people become poor or why poverty persists.[63] Lessons from more developed economies have demonstrated that healthcare is manageable with radical design of public financing to enhance equity, quality and reduce cost. These lessons have shown that a functional system would require public finance of primary care, private funding of supplementary care, multiple-service providers and a well-regulated competition.[64]. Rapid commercialisation of healthcare will not automatically solve the problems of health financing and improve service quality, and it may indeed endanger long-term economic development. Here political choices matter in development planning and resource allocation. The basic systems put in place now in terms of public services and development-financing solutions will fundamentally shape the development and economic structure for decades to come.

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[42] The "socialization" concept was first adopted in the Vietnamese 8th Party Congress in 1996, in which socialization was defined by the principles of social mobilization for financing of public services. Healthcare is defined as the responsibility and immediate concern of each and every citizen, and the government calls for fee contribution and private financing in healthcare provision.
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