**CONFRONTING CORRUPTION IN THE HEALTH SECTOR IN VIETNAM: PATTERNS AND PROSPECTS**

**SUMMARY**

Corruption in Vietnam is a national concern that could derail health sector goals for equity, access and quality. Yet, there is little research on vulnerabilities to corruption or associated factors at the sectoral level. This article examines current patterns and risks of corruption in Vietnams health sector and reviews strategies for addressing corruption in the future. The article builds on the findings and discussion at the sixth Anti-Corruption Dialogue between the Vietnamese government and the international donor community. Development partners, government agencies, Vietnamese and international non-governmental organisations, media representatives and other stakeholders explored what is known about important problems such as informal payments, procurement corruption and health insurance fraud. The participants proposed corruption-reduction interventions in the areas of administrative oversight, transparency initiatives and civil society participation and health reforms to change incentives. The analysis assesses the prospects for success of these interventions, given the Vietnamese institutional context, and draws conclusions relevant to addressing health sector corruption in other countries. Copyright 2012 John Wiley & Sons, Ltd.

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Corruption, defined as abuse of entrusted power for private gain, is a major threat to health system performance and health outcomes (Vian, 2008; Hanf *et al*., 2011; Holmberg and Rothstein, 2011). Theft of medical supplies from facilities and the practice of extorting informal or envelope payments decrease demand for services and prevent quality service delivery. Absenteeism and an internal market for positions make it difficult to have competent people in the right jobs and to use human resources efficiently. Weak financial systems allow opportunities for embezzlement and permit limited resources to be spent on non-priority activities or to support networks of patronage rather than maximising health benefits. Where citizens lack information, they do not have the tools they need to participate in policy decision making or hold their government accountable for performance. Good governance in support of strong health systems therefore requires effective control of corruption (Lewis, 2006; Vian *et al*., 2010).

In Vietnam, the government and donors are increasingly concerned about corruption. A governance study in 2004 identified control of corruption as a key challenge in the country (World Bank, 2005). After passing a new anti-corruption law in 2005, the Government established a central steering committee for anti-corruption headed by the prime minister to coordinate implementation on anti-corruption efforts. Regional committees on anti-corruption were also established, a specialised anti-corruption bureau was created within the govern- ment inspectorate, and special anti-corruption units were placed within the Ministry of Public Security and at the Peoples Supreme Court, charged with monitoring, detection and enforcement (Ha *et al*., 2011).

Yet, perceptions of corruption are still high: in 2008, 85 per cent of citizens perceived corruption in central-level health services, whereas 65 per cent perceived corruption in local health services (World Bank, 2010a). A more recent 2010 survey of citizens found that 28 per cent had paid bribes in hospitals in the past year (CECODES *et al*., 2011). National surveys in 2006 and 2009 found that although Vietnams anti-corruption law is strong, enforce- ment and monitoring are weak (Global Integrity, 2006; Transparency International 2006; Global Integrity, 2009). Politicised institutions, overlapping mandates, widespread nepotism and restrictions on freedom of expres- sion are persistent challenges to good governance, whereas weak public administration systems for functions such as financial management and procurement are also a problem (World Bank, 2005; Global Integrity, 2006, 2009; Jones, 2009). Anti-corruption approaches need to take into account such institutional constraints and characteristics (Fritzen, 2005). This is especially important when mainstreaming anti-corruption policies and programmes in specific sectors such as health (UNDP, 2008).

At present in Vietnam, there is little research on corruption risks or associated factors at the sectoral level. Michael Johnston (2010) argues that in order to tackle corruption, we need to identify current vulnerabilities, including opportunities and incentives, which may be sustaining corruption. A vulnerability analysis gives us an idea of where corruption may be occurring because corruption is very difficult to measure directly. Such an assessment can point to appropriate controls and incentives needed to reduce corrupt dealings (Johnston, 2010).

The purpose of this article is to examine patterns and risks of corruption in Vietnams health sector and to draw conclusions about the likely success of intervention strategies given the institutional context. Our hypoth- esis is that pressure for anti-corruption is likely to grow if, despite overall economic growth, the Vietnamese government fails to deliver promised goals of better health, financial protection and equity in outcomes and financial burden. Current, largely state-centric anti-corruption reforms alone will not be enough to deter abuse of power. We believe complementary efforts are needed to engage the public and organised civil society in the fight against corruption.

The article builds on the findings and discussion at the Donors Roundtable held as part of the sixth Anti- Corruption Dialogue between the Vietnamese government and the international donor community (hereafter, the Roundtable) in November 2009 (Towards Transparency and Embassy of Sweden, 2010). At that meeting, development partners, government agencies, Vietnamese and international non-governmental organisations (NGOs), media representatives and other stakeholders explored what is known about important problems such as envelope payments to medical staff, corruption in the pharmaceutical supply system and health insurance fraud. The participants proposed interventions in the areas of enhanced administrative oversight, transparency and structural health reforms. The analysis assesses the prospects for success of these interventions given the Vietnamese institutional context.

BACKGROUND ON THE VIETNAMESE HEALTH SECTOR

Patterns of corruption vary depending on how funds are mobilised, managed and paid to providers (Savedoff and Hussmann, 2006). It is helpful, therefore, to describe the actual relationships, responsibilities and health financing systems in Vietnam in order to understand the context in which corruption risks arise.

Vietnam is a middle-income East Asian country with a population of 86 million and a per capita GDP of

$1051 in 2009. In 1986, the government committed to a political reform and development strategy based on a market economy with socialist orientation, referred to as *doi moi* (renovation). This resulted in the introduc- tion of market forces in the health system as well as changes to health care financing (Gabriele, 2006). Some of these changes included legalisation of private medical practice in 1986, de-regulation of the pharmaceutical market in 1989, introduction of mandatory state-funded and voluntary health insurance programmes in 1993 and financial decentralisation based on cost recovery principles (Gabriele, 2006; Fritzen, 2007; Ekman *et al*., 2008; Phuong, 2009; Nguyen *et al*., 2010). In 2002, the government expanded financial autonomy in govern- ment health care facilities, giving hospitals the flexibility to raise remuneration as well as expanding interac- tions with private and non-state actors (Ha *et al*., 2011). In addition, policy reforms have increased the role of private clinics and companies, and private financing, in delivery of health services. About 42 49 per cent of patients are covered by health insurance programmes (Ekman *et al*., 2008; Phuong, 2009). Higher level care is mainly delivered in public hospitals, outpatient care is sought in public and private facilities, and most pharmaceuticals are purchased without prescription in the private sector (Ekman *et al*., 2008). Recently, efforts have also been made to revitalise the network of public, primary health care clinics, called commune health centres, which serve rural populations (Fritzen, 2007).

Although the liberalisation of the Vietnamese economy initially helped promote fast growth and was successful at alleviating poverty (Gabriele, 2006), the effects on the health sector have been less positive over time (Ha *et al*., 2010). Health sector reforms have resulted in more choices for treatment and fewer protections for patients, increasing overall health care costs while placing a substantial burden on households and exacer- bating income inequality (Nguyen *et al*., 2009b). Health care spending as a percentage of GDP is high in Vietnam: 7.1 per cent in 2007, compared with 3.7 per cent in Thailand, 4.4 per cent in Malaysia and 4.3 per cent in China (World Bank, 2010c). However, a very large proportion of health spending is out-of-pocket (Ha *et al*., 2010), and the burden of health care costs is limiting access to care. In 2006, household out-of- pocket payments accounted for 61 per cent of the total health expenditures (Phuong, 2009). Moreover, the poor spend a higher percentage of income on health compared with less poor households, and for the poorest quintile of the population, nearly 15 per cent of non-food expenditures go for medicines (World Bank, 2010a). Economic shock from ill health is the most common cause of poverty, pushing an estimated three million people per year below the poverty line because of the burden of paying for catastrophic illness (Thanh *et al*., 2010).

Medicines account for over 50 per cent of the total health care expenditures in 2005 (Nguyen *et al*., 2009a), and rising prices are a concern. A study of medicine prices, availability and affordability in five regions of the country found that public procurement prices paid by facilities were 8.3 times the international reference prices for brand-name drugs and 1.8 times the international reference prices for lowest-price generic drugs, whereas prices to patients were 46.6 and 11.4 times the international reference prices for brand-name and generic drugs, respectively (Nguyen *et al*., 2009a, 2010). At the same time, low-priced generic drugs were generally less available in public sector facilities compared with brand-name drugs. In contrast to most other countries, medicine prices were higher in the public sector than in the private sector and were unaffordable for the lowest-paid government workers or others earning similar wages (Nguyen *et al*., 2009a, 2010).

HEALTH GOVERNANCE FRAMEWORK

Fritzen (2005) argues that the key to predicting success or failure in implementation of anti-corruption measures lies in institutional constraints. According to Fritzen, although political will for combating corruption in Vietnam is high, approaches to anti-corruption have been hampered by factors such as the dominance of powerful actors in policy making, unclear responsibilities for oversight, lack of resources and a state-centric system that leaves little scope for civil society activity (Fritzen, 2005). Table 1 summarises national anti- corruption approaches, institutional constraints and the impact of these factors on reform progress in Vietnam. Although Fritzens framework identifies general institutional constraints that impede anti-corruption strate- gies in Vietnam, it is applied at a whole-of-government level and is not specific to the health sector. In analysing patterns and risks of corruption in the health sector, we adopt a similar institutional perspective; only we will drill down on the particular institutional roles and functions characterising health sector governance as shown in Figure 1 (Brinkerhoff and Bossert, 2008). Brinkerhoff and Bosserts model illustrates the institutional relationships among three categories of health sector players: government agencies (regulators and payers), facilities and personnel (providers), and patients or other civil society organisations that have an interest in health (clients). Government regulators and payers include Ministry of Health, the Vietnam Health Insurance programme, the Drug Administration of Vietnam, provincial government structures and other regulatory agencies. Providers include doctors, nurses, pharmacists and health facilities public, private for-profit and voluntary as well as suppliers. Clients are represented by patient advocacy groups, NGOs, associations of health professionals and other civil society groups active on health issues (Brinkerhoff and Bossert, 2008)