

Reasserting the state in Viet Nam: Health Care and the logics of market-Leninism

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Abstract

The collapse of Viet Nam's state-socialist economic institutions in the late 1980s occasioned an almost complete inversion of the socialist principles that had guided health policy under the Communist Party of Viet Nam since the 1950s. Since the early 1990s, however, the Vietnamese state has reasserted its roles in the health sector. These reassertions have been of two major types. Through *redistributive reassertions* the state has sought to ensure a basic floor of health services for all Vietnamese and bolster its subjective legitimacy, even as public spending on health has remained conspicuously low. Through its *accumulative reassertions*, the state has transformed 'public' health facilities into sites of economic accumulation, thereby responding to the state's weak extractive capacities and gaining political support from within the public health systems. Overall, the article likens reassertions of the state in Viet Nam's health sector represent a contemporary instance of a Polanyian "double movement," albeit within the context of a market-Leninist regime.

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Up until the late 1980s, the Communist Party of Viet Nam (CPV) promoted the development of an entirely state-financed health system that promised health services as a right of citizenship. But the collapse of Viet Nam's state-socialist economic institutions in the late 1980s occasioned a dramatic scaling back of these ambitions. In 1987, Viet Nam's government permitted limited private provision of health care and in 1989 adopted a constitutional provision that permitted public health care providers to charge fees. Public spending on health then declined rapidly as a proportion of total health spending and by the early 1990s, 80 percent of all health expenditure was estimated to be out-of-pocket. Thus, in the span of a few years, the principles governing payment for health care in Viet Nam almost fully inverted.

The history of health care in Viet Nam since the late 1980s is, however, a good deal more complex and interesting than a simple story of 'commodification.' Viet Nam during the late 1980s and early 1990s did indeed experience catastrophic retrenchment in the health sector, the marketization of many aspects of health care, and the ill effects of these processes. But since the early 1990s, the Vietnamese state has also reasserted its roles in the health sector. In this essay, I explain the nature and significance of these reassertions.

The analysis is organized in three sections. In the first section, I provide historical background on Viet Nam's health system and explain how the erosion of Viet Nam's planned economy affected both the principles and institutions governing the provision and payment for health care and Viet Nam's health status. In the second section I show, however, that alongside policies that have shifted the costs of health care from the state onto households, the CPV has pursued certain *redistributive reassertions* of the state. These redistributive reassertions, which began as small and

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mainly legitimacy-seeking targeted-programs, have gradually expanded in their forms, scale, and scope. Through its redistributive reassertions, the Vietnamese state has sought to provide universal access to health services, even as the state's success in doing so has been decidedly mixed. Though the state continues to profess its commitment to ensuring access to health care, public health expenditure remains low, even in comparison to other countries in Viet Nam's same income group.

In the third section, I explain how Viet Nam's government has also overseen certain *accumulative reassertions* of the state in the health sector. By accumulative reassertions, I mean various informal and formal measures the Vietnamese state has taken to promote the health sector as a site of economic accumulation. In part, these efforts represent the government's announced intent: to reduce the dependence of the health system on the central budget. However, accumulative reassertions of the state have the practical effect of commercializing health care and have created incentives to place private interests before public health. The government's recent move to promote further (and weakly regulated) decentralization in the health sector threatens to intensify these perverse incentives.

In this essay, I demonstrate that reassertions of the state in Viet Nam's health sector have responded to the different and sometimes contradictory imperatives of *market-Leninism* (London, 2003, 2009).¹ In market-Leninist regimes, communist parties adopt market institutions and employ market-based strategies of accumulation while retaining Leninist principles of political organization. On the one hand, the subjugation of health care to market principles and out-of-pocket payments contradicts the historically rooted, self-legitimizing ideologies of the communist party and creates pressures on the state to provide various forms of social protection through redistribution. On the other hand, low public health expenditure and the Leninist state's increasing dependence on resources garnered through market-based accumulation reinforces the desire of the lower levels of the state to exploit market opportunities and creates pressures toward the further commercialization and commodification of health care. While total health spending in Viet Nam continues to raise, improvements in health status continues to be uneven across regions and different segments of the population.

1. Health sector retrenchment and its consequences

Viet Nam's health system is the product of a four-decade effort to build a comprehensive state-financed national health system; the subsequent erosion of that system in the 1980s; and the intended and unintended consequences of health policies introduced since the late 1980s. The rapid economic growth that Viet Nam has experienced since the early 1990s has permitted rapid increases in total health expenditure. But low *public* expenditure combined with other state policies have made access to health services contingent on cash payments, while spatially uneven development and weak health sector governance have contributed to sharp divergences in the costs, qualities, and distributions of health care services across different regions and segments of the population. Today, Viet Nam's health policies aim to combine state, household, and insurance sources of finance in a way that would ensure all Vietnamese access to health services.

1.1. Building a state-socialist health system²

The lineage of contemporary Viet Nam's health system can be traced back to the origins of the Communist Part of Viet Nam (CPV) and its efforts to develop a revolutionary socialist state. From its formation in the 1920s and 1930s to the declaration of Viet Nam's independence in Hà Nội in 1945, the CPV's campaign for national independence and socialist revolution included calls for the development of a more effective, broad-based, and equitable health system. Under the yoke of colonialism, health care was not widely available. The CPV's defeat of the French in 1954 created conditions for the establishment of an independent state north of the 17th parallel – the Democratic Republic of Viet Nam (DRV) – and with it the development of a state-financed national health system. Between 1954 and 1975, in the face of war and acute economic shortage, the CPV managed to build a publicly financed health system that covered much of the territory under its control.

In developing the health system, Viet Nam's Ministry of Health (MOH) began with campaigns to improve sanitation and provide vaccinations in rural areas (MOH, 2008). It also developed a health network of clinics and

¹ The journalists Nicolas Kristof and Cheryl WuDunn (1994) were first to use the term *market-Leninism* in a published work. I arrived at the term independently in the mid-1990s and have sought to specify its conceptual, theoretical, and practical meaning.

² For a lengthier analysis, see London (2003).

hospitals and a referral system based on western models of medicine and socialist models in particular. Preventive health and basic health services were to be carried out in commune-level health stations (CHSs) and in district ward-level health centers in urban areas (Hoang, 1965; Bryant, 1998). Curative services were to be delivered through state hospitals administered at the district, provincial, and central-government levels.

Though threadbare in quality and scope and incomplete in geographical coverage, the development of this state-financed health system contributed to historic reductions in mortality and morality in the civilian population, remarkable accomplishments given that they occurred in wartime and in the context of economic scarcity (Merli & London, 2002). After 1975, the CPV extended the health network southwards, incorporating existing hospitals and personnel, while expanding the health bureaucracy and service provision in previously un-served and underserved areas. A detailed analysis of health conditions in Viet Nam during this period is beyond the scope of this essay.

Viet Nam's health policies up until the mid 1980s were "state-socialist" and universalist. Health policies were state-socialist in that they were designed to achieve a state-financed health system based on the collectivist, centrally planned economic institutions of state socialism. At all levels, health services were to be financed through a combination of transfers from the central budget and local resources. In rural areas, agricultural collectives would be responsible for financing the activities of commune-level health workers, while medicine, materials, and labour were allocated through the planned economy. Viet Nam's health policies were universalist in that they promised preventive and curative health services free of charge as a right of citizenship.³

The social and health outcomes of socialist universalism were mixed. On the one hand, the institutionalization of state-funded health services in Viet Nam contributed to declines in child mortality and morbidity, and gradually improved access to all types of medical care. On the other hand, the prevailing scarcity of resources severely limited the quality, scale, and scope of public health services across northern Viet Nam and across the entire country after 1975. As in other state socialist societies, the health system in Viet Nam both reflected and reproduced state-socialist inequalities. Access to comprehensive care was a formal right of citizenship, but the actual availability and quality of services was limited: state elites and urban populations enjoyed greater access and better quality services than did rural and politically marginal masses.

Four successive decades of war (with France, the U.S., Cambodia, and China) placed enormous strains on the economy and the health system in particular. Large areas of the country remain un-served or underserved by the national health network. But by the mid-1980s, the CPV has overseen the development of a sprawling state-financed health system. Viewed historically, the universalist health policies that the CPV pursued in northern Viet Nam since the 1950s and on a national basis after 1975 were truly revolutionary, as they promised universal access to preventive and curative health services as a right of citizenship. However, the consequences of Viet Nam's poor economic performance and wars severely diminished the amount of public resources available for investment in health. Indeed, the fiscal foundations of Vietnamese state socialism were on the verge of collapse.

1.2. Health care and state-socialist involution

The erosion of state-socialist economic institutions in Viet Nam during the 1980s emasculated budgetary resources for health and hobbled the functioning of the state in virtually all its aspects. Declining state revenues and the dissolution of state-socialist economic institutions eviscerated the fiscal foundations of universalist health provision. Budgetary transfers to hospitals at the provincial and district levels shrank. As agricultural cooperatives failed or dissolved, so too did the financial bases of the CHS. Clinics and hospitals struggled to function while health workers' morale plummeted. In many areas, hospital workers went months without wages and had to resort to various improvisational strategies to make ends meet.

In 1987, to alleviate financial strains on the health system, the CPV sanctioned the private provision of health services as well as the limited private sale of pharmaceutical drugs.⁴ In 1989, the CPV (acting through the rubber stamp National Assembly) granted the government formal constitutional authority to introduce user fees. This resulted in the *Prime Minister's Decision No. 45*, which formally permitted the 'collection of partial expenses' (*thu một phần kinh phí*) in public (i.e., state-run) clinics and hospitals.⁵ However, the continuation of the dire fiscal situation meant

³ As stipulated in the constitution of 1980.

⁴ This was permitted by the Ministerial Circular No. 30.

⁵ Decision 45 was issued by the Council of Ministers (1989).

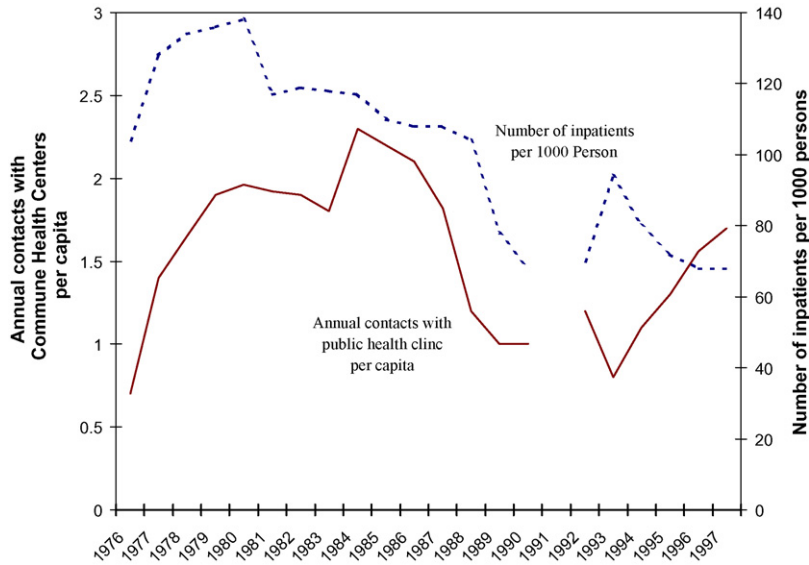


Fig. 1. Adapted from MOH, World Bank (1993, 2001).

that conditions in the health sector deteriorated, further limiting the quality, scale, and scope of state-financed health services and gradually affecting their utilization as seen in Fig. 1 (below).

Whether and to what extent declines in utilization are due to the poor quality of services or the introduction of user fees remains the subject of debate. What was clear that the health sector faced a catastrophic failure of public financing and that the collapse of state-socialism would require new institutional arrangements for health finance.

1.3. Health policies after 1989 and their outcomes

What emerged after 1989 was a largely ad hoc and at times incoherent patchwork of policies whose principal thrust have been to reduce the state’s financial responsibility for health care while at the same time seeking to maintain the state’s leading role in its provision. More specifically, the most salient features of Viet Nam’s health policies since 1989 have been low public expenditure, the consequent shifting of financial responsibilities for health payment from the state onto households, and sustained efforts to frame this shifting of financial responsibilities in a rhetoric of state-led social mobilization. Combined with weak health sector regulation and spatially uneven economic growth, these policies contributed to the increasing subordination of health care and health to the logic of markets.

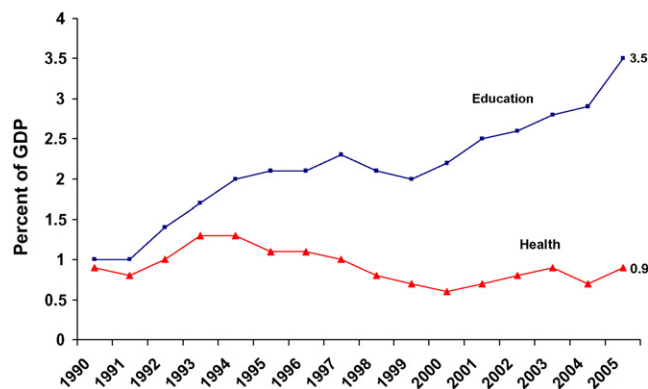


Fig. 2. State Education and Health spending as a percentage of GDP.

1.3.1. Low public expenditure

The most significant attribute of health policies in Viet Nam since 1989 has undoubtedly been the state's low public spending on health. This was unavoidable, as the fiscal crisis that Viet Nam encountered in the late 1980s drained the state of financial resources. However, through nearly two decades of rapid economic growth and continuous increases in revenue, public health spending in Viet Nam has not increased markedly as a proportion of GDP, as state expenditures on other social policy fields such as education have (Fig. 2).

The fiscal weakness and incapacities of the Vietnamese state in the early 1990s certainly prevented the possibility of a swift return to a state-financed system. And economic growth and increases in the scale of the state budget meant that there have been significant absolute increases in public health expenditure. However, public health expenditure has remained low as a proportion of GDP relative to other sectors and has not been sufficient to address the country's health needs.

Internationally, Viet Nam's *public* spending on health remains quite low in per capita terms. As of 2007, this accounted for roughly six percent of the central budget, whereas they represent 18.8 percent in Cambodia, 17.1 percent in Thailand, and 10 percent in China.⁶ As of 2006, public health spending on health in Viet Nam (from the state budget) accounted for roughly 18 percent of total health expenditure, while total public expenditure (comprising budget, insurance, and foreign aid) accounted for 31 percent of total health expenditure. By the mid-1990s, Vietnamese households were shouldering an estimated 80 percent of the total costs of health services through out-of-pocket payments. Today, by all estimates, over 60 percent of total health expenditure is out of pocket. Total per-capita health spending was US\$46 by 2006. As recently as 2006, government health expenditure declined, with 2006 outlays only amounting to 86 percent of 2005 figure, in real terms.⁷ The significance of future increases in public health expenditure will need to be assessed against increases in the costs of care, particularly as Viet Nam in 2007–2008 experienced an inflation of over 30 percent (London, 2008).

1.3.2. Some implications of low public spending

The main implication of this shift was that access to health services beyond a basic level would become – in principle and in practice – increasingly contingent on households' ability to mount out-of-pocket payments. The dependence of health treatment on cash payments tends to contribute to inequity in the accessibility of health services. The health system favors wealthier, urban-based population segments that have better access to better facilities. The poorest population segments (poor and “near-poor”) remain vulnerable in the face of high, privately borne costs of care.

Health care in Viet Nam is proportionately more expensive for the poor. Tipping (2000, cited in Segall and Associates, 2002) has used 5 percent of income as a benchmark for ‘affordable health care.’ Research published in 2000 found that among households who reported illness, spending on health care amounted to 22 percent of poor households' income, compared to only 8 percent for the non-poor (Segall and Associates, 2002). More recent data suggest such conditions persist, as is suggested in Table 1, below.

As Table 1 shows, although the poorest quintile of households' expenditure on health amounted to only 30 percent of that of the richest quintile, health expenditure for poor households consumed over 40 percent of household income (MOH, 2005: p. 23). The high costs of treating illness frequently forces poor households to borrow money from neighbors, sell assets, or seek loans from moneylenders, with the result that many households descend into the health poverty trap – arriving back home from illness weaker, poorer, and in debt. Data from the 2006 Viet Nam Households Living Standards survey suggest these trends have persisted, but could not be quoted for this publication.

It is also important to recognize that low public spending on health also means low wages in the health sector. Indeed, until recently, health sector workers were among the worst paid of all state workers in Viet Nam. With respect to recurrent versus capital expenditures, recurrent expenditures account for roughly 75 percent of the annual health budget. Data indicate that the period from 1991 to 1993 salaries and wages in the health sector increased from 16 to 28 percent of state budget health expenditure and from 36 to 47 percent during the period 1998–2000 (Seachange, 2006). (This reflects salary increases for state workers.) Low wages, in turn, has contributed to low morale, and has also contributed to the proliferation of informal “gift” payments to doctors, a further source of inequity.

⁶ WHO.

⁷ MOH-HPG (2007). Joint Annual Health Review 2007.

Table 1

Average annual per-capita expenditure/inpatient care by income expenditure quintile (2004).

Expenditure group	Average annual per capita expenditure on inpatient care ('000s of VND)	Percentage of those who must pay over 1 million VND	Average annual per capita income	Inpatient costs as a proportion of income (%)
Poorest	511.1	12.1	1262	40.5
Near poor	744.8	16.8	1922	38.8
Average	794.0	18.7	2459	32.3
Better off	1152.9	23.1	3336	34.6
Richest	1865.3	37.9	7359	25.3

Source: MOH (2005: p. 23).

Weak health sector governance has compounded Viet Nam's problems in the health sector. Viet Nam's health sector has always functioned in a more decentralized manner than its formal organization would suggest. But in the transition to a market economy, the MOH was also slow to adopt appropriate governance functions and remains particularly weak with respect to information, planning, monitoring, and strategy (Fritzen, 2007). The government's overall move towards decentralization continues to shift the locus of financial discretion away from the center. The share of total public expenditure from the budget spent by local governments has increased over the years to an estimated 48 percent in 2005, while the figure for the health sector hovers around 80 percent (SRV and World Bank, 2005). The MOH's ability to regulate a highly decentralized health system is among the most important question marks in the evolution of Viet Nam's health policies.

1.3.3. Ideological adjustments

The increasing contingency of health care on cash payments poses special problems for a communist party. In the early 1990s, CPV ideologues justified departures from socialist principles by emphasizing the limited financial powers of the state. Since the early 1990s, Party ideologues have developed a rhetoric of state-led social mobilization, under the heading of 'socialization' (*xã hội hóa*). As a long-time health official and one of the coiners of the concept "socialization" expressed a manual for commune level officials:

The concept of socialization should be understood as an effective and planned cooperation of activities of all social forces following a national direction and a strategy aiming to resolve a social problem. . . For each community, family, citizen, socialization is understood as a process of response to and participation in the leaders' mobilization movement, then becoming a process of active and conscious activities for the sake of improving their own quality of life. . . Socialization is understood as a "social solution" of highly inter-sectoral characteristics, with the participation of many social forces (Đam, 1997).

With some emblematic flourishes, the CPV has promoted "socialization" as a collective mass-mobilization response to "the new situation". Indeed, the rhetoric of socialization is evocative of that from mass mobilizations of Viet Nam's wartime and immediate post-war years. The party line on "socialization" has become an entrenched feature of health policy in Viet Nam. It is lauded as the "correct policy" and is invoked to justify many things, from the need for people to "contribute" fees, to exhorting state-owned enterprises to contribute charitable donations, to the need to promote the privatization of certain aspects of the public health system.

While the CPV has not accorded health budgetary priority, it would be a mistake, however, to conclude that the CPV is not concerned with development of the health sector. A recent example is the party's Resolution 46 of 2005, which criticized "poor management" in the health sector and expressed concern about the political consequences of a health system that is widely perceived to be inequitable. There are also indications that the Party has come to appreciate the merits of more public spending: in 2008, the National Assembly stated its intent to devote at least 10 percent of the national budget for health (Kinh tế Nông thôn, 2006). As it stands, however, Viet Nam's health system exhibits many of the attributes of health systems in poorly regulated market economies.

2. Redistributive reassertions of the state

From the time the CPV began to liberalize Viet Nam's health sector, it has also taken steps to protect various segments of the population through a variety of redistributive means. It has done so in three principal ways: through

“safety-net” programs designed to ensure access to health services for certain segments of the population; through efforts to salvage and gradual expand the national network of state-run and state subsidized health providers, including commune health stations and state hospitals; and, through the gradual development of a national health insurance system. As I will show, these redistributive reassertions of the state in the health sector have addressed different and at times even contradictory state imperatives and their impacts on the health of Vietnamese people have been mixed.

2.1. Safety nets: protecting the poor and vulnerable while protecting legitimacy

Since 1989, Viet Nam has developed a system of safety-nets designed to protect certain segments of the population from the vagaries of a marketized health system. Initially, these safety nets appeared mainly to be legitimacy seeking, as they offered protection for the CPV’s most valued political constituencies and only a limited array of disadvantaged groups. Only several years later, in 1993 and 1994, did the state initiate measures specifically targeting the poor, and these measures did not take effect until the late 1990s. With expanding state revenues, the CPV has called for the gradual expansion of these safety-nets programs. In 2005, the state began a program offering health services to all children under the age of five. Current plans are to eventually merge these safety nets into the national health insurance system, which is addressed later in this section.

When the CPV decided to permit the collection of user fees in 1989, it had major concerns about fees’ potentially adverse impacts. Fees contradicted Article 61 of the 1980 Constitution not to mention a tenet of state-socialism. Some localities even refused to consider collecting fees, at least at the beginning. There were reasons for concern. Fees-for-services threatened not only to undermine the health and wellbeing of the population, but also to alienate several of the party’s key political constituencies. Hence, the [Prime Minister’s Decision No. 45](#) not only permitted the collection of fees, but dictated that fees exemptions or reductions be extended to 10 different qualifying groups, which included members of certain political “priority groups” (such as certain veterans and mothers of certain fallen soldiers, as well as children and orphans).

The fee exemptions and reductions listed in Decision 45 had their limits. First, the granting of exemptions remained dependent on the discretion of local Party cells and hospital administrators. Second, the list of those eligible was quite limited and conspicuously made no mention of “the poor.” Perhaps most fundamentally, even at this early stage, the exemptions and reductions granted covered only a portion of the actual expenses incurred by those seeking treatment. Given the list of beneficiaries eligible for fee reductions and exemptions, it is hard not to conclude that the first round of fee exemptions and reductions were largely or at least significantly legitimacy-seeking measures.

But in 1993 and 1994, the scale and scope of the state’s health sector safety-nets increased, as the state took measures to extend fees exemptions and reductions to the poor. In 1993, the government introduced its Hunger Eradication and Poverty Reduction program (HEPR). The HEPR was actually a set of programs designed to ameliorate the widening gap between high- and low-growth regions and between richer and poorer segments of the population by extending exemptions for health, education, and other services to government-designated poor communes and individuals falling below the state set poverty line. In 1994, the government introduced [Decree 95 \(of 1994\)](#), which those certified by local authorities as officially poor would be exempted from fees, with charges to be covered by the regular budget of the local public health provider. Administering the HEPR program was a massive undertaking. It was not until 1998 that the government even specified the institutional arrangements for the implementation of these programs.

By the end of 1998, the state had established HEPR boards in 6958 communes (out of 7515 at the time), and local authorities commenced their poverty-accounting efforts – using government criteria to identify “poor” households in each commune. The government issued a number of additional policies intended to identify and assist especially needy (usually “remote” and “especially difficult”) areas and ethnic minority groups. This included Decision 135, which stipulated medical fees exemptions for entire “poor” villages. However, the total value of fee exemptions granted by hospitals during the period 1998–2000 amounted to less than four percent of hospital expenditures during the same period. Decisions to grant exemptions again remained subject to the discretion of individual hospitals contingent on the availability of funds, and criteria determining who was “officially” poor were not consistently applied ([MOH, 2005](#)).

Viet Nam’s continuous economic growth and increasing government revenues permitted gradual expansions of the fee exemptions schemes. The first of these occurred in 1999, when the Council of Ministers issued Circular 5, which stipulated health insurance for all households certified as “hungry” as well as those households in the 30-poorest percentile of the poor in any given locality (not including those localities under Program 135). Funding for this

program was, in principle, to be met by a combination of national and local budget sources, as well as “contributions” from “social and economic organizations.” While local funding arrangements were mandatory – their actual scale and impacts depended heavily on the finances of localities (MOH, 2005).

In 2002, the government expanded this same model in the form of Decision 139 and Circular 14 which, in addition to setting a new criterion of eligibility for fee exemptions and reductions (in part, in accordance with a new poverty line), also stipulated that all provinces must establish “health care funds for the poor (Prime Minister, 2002).” Decision 139 also clarified the government’s intent to phase out fee exemptions and reductions by drawing the poor into the national health insurance program, analyzed further below. By 2002, all provinces had established a Health care for the Poor Fund and Management Board, and by 2004, there were some 13.1 million beneficiaries, accounting for 16 percent of the entire population. By one estimate, in 2004, the total funds committed for Decision 139 was 717.7 billion Dong, or roughly \$43 million USD (Trần, 2005).

Perhaps the most ambitious fees exemptions scheme of all was announced in March of 2005, when the government issued Decree 36, granting all children less than 6 years of age free medical treatment.⁸ Some foreign observers regarded this exemption scheme as an example of a “delusional” state policy, in that it is one the state could not possibly afford (Harvard, 2008). Nonetheless, the policy has been carried out. In 2005, household surveys in three provinces showed over 80 percent of children had been issued such cards. People surveyed in the research reported their appreciation of the policy in principle, but complained that without referrals they could only get treatment at the CHS, where equipment and doctors were regarded as inferior, that the paperwork required was excessive, and that when using the cards at hospitals they were subject to long waits (Phan, 2006).⁹ When asked in an interview in 2008 whether this policy was indeed delusional, a senior member of the National Assembly Committee on Budgetary Affairs acknowledged the difficulties, but said the policy would remain as a “goal.”¹⁰

Overall, fee exemptions and reductions, though they have grown in scope, still only reach a limited proportion of the population. Across provinces, districts, and communes, there remains wide variation reported in the accuracy and efficacy of poverty accounting, with numerous reports of patronage involving the arbitrary designation of certain communes and certain households. Existing safety-net programs also generally fail to capture economic migrants. Perhaps most fundamentally, fee exemptions cover only one component of the costs of health services, and poor persons have a hard time making up the large gap between formal fees and other costs, such as transport, medicines, food, lodging fees for relatives, and informal payments. Despite these limitations, the scale and impacts of fee exemptions has grown over time and represent a significant reassertion of the state’s role in the health sector.

2.2. *Salvaging and strengthening the state-run health network*

The collapse of state socialist institutions in the late 1980s placed the financial viability of the state-run health sector into question. Since the late 1980s, public health expenditure has remained low as a proportion of GDP and low in comparison with other countries. However, Viet Nam – first with foreign donor support and later on its own – has effectively preserved and strengthened the state-run health network, and state health providers remain the most important providers of health services. Many of the improvements in the country’s health status since 1989 may be linked to the state’s maintenance of a basic floor of health services – primarily through the continued public finance of commune health stations and public hospitals.

The commune health stations (CHSs) were always a core element in Viet Nam’s national health system. In the early 1990s, however, the CHS were facing acute shortages owing principally to an absence of local sources of financial support. In 1994, Viet Nam’s Prime Minister issued Decision 58, which permitted use of the central budget (through province budgets) to pay and or supplement salaries for three to five CHS staff per commune. Though most of this supplemental funding came into the budget from foreign donors, decision 58 is credited with improving the income and morale of CHS workers and perhaps even rescuing the primary health system of the country. Notably, so such policy support was given to primary care providers in China (Đang et al., 2006).¹¹

⁸ Decree 36 ND-CP, 17/3/2005.

⁹ The same research suggested the proportion of children that had been issued the health cards was overstated. In one province in the south, for example, local authorities reported 96 percent of children had been issued cards, whereas independent research found only 84 percent had.

¹⁰ Interview with the National Assembly’s Committee on Finance and Budget, May 2008.

¹¹ Formerly, localities were responsible for paying local health workers’ wages at the commune level.

In addition to stabilizing salaries, the state moved to increase the numbers and coverage of the CHS, with some success. In 1993, 800 communes in Viet Nam still lacked a CHS and 88 communes lacked both a CHS and a health worker. By 2004, 98 percent (or all but 149) of communes had a CHS and at least one health worker, while 67.8 percent of communes had a doctor. By 2002, 93 percent of communes had a trained midwife, and 90 percent of hamlets (below the commune level) had at least one active health worker, who were paid as low as VNĐ100,000 (USD\$5.50) per month (MOH, 2005). The central government also reasserted its role by specifying funding norms. In 2002, Circular 2002 required all CHS to maintain a basic operational budget of no less than 10 million VND per year, not including wages or funds for health for the poor. It also established a range of compulsory funding norms for the CHS, with the local People's Committee to be held accountable in the case of any shortfalls (Đang et al., 2006). By 2006, Viet Nam's counted some 10,672 state-run clinics at the commune and precinct level (GSO, 2007: p. 559).

Beyond primary health care, Viet Nam's state has continued to expand and upgrade its network of public hospitals, which now exceeds 1000 in number. The scale and functions of Viet Nam's hospitals fall into three main groups, corresponding to secondary, tertiary, and quaternary levels of medical care.¹² Viet Nam's 597 district-level hospitals provide the most basic level of hospital care and constitute the secondary level of services provision in the country's health system. On average, district level hospitals have fewer than 80 beds (MOH, 2000). Viet Nam's 324 province-level hospitals constitute the tertiary level of health. Province-level hospitals and large urban hospitals are administered by Provincial and City Health Departments, respectively. They range from 300 to 500 beds in size. Providing services at the quaternary level of care along with standard outpatient services are Viet Nam's 31 centrally managed hospitals. These are the largest and most technically sophisticated hospitals and average over 500 beds. Almost all are located in Viet Nam's largest cities.

In terms of utilization, district hospitals are the most common site of treatment for Viet Nam's large rural population and for the rural poor. District hospitals, however, vary widely in their sophistication and in the quality of services provided. Unevenness in the quality of district hospitals tends to be reinforced by continued uneven development across localities, combined with a fiscal system which, though redistributive in important respects, fails to compensate for the greater need of poor localities and their populations. Provincial hospitals serve the curative and outpatient needs of both local and regional populations. In comparison to district hospitals, province-level hospitals have seen faster growth in services utilization and many show serious signs of congestion. Hospitals at the central level are the most congested in part because they offer (or are perceived to offer) the highest quality and most sophisticated services. In addition to handling the most complex medical procedures, Viet Nam's centrally managed hospitals are the preferred location for treatment by Viet Nam's increasingly wealthy urban populations.

Although Viet Nam's public spending on health has remained low, the state has evidenced a commitment to gradually expanding the number and upgrading the quality of its public hospitals. In 1989, Viet Nam had 774 hospitals (MOH, 1991). By 2006 there were 1040 (Nghiem, 2006). In 1994, the MOH initiated a program to upgrade medical equipment in the country's hospitals and by 2000, most central and province-level hospitals were – according to state standards – “adequately equipped,” while roughly 60 percent of district hospitals had X-ray machines and 92 percent had ambulances (Đang et al., 2006). Viet Nam's public hospitals are easily the most important site for medical treatment. While the number of private doctors in Viet Nam is increasing, the number of private hospitals remains small. As of December 2007, Viet Nam had 66 private hospitals, with some 3500 beds, accounting for roughly three percent of the national total (MOH-HPG, 2007).

2.3. Health insurance

Evidence of the CPV's early concern with the impacts of commoditizing health was also visible in the Party's early expressed intent to develop a national health insurance system. Indeed, the same government decision that permitted the collection of fees for services in 1989 and the listing of those who were to receive exemptions and reductions also made deliberate mention of the need for the development of a health insurance system. Initially, the Party viewed health insurance principally as a mechanism for mobilizing resources for the health sector in a climate of acute scarcity (Axelson, 2007). Only later did health insurance policies indicate the ambition of building a stable mechanism of health finance for the entire country.

¹² Preventive health services, such as commune health stations, represent the primary level of care.

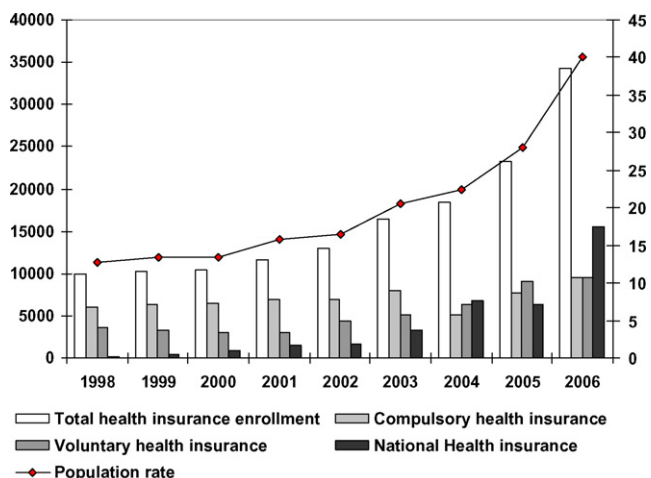


Fig. 3. Health Insurance Enrolment, 1998–2006. Source: [Nghiem Trần Dũng \(2007\)](#).

Since the early 1990s, the state has made concerted efforts to make the health insurance system more coherent and unitary, though with limited results. In September 1994, voluntary health insurance for school children (6 years old until university) was introduced through Circular 14 ([Ministry of Education and Training \[MOET\] and Ministry of Health \[MOH\], 1994](#)), and by the 1995/1996 school year, about half of provincial health insurance offices had established school health insurance.

Two features of health insurance in Viet Nam during the 1990s were particularly noteworthy: first, membership was on an individual basis: dependents were not covered and are not covered up until the present. This runs contrary to international best practices in health insurance and has probably contributed to the low uptake of health insurance by several population groups. Until recently, the national health insurance program left large segments of the population unprotected; the introduction of a new poverty line in 2005 will expand the numbers eligible for the national targeted program (Health care Fund for the Poor), while proposed revisions to that program will make qualifying “near-poor” persons eligible for subsidized health insurance. Still, health insurance covers individuals, not households. The actual administration of health insurance poses practical problems for poor beneficiaries and Viet Nam’s growing population of economic migrants are left uninsured.

Second, until the late 1990s, the poor were not covered by health insurance and tens of millions of rural people were largely left out of the scheme. Notably, Decree 299 did not include provisions for covering the poor and vulnerable. Provinces were instead encouraged to set up their own support systems for these groups ([MOH, 1994](#)). Like fee exemptions, Viet Nam’s health insurance policies have had a significant corporatist element: A government ordinance issued in 1995 stipulated health insurance would be granted to certain veterans and mothers of certain fallen soldiers through the compulsory insurance scheme. As Axelson notes, the poor would eventually become covered by health insurance through policies introduced in 1999 and 2002, as would dependents of three groups: dependents of military officers in active service ([Decree 63 in 2002](#)), beneficiaries of the Health care Fund for the Poor ([Decision 139 in 2002](#)), and dependents of policy officers in active service ([Decree 63 in 2005](#)). But these later developments came only after 2002, the period in which the state began to be more assertive in the pursuit of health insurance.

Since 2002, the government of Viet Nam has been more assertive in its approach to health insurance. Health insurance is compulsory for workers in the formal sector and represents an increasingly important mechanism for health payment, even as the budget remains, by far, the largest source of funding for hospitals and other public providers of health services in Viet Nam. By 2006, roughly 40 percent of Viet Nam’s population was covered by health insurance ([MOH-HPG, 2007; Fig. 3](#)). Yet 50 percent of Viet Nam’s population may be qualified as “near poor”: poor enough to be severely impacted by catastrophic health costs but not “poor enough” to qualify for free health insurance.

Viet Nam repeatedly states its aim of achieving universal coverage of the population by 2010, though in recent months it has hardly mentioned this target, and has instituted policies that seem to take a step back. Recent developments in the health insurance scheme evidence confused priorities and unresolved issues. A health insurance ordinance rolled out in 2004, promised benefits that were later deemed financially unsustainable, while a subsequent

decision rolled back benefits but also increased the price of subscription, pricing out rural households. A more recent government decision raised the cost of voluntary health insurance while reducing coverage. These more recent decisions appeared to lead to a decline in voluntary enrollment, particularly among the poor. The debate about whether to make the health insurance scheme compulsory remains unresolved as of mid-2008.

3. Accumulative reassertions of the state

In the wake of state socialism, Vietnamese health policymakers had to find new institutional arrangements to govern the financing of health services. On the one hand the state's low public expenditure on health has shifted many of the burdens of health finance onto households. On the other hand, it has created powerful incentives within the health sector to maximize budgetary and non-budgetary sources of revenue through both licit and illicit means. While the government has taken a number of significant steps to protect the population from the pernicious effects of fees-based public services, it has simultaneously taken steps to promote economic accumulation within the public sector, so as to reduce public service delivery units' reliance on public finance. This "reassertion" of the state amounts to an effort by the state to improve the financial performance of public-service delivery units by promoting the commercialization of those units' operations.

3.1. Accumulation in the health sector: from cost recovery to commercialization

In their pursuit of state goals, states need resources and revenue in particular. Viet Nam's efforts to bolster its "extractive" capacity has taken many forms, though doing so at local levels of governance (versus at ports and in industrial parks) has proven difficult. These reassertions of the state include the expansion of "cost-recovery" mechanisms, the legalization of private provision of health services within or loosely connected to nominally public health facilities, and the autonomization of public hospitals aimed at the expansion of revenues. These formally sanctioned accumulative reassertions of the state exist alongside and in combination with other forms of accumulation within the health system, including unsanctioned but institutionalized forms, such as "gift payments" to medical staff and informal arrangements whereby hospitals lease equipment from their own staff. These payments have been tolerated by the state, largely because most doctors relied on such payments for the lion's share of their incomes. In Viet Nam, privatization of health service delivery has occurred largely (though not exclusively) within the formal shell of nominally public service providers.

Another illustrative example of autonomous accumulation in the health sector occurred in response to the 2005 policy on health care for children under the age of six. Although some provinces already had similar policies in place on a small scale, the introduction of this national decree led to an explosion in the number of patients in the public health system, particularly in hospitals (Tài Chính Tháng May 2005). At the Central Pediatrics Hospital, for example, average outpatient numbers soared from 600 to 700 per day to some 1000–1200 per day after the Decree's introduction. The hospitals 530 beds, already overloaded before the decree, were after the decree facing some 900 patients. For hospital staff, the volume of work doubled while salaries remained constant. Nurses responsible for administering injections of various kinds saw an increase from 15 to 20 patients per day to roughly 50 per day. Pediatrics hospitals in Ha Noi and Ho Chi Minh City quickly devised strategies to recover costs by offering "policy" and "non-policy" steams for patients, whereby the later received preferential treatment in special rooms and even new wards under the rubric "Services on Demand," in exchange for fees. This tiered arrangement for higher and low or no-fees paying users is quickly developing into an institutionalized feature of health care provision, and is in some respects actually being promoted by the state, as I will argue below (Tài Chính Tháng, 2005).

I believe the state's reassertions in the sphere of accumulation have emerged in response to the state's weak extractive and allocative capacities and functions to achieve and maintain the subjective legitimacy of key political constituencies within the state and among important international constituencies, including international financial institutions, supranational trade organizations, and foreign investors.

3.2. The financial autonomization of hospitals

Since 1989, the state has gradually but unmistakably promoted "cost-recovery" and other methods to finance services. But the most decisive movement toward an accumulative reassertion has come more recently, in a decision by

the CPV (and its state) to embrace autonomization of public services, including health services. As is often the case with decentralization and autonomization schemes, this one was conceived largely without consideration of its health sector impacts.

At the center of the discussion are two government decrees – Decree 10 (effective in 2004) and its replacement, Decree 43 (effective in 2006). The stated aims of these decrees are to improve the quality of public services by conferring greater financial and managerial autonomy to public service delivery units. Specifically, the decrees grant service delivery units greater discretion over service organization, the allocation of financial resources, and the management of personnel. The decrees encourage public service delivery units to finance service upgrades and “resolve” staff wage costs through the development of alternative non-budgetary sources of revenue. To this end, the decrees also encourage service delivery units to adopt a “business model of management” so as to more energetically “mobilize financial resources from society.” Decrees 10 and 43 represent an historic shift in the formal principles and institutions governing the provision and payment for public services in Viet Nam’s hospitals.

Decrees 10 and 43 are likely to affect all aspects of health services delivery and all segments of Viet Nam’s population. That said, a major focus of this section is whether and how Decrees 10 and 43 will affect the quality and accessibility of hospital services in Viet Nam, particularly for poor and near poor segments of the country’s population. Skeptics of decentralization fear that Decrees 10 and 43 will promote the commercialization and commodification of health services, resulting in the worsening of health sector inequalities – a development that would be at odds with the stated principles of the Communist Party of Viet Nam. By contrast, defenders of Decrees 10 and 43 suggest that by reducing hospitals’ overall reliance on the central budget, the decrees will free up scarce budgetary resources, which can then be channeled to those in greatest need.

It bears emphasis that Decrees 10 and 43 do not merely amount to the “legalization of existing practices,” even if their implementation does formally accommodate certain forms of institutionalized *de facto* decentralization and autonomization. Instead, Decrees 10 and 43 actively promote autonomization as a reform strategy. The decrees represent an attempt at reform through autonomization and commercialization and the implementation of the decrees will give local health service delivery units a direct role in deciding the direction and substance of health care reforms.

While Decrees 10 and 43 do not amount to the outright privatization of services, the thrust of Decree 43 is unmistakable: to reduce the burden on the central budget and encourage units to develop new forms of income, in the interest of upgrading the quality and range of services as well as covering staff pay. The emphasis on transitioning to a commercial model of governance is a striking reminder of how far Viet Nam has come from central planning. On the other hand, formally stated aims do not ensure positive outcomes and formally stated principles do not guarantee adherence to principles. Indeed, if there is a “dark cloud” hovering over the implementation of Decrees 10 and 43 in Viet Nam’s health sector, it is international experience with similar measures, in which principles such as accountability, transparency, and responsiveness were cast aside.

Without effective systems of monitoring, regulation, and information sharing, decentralization by decree can ironically eventuate in a situation of “bottom up” decentralization, to the extent that lower levels of government become mainly concerned with “beating” the system (Painter, 2006). Studying responses to decentralizing decrees therefore requires cognizance of both formal and informal dimensions of decentralization. It may also result in the further and formalized development of a tiered system in which health services for the rich and poor become split (IHSP, 2008). The autonomization of health service delivery currently underway in Viet Nam may well counteract some of the redistributive reassertions described above.

The autonomization of public services and health services in particular is a central-state initiative that responds to the weak extractive capacities of the Vietnamese state and the (misguided) faith in decentralization. The redistributive impulse in Vietnamese health policy could not address a more fundamental issue facing the health sector and all other social sectors: the need for additional economic resources. Given the political and budgetary priorities of the Vietnamese state and its limited extractive and allocative capacities, the answer would not be the budget. Instead, the “solution” would be autonomization: allow public service providers to generate their own resources. So does financial autonomization represent a reassertion of the private in the public’s clothing? Certainly, it is an odd type of privatization, whereby the state (and Party and individuals associated with both) seek to generate and exploit the benefits of commoditized health services and mitigate the political risks, with mixed success both with respect to improving the quality and equity of services and protecting the party’s legitimacy.

4. Conclusion

In the wake of state socialism, the CPV adopted policies designed to shift institutional responsibilities for health finance onto the population. Public health spending has been low. But rapid economic growth during this period permitted sustained increases in total health spending and improvements in health status. Still, the cost-shifting policies that the CPV maintained after 1989 have helped commodify health in Viet Nam and make access to health services beyond a basic level contingent on out-of-pocket payments.

In addition to cost-shifting, Viet Nam's health system since 1989 has experienced two reassertions of the state. "Redistributive reassertions" included fee exemptions programs, as sustained commitment to providing a floor of basic health services through the finance of commune health centres, district hospitals, and the development of a national health insurance system. Being small in scale during the 1990s, in recent years these redistributive aspects of health policy have grown and are now important institutionalized features of Viet Nam's health system. The gradual expansion of targeted "safety nets" programs and the national insurance scheme represent a welfare and external legitimacy-enhancing redistributive reassertion of the state. While this redistribution has its limits, it is non-trivial. Unlike in many countries, Viet Nam today possesses a preventive health outlet in literally every local jurisdiction of the country. And, in the last 5 years, targeted programs have expanded in scale and scope and the insurance scheme designed to protect Vietnamese from the harshness of the 'new situation' has gradually been scaled-up.

Another response to catastrophic retrenchment has been an *accumulative reassertion* of the state. Viet Nam's adoption of fees for service principles in the early 1990s formally sanctioned cost-recovery in the health sector. Various informal and illicit forms of accumulation also exist. But recent years have seen efforts by the central state to promote greater accumulation with the state health sector. The autonomization of public hospitals is a strategy by the state to address its own weak extractive capacities and reduce hospitals overall reliance on scarce public sector resources. Alternatively, the incentives that autonomization introduces into hospitals threatens to undermine principles of equity and transform "public" health services into private profit centers.

In any context, the reassertion of the state in the delivery of public services is likely to respond to quite diverse and sometimes contradictory state imperatives. Viet Nam's health sector is a case in point. A discussion of "reasserting the state" in Viet Nam's health sector leads us to the conclusion that the state's reassertions embodied contradictory responses to the realities of a commodified health system in a decentralized society with limited state capacities. Viet Nam's health sector is very much in the process of becoming. Just what it is becoming remains unclear. Whether and to what extent a combination of modest redistribution, health insurance, and state-sponsored market based accumulation strategies within the 'public' health sector actually promote social equity and public health remains to be seen.

Karl Polanyi's famous concept of "double movement" referred to the subjugation of social life to markets and the subsequent need for state intervention to protect human life from being destroyed (Polanyi, 1944). Reassertions of the state in contemporary Viet Nam's health sector represent a contemporary instance of a Polanyian "double movement," albeit in the context of a market-Leninist regime.

References

- Axelson, H. (2007). *The evolution of health insurance policy in Vietnam*. Workshop on Key Health Insurance Policy Issues, sponsored by the Joint Health Policy Initiative (JHPI). Ha Noi.
- Bryant, J. (1998). Demographic change in North Vietnam. *Population and Development Review*, 24, 235–269.
- Council of Ministers. (1989). *Quyết định số 45/HĐBT của Hội đồng Bộ trưởng 24/4/1989 về việc thu một phần viện phí y tế* (Edict No.45 was issued by the Council of Ministers, on 24/4/1989).
- Đang, et al. (2006). *Ensuring Health Care for the Rural Poor in Viet Nam and China: A State or Market Approach?* Hanoi: Medical Publishing House.
- Đam, V. C. (1997). Socialization of Health Care Activities in Viet Nam. In *Implementation of Socialization of Health Care Activities for the People at the Commune Level*. Ha Noi. Communist Party of Viet Nam Central Committee for Science & Education, Ministry of Health, UNICEF.
- Fritzen, S. A. (2007). Reorienting Health Ministry roles in transition settings: Capacity and strategy gaps. *Health Policy*, 83(1), 73.
- GSO. (2007). *Viet Nam statistical Yearbook*. p. 559.
- Harvard University. (2008). *Choosing Success: The Lessons of East and Southeast Asia and Vietnam's Future: A Policy Framework for Vietnam's Socioeconomic Development, 2011–2020*. Harvard University, January.
- Hoang, D. C. (1965). The training of medical and health workers in the Democratic Republic of Vietnam. *Vietnamese Studies*, 6(42), 58 [cited in Bryant, "Demographic Change in North Viet Nam"].

- IHSP. (2008). Đánh giá tác động của việc thực hiện tự chủ tài chính bệnh viện đối với cung ứng chi trả dịch vụ y tế. Assessing the impact of the implementation of financial autonomization with respect to the provision and payment for health services. Nguyễn Khánh Phương, Jonathan London, et al. Institution of Health Strategy and Policy, Ministry of Health.
- Interview with the National Assembly's Committee on Finance and Budget. (May 2008).
- Kinh tế Nông thôn. (2006). Đại biểu Quốc hội đề nghị tăng đầu tư cho y tế cơ sở. <http://www.kinhthenongthon.com.vn/printContent.aspx?ID=10919>.
- Kristof, N. D., & Cheryll, W. D. (1994). *China Wakes: The Struggle for the Soul of a Rising Power*. New York: Times Books/Random House.
- London, J. D. (2003). Viet Nam's mass education and health systems: A regimes perspective, *American Asian Review*, Vol. 21 (June).
- London, J. D. (2008). Unpublished policy brief on "Impacts of the Food Price Crisis on Viet Nam's children." United Nations Children's Fund (UNICEF).
- London, J. D. (2009). Viet Nam and the Making of Market-Leninism. *Pacific Review*.
- Merli, M. G. & London, J. D. (2002). Mortality in North Viet Nam Since 1945. Unpublished paper presented at meetings of Association for Asian Studies, 4–7, April, Washington, D.C.
- MOH. (1991). *Health Statistics of Viet Nam, 1986–1990*. Hanoi: Department of Health Statistics and Informatics.
- MOH. (1994). *Thông tư số 14/1994/TTLB-BGDĐT-BYT ngày 19/9/1994 về việc hướng dẫn thực hiện bảo hiểm y tế tự nguyện cho học sinh* (Circular 14, Ministry of Education and Training [MOET] and Ministry of Health [MOH], 1994).
- MOH. (2000). *Bao Cao: Tình Hình Thực Hiện Công Tác Y Tế Năm 1999 và Phương Hướng Kế Hoạch Năm 2000* (Report: The Situation of Health in 1999 and Planning Orientations for the year 2000). Unpublished Report: MOH, January, 2000. Ha Noi.
- MOH. (2005). Các Giải Pháp Tài Chính Y Tế Cho Người Nghèo" (Health Financing Measures for the Poor). Unpublished research report. Ministry of Health. Hà Nội 2005.
- MOH-HPG. (2007). Joint Annual Health Review 2007. Ha Noi.
- MOH. (2008). 55 Năm xây dựng và phát triển ngành y tế Việt Nam. <<http://www.moh.gov.vn/homebytvn/portal/InfoList.jsp?area=58&cat=1443>>.
- Nghiệm Trần Dũng. (2007). *Health Insurance Department*. Hanoi: Ministry of Health. p. 17.
- Painter, M. (2006). From Command Economy to Hollow State? Decentralisation in Vietnam and China. *The Australian Journal of Public Administration*, 67(1), 79–88.
- Phan Hồng, Phan Hồng Vân, Trần Văn Tiến, Khương Anh Tuấn, Hoàng Thị Phương. (2006). Đánh giá kết quả thực hiện chính sách khám chữa bệnh miễn phí cho trẻ em dưới 6 tuổi tại Ninh Bình, Đà Nẵng và Tiền Giang, Số ra ngày 15/08/2006 (Số 12006).
- Polanyi, K. (1944) 1957. *The Great Transformation: The Political and Economic Origins of Our Time*. Boston: Beacon Press by arrangement with Rinehart & Company, Inc.
- Prime Minister. (1998). *Quyết định số 135/1998/QĐ-TTg ngày 31/7/1998 của Thủ tướng Chính phủ phê duyệt chương trình phát triển kinh tế - xã hội các xã đặc biệt khó khăn miền núi và vùng sâu, vùng xa*. (Decision 135).
- Prime Minister. (2002). *Quyết định số 139/2002/QĐ-TTg ngày 15/10/2002 về việc khám, chữa bệnh cho người nghèo*. (Decision 139, Health care for the Poor).
- Sea Change Partners. (2006). "Vietnam's Health Workforce in Transition: Problems, Policies and Prospects". Unpublished report prepared for The World Bank Office, Hanoi. May 2006.
- Segall Malcolm Associates. (2002). Economic transition should come with a health warning: the case of Vietnam. *Journal of Epidemiology and Community Health*, 56, 497–505.
- Socialist Republic of Viet Nam. (1994). *Nghị định 95/1994/NĐ-CP ngày 27/8/1994 về việc thu một phần viện phí*. (Decree 95).
- Socialist Republic of Viet Nam. (2002). *Nghị định số 63/2002/NĐ-CP ngày 18/6/2002 quy định về khám bệnh, chữa bệnh cho thân nhân sỹ quan tại ngũ* (Decree 63/2002).
- Socialist Republic of Viet Nam. (2002). *Nghị định số 10/2002/NĐ-CP ngày 16/1/2002 về chế độ tài chính áp dụng cho đơn vị sự nghiệp có thu* (Decree 10 effective in 2004).
- Socialist Republic of Viet Nam. (2005). *Nghị định số 36/2005/NĐ-CP ngày 17/3/2005 của Chính phủ quy định chi tiết thi hành một số điều của Luật bảo vệ, chăm sóc và giáo dục trẻ em* (Decree 36 ND-CP, 17/3/2005).
- Socialist Republic of Viet Nam. (2005). *Nghị định số 63/2005/NĐ-CP ngày 16/5/2005 ban hành Điều lệ bảo hiểm y tế* (Decree 63/2005).
- Socialist Republic of Vietnam and the World Bank. (2005). Vietnam Managing Public Expenditure for Poverty Reduction and Growth: Public Expenditure Review and Integrated Fiduciary Assessment, Volume 1. Cross-Sectoral Issues, A Joint Document of the Socialist Republic of Vietnam and the World Bank, Prepared with the support from Like Minded Donor Group, Hanoi.
- Socialist Republic of Viet Nam. (2006). *Nghị định số 43/2006/NĐ-CP ngày 25/4/2006 quy định quyền tự chủ, tự chịu trách nhiệm về thực hiện nhiệm vụ, tổ chức bộ máy, biên chế và tài chính đối với đơn vị sự nghiệp công lập* (Decree 43 effective in 2006).
- Tài Chính Tháng (Finance Monthly). May (2005). *Thực hiện chủ trương khám chữa bệnh miễn phí chi trẻ em dưới sáu tuổi: Căng thẳng chuyển 'đầu tiên'?* No author.
- Trần thị Chung Chiến. (2005). Về tình hình thực hiện các chính sách chăm sóc sức khỏe cho người nghèo ở Việt Nam Tạp chí Chính Sách Y tế Số ra ngày 15/12/2005 (Số 9).