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Confronting Corruption in the Health Sector in Vietnam: Patterns and Prospects

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ABSTRACT

Corruption in Vietnam is a national concern which 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 of corruption in Vietnam’s health sector, identifies key corruption vulnerabilities, 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 organizations, 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.

Keywords: corruption, Vietnam, informal payments, health reform, health insurance fraud, procurement
Strong health systems are essential for improved health outcomes. Increasingly, development partners such as the World Bank, World Health Organization (WHO) and the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) are putting health systems strengthening at the top of the agenda for global health, supporting efforts to transform health systems to expand access, coverage, quality, and efficiency of health services. Governance is one of the building blocks of strong health systems. With good governance, policy makers and leaders are able to align financing and human resources with policy objectives, procure medical supplies efficiently and effectively, and deliver quality services that people want and need (WHO, 2007).

Corruption, defined as abuse of entrusted power for private gain, is a major threat to health system performance (T. Vian, 2008). Theft of medical supplies from facilities and the practice of extorting informal or “envelope” payments decreases demand for services and prevents 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 maximizing 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; Taryn 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 (CSCAC) headed by the Prime Minister to coordinate implementation on anti-corruption efforts. Regional committees on anti-corruption were also established, a specialized Anti-Corruption Bureau (ACB) was created within the Government Inspectorate, and special anti-corruption units were placed within the Ministry of Public Security and at the People’s Supreme Court, charged with monitoring, detection and enforcement (T. T. T. Ha et al., 2011).

Yet, perceptions of corruption are still high: in 2008, 85% of citizens perceived corruption in central-level health services, while 65% perceived corruption in local health services (World Bank, 2010a). National surveys in 2006 and 2009 found that while Vietnam’s anti-corruption law is strong, enforcement and monitoring are weak (Global Integrity, 2006, 2009; Transparency International, 2006). Politicized institutions, overlapping mandates, widespread nepotism, and restrictions on freedom of expression are persistent challenges to good governance, while weak public administration systems for functions such as financial management and procurement are also a problem (Global Integrity, 2006, 2009; Jones, 2009; World Bank, 2005). 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 programs 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. This article seeks to fill this gap by examining patterns of corruption in Vietnam’s health sector, identifying key risks, and analyzing possible strategies for addressing corruption in the future. 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 & Embassy of Sweden, 2010). At that meeting, development partners, government agencies, Vietnamese and international non-governmental organizations, 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, and draws conclusions relevant to addressing health sector corruption in other countries.

**BACKGROUND ON THE VIETNAMESE HEALTH SECTOR**

Patterns of corruption vary depending on how funds are mobilized, managed, and paid to providers (W. D. Savedoff & 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 of 86 million with a per capita GDP of $1,051 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 introduction of market forces in the health system as well as changes to health care financing (Gabriele, 2006). Some of these changes included legalization of private medical practice in 1986, de-regulation of the pharmaceutical market in 1989, introduction of mandatory state-funded and voluntary health insurance programs in 1993, and financial decentralization based on cost recovery principles (Ekman et al., 2008; Fritzen, 2007; Gabriele, 2006; A. T. Nguyen et al., 2010; Phuong, 2009). In 2002, the government expanded financial autonomy in government health care facilities, giving hospitals the flexibility to raise remuneration as well as expanding interactions with private and non-state actors (T. T. 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% of patients are covered by health insurance programs (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 revitalize the network of public, primary health care clinics, called commune health centers, which serve rural populations (Fritzen, 2007).

While the liberalization 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 (B. T. 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 exacerbating income inequality (P. Nguyen et al., 2009b). Health care spending as a percentage of GDP is high in Vietnam: 7.1% in 2007, compared to 3.7% in Thailand, 4.4% in Malaysia, and 4.3% in China (World Bank, 2010b). However, a very large proportion of health spending is out-of-pocket (B. T. 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% of total health expenditures (Phuong, 2009). Moreover, the poor spend a higher percentage of income on health compared to less poor households, and for the poorest quintile of the population nearly 15% 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 due to the burden of paying for catastrophic illness (Thanh et al., 2010).

Medicines account for over 50% of total health care expenditures in 2005 (A. T. Nguyen et al., 2009a) and rising prices are a concern. A study of medicines 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, while prices to patients were 46.6 and 11.4 times the international reference prices for brand name and generic drugs, respectively (A. T. Nguyen et al., 2009a; A. T. Nguyen et al., 2010). At the same time, low-priced generic drugs were generally less available in public sector facilities.
Compared to 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 (A. T. Nguyen et al., 2009a; A. T. Nguyen et al., 2010). High prices may be due to corruption in procurement systems: in a 2005 survey of business opinions on the frequency of bribery in public procurement, Vietnam scored a low 3.0 out of 7 (with 1 being “common” and 7 being “never”) (Jones, 2009). Overuse and irrational prescribing of drugs are also persistent problems (Chang & Trivedi, 2003; Larsson et al., 2000).

**HEALTH GOVERNANCE FRAMEWORK**

Fritzen (2005) argues that the key to predicting success or failure in implementation of anti-corruption measures lies in institutional constraints: in the case of Vietnam, the role of the authoritarian state is an important factor. According to Fritzen, while 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 summarizes national anti-corruption approaches, institutional constraints, and the impact of these factors on reform progress in Vietnam.

<table>
<thead>
<tr>
<th>Vietnam Anti-Corruption Approach</th>
<th>Institutional Constraints to Implementation and Effectiveness</th>
<th>Result</th>
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| **Enhanced administrative oversight and inspections** (e.g. asset disclosure, technical audits) | – Executive dominance: executive authority is uncontestable, few checks and balances  
– Bureaucratic fragmentation: results in weak authority relationships and unclear oversight roles between executive and non-executive actors  
– Under-resourced enforcement efforts, lack of investigation capacity | – Weak incentives for enforcement. Actors in system resist or evade stepped-up enforcement efforts. Particularistic interests of executive win out.  
– Policies vulnerable to reversal at implementation stage.  
– Low numbers of employees disciplined. |
| **Transparency and citizen complaints & participation** (e.g. financial transparency, independent monitoring) | – State-centric system leaves little scope and few organizational platforms for civil society.  
– Civil society characterized by many smaller, informal organizations, rather than strong mass organizations.  
– Corruption is systemic; transparency has less effect on systemic corruption so overall effectiveness of this strategy is low | – Range of independent political action within civil society is limited.  
– Civil society groups unable to use information disclosed to hold government agents accountable.  
– May work in selective settings with strong tradition of civic engagement |
| **Administrative and structural reform** (reduce opportunities and incentives for corruption) | – Closed and centralized policy process produces vague policies that give appearance of unity and allow party insiders discretionary power to interpret as they like  
– Contestation for power and influence among elites dominates reform incentives; implementation of reform is undermined | – Reform process is complex, conflict-ridden, little agreement over controls and management  
– Reversals of reform, controversies and complaints |

Source: Adapted from Scott Fritzen (2005).
In analyzing patterns and risks of corruption in the health sector, we adopt a similar institutional perspective. We apply a governance framework (Brinkerhoff & Bossert, 2008) that allows us to look closely at roles and level of engagement between health systems actors (see Figure 1). These include government agencies (“regulators and payers”), facilities and personnel (“providers”) and patients or other civil society organizations who have an interest in health (“clients”). Government regulators and payers include Ministry of Health, the Vietnam Health Insurance program, 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, non-governmental organizations (NGOs), associations of health professionals, and other civil society groups active on health issues (Brinkerhoff & Bossert, 2008). Using this framework, we can begin to analyze incentives and where space for abuse exists.

**Figure 1**: Health Governance Framework

REGULATORS AND PAYERS

Government is responsible for system performance and achievement of policy goals (Balabanova et al., 2008), including oversight of revenue collection, pooling of funds, and paying providers in ways that encourage efficient, quality service availability. Government also has a standard setting and regulatory role to assure that medicines are safe and effective, individual practitioners are skilled, and facilities are staffed and equipped to assure good care.

The government has expressed concern over equitable access to medicines and has made efforts to stabilize prices through regulatory intervention (A. T. Nguyen et al., 2010). In 2003, the government began requiring price declaration and publication to ensure transparency, although medicine suppliers were still allowed to set prices based on market conditions. While this reform shows government commitment to the goal of affordable care, success has been limited due to the structure of the regulations and lack of monitoring and enforcement. For example, the regulations did not require the declared prices and published prices to be reasonable, and tools for assessing reasonableness of prices (such as specifying international comparison procedures) were inadequate or incomplete. Since drug suppliers
cannot sell at prices above the declared prices, there is an incentive to declare very high prices (A. T. Nguyen et al., 2010).

Studies have shown that providers often do not follow clinical protocols (Bailey et al., 2010), and quality of care is weak. The government has tried to address these problems through the Law on Examination and Treatment (LET), which was adopted in 2009. The process of developing and passing the LET shows some of the weaknesses and strengths of the health regulatory environment in Vietnam.

The LET was designed to update the legal framework for regulating health professions and protecting patient rights (Wedeen et al., 2011). The draft law proposed to create an independent, accountable and transparent regulatory system for licensing of facilities and certification of individual practitioners, with provisions for continuing education, re-licensing, and complaints management. A centralized, independent Medical Council would be the regulatory body.

LET was the result of an improved policy development process characterized by the use of international evidence, extensive technical consultations, and the first Regulatory Impact Assessment ever conducted in the health sector (Wedeen et al., 2011). The process was participatory, involving People’s Committees, provincial health authorities, public and private hospitals, and professional associations, and drawing on technical assistance through WHO, ADB, AusAID and other international organizations. Despite this, key provisions of the draft law – the creation of a centralized, independent Medical Council as regulatory authority and re-licensing facilities and practitioners – were not adopted. Some of the reasons included the Cabinet’s concern that the Medical Council structure did not align with the country’s decentralization goals, questions about the appropriateness of relying on a parastatal organization for state administrative functions, and the fact that implementation of the re-licensing provision in the law—which would require new systems and procedures—was not aligned with the government’s goal of bureaucratic streamlining for public administration reform.

The revised law approved by the National Assembly is vulnerable to inconsistent interpretation and to the forces of corruption, including bribes to issue licenses to individuals who have not achieved standards, or to reissue a license that has been revoked (Wedeen et al., 2011). In addition, the complaints process specified in the law is to be managed at the facility level, which could result in inconsistent application of disciplinary actions and allow opportunities for conflict of interest or corruption.

PROVIDERS

In addition to bribes related to licensing, as mentioned above, types of corruption arising with providers include insurance fraud and over-treatment of patients. Provider payment methods, asymmetric information, and conflicts of interest are risk factors. Information asymmetry occurs when health providers and consumers of services have unequal information about health care needs, service quality, and cost. Conflict of interest occurs when a provider has a secondary financial interest which appears to influence the exercise of professional practice in providing patient care.

Insurance fraud involves billing for ghost patients or services not provided. One story reported in three newspapers (Lao Dong 03/10/2009, Tuoi Tre 03/10/2009 and Vietnam Net 19/06/2009) alleged that a hospital in Hanoi had faked 1,500 claims, totaling about 10 billion VN Dong (approx. $510,200) before the fraud was detected. In addition, fee-for-service insurance reimbursement procedures prompt providers to over-utilize more profitable diagnostic and treatment services (Tangcharoensathien et al., 2011). This is made possible because of information asymmetry: often patients have no other source of information except their doctor, especially in rural areas.
Another risk is that Vietnamese public hospitals are allowed to contract and share user fee revenue with private medical equipment or diagnostic testing companies, bringing profit motivations into public service provision without adequate accountability for performance (Towards Transparency & Embassy of Sweden, 2010). Weak monitoring systems make it difficult to assess whether such public-private partnerships encouraged by government are achieving desired outcomes of service expansion and efficiency, or simply enriching the particular managers involved.

The level at which fees are set, and the frequency with which they are updated, is also a corruption risk factor. Reimbursement rates for basic patient services such as simple diagnostic procedures have not been raised since 1994, which means the fees no longer cover true costs. Fees for newer, high tech services were established more recently and bear a closer relation to the true cost of these services; however, the price of newer technology may be set too high, as experience generally lowers unit costs and volumes increase. This creates an incentive for providers to avoid supplying basic services and to substitute higher tech services.

The Key Improvements in Community Health (KICH) project in Hoa Binh province has tried to develop measures of treatment patterns, in order to identify inappropriate use of services. The project found wide variation in diagnostic testing rates ranging from 6.4 tests per patient visit in Lac Thuy versus 0.3 tests per patient visit in Cao Pong and Ky Son hospitals, as shown in Figure 2. In addition, the analysis noted that among 200 people who had a CT scan, 80% also had an ultrasound, a rate which they considered excessive (Towards Transparency & Embassy of Sweden, 2010).

**Figure 2:** Variation in number of tests per patient-visit in hospitals, Hoa Binh, 2008

The pharmaceutical distribution system provides another example of how information asymmetry can result in abuse of power and over-treatment. Government controls on pharmaceutical promotion are weak (Okumura et al., 2002), allowing pharmaceutical representatives to influence the choices of doctors and hospitals through “commissions” or
kickbacks based on prescribing patterns. An investigation by the Ministry of Health reported that 41% of patients studied had received combined antibiotics, 10% of patients had received 11-15 types of medicine and 7.7% of patient received three types of antibiotics (Acuña-Alfaro, 2009). These numbers indicate irrational drug use and may be caused at least in part by the pharmaceutical company incentives to prescribers. Excessive drug promotion activities result in inflated spending on pharmaceuticals. According to one media story, medicines account for 45% to 60% of hospitalization costs incurred by households (Phap Luat, 29/08/2009). Deficiencies in legal and institutional frameworks may also be a factor in inflated costs, including loopholes under which open competition bidding can be avoided, lack of mandated disclosure of information related to the procurement process, and inadequate legal safeguards proscribing conflict of interest (Jones, 2009).

Finally, informal or “envelope” payments between patients and providers are a growing concern. Informal payments are contributions made to health care providers in addition to any officially-required contributions, for services to which patients are entitled (Gaal et al., 2006). Informal payments may be made in cash or in kind. A Medical University of Hanoi study reported that 70% of medical staff interviewed admitted that they sometimes or often ask for or accept informal payments, though some consider these payments to be gifts (Tuoi Tre, 09/08/2009). In another study, 29% of urban residents who had had contact with health services in the last 12 months said that they had to pay bribes, about double the number who reported paying bribes in 2007 (Towards Transparency, 2011). A recent survey of Vietnamese youth found that 33% of youth who came into contact with medical services reported experiencing corruption, and 8% of youth perceived corruption as “widespread” (Transparency International, 2011).

Informal payments appear related to overcrowding and high demand at the tertiary level. This in turn creates pressures for patients to bribe doctors and nurses in order to be seen sooner, or to be assured of adequate time and attention from providers (T. T. T. Ha et al., 2011). Yet, informal payments also seem to be driven by cultural expectations and ideas of social reciprocity and prevailing attitudes toward corruption. For example, when asked whether a government official receiving a “small gift or money after performing duties” was corruption, 45% of Vietnamese surveyed said yes, while 37% said no and 18% were undecided (World Bank, 2010a). Similarly, when faced with the situation of “giving an additional payment or a gift to a doctor or nurse in order to receive better treatment”, 32% of Vietnamese youth consider this behavior “not wrong,” while an additional 13% of youth acknowledge that it is wrong but still “acceptable” (Transparency International, 2011).

CLIENTS

An important factor in the control of corruption is external oversight and patient involvement, including reporting by media and participation of citizens in facility oversight (Gray-Molina et al., 2001). One-party states such as Vietnam tend to be protective of their legitimacy and seek to minimize dissent (Jones, 2009). Indeed, it is complicated for civil society organizations to be registered as NGOs; the 6-month process is cumbersome and gives State institutions numerous opportunities for discretion over authorization to register in general, as well as the definition of areas of activity in which the organization can engage.

At the same time, media reporting on health sector corruption in Vietnam is surprisingly robust though mainly focused on issues of petty corruption, i.e. front-line government officials or providers accepting bribes or engaged in abuse of office. To assess corruption-related reporting, the United Nations Development Program (UNDP) funded a study which examined reporting from five national-level Vietnamese media outlets between 2008 and 2009 (Acuña-Alfaro, 2009). Topics related to health covered by media reports covered a wide-range of areas, including gaining commissions from sale of medicines (18% of the stories reported), personal gains from health insurance funds (14%), corrupt practices related to financial incentives in management of public hospitals, also known as
“socialization” of public hospitals in Vietnam (7%), demands for bribes and abuse of patients through unnecessary treatment (31%), corruption in licensing (6%), abuses of management power in decisions related to properties or donations (11%), and corruption in personnel management and oversight of medical facilities (13%). The data showed a rise in reporting, with 88 articles published in 2008 and 122 in 2009. In a tightly controlled environment, media still exposed more than two stories per week.

While media reports on corruption may raise public awareness about the problem, this has not created a strong anti-corruption movement in the health sector. One reason is that state controls limit the space for NGOs to operate, especially organizations seeking to engage the public on issues such as government transparency, accountability, and abuse of office. Despite perceptions that corruption is prevalent, Vietnamese are generally satisfied with health services: over 50% are satisfied with central health services, and 45% are satisfied with local health services (World Bank, 2010a). This suggests that people may be resigned to corruption. Corruption may even increase patient satisfaction among those with adequate financial means, because they are able to pay a bribe to access better and faster care. In any case, most people think corruption has not diminished over time (World Bank, 2010a) and many citizens are pessimistic about the fight against corruption. For example, when asked their reasons for not reporting corruption, 28% of Vietnamese youth surveyed stated “it would not help.” (Transparency International, 2011)

ANTI-CORRUPTION INITIATIVES IN THE HEALTH SECTOR IN VIETNAM

Roundtable participants identified and discussed both current and planned initiatives to address corruption in Vietnam. Using the framework in Figure 1, we can categorize these initiatives in terms of which health system actors are most directly engaged. Table 2 captures graphically the results of this mapping. This table clearly reveals the dominance of government actors in accountability and transparency reforms in the health sector, and the relatively limited role of citizens and service users.

Table 2: Current and Planned Anti-corruption Reforms and Governance Linkages

<table>
<thead>
<tr>
<th>Anti-corruption interventions, current &amp; planned in Vietnam</th>
<th>Governance Linkages by Health System Actor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clients/citizens ↔ Government regulators &amp; payers</td>
</tr>
<tr>
<td>Redesign of provider payment systems to change incentives</td>
<td>✓</td>
</tr>
<tr>
<td>Increased transparency in medicines pricing</td>
<td>✓</td>
</tr>
<tr>
<td>Expanded avenues for patient feedback</td>
<td>✓</td>
</tr>
<tr>
<td>Reduced informal payments to providers</td>
<td>✓</td>
</tr>
<tr>
<td>Streamlined administrative procedures</td>
<td>✓</td>
</tr>
<tr>
<td>Improved information systems to detect and deter fraud</td>
<td>✓</td>
</tr>
<tr>
<td>Expanded civil society watchdog monitoring and media reporting</td>
<td>✓</td>
</tr>
<tr>
<td>Managing conflicts of interest among public sector providers</td>
<td>✓</td>
</tr>
<tr>
<td>Increased detection and punishment of officials who accept bribes, kickbacks</td>
<td>✓</td>
</tr>
</tbody>
</table>
Two current reforms are attempting to increase the engagement of civil society and service users in reforms. Examples include work on payment system reform, and efforts to increase accountability through patient feedback.

**Clinical Pathways and Payment System Reform**

Researchers from Vietnamese Health Economics Association (VHEA) are developing a case-based reimbursement methodology which they believe can help improve transparency and reduce perverse incentives in the health care delivery process. Case-based payments, established prospectively based on estimated resource needs for standard care, would replace fee-for-service reimbursement. Under this kind of payment system, providers no longer have the incentive to use many diagnostic tests or potentially ineffective treatments to maximize revenue.

The research team developed care pathways for normal delivery and the treatment of pneumonia and appendicitis. These standard pathways were then compared to actual utilization data to reveal problems (for example, clinicians using expensive sutures without any clinical indication). In late 2009, the researchers began pilot implementation of the case-based reimbursement system in two hospitals. The pilot uses standard costs to reimburse hospitals for the cases treated, a payment method expected to reduce length of stay and unnecessary spending on drugs, diagnostic procedures, and surgery.

**Patient Feedback**

A second example of a citizen/client focused anti-corruption intervention involves increased pressure for integrity. The Hanoi National Hospital for Pediatrics introduced a patient feedback system in 2009 as a way to improve service delivery after their project won a Vietnam Innovation Day (VID) award sponsored by donors. The hospital had problems with overcrowding and waiting times of 4-5 hours.

The intervention team developed six tools to collect feedback from doctors and patients. Patients responded positively to being asked their opinions and were eager to participate. Data from the study are being used to set benchmarks and to identify specific issues for problem-solving. The feedback included information on whether patients felt compelled to pay informal fees, and has contributed to increased transparency about this practice.

**PROSPECTS FOR SUCCESS IN PURSUING HEALTH SECTOR ANTI-CORRUPTION INITIATIVES**

The two examples of experimentation with citizen/client focused reforms notwithstanding, the mapping of reforms in Table 2 reveals the predominant role of government actors in current and planned reform initiatives. The institutional factors constraining anti-corruption reforms highlighted in Table 1 offer some explanatory clues. For example, while NGOs are allowed to exist they are scrutinized by government and their independence is limited. In such an environment, independent structures which could increase accountability for medical care—such as the Medical Council regulatory authority proposed in the draft Law on Examination and Treatment—are too uncomfortable for government and may be considered a circumvention of state responsibilities. In addition, the overall direction of public administration reform in the country—to decentralize and streamline—leads to a climate where people may not adequately consider the risks involved in decentralized regulatory authority and the special requirements for quality control in the health sector (Wedeen et al., 2011). Spending to strengthen quality monitoring, complaint systems, and audit functions may be seen as a low priority in such an environment.

A major challenge to government stewardship in the health sector is the government’s desire to both operate and manage health care delivery systems and set policies and regulations for financing, purchasing, and monitoring quality outcomes. There will be endemic corruption until the government realizes it cannot be both a “player” and a “referee” at the same time.
To effectively mainstream the national anti-corruption approaches (described in Table 1) in the health sector, given the institutional constraints, adaptation and support are needed. The following options could improve the prospect for success. These are based on the discussions at the Roundtable, and are supported by experience and analysis in other countries as well.

**Approach 1: Enhanced administrative oversight**

Many of the health sector anti-corruption strategies listed in Table 2 focus on creating effective checks and balances through administrative oversight. Yet, capacity constraints impede the government from implementing these approaches. Greater attention is needed to identify and fill gaps in government capacity for implementing regulatory action, especially through stronger information and audit systems. Weak accounting systems are risk factors which allow embezzlement, as shown in Zambia. There, a lack of procedures to monitor health spending in relation to performance, and a long and cumbersome audit process, were causal factors in a $4.8 million embezzlement detected in 2009. While procedures were in place to follow up on funds and results, these procedures were not followed (Pereira, 2009), and although previous audits had revealed many problems, audit findings were not released in a timely manner and were not acted upon by the legislature.

Information systems can also help to deter corruption through improved transparency of procurement decisions and doctors’ prescription practices. Monitoring of doctors’ prescription practices can detect relationships between physicians and pharmaceutical companies which can be investigated for kickbacks. Investment in these types of management systems may work because it fits within the strong executive structure favored in Vietnam. Oversight capacity must also be strengthened to assure that complaint mechanisms are being used by clients and staff, and provide adequate protection to complainants.

**Approach 2: Transparency, citizen monitoring, and participation**

Constructive engagement of clients and citizens is helpful in policy dialogue and collaborative problem solving, while citizen monitoring can help promote transparency and accountability. The Affiliated Network for Social Accountability for East Asia and the Pacific (ANSA EAP) has developed many tools and methods for public engagement to increase accountability, and has been involved in initiatives such as training youth to monitor local service delivery in Cambodia, citizen report cards in the Philippines, and participatory budgeting in Indonesia (www.ansa.eap.net). In addition to capacity strengthening of civil society organizations, Vietnam should loosen State controls constraining the establishment and operation of NGOs engaged in advocacy. This will allow them to function more effectively as watchdogs and increase opportunities for citizen voice in the policy-making process.

Civil society organizations engaged in research also have a role in promoting transparency through data gathering and use. For example, if public and private providers are required to disclose procurement bidding information, external monitoring groups could examine the losing bids compared to winning bids, creating more pressure for accountability on decisions to procure cost-effectively. Right now, winning bids may be neither technically better nor cheaper than their competitors, but only winning bids are disclosed.

In the Philippines, Procurement Watch (www.procurementwatch.org) has been engaged in building accountability into government procurement systems by measuring fair market prices and comparing them to what is actually paid. This type of approach has also been implemented in Argentina and Bolivia to deter corruption and inefficiency (W. Savedoff, 2008). Analysis of insurance claim databases is another area where monitoring may help to detect where hospitals are abusing the reimbursement system by ordering excessive testing.
STRUCTURAL POLICY REFORM TO REDUCE INCENTIVES FOR CORRUPTION

The balancing of Vietnam’s market-driven economic reform agenda within its Socialist political framework suggests that the policy reform process must include more engagement of political leadership, the press, and the public at earlier stages. Such engagement can create stronger incentives for government responsiveness (Brinkerhoff & Bossert, 2008). Technical stakeholders must learn to discern and appreciate political interests, and develop skills in policy advocacy. The Reform Impact Assessment process can be used more effectively if it is implemented early in the law development process and used to formally assess the costs and impact on quality, safety, and consumer satisfaction of reform options.

Health sector reform efforts should be attentive to those issues where concern about corruption is strong. For example, inappropriate drug promotion and physician-pharma interactions may lead to higher prices and inappropriate prescribing. These things can be measured and monitored. The WHO has created process indicators for transparent and accountable drug promotion practices as part of the Good Governance in Medicines (GGM). The GGM program approach to increasing transparency in public pharmaceutical systems includes three steps: risk assessment, development of a national framework for responding to identified needs, and implementation of approaches such as procedures for disclosure and management of conflict of interest, web-based medicines registration and licensing systems, and other interventions. To date, 26 countries are participating in the GGM, including Cambodia, Malaysia, Mongolia and the Philippines.

Another important area of patient discontent is informal payments. Informal payments are a complex problem, exacerbated by underfunding of public entitlements to service, overcrowding in tertiary facilities, providers who are inadequately paid, and lack of transparency. While some hospitals have tried to control informal payments, there has been limited success in Vietnam. Government is essentially licensing itself, and may not be likely to condemn government-run institutions where informal payments are prevalent. While patient complaint mechanisms exist, their independence and effectiveness has been questioned, and public trust is low. Greater transparency could help create pressure for policy change. Civil society organizations could try to provide patients with information on their rights and official fee policies. In an environment where there is political pressure on government to reduce informal payments, provider payment reform, which links remuneration more closely to performance indicators, is a strategy that has had some success in Cambodia and Kyrgyzstan (Barber et al., 2004; Gaal et al., 2010; Miller & Vian, 2010).

CONCLUSION

Controlling corruption in the Vietnamese health sector, as in any country, requires changes in institutions, attitudes, and behavior. Controlling corruption is a critical component of governance and is essential to achieve health sector goals of improved quality of care and equity in access and outcomes. Government, providers, and citizens and service users each have a role to play in promoting good governance for better health. Key to success is unlocking the incentives that enable and motivate health system actors to fulfill their roles, and adapting strategies to work within and overcome institutional constraints.
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