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Ideas work better than money in generating reform – but how? Assessing efficiency of Swedish development assistance in health to Vietnam

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Abstract

The current efforts at mobilising greater financial resources for improving health conditions in developing countries, of which the Commission on Macroeconomics and Health (CMH) forms part, rest on two fundamental assumptions. Firstly, that lack of financing, and international development assistance in particular, has been a major reason for lack of improvements in health status and even worsening health conditions in many developing countries. And secondly, following from this, that increased financial allocations to the health sector effectively will turn the trend.

We know from studies of aid that mere financial transfers alone in most cases will not be enough. The health system itself needs reform. Swedish development assistance in health (DAH) to Vietnam is a case in point. It was concluded in a recent evaluation of the Vietnam-Sweden Health Cooperation that it "has made significant contributions in assisting Ministry of Health tackling the turmoil of transition". In this paper we shall contribute to broadening the understanding of effectiveness of DAH by looking at the experiences of the cooperation between Vietnam's Ministry of Health and Sida, lasting nearly 30 years.

Acknowledging one of the main conclusions in the well-known Assessing Aid study, by the World Bank, that "ideas work better than money in generating reform", we pose the question of how this most effectively happens. Swedish DAH to Vietnam demonstrates the importance of fostering institutional learning – on both sides, and the many difficulties of achieving this. An important lesson is the value of long-term commitment and the building of relationships, all of which are qualities that are endangered in today's volatile aid business. Another lesson relates to the limitations of rational planning. Investing in reform means operating in an institutional and political environment where other forces than the aid relationship dictate progress.

1 Aid and reform: what is the link?

1.1 Improving health is politics

There have been dramatic improvements in peoples' health conditions globally over the last fifty years, and Vietnam is a testimony to this, but for large populations the trend has now turned. The reasons are of course complex, having to do with the interplay between man, society and nature. There are constant changes in the biological and physical environment of human beings – new diseases emerge and old ones find fertile grounds for expansion. Man's ability to combat, constrain and adapt to these changes varies enormously, both at an individual and a societal level. This relates to problems of poverty at the individual level as well as the economic resources and governance of societies at large. It is argued that health is both a cause and an effect in these interrelations.

Poor health conditions are both a cause and effect of poverty, of a national economy's ability to grow, and even a country's ability to maintain legitimate and good governance. Although high-income countries tend to have better health, we know that there is no automatic correlation between wealth and good health, at a societal level – as for individuals. There is another correlation that appears to be stronger among countries, the one between equality and good health. This indicates the very important role of politics and the type of policies and systems of governance underpinning health systems, and the role of economic and redistributive policies in general.

The World Health Report 2000 makes health systems performance the core theme.[1] The report defines four basic functions of a health system (see Figure 1): stewardship (or governance), financing, creating resources (physical and human), and delivering services. The attainment of the system depends, first of all of course, on its ability to improve health for all. To achieve this, the report argues, two particular factors have to be added to the model, namely that the system have to be *responsive* to people's expectations of how they should be treated as human beings, and that its *financing is fair*, meaning that the costs of the system are distributed among households according to their ability to pay rather than to the risk of illness. It is obvious that these objectives cannot be met unless there is the political will and a system of governance that is able to regulate, in various ways, transactions between providers of health services and people seeking treatment.

Vietnam represents an interesting case in this respect. The economic reforms that were gradually introduced the latter part of the 1980s turned out to have fundamental impacts on the functioning of the health system, much of which was unintended. This posed major challenges to health policy and governance of the system. Today, Government and its Ministry of Health are in the midst of a reform process searching for viable policy responses that effectively address the new trends in the health situation, and Swedish DAH has been part of this effort. Recent trends in Vietnam's health situation include:

- Growing inequalities in access to health.
- A dramatic decline in both provision and utilisation of public primary health care services.
- Increased pressure on tertiary services.
- Increased self-medication using the liberalised drug market.
- New causes of morbidity and mortality associated with the economic development

Figure 1

These trends represent challenges to policy that touches on basic political questions that go far beyond mere technical solutions to medical treatment and service delivery, namely questions of equal rights and the role of government versus private sector. The differences between rich and poor in Vietnam will in all likelihood continue to increase, and we have not yet seen the end of the crisis in the public sector – both financially and morally. Still, Government and the Party remain committed to equity-oriented health policies, and there is no doubt that this has wide popular support.

> The humanitarian nature and socialist orientation of health activities demand equity in the provision of health care. Circumstances where a poor and sick patient is denied medical treatment because of his/her lack of money should be put to and end. (Socialist Republic of Vietnam, Strategic Orientation for People's Health Care and Protection in the Period of 1996-2000, Ministry of Health, Hanoi, 1996)

Can aid effectively assist Vietnam fulfilling these political ambitions in health care?

1.2 Aid cannot buy reform

Much of the development aid debate is overly focused on the volume of aid. It remains an objective by itself, without adequately addressing its effectiveness. Success is measured in terms of pledges and disbursement. While this serves the interests at least of donor organisations, there is a growing volume of studies showing that there is no positive correlation between the size of aid and its effectiveness – i.e. the attainment of development goals.

Aid as a pure monetary resource is most effective in countries with well-functioning institutions, the "right" policies, and a governance system ensuring popular participation and accountability, the *Assessing Aid* study of the World Bank concluded.[2] And the dilemma is, that these countries are generally not the most needy if we see aid as a means of closing the many big gaps between the current level of development indicators and the international development targets (IDTs) that have been formulated. A set of 5 targets and corresponding indicators were endorsed by OECD's Development Assistance Committee in 1996, and for three of them people's health status has been selected as the development barometer. These include infant and child mortality (IDT: the death rate of infants and children under five years to be reduced by two-thirds the 1990 level by 2015), maternal mortality (IDT: to be reduced by three-fourths the 1990 level by 2015), reproductive health (IDT: services to be available through the primary health care system to all who need them by 2015), and HIV/AIDS prevalence (IDT: achieve a reduction of 25% in HIV infection rate among 15-24 years-old by 2005).

Generally, where the gaps in terms of health indicators are the widest, the problems of institutional capacity, the policy environment and governance system are at the same time the greatest. Collier and Dollar suggest a way to handle this classical need-ability dilemma in development aid, when translating findings from the *Assessing Aid* study into concrete recommendations to donors, for instance in a recent report on Norwegian aid. They take the position that a country's policy performance should be the major factor in decisions on aid disbursement, rather than need – or the donor's own strategic interests for that matter, which seems to have been the pattern so far.[3] The corollary to this is that a process of reforming the health sector has to be firmly established before large amounts of aid will make an impact on the health status of a county's population. If so, can aid do anything to stimulate such processes of reform?

The position of Collier and Dollar understandably provokes reactions from those that give primacy to the humanitarian rationale for aid, and promote rights-based approaches to development such as in access to health services. The findings of the *Assessing Aid* study was further corroborated by the recently published study *Aid and*

Reform in Africa.[4] Where *Assessing Aid* concluded fairly categorically that variables under donors' control had no influence on the success or failure of reform, based on econometric correlation, *Aid and Reform in Africa* brought in empirical evidence from the analysis of national political processes:

> That the 10 countries in our study all received large amounts of aid, including conditional loans, yet ended up with vastly different policies suggests that aid is not a primary determinant of policy (p.2)
>
> The key to successful reform is a political movement for change, and donors cannot do very much to generate this (p.34)

This most recent research on aid effectiveness does not conclude that policy is entirely independent of aid. There is the negative influence of aid on policy – that large amounts of aid to countries with bad policy tend to sustain those poor policies. But there is evidence of positive impacts as well. *Aid and Reform in Africa* concludes:

> The lessons from the Ghana and Uganda cases [classified as successful reformers according to the study] are that donors should concentrate on technical assistance and other soft support without large-scale budget or balance of payments support in the phase before governments are serious about reform (p. 6)

Generally, we can distinguish between three types of strategic approaches by aid agencies for promoting policy reform. There are the two forms indicated above, i.e. the buying of reform using the volume of the aid as a carrot for accepting donors' advice, and secondly the stimulation of reform through a mutual learning approach involving sharing of ideas in a more open-ended partnership. The third type is the well-known coercing of reform, by attaching policy conditionality to the aid or loan agreement.

According to Joan Nelson, in a study from 1996, the diminishing use of conditioned loans reflects a growing thinking about their limited effectiveness.[5] The initial economic policy reforms focusing on stabilisation – fiscal balance and reduced inflation – involved a limited and concrete repertoire of changes in macroeconomic policy that in most countries could be effected by a small circle of high-level economic officials of government. The components of later phases of economic reform, moving towards liberalisation – reducing government controls in the economy, privatisation and promotion of the private sector – and the rehabilitation of essential public sector functions involved progressively more complex institutional reforms. It is virtually impossible to carry out financial sector reforms or labour market liberalisation in the same manner as devaluation, Joan Nelson argued. The same can be said about health sector reform.

Hence, there is a growing consensus that wherever reform is required, aid can neither buy it nor force it. Better than carrots and better than sticks are the ideas that aid can contribute to those working for reform. If so, we would greatly benefit from the lessons of aid in countries with successful reforms. Vietnam is one such country, according to the World Bank, with its economic reforms in particular. Vietnam seems to represent a case where technical assistance and policy dialogue with donors, in the pre-reform period, were helpful in developing the reform. In the health sector, Sweden has been the main donor contributing to policy reform.

We know from evaluations of technical assistance and policy dialogue, however, that there is not only one way of doing this and that the history of aid in this respect represents both successes and failures. From Ghana and Uganda, according to World Bank, two lessons stand out: (a) that aid assisted the learning both from other countries and from own policy experiments, and (b) that processes of mutual learning between local counterparts and foreign experts were important. We shall see that there are similar lessons from the Vietnam-Sweden Health Cooperation (VSHC). The aim of this paper is to improve our understanding of *how* this happened.

We know that aid can function as an important channel for new ideas, exchange of experience and the gradual building of competence and capacity in organisations critical for a well-functioning health system. And research tells us that what determines the success of these aspects of aid is not the size of budgets. Non-monetary factors play a far more important role in determining the effectiveness of aid to reform. But what are these factors and how to take account of them in aid planning? We are thinking about factors such as time, professional quality, communication skills, patience, trust and finding the right partners. It is of paramount importance that we in a new drive for raising the levels of DAH do not overlook these hard-won – and costly – lessons.

1.3 Limits of rational planning

Another important concern is to warn against the tendency among donors to look for instrumentalist strategies for aid. Supporting health system reform means entering a terrain where classical methods of rational planning, based on logical frameworks of cause and effect, are not well suited. The impacts of aid remain largely unpredictable, which calls for rethinking both approaches to planning as well as definitions of what aid effectiveness is.

This can be illustrated with an image from skeet shooting, a type of sport shooting that simulates bird hunting using shotguns. This poses two particular challenges to the shooter: he or she does not know in which direction the clay pigeon will be released, and to hit the target he or she cannot aim at it directly when pulling the trigger but have to judge where it is likely to be when the shot reaches there. These challenges represent a good metaphor for illustrating what it is like for an aid donor to aim at policy reform.

- The donor cannot dictate the direction of the reform
- The donor have to be able to respond quickly when the direction is observed
- The donor have to adjust for the movement of the target
- The donor have to use broad interventions (like shotgun ammunition) to increase the probability of hitting

And to complicate this act of shooting further, the donor rarely holds the gun alone, and cannot single-mindedly pull the trigger. There are recipient institutions involved. Getting this act of “tandem shooting” to work requires understandably a high level of cooperation and effective communication. It should come to nobody’s surprise that the chances of missing the target remains high. Investing in reform is a high-risk form of aid.

Therefore, to evaluate the role of Swedish aid and its effects on health sector reform in Vietnam, it is necessary to problematise the *concept of effectiveness*, as it normally is presented in the development jargon. The concept is generally based on the notion of rational planning underpinning most development work, resulting in a definition of effectiveness that is related to the extent to which interventions 'reach their stated objectives'. Success, in other words, is linked to the ability of planners to anticipate development trajectories. But this does not make sense when we are dealing with political processes that are largely unpredictable and the linkage between aid and reform is tenuous.

This is not to say that aid does not have effects, as noted above, but we need to revise the way we appreciate such effects. When we make the distinction between output (or immediate result) and effect (or outcome, impact), it remains as a reasonable requirement on all development investments that outputs are reached more or less as planned, but moving to the level of effect or impact the same argument is far from obvious.

- There are great limitations on the extent to which it is possible to realistically predict the longer-term effects of aid on political processes. Hence, stated objectives are only measurable if they are short-term and narrowly defined – more like outputs. If broadly defined they will have to serve the purpose of development aspirations only, rendering any form of "measurement " of effectiveness meaningless.

- We have to expand our notion of effectiveness beyond the achievement of planned targets, to include the more loosely defined "contribution" to desirable development processes, which is observed ex post. What turns out to be desirable cannot always be determined *a priori* – it may come as a lesson from the development process itself. Aid can have, and often will have, desirable effects that were unintended and could not be pre-planned. The point is that by realising this one will apply a more iterative approach to the planning of aid, and the *ex post* assessment of its effectiveness.

The case of the Vietnam-Sweden Health Cooperation (VSHC) is a good case for illustrating these points.[1] The overall objective of VSHC, in the current programme agreement, is formulated as "contributing to an improvement in the health status of the people of Vietnam". This has been the main justification for the cooperation since the start in 1974, but the approaches and the underlying assumptions about the role of aid have changed considerably. It has been a history where Swedish aid consistently have been faced with the criticism of missing the target, while it at the same time has been part of important processes of learning which influenced the pace and content of reform in Vietnam. Do we see this as effectiveness or failure?

In the following section we shall look at the main trends and events shaping the historical development of VSHC before turning to a discussion, in the third section, of the effects of concrete approaches within the aid programme.

[1] The term VSHC was officially used from 1994 onwards, but we use the term for the full length of the cooperation, since 1974.

2 Aiding Vietnam's health system: a moving target

The Vietnamese-Swedish bilateral cooperation is an interesting story of an aid relationship that seems to have become more and more rare – that of a largely politically motivated partnership surviving several decades of domestic political turmoil and rapidly changing fads and fashions in the development business. It has been subjected to major changes in Vietnam, the pace and direction of which it was not possible for any planner to anticipate, let alone Swedish aid bureaucrats and consultants. The mere continuity of the relationship seems to have been an important factor in itself, determining the effects of the aid, although the two parties rarely shared the same expectation. Another factor has been the role of aid as a "laboratory" – mostly by default. We can look at this history distinguishing between three main phases of post-war developments in Vietnam, which more or less overlap the turn of decades.

If we go back to the elements of a health system presented in Figure 1, we shall see that VSHC through the three phases have changed its focus. In the 1970s the aid contributed mainly to the creation of resources, whereas during the 1980s delivery of services became the focus of attention. From the early 1990s VSHC gradually came to focus more and more on the issue of stewardship in the form of policy-development.

2.1 The 1970s: confidence but no capacity

Vietnam during the 1970s moved from a war economy with a high level of political commitment and voluntarism to a post-war period characterised by a progressively failing centrally planned economy and growing popular disillusionment. The political contacts between Sweden and Vietnam started at the height of the Vietnam War (or the American War, as it is referred to in Vietnam) in the late 1960s. What emerged was not a conventional aid relationship similar to what Sweden had developed with several other countries at the time, like in Africa.

Sweden was the first Western country establishing political relations with the Democratic Republic of Vietnam (DRV), or North Vietnam. In Sweden the popular sentiments against the American involvement in Vietnam ran high, and the Social Democratic Party, with then Prime Minister Olof Palme as the dominant figure, was seeking a role in international politics as a non-aligned Western country. DRV on its part welcomed the limited opening to the West that collaboration with Sweden offered, not so much for strategic reasons, as for what it offered in terms of access to Western technology and know-how.

When the first announcement of a bilateral aid programme was made in 1969 Sweden's position was not only influenced by sentiments of solidarity with North Vietnam in the war, but also a fledging domestic debate on aid resembling what we have had in the wake of *Assessing Aid*. This was based on the argument that aid should be given to countries with the "right" policies, and in that case with very few strings attached. In the radicalised Sweden of the late 1960s, the notions of what constituted a "right" policy for Vietnam were rather different from today. Many in Sweden's Ministry of Foreign Affairs, at the time, argued that Vietnam was a deserving candidate for this form of unconditional aid. At the other side of the table, there was a self-confident government of DRV about to secure victory in the war, but at the same time both ambivalent and extremely careful in its first official dealings

with a Western capitalist country. These factors resulted in negotiations as if between equals, despite the fact that the two parties were highly unequal in terms of resources and political motivations.

Surprisingly to the Swedes, warn-torn Vietnam did not want conventional humanitarian or reconstruction aid. It wanted technology transfer as the core element of the aid programme. Sweden, facing potential US sanctions, could not offer anything that could be seen as having military importance, hence Vietnam cleverly suggested forest industry technology, a sector where Sweden was world-leading, in the form of a modern paper and pulp mill. Based largely on humanitarian arguments, and the fact that Sweden, through Swedish NGOs, had provided medical supplies and equipment, the health sector was included as well. This decision was also greatly influenced by the unprecedented public protest in Sweden with the news of the American bombing of the Bach Mai hospital in Hanoi December 1972. Vietnam, wanting transfer of medical technology, suggested the building of a new hospital. An agreement was reached in 1974 to raise a children's hospital in Hanoi (the Institute for the Protection of Child Health) and later in 1975 a second hospital was added – the Uong Bi General Hospital in the Quang Ningh province north of Haiphong.

Vietnam's health system at the time when Sweden entered the scene was a mix of old and new. But first and foremost it was a system shattered by the effects of the war. The health system is influenced by four different traditions emanating from different historical periods. There is the ancient tradition, referred to as "southern medicine", based on locally available herbs that people know how to use themselves or apply with the assistance of traditional healers. Self-medication is the most common still today. The Chinese influence, which came in later, of both medical theory based on Confucianism (the principle of Ying-Yang balance) and imported medicines – so-called "northern medicine", laid the foundations of a community health system where village teachers educated at mandarin schools also functioned as medical practitioners. The French influence of Western hospital-based curative medicine catered mainly for the urban elite, which included also the leaders of the independence movement and revolution to come. The socialist model, developed during the 1950s and 60s, flagged the motto "prevention is better than cure". It was a centralised system with community outreach focusing on teaching people basic knowledge about health and hygiene, and providing fully subsidised curative services. The effectiveness of the primary health care system depended largely on the mobilisation of local resources and the traditional respect given community health workers, because at the central level the state placed most of its resources in developing the hospital network.

The success of the socialist model of community health workers in reducing morbidity and mortality from communicable diseases was considerable. The collectivisation of agricultural production created a resource base for local level public services, and the extensive paramilitary organisation of the society also played its part. The political emphasis on health care and education not only included grassroots approaches, however. It was also related to the ideology of the Communist Party to promote a scientific revolution, including advancements in curative medicine and higher education. This explains way Vietnam wanted to use the Swedish link to develop its tertiary level health system, not its primary health care. It wanted model and teaching hospitals where its doctors, mostly trained in Soviet Union and Eastern

Europe, could improve their skills in modern Western medicine. Sweden's priority was to support the network of community health centres throughout the country, but gave in on Vietnam's demand for equipment and advanced technology. "The understanding, patience and impartiality of the Swedish side during the discussions is my most valuable lesson of 26 years of cooperation", Nguyen Van Loc, responsible for foreign aid in Ministry of Health, later commented.[6]

The agreement to install two modern "Swedish" hospitals in war-torn Vietnam was a decision that defied Sida's own planning guidelines, and which definitely would not have survived a logical framework analysis (LFA) of today. The decision was essentially an act of political solidarity, not of rational planning. Not only did Sweden greatly overestimate the capacity of the Vietnamese state as implementer, so did the Vietnamese themselves stimulated by the victories at the battlefield. The projects that initially were conceived as Vietnamese construction ventures, with Swedish support in financing imported materials and in training on new technology, gradually took the form of Swedish turnkey operations with major input of Swedish management and technicians. Part of the problem was that Sweden had very limited knowledge about how Vietnam functioned, and that the Vietnamese regime did its best to keep it that way – confined by the logic of war secrecy and the perceived threat of capitalist influence.

No one, in 1974, believed that it should take until 1999 before Sida – at least for the time being – spent its last *krona* (SEK) in support of the two hospitals. Nevertheless, the hospitals were completed, in 1982 and 1983, spending far more time and money than initially envisaged, and gradually became two of the best functioning hospitals in Vietnam. While the cost-efficiency of this aid, in a narrow sense, is questionable, its effects can be traced beyond the physical confines of the two hospitals.

Sweden's willingness to base the aid relationship solely on Vietnam's priorities was not sustained for very long, but the fact that it started this way, for political reasons, meant a lot for the later development of the partnership. The fact that it was also about building two very visible, modern institutions also mattered.

2.2 The 1980s: system crisis and budding reforms

When the construction workers eventually had completed their job in 1982-83, both parties realised that Vietnam was not in the position to operate the two "Swedish-made" hospitals without further assistance. Sida did not hand over a key and leave. Ministry of Health had already by then submitted, and Sida had approved, a request to prolong the Swedish assistance beyond the construction phase, into full-scale support of hospital operation, including medical guidance, management, training at all levels, and medical and spare parts supplies.

By the early 1980s, however, the nature of the aid relationship had clearly changed. Other Western donors who had come in with the end of the war had already left, in protest over Vietnam's intervention in Cambodia in 1979. Despite mounting criticism at home, both centre-right and labour party governments in Sweden, at the time, decided not to follow the example of other Western donors. Sweden stayed on, also motivated, of course, by the problems it would have created leaving behind a half-completed paper mill and two hospitals. But Sweden, using the power of the purse

and supported by the international trend of aid conditionality, now took the position of a more interfering partner. It started advocating the needs for change at various levels of the system.

A first step in the health sector was to revive the original concern for strengthening primary health care. In 1982, with the adoption of the principles of the Alma Ata declaration of 1978 on primary health care to people everywhere, Sida urged the Vietnamese side to include PHC in the Cooperation. This decision was also motivated by the criticism in Swedish media of the hospital projects, and growing insights to the shortcomings of the Vietnamese primary health care system. In 1983 the Yen Hung Rural Health Project was started, aiming at improving preventive care and the referral system in the catchment area of the Uong Bi hospital.

This was a time of changing international aid paradigms, not only on aspects of primary health care and drug supply. Sweden generally took a broader interest in living conditions and economic reform. Vietnam, in many respects, was now in a weaker position, and the pressure for reform had already started from below (in Vietnam referred to as "fence breaking"). In the health cooperation, this gradually led to a move away from an emphasis on "hardware" – i.e. supply of equipment and materials, to transfer of knowledge in the form of institutional development.

While Vietnam continued keeping the Swedish aid in isolated project environments, the system gradually started opening up. All projects of the Cooperation – the two ongoing hospital projects, the rural health project in Quang Ninh Province (started in 1983 and reorganised in 1986), the provision of drugs projects (from 1983), and a medical equipment project (from 1986), not only progressively expanded their "software" components but also slowly moved their activities closer to the mainstream activities of the Ministry.

2.3 The 1990s: economic growth and public health sector crisis

The "renovation" reforms – *doimoi* – were approved by the Party Congress in 1986, but it was not until 1990 that the new policies started having a real effect. The major economic crisis of 1989 had forced the government to remove remaining legal and institutional barriers. This started in 1990 the transition to a so-called socialist-oriented market economy, which radically transformed economic life in Vietnam. The liberalisation of the market, removal of restrictions on foreign trade and abolition of agricultural co-operatives led to double-digit economic growth rates, and major improvements in living standards for the majority of the population.

The effects on the public health system, however, were devastating. The opening-up for household-based agriculture, allowing farmers to manage private holdings on long-term leases, resulted in the collapse of agricultural co-operatives. Since they had been the main revenue base for the community health stations, the consequence was that drugs were not available and brigade nurses and village health worker did not receive their salaries, in cash or kind. Many had to look for other income opportunities. The number of community health workers declined from 58,700 in 1985 to 37,700 ten years later.[7] State finances were extremely constrained, and with little priority given to health. There were not the resources to keep to the promulgated political aim of free health services for all. In 1989 hospitals were authorised to

charge patients a partial hospital fee. A weakened Ministry of Health realised that the new Vietnam emerging required new approaches in health, and slowly opened the door for Sida eager to help on broad based institutional development, and with the VSHC agreement in 1994, also on policy work.

The combination of progressively deteriorating public services, improvement in personal incomes, and the growing availability of drugs in the market, led to a marked shift in health seek behaviour towards self-medication and the purchase of "private" medical treatment. The demand for the latter was mainly met by public practitioners taking additional payments from patients willing to pay for better service, and increasingly also starting more regular private practice, which was legalised in 1989. This development spurred inequity in health, greatly favouring groups benefiting from the economic growth, leaving the marginal and poor further behind.

An uncontrolled establishment of private pharmacies took place at a point of time when trade with foreign producers of drugs was opened up. While positive consequences could be distinguished in the area of drug costs, very negative and potentially dangerous consequences followed with a rapid increase in antibiotic resistant bacteria due to uncontrolled use of prescription drugs.

The 3-year programme agreement of 1990 marked the first shift in development terminology as it was broadened to also include 'policy dialogue'. Two new projects were created to support central functions of the Ministry (the Central Level Integration Project and the Training System Support Project), bringing the VSHC one step closer to the higher circles of decision-making. This trend was to be further reinforced with the agreement in 1994, which took the next step conceptually and made 'policy development' one of its cornerstones. The approach was a broad based strengthening of the capacity of Ministry of Health, mainly at central level, involving most of its departments.

The prolongation of the cooperation beyond the 1990-1993 period was not without a number of teething problems. Ministry of Health was not yet prepared to invite Sida to take a more direct and active role in the reform process. The combination of the old tradition of keeping foreigners away from departmental corridors, and the general bewilderment about how to respond to the country's new health problems, led to a stalemate. The existing agreement had to be extended twice, before under heavy political and bureaucratic pressure a new agreement was signed in October 1994.[2] Sida drafted the text almost exclusively, and the Planning Document completed about the same time was the product of substantial involvement of Swedish consultants. The ownership by Ministry of Health to the main content could be seriously questioned. In 1994 the majority of the Ministry's departmental heads and managers seemed to hold the view still that Swedish aid primarily was a financial resource for helping business as usual. They did not subscribe to the idea of Sida to use Swedish funds and technical assistance to spearhead institutional and policy reform. In general, the Ministry at the time had no organisational culture for experimenting and learning. It was geared towards the executions of instructions from above.

[2] Specific Agreement between the Government of Sweden and the Government of the Socialist Republic of Vietnam on Health Cooperation October 1, 1994 -–December 31, 1999

But there were also reformers in the organisation. To them, VSHC was an important asset, not only the money, but its historical legacy as well. Swedish advice was politically acceptable. Many within the Ministry had had the opportunity visiting Sweden during the previous 20 years of cooperation and saw the Swedish health care system as a model to follow. A step of some symbolic importance had been the final acceptance by the Government, in the late 1980s to allow the Swedish consultancy firm involved in the programme to operate from within the premises of the Ministry of Health. In 1994, steps were taken to move the consultants even closer to their ministerial counterpart – the Cooperation Management Office.

Though at the higher level a consensus had emerged that Swedish support needed to include also health policy work and to reinforce the capacity building work already going on, the translation of these somewhat abstract ambitions into concrete and realistic plans turned out to be more difficult than anticipated. It was not made easier by a number of associated requirements put on the table by Sida.

Sida wanted to see a distinct move away from the project approach of the past to a more integrated programme, both in the way it would function as an integral part of the Ministry's regular work, and the way different components would reinforce and support each other. The concept of "areas" was introduced to facilitate this change, which functioned as a compromise between Sida's concern for better integration of the aid, and Vietnam's decision to continue separate management of aid. Hence, "areas" within VSHC are more than simply areas of investment within a broader range of activities of a department. An "area" is *de facto* a project organisation with its own temporary management set-up, including Head of Area and a team of implementers. The fact that areas are functionally linked to Departments within the Ministry, and the Head in most cases is also the head of the department, was nevertheless an important step towards better integration of Swedish aid in the Ministry's regular activities.

The 1994 agreement defined the following areas:

- Overall health policies, through the support primarily of a new Health Policy Unit established within the Ministry, today forming part of the Department of Planning.
- Drug policy and drug control, with the Drug Administration of Vietnam as the main agency involved, under the supervision of the Department of Pharmacy.
- Primary health care policy, through the support of a separate Primary Heath Care Unit.
- Support to primary health care services in remote mountainous areas.
- Training systems support through Department of Science and Training.
- Mother and child health and family planning (MCH/FP), by supporting the department of the same name.
- Phasing out of the hospital project in cooperation with the Department of Therapy.
- Health insurance.

It is worth noting that all key departments of the Ministry in this way got a share and a stake in the programme. As it turned out later, not all areas moved according to plans and the expectations of Sida. Two were closed prematurely – primary health care and MCH/FP), and in one case, health insurance – an issue pushed by Sida, the time was not yet ripe. The area never started, but the issue is now resurfacing through the work of the Health Policy Unit on health financing.

In 1994 Sida also wanted to change the role of consultants, to become more advisory, as well as to reduce the overall level of technical assistance. In periods during the 1980s there had been more than 30 long-term consultants. Now Sida aimed for only one or two, but ended up with some more. Sida tried to insist that the Ministry took charge of drafting plans, but as it turned out it was not capable of presenting plans of the standard wanted by Sida and to prevent further delays consultants were brought in to assist the process. While Sida on the one side hand insisted on national ownership of the planning process, on the other hand, it also created its own stumbling blocks by insisting that planning had to follow the new standard requirements Sida adopted about the same time, namely logical framework analysis (Result Oriented Project Planning).

Ironically, this requirement in the case of the 1994 agreement was introduced at the time when Sida already had announced the total amount it was prepared to spend – 250 million SEK. Not surprisingly, therefore, plans were created in response to this level of spending, rather than realistic assessments of needs and capacity. What came out of the planning process was a complex and loosely defined programme for addressing a set of very ambitious objectives. The plans provided limited guidance on practical strategies for how to go about it. The overall objectives were:

- Contributing to an improvement in the health status of the people of Vietnam, especially in disadvantaged areas.
- Increasing the efficiency and effectiveness of the Ministry of Health in providing health services.
- Contributing to a reduction of inequity with regard to gender, geographical location and ethnic origin in the provision of health care.
- Increasing the capacity of the Ministry of Health to address the issue of financing health care and to maintain the provision of services.

From day one of the 1994 agreement started a gradual process of finding and redefining approaches, and, probably the most difficult part for both Ministry of Health and Sida, developing a new system of aid management. Many things were to be changed in the process of slowly bringing VSHC “under the skin” of Ministry. It is to the credit of Sida and Government of Vietnam that this process was greatly facilitated by a flexible planning procedure, based on annual reviews and plans of operation.

An evaluation of VSHC in 2000 observed that the programme, compared with the situation in 1994, had succeeded in becoming an important element of several learning and reform processes of the Ministry of Health – which indeed was a major implicit objective.[8] While it is too early to judge the outcome of these processes on the health system, not to mention the health status of the population, there are other dimensions of effectiveness worth noting:

- The ownership by the Ministry of Health has steadily increased over time. This can be seen in the annual planning process, where consultants no longer play a dominating role.
- There has been a continued building of trust, and transparency with respect to intra-Ministerial operations has improved, although corruption and the old

political culture of secrecy continue to smokescreen many activities of the Ministry.

- The quality of the policy-making process has improved significantly. This applies to the quality of the research inputs and the utilisation of these inputs, as well as the consultation with other stakeholders. The development of the National Drug Policy, supported by VSHC, also demonstrated that policy-making is a difficult process of "muddling through" rather than a "logical" exercise, and that it takes time.
- The management of the aid has become more integrated within the Ministry, greatly facilitated by the decision to merge the office of the Swedish programme management consultant with the counterpart set-up in the Ministry. But it took until 1999 before this could be implemented, with the agreement for a 3-year extension of the cooperation (1999-2002).
- Improvements in the professional dialogue and the use of international advisers can be observed. The "advice-receiving" capacity of Ministry has significantly improved.
- The management of the aid has gradually improved. VSHC represents today probably the best managed aid programme in the Ministry. Substantial investments have been made in standardising procedures on tasks such as contracting of local consultant, training abroad, recruitment of staff, and commissioning of studies.

In the following we shall look at the effectiveness of some of the main approaches of VSHC during the last 6 years.

3 Stimulating health system reform: the effectiveness of particular approaches of Swedish DAH

In the previous section we have seen how Swedish DAH gradually evolved from "hardware" to "software", from Sida believing in the Vietnam's health system to pushing the system towards reform, and from Swedish technical assistance being on the fringes to becoming trusted advisors to the Ministry. The reform agenda that gradually took form in the early 1990s contained four basic strategies:

- To improve the individual skills of staff of the Ministry
- To improving the institutional capacity of key entities of the Ministry
- To assist in the development of new policies
- To enhance Vietnam's ownership of the programme

3.1 Investing in people: the building of competence

Different types of training have been a major aspect of VSHC. Typically this has included:

- On-the-job training
- Training in Vietnam
- Training abroad

It is in the area of individual competence development where the impacts of Swedish aid most clearly can be observed. This is widely recognised. It is not only a question of formal skills. Probably of equal importance has been the international exposure that VSHC could offer. Very many officials of the Ministry of Health have had their first

visit abroad financed by Swedish taxpayers. When Vietnam opened up to the world outside the family of countries influenced by the former Soviet Union, few established networks were available. The relative generosity within VSHC to make available contacts with Japan, China, Thailand, Philippines, Malaysia etc. was a very positive contribution.

The training abroad activities of VSHC (since 1994) were evaluated in 1999.[9] The programme spent 6.3 mill SEK (70 % of planned) on study trips, participation in conferences and attending formal training course. Formal training consumed less, only 30 % of the cost. In total, 342 health sector staff benefited from these activities, of whom 241 participated in management related training. It is impossible to measure the value of this international exposure, but undoubtedly it has greatly contributed to the capacity of the Ministry to make use of foreign consultants and deal with donors.

An important indirect effect of VSHC has been the increasing number of staff able to communicate in English. Formally, participants in training abroad activities have to pass an English test. Although this was not always strictly observed, it has been an important incentive. The Ministry insists on conducting all official meetings and seminars in Vietnamese, using professional translators, but there is a growing number of the staff who engage in a direct dialogue with foreign advisers and aid representatives without interpreter. It also matters that government no longer regards such contacts as a security risk.

In terms of skills development training abroad is not considered the most effective way of spending money. Several reports indicate that transfer of knowledge, in the Vietnamese context, most effectively takes place through on-the-job training.[10] The main reasons seem to be that language problems make formal teaching by foreigners not very effective, and that the communication problem can better be overcome through longer-term working relations between foreign experts and local counterparts. One effect of the many Swedish consultants working at the two hospitals, was a gradual change in working routines and professional roles, for instance in upgrading the role of hospital nurses.

It is the experience of VSHC that the so-called long-term advisers were the most useful, and clearly the ones most appreciated by the staff of the Ministry. The value of the considerable number of short-term advisers commissioned by VSHC can be questioned. Most of the reports they produced were never translated into Vietnamese, and hence played only a marginal role in policy development. An important step taken by Sida is to move more of the responsibility for identifying the needs for consultants and the screening of candidates to the Ministry.

Many in government today share the view that Vietnam should reduce the number of foreign consultants. They argue that a more effective form of competence building is well-prepared courses in Vietnam using high calibre international lecturers. The general competence of higher level personnel within the Ministry, and its affiliated institutions, is such that formal training in Vietnam, using foreign experts, will be more effective than in the past. The challenge remains, however, not to jeopardise links between Vietnamese and international specialists fostering processes of mutual learning. There is all the reason to believe that this will become a critical component of successful health sector reforms in a Vietnam becoming more and more

internationally exposed. Recent attempts within VSHC to foster more institutional collaboration between Vietnamese and foreign organisations is therefore a step in the right direction.

3.2 Investing in institutions: organisational development

The impacts in terms of organisational development are less obvious. Clearly, one cannot assume that investment in individuals automatically lead to better organisations. One definition of organisational development links progress to the ability of an organisation to gradually improve both its ability to deliver expected outputs and to carry out changes on its own, making it more responsive to its clients and to changes in its operating environment.[11] As mentioned above, the scope of VSHC have moved from a focus on services as the main output to policies. There is evidence to suggest that VSHC has been instrumental in improving the capacity of the Ministry of Health to formulate policies that are more relevant, and hence have become more responsive to changes in its environment. In the following we shall discuss some of the factors constituting the ability of the Ministry to carry out changes on its own, and the effects of VSHC.

At the level of strategic policies, Vietnamese political and administrative institutions represent a high degree of continuity, historical consciousness, and the ability to think long-term. Dealing with operational aspects of policies, however, the learning capability of the system is weak. It suffers from a tradition of vertical organisation and centralised decision-making, which have rendered sharing of experiences horizontally in the system very difficult. Institutional rivalry and turf battles have been common place. This has rendered aid coordination difficult, and the influx of aid often has the opposite effect, of reinforcing institutional barriers rather than bringing them down.

The implementation of primary health care is a case in point. From 1989 onwards PHC activities were carried out through different vertically organised national programmes, each focusing on a single priority health problem. There were dozens of such, with its own management set-up headed by a national director. Many of these programmes have attracted donor finances, often described as “pilot projects”. The term denotes a form experimental approach, but this was rarely the actual case. A pilot project typically provided parallel financing to the regular implementation of a national programme, limited to specific target areas or sections of the organisation. Rarely was there a systematic attempt to collect lesson learned, and even less so, comparing the experiences of the many pilot projects.

Quality of planning and monitoring

Sida instructed the Ministry to adopt Logical Framework Analysis (LFA) for preparation of annual operational plans and the structure of these plans generally follow this framework. Still, it appears to be have been difficult for Ministry to retain a functional link between the formulation of objectives and the identification of activities. The objectives remain very broad and the situation analysis is often weak. We observe for instance, that there are omissions of a number of greatly important trends in Vietnamese society – such as urbanisation, modernisation of values, and new trends in health seek behaviour of the population. We also note that there is little continuity in the overall analysis from one plan to the other. The annual plans tend to

go rather directly to the point of formulating individual projects and normally give good and clear direction for work for the coming year. It is rather difficult, however, to find the relation to overall objectives. The problem is probably not the inability of planners at the Ministry to grasp the LFA concepts, but that the approach itself is not well suited to the kind of development work VSHC finances.

An impressive number of progress reports have been produced, and a major self-assessment was undertaken in 1997.[12] Still, it is a general complaint from Sida that it faces difficulties in its monitoring of the programme. The problem is twofold. Sida has come to realise that demanding progress reports, by itself, does not enhance the quality of monitoring. The initial requirements imposed by Sida, in this respect, were formidable, and halfway in 1996 the parties agreed to less demanding routines. It remains a problem, however, that the system all the time has been geared towards expenditure and activity-based reporting, and not result-based.

In the absence of independent sources of reporting and research, the verification of information provided by the health system remains a weak point. The substantial increase in health related studies has improved the situation, but quality of research has been a problem. One factor causing this has been the tendency that commissioning of research and consultancy work has become an important source of personal income for high level civil servants.

Management

Integrated management at district and commune level
Aid management: coordination
High turn-over at managerial level

Experimenting

Pilot projects: a funding strategy more than a designed experiment

Building new institutions

VSHC during the 1990s contributed to the build-up of two important organisations - the Health Policy Unit and Vietnam Drug Administration.

The Health Policy Unit (HPU) in the Ministry of Health is a brainchild of VSHC. The unit "…is in charge of studying and synthesising policies on development of the public health system and constitutes a key body in studying and drafting the above-mentioned policies to be submitted to competent authorities for approval".[3] Over the period two main issues around HPU have been insufficient manpower – particularly of senior officers – and its place in the organisation. It has frequently been mentioned that HPU has insufficient absorption capacity to follow-up on the many policy studies it initiates. While this may be the case, it needs also to be understood that the question of reformulating policy options from studies and bringing them to relevant political bodies for final comment is partly outside the mandate and competence of HPU. The Unit represents today the core of policy competence within the Department of Planning. It is of some concern therefore that it still remains an outfit primarily for making use of Sida funds. Today, practically all activities of HPU are Sida-funded.

[3] Ministry of Health decision 1023/BYT-QD 22/12/1993.

Sida is, however, not the only donor offering support to health policy work, but this seems not to have benefited HPU so far.

It will be a test on the sustainability of the HPU-investments, whether MoH gradually makes use of this capacity in all overall policy work, irrespective of source of funding. In fact, in a recent EU-proposal there was a provision for another "policy unit", and it remains to be seen whether World Bank funded policy work will be managed by the "Swedish" HPU or some parallel outfit.

Policy development requires highly qualified manpower, for which there is a high demand in Vietnam. It has been difficult for the Ministry to attract the right people and retain the best ones among its own "graduates". Aid money can fill in part of the incentive gap created by low government salaries, but Government understandably has been reluctant in allowing project-based recruitment in the ministries using aid money. In 1995, Ministry of Health was allowed, however, to start contract recruitment of local staff to VSHC. This was an important step towards gradually modernising manpower policies of the Ministry.

3.3 Investing in policy-making: making policies more relevant

VSHC has supported policy-making both on horizontal and vertical policy issues. The latter deals with diseases or causes of poor health, while the former gives direction to the development of the health system. In the case of Vietnam, two health policy issues of principal importance came to the fore with transition to a market economy, namely the role of the state in financing of health services, and the important ethical question about access to health services.

Horizontal policies: issues of financing and equity
The role of public financing of people's health care expenditures has reached a comparatively low level. The World Bank in 1999 estimated that as much as 81% of health care financing is private.[13] Still it remains a political priority of the government, at least on paper, to ensure that basic care can be guaranteed also for the poor. "But we are still confused on how to finance this", Pham Manh Hung, Vice Minister of Health stated in a recent interview. "Our approach will have to include elements of user fees, health insurance, and special programmes for the poor", and as a compliment to Sida he added: "Sida has helped us develop health financing policies, and we would like to continue relying on Sida's assistance".[4] The latter statement must be interpreted in the light of the Ministry's skirmishes with the World Bank over the preparation of the Bank's Health Sector Review for Vietnam, which represents an interesting case illustrating impacts of Swedish DAH.

Part of the World Bank's conceptualisation of a "sector review" is that it should be regarded as government document, which in many cases is negated by the very process of writing the review. The Ministry of Health took issue with the process of preparing the Health Sector Review, and refused to accept the policy recommendations formulated essentially by foreign consultants. This was partly an

[4] Interview, October 10, 2000.

issue of policy content, especially on health financing and the extent of privatisation, where "Swedish" ideological influence is quite apparent, and partly ownership more generally. HPU decided to prepare its own "Public Health Report" for Vietnam, with strong support from VSHC both through a long-term advisor working at HPU and footing most of the bill. Ironically, Sida through other channels was a major sponsor of the World Bank exercise. May be this is an example of the flexibility needed when aiding reform.

The work of the Health Policy Unit and the general emphasise of VSHC on equity concerns have been an important factor bringing back, so to say, the old egalitarian ideology. The decision by government in 1994 to provide a nominal salary to Village Health Workers from central government's budget, was an important step in arresting further deterioration in the primary health care system. The Health Policy Unit was instrumental in preparing for this decision.

The equity perspective is a leading theme in the Vietnam Public Health Report, and has been flagged in a number of seminars and conferences supported by VSHC. One of the conferences resulted in a book with many contributions from the Ministry of Health.[14] A top-level conference in 2000 focused on how to improve services among "disadvantaged groups" – i.e. ethnic minorities, mostly living in mountainous areas. The Ministry also prepared, with VSHC assistance, a policy document outlining a "Strategic orientation on health care and protection for people in mountainous and remote areas in the period 2001-2010"

In the area of horizontal policies, it is characteristic that many of the "horizontal studies" came in late in the period of cooperation, indicating that it has taken time for the Ministry "to open up". This work in progress, notwithstanding, it is still not possible to fully understand the *economic realism* behind the suggested policy framework. While mechanisms for resource mobilisation are being developed, the full impact of the macroeconomic situation in Vietnam on these mechanisms remains uncertain. The *governance mechanisms* needed for the implementation of the policies suggested remain to be analysed and decided on. A general observation is that the policies have a tendency to see the health system of Vietnam predominantly as a government operation.

Vertical policies: new important initiatives

In the area of vertical policies, an impressive number of statements are directly related to policy studies that have been undertaken within the framework of VSHC. Clear examples are the studies on accident and injury prevention, studies on perinatal mortality reduction in Vietnam, and studies on the national tobacco control policy. The work by the Vietnam Drug Administration on a National Drug Policy and the ongoing preparation of a Drug Law, are major steps in reining in some of the negative consequences of liberalising the drug market.

However, also in the area of vertical health policies there are sectors given considerably less attention. Mental health is one of them. HIV/AIDS may also need a structured form of vertical policy analysis. The two main policy documents issued by Ministry of Health during the 1990s (Strategic Orientation for People's Health Care and Protection in the Period 1996-2000, and Strategy for People' Health Care During 2001-2010) give almost no attention these issues. As maintained above, the 1994

agreement made policy development a core task, but the ownership to this approach was not widely shared in the Ministry. The bulk of the various department heads still regarded aid as a source for beefing up the meagre budgets, and not as an instrument for change. Six years later this attitude has changed, not because VSHC changed it, but VSHC made some important contributions.

A next important step would be to draw a clearer line between the policy work of the Ministry of Health on the one side, and the implementing organisations on the other. Studies will support efficient policy making better, if they reflect independent and professional opinions more clearly than now. In recent years more studies have been commissioned to structures outside the Ministry, which have contributed to a gradual build up of research competence also outside the ministerial sphere.

3.4 Promoting national ownership

Vietnam has a strong political tradition of independence in policy making, resisting what is perceived as impositions by outsiders. It is worth noting that Sida's flexibility in terms of international study tours has helped to bring about an understanding that Swedish support in policy matters has been non-aligned – not dominated by a wish to market a particular model.

In planning, setting of priorities
In implementation
In monitoring and accountability
In coordination of Swedish DAH – aid coordination

4 Conclusion: Prescription or partnership - what role for DAH?

Investing in reform is a high-risk form of aid. Achievements are neither predictable nor easily measurable. General lessons on aid and reform have told us the limitations of donor-driven approaches. Policy-based conditionality has not been effective, at least not in the long run. Investing in reform means operating in an institutional and political environment where other forces than the aid relationship dictate progress. On the part of the donor, it requires ability to adjust to new opportunities being created and sensitivity to domestic political matters. On the part of the recipient, it requires a felt need for change and willingness to engage in partnerships for mutual learning. To both parties, time is a crucial factor, and the ability to communicate is critical. We find that individuals matter a lot – as builders of trust and carriers of insight and empathy about the other party. On both sides there needs to be a meeting of minds and a sense among key players that they are able to forge a strategic alliance. Neither donors, like Sida, nor recipients, like MoH, represent monolithic agencies. Taking the risks of investing in reform – and to succeed, require brokers and entrepreneurs on both sides of the partnership.

We find that VSHC has parts of all these elements in place:

- A flexible planning process
- A long history of cooperation with building of trust
- A sense of shared values in terms of political priorities

- Individuals with a long-standing commitment to the cooperation
- An increasing number of people with relevant skills

All of this will not by itself create a successful health system reform, but it increases the probability that investment in capacity building leads to institutional development, and that investment in policy formulation leads to effective implementation of relevant policies. However, the glass is only half-full.

While there has been significant improvements in individual competence, through VSHC, there is still a lot to do to improve institutional efficiency. There is obviously a need to continue the work towards reducing the overhead costs of the progamme, much of which is related to the lack of trust on the part of Sida in the Ministry's own monitoring and financial control procedures, and its is upon the Ministry to take measures that will improve the level of confidence on the part of Sida, and pave the way for more partnership and less control.

While VSHC has contributed to an impressive number of policy-relevant studies, and the enactment of concrete policies, there is still a long way before this policy work has made a real impact in the field. There is a need to shift the focus towards operationalisation of policies. How to implement the new policies? Much of this will have to deal with the future role of provinces and districts, and the role of the private sector, as health system actors independent of the Ministry of Health. Supporting the implementation of new health polices will require new institutional frameworks for aid cooperation, and only the future can tell whether the reform process will take Swedish DAH also in those directions.

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