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Issue Paper

Ideas work better than money in generating reform – but how?

Assessing the efficiency of Swedish development assistance in health to Vietnam

prepared by
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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 improvement in health status and even a worsening of health conditions in many developing countries. And secondly, following from this, that increased financial allocations to the health sector will effectively 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 will contribute to broadening the understanding of the effectiveness of DAH by looking at the experience of 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 happens most effectively. Swedish DAH to Vietnam demonstrates the importance of fostering institutional learning – on both sides – and the many difficulties in the way 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 intricate 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 ground for expansion. Man's ability to combat, constrain and adapt to these changes varies enormously, at both an individual and a societal level. This relates to problems of poverty as well as to 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. Another correlation, between equality and good health, appears to be stronger. 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, firstly, on its ability to improve health for all. To achieve this, the report argues, two particular factors have to be added to the model: the system has to be *responsive* to people's expectations of how they should be treated as human beings; and its *financing must be 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 in the latter part of the 1980s turned out to have fundamental impacts on the functioning of the health system, much of which were unintended. This posed major challenges to health policy and the 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 development assistance in health (DAH) is part of this effort. Recent trends in Vietnam's health situation include:

- Growing inequalities in access to health services.

[1] World Health Organization. *The World Health Report 2000 – Health Systems: Improving performance*. Geneva, 2000

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

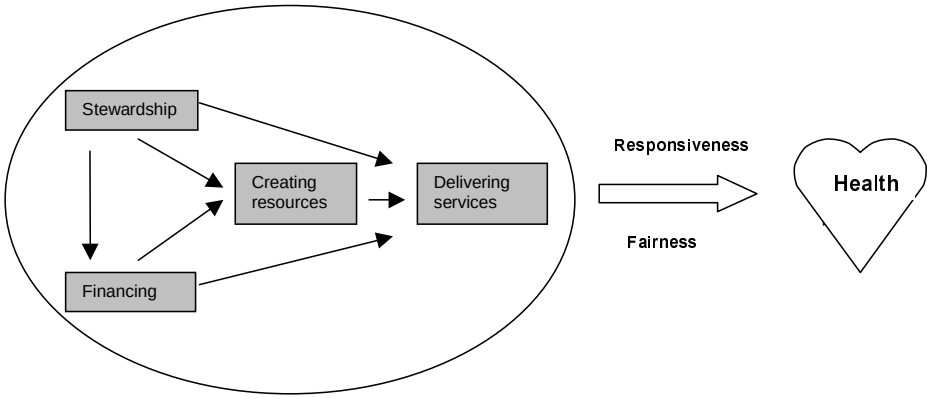

Figure 1: Factors in a well-functioning health system (WHO)

These trends represent challenges to policy that touch on basic political questions and 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 an end.[2]

Can aid effectively assist Vietnam in 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

[2] Socialist Republic of Vietnam, *Strategic Orientation for People's Health Care and Protection in the Period of 1996–2000*, Ministry of Health, Hanoi, 1996

concluded.[3] And the dilemma for donors 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 it is worth noting that for four 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 of the 1990 level by 2015), maternal mortality (IDT: to be reduced by three-quarters of 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 a quarter in the HIV infection rate among 15 to 24-year-olds by 2005).

Generally, where the gaps to cover in terms of health indicators are the widest, the problems of institutional capacity, policy environment and governance system are at the same time the greatest. This represents the classical need-ability dilemma in development aid. When translating the findings of the *Assessing Aid* study into concrete recommendations to donors, for instance in a recent report on Norwegian aid, Collier and Dollar take the position that a country's policy performance should be the major factor in decisions on aid disbursement. The highest priority would be given to good performers with the highest rates of poverty. Aid should not be allocated on the basis of need alone, or of the donor's own strategic interests, which seems to have been the dominant pattern so far.[4] The corollary to this argument is that a process of reforming the health sector has to be firmly established before large amounts of DAH will make an impact on the health status of a county's population.

The position of Collier and Dollar understandably provokes reactions from those who give primacy to the humanitarian rationale for aid, and promote rights-based approaches to development such as in access to health services. The recent global health initiatives (e.g. Roll Back Malaria, Stop TB and Global Alliance on Vaccines and Immunisation – GAVI) seem to be driven by such concerns, largely downplaying the issue of aid effectiveness.

If the aid and reform argument holds true, the basic question is whether donors just have to wait until national reform processes reaches the required state of maturity, or whether there is anything aid can do to stimulate such processes of reform? The findings of the *Assessing Aid* study has been further corroborated by a recently published study on *Aid and Reform in Africa:*[5]

> 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)

[3] World Bank. *What Works, What Doesn't, and Why.* Oxford University Press, 1998

[4] Collier, Paul and David Dollar. *An Assessment of the Effects of Norwegian Development Assistance on Poverty Reduction and Conflict Prevention.* Development Research Group, World Bank, Washington DC, March 2001

[5] Devarajan, Shantayanan, David R. Dollar and Torgny Holmgren (eds.). *Aid and Reform in Africa – Lessons from Ten Case Studies.* World Bank, Washington DC, 2001

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 a more nuanced picture based on the analysis of concrete national political processes. It 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:

> The lessons from the Ghana and Uganda cases [classified as successful reformers according to the study, our comment] 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 conditional loans reflects a growing belief that their effectiveness was limited.[6] 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 over 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, accepting that policies, to be effective, have to grow from national political processes. In that case, what can we learn from aid in countries with successful reforms? Vietnam is one such country, according to the World Bank, referring to its macroeconomic policies in particular. Vietnam's reform evolved from domestic pressures, but aid in the pre-reform period, in the form of technical assistance and policy dialogue, was helpful in shaping the reform. In the health sector, Sweden has been the main donor contributing to 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 the World Bank, two lessons stand out: (a) that aid assisted the learn-

[6] Nelson, Joan M. 'Promoting Policy Reform: The Twilight of Conditionality?, *World Development*, Vol. 24, No. 9, pp. 1551–1559, 1996

ing both from other countries and from their 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 in a new drive for raising the levels of DAH we 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 has 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 has to be able to respond quickly when the direction is observed.
- The donor has to adjust for the movement of the target.
- The donor has to use broad interventions (like shotgun ammunition) to increase the probability of hitting.

And to complicate further this act of shooting, 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 as a surprise to nobody that the chances of missing the target remain 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 is

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

normally 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 when 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 in 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 realistically to 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. 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 Planning Document of 1994 does recognise the problem of measuring effectiveness in relation to this objective:[7]

> (I)t will be intrinsically impossible to identify with any precision the extent to which objectives are achieved *as a result of* (original emphasis) the support and the extent to which objectives are achieved as a result of other factors such as the Ministry's own inputs.
>
> The indicators given for each Support Area … should be seen as general sets of possible search areas for the further elaboration of indicators (in the form of outcomes of activities) in the Plans of Operation.

When the planners entered these reservations and lack of specificity in a document supposedly formulated on the basis of Sida's new manual for result-oriented planning, it reflected many years' experience of working in Vietnam, and a

[7] Ministry of Health. 'Planning Document for the Vietnam-Sweden Health Co-operation 1994–1999'. Hanoi, 24 September 1994, p.12

history where the approaches and the underlying assumptions about the role of aid had changed considerably. It had been a history where Swedish aid consistently had been faced with the criticism of missing the target, while at the same time it was part of important processes of learning which influenced the pace and content of reform in Vietnam. Do we see this as effectiveness or failure?

Swedish DAH to Vietnam has been significant in financial terms, but never a dominant element of either Swedish aid to the country (never exceeding 15%) or total aid to the Ministry of Health. Sweden disbursed a total of 1.1 billion SEK (approx. 140 million USD) to Vietnam's health sector between 1974 and 1999: over 1974–1993, 926 million SEK, and over 1994–1999, 189 million SEK.

It is difficult to assess the relative importance of this assistance in financial terms, for two main reasons. The Vietnamese *dong* was not a convertible currency for the main part of this period, and depending on the exchange rate used (official or some estimated shadow rate) one will arrive at different levels of importance. Besides, the official statistics on total health expenditure and the public health budget are not fully reliable or available. From 1991 there is, however, a consistent time series of public spending on health. This indicates an impressive 20% annual rate of growth during the 1990s. The growth in development assistance in health has been less, but again reliable figures on total aid disbursements are not available.

In 1990 it was estimated that foreign aid constituted about 25% of the health budget, with Sida and UN agencies (UNICEF, WHO, UNFPA and FAO) as the main contributors. In 1998, the figure was 18%. The Ministry of Health has issued a compilation of projects in the health sector up to the end of 1998 that were supported by multilateral and bilateral agencies (excluding NGOs).[8] This shows that Sweden only ranked 9th in terms of commitments, and 6th in terms of disbursement. The World Bank had become a major player, with commitments six times that of Sweden (with Japan as number two), but struggling with serious disbursement problems. The disbursement of the World Bank was only slightly above that of Sweden. Although, Sweden is no longer a dominant donor to the health sector in financial terms, the nature of the aid relationship is still unique.

This relationship can partly be illustrated by disbursement figures for VSHC during 1994–99. They reflect two important features of the cooperation – flexibility and capacity building. Firstly, we see that much did not move as initially planned within the various areas of support. This could have led to a stalemate and protracted renegotiations, as has been the case in other aid relationships, but there was enough trust and established goodwill to allow for flexibility – on both sides. Secondly, there was a gradual change in the relative portion of investments in people versus investments in kind, at the expense of the latter, compared with the original agreement. This can be seen, for instance, in the reduced support to "disadvantaged areas", which initially included large amounts of medical supplies, and the increase in support to "drug policy and control", which was more focused on policy work. This shift towards a much more demanding form of aid, in management terms, would not have been possible without a gradual broadening of the partnership at the working level.

[8] Ministry of Health, 'Compendium of on-going projects in the health sector at end 1998 classified by programme'. Project Coordination Department. Hanoi, 2000

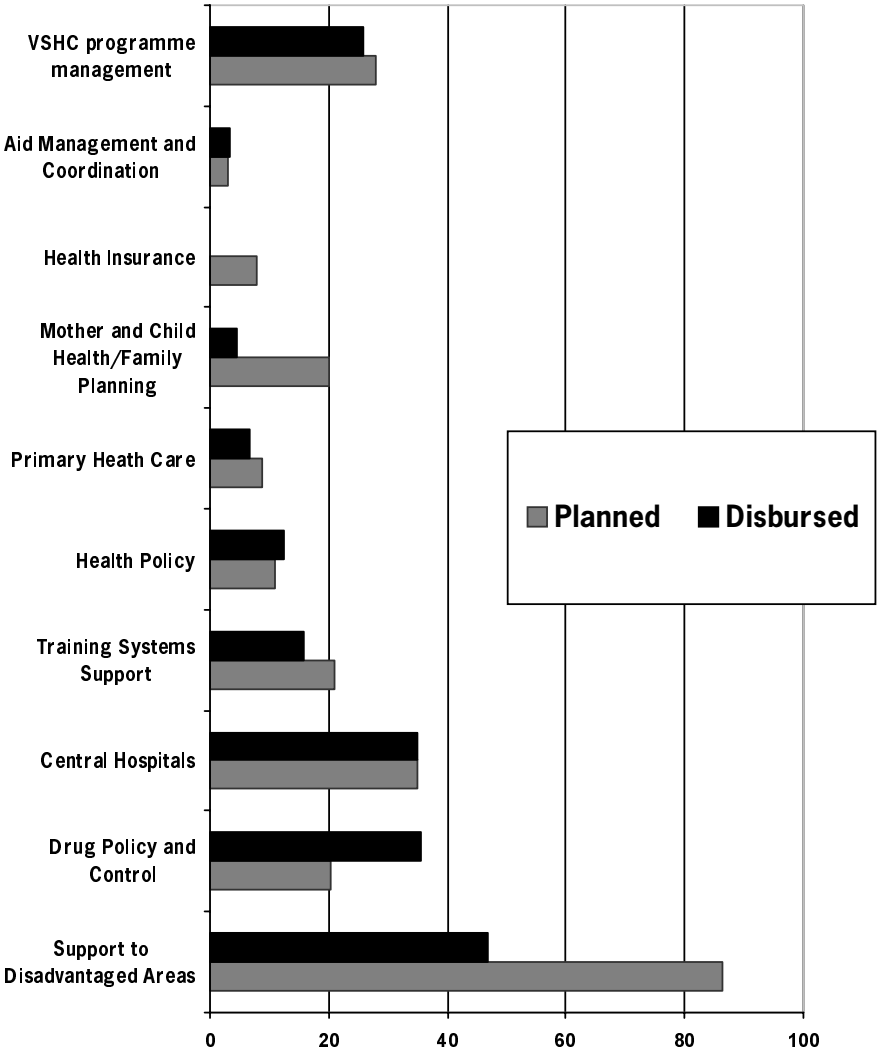

Figure 2: Disbursement of funds under VSHC 1994–1999 – million SEK

That there are limits to rational planning in this type of aid – aid to reform – does not mean that planning in general is a waste of time. But it is an argument for a different kind of planning – iterative planning. Rather than trying to project investments for extended periods of time, following a means-end logic, planners should focus on building mechanisms for responsiveness based on learning by doing. This implies that most of the planning becomes an integral part of implementation, rather than a distinct pre-project activity. Massive investment in project preparation, typical for instance of many donor sector programmes and loans, appears to be more attractive to donors and their partners than the alternative, but seems not to pay off in terms of effectiveness. The alternative requires a working relationship based on trust, continuity in staff, insights and continuous dialogue. It implies the donor becoming much more a party to the day-to-day implementation, and the learning from it, and for the recipient being willing and able to engage in a process of mutual learning.

In the following section we will look at the main trends and events shaping the historical development of VSHC, bringing it bit by bit closer to a mode of cooperation that effectively stimulates policy reform. In the third section we will look at some of the concrete approaches within the aid programme in more detail.

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, and even less so foreign 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 expectations along the road. 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 development 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 will see that through the three phases VSHC has 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

During the 1970s Vietnam 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 to establish political relations with the Democratic Republic of Vietnam (DRV), or North Vietnam. In Sweden, popular sentiment 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 for 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 a developing country 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 motivation.

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 opted for forest industry technology, a sector where Sweden was world-leading, in the form of a modern paper and pulp mill. The "aid argument" was that Vietnam needed paper for schoolbooks. Based largely on humanitarian arguments, and the fact that Sweden, through Swedish NGOs, had provided medical supplies and equipment since mid-1960, the health sector was included as well. This latter decision was greatly influenced by the unprecedented public protest in Sweden with the news of the American bombing of the Bach Mai hospital in Hanoi in December 1972. Vietnam, again emphasising technology transfer, suggested the building of a new modern hospital. An agreement was reached in 1974 to construct 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.

There could have been other ways to support the health sector. 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 of Vietnam 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 "health service" still today. Later, the Chinese influence of both medical theory based on Confucianism (the principle of the 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 to community health workers. 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 society also

played its part. The political emphasis on health care and education not only included grassroots approaches, however. It also included advancements in curative medicine and higher education, which was justified by the ideological commitment of the Communist Party to promoting a scientific revolution. This explains why 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 the Soviet Union and Eastern Europe, could improve their skills in modern Western medicine. Sweden's priority was different, namely to support the network of community health centres throughout the country. The Swedish negotiators, however, gave in to 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.[9]

The agreement to install two modern "Swedish" hospitals in war-torn Vietnam was a decision that defied Sida's own planning guidelines at the time, and which definitely would not have survived the rigour of today's logical framework analysis (LFA). 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 on 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 inputs 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 would take until 1999 before Sida – at least for the time being – spent its last *krona* (SEK) in support of the two hospitals. The construction of the hospitals was completed in 1982 and 1983, spending far more time and money than initially envisaged. Thereafter they 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. It added prestige and a fear of the "white elephant" syndrome on both sides in the cooperation.

2.2 The 1980s: system crisis and budding reforms

When the construction workers had eventually completed their job in 1982-83, both parties realised that Vietnam was not in a position to operate the two "Swedish-made" hospitals without further assistance. Sida did not hand over a

[9] The quotation is from a brochure published by the Swedish Embassy in Hanoi, 1999, *Health for all. The Vietnam-Sweden Health Cooperation 1973–1999.* Swedish Embassy, Hanoi, 1999

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

While Vietnam continued keeping the Swedish aid in isolated project environments, the system slowly 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 gradually 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 demise 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 of 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 workers 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.[10] 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, which was eager to help on broad-based institutional development and, with the five-year 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 seeking 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 had been legalised in 1989. This development spurred inequity in health, greatly favouring groups benefiting from the economic growth, leaving the marginalised and the 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 the uncontrolled use of prescription drugs.

The three-year programme agreement of 1990 marked the first shift in development terminology as it was broadened also to include 'policy dialogue'.[11] 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 the Ministry of Health, mainly at central level, involving most of its departments.

The prolongation of the cooperation with the running out of the 1990–1993 agreement period was not without a number of teething problems. Many within

[10] Nguyen Van Tuong et al. 'Changes in the health sector during renovation in Vietnam (1987–1998)'. In Pham Manh Hung et al. (eds.). *Efficient, Equity-Oriented Strategies for Health. International Perspectives – Focus on Vietnam*. Centre for International Mental Health. Melbourne, 2000.

[11] Valdelin, Jan et al. *Doi Moi and Health. Evaluation of the Health Sector Co-operation Programme between Viet Nam and Sweden.* SIDA Evaluation Report 1992/3. Stockholm, 1992

the Ministry of Health were 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.[12] Sida drafted the text almost exclusively, and the Planning Document completed about the same time was the product of a substantial involvement of Swedish consultants. The ownership by Ministry of Health of the main content could be seriously questioned. In 1994 the majority of the Ministry's departmental heads and managers seemed still to hold the view that Swedish aid was primarily a financial resource for helping business as usual. They did not subscribe to Sida's idea of using 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.

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 acquiescence of the Government, in the late 1980s, in allowing 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 (CMO). It took until 1999 before the consultants became an integral part of the CMO set-up.

Though at the higher level a consensus had emerged that Swedish support needed also to include 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

[12] Socialist Republic of Vietnam. '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. Hanoi, 1994

cases is also the head of the department, was nevertheless an important step towards better integration of Swedish aid into 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 of five provinces in the North – the home of several ethnic minorities.
- Training systems support through the Department of Science and Training.
- Mother and child health and family planning (MCH/FP), by supporting the department of the same name.
- Phasing out the support to the two hospital projects, 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 plan and the expectations of Sida. Two areas were closed prematurely – i.e. primary health care and MCH/FP. In the case of health insurance – an issue that had been pushed by Sida – the time for moving ahead, apparently, 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 towards becoming 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 the Ministry was not capable of presenting plans of the standard wanted by Sida. To prevent further delays, therefore, short-term consultants were brought in to assist the process.

While Sida on the one 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 after Sida had already 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 to 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:

- 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.

The plans provided limited guidance on practical strategies for how to go about it. From day one of the 1994 agreement, a gradual process of finding and redefining approaches started, 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 the 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.[13] 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:

- 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 to 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.
- Improvements in the professional dialogue and the use of international

[13] Jerve, Alf Morten et al. *Tackling Turmoil of Transition. An evaluation of lessons from the Vietnam-Sweden Health Cooperation 1994 to 2000*. Sida Evaluation 01/03. Department for Democracy and Social Development. Sida. Stockholm, 2001

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 local consultants, training abroad, recruiting staff, and commissioning studies.

In the following we shall look at the effectiveness of some of the main approaches of VSHC during the last six 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 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 mid-1990s contained four basic strategies:

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

3.1 Investing in people: the building of competence

Human resources development has probably been the most important direct outcome of aid globally, creating opportunities and arenas for learning that otherwise would not come. The aggregate effect of all these new individual skills and experiences is impossible to measure, and depends largely on political and institutional conditions over which the aid has little influence. VSHC is no exception, but it is evident that at a critical juncture in the political reform process of Vietnam Swedish aid offered a unique window of opportunity for learning, namely to countries outside the socialist block. It is in the area of individual competence development where the impacts of Swedish aid can most clearly be observed. This is widely recognised.

Different forms of competence building have taken place within VSHC. We can distinguish between (a) training abroad, (b) formal training in Vietnam and (c) on-the-job training involving long-term consultants.

Competence is not only a question of formal skills. Of major importance in the context of VSHC has been the *international exposure* it 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 towards facilitating contacts with countries such as Japan, China, Thailand, Philippines and Malaysia was a valuable contribution.

The *training abroad* activities of VSHC (since 1994) were evaluated in 1999.[14] The programme spent 6.3 million SEK (70% of planned) on study trips, participation in conferences and attending formal training courses. Formal training consumed less, only 30% of the costs. In total, 342 health sector staff benefited from these activities, of whom as many as 241 participated in management re-

[14] Ministry of Health. 'Assessment on the implementation of training abroad activities within the Vietnam-Sweden Health Cooperation 1994–1999'. Hanoi

lated training. The value of the many short visits abroad in terms of acquiring new skills has been questioned, but it undoubtedly contributed greatly to the capacity of the Ministry for making use of foreign consultants, dealing with donors and harmonising its own policy and planning "vocabulary" to that of the international community.

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 direct dialogue with foreign advisers and aid representatives without an 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*.[15] 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 reported effect of the many expatriates 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, about 25–30 annually, has been 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 has been to move more of the responsibility for identifying the needs for consultants and the screening of candidates to the Ministry, which includes paying the costs for giving the Ministry the opportunity to interview alternative candidates.

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 sister institutions are therefore a step in the right direction.

[15] Jerve, Alf Morten et al. *A Leap of Faith. A story of Swedish aid and paper production in Vietnam – the Bai Bang project, 1969–1996.* Sida Evaluation Report 99/4. Sida, Stockholm, 1999

3.2 Investing in organisations: building a capacity for change

The impacts in terms of organisational development are less obvious. Clearly, one cannot assume that investment in individuals automatically leads 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.[16] At a minimum, this would require (a) that the organisation improves its ability to learn by sharing experiences and coordinating activities between different levels and sections of the system, (b) that its management becomes performance based, and (c) that its ability to involve customers and clients in its planning improves.

As mentioned above, the scope of VSHC 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 culture of learning in the Ministry of Health, and has contributed to an enhanced capacity to carry out policy experiments.

At the level of strategic policy, 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 in the system very difficult. Several studies have pointed to the problems of coordination, both horizontal (i.e., the relations between central, province and district) and vertical (i.e., the relations between different national programmes – such as EPI, malaria control, and family planning). Institutional rivalry and turf battles have been commonplace. This has rendered aid coordination difficult, and the influx of aid often has had the opposite effect, of reinforcing institutional barriers rather than bringing them down.

From the mid-1980s onwards, a dominant feature of primary health care has been different vertically organised national programmes, each focusing on a single priority health problem. There were dozens of these, each with its own management set-up headed by a national director. At lower levels these programmes scrambled for scarce managerial and operational staff resources to meet implementation targets. This competition was reinforced when many of these programmes attracted donor finance.

The first PHC project of VSHC, in the Quang Ningh province, contributed to focusing the Ministry's attention on these problems. It took several years before the Provincial Health Bureau came along, and started rationalising the management of vertical programmes at its level. Ten years later, during the second half of the 1990s, the Support to Disadvantaged Areas has developed special training courses on integrated management aiming at district and commune health staff.

Another aspect of learning relates to experimentation. Typically, a lot of aid comes under the label "*pilot projects*". The term denotes a form of designed experiment, but this is not often the case in practice. There may be an element of novelty in the project, but rarely is there a systematic attempt to collect the les-

[16] Andersson, G. and P. Winai. *Diagnosis of Organisations in Development Cooperation*. Report to Sida, Stockholm, 1997

sons learned, and even less to compare the experiences of the many pilot projects – supported by different donors. A pilot project typically is just a convenient term for what is essentially a parallel donor financing of a regular national programme, limited to specific target areas or sections of the organisation. The design and follow-up of public policy experiments remain a weak aspect of the Ministry and VSHC, but there are signs of improvement with better integration of the aid and more staff coming into the organisation with required professional training.

There has been a major emphasis on planning within VSHC. There are two sides to this coin. One the one side, there is the difficult task of reforming the strongly ingrained practice of supply and target driven planning, to one that is sensitive to demands, needs, capacity and actual performance. While Sida has insisted on result reporting, the results that the monitoring systems pick up are generally in terms of deliverables and activities performed. An impressive number of progress reports have been produced within VSHC, and a major self-assessment was undertaken in 1997.[17] Still, it is a general complaint from Sida that it faces difficulties in grasping the effects of the programme. The emphasis on result-based planning has to remain. The other side of the coin, however, is that a donor's demand for frequent and sophisticated progress reports probably is not the most effective way of enhancing the quality of monitoring. Sida has come to realise that the initial requirements it imposed were, in this respect, dysfunctional, and halfway through 1996 the parties agreed to less demanding routines.

Part of the problem is also the *concept of planning* based on Logical Framework Analysis (LFA), imposed by Sida. While this is intuitively the most sensible – i.e. rational – way of matching problems and ends, and ends and means, the experience is that the kind of "change agent" role envisaged for VSHC does not lend itself easily to this kind of programming. Looking at the annual operational plans of VSHC, it appears to be have been difficult for the Ministry to retain a functional link between the formulation of objectives and the identification of activities. Besides, the objectives remain very broad and the situation analysis is often weak. We observe for instance, that there are omissions of a number of very important trends in Vietnamese society – such as urbanisation, modernisation of values, and new trends in health seeking behaviour in 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 at that level normally give good and clear direction for work over 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.

The alternative is to enhance the capacity for what we referred to above as iterative planning, for which critical elements are the quality of information and analysis of what happens in the health system with different kinds of interventions, and the flexibility of the planners and decision-makers in responding to this. A very important feature of VSHC has been the surprisingly high degree

[17] Ministry of Health. Result Analysis Report on Vietnam-Sweden Health Co-operation 10/1994 – 6/1997. Hanoi, September 1997

of flexibility and consideration existing in the cooperation underneath the rigidity of the formal structure of planning and reporting. It can be argued that one of the most outstanding features of VSHC since the beginning was that it in fact continued. There have been no want of justifications for discontinuation over the years.

The conditions for iterative planning are improving, and one testimony to this, at the central level, is the Health Policy Unit (HPU) – 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".[18] Over the period, the capacity for studying and synthesising has steadily improved, but more importantly the Unit has evolved as a dynamic initiator of policy debates. It is important that Sida, as the main financer of HPU's work, continues to accept the evolving nature and unpredictability of these political processes, allowing HPU to play a flexible and proactive role.

One of the main constraints in the building of HPU as an institution has been *insufficient manpower* – particularly of senior staff. 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 of its own "graduates". Aid money can fill in part of the incentive gap created by low government salaries, but Government has understandably been reluctant to allow project-based recruitment in the ministries using aid money. In 1995, however, the Ministry of Health was allowed to start contract recruitment of local staff to VSHC. This was an important step towards gradually modernising the manpower policies of the Ministry.

Another issue raised with respect to HPU is that of 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. It must be accepted that a fair share of HPU's work may end up having little impact.

Where demands on HPU can rightfully be placed is in assuring the *quality of the research* input. It remains a concern that too many studies are being commissioned "in-house". One factor causing this has been the tendency that the commissioning of research and consultancy work has become an important source of personal income for high level civil servants. There is a need for the Ministry to make increased use of independent sources of reporting and research. The verification of information provided by the health system remains a weak point.

Studies will support efficient policy making better if they reflect independent and professional opinions more clearly than now. Donors often use this, besides quality, as a justification for relying primarily on foreign consultants. There has been a positive trend within VSHC for relying less on Swedish and other foreign consultants. A number of factors have contributed to this development, which is not the case with all donors to the health sector. The increased ownership of the

[18] Ministry of Health. Decision 1023/BYT-QD 22/12/1993.

programme within the Ministry has mattered, and so has the recognition of the need to balance demands for quality against the need to build national capacity. It is also a factor that the number of qualified local consultants is increasing, and that Sida's capacity for appreciating the relevance of their qualifications in a local context, despite the usual English language problems, has improved.

Questions about *institutional sustainability* are commonly raised when organisations become too dependent on development aid – short-term and insecure as this type of financing often is. Because, by contrast, Swedish DAH to Vietnam has been exceptionally predictable and stable, it is worrying that HPU remains an outfit primarily for making use of Sida funds given the fact that the Unit represents today the core of policy competence within the Department of Planning. Sida is 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 for the sustainability of the HPU investments whether Ministry of Health gradually makes use of this capacity in all overall policy work, irrespective of source of funding. In fact, in a recent EU proposal there is provision for another "policy unit", which is still being considered, and it remains to be seen whether World Bank funded policy work will be managed by the "Swedish" HPU or some parallel outfit.

3.3 Investing in policy-making: making policies more relevant

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 the provision of health services, and the important ethical question about access to health services. This is against the background of a dramatic drop in the utilisation of public health facilities, especially at primary level, and growing disparities in access to quality services. Despite its ambitious objectives, listed in section 2 above, there is little VSHC can do to influence these trends directly. Where the programme can play, and has played, a role is in helping the Ministry of Health and Government to develop its own position. The relevance of VSHC in terms of policy-making includes not only identification of the "right" policies, in more technical terms, but equally importantly stimulating a debate on what is "right", in political terms. The latter was never expressed in planning documents, but is an important indirect effect of Swedish DAH to Vietnam.

Vietnam has been going through a decade of economic liberalisation and a general "privatisation" of economic and social life. The World Bank in 1999 estimated that as much as 81% of health care financing is private, which is very high compared to most other countries.[19] It is of significance, therefore, that it remains a political priority of the government to ensure that basic care can be guaranteed also for the poor. Although government has been able to raise public investment in health as a share of the national budget, "we are still confused on how to finance this", as Pham Manh Hung, Vice Minister of Health commented 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".* It is evident that the

[19] World Bank. 'Vietnam Health Sector Review'. Draft. Hanoi, November 1999

* Interview, October 10, 2000.

work of the Health Policy Unit has nurtured a policy shift in government from a user fee focus towards a gradual development of rural health insurance.

The statement of Pham Manh Hung must be interpreted in the light of the Ministry's recent skirmishes with the World Bank over the preparation of the Bank's Health Sector Review for Vietnam. Part of the World Bank's conceptualisation of a "sector review" is that it should be regarded as a government document, which in many cases is negated by the very process of writing such reviews usually with a heavy input of World Bank related consultants. The Ministry of Health took issue with the process of preparing the Vietnam Health Sector Review, and refused to accept the policy recommendations formulated essentially by foreign consultants. This was partly an 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 by footing most of the bill. Ironically, Sida was a major sponsor of the World Bank exercise through other channels. Maybe this is an example of the flexibility needed when aiding reform.

Evidently, the work of the Health Policy Unit and the general emphasise of VSHC on equity concerns have been an important factor revitalising, so to say, the old egalitarian ideology. 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 several contributions from the Ministry of Health.[20] 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".

From the start the Health Policy Unit was instrumental in developing strategies for arresting further deterioration in the public health care system. One important step was the decision by government in 1994 to provide a nominal salary to Village Health Workers from central government's budget. This prevented a total collapse of the network of commune health stations.

It is characteristic that these kinds of "horizontal" initiatives dealing with the general direction of health system development came in late in the cooperation, indicating that it has taken time for the Ministry "to open up". As maintained above, the 1994 agreement made policy development a core task, but ownership of this approach was not widely shared in the Ministry. Most of the various department heads still regarded aid as a source for beefing up meagre budgets, and not as an instrument for policy change. Six years later this attitude has changed, not because VSHC changed it, but VSHC made some important contributions.

The relevance of VSHC is also evident in more vertical policy areas dealing with specific diseases or causes of health problems. Some examples are initiatives relat-

[20] Pham Manh Hung et al. (eds.). *Efficient, Equity-Oriented Strategies for Health. International Perspectives – Focus on Vietnam.* Centre for International Mental Health. Melbourne, 2000.

ed to new health problems in the wake of development, such as studies on accident and injury prevention, and studies leading to the formulation of a 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.

3.4 Investing in partnership: how to deal with the issue of ownership

The concept of "national" ownership of development assistance is problematic, not least in the context of reform. One cannot assume that a recipient government represents a monolithic system, let alone a nation as a whole. There are different and competing interest groups, and this dynamic will often be the dynamo driving a reform process. To assume that broad consensus exists or can be achieved is naïve. Thus, a critical decision for a donor seeking to stimulate reform is the identification of the right strategic partners, which may be ministries, local governments, non-governmental organisations or individuals for that matter. This is a difficult assessment that requires insight in national conditions.

Partnership, as distinct from a mere negotiated contractual arrangement for aid, defines a relationship of mutual learning shaping the cooperation. This need not be an equal relationship, and in the case of aid never is. It works only if the partners have a mutual understanding of their different powers and interests. The experience of Swedish DAH working with the Ministry of Health as the official partner illustrates two important points on partnership. Firstly, it has taken a very long time to build partnerships, and progress has been highly uneven depending on how different leaders and units responded to opportunities for cooperation. Secondly, rather than by attempting to prescribe the direction and content of policy and institutional reforms, the effectiveness of VSHC is linked to long-term and largely unconditional support to key partners – in terms of individual training and organisational development. One of Sida's most important decisions, therefore, has been when to discontinue support because a process of building partnership does not take off. The decision by Sida in 1996 to terminate several areas of the cooperation was a legitimate move that sent appropriate signals to the partners.

There is a delicate balance between partnership in aid and aid dependency. In this perspective aid management is critical, since heavy doses of free-floating aid may do more harm than good. The attempts at better integration of VSHC into the regular work of the Ministry have exposed many of the weaknesses of the system in terms of personal incentives, personnel management and financial management. The response to this, however, ought not to be a reversion to aid enclaves and project islands, but to continue pushing for institutional reforms. The process of rebuilding peoples' confidence in the public health system is intimately linked to the general challenge of the public sector in Vietnam to raise working morale and the level of professional commitment to the system.

The combination of a donor community eager to push big money – Vietnam is currently high on the list among development partners – and a recipient system where "private enterprising" in the public sector becomes a dominating force has been damaging to many countries. "Private enterprising" refers not only to ways of securing personal benefits by corrupt means, but also the tendency of allowing leaders of units of the system to develop donor relationships in the absence of overall coordination. As seen from the health sector, Vietnam appears to be at a crossroads in terms of aid management.

There is no doubt that rapid growth of donor funding has created major problems for the health sector with respect to overlapping and competing activities, inefficiency and misuse of funds, and inconsistencies in strategies and policies. The donors have their share of responsibility for this, and for finding ways of reducing the problems, but the willingness and capacity of the Ministry to deal with the issue seem to be a more critical issue. It is necessary to ask whose interests improved coordination of aid is supposed to serve. We can differentiate between four different agendas:

- Coordination of *overall policies*. The concept of a sector-wide approach (SWAP), as promoted by some key donors, e.g. the World Bank, is based on the assumption that it is both possible and desirable to aim at a process of consensus building between the Government of Vietnam and all major donors to the sector. The Government appears reluctant to take on board this concept as a matter of sovereignty in policy making. A recent study on the feasibility of SWAP in the health sector reported: "It was made abundantly clear that all policies and plans are the responsibility of the Vietnamese government, not the donors".[21]

- Coordination at the level of *project planning*, including the monitoring of *financial flows*. This necessitates an effective information system, including record keeping on plans, budgets and expenditures. In order to ensure coordination, not merely data collection, some unit in the system needs to be empowered to intervene, if necessary, in fairly detailed processes of activity planning and disbursement of funds between donors and sections of the Ministry. There is, however, widespread resistance within the Ministry towards centralising such powers.

- Coordination of *lessons* and model development coming out of the many donor projects. This implies that the Ministry establishes capacity to compile, analyse and disseminate lessons from the "living laboratories" of donor projects. The Health Policy Unit may perform such a role, but there seems to be no one in the Ministry pushing the issue of making the unit less "Swedish".

- Coordination of *procedures* for managing externally assisted activities. It is only on this agenda that some progress in terms of aid coordination has been made, through the creation of a Project Coordination Department in 1998 with assistance from VSHC. But the work of the Department is still in the preparatory stage, and it is highly uncertain whether other donors will accept procedures that deviate from their current practices.

Vietnam has a strong political tradition of independence in policy making, resisting what is perceived as imposition by outsiders. Sida's flexibility in adjusting to Vietnam's shifting polices has been important in fostering a sense of partnership in health sector reform. There is an imminent danger, however, that the current aid boom may weaken the Vietnam-Sweden partnership, as many donors now attempt to trade aid money for policy influence. Vietnam is in the driver's seat, but how it will drive remains to be seen.

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[21] Community Health Training and Consulting Network. *A sector-wide approach to health care support in Vietnam?* Report submitted to the embassies of the Netherlands and Sweden. Hanoi Medical University, Hanoi, 2000, p.12

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

In this paper we have emphasised that 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 the 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 Vietnam's Ministry of Health, represent monolithic agencies. Taking the risks of investing in reform, and succeeding, requires 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 will lead to institutional changes, and that investment in policy formulation will lead to effective implementation of relevant policies. However, the glass is only half-full.

While there has been significant improvement 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 programme, 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. It is up to 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 to go before this policy work makes a real impact in the field. There is a need to shift the focus towards the operationalisation of policy. How to implement the new policies? Much of this will have to deal with the future role of provinces, districts and 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 also take Swedish DAH in those directions.

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