Social Science & Medicine 96 (2013) 232–240

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

The promises and perils of hospital autonomy☆ Reform by decree in Viet Nam

Jonathan D. London

Department of Asian and International Studies, City University of Hong Kong, Tat Chee Avenue, Kowloon, Hong Kong Special Administrative Region

ARTICLE INFO

Article history:
Available online 30 July 2013

Keywords:
Viet Nam
Health Sector
Hospitals
Decentralization
Governance
Health policy

ABSTRACT

This article investigates impacts of hospital autonomization in Viet Nam employing a "decision-space" framework that examines how hospitals have used their increased discretion and to what effect. Analysis suggests autonomization is associated with increased revenue, increasing staff pay, and greater investment in infrastructure and equipment. But autonomization is also associated with more costly and intensive treatment methods of uncertain contribution to the Vietnamese government's stated goal of quality healthcare for all. Impacts of autonomization in district hospitals are less striking. Despite certain limitations, the analysis generates key insights into early stages of hospital autonomization in Viet Nam.

Introduction

In recent years governments around the world have adopted hospital autonomization measures as part of broader health system reforms. Prospective benefits of autonomization include enhanced efficiency, improved responsiveness to local needs, and better health outcomes. Prospective risks include reduced efficiency, the marginalization of public interests, and deleterious health outcomes. There is, however, no consensus as to autonomization's merits or demerits, despite an increasing volume of research on the subject. Nor is consensus likely. Hospital autonomization is complex and its effects are difficult to measure, while evidence marshaled for or against it is typically too mixed to permit generalization. Furthermore, autonomization is deeply politicized and its analysis is clouded by normative assumptions about states and markets in the creation and allocation of health services. As such, inquiry is perhaps best directed to probing autonomization's impacts in specific settings.

This article probes the impacts of autonomization in Viet Nam on hospitals' discretionary powers and with respect to various functional and performance outcomes. The analysis draws on the first substantial empirical investigation of hospital autonomization in Viet Nam, in which the present author was a co-investigator. It finds that autonomization is transforming hospitals' management and financial functions, though in highly varied ways and with uncertain implications for the quality and accessibility of care. The analysis questions the merits of autonomization as it is being practiced in Viet Nam, where health sector governance remains weak.

Hospital autonomization

Hospital autonomization increases public hospitals' managerial autonomy while retaining public ownership and government structures of accountability. As such, it entails a shift from centralized management to the formation of quasi-independent service-delivery organizations. A major impetus for undertaking autonomization has been the desire to overcome perceived inefficiencies of centrally-managed, budget-financed hospital systems in a way that stops short of privatization and protects the social missions of public health (Preker & Harding, 2003). Often, hospital autonomization has occurred within the context of broader decentralizing reforms, introduced for reasons varying from efficiency to politically expediency (Lieberman, Capuno, & Van Minh, 2005). In developing countries, the World Bank has promoted decentralization and autonomization through advocacy, finance, technical assistance.

The volume of policy and scholarly analysis of hospital autonomization has increased in recent years, evidenced by the appearance of three edited volumes (Govindaraj & Chawla, 1996; Preker & Harding, 2003; Saltman, Durán, & Dubois, 2011) and numerous

E-mail address: jdlondon@cityu.edu.hk.

0277-9536/$ – see front matter © 2013 The Author. Published by Elsevier Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.socscimed.2013.07.009

articles focused on the experiences of specific countries including, in Asia, China (e.g. Hipgrave, Sufang, & Brixi, 2012; Yip, Hsiao, Meng, Chen, & Sun, 2010), India (Sharma & Hotchkiss, 2001), Thailand (Hawkins, Srisasalux, & Osornprasop, 2011) and, Viet Nam (Wagstaff & Bales, 2012). As these studies show, the nature, scope, and outcomes of hospital autonomization have varied considerably across countries. While credited with improvements in service quality and efficiency gains in such areas as inventory management, autonomization has also been linked to deteriorations in the quality of care and increases in the cost of care (Bossert & Beauvais, 2001; Bossert, Kosen, Harsono, & Gani, 1996; Gao, Tang, Tolhurst, & Rao, 2001, Segall, 2003). By contrast, Wagstaff and Bales contend that "there "is no hard evidence" that autonomization promotes efficiency; nor is there any "hard evidence" that autonomization damages equity and financial protection (Wagstaff & Bales, 2012, p. 3)." The difficulties in evaluating impacts of autonomization are indeed manifold. Clear evaluation strategies are typically absent, foreclosing cross-case comparison, while baseline data are frequently lacking, increasing reliance on simple before and after comparisons (Over & Watanabe, 2003). Finally, research on autonomization is politicized. Notes one analyst, there is "far more argumentation in favor of the merits of privatization and corporatization than scientific evaluation of their benefits (Braithwaite, Travaglia, & Corbett, 2011, p. 150)." Perhaps the only generalizable conclusion to be drawn is that outcomes of autonomization are profoundly contingent. With this in mind we now turn to the case of Viet Nam.

Hospital autonomization in Viet Nam

With its history of central planning and recent record of rapid market-based economic growth, Viet Nam represents a particularly interesting setting for the analysis of hospital autonomization. Viet Nam's market-transition occasioned profound changes in the principles and institutions governing the country's health system and its public hospitals in particular. Although Viet Nam's market-transition generated acute pressures on the health sector, basic health services were not subject to the kind of malign neglect observed in China (London, 2013; Wang, 2010). While sustained economic growth, increases in health spending, and international aid have contributed to significant if uneven improvements in Viet Nam's health status. In comparison to other countries of comparable income, Viet Nam scores well on such indicators as life expectancy, infant and child mortality, and morbidity.

Yet Viet Nam's health system exhibits numerous deficiencies. These include unevenness in the quality of care, overcrowding, reliance on out-of-pocket payments, breakdowns in the referral chain, and medical corruption (MOH, 2009; Ramesh, 2012). While total health spending has increased markedly, public health expenditure remains low as a proportion of GDP, reflecting a broad shifting of institutional responsibilities for health payments from the state onto households, and contributing to income-based health inequalities. The expansion of state health insurance has introduced a degree of protection. Yet coverage remains limited and access to quality care is highly contingent on household payments (London, 2013).

Viet Nam's public hospitals

As of 2007, 95 percent of Viet Nam's 1119 hospitals were public and all but 48 fell under state ownership (MOH, 2007). Viet Nam's hospitals are diverse, differing "vertically" in scale and function and "horizontally" in the socioeconomic context of their operations and in the qualities of their infrastructure, management, staff, and services. With an average number of beds below 80, Viet Nam's 597 district-level hospitals represent the first level of hospital care and are where the majority of Viet Nam's large rural population seeks treatment. Variation in district hospitals' sophistication and service quality broadly reflects regional socioeconomic disparities. At the secondary level are 324 provincial and municipal hospitals, located mostly in provincial towns and major cities. Ranging from 300 to 500 beds, these hospitals provide services to local and regional populations. Since the 1990s provincial and municipal hospitals have seen fast growth in service utilization and are commonly overcrowded. At the tertiary level are 31 centrally-managed hospitals, mostly located in large cities. Averaging over 500 beds, these are Viet Nam's most technically-sophisticated hospitals. Not surprisingly, central hospitals are preferred over provincial ones, while district hospitals are least preferred, undermining the referral chain.

Until 1989 hospitals in Viet Nam were financed largely through the state budget. Yet by 1989 Viet Nam had entered a fiscal crisis and for much of the 1990s, public spending on health remained at very low levels, while incomes grew. Decrees issued in 1989 and 1995 permitted hospitals to charge fees and retain a share of revenues for general purposes and staff bonuses. The significance of such income varied. In wealthier provinces and in cities, hospitals were able to tap into rising incomes and increased demand for services. Rural areas saw much slower incomes growth, however.

Facing limited budgets, hospitals depended on a patchwork of informal autonomous measures, ranging from provision of private services on hospitals premises to quasi-legal and illicit business schemes to the receipt and solicitation of informal payments. Quasi-legal business ventures took diverse forms. As early as 1996, for example, Da Nang hospital (which is included in this study) formed a joint venture with Saigon Textiles Company, whereby the latter installed medical equipment to be offered on a fees-paying basis. A different sort of venture could be observed at rural district hospitals, where it was not uncommon to observe medical staff selling noodles outside the hospital gates. Hospital autonomy in Viet Nam is thus, not strictly new. And over time, hospitals became increasingly reliant on non-budgetary sources of revenue to maintain their operations. Generally, the improvisational strategies hospitals undertook outpaced policy reforms issued by the center. Until 2012, for example, most hospital fees were fixed to a schedule set in 1994. More often, policies appeared as post-hoc efforts to contain already existing practices.

Autonomization by decree

Autonomization measures in 2002 and 2006, however, represented a significant policy shift. Issued in 2002, Government Decree 10 stipulated all income-generating (public) service-delivery units (SDUs) be classified as fully or partially financially-autonomous entities, according to their relative dependence on budgetary transfers. To reduce strains on the central budget, Decree 10 encouraged SDUs to develop alternative income sources and channel resultant revenues into investment and human resource funds. Depending on their designation, SDUs were permitted degrees of discretion over the management and organization of services and the allocation of income. SDUs would bear independent responsibility for accounting, reporting, audits, and financial transparency requirements. Non-budgetary sources of revenue could include self-generated income, external grants, loans, and gifts.

While Decree 10 promoted autonomization, it tightened regulations governing hospitals' use of revenues by restricting claimancy rights to net revenues (viz. minus recurrent expenditures). It further stipulated that some of these revenues be invested for upgrading facilities and that only a portion of net revenues (albeit