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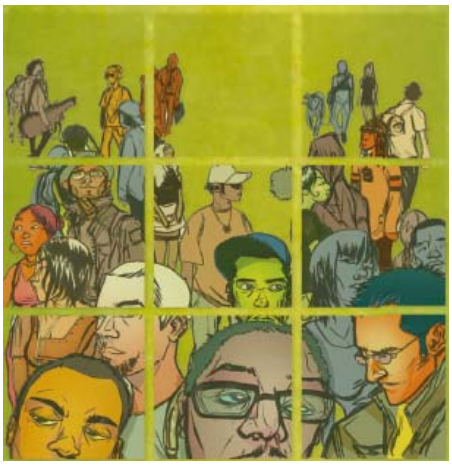

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1. Introduction

This paper analyses the impact of external aid for health on overall financing of the health sector in Viet Nam. Two aid modalities are assessed – general budget support and donor funded health projects – with the key question being whether these aid modalities have led to increased government spending on health.

Viet Nam is one of the bright stars in the constellation of developing countries, having "lifted millions of people out of poverty while ensuring the benefits of its vibrant market economy are fairly evenly distributed across society"[1]. Remarkable gains have also been made in health, with under-five child mortality more than halving between 1990 and 2007 (from 58 to 26 deaths per 1,000 live births) and infant mortality reducing by almost two thirds in the same period (from 44 to 16 deaths per 1,000 live births) [2]. However, there remain significant inequalities in access to health care and health outcomes across Viet Nam, with ethnic minority groups particularly disadvantaged [3]. Further, Vietnam has very high-levels of out-of-pocket spending in health (though this has decreased in recent years, from 67% of total health expenditure in 2005 to 56% in 2007).

Donors have rewarded Vietnam's overall development progress with generous aid programmes. According to the OECD Viet Nam received USD 2 487 million in official development assistance in 2007 making it one of the top ten aid recipients in the world. The country also has a reputation for taking a strong lead in disciplining its donors and pushing for more efficient and effective forms of aid delivery. It was one of the first countries to adopt the Paris Declaration on Aid Effectiveness, which it localised into the "Hanoi Core Statement" in 2005 [4] and has well-developed structures for donor co-ordination and dialogue [5].

2. External aid for health: nature, politics and processes

Donor engagement in Viet Nam is relatively recent as many Western countries only re-established diplomatic relations following *Doi Moi*, the period of economic reform that began in the late 1980s. The first World Bank loan *for health* was provided in 1996: US$ 123 million for infrastructure. Since then aid for health has grown. The growth in health aid has coincided with the government policy of "socialisation" which aims to attract resources from donors, the private sector and individuals to supplement government spending. According to the OECD DAC, disbursements of official aid to Viet Nam in the categories of "health" and "population policy and reproductive health" (which covers HIV) totalled USD $143 million in 2007. It is important to note, however, that these disbursement figures may be significantly higher than what is actually spent in the country, since the DAC definition of disbursement only implies disbursement from the donor's treasury. Indeed, National Health Accounts (NHA) estimated that $56 million of donor support was spent on health in 2007.

According to the DAC figures, 35 per cent of health aid to Viet Nam is in the form of investment projects (infrastructure, etc); 25 per cent is technical cooperation and just 0.8 per cent is recorded as sector programme support – this low level of un-earmarked funding in health is in stark contrast to the high levels of general budget support (see below).

DAC figures also suggest a fairly high degree of fragmentation, with 58% of health aid provided to Viet Nam between 2002 and 2006 in the form of small projects of less than $500,000. Only 5% of the health projects were for amounts equal or above $10 million. This finding is confirmed by a separate OECD study which found that 11 out of 24 health donors in Viet Nam represent less than 10% of total health funding [6], and by a 2008 WHO survey of health donors in Viet Nam, which recorded over 107 separate health projects, of which just 8 (7 per cent) involve some kind of co-financing [7]. One reason for the high number of relatively small projects is that any grant larger than US$ 500 000 must be approved by the Ministry of Planning and Investment, a lengthy and complex process which many "downstream" ministries would prefer to avoid.

Communicable disease control is a major priority for health donors in Viet Nam, in line with global trends. In HIV in particular there is a significant donor presence: the WHO survey found 12 major donors and five UN agencies each running their own HIV projects. Donor funding was equivalent to 80-90% of total HIV spending, a much higher proportion than in other disease programmes and in the sector more broadly [7].

As Viet Nam continues to develop economically and become richer it is likely that many donors will scale back their support to health and to HIV. This has lead to concerns about sustainability, particularly in relation to the provision of anti-retroviral therapies (ART), which are heavily funded by donors, and which will become increasingly costly as patients move on to second and third line regimens. The WHO survey suggests that this is unlikely to be a problem in the medium-term as no HIV donors have immediate plans to pull out, but suggests that there will be significant uncertainty from 2012-on, particularly if the US government moves away from HIV as global priority [7].

Examined from the perspective of the Paris Declaration, then, health aid to Viet Nam has a number of "ineffective" attributes. Data on financial flows are poor, inconsistent and reported irregularly; aid fragmentation is high, with a large number of small projects; there is an over-reliance on project aid with little experience of other aid modalities; and, in certain sub-sectors there is significant donor dependence.

General budget support and its implications for health

The budget support mechanism in Viet Nam is called the *Poverty Reduction Support Credit,* or PRSC. The mechanism is managed by the World Bank, and brings together funds from a number of bilateral donors, as well as revenues from the World Bank itself, into a single pool. Funds are transferred from the World Bank directly to the State Bank of Viet Nam where they are mixed with general government revenues.

PRSC disbursement is linked (though not conditional on) the achievement of a set of policy actions or 'triggers'. Each PRSC contains around 10 triggers and 20 associated benchmarks covering all sectors, which form the focus of a series of *policy dialogue* meetings between donors themselves, and between donors and the government. The triggers are linked to Viet Nam's socio-economic development plan, and in practice tend to focus on specific actions – such as the passing of a new law – which can be easily measured and achieved within the timeframe of the annual PRSC cycle. Though there is no formal relationship between achievement of the triggers and disbursement of funds, it is understood that failure to achieve triggers may lead donors to reconsider their financial contribution to the PRSC. Thus both government and partners take the process of setting triggers extremely seriously.

In Viet Nam the PRSC process began in 2001 (PRSC 1) and by 2009 was up to its eighth round (PRSC 8). In that time the size and balance of disbursements has changed significantly, from USD $177 million in 2002, of which $145 million was provided by the World Bank and

just $32 million by other donors (in 2007 prices), to $334 million in 2007, with the World Bank providing $175 million and partners $159 million.

In health there is typically a single trigger with perhaps one or two associated benchmarks. Negotiations associated with PRSC 9 trigger (in 2008) reveal the limitations of the PRSC as a forum for policy dialogue at sector level. At the beginning of the PRSC9 negotiations, donors proposed a trigger related to the establishment of an independent medical council with disciplinary powers. At the time, establishing a medical council was on the Ministry of Health policy agenda as part of a bundle of reforms associated with the accreditation and licensing of health professionals. By including this trigger in the PRSC, donors hoped to send a strong, positive signal to government encouraging them to pursue this reform direction. However, soon after the trigger was proposed the government shifted its position and backed away from the idea of an independent council, which meant that the trigger flipped from being in line with government policy, to being at odds with it.

Controversy intensified when donors attempted to use the PRSC mechanism to express their opposition to the Government's new policy direction, and force them back on the original reform path. Unsurprisingly, donors failed and the final wording of the trigger – "*adopt national standards and establish a unified licensing system to license health practioners"* – reflected the government's decision to keep control of the licensing system itself. This example illustrates the limitations of the PRSC mechanism as a forum for dialogue. Its principle role is to make sure that existing commitments are honoured; it is not a mechanism through which to pursue reform nor to negotiate difficult issues. Indeed, if partners try to use the PRSC to influence 'real time' policy discussions – as with the health trigger in 2009 – they are likely to fail.

In this connection it is useful to compare health triggers with another non-economic issue: gender. A European Union review [9] found that a total of nine gender triggers and benchmarks were included in Viet Nam's PRSCs between 2000-2008. Of these, only two were met, with others being delayed, reported as 'not implemented' or off track. These failures had no impact on donor funding of the PRSC. Similarly the 2008 health trigger (which focussed classification of private health facilities) was reported as "unmet" but this had no impact on the level of PRSC financing. This point is important because it goes to the heart of the budget support 'contract' – i.e., that donors provide resources directly to government in return for access to and influence over strategic policy discussions [10]. Our analysis suggests that in Viet Nam this 'contract' is not function well, i.e., budget support 'buys' only limited influence and leverage over policy decisions.

3. External aid for health and government health spending[3]

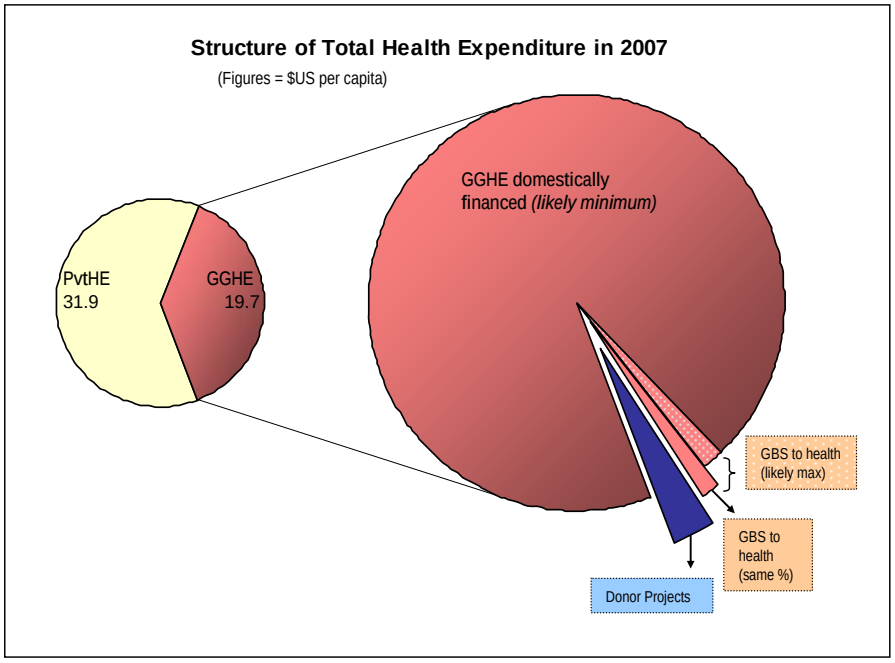
Total health expenditure in Viet Nam was VND 71 trillion in 2007, equivalent to USD $4396 million or $52 per capita. A little more than a third of this ($1677 million) was spent by government. Disaggregating general government health expenditures, $623 million was spent on social health insurance, $997 million through the state budget (excluding health insurance contributions), and $56 million by donor-funded projects[4].

Whilst donor-funded health projects are therefore not insubstantial, they amounted to only 3.4% of general government health expenditure and 1.3% of total health expenditure in 2007. This is considerably lower than the 8%-10% they represented for most years 1995-2005. In addition, some of the funds from general budget support (GBS) may have fed into government health spending. Total assistance through this modality was $334 million, or $3.9 per capita, in 2007 (disbursements).

However as discussed in Section 2, it is not possible to ascertain the precise proportion of GBS funds actually spent on health, since they enter into the government's general revenue stream. In hypothesizing the influence of GBS on government funding for health, at least three scenarios are possible. One could assume the proportion of GBS feeding through to health would mirror the proportion of the government's overall budget allocated to health. In this case, the amount of GBS effectively spent on health would be $25 million in 2007 (with external financing for health then totalling $81 million). If, though, government used GBS funds to increase health spending at a faster rate than for other areas, then the proportion would be higher (in Figure 1, this is shown as a doubling of the proportion of GBS allocated to health, with external financing for health $105 million). Finally, if *none* of GBS was allocated to health, then external financing for health would equal the $56 million from donor-funded projects. Figure 1 frames such estimates of external spending on health within overall government and total health expenditures.

[3] All figures in this section come from the Vietnamese government's National Health Accounts, other than figures for general budget support, which come from the World Bank.
[4] Whilst the majority of donor projects are channelled through the health ministry, some projects – such as support from international NGOs – are not.

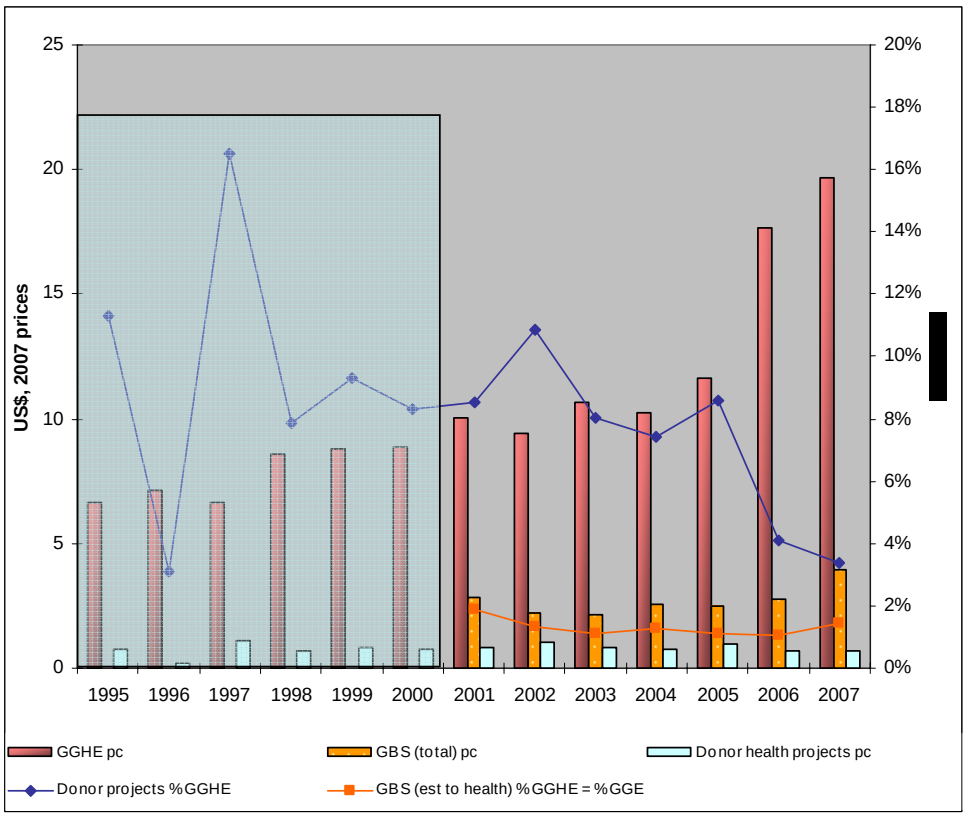
Figure 1 Health spending and the contribution from external sources



Thus although the precise contribution of general budget support to health spending is inherently unknown, figure 1 illustrates that GBS is unlikely to account for a substantive proportion of general government health expenditure in Viet Nam. This is certainly true for its contribution to government finances as a whole, with general budget support equal to 1.5% of general government expenditure in 2007 (and between 1.1% and 1.9% since its introduction in 2001).

Figure 2 compares historical trends in general government health expenditure (GGHE) from all sources, alongside GBS and donor-funded health projects. Donor-funded health projects have in recent years become less significant as compared with the late 1990s (though with some year-to-year volatility within this period). This is both in absolute terms and as a share of government health expenditure. For GBS, there is no obvious indication of a positive or negative influence on GGHE. Government health spending did, though, increase markedly in 2006. Three major policies explain much of this increase: first, investment in the local health care network (Prime Minister Decision 225/2005); second, salary increases for public sector workers (Decrees 204, 205 and 208 in 2004); and third, inclusion of the poor into social health insurance (Decree 63/2005).

Figure 2 Government health expenditure and external aid, 1995-2007



Regression analyses offer further insights into the effective share of GBS allocated to health (although statistical power is limited by small sample sizes). These show the impact of both GBS and donor health projects on government health spending, controlling for other factors. The results of this work are summarised in Table 1.

Table 1 Regression results

Independent variables	*Dependent variable specifications (p-values in brackets)*		
	Model 1a: ln ($GGHE_{excl\ DHP}$)	*Model 1b*: ln ($GGHE_{all\ sources}$)	*Model 2*: ln ($GGE_{all\ sources}$)
ln (GBS)	- 0.002 (*p*=0.381)	- 0.002 (*p*=0.346)	0.001 (*p*=0.048)
ln (Donor health projects)	- 0.186 (*p*=0.088)	- 0.102 (*p*=0.281)	NA
ln (GDP)	1.875 (*p*<0.001)	1.745 (p<0.001)	1.399 (*p*<0.001)
Adjusted R-squared (n = 13 in all models)	0.8736	0.8760	0.9883

Abbreviations: excl DHP = excluding donor health projects, GBS = general budget support, GGHE = general government health expenditure, GGE = general government expenditure.
Note: the *runs test* found no evidence of autocorrelation in any of the regressions (although the *Durbin-Watson test* was inconclusive in all regressions. This, though, probably reflected the small sample size. To further evaluate, *Prais-Winsten adjusted regressions* were run. These produced very similar results to OLS specifications, indicating autocorrelation is unlikely to be a major concern here).

Results show that whilst *GBS* had a slight positive impact on general government expenditure (Model *2*), it had no significant impact on GGHE (Models *1a* and *1b*). This implies that – at best – GBS had no significant influence on the government's allocation choices between sectors (Model *1a*). More worryingly for health policymakers, it could imply that none of GBS flows through to health (Model *1b*).

Regression results also suggest that *donor health projects* are slightly fungible (Model *1a*). That is, a 10% increase in donor health projects is associated with a 1.86% decrease in $GGHE_{dom+gbs}$ (*p*-value = 0.088). Further, although donor health projects by definition increase GGHE in any given year, they had no statistically significant effect on GGHE over the years 1995-2007 as a whole (Model *1b*). This reflects the fact that domestically financed GGHE was considerably higher when donor health projects were lower (1996, 2006 and 2007), and vice versa (1997)[5].

A more important determinant of GGHE is the speed in which Viet Nam's economy grows. Increases in GDP led to greater general government revenues, some of which fed through to increased government health spending.

4. Conclusions

External aid for health has not had a marked positive impact on total or general government health spending, despite Viet Nam being amongst the top ten aid recipients globally [11]. This reflects the country's rapid economic development, with aid therefore representing a small and declining share in health expenditure. It also reflects large increases in government financing for health in recent years, following the expansion of health insurance and investment in the local health care network.

Moreover, simple quantitative analyses of historical trends in health financing suggest that donor health projects have been partially fungible. That is, although they provide additional health financing in any given year, this positive impact is offset by reductions in domestic allocations to government health spending.

[5] Indeed, this is likely to explain the initially surprising negative coefficient for *ln (donor health projects)* in Model *1b* (notwithstanding its statistical insignificance).

General budget support has also had little impact on health spending. GBS donors would likely argue that their relatively small resources have been influential in catalysing and sustaining reform which has in turn facilitated economic growth. This may be so, but qualitative analysis suggests that policy dialogue associated with the GBS mechanism does not priorities social sector issues, such as health, with donors being more focussed on 'big picture' issues such as governance and economic management. This critique is supported by our quantitative analysis, which shows that little (or any) of funding through this modality has flowed through to health.

Our findings have significance for global policy debates on *what constitutes effective aid*. Channelling resources through discrete projects is often assumed to be one way of ensuring additionality, while budget support is often discounted because of the risk of fungibility. In Viet Nam at least, neither aid modality seems to have much impact on overall government health spending, though the limitations of our data suggest that further work is needed.

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