Reorienting Health Ministry Roles in Transition Settings: Capacity and Strategy Gaps

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Abstract

Health authorities in developing countries must often cope with rapid changes in the administrative, policy and socioeconomic contexts in which they work. Changes in this external environment have important implications for the roles that health planners can effectively play and the leverage they exercise throughout the system. This paper examines the challenges associated with reorienting ministry roles from administrative fiat to overall orchestration and strategic steering, using health workforce management in transitional Vietnam as a backdrop. Decentralization, commercialization of services and rising inequalities have reduced the efficacy of the administrative controls and standardized strategy on which Vietnam’s Ministry of Health has traditionally relied. Reorientation, in Vietnam and elsewhere, depends on bridging significant capacity and strategy gaps, notably in the strengthening of information, planning and accountability systems that respect both the limitations of central control and the diversity of local conditions.

Keywords: health systems strategy; capacity; developing countries; health ministry; workforce; Vietnam

1. Introduction

Even in this ‘age of decentralization’ [1], the importance of the policy and supervisory functions played by central level authorities is well established in both the academic and ‘grey’ literature. Classic central functions include providing overall policy guidance, delineating the appropriate scope of public and private actors, promoting equity of access across regions and socioeconomic groups, and setting and enforcing minimum standards of service quality and professional ethics [2, 3].

Yet while the specific forms they take and the pace of change both vary, the health sectors in a broad range of developing countries are experiencing some similar pressures – pressures that are straining the ability of the central health authorities to exercise effective influence. One is public sector decentralization, varying in intensity and scope [4]. Another is the expansion of market forces in the provision of health services and an increasingly differentiated set of commercialized services on offer [5]. A third – both cause and consequence of the first two – is increasing inequalities in health outcomes and access across regions and socioeconomic groups [6]. The first two pressures have shifted the locus of much decision-making both downward (to lower levels of government and to facilities) and outward (to the public and private sectors), while the third has increased the complexity of policy making and service provision.

How well equipped are central authorities to steer the health sector in developing countries? What impact do the changing policy environment and other pressures have on the mechanisms by which health authorities exercise supervision and control? This paper examines one traditional ministerial function which health planners across a range of developing countries find increasingly problematic: management of the health workforce. The case of Vietnam, which has experienced profound institutional changes in its transition to a market economy, highlights both the importance of effective macro-level steering in turbulent
settings and the capacity and strategy gaps that must be bridged for effective reorientation to occur.

2. Workforce management as a pressure point

Several factors make workforce management an important arena in which to assess ministry roles and effectiveness. First, analysts have long pointed to central level capacity shortcomings underlying strategic workforce management [7]. Information systems relating to the workforce tend to be sketchy, and planning is technical rather than strategic in nature, leaving “key questions about the distribution, qualifications, motivation, development, and performance of staff unexplored” [8]. Centralization is often cited as a key problem. In attempting to incentivize and hold accountable personnel dispersed throughout the health system, ministry authorities are often doubly constrained: by one-size-fits-all civil service rules as well as over-reliance on administrative norms and regulations imposed by fiat. Implementation capacity and the appropriateness of centralized rules in diverse facility settings are both neglected in the process.

A second rationale for examining workforce management is that this picture of centralization is changing. Once thought of as almost completely centralized in developing countries, HRM is increasingly a shared function of central ministries, local governments and facilities [9]. While central authorities retain control over the basic wage envelope and the determination of overall staffing numbers, performance evaluation and establishment of incentive schemes often fall to local governments, often as a matter of de facto practice than de jure authority.

Third, decentralization efforts have highlighted new capacity gaps in workforce management. A study of China’s health sector highlights the “difficulties involved in efforts to influence provider behavior through a national level legislative framework in a situation of decentralization of control over those providers, due to extreme regional variation in economic situations and limited resource inputs from the centre” [10]. Some analysts point towards a “tension between the objective of increasing efficiency and local government autonomy, on the one hand, and the quality and equity benefits of a uniform national service cadre with vertical mobility, on the other” [4]. Poorly coordinated decentralization reforms typically initiated from outside the health sector can often coexist with continued reliance on centralized bureaucratic controls within health ministries to result in an overall lack of effective steering or accountability [2].

A key lesson from the literature is that these capacity shortcomings matter. The resulting “fragmentation” of workforce management in many countries can even pose a “threat to worker’s well being” if it negatively affects professionalism, career mobility, expectations of supervision and support, and the timeliness of salary payments [11]. Loss of morale combined with and routine weaknesses in accountability and support systems can accentuate problems of drug overprescription, unofficial payments and poor service quality that often motivated calls for health sector decentralization in the first place [12].

The challenge for health ministries relates both to strategy and instrumentation. Ministries must adjust their strategies and interventions to avoid the twin dangers of bureaucratic standardization (resulting in reduced relevance in local conditions) and micro-management (which is neither effective nor feasible). Where the policy-implementation gap is bridged, it is usually due to the development of “specific guidelines developed by organizations of health professionals or other advisory bodies” for the implementation of health laws and policies “to bridge the gap between legal theory and everyday practice.”[13] The case of Vietnam, to which we now turn, shows why this can be so difficult.

3. Context: Vietnam’s health sector in transition

If institutional context shapes the constraints and opportunities for central health authorities to manage the sector, then Vietnam’s health sector has seen these parameters shift considerably since the advent of ambitious market-oriented reforms in the late 1980s [12]. It has faced three ‘generations’ of reform challenges. The first, attained by the advent of the market reforms, relates to the achievement of excellent public health results relative to levels of socioeconomic development, based largely on the mobilization of paraprofessionals in service of a strongly public health-
oriented sector [14, 15]. Yet the accumulated dysfunctions of the centralized economic system, and the transition to a market economy itself, posed a potentially dire threat to this model. The system of agricultural cooperatives on which health delivery systems had been based collapsed by the late 1980s. For several years, health workers went largely unpaid and either quit the system or resorted to unregulated user fees. Health authorities scrambled to piece together a coherent response to these radical changes in the environment.

In many ways, they were successful in doing so, and the story of how they did so over the 1990s marks the ‘second generation’ of health challenges and reforms. In 1992, a law on private sector involvement in the provision of health services was introduced, attempting for the first time to regulate – and thus legitimate – a private sector in health. By 1996, salaries for health workers at the grassroots had been standardized and centralized. Rapidly expanding public health expenditure was driven by economic growth, an expansion of the share of GDP captured by the government, and increasing official development assistance following the lifting of the US embargo in 1994. It enabled a round of very substantial new investments in infrastructure, medical equipment, and a highly successful expansion of targeted national health programs focusing on endemic diseases [16]. Even though some output indicators such as utilization rates for commune health center services fluctuated or stagnated, most health outcome indicators showed continued improvement – a marked contrast to many transitional health systems [17].

A ‘third generation’ of challenges is now facing health authorities, comprising powerful forces that are acting on the public sector of a number of other developing countries, not only in ‘transition’ settings. One force is decentralization. From one of the most centralized countries in the world on paper at least, formally, a range of reforms have expanded subnational authority since roughly the mid-1990s [19]. The budget share of total public expenditure spent by local governments has increased over the years to 48%; the figure for the health sector hovers around 80% [20]. Provinces have become the pivotal players on the local government scene.

A second major trend is towards the commercialization of services, following the ascent of the market more generally in Vietnam. If Vietnam remains on paper a highly state-centric system in which “there is little scope for the organization of activity independent of the party-led command structures,” [21] in practice authorities have shown a great willingness to expand the reach of market forces in service provision. ‘Socialization’ (as the expanded reach of user fees and private actors in service provision is termed in the Vietnamese political lexicon) coexists with remaining ideological tensions and, more importantly, material conflicts of interests on the part of some ministries stemming from an incomplete agenda of administrative reform [22].

A third element is growing inequalities. Regional, rural-urban and socioeconomic inequalities are all accelerating over the transition period. Aggregate inequalities in income distribution are following the same steep path experienced by China more than a decade earlier [23]. More politically significant are indications that the poverty gap between Vietnam’s minorities (comprising 18% of the population) and the majority Kinh population, and between the highlands and lowlands, are accelerating rather than narrowing over the past seven years [23]. Growing inequalities pose an important capacity challenge for the government. While lauded for its pro-poor policies, the government is struggling to plug gaping coverage gaps for essential services; for instance, less than 10% of those identified by the government as poor received access to certificates, to which they were as a matter of policy entitled, mandating exemptions from all health user fees [24].

Public administration reform (PAR) lies at the heart of the government’s attempt to rationalize and actually harness the centrifugal forces of decentralization and commercialization. It has a number of formal components, including the redefinition of the roles of state and non-state actors in service provision and the restructuring of state machinery to focus on macromanagement and regulatory roles. Civil service reform figures prominently too, including the dual aims of boosting salaries while reducing personnel numbers and providing better training and supervision. Several recent reviews of PAR have noted incremental progress on restructuring and decentralization, but the speed of reforms is considered to be slow, its scope incremental
and its impact in some highly important areas, such as anti-corruption, minimal to date [22, 25, 26].

4. Findings: Capacity and strategy gaps in health workforce management

4.1 Scope and data

While some decentralization of personnel functions is anticipated in the government’s PAR program, some of the basic facilitative conditions for broader reforms that could have a significant impact on performance – such as decentralization of personnel and introduction of market-like incentives to service delivery – are simply not yet in place [25]. A closer look at the human resource management in the health sector makes this clear. This section assesses two dimensions of the central-level ‘steering’ or coordination of human resources in the health sector: attempts to address imbalances in the composition and deployment of the workforce; and the restructuring of incentives for managerial efficiency and responsiveness.

This investigation draws on several sources. A review of source language commentary on workforce issues in the Vietnamese press and academic circles was complemented by analysis of several editions of health statistics yearbooks. Fieldwork in late 2005 centered on interviews with donor officials and Ministry of Health officials, and on stakeholder workshops attended by a broad cross-section of health sector managers in three provinces representing the northern, central and southern regions: Thai Nguyen, Thua Thien Hue and Kien Giang. These consultations focused on two areas: a) the adequacy from the central and local perspectives of workforce-related policies; and b) local efforts to solve or bypass these perceived inadequacies.

4.2 Rectifying or amplifying workforce imbalances?

A classic objective of workforce management is the attempt to achieve an optimal system-level balance between the supply and demand of health workers, their functional specializations, and their distribution across facilities and regions [27]. Health planners must assess current values in these areas from two points of view: their impact on the overall goals set for the health sector, and the capacities they have to intervene to rectify any imbalances [28]. Both have proved problematic in Vietnam, where central authorities have relied heavily on administrative norms and a centralized strategy that are both failing to gain traction in conditions of decentralization, commercialization and rising inequalities.

By 1996, the overall number of Vietnamese health sector personnel had stabilized after an initial fall in the early transition period (when they went unpaid). From 1996-2000, it increased by approximately 15% to the year 2000, after which it held steady due to a policy to reduce the overall civil service headcount. In order to reach this target, the number of doctors in particular showed dramatic increase in linear fashion since right up to 2000, at which point it basically stabilized; from 9,000 to just approximately 50,000 at present [29]. Yet five important imbalances pose difficulties for the health ministry.

1. A shortage of nurses and technical personnel. Ministry officials bemoan their inability to raise the ratio of nurses to doctors, exceedingly low by international comparison. An insufficient numbers of nurses is said to be one of the main causes for the chaotic situation found inside many hospitals, where family members of patients are required to provide food, laundry and even bed linen.\(^1\) The number of laboratory technicians, in turn, has apparently fallen since 2000. Reports of expensive medical machinery going unused for lack of technicians have been frequently cited in the both the specialist literature and press [30].

2. Regional imbalances. Doctors and specialists are heavily (and increasingly) concentrated in major urban centers, where the accelerated commercialization of health services translates into far higher earning potential. One Vietnamese analyst compared death rates associated with the most common causes of mortality to medical personnel deployments, concluding that these imbalances are serious enough to affect overall mortality rates in the coastal and mountainous regions [31].

\(^1\) Personal communication with Dr. Trinh Hung Cuong, Health Strategy Institute on December 29, 2005.
3. **Facility-level imbalances.** Commune health centers (CHC) serve as the multi-purpose facility at the base of the health referral system and as the main point of contact with the formal health system for many rural residents [15]. A CHC located two kilometers from a district center would have a different profile and capacity requirement compared with one separated from the nearest hospital by thirty kilometers and an unreliable, seasonal-access road. Yet planning norms regarding CHC infrastructure, medical equipment, drug availability and above all staffing norms are for most purposes completely standardized [32]. In some local facilities in the Mekong Delta, managers of some CHCs have turned to contracting staff out of user fee receipts, but provinces outside this region appear not to have allowed such flexibility. Thus two types of imbalances can arise: between highly variable local demand for CHC services and uniform operational capacity to service it; and between those few facilities that are able to win contracting flexibilities and the majority which cannot.

4. **Service imbalances.** Provincial governments, in conditions of fiscal decentralization, have varied capacity to field paraprofessional ‘village health workers’ at the grassroots. The very small stipend offered for such workers is itself dependent upon provincial coffers, and training and supervisory capacity has proven limited in remote areas [32]. As a result, the overall proportion of workers oriented towards curative as opposed to preventive health care has fluctuated. After revitalizing and retraining paraprofessionals since 1998, with some 90,000 in place by 2003, their numbers since 2002 have begun to fall on the order of 10% per year [29], raising questions of the sustainability of the effort, particularly in fiscally poor regions where their potential role is greatest.

5. **Rise of the private sector.** The imbalances above are exacerbated by the rise of the private sector which has become quite extensive in health [29]. Of 1,200 communes included in a recent National Health Survey (about 10% of all communes), 71% had private healthcare providers, a figure rising to 97% for urban or district-center wards. Yet only 5% of the poorest quintile of communes has even one private sector doctor [34].

How is the Ministry of Health positioned to address these imbalances? And to what extent is the Ministry itself partly contributing to them? On one hand, the breadth of the basic infrastructure for health in Vietnam continues to be impressive; as shown in the steady rise in the proportion of commune health centers with a doctor. But five types of capacity and strategy gaps are evident.

The first area of concern is the continued use of central planning-inspired norms for the production of health personnel. Current norms in force specify ratios of nurses, midwives and technical personnel per doctor (2, .5 and .5, respectively) date from a circular issued in 1975, and bear little relation to actual figures for the same (1.39, .37 and .02, respectively) [29].

A second strategy gap relates to the positioning of the commune health centers themselves. These have not yet found a robust function and corresponding structure of ministry investment. The mix of investments in infrastructure and continued attempts to push against the grain of market incentives by a policy emphasis on posting doctors (rather than assistant doctors or other personnel) to the CHCs both suggest more of a role in curative provision than the CHCs are likely to play in an increasingly differentiated health sector.

Third, the patterns of intervention of the health authorities in the imbalances question may not be particularly effective. Against the powerful forces of decentralization and commercialization, training requirements are primarily dictated via a system of administrative fiat – controlling the number of places available for study in particular functional specializations at medical colleges disbursed throughout the country. This is being effectively undermined by the opening of training to a secondary list of fee-paying students in the medical schools, which is having a potentially unpredictable effect on the overall numbers.

A fourth area of concern relates to a lack of policy coordination stemming from bureaucratic fragmentation in a decentralizing system. One example of the interaction of policies, training and market effects is

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2 The planning norm still in force is Decision 07 of the State Planning Commission, issued on 23-1-1975.

3 Personal communication with Dr. Nguyen Bach Ngoc of the Vietnam Health Strategy Institute, January 20, 2006.
shown by the impacts of the policy of ‘free health care for children under 6’ on the training and deployment of pediatricians in 2003. While the policy is popular, the ability of the health sector to implement it is questionable. Some hospitals, such as the provincial hospital in Lai Chau, have failed to deploy any pediatric specialists, who will face a smaller return from user fees than other doctors given the new policy. Ministry officials note the policy has contributed to a decline in the graduation rates of medical students with a pediatric specialization.4

The most profound capacity gap relates to regulation of the private sector. Health ministry regulations allow only those health workers who have spent at least five years in a public health establishment to work privately. Compliance with this regulation is highly variable: upwards of 90% report themselves to be properly registered in the northern part of the country, while in the south two-thirds of private sector workers fail to register with the authorities [34]. Regulations also stipulate that private service providers are not allowed to sell drugs on their premises, but rather (in the case of doctors) only to fill out prescriptions. Yet recent evidence indicates that 85% of private providers ignore this regulation [34].

4.3 Harnessing managerial autonomy or ‘flying blind’?

The centralization of commune health worker salaries in 1996 in many ways marked the end of organizational disruption that had plagued the health sector since the collapse of agricultural cooperatives. Yet average basic salaries for health workers up to 2001 had stabilized at the modest level of approximately US$30 per month [16, 35], a low figure both in absolute terms (few households could survive on one such base salary alone) and relatively (salaries for much of the rest of the civil service had grown faster). Analysts of developing country health sectors often blame such low levels of official salary for the inability of the health authorities to curb phenomena such as illicit user fees and drug overprescription [16, 33]. In Vietnam, such a diagnosis underlies a major recent thrust in the government’s public administration reform program [38], one which illuminates the challenge of health workforce management.

In December 2002, Vietnam’s Prime Minister issued a major decree: henceforth, service delivery units, including hospitals and potentially health clinics as well, would be granted both considerably greater managerial autonomy and the ability to keep locally generated revenue. The intention of “Decree 10” was “to create flexibility and incentives for introduction of new and better services, and for mobilization of additional resources to finance these developments,” [20] as well as to promote cost saving and productivity improvements. But the ink was barely dry on the Decree when a number of concerns were raised, notably for the health sector. Would the newly empowered managers of hospitals, for instance, use their new autonomy to merely market and raise prices for elective services of little health benefit to the population? How would autonomy affect public health support functions and the willingness of facilities to serve individuals with limited purchasing power – the poor?

Decree 10 has only been rolled out to central and local-level hospitals within the past three years, and that unlike administrative decentralization to local governments it was not piloted prior to its introduction [37], making evidence regarding its impacts to date limited. The 2005 Public Expenditure Review jointly conducted by the Ministry of Finance and the World Bank offer several pilot studies on Decree 10 were conducted [20,36], and the topic featured prominently in stakeholder workshops conducted in the three provinces of this study. These studies and consultations suggest that facility-level managers have responded to greater autonomy in three ways.

First, they have expanded revenue-generating ‘special services’ of a higher quality and price than normal hospital services, in the process increasing hospital revenue as much as 86% within two years [36]. Second, they have reduced or held constant outlays on non-revenue-enhancing items – including public health support functions (for which central-level subsidies have remained constant since the introduction of Decree 10), and discretionary expenditures to improve service

4 The case study on free health care for children under six was compiled from several articles in Lao Dong newspaper over March and April, 2005.
access of the poor. Third, a high proportion of ‘profits’ has been distributed as ‘bonuses’ to staff, often in some (locally variable) proportion to the involvement of these staff in the more revenue-enhancing services. The consultations also suggested that the impact of Decree 10 across facilities was highly variable: first, because some facilities had already been informally maximizing revenues and worker bonuses in the above way without central-level authorization; and secondly, because some were unable to identify or expand revenue-generating services due to differences in market placement, user base or mandate.

Evidence thus suggests that the process of commercializing services combined with formalizing managerial autonomy over the service delivery units is having a significant impact in central and local hospitals where Decree 10 has been applied. Going forward, a critical question concerns the ability of central and local authorities to design and implement expanded managerial autonomy in a way that strengthens overall steering and coordination systems. Institutional analysis indicates the challenge will be steep, as the role of the central health authorities both in promoting and in holding accountable the health workforce continue to suffer from serious capacity and strategy gaps.

First, the capacity of ministry authorities use remuneration as a tool to steer workforce behavior and incentives, already highly limited, is set to decline further. With base salaries both low and varying little by region, specialization or level of education, ministry and local officials have over the past ten years experimented with a complex system of supplemental payments \[phu\ cap\] that attempt to shape incentives of workers in a range of areas, such as relocating to remote areas or working assignments considered a ‘hardship’, such as providing working with HIV and psychiatric patients [19]. This system has never been showed to be effective, given the limited size of the \[phu\ cap\] in comparison with the diverse additional sources that health workers often tap, such as supplemental work and (approved or illicit) informal payments by users. If health authorities have faced difficulties in gaining leverage over health worker motivation through \[phu\ cap\] payments, that task has become essentially impossible (though not formally abandoned) through the accelerated commercialization of services that is both reflected in, and reinforced by, Decree 10 [38].

Second, accountability and performance management systems might in theory help address the negative aspects of commercialization without losing its benefits. Yet these systems, whether viewed in terms of traditional, top-down supervision or its emerging alternatives, are at present too weak to play this role.

Consider first technical supervision, which remains infrequent and of poor quality [32]. The weakest link lies in the management information systems that could assist in lending coherence to such supervision. In some critical output-related areas such as immunization coverage and the monitoring of mortality rates, information systems appear to be functional; after all, Vietnam’s national programs (such as the anti-malarial and tuberculosis programs) are reputed to have gained in effectiveness over this period [16]. In several key areas, however, information systems appear to be either entirely lacking or to be based on such partial sources of information (such as official salaries) as to render judgments actually misleading. In a broader sense, the ‘strategy gap’ lies in the lack of an effective framework for ensuring minimum service standards of access and quality that is based on the highly varied local environments [32].

The policy of managerial autonomy also seeks to supplement technical supervision with ‘customer voice’ linked to market competition as a source of accountability. Yet two classic limitations with respect to customer voice are very much evident on the Vietnamese scene, particularly in poorer and more
remote localities: monopoly service provision and asymmetrical information [36]. In many areas of Vietnam, effective competition for the range of health services provided – in a district hospital, for instance – is limited to urban residents or non-existent, laying open the possibility that commercialization will result in price gouging [33, 36]. And while patients can observe some aspects of the quality with which they are being treated – such as waiting times or doctor demeanor etc. – they have less capacity to assess the application of specialist knowledge to their case. The effect is to diminish the capacity of patients to effectively direct their ‘voice’ to the most responsive health providers.

Central authorities have not yet proven adept in harnessing autonomy by adjusting regulatory and enforcement efforts to prevent price gouging, or by enhancing consumer choices through the provision of market-enhancing performance information. Their lack of disaggregated information systems on local performance coupled with a blunt approach to performance monitoring leaves them essentially ‘flying blind’ when transferring managerial autonomy to hospitals and clinics.

5. Discussion

The manner in which Vietnamese health planners have struggled to reorient their roles casts light on dual gaps in strategy and operational capacity that are generally experienced in transition settings. A common emphasis is found on management via administrative and planning norms, which can often be considerably removed from the realities on the ground on which they seek to have an impact. In Vietnam’s case, this is seen in several areas. One example is the attempt to regulate the aggregate composition of the workforce via proportional norms (of nurses to doctors etc.) that have not changed for literally decades and which bear little relation to prevailing conditions. In workforce management, it is evident in the attempt to fine-tune supplemental pay scales to provide incentives for types of workforce behavior – such as relocating to remote rural locations – when in fact such incentives are dwarfed by actual income differentials that are in part the direct result of health policies providing greater managerial and financial autonomy to service delivery units. A gap between administrative norms and reality is also evident in the regulation of the private sector, where in some regions only a minority of private sector health workers are properly registered, and where a coherent approach to quality regulation is not yet present.

Administrative and planning norms also reinforce a ‘strategy gap’ in transition settings, seen in the Vietnamese case in two arenas. One is the persistence of a ‘one-size-fits-all’ approach to regulation and standard setting. This approach is increasingly at odds with grassroots realities in the context of accelerating inequalities – both of health outcomes and local capacities – across differently situated local government and service delivery units. The second is a lack of strategic focus on shifting ministry interventions towards areas supporting informed choices about the quality of healthcare offered in different facilities. Greater differentiation of strategy by region, and support for the decentralized enforcement via ‘consumer voice’ of health care quality are exactly what is needed to make managerial autonomy and the commercialization of services work coherently as a strategy, but the Ministry has to date largely shied away from such measures.

These capacity gaps are typically reinforced by weak management information systems in transition (and more generally developing) countries [39]. In Vietnam, challenges such as the fine-tuning pay systems to reward overall performance, the enforcement of minimum standards of performance, and the differentiation of strategy to fit with diverse conditions in facilities and localities, all require substantially enhanced information systems not only at the ministerial level, but throughout the health management system. These have proven difficult to build up due to organizational culture and strategic ‘blind spots’ (such as the emphasis on standardized approaches to diverse regions) as much as technical and resource constraints.

External assistance can play in assisting health ministries and provincial actors to overcome such capacity and strategy gaps. Sector-wide approaches offer a potentially valuable platform for addressing the limitations of traditional capacity building programs [40]. In so doing, partnerships between donor, central and local actors to promote positive change will be essential. Neither ‘blueprint’ models of change nor those that fail to provide strong central-level leadership
are likely to succeed. Building effective capacity for adaptive ‘learning by doing’ throughout all levels of the health system will be essential, underlining the need for enhanced information systems has been highlighted throughout this report. In pursuing sector wide and other new approaches to capacity building, an explicit focus on capacity and strategy gaps to the reorientation of central ministry roles will be essential.

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