Abstract

Making the Welfare State Work:
Social and Cultural Embeddedness of Welfare Mix
in Post-Socialist Vietnam

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This dissertation aims to contribute to understanding of performance of welfare institutions. How is the performance of welfare institutions relevant to its social and cultural environment? In order to answer this question, this paper focuses on how reforms of the healthcare sector have led to the current situation in Vietnam by comparing Northern and Southern region of the country where different level of "social capital" and "welfare mix" exist within the same welfare system. For example, it explores how the characteristics of traditional and cultural arrangements affect the exchange of social welfare resource between community members in the informal sector and the performance of welfare institutions, especially in the formal healthcare service sector. Informal welfare in this paper refers to financial support of private income transfers by family members and rotating credit systems with village residents whereas formal welfare defines the achievement of preventive healthcare service system by commune health stations.

The protective arrangements, the outcome of traditional and cultural concerns, of commune health stations, families(relatives), neighbors and voluntary associations are commonly witnessed in both regions. However, welfare mix is developed differently according to each region's traditional and cultural norms. The research proves that the type of protective arrangements in North can be summarized as commune health stations, individuality of family unit, village communities (dinh), and closed network that is formed from solidarity of family, relatives, and neighbors. The people in North who are under the social network structure of face-to-face contact share their moral norms by sharing family events and rotating credit associations as informal welfare institutions and resources within the village community. They also actively participate in preventive health care services by commune health stations and it enables the stations to provide better and effective protective medical service.

On the other hand, protective arrangements in South can be categorized as commune health stations, individuality of family members, voluntary associations (hoi), and open network. Unlike the people in North, they have a high tendency of individualism of community members and the resource exchange has been conducted based on less strong ties. So, the range of community is much wider than the one in North and sharing family events and rotating credit associations function as maintaining their contact. They also react differently to health care services by commune health stations and visit the stations only when necessary. Therefore, it hinders the stations to plan and implement protective medical services persistently.

Understanding the mixture of welfare in North and South Vietnam agrees that the formal system can be determined based on different level

of social capital. The previous research argues that weak ties with horizontal social structure can facilitate the success of system because the level of social trust and cooperation can be enhanced. However, the example of Vietnam does not correspond to it and thus voluntary associations in North and South need to be highlighted.

Voluntary associations in North and South have the same way to operate the system with the same goal but the characteristics are different: the one in South is inter-village system and North shows intra-village system. The previous studies on social capital in general consider the one in South as the ideal case. However, it is confirmed protective arrangements in North where the associations demonstrates intimate relationships of family, relatives, and neighbors promote systematic management of commune health stations better. When the social network gets expended through voluntary associations like South, the social trust and cooperation cannot be advanced without strong ties. To sum up, the level of social cooperation can be differentiated by the types of ties and the degree of intimacy. It is important to expand the relationships and intimacy built by the trust and norms from the social network of face-to-face contact. The case of North and South Vietnam illustrates that expansion of social cooperation at the community level can expedite the success of the system.

Key Words: Vietnam, Hong River Delta, Mekong River Delta, welfare mix, embeddedness, healthcare service, commune health station, community, private income transfers, voluntary rotating systems, social capital, reciprocity