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User Fees, Financial Autonomy and Access to Social Services in Viet Nam

UNITED NATIONS VIET NAM

Ha Noi
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The Mission of the United Nations in Viet Nam

The United Nations, in partnership with the government and people of Viet Nam, works to ensure that all Vietnamese people enjoy an increasingly healthy and prosperous life with greater human dignity and expanded choices. Collectively and through its individual agencies, the United Nations cares and creates opportunities for the poor and most vulnerable, and for youth, to whom the future belongs.

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FOREWORD BY THE UNITED NATIONS RESIDENT COORDINATOR

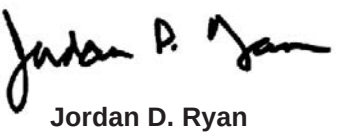
The United Nations in Viet Nam is committed to promoting the values of the Millennium Declaration. Prominent among these is the principle of *inclusive development*, according to which national development should not only create a more wealthy society but also protect the poorest and most vulnerable people from deprivation, isolation and marginalization.

Universal access to high quality health and education services is integral to inclusive development. Viet Nam's record in this regard is impressive, achieving rates of literacy and child mortality superior to those of some middle-income countries. Yet increasing demand for quality health and education services has placed a heavy burden on public finances. In response, the government has instituted a system of user fees for some services, and has moved to increase the financial autonomy of service providers to increase the responsiveness and efficiency of these institutions.

These policy changes have brought much needed additional resources into the system and improved the quality of service delivery in many locations. The government has at the same time established new programmes to help the poorest people retain access to basic social services.

However, the question of access to quality social services remains an important one, both for the government and the United Nations agencies in Viet Nam. We in the United Nations are eager to support the government, the research community and other stakeholders in collaborative efforts to gain a better understanding of the impact of 'socialization' on the poor and other vulnerable people.

The present United Nations Discussion Paper represents an early attempt to gather existing information and suggest potentially fruitful avenues of future, practical policy-oriented research on these questions. We hope that the paper stimulates discussion and helps to move the research agenda forward.



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LIST OF ACRONYMS

CHS	Commune Health Station
CPRGS	Comprehensive Poverty Reduction and Growth Strategy
GDP	Gross Domestic Product
GER	Gross Enrolment Rate
GSO	General Statistical Office
HCFP	Health Care Fund for the Poor
MDGs	Millennium Development Goals
MOLISA	Ministry of Labour, Invalids and Social Affairs
MOET	Ministry of Education and Training
MOH	Ministry of Health
NHA	National Health Account
NER	Net Enrolment Rate
PPAs	Participatory Poverty Assessments
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
VDR	Viet Nam Development Report
VHLSS	Viet Nam Household Living Standards Survey
VLSS	Viet Nam Living Standards Survey
VND	Viet Nam dong
VNHS	Viet Nam National Health Survey
WHO	World Health Organization

EXECUTIVE SUMMARY

Viet Nam's social and economic achievements in the past decade are impressive. High rates of economic growth, combined with a relatively egalitarian land holding system, have contributed to a dramatic decline in the incidence of poverty. Rapid growth in tax revenues and other sources of state revenue have made it possible for the government to sustain and build upon earlier achievements in health and education. Viet Nam's general education and health indicators are far better than those of countries at similar levels of income, and even many at higher income levels. However, these gains have not been uniformly distributed across all segments of the population, and major inequities remain in access to and the quality of social services.

Recently the government has granted financial and managerial autonomy to the revenue-raising public service entities, including government health facilities and schools. The Decree on Financial Autonomy (Decree 10) grants sweeping powers to revenue-raising public agencies to manage their revenue and expenditure accounts, exploit alternative revenue sources, and make decisions concerning staffing levels and remuneration. This decree has far reaching implications for the delivery and financing of health services as it creates incentives for public entities similar to those of for-profit providers. Concerns have been expressed over the implications of this decree for the cost burden of publicly provided health services and the accessibility of health services for the poor and vulnerable.

This paper contributes to the current debate by reviewing existing information on the implications of user fees and greater financial autonomy of service providers on the accessibility of publicly provided health and education services, especially for the poor and near poor. The paper addresses the issue of the accessibility and affordability of social services before and after the introduction of Decree 10 and Viet Nam's past experience with user charges. The implications of Decree 10 for the affordability of social services are discussed using available data from hospitals that have already implemented the decree.

The review of user fees in health and education suggests that the private costs of these services represent a significantly larger proportion of household non-food budgets for the poor and near poor than for the non-poor. At the same time, the quality of health and education received by the poor and near poor remains deficient. Hospital costs are onerous, especially in the case of hospital admission. The cost of a single service contact with a district hospital takes up over one-fifth of annual non-food consumption expenditure for a person from the poorest population quintile, and as much as 44 percent if the illness requires

an admission to a provincial hospital. The high cost of accessing public hospitals can lead to long-term impoverishment of households, which are often forced to sell assets and/or borrow to finance the cost of their hospitalisation.

For the poor and near poor the financial burden of education is also substantial, especially at the secondary level, for which the private costs per child take up eleven and nine percent, respectively, of poor and near poor households' annual non-food expenditures. Evidence from Viet Nam and other low-income countries suggests that higher direct private costs of schooling reduce the likelihood that parents, especially poor and near poor parents, will enrol their children in school.

Although there are various exemption mechanisms in place to protect the poor and vulnerable, these mechanisms reach only a small fraction of the target population and provide inadequate protection. Moreover, the level of resources allocated to national targeted programmes remains inadequate and eligibility requirements are too restrictive. Coverage should improve following the introduction of the Health Care Fund for the Poor (Decision 139) in 2002. There is, however, wide geographic variation in the percentage of poor and near poor households covered by the programme. Some concerns have already been raised about the ability of poor provinces to fund the programme, the adequacy of benefits, and low reimbursement rates to providers. Low reimbursement rates make it difficult for the poor and near poor to obtain quality health care services in the absence of informal payments. With the majority of poor provinces opting for direct reimbursement of providers at the existing level of user charges, the quality of care provided to beneficiaries is uneven and access to higher-level public hospitals is limited to better-off patients.

Granting public entities financial and managerial autonomy helps health and education facilities raise revenues and improves the quality and efficiency of services. However, differences in the revenue-raising capacities of public institutions suggest that full implementation of Decree 10 may exacerbate regional inequalities and could lead to the emergence of two-tiered health and education systems. This outcome would conflict with the government's stated goal of ensuring high quality education and health services for all. Moreover, any increase in fees would add to the financial burden on households, especially poor and near poor households.

The limited availability of reliable information on the impact of user fees and financial autonomy remains a constraint on effective policymaking. The main recommendation of the paper is the need for a comprehensive research programme to collect and analyse new information on the relationship between user fees and financial autonomy on accessibility to quality social services, particularly for the poor and near poor.

1. INTRODUCTION

Doi moi, the wide-ranging economic reform programme launched by the Government of Viet Nam in 1986, has successfully effected the transition from central planning to a market-based economic system. In contrast to many other transition countries, Viet Nam's economy has performed exceptionally well during the reform period. During the 1990s the average rate of growth of gross domestic product (GDP) was 7.6 percent. Exports have soared and macroeconomic balance has been maintained. More rapid economic growth, combined with a relatively egalitarian land holding system, has contributed to a dramatic decline in the incidence of poverty. The percentage of the population below the poverty line fell from 58 percent in 1993 to 37 percent in 1998 and 24.1 percent in 2002. Significant gains have also been recorded in the social sector. Building on earlier progress, the country's key health and education indicators have continued to improve. Viet Nam's basic social indicators are superior to those of countries at similar levels of income, and even some richer countries. Viet Nam's infant mortality rate is already among the lowest in the Asia-Pacific region and life expectancy compares favourably to many middle income countries. Literacy stands at about 92 percent, up from four percent on the eve of independence in 1945, and primary school enrolment is almost universal for girl and boys. However, these gains have not been uniformly distributed among all segments of the population (Bhushan et al, 2001; VDR, 2004). Inequality has increased and millions of people still live just above the poverty line. Children from the poorest quintile of the population are three times more likely to be stunted than children from the richest population quintile. Moreover, major inequities remain in terms of access, quality and spending on social services (Bhushan et al., 2003; World Bank et al., 2001; World Bank, 1997).

The *doi moi* reforms have directly affected the delivery and financing of social services. The legalization of private provision of health services and education, and the introduction of user charges for social services have effectively transformed the role of the public sector in the provision and funding of services. While the introduction of user charges has provided health and education facilities with extra resources to improve coverage and quality, they have also imposed an additional financial burden on the poor and vulnerable.

Recently the government has granted financial and managerial autonomy to revenue-raising public service entities, including government health facilities and schools. The Decree on Financial Autonomy (Decree 10) grants sweeping powers to revenue-raising public agencies to manage financial and human

resources, and to exploit alternative revenue sources.[1] The decree has far reaching implications for the delivery and financing of health services as it provides managers of public health facilities with incentives similar to those of for-profit private facilities. Public concern has already emerged over the implications of this decree for the cost burden of publicly provided health services and the accessibility of health services for the poor and vulnerable.

This paper contributes to the current debate by examining the implications of user fess and Decree 10 for publicly provided health and education services, especially the access of the poor and near poor. The paper analyses Viet Nam's experience with user charges and their impact on the affordability of social services. The analysis is primarily based on two recent household surveys: Viet Nam Household Living Standards Survey (VHLSS, 2002); and the Viet Nam National Health Survey (VNHS, 2002). These sources are supplemented by data from hospitals that have implemented the decree. The paper is also informed by discussions with key stakeholders including government officials from the relevant ministries.

The structure of the paper is as follows. Section 2 provides an overview of the utilization of health services and examines the financial burden of health care costs on the poor and near poor. Section 3 examines the implications of Decree 10 for the delivery and financing of publicly provided health services. In section 4, the paper reviews school fees and other contributions, and assesses the financial burden of basic education on the users of these services. The implications of Decree 10 for basic education are explored in section 5. The final section concludes and provides some recommendations for further study relating to the financial burden of publicly provided health and education services.

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[1] Inter-Ministerial Circular no. 21/2003/TTLT-BTC&BGD-BNV provides guidelines for financial management of revenue earning public service delivery units in the sectors of public education and training. Decree no. 10/2002/ND-CP regulates financing of revenue generating service delivery agencies. Decree no. 25/2002/TT-BTC sets out guidelines for implementation of Decree no. 10/2002/ND-CP dated 16th January 2002 on the financial mechanism applicable to income generating-service units. Inter-Ministerial Circular no. 13/2004/TTLT-BYT-BNV provides guidelines for financial management of revenue earning public service delivery units in public health.

2. HEALTH

2.1. An Overview

The public health sector came under increasing pressure during the second half of the 1980s. Poor economic performance and a steady erosion of the two main institutions of the central planning system, state owned enterprises and agricultural cooperatives, made it difficult for the state to sustain its vast network of health facilities. By the late 1980s Viet Nam's health care sector was in serious crisis. By 1989 health care spending constituted only 3.3 percent of total government spending, and the government could meet only 40 percent of the most urgent health care needs (Witter, 1996; Guldner and Rifkin, 1993). In 1989, the government implemented a series of new policy measures including the legalization of the private provision of health services, the liberalization of the pharmaceutical industry, the introduction of user charges at higher levels of the public health system, and the promotion of health insurance.

2.1.1. User charges

A user charge system was implemented in 1989 allowing public hospitals at the district, provincial and central levels to charge a basic consultation fee of between US$0.07 and US$0.27 (Prescott, 1997). Depending on the type of services provided and drugs or other supplies consumed, health facilities were also allowed to charge supplementary fees. The user charge system was modified in 1994 and again in 1995 (Knowles et al., 2003: Table 3.1-1). These modifications sought, among other things, to improve the fee collection mechanism by making hospital directors directly responsible for the collection of fees as well as for the authorization of exemptions. They also provided a more detailed fee structure, setting out the range of fees each type of hospital and clinic could charge for each type of consultation, diagnostic test and procedure. For the most part, patients are required to pay for drugs. In practice, however, charges vary greatly across and even within provinces, with some hospitals choosing not to enforce the national indicative fee structure, while others imposing additional charges.

The guidelines on the use of collected fee revenues were also modified, reducing the bonus/reward to health workers from 35 percent to 25-28 percent, and increasing the share of non-wage expenses from 60 percent to 70 percent. The latter can be used for medical equipment, drugs and other supplies such as blood, chemicals and x-ray materials. The remaining two to five percent is to be contributed to a supporting fund for the hospital. However, in the absence

of effective monitoring systems, these guidelines have not been followed closely, and anecdotal evidence suggests that some hospital directors have been more flexible in allocating fee revenues.

2.1.2. Health insurance

To supplement public health funding, the government also introduced a formal social insurance scheme in 1993 after a few years of pilot studies. The insurance scheme consists of two separate parts, one compulsory and one voluntary. They both cover the costs of inpatient and outpatient treatment and some drugs in public health facilities. The compulsory scheme is targeted at current and retired civil servants and employees of state enterprises, as well as those of private enterprises with more than ten employees. The voluntary scheme is for the rest of the population. Dependents are not covered by these schemes.

The coverage rate remains low at about 20 percent of the population. Only nine percent of the poorest population quintile is covered as compared to 36 percent of the richest quintile (VNHS, 2002). The voluntary scheme covers only ten per cent of the target population and over 90 percent of voluntary enrolees are school children. Public hospitals are reimbursed on a fee-for-services basis, subject to some ceilings for services provided to the insured. The social-economic plan 2001-2010 adopted at the Ninth Party Congress calls for universal health insurance coverage by 2010.

2.1.3. Private providers

The legalization of private medicine and pharmaceutical trade brought the shadow sector into the open and led to the rapid expansion of private practice. By 1993 per capita out-of-pocket expenditures on health services had reached $7.27, accounting for 84 percent of total health spending (Quan, 1999). More recently, the government has encouraged investment in private medicine, and private hospitals and clinics are now more common.

The relationship between the public and private sectors is poorly defined and much of the care delivered by the private sector lies beyond the influence and control of the government. Many of the doctors and assistant physicians working in public health facilities also run their own private practices before and after working hours in public health facilities to top up their low official salaries (Witter, 1996). In some public hospitals, physicians and nurses run private medical practices within public sector working hours, using public sector health facilities and equipment (Dung, 1996). At the same time, semi-private

wards within public hospitals, which in some cases have their own operating theatres and post-operation recovery rooms, are now common (World Bank et al., 2001). The result is that some public sector providers have begun to act more like private sector agents.

2.2. The implications of user charges and the legalization of private medicine

The following section briefly discusses the implications of user charges and legalization of private medicine for the delivery and financing of health services. Particular attention is paid to the accessibility of health services and the cost burden on the poor and vulnerable.

2.2.1. Shifting the burden of health care costs to patients

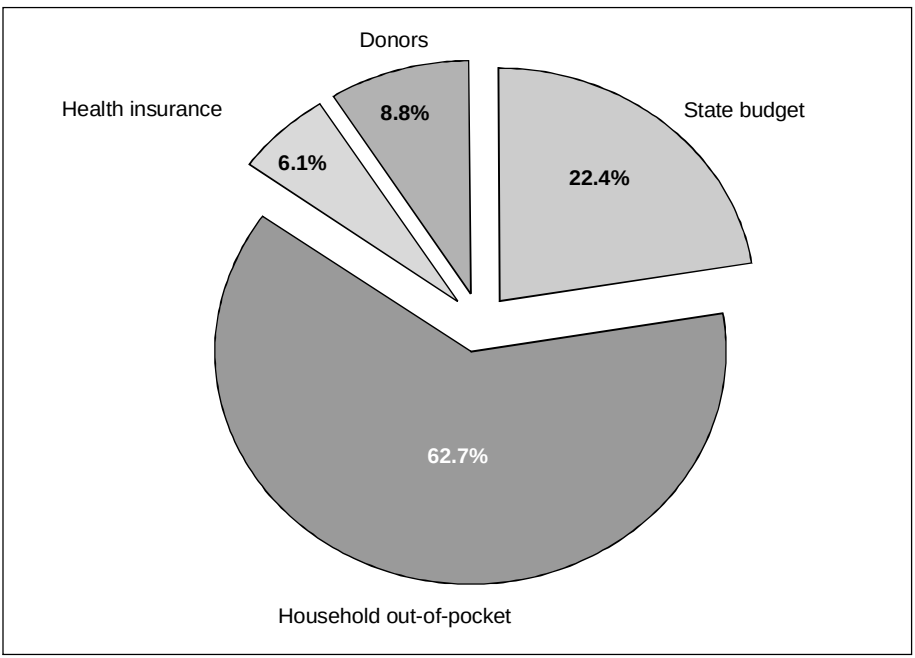
Revenues from official user charges increased by as much as 33 percent in real terms between 1994 and 2000 (Knowles, 2003). The contribution of user charges to total public health expenditure, however, remains modest, amounting to 16.7 percent of the government health budget in 2002 (Knowles, 2003). However, since user charges are largely collected at the hospital level, this modest cost recovery rate greatly underestimates the significance of user charges to hospital financing. The share of user charges in total hospital revenue has risen dramatically, from nine percent in 1994 to 30 percent in 1998 (World Bank et al., 2001). The relative importance of fee revenue in hospital budgets varies greatly across hospitals. Fee revenue tends to be relatively more important to provincial hospitals and hospitals specializing in surgical specialties or diagnostics (Dong, et al. 2002: Tables 1, 9; Phuong, 2003). In Can Tho province, for example, fee revenue in the Centre for Medical Diagnostics and in the Ophthalmologic Hospital accounted for 466 and 236 percent of transfers from the state budget, respectively (Phuong, 2003).

In addition to official user charges, patients also make various forms of informal payments that are not reported to the Ministry of Health. In the case of hospital visits it is also common for richer patients to pay higher 'hidden' fees in order to receive better care (Dung, 1996). Anecdotal and survey evidence suggests that 'envelope' payments are significant. According to one recent study, such payments to health care providers accounted for as much as 36 percent of hospital fees and 20 percent of total hospital bills for patients receiving higher quality inpatient care (Tran, 2001). Side payments are an important source of income for many doctors, especially those in certain specialisations. The tradition of providing practitioners with 'gifts from the heart' for services blurs the distinction between gratitude and required non-discretionary payments.

Without these payments, patients are less likely to obtain prompt and thorough treatment, or in some case any treatment at all (Anh, 2002).

The legalization of private medicine and rising fee revenue has increasingly shifted the burden of health care financing to households. Several estimates exist of total public and private health expenditure for selected years. According to the most recent estimates from the National Health Account (NHA, 2004), private out-of-pocket expenditures accounted for 63 percent of total health finance in 2000 (see Figure 1). Estimates based on the Viet Nam 1997-98 Living Standards Survey put the contribution of household out-of-pocket payments as high as 80 percent (World Bank et al., 2001). The share of out-of-pocket expenditures on health services in total household expenditure also varies greatly across regions, ranging from 77 percent in the Mekong Delta to 47 percent in the Northwest (NHA, 2004). With out-of-pocket payments accounting for such a large share of total health spending, health care costs, and especially hospital costs, are now a serious burden on many low and middle-income households.

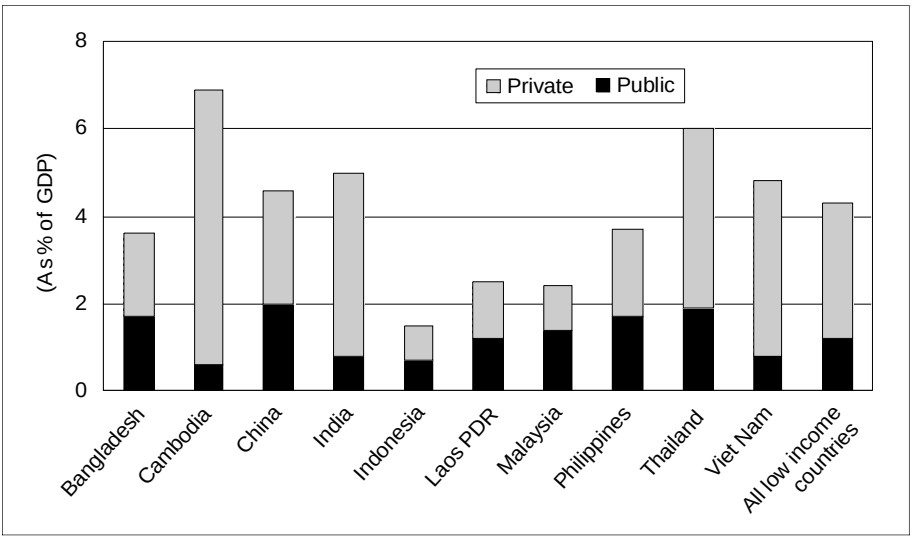
Figure 1. Sources of health care financing , 2000



Source: NHA, 2004.

State health budgets also grew in the 1990s, but at a slower rate than fees and insurance reimbursements (both off-budget items) (Knowles et al., 2003). The state health budget (excluding ODA) in 1994 prices increased at an average annual rate of 13.4 percent over the period 1992-2002, raising health budgets from about 1.0 to 1.4 percent of GDP in 2002 (World Bank, 2004). Yet public health funding as a share of GDP is still low compared to other countries in the region (see Figure 2).

Figure 2. Healthcare expenditure among selected Asian developing countries (As % of GDP)



Source: World Bank et al., 2001.

2.2.2. Higher staff bonuses

The rapid growth of revenues from user charges and insurance helped hospitals to acquire much needed medical equipment, drugs and other supplies. It also enabled them to improve staff morale by increasing bonus payments. According to an extensive survey of public hospitals in 1996 by the Ministry of Health, staff bonuses, which are entirely financed out of patient revenue, doubled in real terms each year from 1994 to 1996 (MOH 1996, cited in World Bank et al. 2001). Indeed, for some categories of hospitals, bonuses were larger than base salaries. As a consequence, in 1996, bonuses-accounted for 30 percent

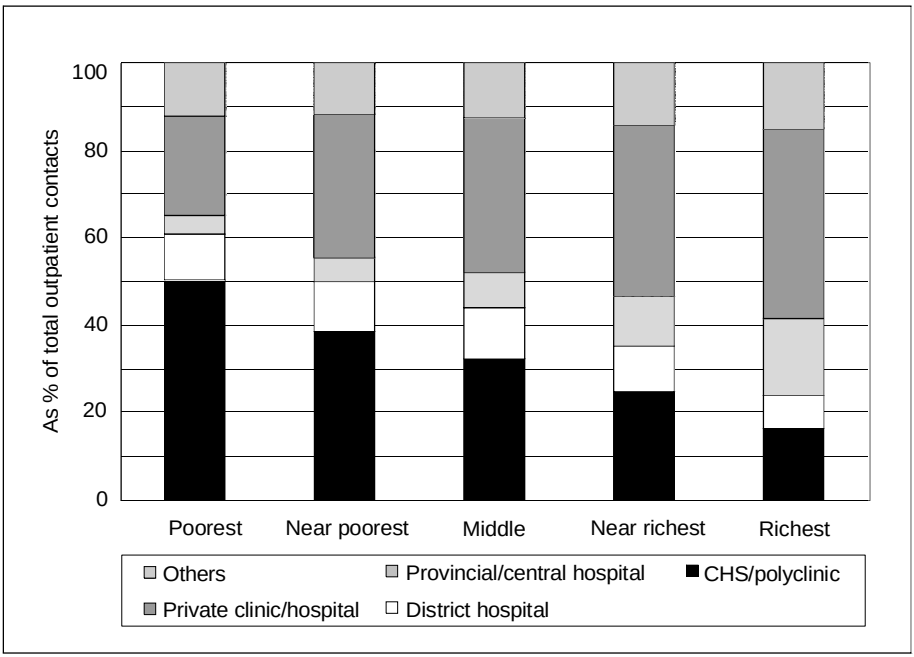
of total hospital staff income (World Bank et al., 2001). Although the salaries of public health care providers have increased several times since the inception of health reforms in 1989, such salaries, like those of many other employees in the public sector, remain low in both absolute and relative terms. In 2002 salaries of public health care providers accounted for only 35 percent of total recurrent central and local state health budgets (World Bank, 2004).

2.3. Utilization and affordability of health care services

2.3.1 Utilization of outpatient health services

Figure 3 presents the distribution of outpatient service contacts by sample households across providers and expenditure quintiles over a four-week reference period. The share of contacts with public hospitals and with private clinics and physicians in total household service contacts tends to vary positively with income. Higher income households tend to use the provincial/central

Figure 3. Outpatient contacts, by providers and per capita consumption expenditure quintile



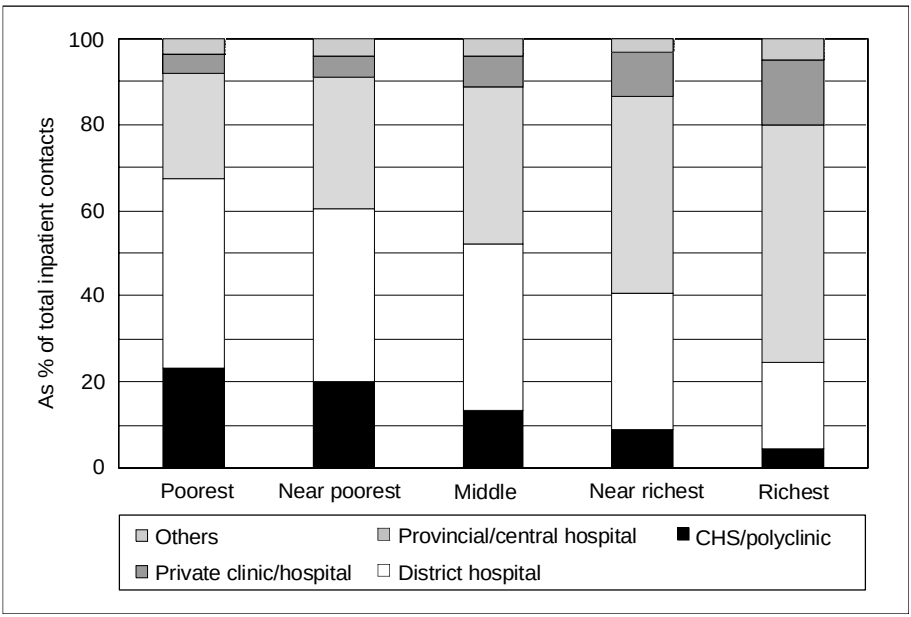
Source: VNHS, 2002.

hospitals and private clinics/hospitals far more than the poor and near poor. The share of contacts with provincial/central hospitals for the richest 20 percent of the population was almost 4.5 times that of the poorest quintile. In contrast, Community Health Stations (CHS) and polyclinics were used more frequently by low and middle-income households. The quality of services provided by public hospitals and private clinics and physicians is generally perceived by patients to be of a higher quality than that provided by CHSs (Dong, 2002; Tipping et al., 1994).

2.3.2. Utilization of inpatient health care services

The distribution of inpatient service contacts by economic group follows a similar pattern. High-income households use higher quality provincial/central hospitals while low and lower income groups use CHSs and district hospitals (see Figure 4). CHSs and district hospitals accounted for over two-thirds of all inpatient contacts for the poorest expenditure quintile as compared to 24 percent for the richest quintile.

Figure 4. Inpatient contacts, by providers and per capita consumption expenditure quintile



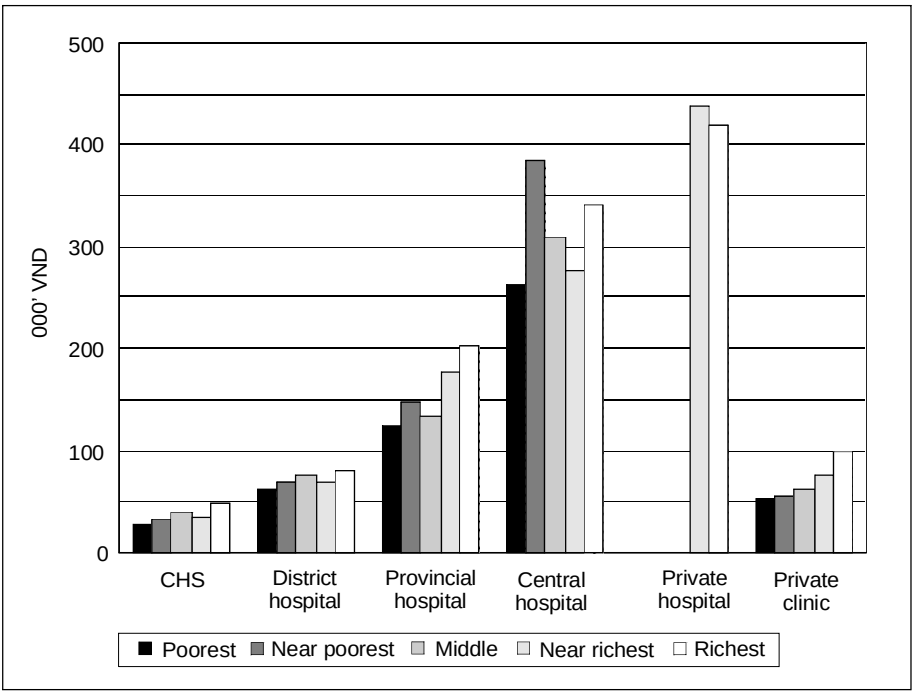
Source: VNHS, 2002.

2.4. Private out-of-pocket payments for health services

2.4.1. Out-of-pocket expenditure per outpatient service contact

Figure 5 shows total out-of-pocket expenditures per outpatient contact across economic groups with no health insurance or eligibility for fee exemptions. The average out-of-pocket cost per contact varies significantly across providers as well as across economic groups. The richest 20 percent of the population spent 1.6 times the amount spent by the poorest 20 percent of the population on each outpatient visit to CHS and provincial hospitals. The difference in out of-pocket expenditure per outpatient between the poorest and richest households is even more pronounced in the case of private clinics, where the former spent almost twice as much as the latter on each outpatient service contact.

Figure 5. Average out-of-pocket expenditure per outpatient contact by the uninsured



Source: VNHS, 2002

Drug costs make up a large proportion of household out-of pocket payments (Segall, et al., 1999). According to the VNHS data, drug costs accounted for 69 percent of the average cost of each outpatient contact. Most government health facilities run their own pharmacies and some commune health workers sell medicines privately. Drugs are generally sold at a mark-up ranging from 12 to 15 percent, and profits often finance bonuses for health workers. This system encourages over-prescription, especially of more expensive items. Over-prescription is a product of the rapid transition from a centrally controlled pharmaceutical industry to a weakly regulated market system that fails to curb the aggressive marketing strategies of foreign and domestic drug companies. Moreover, there is little effective supervision and monitoring of the prescribing behaviour of health care providers, and the national essential drugs policy has yet to be fully implemented (Chalker, 1995; Chuc and Thomson, 1999).

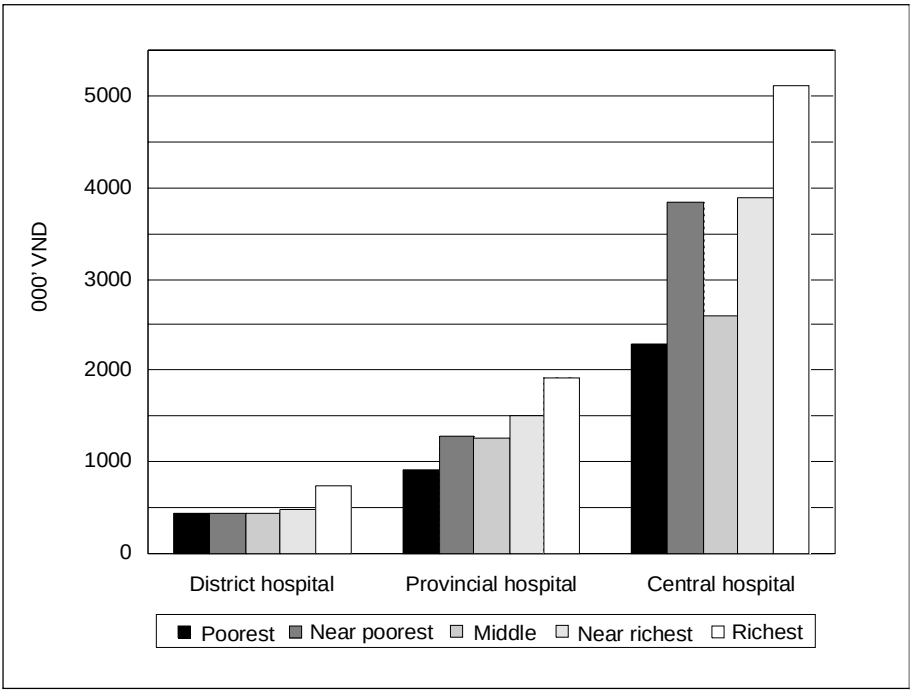
According to a recent study involving 27 private and *non-private* physicians in Ho Chi Minh City, current prescription practice is characterized as excessive, inappropriate and 'unethical' (Lennroth et al., 1998). Prescription practices are, according to some physicians interviewed, driven by their dependence on drug selling to boost their incomes, as well as by the patients' requests for certain drugs. Similar results have been reported in China where providers tend to over-prescribe, but patients' influence on prescribing behaviour of the physicians was found to be a less important factor (Zhan, Tang and Guo, 1997).

2.4.2. Out-of-pocket expenditure per inpatient service contact

Illness requiring hospitalisation imposes a heavy financial burden on households, especially those from the low and middle-income groups. Figure 6 presents total out-of-pocket expenditure per inpatient contact among the uninsured by provider. The total cost includes the cost of medicines purchased outside of hospitals, transportation, and food and lodging for accompanying family members. Out-of-pocket payments per inpatient contact vary positively with income, with the richest 20 percent of the population spending more than twice as much per inpatient contact at provincial hospitals as the poorest 20 percent. Higher spending per contact by non-poor households partly reflects better care and partly over provision of services (World Bank et al., 2001).

Financial incentives that encourage hospitals to over-provide high technology services have been documented in several developing countries (Barnum and Kutzin, 1993). Currently, Viet Nam imports costly medical technologies with no systematic assessment of the costs and benefits of such equipment, the appropriateness of new technologies, or their public health impact (Gellert, 1995). Costly technologies may not only lead to unnecessary diagnostic tests

Figure 6. Average out-of-pocket expenditure per inpatient contact by the uninsured



Source: VNHS, 2002

but may also exacerbate disparities between large urban hospitals and smaller rural centres that can rarely afford to invest in such equipment.

2.5. The heavy financial burden of illness

Table 1 presents total household out-of-pocket expenditure per inpatient contact as a percentage of non-food expenditures. Households, especially the poor and near poor, generally have more discretion over non-food than food expenditures. The ratio of total out-of-pocket expenditure per inpatient contact over the household's annual non-food expenditures therefore provides useful information about the affordability of inpatient care.

Even though poor households use hospitals far less frequently than non-poor households, whenever poor households do use hospitals each contact imposes a heavy burden on the family. The cost of a single inpatient contact at a district hospital takes up over one fifth of annual non-food consumption expenditure for a person from the poorest population quintile, as compared to less than

Table 1. Average out-of-pocket expenditure per inpatient contact as percentage of household annual non-food consumption expenditure, by per capita consumption expenditure quintile

	Per capita consumption expenditure quintile					
	Poorest	Near poorest	Middle	Near richest	Richest	Average
All providers	28.2	25.9	18.7	19.1	13.4	20.3
District hospital	20.8	13.4	9.5	7.0	4.7	8.5
Provincial hospital	44.4	39.2	26.9	21.4	12.1	25.9
Central hospital	111.5	117.0	55.6	55.5	32.2	68.0

Source: VNHS, 2002

five percent for the richest quintile. The cost burden per hospital contact is even greater if the illness is severe enough to require admission to a higher-level public hospital, such as a provincial or central hospital. Indeed, as Table 2 indicates, for the poorest and near poorest households a single admission to a provincial hospital accounts for 44 and 39 percent of household annual non-food expenditures, respectively. The financial burden is even heavier if an admission to a central hospital is required. The total cost of a single admission to a central hospital takes up on average 68 percent of non-food expenditures. The corresponding ratios for the poorest and near poorest population quintiles are 117 and 111 percent, respectively.

The high cost of accessing public hospitals can lead to long-term impoverishment of households (Ensor and San, 1996). According to a recent Participatory Poverty Assessment (PPA) in Tra Vinh province, 57 percent of households that had become poorer over time cited illness as the main reason for the decline in living standards (Oxfam, 1999). A recent study of the financing of inpatient care in one of the poorest provinces of Viet Nam indicates that almost half of those in the lowest four quintiles relied solely on selling assets, and 19 percent on borrowing, to meet hospitalisation costs. By contrast, over 60 percent of households in the richest quintile relied on their savings to finance the cost of hospitalisation. Similar results have been reported for China (Yu *et al*., 1997; Hossain, 1997).

2.6. Exemption mechanisms

Since the introduction of user charges in 1989 various formal mechanisms have been developed to exempt certain classes of individuals from treatment fees, including war veterans, the disabled, orphans, ethnic minorities and the

very poor, children under the age of six, as well as individuals with certain ailments such as malaria, tuberculosis and leprosy. Most of the early schemes relied heavily on local financing and consequently were implemented in the more prosperous provinces (Knowles, 2003). Coverage rates also remained low under some other national schemes due to insufficient funding and complex procedures for identifying beneficiaries (Knowles, 2003).

In late 2002 the government introduced a new initiative (Decision No. 139) instructing provinces and centrally-run cities to establish Health Care Fund for the Poor (HCFP).[2] This new initiative builds on previous efforts to fund health care for the poor. The HCFP covers the poor, residents of communes with very difficult socio-economic circumstances, and ethnic minorities in four Central Highland provinces and six other disadvantaged provinces in the northern mountainous region. The HCFP provides beneficiaries with either a free health insurance card with an annual premium of 50,000 Viet Nam dong per person or pays actual medical expenses incurred at public health facilities (subject to some ceilings). These funds are mostly financed through the central budget (75 percent), with the rest derived from provincial budgets and contributions from national and international institutions and individuals.

As of 2003, there were, according to official government reports, over 11 million HCFP beneficiaries, representing 84 percent of the target population. One third of beneficiaries had been granted health insurance and two thirds were entitled to reimbursement of health care costs (MOH, 2004). However, large variations exist in the percentage of the targeted population covered under the programme, ranging from 58 percent in the Northern Mountainous region to 90 percent in the Red River Delta and South East regions (MOH, 2004). Information is lacking on actual benefits offered by the programme and its impact on utilization of services. However, some concerns have already been raised about the ability of the poor provinces to adequately fund the programme, the adequacy of benefits, and low reimbursement rates for providers (Knowles, 2003). Since 25 percent of total funding for the programme is to be raised from sources outside the central government budget, including from provinces, the fiscal burden is heavier on poor provinces in which a high percentage of the population is eligible for HCFP benefits. For example, targeted HCFP beneficiaries account for more than two-thirds of total population in the five northern provinces, and less than five percent in more prosperous provinces such as Ha Noi, Da Nang and Ho Chi Minh City (Knowles, 2003). The fiscal

[2] Decision No. 139/2002/QD-TTg (dated October 15th, 2002) and the Inter-Ministerial Circular No. 14/2002/TTLB/BYT-BTC (dated December 16th, 2002) relates to the organization of health care provision, establishment, management and clearance for the Health Care Fund for the Poor.

burden would be even higher if poor provinces were to provide full funding to health facilities. Reimbursement of public health facilities at the existing level of user charges does not cover the full cost of services, with the result that responsibility for the costs of extra services falls to provincial governments. Yet at present provincial government budgets do not provide for increased services (Knowles, 2003). Moreover, low reimbursement rates make it difficult for the poor and near poor to obtain quality health care services in the absence of informal payments. Low reimbursement rates pose a more serious problem in provinces that have opted for direct reimbursement of public health providers rather than health insurance cards. Reimbursement rates under the insurance programme are generally higher than existing user charges. With the majority of poor provinces opting for direct reimbursement of providers at the existing user charges, questions remain concerning the quality of care provided to beneficiaries (MOH, 2004).[3] Finally, the implementation of the programme has been slow, the identification of eligible beneficiaries is complex and time consuming, and accessing benefits at higher-level public hospitals remains costly to patients (MOH, 2004).

2.6.1. Coverage and targeting of exemptions

Table 2 presents recent information on the coverage and targeting effectiveness of hospital fee exemptions.[4] Four observations can be made on the basis of these data. on the basis of these data. First, far more patients from lower income households receive partial or full exemptions than from higher income households. About 27 percent of the poorest inpatient care users received exemptions as compared to five percent of patients from the richest population quintile. This suggests that targeting fee exemption/ reductions to protect the poor from the financial costs of hospitalisation are relatively effective and the leakage rate is not high by international standards (UNDP, 2004).[5] Second, the coverage rate is rather low, as slightly more than one quarter of patients from the poorest population quintile received exemptions. The coverage rate is even lower for the second poorest population

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[3] The share of HCFP beneficiaries covered by the direct reimbursement method ranged from 100 percent in the Central Highlands to 83 percent in the Northern Mountains and 67 percent in the Mekong Delta. In contrast, the health insurance method accounted for 100 percent in the South East and about 69 percent in the Red River Delta (MOH, 2004).

[4] This section uses the 2002 VNHS to assess the coverage and targeting of exemptions. Since the VNHS was completed prior to the implementation of the HCFP, it does not capture HCFP beneficiaries.

[5] Sixty-three percent of all fee exemption/reduction went to the poorest and near poorest population quintile while only about 20 percent of all exemption/reduction went to the near richest and richest population quintile.

quintile. Third, while far more patients from low-income households benefited from hospital fee exemption/reductions than patients from high-income households, the reverse is true for those with insurance. Partial or full payment by insurance accounted for only eight percent of the poorest patients as compared to 29 percent for the richest patients. Fourth, the coverage rate for both fee exemptions and insurance is very modest, with over two-thirds of households paying for inpatient care from their own resources. The percentage is even higher for the near poorest and middle population quintiles which benefited less from fee exemption/reductions or insurance than other income groups.

Table 2. Inpatient contacts, by method of payments and per capita consumption quintile

	Per capita consumption expenditure quintile					
	Poorest	Near poorest	Middle	Near richest	Richest	Average
Out-of-pocket	65.4	70.3	69.0	64.0	66.8	67.2
Partial or full exemption	26.6	16.5	12.0	8.7	5.1	13.6
Insurance	8.0	13.2	18.9	27.2	28.0	19.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: VNHS, 2002

It should be noted that even though insurance and hospital fee reductions lessen the financial burden of hospitalisation on the poor and vulnerable, the benefits are rather modest. Fee reductions and insurance reduce average out-of-pocket payments per inpatient contact by 44 and 26 percent, respectively (NNHS, 2002). Out-of-pocket expenses remain high, especially considering indirect costs such as transportation, and lodging and food for relatives accompanying patients.

The data suggest that for a large segment of the population the costs of hospitalization will remain onerous as long as the resources allocated to national targeted programmes for the poor remain inadequate and eligibility criteria are restrictive. Eligibility for the national targeted programmes for the poor is often based on criteria established by the Ministry of Labour, Invalids and Social Affairs (MOLISA), which are in turn determined by the availability of resources. According to the MOLISA criteria, for example, only 14.3 percent of households were very poor in 2002, compared to 29 percent according to the alternative poverty line produced by the General Statistical Office.

3. IMPLICATIONS FOR EFFICIENCY AND EQUITY OF GRANTING PUBLIC HEALTH FACILITIES FINANCIAL AUTONOMY

Recently the government has granted financial and managerial autonomy to revenue-raising public service entities, including government health facilities and schools. The Decree on Financial Autonomy (Decree 10) grants sweeping powers to revenue-raising public agencies to (i) manage their revenue and expenditure accounts; (ii) exploit alternative revenue sources; (iii) restructure staffing; (iv) adjust employees' salary and wage packages subject to some ceilings. By converting state budget appropriations to a block grant fixed over three years, revenue-raising public service agencies are allowed to use the bulk of savings from the allocated state budget to increase staff remuneration and establish reward, welfare and reserve funds for stabilizing employees' incomes. The stated objectives of these new management mechanisms are among other things, to improve efficiency, expand the quality of service provision, and encourage agencies to exploit alternative sources of revenue.

The decree has far reaching implications for the delivery and financing of health services as it provides managers of public health facilities with incentives that are similar to those of for-profit private hospitals. A full discussion of these implications is beyond the scope of this paper. Using available evidence from several hospitals that have already implemented Decree 10 and evidence from other countries, the following section examines some of the implications of Decree 10 for the accessibility of health services, especially for the poor.

3.1. Improvements in quality and efficiency

Since many public health facilities are severely under-funded, any increase in revenues helps health facilities to improve the provision of services. Additional revenues help public health facilities to acquire badly needed equipment and to improve staff morale by paying higher salaries. Autonomy with regard to human resources provides some agencies with the opportunity to assume local control over hiring and therefore the quality of personnel.

According to available evidence from hospitals that have implemented Decree 10, additional revenues can be significant. One large Ha Noi-based public hospital, for example, was able to increase revenues by as much as 27 billion Viet Nam dong (86 percent) within two years after implementation of Decree 10 (World Bank, 2004). This rapid increase in revenues was mainly achieved

by providing 'special services' that are not currently regulated under the national fee structure.

However, the potential for revenue raising and improvement in quality and efficiency depends very much on the location, type, and level of services provided by these facilities. For example, public hospitals that are located in poor regions of the country are less likely to be able to collect as much revenue as those located in affluent regions. Unless there is a reallocation of state health budgets, a greater reliance on user financing can lead to a deepening of regional inequality in terms of the quality of health services. Moreover, health facilities that focus on preventive or educational services have fewer opportunities to raise revenues. The available evidence from hospitals that have implemented Decree 10 does not indicate any change in the allocation of state health budgets.

3.2. Patient skimming

One of most serious side effects of Decree 10 is that it encourages public hospitals to skim high-income patients with less serious health problems as a way of securing revenues. It is known that for-profit hospitals often admit patients who are relatively easy and profitable to treat and refer those patients with chronic and serious conditions to other hospitals, normally higher-level public hospitals. Consequently, the very sick and poor are often denied access. Anecdotal evidence from hospitals that have already implemented Decree 10 suggests an increase in the referral rate after the implementation of the decree.

3.3. Over-provision of services

Increasing reliance of public hospitals on patient revenues changes the incentive structures under which providers operate, with serious consequences for efficiency and equity. Provider's treatment decisions may be influenced when the official user charge system allocates a portion of fee revenues to employee bonuses. Since Decree 10 promises richer rewards and bonuses than those allowed under the user charges system, providers have stronger incentives to induce demand by over-providing expensive services to those who can afford to pay official fees and generous 'gifts'. The risk of over-provision is likely to be high in an environment in which regulation and control mechanisms are weak, in which professional self-regulation is absent, and when providers are poorly paid. The problems of over-utilization and cost escalation have also been noted in other transition economies, especially China (Ensor, 1998; Bloom et al., 1995; Chen, 1997; Preker and Freachem, 1994).

Concerns have already been raised in Viet Nam over the tendency of providers, including the state salaried physicians, to favour services that generate the largest payments (Viet Nam News, 2004). Empirical evidence of over-provision of services per hospital contact, especially inpatient contacts, has begun to emerge. The mean number of diagnostic tests administered to patients in public hospitals varies significantly depending on the way in which patient care is financed. The mean number of diagnostic tests administered to insured and fee paying patients is three to four times the mean number of tests administered to patients granted partial or full exemptions (Phong et al., 2002).

3.4. A two-tiered public health system

Existing differences in the revenue-raising potential of public health facilities means that some facilities, such as those located in more affluent regions or urban centres, can raise more revenues than facilities located elsewhere. Higher patient revenue enables public health facilities to improve quality, pay higher salaries and bonuses, and attract more qualified staff. In the absence of a significant reallocation of state resources, the full implementation of Decree 10 may accelerate the move towards a two-tiered health system: namely, one that provides high quality health care for those who are willing and able to pay and one that provide low quality care to less affluent individuals. Moreover, Decree 10, when combined with the ongoing fiscal decentralization, is likely to weaken national norms and controls that are currently exercised by the central government.

3.5. Commercialisation of health services

Decree 10 legitimises the private provision of services, such as diagnostic services, that is already taking place informally in some public health facilities. It also encourages the managers of public health facilities to look for alternative sources of financing to invest in medical equipment, including funding from staff and outside private interests. The problem of commercialisation of health services and the escalation of costs has been demonstrated in other transition economies. In China the transition from a centrally controlled public health system to a poorly regulated fee-for-service system has led to profiteering by providers working in both public and private health facilities and direct participation of drug manufacturers and manufactures of medical equipment in financing public hospitals (Bloom and Xingyuan, 1997; Bogg et al., 1996; Liu, Liu and Meng, 1994). A comparative analysis of health care costs in the developed countries suggests that total health care expenditure is lower on average in systems predominantly funded through general taxation (OECD,

2002). Indeed, the larger the private share of health care financing, the more difficult it is to control health expenditure (Evans, 2002).

3.6. Affordability of health services

The introduction of Decree 10 has led to growing concern over the level of fees charged by public health facilities. It should be noted that there is nothing explicit in Decree 10 that allows public health facilities to raise the level of fees since the Prime Minister currently sets the fee structure. However, the implementation of the Decree has created material incentives for public hospitals to provide more 'special services' that are not covered by the existing fees structure, and for pressuring the government to raise the level of fees. As the pressure for higher fees intensifies, it will become more difficult for the government to resist. Any increases in fees would add to the already heavy financial burden on households, especially on the poorest and near poorest households, unless subsidies are provided. Although the recently established Health Care Fund for the Poor should help reduce the financial burden of higher fees, the HCFP applies the same criteria used by other hospital fee exemption/reduction schemes in establishing eligibility. These criteria, as noted earlier, are too restrictive and exclude a large proportion of the very poor and near poor. Moreover, an increase in fees makes it difficult, especially for poor provinces, to fund the HCFP since reimbursement rates must also rise with fees.

4. EDUCATION

4.1. An overview

Viet Nam's publicly provided and financed education system was also adversely affected in the initial phases of the transition to the market. Low growth and higher inflation combined with a steady decline in government spending led to a rapid deterioration of school infrastructure, teacher motivation, shortages of textbooks, and increased use of double or even triple shifts in primary and secondary schools (World Bank, 1993). The gross enrolment rate at the secondary level declined from 43 percent in 1985 to 33 percent in 1990 (Glewwe and Jacoby, 1998).[6]

4.1.1. Non-public provision of services and user charges

Viet Nam's education system was profoundly affected by the reform measures of the late 1980s and early 1990s, especially in the areas of the financing and delivery of education services. These changes include a new system of cost sharing or 'socialization' of education, as it is called in Viet Nam, and the emergence of semi-public and people-funded schools as well as private schools and universities. The new system of user charges and the private provision of education were meant to mobilize additional resources for education, foster parental involvement in decision-making regarding school curriculum and finance, increase the accountability of schools and commune authorities in the delivery of educational services, and diversify the provision of educational services.

While the state remains the dominant provider at all levels of education, enrolment in semi-public and people-funded schools as well as in private schools and universities is growing. Among non-public educational institutions, semi-public secondary schools have grown faster than others by attracting students who could not gain entry into public schools. Semi-public schools operate on a cost recovery basis using buildings and facilities provided by the state. Semi-public and private schools accounted for 47 percent of total upper secondary enrolments in 2004 (World Bank, 2004). The quality of education provided by semi-public and private institutions is generally viewed by the Vietnamese to be inferior to that of public institutions.

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[6] The gross enrollment rate is defined as the ratio of all children enrolled over the total school-aged population.

In 1989, an official fee system was introduced, under which parents were required to pay fees equal to the value of one kilogram of rice per month for each child enrolled in primary school grades 4 and 5, and two kilograms of rice per month for each child enrolled in lower secondary school. Grades 1 to 3 remained free of charge, at least in theory. Students were also asked to pay for their textbooks. Fees could be used for maintenance, supplies, and to supplement teachers' salaries. The extent to which the introduction of fees contributed to the subsequent decline in enrolments is not clear (Glewwe and Jacoby, 1998). However, four years after their introduction, primary school fees for grades 4 and 5 were abolished, and parents were required to pay a monthly fee of about VND4,000 per month for lower secondary school pupils. Authorized fees are higher in urban areas than in rural areas, and they also increase with grade level.

In the 1990s a greater reliance on cost recovery and non-public provision of education, health and culture was launched through a number of resolutions and decrees that have become known as the 'socialization' movement. Not only did these resolutions and decrees provide the legal framework for the involvement of the non-public sector in the provision of education, health and culture, but they also encouraged self-financing within public institutions. Moreover, People's Councils and People's Committees were also assigned 'responsibilities and rights', including the right to determine fees, charges and other contributions[7]. Funding from 'socialization', including overseas development assistance, is expected to increase to 40 percent by 2010, up from 29 percent in 2000 (Viet Nam Education Forum, 2003). Despite the growing significance of fees and contributions in total spending on education, these sources are rarely reported in official documents. Although most of the contributions by parents are earmarked for specific purposes, schools have flexibility in the allocation of revenues.

4.1.2. Growing private cost burden of basic education

After a significant reduction in the early 1990s, state spending on education rose considerably in the mid 1990s and early 2000s. The government education budget increased at a rate of 22 percent per year in real terms between 1993 and 2002. Public spending on education increased as a percentage of the GDP from 2.2 percent in 1992 to 4.2 percent in 2002 (World Bank, 2004). The share of public resources devoted to education also rose from 9.8 percent of the total state budget in 1992 to 16.9 percent in 2002.

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[7] Article 25 of the Law on State Budget, dated March 20, 1996.

At the same time the introduction of school fees and a greater reliance on quasi-compulsory parental contributions shifted the financial burden of education away from the state and towards users of these services. By 1994 the private cost of schooling, including fees and contributions, school uniforms, textbooks and transportation, accounted for 48 and 59 percent, respectively, of total spending on primary and lower secondary education (World Bank, 1997). The private cost of schooling per primary school pupil per year almost doubled in real terms between 1993 and 1998 from 90,000 VND in 1993 to 175,000 VND in 1998 (all in constant 1994 prices). The increase in private costs per lower secondary school child was 42 percent over the same period (VLSS, 1993, 1998).

4.1.2. Regional variations in quality

Total spending on education per pupil varies greatly across regions. Although state expenditures are more evenly distributed across regions than in the past, wide variations in state and private spending per pupil still exist. Total spending per child in primary school in the Northern Mountainous and North Central regions was about 22 percent below the national average and only 54 percent of spending per child in the South Central region (Nguyen, 2002).

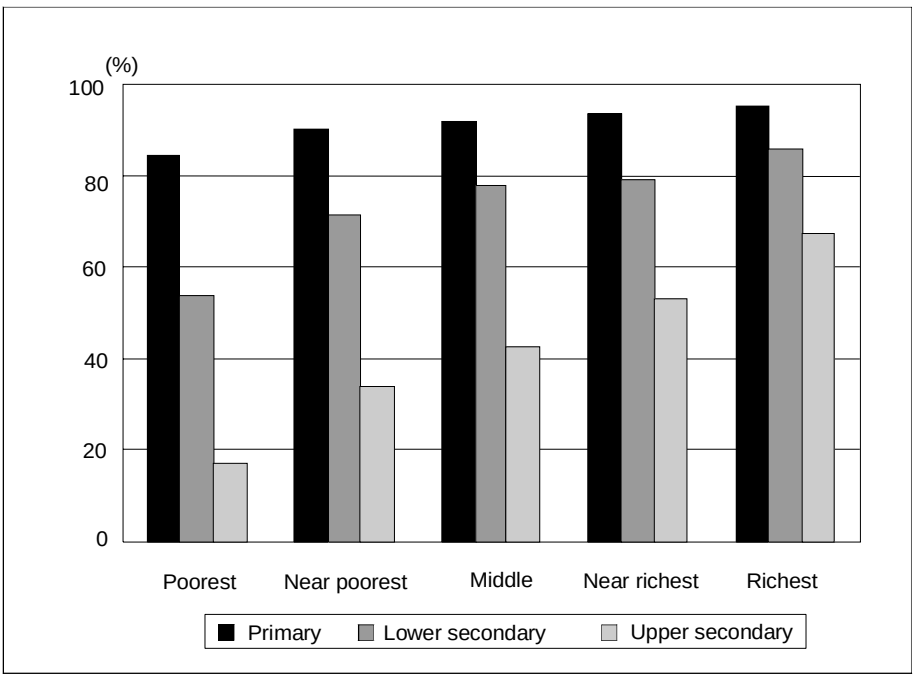
These differences in spending contribute to variations in the quality of education. In the poor mountainous regions, the allocated state budget for primary education is only sufficient to cover expenditures on personnel, leaving no resources for teaching and learning materials (Education Forum, 2003). Poor regions, including the North West, the Central Highlands and the Mekong Delta, also score far below the national average in terms of classroom materials and furniture (World Bank, 2002). In terms of student performance in mathematics, students from the North West, the Central Highlands and the Mekong Delta rank below the national average. In recent years, the government has launched several initiatives to improve the quality of basic education, such as the introduction of a new primary school curriculum that envisions the introduction of improved teaching methods and materials and a significant increase in the numbers of hours per week for instruction of core and optional subjects. However, limited resources and poor training of teachers, especially outside urban centres, have hindered implementation of the new curriculum.

4.2. School enrolments

After a decline in the early years of transition, school enrolments have increased significantly over the past decade. At the primary level the net enrolment rate (NER) rose from 87 in 1993 to 90 percent in 2002 while the NER at the lower

secondary level increased from 30 to 72 percent.[8] The NER at the upper secondary level also rose significantly from seven percent to 42 percent. The greatest increases in participation rates in primary education have been in the poorest and near poorest population quintiles. However, as Figure 7 shows, the gap in participation rates between the poorest and the richest quintile remains large both at the lower and upper secondary levels.

Figure 7. Net enrolment rates, by level of education and per capita consumption expenditure quintile



Source: VHLSS, 2002

Differences in participation rates between ethnic minorities and the majority Kinh are also still high, especially at the secondary level. At the lower secondary level, only 48 percent of school age ethnic minority children attended lower secondary school in 2002, compared to 76 percent for the Kinh and Chinese

[8] Net enrolment rates express enrolment of the official age group for a given level of education as a percentage of the population in that age group.

populations. Evidence from PPAs suggests that enrolment rates are even lower for minority girls.

In ratifying the Millennium Declaration, the government committed itself to achieving the Millennium Development Goals (MDGs), including universal primary education by 2015, the elimination of gender disparities in primary and secondary education by 2005, and in all levels of education by 2015 (UN, 2003). These goals are further elaborated in the Comprehensive Poverty Reduction and Growth Strategy (CPRGS) (Government of Viet Nam, 2003). Achieving universal primary education will not be a simple matter as almost three quarters of school age children not currently attending primary school are from the poorest and near-poorest population quintiles.

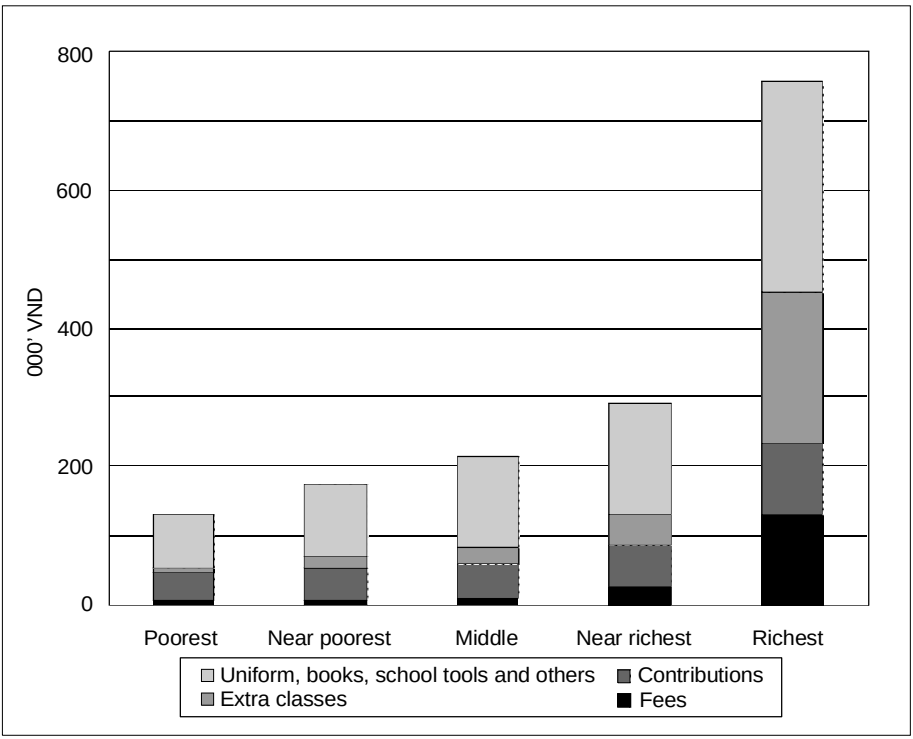
4.3. Private out-of-pocket expenditure on basic education

While the government is still the main provider of education at all levels, the public share of total spending on education is low, especially at the secondary and higher education levels. Out-of-pocket payments account for over 58 percent of total spending on lower secondary education. At the primary level, the state finances a higher share of total spending, with households' out-of-pocket expenditures accounting for about 39 percent of the total (Government of Viet Nam-Donor Working Group, 2001).

Total private out-of-pocket spending per child in primary and secondary school is shown in Figures 8 and 9. The private costs of basic education vary considerably among different income groups, with the richest parents spending almost six times more per child enrolled in primary school than the poorest households. The private cost of schooling is far higher at the lower secondary level than at the primary level. It costs parents on average almost 70 percent more to send a child to secondary than to primary school.

Although fees are not authorized at the primary level, parents do, in fact, pay school fees. In addition to fees, parents are required to pay a wide range of other contributions, both formal and informal. These contributions are levied per child and vary little with the economic status of the household. For the poorest and near poorest households, these contributions account, respectively, for 32 and 27 percent of the total private cost per child in primary school. Extra classes also constitute significantly to the private costs of schooling per child, especially for households that can afford private tutoring offered by schoolteachers on an informal basis.

Figure 8. Average annual out-of-pocket expenditure per child in primary education, by per capita consumption expenditure quintile



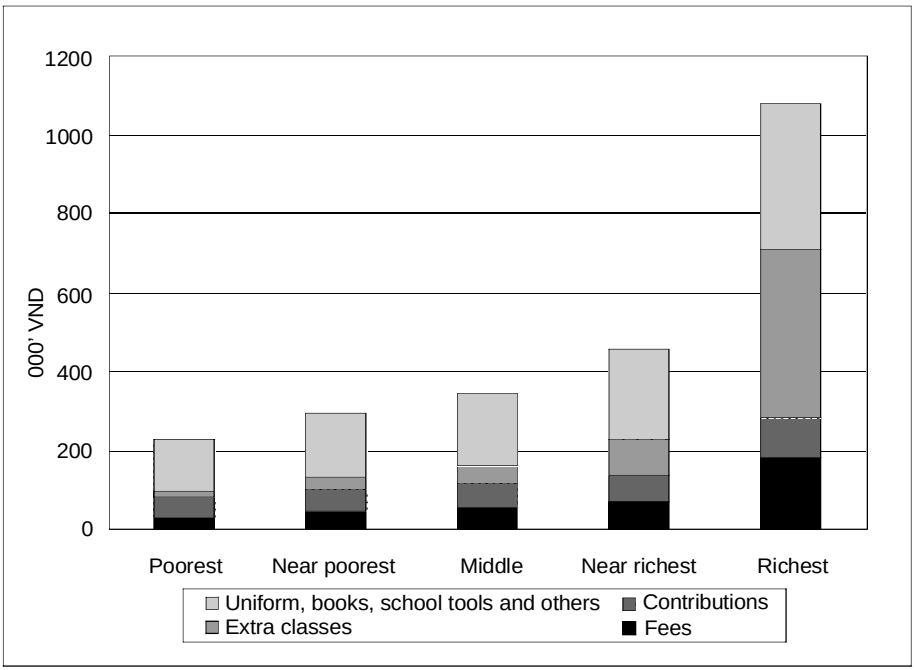
Source: VHLSS, 2002

Expenditures on extra classes accounted for 24 percent of total expenditure per child in lower secondary school and 17 percent in primary school. Household expenditure on extra classes also varies considerably across economic groups, with the richest households spending almost twice as much on extra classes as the poorest households spend on fees, contributions, textbooks, uniform, and extra classes combined at the lower secondary level.

4.4. The affordability of basic education

Table 3 reports the ratio of private out-of-pocket spending per child to household non-food expenditures. We refer to this indicator as the *affordability ratio*. The financial burden of schooling varies considerably across educational levels and income groups. The annual direct private cost of schooling per child takes up on average 4.4 percent annual non-food expenditures at the

Figure 9. Average annual out-of-pocket expenditure per child in lower secondary education, by per capita expenditure quintile



Source: VHLSS, 2002

primary level and 7.4 percent at the lower secondary level. For the poor and near poor the financial burden is especially heavy at the secondary level. The affordability ratios for these groups are eleven and nine percent, respectively.

Table 3. Average annual out-of-pocket school expenditure per child as percentage of household annual non-food consumption expenditure, by per capita expenditure quintile

	Per capita consumption expenditure quintile					
	Poorest	Near poorest	Middle	Near richest	Richest	Average
Primary	6.3	5.3	4.5	4.3	4.8	4.4
Secondary	11.0	8.9	7.2	6.7	6.8	7.4

Source: VNHS, 2002

The affordability ratios in Table 3 do not control for the quality of education received by children from different income groups. Observed disparities in the financial burden of basic education would be even greater if children from the poorest and near poorest households received education of a quality similar to that enjoyed by children from non-poor households. For example, if expenditures on extra classes of the poor and near poor were equal to the national average, the affordability ratio for lower secondary school attendance would rise to 15.5 percent. Nor do the cost data control for differences in grade repetition among pupils. Grade repetition rates in primary school vary by economic group, from 25 percent for pupils from the poorest quintile to eight percent for those from the wealthiest quintile (Nguyen, 2002).

Evidence from Viet Nam and other low-income countries suggests that higher direct private costs of schooling reduce the likelihood that parents, especially poor and near poor parents, will enrol their children in school (Oxfam, 2002). PPAs indicate that poor and near poor households withdraw their children, especially girls, from school when households face financial crises resulting from unexpected events, such as a catastrophic illness requiring hospital admission. The government has recognized the potential financial burden of basic education on poor households in the Comprehensive Poverty Reduction and Growth Strategy (Government of Viet Nam, 2003), and educational sector strategies including the Education for All Plan (MOET, 2003) and the Education Development Strategy (MOET, 2001), all of which identify the elimination of fees in primary and lower secondary schools for poor children as a core policy objective.

4.5. Exemption mechanisms

Various education assistance programmes aimed at poor households, ethnic minorities, the disabled, veterans, policy households and those living in remote communities have been put in place. These programmes are designed to help poor children stay in school and consist of exemptions from and reduction of fees and contributions, provision of textbooks and notebooks and scholarships for very poor pupils. The components vary in terms of financing and coverage. Exemptions from school fees and contributions have received more funding and cover a larger share of the population than other components.

4.5.1. Coverage and targeting of exemptions

According to recent VHLSS data, over 84 percent of all reductions in school fees and contributions were directed to ethnic minorities, people living in remote

areas and the poor. Targeting of exemptions and reductions is relatively effective and the leakage rate is low by international standards (UNDP, 2004). However, the exemption mechanisms directed to the poor cover only 7.4 percent of children from the poorest and near poorest households in primary school. The coverage rate is slightly higher at the lower secondary level (10.3 percent). Even for poor households that receive exemptions/reductions, out-of-pocket expenditures are high, especially at the primary level. Since fees and contributions take various forms, full or partial exemptions often apply to some fees and contributions but not to all. As Table 4 indicates, while exempted children from the poorest households pay only three percent of full fees at the primary level, they pay as much as 40 percent of contributions. At the lower secondary level, benefits from exemptions from fees and contributions are far smaller. Moreover, as Table 4 indicates, there is little variation in the amount of reduction in contributions received by different economic groups.

Table 4. Average out-of-pocket expenditure on school fees and contributions per child by the exempted households (as percentage of expenditure by the non-exempted households)

	Per capita consumption expenditure quintile					
	Poorest	Near poorest	Middle	Near richest	Richest	Average
Primary education:						
Fees	3.1	4.1	9.5	2.8	17.7	4.9
Contributions	40.1	33.3	48.3	48.2	41.4	35.0
Lower secondary education:						
Fees	42.4	28.8	31.9	31.6	15.2	27.7
Contributions	70.8	61.0	73.2	53.8	63.9	59.9

Source: VNHS, 2002

The heavy financial burden of basic education suggests that exemptions do make a difference to primary school enrolments among poor children (Nguyen, 2004). A comparison of households receiving school fee or contribution exemptions with similar households that did not have access to benefits suggests that exemptions increase the likelihood of enrolment in primary school by 11 percent.

5. GRANTING PUBLIC EDUCATION FACILITIES FINANCIAL AUTONOMY

Decree 10 encourages revenue-raising public educational institutions at all levels to manage their revenues, expenditures and staffing autonomously, while also seeking alternative revenue sources. As in the case of the health sector, the decree has far-reaching implications for the delivery and financing of educational services, especially at higher levels of education. It provides schools with incentives that are similar to those of for-profit private educational facilities. As data from educational facilities that have implemented Decree 10 are still limited, it is not yet possible to assess the implications of the decree for enrolments, revenues from fees and contributions and state budgets. The following section therefore briefly explores the potential implications of Decree 10 for the delivery and financing of basic education in part based on experiences in other developing countries.

5.1. Improvements in quality and efficiency

Public schools can raise additional revenues by implementing Decree 10, and these revenues can help schools to acquire badly needed equipment and teaching aids and to pay higher salaries. The potential for revenue raising and improvements in quality and efficiency, as discussed earlier with reference to the health sector, depends very much on the location and level of educational services provided. For example, the potential for raising revenue is far greater for vocational schools and universities than for primary and lower secondary schools. Tuition fees already account for one fifth of total expenditures for vocational schools, colleges and universities, and higher fees in these institutions are less likely to deter students who are mostly from higher income households. In contrast, the potential for revenue raising is far smaller for primary and lower secondary schools, especially for those located in poorer regions.

Greater opportunities also exist for higher educational facilities to identify alternative sources of funding. There is already a sizeable and growing private sub-sector that makes use of public resources and provides a variety of services, including professional degree programmes, research, and consultancy. Primary and lower secondary schools will find it difficult to identify similar opportunities. Space and equipment limitations make it more difficult for primary and lower secondary schools to increase their revenues by increasing enrolments.

5.2. A two-tiered public education system

Although public schools may find it difficult to increase revenues by increasing enrolments, some schools will resort to student skimming and higher fees. Public schools located in more affluent areas can increase fees and use the additional resources to improve quality, pay higher salaries and bonuses, and attract more qualified staff. Higher quality in turn attracts better-off students making higher formal and informal fees possible. In the absence of a significant reallocation of state resources, the full implementation of Decree 10 may therefore accelerate the development of a two-tiered education system.

6. CONCLUSIONS AND RECOMMENDATIONS

6.1. Conclusions

This discussion paper has examined the implications of user fees and financial autonomy for the accessibility of publicly provided health and education services. A review of Viet Nam's experience with user fees in health and education suggests that the private costs of these services represent a significantly larger proportion of household non-food budgets for the poor and near poor than for the non-poor. Even though poor households use hospitals far less frequently than non-poor households, each contact imposes a heavier burden on the poor. The high cost of accessing public hospitals can lead to long-term impoverishment, as the poor are forced to sell assets or borrow to finance the cost of healthcare.

The private costs of basic education also vary considerably among different income groups, with the richest parents spending almost six times more per child enrolled in primary school than the poorest households. Although fees are not authorized at the primary level, parents do pay fees in addition to a wide range of other 'voluntary' contributions. These contributions are levied per child and vary little with ability to pay. For the poorest and near poorest households, contributions accounted, respectively, for 32 percent and 27 percent of the total private cost per child in primary school. Extra classes also constitute a significant proportion of the private cost of schooling per child, especially for households that can afford the private tutoring offered by schoolteachers on an informal basis.

For the poor and near poor the financial burden is substantial, especially at the secondary level, where the private cost of schooling per child amounts to eleven and nine percent of annual household non-food expenditures. Even though formal mechanisms exist to exempt certain classes of individuals from school fees, these mechanisms reach only a small fraction of the poor and vulnerable population, and provide inadequate protection. Because of the low coverage rate of exemption programmes and inadequate benefits, exemptions have a limited impact on the financial burden of basic education.

Given existing differences in the revenue-raising capabilities of public health and education facilities, the full implementation of Decree 10 could lead to a deepening of regional inequality, patient and student skimming, the commercialisation of social services, and a more onerous financial burden on households, especially the poorest. In the absence of a significant reallocation of state resources, the full implementation of Decree 10 could accelerate moves

toward two-tiered systems that provide high quality healthcare and education for those who are willing and able to pay and low quality services to everyone else.

One of the most serious potential side effects of Decree 10 is that the new rules encourage public hospitals to skim off high-income patients with less serious health problems while denying access to the very sick and poor. Moreover, since Decree 10 promises richer rewards and bonuses than those allowed under the user charges system, health workers have a greater incentive to over-provide expensive services to those who can afford to pay official fees and generous 'gifts'. The implementation of the decree creates the material incentives for public hospitals to provide more 'special services' that are not covered by the existing fee structure, and to pressure the government to raise the level of fees. The financial burden of higher fees charged at government health facilities on the poor and near poor would be even larger if private clinics/practitioners follow suit and raise their fees.

6.2. Recommendations

Effective policymaking requires up to date and complete information. In view of the limited availability of empirical evidence on the subject of the affordability of social services in Viet Nam, the main recommendations of this discussion paper relate to the broad contours of policy research needed in this area.

The paper identifies seven empirical issues requiring further research. Careful analysis of these issues is needed to help policymakers make informed judgements on the development of the user fee system and financial autonomy for service providers. The issues identified in this paper can be summarized as follows:

1. The impact of user fees and financial autonomy on the quality of health and education services, including the acquisition of needed equipment, staff recruitment and retention and capacity building;
2. The impact of user fees and financial autonomy on the affordability of social services, particularly for poor and near-poor households, and the relationship between health and education spending and poverty dynamics;
3. The impact of Decree 10 on the actual benefits received by beneficiaries of the Health Care Fund for the Poor and other programmes to improve access;
4. The related question of the emergence of two-tier health and education systems, in which those who are willing and able to pay more gain

access to high quality services while others must make do with second-class provision;

5. The incidence of patient and student skimming, in other words the frequency with which health and education providers favour fee-paying, low cost patients and students (for example those with less serious illnesses or students that do not have special needs) and exclude non-fee paying or more problematic clients;
6. The frequency and extent of over-provision of drugs, diagnostic tests and other profitable services to fee-paying clients as a means of increasing revenues.
7. The balance between private and state financing of basic services in comparative regional perspective and over time in Viet Nam, and implications for the level of public support for the provision of education and health services particularly for poor and vulnerable people.

A significant amount of information has already been published on these topics, and more can be gleaned from existing surveys. However, there is a pressing need for additional data collection in the form of dedicated surveys of service providers and users designed specifically to shed light on these issues. Cooperation among government agencies, donors, researchers and the public is urgently needed over the coming years to formulate and implement a comprehensive and timely policy research programme. Practical research of this sort would make a real contribution to Viet Nam's efforts to ensure quality education and health services for all its citizens, and in doing so to achieve the Millennium Development Goals.

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