

***THE WELFARE STATE: VIETNAMESE DEVELOPMENT AND
SWEDISH EXPERIENCES***

**Ari Kokko
Stockholm School of Economics, EIJIS
Patrik Gustavsson Tingvall
Stockholm School of Economics**

**Working Paper 235
June 2007**

Postal address: P.O. Box 6501, S-113 83 Stockholm, Sweden.
Office address: Hölländargatan 30 Telephone: +46 8 736 93 60 Telefax: +46 8 31 30 17
E-mail: japan@hhs.se Internet: <http://www.hhs.se/eijs>

The Welfare State: Vietnamese Development and Swedish Experiences

Ari Kokko
Stockholm School of Economics, EIJIS
Patrik Gustavsson Tingvall
Stockholm School of Economics

June 2007

Abstract

The purpose of this paper is to track the development of three components of the Vietnamese welfare state since the introduction of market-oriented economic reforms in the late 1980s: education, health, and social insurance. This is done with reference to Sweden's historical experiences of economic and social development. While Vietnam has achieved remarkable success in both the education and health sectors, with increasing literacy rates, school enrolment rates, and improving health indicators, it is clear that the Vietnamese welfare state is fragmented. Access to social services and social security varies across social groups and geographical regions, and some parts of society are becoming marginalized, in the sense that they – and their children – have limited possibilities to improve their living standards, or to benefit from the general development of the Vietnamese society. On the basis of Swedish experiences, the authors argue for gradually increased investments in the social sectors and a stronger focus on universal rather than means-tested benefits, and provide some more specific suggestions for reforms in education, health, and social insurance.

Key Words: Vietnam, economic reforms, education, health care, social insurance

JEL code: O10, I18, I28, I38, H55

Introduction

Although Sweden and Vietnam are similar in the sense that the public sector accounts for a large share of GDP, there are fundamental differences in the role of the state in the two countries. In Vietnam, the state provides public goods, but it is also a dominant actor in the manufacturing sector. State-owned enterprises produce 40 percent of industrial output, with an additional 5-10 percent coming from joint ventures between state-owned enterprises and foreign firms. In Sweden, the public sector share of GDP is even higher, but the state is hardly involved in manufacturing or primary production. Instead, the main role of the Swedish state is related to welfare and redistribution (Kangas and Palme 2005). The Swedish welfare state is built on the principle that all residents have equal rights to education, health care, and social insurance, irrespective of their individual income, wealth, or social position. To guarantee access, the state has taken on the main responsibility for financing these services. Nearly two-thirds of government expenditures are therefore used for education, health care, and social insurance. Although the costs for the welfare state are high – the tax revenues needed to maintain the desired level of social welfare reach above 50 percent of GDP – it has been possible to combine equity with growth and development. In recent years, economic growth has exceeded the EU average. In terms of competitiveness, Sweden has been ranked in the top 3 among the 117 countries included in World Economic Forum's *Global Competitiveness Report* during the last few years.

Welfare is an important concept also for the Vietnamese state. Before the introduction of economic reforms in 1986, it was clear that the state had the main responsibility for education, health care, and other social safety nets. However, after Doi Moi, the role of the state has changed radically. In health care, elderly care, and education, the financing burden largely shifted from the public sector to individual households. Thanks to the successful growth of the Vietnamese economy, the private sector has been able to take on this financing burden, and many indicators suggest the Vietnam has performed very well in the social sectors. Poverty has been reduced radically, school participation rates and literacy rates have increased, life expectancy is higher than before Doi Moi, and deaths from infectious diseases have fallen dramatically. However, the introduction of market principles in the social sectors created new challenges. In particular, it was clear that substantial gaps in access to social services were emerging. For those population groups that could afford it, Doi Moi brought the opportunity to benefit from services of much better quality than what had been available in

the mid-1980s. For poorer groups, the costs of these services were often prohibitive. The need to complement the increasingly market oriented solutions in education and health care with programs focusing on the most vulnerable population groups was clear already by the early 1990s. A variety of National Targeted Programs were established to extend access to health care and education to the poorest households, and special programs were introduced to support the development of the poorest villages. Most of these were integrated into the Hunger Eradication and Poverty Reduction Program in the mid-1990s. In 2002, the emphasis on poverty reduction was strengthened when Vietnam introduced a Comprehensive Poverty Reduction and Growth Strategy (CPRGS) as the main policy document, albeit with mild pressure from the donor community. This development can be seen as a gradual shift from a purely growth oriented development strategy to one where equity and social issues play a more important role.

The purpose of this paper is to track the development of three components of the Vietnamese welfare state since Doi Moi: education, health, and social insurance. This will be done with reference to the Swedish experiences in the same areas. While the present Swedish welfare state is arguably of little relevance as a benchmark for Vietnam, it may be useful to examine Vietnamese developments in light of Sweden's historical experiences of economic and social development. This paper is therefore made up of two main parts. The following sections outline the emergence of the Swedish welfare state in the three areas education, health care, and social insurance. Thereafter, we turn to a discussion of the Vietnamese experiences during the past two decades. The final part of the paper provides some concluding comments and a tentative assessment of the achievements and remaining challenges for Vietnam.

The Swedish Welfare State

As long as Sweden remained an agricultural economy, there was little need for any comprehensive welfare state. In pre-industrial society, the household was the center of social and economic activity, and most of the challenges facing individuals could be handled within the household. Since the households typically controlled their own production capital (mainly their land) they could vary the labor input and share the production results between the household members according to the need of each member. Each household cared for its children and elderly, and although the work input of the older generation was often limited, it was important at the margin. For instance, elderly people contributed to household incomes

by caring for the children, so that adults could devote their labor to farming and other productive activities. Technologies were simple, and the skills needed to sustain the farming system could be passed from parents to children. The great weakness of pre-industrial society was related to health. Specialized medical skills were rarely available and diseases could rarely be cured. This was reflected by low life expectancy. The only groups that fell outside this frame were the landless, the disabled, and orphans, widows, and others without a family. The limited social security that was available was often provided by the church. The role of the household was somewhat weaker in the cities, where the guilds took on some responsibility for education and social security; similarly, the state provided substantial security for public servants.

The traditional social structure began to disintegrate with the industrialization process. The shift from subsistence based farming to manufacturing meant that households lost the control over their working capital. Few households had sufficient funds to invest in industrial machinery. Instead, the former farmers began to work for entrepreneurs, who controlled the capital stock and financed their investments by borrowing from banks and capital owners. This change in the ownership of working capital made it more difficult for the household to fully use its labor resources. In particular, it became difficult to adjust to situations where the external demand for labor diminished, and situations where a working household member fell ill – these cases led to income losses that threatened the livelihood of the household. Education also became more important as more specialized jobs were created: with more education, it was possible to find better jobs, with higher income and more job security. A stronger social protection system was needed, both to provide a livelihood for the sake of the households and to maintain social stability. The widespread poverty that emerged each time the demand for labor diminished resulted both in increased crime as well as political protests as workers began to organize. One problem was that the government had no instruments to stabilize the swings in the economy that were driven by lags between investments and production or other variations in the business cycle. In 1843, the Swedish economist Jakob Lundell published an article where he suggested a new role for the government. His idea was that economic development could be smoother and more predictable if the government provided education and employment services, so that workers could more easily be allocated to sectors that demanded labor. Moreover, this would also result in a more equal distribution of prosperity, reducing social tensions. In other words, Lundell saw welfare institutions as a requirement for the development of the market economy. However, at that time, most

economists believed in a laissez-faire economy, where the state's role was limited to protecting private property rights.

During the second half of the 19th century, economic inequality grew deeper as industrialization accelerated, and the expansion of international trade created vast fortunes among entrepreneurs and capital owners. Fundamental reforms were seen in the legal sphere, where new business laws were made, in the financial sector, and in the education sector, where technical universities and colleges were established to strengthen the skills needed by industry (Kokko 2005). Much less happened in the social sectors. Although workers began to organize in labor unions and political parties, they had little influence at the policy-making level. One reason was that voting rights were related to ownership of real estate and property. At the beginning of the 20th century, only 10 percent of the population were allowed to vote in national elections: women had no vote at all. This notwithstanding, the labor organizations contributed to the establishment of voluntary unemployment and health insurance programs, and put heavy pressure on employers to accept collective agreements in the labor market.

The pressure from the labor unions and the Social Democratic party, which had been established in 1889, started yielding some results during the first decade of the 20th century. The first collective agreements, regulating not only wages but also working times and working conditions, were signed in 1905. The right for workers to organize in labor unions was established in an agreement the following year. Universal suffrage for men was introduced in 1909. Women had to wait another 10 years before they won the right to vote. The first steps towards the creation of a welfare state were also taken in the form of a universal pension insurance system introduced in 1913, and an insurance for work-related injuries covering the entire work force in 1916. The establishment of a general health insurance was also discussed at this time, but the plans were not realized for several decades because of the economic crisis following the First World War (Edebalk 2000).

The economic plight caused by the war did not only proscribe further welfare reform, but it also sustained the tension between labor and capital, which had already resulted in several large strikes and lockouts during the first decades of the 20th century. However, the socialist revolutions in Russia and several of its border nations had a strong impact on the Swedish political landscape. The fear of a similar development motivated the Swedish conservative parties to seek collaboration with the main left wing party, the Social Democrats. This resulted in the improvement of labor conditions in the industrial sector, for example, a law limiting the working day to 8 hours in 1919, and a law establishing the role of collective agreements a decade later. Yet, the Great Depression in the late 1920s complicated the

situation: industrial production contracted and unemployment soared throughout the world when countries turned to beggar-thy-neighbor policies and raised their barriers for international trade and capital flows. In the Swedish case, the Great Depression culminated in a severe political crisis when the military open fire on a labor demonstration in the village of Ådalen in 1931, killing five workers. The event strengthened the labor movement, and the Social Democrats advanced in the elections the following year, forming a coalition government with the agricultural party. In terms of national politics, this can be seen as another cornerstone in the creation of the Swedish welfare state.

The new government acted in two areas. Firstly, the Social Democrats were inspired by Keynesian ideas and introduced expansionary fiscal policies to maintain aggregate demand and reduce unemployment. The main areas for government-led employment programs were infrastructure and housing construction in the growing cities. Secondly, important reforms were made in labor legislation, health care, education, and other social areas. These included increased pensions, voluntary unemployment insurance, statutory vacation, support to widows and orphans, and improvements in maternal health care. The new political climate was also manifested in labor market relations. From 1938, the labor unions and the employers' federation institutionalized a system where wages and other labor market related issues (including some social insurance programs) were negotiated at the central level. This system contributed to the consensus-based political relations that characterized the Swedish welfare state during the second half of the 20th century. It also contributed to a relatively high degree of income equality, since most wage agreements mandated a relatively small gap between the minimum and maximum incomes.

The remaining building blocks of the welfare state were added after the Second World War. Sweden had not taken an active role in the war and the Swedish industrial sector was therefore intact when the war ended in 1945. The subsequent reconstruction of Europe led to a boom for the Swedish manufacturing sector. The combination of rapid economic growth, continued worries about social and labor market conflicts, and a Social Democratic government with close relations to the labor unions provided a solid platform for further expansions of the welfare state. In particular, there was a belief that society could afford a more generous social security system. Another increasingly important political goal was to mitigate inequality. To these ends, a general child allowance and housing and study allowances were introduced, a universal health insurance system was introduced, the unemployment insurance was extended, pensions were reformed, education investments grew, and regional transfers were built into the system. Particular efforts – mainly related to the

establishment of an extensive system of public childcare – were made to facilitate female labor force participation.

To finance these reforms, taxes were increased to relatively high levels. The largest part of the tax burden was on labor (and consumption) rather than on capital (and production) – in fact, Swedish capital taxation was not very high in an international comparison. Income taxes were progressive, emphasizing the egalitarian nature of the system. Apart from the healthy growth of the economy, the universal character of most welfare benefits was of utmost importance to explain the general acceptance of the increasing tax burden. The fact that most benefits were (and are) available for all residents in the relevant population group (irrespective of income) meant that tax payers could rely on receiving something in return for their taxes. For instance, most families understood that the expensive public childcare system was important both for female labor force participation (since women did not have to stay at home to take care of their children) and as a source of jobs. It is also important that Sweden avoided a situation where the poorest groups were at the mercy of the generosity of the ruling political elite. The emphasis on “rights” rather than “benefits” probably reduced social gaps and avoided the stigmatization that may follow from identifying “poor” groups. Moreover, the administrative costs were kept low, since there was no need for targeting. The social stability that was created by the welfare state functioned very well for several decades, raising the income and living standard of the Swedish population to a top-three position in the international per capital income list by the 1970s.

At its height, in the early 1980s, the Swedish welfare state rested on three important core components: a public education system without tuition fees, a public health care system that guaranteed all residents the best available care with only nominal user fees, and a generous insurance system covering income losses due to unemployment, ill health, and old age. Over time, the views regarding the welfare state had changed, from the common attitude in 1950s that it was a by-product of economic growth, to the view that the welfare state and its social security system is a requirement for economic growth and social stability. At the same time, for its sustainability, the system assumed a high level of economic growth and a high labor market participation rate. By the 1980s, it was increasingly clear that these assumptions were no longer appropriate. Decreased birth rates and longer life expectancy meant that an increasing share of the population was outside the labor force. The generous welfare benefits in combination with high personal income taxes may also have reduced the incentives for work. The result was a reduction in the growth rate of the economy, which put heavy pressure on the welfare state. From the early 1990s, a number of reforms were therefore introduced in

order to re-establish the balance between costs and revenues. In particular, these focused on strengthening work incentives through a reduction in personal income taxes and cuts in the cost and benefit levels of the pension and health insurance programs. However, the questions discussed during the reform process did not concern the existence of the welfare state, but rather its form and organization. The common belief in Sweden is still that the welfare state is a prerequisite for stable economic and political development, and the economic recovery that has taken place during the past decade seems to corroborate this view.

An early insight from the Swedish experience is that the optimal structure and nature of the welfare state varies with the characteristics of the economy. The economy's growth rate and income level, the population structure, and the political structure are some of the variables that determine the shape of the welfare state. The following sections describe how the main building blocks of the Swedish welfare state – the education, health, and social insurance systems – have developed during the past century.

The Education Sector

The history of the formal education system in Sweden dates back about 1,000 years, and has its origin in the introduction of Christianity: the first schools were established by churches and monasteries to educate priests and other church officials. The so called “cathedral schools”, the oldest of which was established in Lund in 1075, also prepared students for university education abroad (mainly Paris and some of the first German universities). Sweden did not have any universities until the 15th century, but the cathedral schools in Lund and Uppsala were gradually upgrading their standard, and provided higher education already from the Middle Ages. The oldest Swedish university, in Uppsala, was established in 1477, while Lund University was established in 1668. Aside from theology and law, the universities also had faculties of medicine and philosophy, but sciences did not take on a strong role until the second half of the 18th century. The development of higher education accelerated during the 19th century, when several new universities and technical colleges were established.

Several institutions for education at lower levels had already been established by that time. A system of lower and upper secondary schools was set up in the early 17th century to replace the cathedral schools. The first law mandating some primary education was introduced in 1686. Each priest was responsible for educating his parish in Christianity, which included the ability to read the bible. A government resolution in 1723 stated more explicitly that all parents should teach their children to read. The formal primary and secondary schools

of this time were to a large extent financed by the municipalities and the church, and focused on the middle class. The primary and secondary education of the upper class was instead the responsibility of private teachers. The quality of teaching varied greatly, but the young men of the nobility were for a long time guaranteed seats in the academies irrespective of their educational background. An important step towards equality in higher teaching was taken in 1693, when university entrance exams were introduced for all prospective students.

In 1842, Sweden became the first country in the world to introduce compulsory primary schooling. Each municipality or parish was required to set up at least one school with at least one teacher, with financing from the local authorities. A system with state subsidies to primary schools in poor municipalities was introduced about one decade later. Although the education provided by the compulsory primary schools was simple (and initially strongly influenced by the church) and although the rate of seasonal absenteeism was high (since children were needed as farm workers) it was successful in diffusing basic skills in reading, writing, and arithmetics. Within some decades, around 80 percent of all children attended primary school, and almost the entire population was literate. Only a few percent of the students continued after five or six years of primary education to secondary school or other forms of higher education, but the strong human capital base that was established contributed strongly to the rapid industrialization of the economy during the second half of the 19th century (Kokko 2005).

The following decades witnessed a gradual strengthening of the education system, with an extension of compulsory primary education to seven years, and several types of schools established at the secondary level, with theoretical as well as vocational orientation. Some of the secondary schools were financed by the state, while others were private. However, upper secondary education remained socially segmented until the end of World War II: the few students continuing to tertiary education were mainly from the more affluent population groups. The main obstacles for students from poorer families were not the formal tuition fees, but rather the living costs and the opportunity costs in terms of foregone labor income. During the decades after the World War, public investment in education increased, with an expansion mainly at the upper secondary level. Compulsory education was extended to nine years, and efforts were made to promote higher education among students from less privileged backgrounds. Formal tuition fees were dropped and an extensive system with subsidized student loans was introduced. The expansion of the education system was one of the main components in the construction of the Swedish welfare state. The effects were seen at a large

scale during the 1960s, when university education began to expand rapidly as the cohorts from the 1950s progressed through the educational system.

Today, the Swedish public school system is made up of a compulsory part covering nine years of primary and lower secondary education, and a non-compulsory part including kindergarten (for children below six years of age) and pre-school (for six-year old children), upper secondary school, and tertiary education.¹ At the age of sixteen, after nine years in the compulsory education system, pupils are free to choose whether to continue to the upper secondary level. Almost all students continue directly to upper secondary schooling and the vast majority of these graduate after three additional years. Upper secondary schooling is divided into a number of different programs. These include vocational programs as well as programs that are more theoretical and prepare for continued tertiary/university education. Yet, all upper secondary school programs are broad enough to ensure that the students are entitled the right to apply to some university programs. In 2002, 43 percent of all pupils finishing an upper secondary level education continued to higher level studies (university).

Primary and secondary education is free for the students.² The government finances not only the education itself but also transport, books, and free meals. It should also be noted that the opportunity costs of upper secondary education have been reduced dramatically during the past decades. In principle, decisions about upper secondary study do not have to take into account any foregone earnings from paid employment, since it is almost impossible to find a job in Sweden with only lower secondary education.

Most universities and post-secondary institutions are run by the state and are also free of charge. However, at the tertiary level, meals, books and travel cost are not directly covered by the state, although all students qualify for subsidized loans to cover their living costs.

There is a broad consensus in Sweden that education should be free and equally distributed to all citizens irrespective of location and family income. There are several reasons for this. First, there are no strong reasons to believe that pupils from richer families are generally more intelligent than pupils from poorer households. Therefore, from an economic efficiency point of view, with equal access to education the distribution of pupils to different programs and subsequent job positions will be efficient. Moreover, from a social perspective, equal access reduces the social tensions that are likely to occur if only wealthier households have economic resources to send their children to school and subsequently to higher education. Hence, unequal education possibilities will not only lead to inefficient resource

¹ Some adult secondary schooling programs also exist within the public schooling system.

² There is a fee for childcare/kindergarten and pre-school for children below the age of six.

allocation, but may also trigger social conflicts that are harmful for the society as a whole. The Swedish domestic support for an “everything-included and free-for-all” education system has not been seriously challenged since it was introduced in the 1950s.

The national objectives and guidelines for the public education system are formulated by the parliament and stated in the education act. According to this act, all children and youths have equal access to education, irrespective of gender, place of residence, or their financial or social situation. Primary and secondary education is carried out by the municipalities according to the guidelines and norms provided by the parliament, with funding from the federal budget. Administration is decentralized to the school level, where the principal makes up a work plan for the school. From the eight education year and onward pupils are awarded grades. All pupils have the right to achieve a pass grade: if a pupil fails grade he or she is entitled to re-sit the course. Pupils’ grades are set by their teachers. However, to ensure that a similar level of knowledge is provided independent of place of residence, a number of national tests are performed. The National Agency for Education is responsible for following up, supervising, and evaluating the schools and the schooling system. The state universities are organized as independent government agencies.

In total, the public expenditure on education amounts to almost eight percent of GDP, which is among the highest levels in the world. Most of the funds are used for public schools and universities, but pupils are also free to attend independent schools that are often operated in accordance with some special pedagogic idea or by some specific interest group. These are also financed with public funds. Independent schools must be open to all and they must fulfill standards defined by the education act and approved by the National Agency for Education: unlike public schools, they are allowed to charge a symbolic fee. Independent schools are overrepresented in the large cities and roughly 3.5 percent of all pupils attend an independent school.³

During the 1990s, the concept of life long learning has received increased attention. The idea is that all adults should have the right to achieve a secondary level degree. A certain level of education gives people the possibility to participate more actively in society and rising levels of education may fill knowledge gaps. Moreover, with a relatively high minimum level of education, the possibilities to adjust the production structure according to a more knowledge intensive economy are greatly improved. To achieve an increased education level among adults, a wide range of educational opportunities are available. The most important

³ For details on the Swedish education system, see e.g. National Agency for Education (2000), Fransson (2001).

recent program was a five year project labeled the Adult Education Initiative launched in 1997. It is estimated that roughly ten percent of the total population benefited from this program. The impact of the Adult Education Initiative program is reflected in Table 1, which shows that the share of residents attending training program lasting at least four weeks was remarkably high in comparison with the EU average in the late 1990s.

Table 1. Share of Population Aged 25-64 in Training Programs, 1996-2001 (percent)

	1996	1997	1999	2000	2001
Sweden	26.5	25.0	25.8	21.6	17.5
EU	5.7	5.8	8.2	8.5	8.4

Source: Eurostat, General Statistics. Covers only programs that are four weeks or longer.

Public health care

Health care and medical care form the second basic pillar of the Swedish welfare system. The principle underlying the Swedish health care system is that health and medical care should be provided on equal terms and according to need of each individual. The financing of health care is based on solidarity and not viewed as a matter of social insurance: instead, health care is seen as a matter of public interest. Hence, health care costs are mainly financed by taxes rather than fees or insurances. Overall, the public sector accounts for about 90 percent of all health care expenditures, with private financing covering the remaining 10 percent. The private share is mainly used for dental care and medicines: formal user fees for health care only cover some three percent of the sector's total costs.

The questions discussed in the Swedish health care debate are not mainly related to "Who should pay?" but rather focused on what level of health care services the public system should guarantee, and how the services should be organized and delivered to the public. These are critical issues, since there is a tendency over time for health care costs to increase. One reason is the changing population structure. In 1950, 10 percent of the Swedish population had reached the age of 65 – today the corresponding figure is 17 percent. Demographic predictions points at in 2030 nearly one-fourth of the Swedish population will be older than 65 years.

It is estimated that the public expenditures per capita for retired people are about three times higher than those for people in the labor force (Edebalk 2004). Although some of the differences are driven by the costs for pensions, it is also clear that medical care of the elderly

is taking an increasing share of the budget.⁴ This is illustrated in Table 2 that shows how Swedish health care costs have developed over the past century. In the early 20th century, health care was largely privately financed and public resources were used to support simple health care services for the very poorest. Life expectancy was low, largely because of improper nutrition and diseases. The lack of cures and medicines kept the health care budget relatively low. Over time, several parallel developments have occurred. New cures, equipment, and treatment methods have been developed and health care costs have increased in tandem. With an aging population these changes have made health care financing increasingly important.

Table 2. Health, Life Expectancy, Doctors, and Income in Sweden 1900-2000

Year	Health care costs/GDP (percent)	Life expectancy, years	Medical doctors per 1000 citizen	Per capita income, USD (2000 prices)
1900	0.6	51	n.a.	2,400
1920	1.0	56	n.a.	3,400
1940	1.9	64	n.a.	5,600
1960	5.4	71	0.9	9,500
1980	9.5	73	2.2	16,200
2000	7.7	77	3.2	22,400

Sources: LIF (2004); Statistics Sweden (various issues); Socialstyrelsen (2001); OECD (2005), Edvinsson (2005).

Until World War II, the financing responsibility remained largely with the households, although various insurance systems were developed to reduce the financial risks connected to health problems. However, after the end of World War II, health care became an issue with strong political connotations. Those who could afford treatments and medicines had a chance to get cured, while those who could not afford it were left suffering. This was clearly contrary to the egalitarian visions of the Social Democratic policy. Several programs were therefore established to improve access to health care. The programs included not only health care in general, but *public health* also became an important policy area. Given the state of public health, the potential costs for providing the best available care to all patients would simply have been prohibitive. A better way to use scarce public resources was to focus on prevention, to reduce the incidence of disease and ill health. Hence, the public health programs introduced

⁴ Ministry of Health and Social Affairs (2005b)

during the 1930s did not only focus on traditional areas, like primary health care and maternal health, but also on hygiene and sanitation, housing standards, and nutrition.

During the 1950s, the responsibility for health care shifted to the public sector. The introduction of the universal health insurance in 1955 marks the completion of this transition. In its early stages, it included protection both for health care cost and for income losses during illness – over time, the financing of health care costs has shifted from the health insurance to the central government budget. As a result, the health care sector has become highly centralized in terms of policies and financing. Today the Ministry of Health and Social Affairs monitors and analyzes health care providers, drafts legislation, and negotiates and discusses policy issues. It is supported by a number of agencies, such as the National Board of Health and Welfare, the Medical Responsibility Board, and a host of other institutes. The policy proposals are presented to the parliament, which decides about guidelines and rules for how health care should be provided. The parliament also decides about the central budget, which provides the funds needed to realize the policies. However, implementation is decentralized to the municipalities and county councils. The municipalities are responsible for primary care and care of the elderly (i.e. technically less advanced care). Private care providers are also allowed to supply health care, and may receive public financing with the same restrictions, financial limits, and rules as public hospitals. Publicly financed private care providers are concentrated in primary care and account for ten percent of total health care costs. Fully private health care, where the patients cover the full costs of the treatment, are very rare, and can mainly be found in areas like cosmetic surgery and dental care.

In 2002, the total costs for the Swedish health care sector amounted to somewhat above 9 percent of GDP. Roughly 20 percent of the expenditures are directed to primary care. Specialized physical care accounts for roughly 60 percent of total health care and medical expenditures. Another 10 percent are used for specialized psychiatric care. The remaining share is used to cover expenditures for other health and medical care, dental care and other activities, e.g. information campaigns.⁵ While the total costs for this system may appear to be very high (in 2004, the per capita expenditures for health care exceeded USD 3,000), it is not remarkably high in comparison with other developed economies. In terms of costs and cost control, it appears that different institutional and organizational solutions seem to generate very different outcomes. Table 3 provides a comparison of health care costs and some health indicators for several advanced industrialized economies. It can be seen from the table that

⁵ Ministry of Health and Social Affairs (2005a)

countries like the US have much higher health care costs, although neither the number of doctors per capita, life expectancy, nor the share of old people is any higher than in Sweden.

Given the combination of a rapidly aging population and the rapid pace of innovation and technical progress in the health care sector, it is obvious that there is a risk that health care costs may increase rapidly in the future. A scenario where most diseases can be cured if only enough funds are invested in treatment and medicines is not unlikely. However, the costs for providing the best available care for every resident could easily be prohibitive, even for a relatively wealthy welfare state. The focus on public health has therefore reappeared in Swedish health policy. The simple idea is that by promoting a healthier lifestyle, the pressure for medical care may be reduced. The potential welfare gains from this kind of preventive action may be large – a common example concerns the prevention of HIV infections through the use of prophylactics.

Table 3. Health Care: An International Comparison, 2002

Country	Health care costs/ GDP (percent)	Public sector financing of health costs	Medical doctors per 1,000 citizen	Life expectancy	Population > 79 years old (percent)
USA	14.6	44.4	2.4	77	3.3
Germany	10.9	78.2	3.3	78	4.0
France	9.7	76.3	3.3	79	4.1
Sweden	9.2	85.2	3.0	80	5.2
Italy	8.5	75.1	4.4	78	4.4
UK	7.7	83.4	2.1	77	4.3

Note: Data refer to 2002 or closest possible year.

Sources: LIF (2004); Statistics Sweden (various issues); OECD (2005); OECD (2002); Statistics Sweden (2005).

The Swedish National Institute of Public Health plays a central role for policy developments in this area. The institute supervises the health sector in broad terms, gives advice to the government, and monitors the implementation of the Swedish health policy. In addition, there are a large number of small voluntary organizations that play an important role for public health. The overarching aim of Sweden's national health policy is to facilitate the creation of social conditions that promote good health. To achieve these goals a number of objective domains are formulated. These objective domains can be divided into structural issues on the one hand and lifestyle issues on the other hand. Examples of structural issues are to ensure economic and social security, good working conditions, a safe environment and safe products.

Examples of lifestyle issues are to promote physical activity, good eating and drinking habits, and to reduce the use of tobacco and alcohol. It should be noted that the increased attention on public health is not a unique Swedish feature, but many other developed countries have also shown an increased attention towards a broader perspective on public health.⁶

The social insurance system

Over time, the Swedish welfare state has created two distinct social insurance systems.⁷ There is one public insurance system and one negotiated system that is related to labor market participation.⁸ Public social insurance covers all residents of the country, and provides a safety net in three different areas. The first area, *parental insurance*, is related to family policy, and aims to guarantee a reasonable standard of living for all children. It includes parental insurance (compensation for the parents staying away from work to care for sick children), child allowances, and housing allowances for families with children below 18 years of age. The second area is *public health insurance*, where the main aim is to guarantee compensation for the income losses related to sickness. The benefits include sickness allowance, temporary disability pensions, disability pensions, early retirement pensions, and industrial injury compensation. The objective of *age related insurance* is to guarantee a reasonable standard of living for elderly people. The main item in this category is the national basic pension, but there are also widow's pensions, housing allowances for elderly with low incomes, and partial pensions.

Negotiated social insurances are built on agreements between the actors on the labor market. The negotiations are held at the central level (between representatives for the national labor unions and the national employers' federation) and the insurances cover the participants in the labor force. The negotiated agreements are complementary to the public social insurances, although the distinction between the two forms of insurance is not always clear. These insurances cover areas such as compensation in case of disease and occupational injury, unemployment benefits, income-related old-age pensions and death benefits.

In addition, there is also a private insurance market. Due to the relatively broad coverage of public and negotiated insurances, the private market has mainly focused on households' property insurance needs and life insurances. However, the last two decades have witnessed an unprecedented increase in private pension insurances. New products on the insurance

⁶ See e.g. The Swedish National Institute of Public Health (2005).

⁷ For a detailed description, see e.g. SOU 2001:57.

⁸ In addition, there is a compulsory third-party traffic (liability) insurance.

market in combination with increased uncertainty about the real value of public and negotiated pension plans has motivated many people to join various private pension insurance plans. Only four percent of the population in the 18-64 age category had a private pension account in 1984, but the number had increased by almost a factor of nine, to 35 percent, by the year 2000.

In terms of expenditures, the costs for the social insurance system amounted to about 17 percent of GDP in 2002. Out of this, the *parental insurance* accounted for 18 percent, *public health insurance* accounted for 32 percent, and the share of *age related insurance* was 41 percent.⁹ The social security system, which provides support for individuals and families with special problems (related e.g. to long-term unemployment) accounted for the remaining costs of the social insurance system.

The Swedish welfare system is mainly financed by various taxes (general taxes, taxes on employees and taxes on employers). Table 4 shows how the costs of the social security system are divided between taxes on employees, employers and the government (central and local) in the form of general taxes(e.g. VAT) for a number of countries.

Table 4. Financing of Social Insurance, 1960-1990 (percent of total costs)

	Taxes on employees		Taxes on employers		General taxes	
	1960	1990	1960	1990	1960	1990
Sweden	45	4	10	81	44	15
Finland	33	10	19	63	48	27
Denmark	44	8	0	2	56	90
Germany	47	43	41	43	12	14
USA	28	26	72	73	0	0

Source: SOU 2001:57.

The general pattern in developed economies is that the financing of the social insurance system is increasingly connected to taxes on employers, while the relative importance of general taxes is decreasing. This is largely explained by demography. Over time, the costs of the pension system have increased in line with the increasing life expectancy, and these costs – as well as the costs for unemployment and health insurance, which are becoming more important – are largely financed through the labor market.

⁹ Statistics Sweden (2004).

Pensions

In 1913, Sweden introduced a flat rate public pension system, which guaranteed a small annual monetary benefit to all elderly citizens. Although this so called “people’s pension” was small – still in the 1930s, it corresponded to only 9 percent of the annual net income of industrial workers – it was important in two ways. Firstly, it provided a small but important financial contribution to all households with elderly members. The fact that the pension was not large enough to provide a sustainable living was typically not critical, since it was still common that children cared for their elderly parents. In many cases, particularly in rural areas, it was also important because it was a monetary contribution. Many rural households were subsistence oriented, and pension funds made up a substantial part of their monetary purchasing power. Moreover, the poorest elderly people, e.g. those without relatives, could receive some supplementary support – over time, this supplement came to apply for the majority of retired people. Secondly, the pension was universal, which established an important principle for the Swedish social insurance system in general. As noted earlier, universal benefits (that are not means tested) tend to provide a notable return to the middle class, who account for most of the financing in the form of tax payments: this helps avoid situations with a clear polarization between those groups that pay for public welfare and those that benefit from it (see further Edebalk 2000).

During the decades after World War II, the pension system was gradually reformed through increases in the guaranteed “people’s pension” and the addition of an earnings-related part that provided a higher pension to individuals whose tax contributions were larger.¹⁰ Prior to a large pension reform of 1959, the earnings-related supplement was close to zero but has grown increasingly important since that time. Table 5 shows how pension replacement ratios, i.e. pensions as a share of work incomes, have developed since 1930.

Table 5. Pension Replacement Ratios in Sweden 1930-2000.

Year	Average annual “people’s pension” net of taxes as share of AIW income net of taxes	Average public pension (including supplements) net of taxes as share of AIW income net of taxes
1930	9%	n.a.
1950	22%	n.a.
1960	28%	28%
1980	49%	72%

¹⁰ The main reform related to earnings-based pensions came in 1959, and was known under the acronym ATP – Allmän TilläggsPension (General Supplementary Pension).

2000	36%	62%
------	-----	-----

Note: AIW = Average Industrial Worker.

Source: Statistics Sweden (various issues); Kangas and Palme (1989).

A first point to note is the low replacement ratio for the guaranteed people's pension until the 1960s. The low level of benefits was motivated with cost considerations: at the time, it was believed that these were the maximum levels that could be financed given the existing tax base. A second point is the increasing replacement rate for the total pension package, including the earnings-related supplement, until the 1980s.

Until the 1990s, the system was in principle a pay-as-you-go plan, where the current contributors funded the pension payments to retired beneficiaries. The income-based pension was calculated as a share of the work income during the 15 highest paid working years (later raised to the 30 best working years). However, it soon became clear that the combination of an aging population and decreasing productivity growth would put severe pressure on the system. It was estimated that the old pension plans would eventually have led to current pension expenditures exceeding 30 percent of GDP.¹¹ The total tax burden needed to finance this would have created very substantial tax wedges, and resulted in large welfare losses due to even lower growth. There were also concerns about redistributive effects. More affluent population groups tend to study longer and live longer than poorer groups: they therefore pay during fewer years and collect pensions over a longer period. These observations suggest that pay-as-you-go systems where the pensions are determined by the earnings during a few of the best (income) years may lead to redistribution of income from the poor to the rich. It was therefore clear that the system had to be reformed. After long debates, a fundamental reform was introduced in the early 1990s to establish a closer link between current payments and future benefits. For instance, the income-related part of the pension is now based on the individuals' total income during all years of labor market participation, and there is no automatic adjustment to inflation, but rather to the average work income in society. The monthly amount of pension benefits is not guaranteed, but instead calculated on the basis of life expectations: if the average life expectation increases, the monthly amounts will have to be reduced. Individual pension accounts have also been established, and some of the funds are invested according to the individual choices of the policy holders.¹² However, shifting the

¹¹ By contrast, in the UK where state retirement benefits are lower, public pension costs are expected to reach 6 percent of GDP in 2030 (Financial Times, 23 Aug, 2000).

¹² See e.g. World Bank (1994), Congressional Budget Office (2004), and Financial Times (2000) for a discussion about pension reform.

system can not be done without putting an extra burden on some generation.¹³ During the transition process, the working population must not only fund the pensions of the elderly people who did not accumulated any resources for a fully funded system, but also accumulate funds for their own pensions. It is therefore not surprising that the Swedish replacement ratios have diminished since the 1980s, as shown in Table 5.

Health insurance

Health insurance makes up the second largest component in the Swedish social insurance system, after retirement pensions. Health care costs are in principle covered through the general budget. The main function of the present health insurance is to protect against the income losses caused by ill health. Like many of the other major components of the Swedish welfare state, universal health insurance was introduced in the 1950s. Before that time – in fact, already from the 18th century – there had been various private health insurance plans covering parts of the population. Most of these were limited to members from specific professions or even specific companies (the most favorable conditions applied for state employees) although the first health insurance program that was open to any paying member was set up as early as 1761 (Edebalk 2005). The popularity of these programs increased over time, but they left large parts of the population outside the system. For instance, in 1930, they only covered about one-fifth of the adult population (Edebalk 2005). By that time, the arguments for universal health insurance were widely discussed, and a government committee had proposed already in 1919 that a compulsory program should be introduced. The proposal was rejected with reference to weak public finances, but it reappeared in the late 1930s, and eventually led to the introduction of a universal health insurance plan in 1955. Apart from covering health care costs, it provided compensation for income losses: after the first three days of illness, the compensation was about 55 percent of the lost income. During the following decades, the rules were gradually made more generous, and by the late 1980s, the insurance covered 100 percent of the income losses from the first sick day, as shown in Table 6. In principle, the employers could request a doctor's certificate from the first sick day, but in practice, a certificate was required only if the sick leave exceeded one week.

Although the generous health insurance was commendable from a social perspective, it turned out to be a very costly insurance form. During the 1950s, the average number of compensated sick leave days per worker was 10-15 days per year. By the late 1980s, this had

¹³ Hassler and Lindbäck (1999) show (under fairly general conditions) that a pay-as-you-go system can not fully mimic a fully funded system.

increased to over 30 days, in spite of great improvements in job safety and environmental conditions. This contributed to very substantial costs, not only in terms of insurance payments, but also in the form of lost production and lower growth rates. The accelerating costs triggered an intensive debate on the reasons for the apparent deterioration of the public health status and on the design of an optimal insurance system. Several arguments have been proposed as explanations for the increased number of sick leave days. Some commentators have focused on increased stress and uncertain employment conditions. Others stress the changing composition of the labor force. Women and elderly have more sick leave days than young men, and the share of females and elderly in the labor force has increased steadily since the 1950s. There is also a well established relation between the business cycle and the number of sick leave days: when the economy is booming and unemployment is low the number of sick days increases.

However, the maybe most intensively debated issue concerns how the incentives for work are related to the level of compensation in the social security system. Henrekson and Persson (2004) analyzed Swedish data spanning the period 1950-2000 and found a positive relation between the level of sick leave days and the compensation level. The question suggested by their findings is “What is the optimal level of sick leave compensation?” A compensation level that is too high may contribute to a climate where it is considered more or less “normal” to take sick leave even for minor ailments. On the other hand, a low compensation level may force workers to drag themselves to work although they are ill, thereby weakening their own health and passing on infections to their colleagues. In the Swedish case, there was a substantial reduction in the compensation level in 1991, and frequent changes in the rules between 1993 and 1998. These adjustments reflect both the fact that health insurance is politically sensitive, and that the costs make up a heavy burden on public finances. Hence, the compensation level has been reduced when the economy has been in trouble (in particular, during the financial crisis in the early 1990s) but attempts have been made to restore the benefits when the financial situation has been less pressing.

Table 6. Sick Leave Compensation in Sweden 1955-2005

Period	Compensation level
1955-1962	55 %, first three days not compensated.
1963-1966	65 %, first three days not compensated.
1967-1973	80 %, first day not compensated
1974-1987	90 %, first day not compensated
1988-1991:02	100 %, reduction to 95% after 90 days

1991:03-1993:03	Day 1-3 75 %, thereafter 90 %,
1993:04-1993:06	Day 1 0%, day 2-3, 75 %, day 4-14, 90 %, day 15-90 90 %, day 90+, 80 %.
1993:07-1995:12	Day 1 0%, day 2-3, 75 %, day 4-14 90 %, day 15-90, 90 %, day 91-365 80 %, day 365+ 70%
1996:01-1996:12	Day 1 0%, day 2-28 75 %, day 29-90 85 %, day 90+ 75 %
1997:01-1997:12	Day 1 0%, day 2-14 85 %, day 15-90 85 %, day 90+ 75 %
1998:01-1998:03	Day 1 0%, day 2-14 80 %, day 29-90 90 %, day 90+ 80 %
1998:04-	Day 1 0%, day 2-14 80 %, day 15-90 90 %, day 90+ 80 %

Source: Henrekson and Persson (2004).

One of the most important lessons to be drawn from the experiences of Sweden and other developed countries is that demographic changes and economic development have important effects on the pension systems. Countries with young populations are likely to benefit both from rapid economic growth and low expenditures for pensions and elderly care. An aging population obviously puts pressure on the pension system. Moreover, as the economy develops the need for schooling increases. The result is a reduction of the share of the population in the labor force. Pension systems should be constructed so that they are robust to these kinds of changes in demographic composition. More specifically, this is an argument for a movement toward a fully funded system. One question that remains is how to compensate the older members of the current generation, who have no possibilities to set aside sufficient savings for their future pensions to survive in a fully funded system.

The Vietnamese Welfare State

The changes that have taken place in the Vietnamese welfare state since the introduction of Doi Moi can be considered more radical than those in the Swedish welfare system during the past half-century. During a few years after 19886, Vietnam made a transition from a socialist economy, where the responsibility for production and social welfare rested with the state and the collective, to a more market oriented economy, where the household was initially forced to take on increasing responsibility for all aspects of social welfare. The main exception was the state sector, where civil servants, party officials, and workers in state-owned enterprises remained protected by the state. However, many households were unable to meet the tough financial requirements related to education, health care, and elderly care. Without access to the public social security systems, and without the financial means to buy the private alternatives, they were drifting into permanent poverty, without possibilities to improve their position in society. This problem was recognized at an early stage, and since the early 1990s,

the economic and social policies of the Vietnamese state have included several programs targeted at the most vulnerable population groups. Many of these have been organized under the auspices of the Hunger and Poverty Eradication Program that was established in 1995, and the Comprehensive Poverty Reduction and Growth Strategy from 2002.

Education

The Vietnamese state has prioritized education during most of its modern history, following age-old traditions manifested e.g. in the Temple of Literature in Hanoi. From the early 1950s and during the following three decades, policies in the Democratic Republic of Vietnam were based on socialist ideals promising access to publicly funded education for all, as a right of citizenship. These principles were introduced also in the southern parts of the country after reunification in 1975. The economic crisis of the 1980s made it impossible to fulfill the promises, and the development of the education sector since the introduction of *Doi Moi* has shifted much of the responsibility for financing to private households. Yet, education has remained an important item in the government budget, and the share of public spending devoted to education has increased steadily since the early 1990s. At present, education accounts for over 18 percent of total public expenditure and about 4 percent of GDP. Virtually all children are enrolled in primary school, and broad indicators of educational standard, such as literacy rates, are higher than for other countries at similar levels of income.

Looking to the Vietnam's development objectives, it is obvious that the ambitions for the future are also high. The present plans and strategies are summarized in the Education For All plan (EFA) for the period 2003-2015, which was designed by the Vietnamese government with support from UNESCO. It states that before the year of 2015, all children should not only enter but also complete five grades of primary education and four years of lower secondary education.¹⁴ The quality of education and education infrastructure is to be improved, at the same time as education should be available and affordable to all. Priority should be given to disadvantaged groups. Curriculum reforms are to be implemented, and teacher development programs will be extended. The concept of lifelong learning is to be introduced, with literacy and post-literacy programs reaching out to all adults below the age of 40.¹⁵

¹⁴ SRV (2003), National Education For All (EFA) Action Plan, 2003-2015, pp vii-viii.

¹⁵ The objectives for Vietnam's education policy are also included in the Comprehensive Poverty Reduction and Growth Strategy (2002), the Education Strategic Development Plan for 2001-2010 (2003), and the Secondary Education Master Plan (2002).

These targets are impressive even in comparison with countries at substantially higher levels of development. At the same time, it is clear that they make up a great challenge to a country at Vietnam's level of development. Although the traditional respect for learning and the investments in mass education since the 1950s provide a good base for the EFA plan, there are also weaknesses related to the financing and distribution of resources. In particular, students from poorer families have limited access to upper secondary and higher education. To a great extent, these weaknesses have their roots in the structural changes that have occurred after the advent of Doi Moi.

Education before Doi Moi

In colonial Vietnam, access to public education was limited to a small urban elite. Some private schools were established outside the main cities, but high tuition fees made up an effective barrier to entry for the great majority of the population: education was essentially a luxury good reserved for the privileged population groups. One of the main objectives of the Vietnamese Communist Party under the leadership of Ho Chi Minh was therefore to establish a system of mass education that would eradicate illiteracy among the younger generations. In fact, the establishment of new schools started already before the end of the colonial era, and continued throughout the 1950s and 1960s. Given the limited amount of resources available for provision of social services during this time – public resources were drained by the war effort – it was clear that the state could not provide much higher education. Moreover, the available resources were not distributed equally across the population, instead favoring the new elite of the nation: those employed by the state and the party.

Yet, substantial improvements were made both regarding the quantity and quality of education. The number of primary school students in the DRV increased rapidly. By 1957, the number of primary students in the northern part of the country was three times higher than the total number in all of Vietnam in 1939. Both enrollment rates and the number of teachers continued growing steadily until the reunification of the country in 1975. At that time, a new education drive was initiated with a focus on the southern parts of the country, and school enrollment rates increased substantially between 1975 and 1980. The number of students in primary, lower secondary, and upper secondary education increased by 19, 25, and 28 percent respectively during these five years (London 2004). At the same time, efforts were initiated to harmonize the education systems of the two parts of the country. The south had inherited a system with twelve years of pre-university education, whereas the northern model only had ten years of primary and secondary school: the objective was to introduce the 12-year system

(five years of primary, four years of lower secondary, and three years of upper secondary education) in the whole country.¹⁶ Thousands of Vietnamese were also sent to the Soviet Union and other east block countries for higher education. By the early 1980s, it was clear that the country's educational standard – both in terms of literacy and more sophisticated indicators – was much higher than that of most other countries at comparable levels of income.

However, by the mid-1980s, the education system had started to suffer from the stagnation of Vietnam's socialist economy. Growth rates were low both because of problems in collectivizing industry and agriculture in the southern part of the country, and because of the costs connected to the involvement in the Cambodian conflict. The quality of public services, including education, deteriorated when government revenue fell short of the financing needs. The result was a decline in school enrollment rates, particularly at the secondary school level. Some families simply kept their children at home when the public education system failed to provide any meaningful teaching. For other families, education became too expensive because of the emergence of unofficial school fees: to supplement insufficient salaries, teachers started requesting payments directly from their students. Moreover, the announcement that government would no longer be able to guarantee jobs for upper secondary and higher education graduates reduced some of the incentives for schooling (World Bank 1997). Enrollment rates did not recover to their 1985 levels until the mid-1990s.

Market orientation and commercialization

The introduction of Doi Moi in 1986 did not provide any immediate cure for the ailing education sector, although market oriented principles were gradually introduced to compensate for the lack of public funding. For instance, formal tuition fees for secondary school and higher levels of education were introduced in 1989 (there are no formal tuition fees for primary school), and legislation permitting private and “semi-public” schools was introduced some years later.¹⁷ By 1993, private schools were allowed at all levels except primary education. These measures augmented the supply of educational services, but high out-of-pocket costs remained a problem. Nominal tuition fees and a host of other costs and

¹⁶ This objective was not reached until 1989.

¹⁷ Semi-public” schools (and semi-public classes in public schools) receive some state subsidies, but less than the public schools. They charge fees that are three to four times higher than those in public schools, and focus on students who failed to pass the formal entrance exams for public secondary school but still have the financial means to pay the higher school fees (London 2004).

fees amounted to a large share of the non-food budget of the average household. The immediate result was increasing social and regional gaps in access to education. In wealthier localities where households could afford these costs, enrollment rates increased faster; in rural areas and poorer urban neighborhoods, growth was slower, particularly for post-primary education. The differences were enhanced by the decentralization of the education system. With the exception of tertiary education and some technical and vocational secondary schools, all areas of education were (and are) administered at the district or province levels, albeit with financial contributions from the central budget.¹⁸ This means that the local households' ability to pay is one of the determinants of the quality of education. Mountainous areas and other relatively poor regions are rarely able to match the education standards established in Hanoi and Ho Chi Minh City. For instance, diagnostic tests across the country in 1998 revealed that the reading and mathematics skills of grade 5 students in many outlying provinces were only 30-40 percent of those in Hanoi. By 2003, the gap had diminished significantly, but in particular reading skills remained weaker in the provinces.¹⁹

Private education costs

Nominal tuition fees make up only a relatively small share of the out-of-pocket costs for education. In addition to tuition fees, which are set according to standards established by the central government, most schools require several other types of fees and contributions. These include special "construction fees" for school maintenance, as well as fees for parent associations and insurance. In addition, costs for books, supplies, school uniforms, transportation, and meals are borne by the student's household. Another large item on the expenditure side is the cost for "extra tutoring". The informal tuition fees from the late 1980s have in principle been institutionalized in the form of fees for extra class hours, often given at the teacher's home. A common view among both students and parents is that these extra classes are essential for passing the entrance exams for higher levels of education. In the mid-1990s, formal tuition fees made up less than 10 percent of the total out-of-pocket costs for secondary school students in urban areas, and less than 20 percent of the total payments in rural areas. The largest individual expenditure item (apart from meals away from home) was instead "extra tutoring", which accounted for nearly half of all non-food costs related to education (in urban areas).

¹⁸ The responsibility for nurseries, kindergartens, and primary schools is at the district level, while secondary schools and some colleges are administered by the provinces. Private institutions are found mainly at the pre-primary and tertiary levels.

¹⁹ SRV (2005), Table 10.27.

In absolute terms, the average annual out-of-pocket payments for education in 1996 ranged from VND 149,000 for primary school students to VND 679,000 for upper secondary school students. In relative terms, these costs corresponded to 9 - 40 percent of the average annual per capita consumption expenditure at the time (World Bank 1997). It is clear that this constituted a very substantial financing burden for the poorest population groups. As an example, if a family in the poorest quintile of households had decided to spend VND 679,000 to send a child to upper secondary school, their out-of-pocket payments for education would have been equal to the annual consumption of one family member. However, the actual education expenditures for students from poor families stayed well below the average expenditures, simply because poorer households could not afford to reach the averages. Table 7 summarizes some data on private education expenditures in 1996, with emphasis on the differences between the poorest and richest population groups. The private expenditure per student in the poorest quintile was roughly half of that in the richest quintile. Most of the difference was explained by the costs for “extra tutoring” for students from richer families: poor families were essentially forced to cut out these expenses.

Table 7. Private Expenditures on Education in 1996 (‘000 VND)

Level of Education	All	Poorest quintile	Richest quintile	Rich/poor
Primary education	149	97	256	2.64
Lower secondary education	309	195	441	2.26
Upper secondary education	679	392	787	2.01

Source: World Bank (1997), Table 3.10.

The strong economic growth since the mid-1990s has improved even the poor households’ ability to pay for education, but there are still substantial differences in expenditures between income groups. In fact, the expenditure gap between the richest and poorest quintiles has increased since the mid-1990s. In 2002, the richest fifth of Vietnamese households spent an average of VND 756,000 per student on primary education per student and VND 1,076,000 per student on lower secondary education. The corresponding number for the poorest quintile was VND 130,000 and VND 226,000 respectively (SRV 2005). Education expenditures as a share of the total household budget were roughly the same for rich and poor families, at 2-3 percent of total consumption, but they constituted a heavier burden for poor families. Food accounts for nearly 70 percent of total consumption for the poorest households but less than 40 percent for the richest households, which leaves substantially less room for non-food

expenses, e.g. for education, in poor households (Nga Nguyet Nguyen 2004). Thus, although the situation has improved somewhat during the past decade, sending children to secondary school is still a difficult financial decision for a poor household.²⁰

Public investment in education

Vietnam's strong economic performance has not only contributed to a very substantial reduction in the share of the population living below the poverty line, but also provided more resources for the public sector. A substantial share of these resources has been directed to the education sector. Table 8 shows that the real value of public education expenditures tripled between 1991 and 2002. The share of education in the public budget increased from 13-14 percent in the early 1990s to around 17 percent in 2002 (and further to 18.6 percent in 2004). The increase in the GDP share of public education expenditures has been even larger, since the ratio of public expenditures to GDP has grown over time. During the last years, Vietnam has invested more than 4 percent of GDP in public education, which is comparable to many countries at higher levels of income and development.

Table 8. Public Spending on Education 1991-2002

	1991	1994	1998	2000	2002
Public expenditure on education (trillion VND, 1994 prices)	25.8	42.8	49.7	64.1	78.0
Education share of public expenditure (percent)	13.6	14.0	17.4	15.1	16.9
Education share of GDP (percent)	1.9	3.5	3.5	3.5	4.2

Source: World Bank (1997), Table 3.3 and SRV (2005), Table 10.1.

Adding the households' direct financing of education, Vietnam's total investments in this sector are likely to approach 7 percent of GDP, which is close to the level in many OECD countries. Table 9 shows how the financing burden has been divided between state subsidies and private out-of-pocket expenditures across different levels of education since 1993. In the early 1990s, the state's share of financing was limited to 35-45 percent of total expenditures, with most of the costs covered by private households. Since then, the state share has increased steadily, particularly for primary education where it reached above 70 percent in 2002. Overall, in lower secondary education, there has also been a notable increase in the public

²⁰ The cost for sending one child to secondary school is about 10 percent of the poorest households' non-food consumption. Assuming an average household size of four persons, this corresponds to about 12 percent of average annual per capita consumption, which is about 6 percentage points lower than in 1996.

sector's financing share, but private financing still accounts for nearly half of total expenditures in upper secondary school. Meanwhile, the private financing share of tertiary education was only around 15 percent in the early 1990s (World Bank 1997, Figure 5:12). Increasing tuition fees at universities have gradually raised the private costs of university education since that time, but for most types of higher education, the private financing share remains below 20 percent (SRV 2005).

Table 9. Funding of Education Expenditures (percent)

Level of education	1993	1998	2002
Primary education			
State subsidy	45	55	73
Household	55	45	27
Lower secondary education			
State subsidy	34	62	59
Household	66	38	41
Upper secondary education			
State subsidy	40	47	52
Household	60	53	48

Source: SRV (2005), Table 10.8.

These differences in financing burdens partly reflect the distribution of state spending across different levels of education. The bulk of public funds have been direct to primary and lower secondary education since the early 1990s – typically over 50 percent of the total – but these funds have been shared among a large number of students. Total enrollment at the primary and lower secondary level stood at around 11 million in the early 1990s and increased to 15-16 million students by the late 1990s. The number of students at the tertiary level has increased much faster, from around 130,000 in the early 1990s to over 800,000 in 2003-2004. Although their share of total education finance has diminished during the same period, from around 15 percent of the total to 10 percent, each tertiary student receives a substantially higher share of total state investment than students at lower levels. In the last few years, the Vietnamese state has on average spent about five times more money on each student in tertiary education than on primary or lower secondary students (SRV 2005). Given that students entering the tertiary level are mainly from relatively wealthy households, it is also clear that public funding of university education has a regressive bias. In fact, with the exception of primary education, public spending at all levels of education has been regressive until recently, meaning that the wealthier groups received a higher share of public resources than their share of the population. The incidence of benefits for the richest and poorest income

groups is illustrated in Table 10. There are two notable observations. First, it can be seen that the distribution of benefits has become more progressive over time, with particularly large advances in secondary education. Second, there is still a very large gap in upper secondary education, where the richest quintile receives a subsidy that is nearly three times larger than that received by the poorest fifth of the population. The situation in tertiary education, which is not shown in the table, is even more skewed, since very few students from the poorest quintile continue to higher education.

Table 10. Distribution of Public Education Expenditures (percent)

Level of education	Poorest quintile	Richest quintile	Rich / Poor
Primary education			
1998	26	12	0.46
2002	31	13	0.41
Lower secondary education			
1998	13	21	1.62
2002	20	14	0.70
Upper secondary education			
1998	4	38	9.50
2002	9	26	2.89

Source: SRV (2005), Table 10.16.

Participation rates

Differences in education participation rates across population groups also reveal that the private financing burden affects education decisions. Table 11 summarizes some data on how participation rates at different levels of education developed between the early 1990s and 2002. A first point to note is that the richest quintile has markedly higher participation rates than the poorest quintile for all levels of education. The gap is systematically larger for higher levels of education, which is consistent with the pattern of out-of-pocket expenses: the private cost burden increase with the level of education. The differences were more pronounced in the early 1990s, and have gradually diminished as a result of increased public investment (including programs to exempt poor households from tuition fees) and economic growth (strengthening the household's ability to pay for education). It is particularly encouraging to note that the gap in primary education had almost been bridged by 2002. The overall enrollment rate in primary education is also quite high, and Vietnam is not very far from a situation when virtually all children will be enrolled in primary school. Yet, the gaps for higher levels of education – in particular university education – are still uncomfortably high.

The low university enrollment rates of students from poor households are not only connected to the high costs for university education, but also a result of inequalities at the secondary school level. As noted earlier, students from wealthier households receive significantly more teaching in the form of extra classes, which improves their chances to pass the tough university entrance exams.

A second point to note is the low post-primary enrollment rate for students from the poorest households. Only about half of these students continued to lower secondary school, less than one-fifth enrolled in upper secondary school, and a mere 0.4 percent took part in post-secondary education. This suggests that the great majority of poor students will find it very difficult to advance from the poorest quintile. The contrast with students from the richest quintile is striking. Two-thirds of these are enrolled in upper secondary school, and nearly one-third continue to some form of higher education: this is comparable to tertiary enrollment rates in many OECD countries. In fact, thousands of Vietnamese students, primarily from the wealthier strata of society, are also enrolled at universities in various OECD countries, mainly the US, Australia, the UK, and other European countries. Hence, students from richer households have a very good chance to remain among the country's wealthy elite. The reinforcement of the social structure suggested by these statistics may be an obstacle for the development of a sustainable welfare state. It suggests a pattern where some groups risk becoming permanent beneficiaries of social transfers, whereas others become permanent contributors to the financing of these transfers. Neither position is likely to be politically sustainable in the long run.

Table 11. Net Participation Rates in Education (percent)

Level of Education	All	Richest quintile	Poorest quintile	Rich/poor
Primary education				
1993	87	93	72	1.3
2002	90	95	84	1.1
Lower secondary education				
1993	30	55	12	4.6
2002	72	86	54	1.6
Upper secondary education				
1993	7	21	1	21
2002	42	67	17	3.9
Post secondary education				
1993	3	9	0	-
1998	9	29	0.4	72

Source: SRV (2005) and Nga Nguyet Nguyen (2004).

One important determinant of whether it is rational for an individual to take on the costs of education is the expected rate of return to education. In a country like Vietnam, it is obvious that education does have a positive impact on income. Formal analysis suggests that one additional year of schooling results in an expected return of roughly 3.9 percent, which is not very different from estimates for Sweden.²¹ In an international comparison, these estimated rates of return are relatively low, and connected to the compressed wage structures in both countries. However, with an increasingly important private sector that demands skilled labor and pays substantially higher salaries than the public sector, it is very likely that these estimates understate the true differences between the income potential related to different levels of education in Vietnam.

Health care and social insurance

Like the education sector, the Vietnamese health sector before 1975 was characterized by concerns for equity and an objective to provide universal access to the public health care system. Although the lack of resources inhibited the development of more sophisticated health care services, Vietnam was remarkably successful in primary and preventive health care. The base of the health system was made up of thousands of commune health stations that were set up in the northern part of the country from the late 1950s. By the mid-1960s, North Vietnam had nearly 5,500 such stations covering all lowland villages and 80 percent of upland villages (London 2004). The health stations provided basic preventive and curative health services, and were particularly important for the implementation of the country's public health policies, including vaccination and health education campaigns – more complicated operations were undertaken at polyclinics and hospitals at the district and province levels. Like other public services, health care facilities (and medicines) were financed from the state budget. As a result of substantial investments in primary health care, North Vietnam's health status improved dramatically between the mid-1950s and the mid-1970s. However, in spite of the socialist rhetoric of Vietnam's political system, the system could not be characterized as egalitarian. The health services provided to the majority of the population were very basic, and the best services and facilities were reserved for state employees and urban groups (London 2004).

²¹ For Vietnam, see Nga Nguyet Nguyen (2004) for Sweden, see Arai and Kjellström (1993).

The system of commune health stations was rapidly extended to the southern provinces after the reunification of the country in 1975, which led to further improvements in the national health status.²² However, the weak performance of the socialist economy soon started causing severe problems also for the health sector – the fiscal resources of the state were simply not sufficient to finance the public health care system. The commune health stations were particularly severely affected. In 1980, the central budget had financed 43 percent of their operating costs, with the remainder covered locally. By 1985, the central budget share had fallen to 13 percent, at the same time as the agricultural cooperatives that had accounted for the bulk of local financing were beginning to disappear (London 2004). The funding shortages contributed to a decline in the quality of services also in polyclinics and hospitals, with diminishing resources for equipment, medicines, and even medical staff. The number of public health workers started falling in the mid-1980s and continued declining for a whole decade, from about 262,000 in 1986 to 212,000 a decade later (MoH 2002).

One response from health stations, hospitals, and other service providers was the introduction of unofficial fees to compensate for the lack of funding from the state budget. The result was that individuals were forced to pay more for services that were often of lower quality than before. Some of the public reactions to this degeneration in health care services during the late 1980s have been recorded (World Bank 1993). For instance, the average annual number of outpatient consultations per capita fell from over two in the mid-1980s to only one in 1990, while the inpatient rate dropped from 105 admissions per 1,000 persons per year in 1987 to 68 in 1990. The reduction in health care utilization – with predictable negative effects on public health and welfare – was not evenly distributed across the population. Instead, effects varied across population groups and regions, with a more severe impact on the poorer segments of society that could not afford the additional costs.

The health policy changes that were introduced in response to the fiscal crisis changed the character of the Vietnamese health sector in a fundamental way, both regarding the structure and operations of the system and its political ambitions. One of the reforms during the first years of Doi Moi was a legalization of user fees in public health facilities: like many of the other market oriented reforms at the time, this measure was an acknowledgement of already existing practices rather than a new path-breaking policy innovation. The costs for drugs – which had earlier been borne by the state – were shifted to the users, and some private

²² The fact that individual users did not have to cover the costs led to relatively intensive use of health care services. The average annual number of contacts with the health care system increased sharply from 0.7 in 1976 to 2.3 in 1984. (MoH 2002).

and semi-private service providers were allowed. The most common private facilities are pharmacies, although there are also private polyclinics and a small number of private hospitals. Most of these are manned by medical staff from the state-owned health facilities who work extra hours to raise their earnings.

Moreover, the government and the VCP withdrew from its earlier ambition to guarantee universal access to health care (and education): these guarantees were dropped from the 1989 revision of the 1980 constitution and the new constitution that was introduced in 1992 (London 2004). Instead, the financing burden for health care was shifted from the government to the users, with only limited public subsidies. It is estimated that some 80 percent of total health costs are directly financed by the users, with the state budget share estimated at less than 15 percent – the balance is covered by foreign aid and various kinds of insurance policies (MoH 2002). Since the early 1990s, annual public health spending has been fairly stable at 5-7 percent of total government expenditure, corresponding to about 1.5 percent of GDP. In recent years, this process has, somewhat paradoxically, been referred to as “socialization”: the different social groups are expected to take increasing responsibility for financing their own health and education needs.

The new health policy has had two major effects since the late 1980s. Firstly, it should be noted that many of Vietnam’s health indicators have improved substantially since the late 1980s (although many of the improvements did not commence until 1992-1993). For instance, life expectancy at birth increased from about 65 years around 1990 to 71 years in 2003. The total fertility rate declined sharply over the same period, from 3.8 to below 2 (SRV 2005). Child mortality and maternal mortality rates diminished even faster, as shown in Table 12.

Table 12. Health Indicators for Vietnam 1990-2003

Indicator	1990-1991	1992-2002	2003
Life expectancy at birth (years)	65	68	71
Infant mortality rate (per 1,000 live births)	45	37	21
Under 5 mortality rate (per 1,000 live births)	62	42	33
Maternal mortality rate (per 100,000 live births)	160	100	85

Source: SRV (2005), Table 12.1.

Many vaccine-preventable diseases have also been brought under control through broad immunization programs, and the share of deaths caused by infectious disease declined from over one-half in the mid-1980s to about one-third in 1999 (MoH 2002). In particular, Vietnam has been successful in fighting cholera, malaria, diphtheria, pertussis, Japanese encephalitis,

tetanus, and measles. Some diseases like polio and infant tetanus have been eliminated altogether (MoH 2002, SRV 2005). Overall, it is also clear that the best health care facilities in Vietnam (which are mainly found in the urban centers Hanoi and Ho Chi Minh City) are much closer to international standards today than before the 1990s.

The reason for the marked improvements in the country's health status has undoubtedly been the high economic growth rate achieved since the early 1990s. Income growth has been strong enough to accommodate the increases in private health expenditures resulting from the 'socialization' of health care. Thanks to improved ability to pay, the average number of annual contacts with health care facilities increased from about one in the early 1990s to more than three in the late 1990s: of these, more than half were with private health facilities (Trivedi 2004). However, growth has not been equally distributed between regions and population groups, which means that the gains in health status (and the increase in the use of health facilities) are also unequally distributed. For instance, in the mid-1990s, the infant mortality rate in the poorest quintile of the population was twice as high as that in the richest quintile – similarly, the infant mortality rate in the central highlands was more than twice as high as that in the Red River delta and the HCMC region (MoH 2002).²³ Rates of child malnutrition vary significantly across regions and social groups depending on their ability to pay for health care (Gwatkin et al. 2000). The increasing frequency of some infectious diseases like tuberculosis and typhoid since the late 1980s and early 1990s may also be related to unequal access to (or unequal ability to pay for) health care.

Health expenditures

Hence, health expenditures have become an important part of the household budget and an important determinant of the living standard of most Vietnamese families, particularly the poor. This is the second main effect of the 'socialization' of the health sector. It is estimated that the poorest quintile of the population used nearly one-quarter of their disposable income on health services and drugs around year 2000 (MoH 2002). For the richest quintile, the corresponding figure was 9 percent. The bulk of these expenses – towards 70 percent – are for drug purchases (UNDP 2005). However, these averages do not properly reflect how severe the situation is for those households that actually need to use health care services. For instance, Wagstaff and Pradhan (2005) report that the cost of a single hospital visit in the early 1990s was equal to 41 percent of the annual non-food consumption of the poorest 20

²³ SRV (2005) reports even larger infant mortality gaps in 2001-2002, noting a four-fold difference between the rate for the Northern Uplands (40.9) and the South-eastern region (11.3), and between household with no formal education (58.6) and households where some members had completed secondary school (13.2).

percent of the population. The situation had not improved by the late 1990s. At that time, the average nominal user fee for a single inpatient treatment was equivalent to 45 percent of the annual non-food budget of the poorest quintile of households. The fee for a single visit to a polyclinic consumed 9 percent of their annual non-food budget (MoH 2002).

In addition to the nominal user fees, it is also common that patients pay informal user fees to doctors and other medical staff in order to guarantee good service. These informal payments are arguably motivated by continuing financing shortages, although nominal user fees and increased contributions from the central government have added to the official budgets of hospitals and other health care facilities. It is unclear how large these informal fees are. Official statistics from hospitals suggest that the nominal user fees account for about 40 percent their aggregate revenue, but there is a very large gap between the user fees reported as revenue by hospitals and the fees reported by patients. For instance, SRV (2005) observes that reported household spending for user fees was nearly five times larger than the user fee revenues reported by hospitals in 2001-2002. Adams (2005) notes that the fee payments reported by patients are sometimes up to 14 times larger than those recorded as hospital revenue. These gaps presumably give some indication about the size of the informal fees – they are substantial whether the true number is five or 14 times above the official user fees.

Looking at the pattern of health care use, it seems clear that cost differences, including formal as well as informal fees, have a strong impact on the kinds of health care demanded by different segments of the population. The poorer population groups mainly use community health stations or self-medicate (as indicated by the large share of total health expenditures used for drugs), whereas the richer groups seem to prefer polyclinics and state hospitals (Prescott 1997, Trivedi 2004). As a result, public health spending has a regressive bias: the average public health care subsidy received by the richest quintile of the population is more than twice as large as that received by the poorest quintile (SRV 2005, Adams 2005). About half of the resources for inpatient services at state hospitals are used by the richest quintile of the population (UNDP 1999).²⁴

One consequence of the increasing private health costs is that adverse health shocks – e.g. sudden illnesses or accidents – have emerged as the main threat to the financial stability of individual households. Apart from the substantial direct health care costs, these events also

²⁴ Regional differences in public health funding also contribute to this pattern, as more wealthy provinces are able to source more funds for health care. For instance, Hoang Van Minh et al. (2004) note that public health spending per capita in 1998 varied from a low of VND 20,000 in Nghe An, which belongs to the poorest provinces, to a high of VND 313,000 in Da Nang, which is relatively prosperous (although most provinces were clustered in the VND 30-50,000 range).

lead to reductions in earned income: the income losses may be very serious if the health problems affect the bread-winners of the household. Hence, health shocks are the most common reason why (even relatively affluent) households fall below the poverty line or fall deeper into poverty (World Bank 1999). It is estimated that health care costs pushed 2.6 million people below the poverty line in 1998, increasing the poverty headcount by nearly one-fourth (Wagstaff and van Doorslaer 2001). The high costs for health services also have negative effects on public health, as people hesitate to seek medical help for non-acute problems (which may contribute to the diffusion of infectious diseases) or self-medicate instead of seeking professional advice (which may e.g. lead to the emergence of resistant strains of bacteria).

Health insurance

To mitigate these problems, a health insurance system was introduced in 1993. The Vietnam Health Insurance (VHI) program has been revised a number of times since its establishment and now comprises several separate insurance plans. Its main part is a compulsory insurance that initially covered state employees (including military personnel), communist party officials, pensioners from state sector jobs, ‘persons of merit’ (e.g. war veterans), employees in foreign-invested enterprises, and workers in privately owned enterprises with more than 10 employees. From 2005, the compulsory plan was extended to cover workers also in smaller privately owned enterprises. Initially, the plan was administered at the provincial level, but the administration was centralized in 1998 since many provinces recorded substantial deficits in their VHI funds. The insurance covers official fees for inpatient and outpatient health care, as well as the medicines used in inpatient care. In 1998, a 20 percent co-financing requirement (up to a maximum of six times the annual minimum wage) was implemented to control the costs of the system, but this was dropped in 2005. The insurance fees amount to 3 percent of the salary (or pension), shared between payments by the employee (1 percent) and the employer (2 percent).

A second part of the insurance system is made up of a voluntary insurance plan that has mainly attracted students (although it is in principle open for everyone, including foreigners). The fees for students and school children are lower than for the compulsory insurance – VND 15,000 to 45,000 – but can reach up VND 100,000 for other groups, depending on the province and category of beneficiary. The benefits for students are also less generous, including in principle only inpatient fees (although some larger schools have received VHI support to set up school clinics). However, farmers, dependents of compulsory plan members,

and other groups paying the higher insurance fees for the voluntary health care plan qualify for the same benefits as those in the compulsory scheme (Hoang Van Minh et al. 2004).

During the first years after 1993, most of the participants in the VHI were state sector personnel and ‘socially privileged’ citizens, but the number of private enterprise employees has gradually increased, beginning with foreign-owned firms. Yet, most private domestic enterprises have remained outside the scheme until recently. For example, while the majority of SOEs and foreign-owned firms had joined by 2002, only about one-fifth of private domestic firms paid to the ‘compulsory’ health insurance program at that time. Students and school children joined the voluntary insurance scheme in relatively large numbers from 1995, and in recent years, the total coverage has increased after all participation by other groups has also increased notably. This notwithstanding, until 2002, the total coverage of the insurance system was limited to some 15 percent of the total population (see Table 13). The coverage among the poorest population groups was even lower, and it is fair to claim that the compulsory health insurance system reached mainly the relatively affluent part of the Vietnamese population. For these population groups, the insurance system provided important benefits, both financially and in terms of their health status (Wagstaff 2005; Wagstaff and Pradhan 2005).²⁵

Table 13. Number of Participants in VHI Plans 1993-2002

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Total number of members	3.80	4.25	7.10	8.63	9.55	9.76	10.23	10.40	12.51	13.03
Compulsory	3.47	3.71	4.87	5.56	5.73	6.07	6.35	6.47	6.98	6.98
Voluntary	0.33	0.54	2.23	3.07	3.82	3.69	3.38	3.09	4.04	4.39
Poor	--	--	--	--	--	--	0.49	0.84	1.49	1.67

Source: Hoang Van Minh et al. (2004) and MoH (2002). Detailed data for the period after 2002 are not available.

With only formal sector employees and students covered by the compulsory health care system, it was clear that it did not have any fundamental impact on the ability of poor population groups to access health care services. A number of other social protection schemes aiming to reduce poverty and to provide social services to particularly vulnerable groups have therefore been introduced over time. Most of the earlier programs were consolidated in 1996

²⁵ It should be noted that health care remains expensive due to the high informal ‘treatment fees’ and the cost of medicines that are not covered by the VHI. Moreover, the health insurance schemes do not provide any compensation for the income lost due to illness.

in the so-called Hunger Elimination and Poverty Reduction (HEPR) program. This includes the Social Guarantee Fund for Veterans and War Invalids, which provides support to war veterans and others who ‘contributed to the revolution’, the Social Guarantee Fund for Regular Relief, which supports orphans, disabled and elderly people, the Contingency Fund for Pre-Harvest Starvation and Natural Disasters, and a number of National Development Programs that have social components (van de Walle 2003). In addition, the health care budget finances a broad National Target Program focusing on ten specific public health objectives. These include prevention and treatment of malaria, tuberculosis, dengue fever, leprosy, goiter, child malnutrition, HIV/AIDS, and mental illness, as well as food safety and immunization programs (SVR 2005), and several of these serve poor communities as well as more affluent population groups. There are also some localities with hospitals providing free health care for poor people, but they are too few to make any real impact (Hoang Van Minh et al. 2004).

In addition, from the late 1990s, the increasing emphasis on poverty reduction (not least through the introduction of the Comprehensive Poverty Reduction Program, CPRSG, in 2002) has resulted in attempts to extend the health insurance scheme to poor population groups.²⁶ For instance, the establishment of the Social Security Fund in 1999 was intended to facilitate the delivery of free health care cards to a target group of 4 million of the poorest citizens. However, it relied heavily on funding from the provincial budget, and the lack of funds in most provinces meant that the targets could not be reached: only about 1.5 million free health insurance cards were distributed in the first three years of the program (as shown in the row ‘Poor’ in Table 13). In 2002, a Health Care Fund for the Poor was therefore established in each province to provide more resources for health care.²⁷ This fund was to be used for buying health care cards for up to VND 50,000 per person and year, or to reimburse the health care costs of poor people directly: 75 percent of the financing was to come from the central government, while the remainder was to be sourced locally. (In 2003, the value of the free health insurance card provided by the Fund was raised to VND 75,000). The potential beneficiaries of the Fund included members of household classified as poor, all residents of the poorest communities, and minority households in the Northern and Central Highlands. In

²⁶ Before that, in the mid-1990s, there were attempts to exempt the poor from user fees. However, it proved impossible in practice to administer these fee exemptions, since health care facilities refused to provide adequate care to non-paying patients. See SRV (2005).

²⁷ This is known as Decision 139.

total, it was estimated initially that some 15 million people could qualify for the benefits.²⁸ From 2003, this number increased substantially, since free health insurance coverage was extended also to all children under six years of age.²⁹ The number of poor people holding free health care cards or receiving reimbursement increased quickly after 2003. SRV (2005) reports that about 3.6 million people had received free health care cards by the end of 2003, and an additional 7.4 million people had benefited from direct reimbursement. Taken together, the various health insurance schemes covered nearly 31 million people in 2006, or about 37 percent of the total population (Viet Nam News 2006). Yet, financing constitutes a serious bottleneck, both for the public health insurance fund, which is running a substantial deficit, and for the beneficiaries, who still have to cover informal health care fees and costs for medicines.³⁰ In addition, it is frequently complained that holders of free health care cards receive sub-standard care, as the card signals that they are not likely to afford high informal payments to health care providers. This notwithstanding, the ambition is to expand the reach of the health care insurance plans, so that the combination of compulsory health insurance, voluntary health insurance, and free health insurance will cover 100 percent of the population by the year 2010.

Taking all these different programs into account, it can be argued that the Vietnamese government spends substantial amounts of money on targeted social programs and safety nets that compensate for the undesirable distributional effects of the ‘socialization’ of health care (and education). During the 1990s, the social programs accounted for between 10 and 15 percent of total public spending, which is roughly twice as much as the state health budget or nearly as much as the education budget. Since 2005, these costs have increased substantially, as a result of the extension of health insurance to children and poor households. However, there is reason to doubt how efficient these safety net programs were during the period for which data are available.

One concern is that payments to war-contributors made up a major share of total funds earmarked for social programs – over 60 percent of all social security and safety-net

²⁸ Individuals are defined as ‘poor’ if their monthly income is below VND 80,000 in mountainous and island regions, below 100,000 in the rural plains, and below 150,000 in urban areas.

²⁹ See Decision 2756/2003/QĐ-BYT. There are in total about 9-10 million children under the age of six in Vietnam.

³⁰ Viet Nam News (2006) report that the deficit of the Health Insurance Fund is expected to record a deficit of about VND 2.1 trillion in 2006, compared to a deficit of VND 300 billion in 2005. Data from SRV (2005) suggest that the average cost for the health insurance cards provided through this program was slightly above VND 30,000, while the average reimbursement was about VND 25,000. These sums are very small compared to the total costs of episodes of ill health. For instance, the official user fee for a medical examination for issuing an employment eligibility certificate is in the range VND 18,000-50,000 depending on province and type of hospital (Hoang van Minh et al. 2004).

expenditures during the first half of the 1990s, and around 40 percent of expenditures towards the end of the decade were directed to war veterans and other privileged groups (UNDP 1999). These payments were not means-tested, and may therefore not have targeted the most vulnerable groups. The same concern applies for the pensions of the civil servants who retired before 1995, which occupied 30-40 percent of the designated social safety-net expenditures during the 1990s.³¹ Consequently, many individuals in eligible population groups did not receive any benefits. For instance, in 1993, only 10 percent of orphaned children, 5 percent of disabled persons, and 2 percent of solitary elderly received any public social protection services. By 1998, government sources reported that the shares had increased substantially, but the great majority of orphans, disabled persons, and solitary elderly were still left without any public support (UNDP 1999). Similarly, examining the patterns of social transfers in the form of education scholarships, social insurance funds, and social subsidy funds, van de Walle (2003) concluded that the programs helped few people escape poverty, and protected even fewer from falling into poverty. Van de Walle's disappointing conclusion was therefore that the public safety net 'appears to have been largely irrelevant to the country's recent poverty reduction record'. It should, however, be noted that these assessments were made before the establishment of the Health Care Fund for the Poor, which is likely to reach a larger share of the poor population. In particular, the extension of free health insurance to children under the age of six is an important step to improve poor people's access to health care. At the same time, it should be noted that the extension of free health care to children is not a targeted but rather a universal program.

Hence, in spite of the large number of targeted social programs, many poor people have fallen outside the insurance systems as well as the other social safety nets. In addition, a substantial share of the population lives just above the poverty line.³² This group is typically employed in farming or the informal urban sector, where there is no compulsory insurance coverage to date. Their incomes are not high enough to cover the costs of sudden health shocks, but they are not low enough to qualify them for the support programs targeting the 'poor'. How do these individuals handle the high health care costs? On the basis of survey results, Hoang Van Minh et al. (2004) suggest that there were three main responses in the early 21st century. Firstly, about one-fourth of the people in the poorest quintile of the population reported that they discontinued their health treatment before it was completed and

³¹ The pensions for civil servants retiring after 1995 are administered through the Vietnam Social Insurance Agency.

³² MoH (2002) estimates that at least 28 million Vietnamese, or over one-third of the population, had a consumption level just above the poverty line in the late 1990s.

they had recovered. About the same share of the poorest group responded by restricting other expenditures (e.g. for food and education) in order to afford the necessary health care costs. Their most common coping mechanisms, however, were to increase debt or sell assets in order to cover health care expenses. Fewer of the people in the second and third quintiles – those that could be characterized as ‘nearly poor’ – reported that they interrupted health care because of the lack of funds, but borrowing and asset sales were as common as among the poorest quintile. It is safe to conclude that the loans in question do not come from the formal banking system, but rather from friends and relatives and other parts of the local community – perhaps what is intended by the ‘socialization’ of health care. The most common response in the richest quintile, by contrast, was that they were not influenced by high health care costs: only some 5 percent of the richest households reported that they had been forced to increase debt or sell assets to manage. In this population group, it appears that socialization does not play any substantial role thanks to higher incomes and better insurance coverage.

Social security and pensions

Another area where socialization is the norm is elderly care. Traditionally, care of the elderly was the responsibility of the extended family, with parents living together with one of their adult children. In the northern parts of the country, elderly parents were typically the responsibility of a married son; in the south, it was also common that married daughters took responsibility for their parents. During the socialist era, some of this responsibility was shifted to local cooperatives, which were encouraged to set aside some minimum allocation of consumer goods to support the elderly – if the cooperative was not able to this, the government could provide some subsidies (Cuong et al. 2000). Meanwhile, state employees constituted an elite group that could rely on formal state pensions as their main source of income.

With the dissolution of most local cooperatives after Doi Moi, the responsibility for elderly care reverted to the extended family. The exception was state employees, including government officials, SOE employees, and members of party organizations. Their pension and social security benefits remained the responsibility of the state, and were managed by the Ministry of Labor, Invalids, and Social Affairs (MOLISA). In addition to the health insurance benefits that were discussed above, the social security for state employees included coverage for maternity, occupational accidents and diseases, as well as pension, early retirement, and survivorship benefits. The costs for these benefits were covered by the current state budget.

In 1995, the administration of the state pension system was moved to the newly established Vietnam Social Insurance Agency (VSI). At that time, the groups holding compulsory health insurance were also requested to join a compulsory social insurance and pension program: aside from state employees, these groups include workers in private firms with more than 10 employees and employees of foreign-invested enterprises. In 2002, these two insurance schemes – the health insurance and the social insurance plan – merged under the Vietnam Social Insurance Agency. The cost of social insurance is relatively high, amounting to 20 percent of the employee's basic salary (with 15 percent paid by the employer and 5 percent paid by the employee) in addition to the 3 percent required for the health insurance. At the same time, the benefits provided by the insurance plan are fairly generous. In addition to health care costs, the social insurance covers income losses during sickness and maternity, compensation for occupational injuries, early retirement, and old-age pensions.

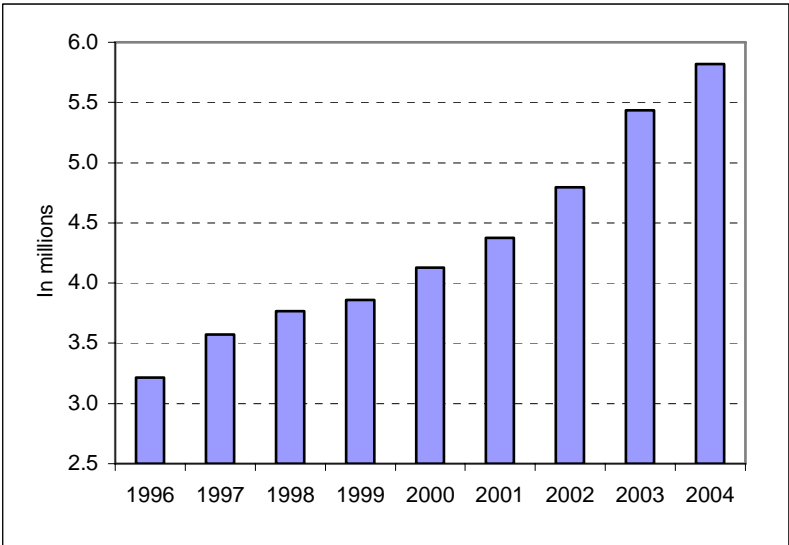
The sickness benefit is equal to 75 percent of the employee's salary, payable from the first day for 30-50 days per year depending on the number of years in the insurance system. Women are allowed four to six months of maternity leave with full salary, with an extra 30 days of paid leave from the third child. They are also entitled to receive sickness benefits for up to 20 days per year to care for sick children. In case of occupational injuries, workers are fully compensated for income losses during treatment, and additional benefits in case of lasting disability. There is no unemployment insurance at present, but the inclusion of such a component is discussed in proposals for a future law on social insurance (Nguyen Quang Minh 2005).

There are no universal pensions in Vietnam: in principle, only those who have contributed to the social insurance system qualify for pension benefits, which are proportional to their contributions. The retirement age is 60 for men and 55 for women. The monthly pension is based on the average salary for the last 10 working years. Those who have contributed to the pension scheme at least 15 years receive 45 percent of this base salary, and each additional contribution year adds 2 percent (for women, 3 percent) to the monthly pension. Hence, the maximum pension is equivalent to 75 percent of the base salary, and requires 30 working years (for women, 25 working years) in the system.³³ The minimum pension, irrespective of the base salary, is equal to the minimum wage. Beneficiaries, in particular those that have fewer than 20 years of contributions, can also receive lump-sum payments at the age of retirement.

³³ Fewer working years are required from war veterans and contributors who have worked in heavy or hazardous jobs, or in some of the least developed provinces.

The coverage of the Vietnam Social Insurance Agency increased from about 3.1 million people in 1996 to 5.8 million in 2004, as shown in Figure 1. In 2005, compulsory coverage was extended to all employees in registered enterprises, which means that some 10 million employees are formally required to contribute to the social insurance system. While the large majority of all employees in the public sector and foreign-invested enterprises do participate in the system, most privately owned firms remain outside. This is possible since authorities do not expend much resources to ensure compliance, and because the fines for failing to make the required contributions are low. Yet, excluding pre-existing pension commitments (to war veterans and state employees) the pension insurance plan appears to be financially sustainable in the short run, in spite of the limited contributions from private firms. At present, there are nearly 17 contributors for each beneficiary in the new pension scheme, and the number of contributors will exceed the number of beneficiaries by a wide margin for the next couple of decades. The pension costs for war veterans and those state employees that were retired before 1995 are also falling over time.

Figure 1. Contributors to Vietnam’s Social Insurance Program



Source: Vietnam Development Report 2006.

However, the long run sustainability of the pension program is uncertain (World Bank 2005). Since it is a pay-as-you-go plan, it is sensitive to the demographic structure of the population. The aging of the population together with weak incentives to accumulate the maximum number of contribution years is likely to create substantial deficits in about three decades. The sustainability of the pension plan is sensitive both to the balance between beneficiaries and

contributors (i.e. demographic structure) and to life expectancy.³⁴ The present structure of the plan assumes that the average individual will benefit from pension payments for 12 years: with average life expectancy already at about 71 years (and probably higher for the relatively privileged groups that qualify for social insurance) deficits are easy to foresee. The short term components of the social insurance program (benefits for sickness, maternity, and occupational injuries) appear to be in financial balance at present, but experiences from countries like Sweden suggest that the utilization of benefits may vary over time, and adjustments of benefit levels may therefore be necessary. In particular, the aging of the population will not only raise pension costs but is also likely to have direct effects on the overall demand for health services.

Concluding comments

Any assessment of the Vietnamese welfare state must necessarily be multi-faceted. On the one hand, Vietnam has achieved remarkable success in both the education and health sectors, with increasing literacy rates, school enrolment rates, and improving health indicators. On the other hand, the welfare state is fragmented, and access to social services and social security vary across social groups and geographical regions. The most serious consequence of this is that some groups of society are becoming marginalized, in the sense that they – and their children – do not have any realistic possibilities to improve their living standards, or to benefit from the general development of the Vietnamese society. The most severe gaps are not those between regions and provinces. Instead, in absolute numbers, most of the poor and vulnerable groups live in provinces that are relatively wealthy – the Red River delta and Ho Chi Minh City with surrounding provinces. There is no doubt that improvements are necessary, but there is no consensus about what are the priorities and how much it is possible to invest in the social sectors.

The experiences of Sweden arguably provide some guidance regarding these important questions. Firstly, Sweden offers an important insight regarding the importance of social stability. Although the first decades of the 20th century were characterized by a struggle between labor and capital, it was less fierce than in many other countries, and it resulted in a compromise that has survived to the present. This has created an unusual degree of political stability, where the overall character of society is not likely to change much even if political power shifts from one of the main political parties to another. The stability, in turn, guarantees

³⁴ See e.g. World Bank (1994).

that the rules of the game are very predictable and that the degree of uncertainty for long-term investors is minimized. There are no doubts about the priority given to the welfare state. In essence, the internal security that is provided by a society that does not exclude any population groups from participation and opportunity is equally important as security from external enemies and threats. In this light, the question is not whether Vietnam can afford to invest more in social welfare, but rather whether Vietnam can afford not to. A scenario where disadvantaged and disheartened population groups lose their hopes for future is highly undesirable.

A second lesson is related to the how the welfare state is organized. One of the main characteristics of the Swedish welfare state is that most benefits are universal rather than means-tested. This is closely related to the ambition to avoid exclusion: by defining universal benefits, it is not necessary to identify those groups that are considered particularly weak or vulnerable. This also makes it possible to avoid a polarization of the population into those that pay for social security and those that draw on the benefits of the system. Instead, all residents are net payers during some part of their life cycle, and net beneficiaries at other times. This is also an important step for creating acceptance for the increasing tax burden that is needed to finance public welfare.

The third lesson concerns the time dimension of reforms. The core of the Swedish welfare state was established at a time when economic conditions were favorable, both from the perspective of government finances and private incomes. Economic growth provided the resources necessary to finance investments in health, education, and social insurance systems. At the same time, there were mistakes made in the design of the Swedish welfare state. For instance, the pension system did not fully account for the aging population, which eventually forced new reforms that are putting substantial pressure on the current generation. With growth rates expected to exceed seven percent per year in the near future, Vietnam has the financial conditions to raise its level of ambitions in the social sectors. At the same time, it is possible to predict significant demographic changes in the future, leading to increasing life expectancy and an aging population in Vietnam as well. These predictable changes should be reflected in the design of both the health care and pension systems.

Looking more specifically at the education, health, and social insurance sectors, it is also possible to identify some challenges that may require attention in the near future (or already at present). In the education sector, Vietnam has already progressed relatively far, with the increasing number of children receiving basic education as the single most remarkable achievement. The objectives set out in the EFA plan are also commendable, and

will require substantial investment in the future. In addition, two reform areas appear particularly urgent. Firstly, there is reason to review the structure of and dependency on fees and charges, and to phase out the nominal charges for primary and secondary education. To achieve a more egalitarian education system, it may also be necessary to consider public support to public transportation and meals at school. Secondly, the most notable social inequity in the present education system seems to be related to the practice of “extra classes” in secondary school. Even if children from poor households are allowed to enter secondary schools – perhaps even without formal fees – they are still unable to reach the same study results as children from wealthier homes, who receive strategically important extra teaching. One measure to reduce this bias would be to expand the education program to reach the international standard of 900 teaching hours per school year. In addition, it would be essential to adjust teachers’ salaries to make it possible to reach a decent standard of living without giving private extra classes.

In the health sector, the current ambition to extend health insurance to all citizens within the next few years is commendable. However, as long as the practice of side payments to health care staff is maintained, there will be a substantial gap between the health care that is offered to patients with only insurance coverage and to patients who are also able to pay on the side. This puts much emphasis on the need to carefully define what types of health care the universal health insurance will actually cover. Here, Vietnam will face a difficult dilemma, since the health insurance system will not be able to fund the best available care and the most effective modern medicines for the whole population: the Health Insurance Fund is already generating a large deficit. It seems difficult to avoid a situation where there is a substantial gap between what is offered by the public health care system and what is available to paying customers in the private health care sector. At the same time, this dilemma turns attention to public health policy, which is weakly developed in Vietnam. The available public funds could undoubtedly be used more efficiently if a larger share was diverted from curative care to public health policy. Measures to promote primary health care, safe sex, traffic safety, reduced smoking, alcohol, and drug abuse, and other similar areas would improve public health and reduce the resource requirements in curative health care. Moreover, although it is easy to predict the rapid aging of the Vietnamese population over the coming decades – and with it an increase in the demand for health care services – there does not appear to be any comprehensive strategy for how these challenges will be met in a five to ten-year perspective.

The aging of the population is a challenge also for the social insurance system. The present pension system is not likely to be sustainable if the life expectancy of the population

increases at the same pace as in other countries that have developed rapidly. The most important problem related to the pension system, however, is its small coverage. With the present structure, the great majority of the Vietnamese population cannot expect any pensions, but will instead be dependent on their children and relatives for support. While this may be possible to manage in rural areas, it is likely to create tensions in urban areas, where rising populations and high land prices are already severe problems. There is a risk that the elderly generations will be seen as a burden rather than as an asset. Here, it is likely that a reform of the pension system could make a vital contribution. By providing a low universal pension to all elderly citizens – perhaps from the age of 67 or 70, rather than the nominal retirement age – it would be possible to strengthen the independence and role of elderly people. By making the system universal rather than targeting only the most vulnerable groups, it would also be possible to avoid administrative costs and establish the structures needed for the future, when Vietnam is wealthy enough to afford a more generous pension and social welfare system for all citizens.

References

- Adams, S. (2005), “Vietnam’s Health Care System: A Macroeconomic Perspective”, paper presented at *International Symposium on Health Care Systems in Asia*, Hitotsubashi University, Tokyo, January 21-22.
- Arai M. and C. Kjellström (1993), “Returns to Human Capital in Sweden”, in A. Björklund and A. Forslund, eds., *Studier av svensk utbildning*, Ekonomiska Rådets Årsbok. Stockholm.
- Congressional Budget Office (2004), “How pensions financing affects returns to different generations”, Long Range Fiscal Policy Brief, No 12, September 22, Congressional Budget Office, Washington, DC.
- Cuong, Bui The, Truong Si Anh, D. Goodkind, J. Knodel and J. Friedman (2000), “Older People in Vietnam amidst Transformations in Social Welfare Policy”, in D.R. Phillips, ed., *Ageing in the Asia-Pacific Region: Issues, Policies and Future Trends*, Routledge, London and New York.
- Edebalk, P.G. (2000), “Emergence of a Welfare State – Social Insurance in Sweden in the 1910s”, *Journal of Social Policy*, 29, 4, pp. 537-551.
- Edebalk, P.G. (2004), ”Hur skall vi betala framtidens äldreomsorg?”, in H. Jönsson, ed., *En kompanjonbok till Forskningsetik och perspektivval*, Studentlitteratur, Lund.
- Edebalk, P.G. (2005), “Sjuklön och sjukpenning – 1955 års sjukförsäkringsreform och sjuklönefrågan”, Working Paper 2005:04, Socialhögskolan, Lund University:
- Edvinsson, R. (2005), *Growth, Accumulation, Crisis: With New Macroeconomic Data for Sweden 1800-2000*, Ph.D thesis, Department of Economic History, Stockholm University.
- Eurostat (various issues), *General Statistics*.

- Financial Times (2000) "Pay-as-you-go pensions face a bleak future", *Financial Times*, August 23.
- Fransson K., (2001), "Redovisning av skolverkets utredningsuppdrag: Trettio år med 'skolarbetsliv' – en översikt", mimeo, Lärarhögskolan i Stockholm, Stockholm University.
- Glewwe P. (2004), "An Investigation of the Determinants of School Progress and Academic Achievement in Vietnam", in Glewwe et al., eds. (2004).
- Glewwe, P., N, Agrawal and D. Dollar, eds (2004), *Economic Growth, Poverty, and Household Welfare in Vietnam*, The World Bank, Washington DC.
- Gwatking, D.R., S. Rustein, K. Johnson, R.P. Pande, and A. Wagstaff (2000), "Socio-economic Differences in Health, Nutrition, and Population in Vietnam", mimeo, HNP / Poverty Thematic Group, World Bank, Washington DC, May.
- Hassler J. and A. Lindbäck (1999), "Can and Should A Pay-as-you-go System Mimic A Funded System?", mimeo, Institute for international Economic Studies, Stockholm University.
- Henrekson M. and M, Person (2004), "The Effects on Sick Leave of Changes in the Sickness Insurance System", *Journal of Labor Economics*, 22, 1, pp. 87-112.
- Hoang Van Minh, Nguyen Khang and Nguyen Viet Dung (2004), "Health Care Financing for the Poor in Vietnam", Working Paper No. 2004: 8, Human Development Sector Unit, World Bank, Washington, DC.
- Kangas, O. and M. Palme (1989), *The Social Citizenship Indicators Register*, Swedish Institute of Social Research (SOFI), Stockholm University.
- Kokko, A., (2005), "Excess Capacity in Swedish Industrial Development", *International Journal of Learning and Change*, 1, 1, pp 122-140.
- Lindh T. and B.Malmberg (2004), "Demographically Based Global Forecasts up to the Year 2050", Institute of Future Studies Report No. 2004:7, Stockholm.
- LIF (2004), *FAKTA*, Läkemedelsindustriföreningen, Stockholm.
- London, J. (2004), "Rethinking Vietnam's Mass Education and Health Systems" in D. McCargo, ed. *Rethinking Vietnam*, RoutledgeCurzon, London.
- Ministry of Health and Social Affairs (2005a), "Health and Medical Care in Sweden", Fact Sheet No 15, May, Government Office, Stockholm.
- Ministry of Health and Social Affairs, (2005b), "Policy for the Eldery", Fact Sheet No 14, May, Government Office, Stockholm.
- MoH (2002), *Vietnam Health Report 2002*, Ministry of Health, Hanoi.
- Nga Nguyet Nguyen (2004). "Trends in the Education Sector", in Glewwe et al., eds. (2004).
- Nguyen Quang Minh(2005), "Some Issues of Social Insurance Bill", *Vietnam Law & Legal Forum*, 12, 133, September, pp. 17-19.
- OECD (2005), *Health at a Glance: OECD Indicators – 2005 Edition*, OECD, Paris.
- OECD (2002) *Health data*, 4th edition, OECD, Paris.
- Pham Duc Thanh (2005), "Some Issues About Social Insurance in Vietnam", *Journal of Economics and Development*, No. 94, pp.12-13.
- Prescott, N. (1997), "Poverty, Social Services, and Safety Nets in Vietnam", World Bank Discussion Paper No. 376, World Bank, Washington, DC.
- Socialstyrelsen (2001). *Folkhälsorapport 2001*, Epidemiologiskt Centrum, Socialstyrelsen, Stockholm.
- SRV (2003), *National Education for All (EFA) Action Plan 2003-2015*, Socialist Republic of Vietnam, Hanoi.
- SRV (2005), *Vietnam: Managing Public Expenditure for Poverty Reduction and Growth. Public Expenditure Review and Integrated Fiduciary Assessment. Volume 2: Sectoral Issues*, Socialist Republic of Vietnam and the World Bank, Hanoi.

- SOU (2001), *Välfärdens finansiering och fördelning*, Statens Offentliga Utredningar 2001:57. Fritzes, Stockholm.
- Statistics Sweden (Various years), *National Accounts*, Statistics Sweden, Örebro.
- Statistics Sweden (2004), *Statistisk årsbok för Sverige 2004*, Statistics Sweden, Örebro.
- Statistics Sweden, (2005), "Statistiska Meddelanden", SM 0501, Statistics Sweden, Örebro.
- Swedish Agency for Education (2000). *Education For All: The Swedish Education System*. Skolverket, Stockholm.
- The Swedish National Institute of Public Health (2005), *The 2005 Public Health Policy Report*, Statens folkhälsoinstitut, Stockholm.
- Trivedi, P.K. (2004), "Patterns of Health Care Use in Vietnam: Analysis of 1998 Vietnam Living Standards Survey Data", in Glewwe et al., eds. (2004), pp. 391-425.
- UNDP (1999), *Basic Social Services in Viet Nam: An Analysis of State and Donor Expenditures*, UNDP and MoLISA, Hanoi, December.
- UNDP (2005), *User Fees, Financial Autonomy and Access to Social Services in Vietnam*, UNDP, Hanoi, August.
- Viet Nam News (2006), "Health Insurance Fund reports cash shortage of VND1.2 trillion", *Viet Nam News*, June 29.
- Wagstaff, A. (2005), "The Economic Consequences of Health Shocks", World Bank Policy Research Working Paper 3644, World Bank, Washington, DC, June.
- Wagstaff, A. and E. van Doorslaer (2001), "Paying for Health Care: Quantifying Fairness, Catastrophe, and Impoverishment, with Applications to Vietnam 1993-98", World Bank Policy Research Working Paper No. 2715, World Bank, Washington, DC, November.
- Wagstaff, A. and M. Pradhan (2005), "Health Insurance Impacts on Health and Nonmedical Consumption in a Developing Country", World Bank Policy Research Working Paper 3563, World Bank, Washington, DC, June.
- van de Walle, D. (2003), "Testing Vietnam's Public Safety Net", Social Protection Discussion Paper Series No. 319, World Bank, Washington, DC.
- World Bank (1993), *Vietnam: Transition to Market*, World Bank, Washington, DC.
- World Bank (1994), "Redistribution across income levels in pay-as-you-go", Development Brief No. 44, World Bank, Washington, DC.
- World Bank (1997), *Vietnam: Education Financing. A World Bank Country Study*, World Bank, Washington, DC.
- World Bank (2006), *Vietnam Development Report 2006: Business*, World Bank, Hanoi.