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25-29 Phan Boi Chau, Hanoi, Viet Nam

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Editing: Juliette Elfick
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*Empowered lives.
Resilient nations.*

Social Services for Human Development

Viet Nam Human Development Report 2011

FOREWORD

Ten years ago, the very first Viet Nam Human Development Report was launched. It focused on the *doi moi* policy reforms and their impact on poverty reduction and human development. In the ten years since 2001, Viet Nam has changed rapidly. Remarkable growth over the past two decades has meant that poverty levels have fallen substantially. Viet Nam's human development has also been rising steadily and the country is now at the medium human development stage, along with countries like India, Indonesia and the Philippines. However, the growth momentum generated during the *doi moi* reforms is starting to lose steam, due to both internal and external factors.

As a middle-income country, Viet Nam is now facing new development opportunities. Yet there are also challenges which need to be tackled – particularly if Viet Nam is to overcome the so-called 'middle-income trap'. These challenges include less-developed infrastructure, a low level of specialization and economic competitiveness, poor science and technology capacity and an unskilled labour force. These all threaten the sustainability of Viet Nam's achievements and hinder further human development.

A new development approach is therefore needed if Viet Nam wants to achieve better quality, sustainable growth. As part of this, Viet Nam should concentrate not just on achieving income growth but also on improving human development, by for instance providing better quality health and education services, creating decent jobs for a young and growing labour force, strengthening governance and creating strong and effective institutions. Ensuring a greater balance between economic growth and social, human and sustainable development goals is essential to ensure that all citizens can benefit from the development process, and for Viet Nam to achieve its goals of becoming a modern, industrialized nation.

The human development concept already features prominently in Vietnamese policies. It is enshrined

in the Vietnamese constitution, and the new Socio-Economic Development Strategy and Plan both highlight the importance of social equity and of promoting quality of life. A healthy, well educated population with access to quality social services and social protection is one of the central aims of government policies. As mentioned in the new Socio-Economic Development Strategy, human capital and human development play a critical role in turning Viet Nam's development vision into reality.

The central tenet of this Human Development Report – *Social Services for Human Development* – is that economic growth in and of itself does not automatically bring about higher human development. A country's success cannot be measured simply by national income. Rather, people are the real wealth of nations and investing in their human development is the best way to attain sustainable growth and development. With income inequality rising and significant social and economic disparities in some of Viet Nam's regions and provinces, we feel now is an opportune time to re-examine human development in the country.

This national Human Development Report provides an evidence-based analysis of Viet Nam's human development progress at the sub-national level, focusing specifically on issues around health and education. It looks at the challenges many Vietnamese face in accessing basic social services. The report shows how rising economic inequality is accompanied by persistent disparities in key education and health indicators. It concludes that if Viet Nam is to continue moving to higher levels of human development, ensuring universal, equitable access to health and education is essential.

For the first time in Viet Nam, the report also introduces a national Multi-Dimensional Poverty Index. This innovative index builds on the substantial work already undertaken by government and UN agencies in Viet Nam, particularly in measuring multi-dimensional child and urban poverty.

The Multi-Dimensional Poverty Index in this report measures deprivations in health, education and living standards across Viet Nam's provinces and regions. It is the first index of its kind to be applied for the general population and at the sub-national level, and it provides an important baseline for measuring non-monetary poverty in future.

We hope policymakers, parliamentarians, researchers and other stakeholders will find the report a timely and useful starting point for discussions on how to further advance human development in Viet Nam. The analysis in the report offers an opportunity to reflect on how to best build an equitable and inclusive development model that expands choices and generates opportunities. Such a model will

help ensure that Viet Nam's strong development success story can continue. This will also require careful consideration as to how to finance public investment and public services in the social sector.

The report is the result of extensive collaboration between many dedicated people. It draws on a number of excellent working papers prepared specifically for the report. The authors have also benefited from insights provided by government agencies, the research community, including colleagues at the Viet Nam Academy of Social Sciences, development partners and other UN agencies. We would like to thank all those who contributed their time and efforts.



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The opinions, analyses and recommendations contained in this document do not necessarily reflect the opinions of the United Nations Development Programme. The report is an independent publication commissioned by UNDP.

ACKNOWLEDGEMENTS

This Human Development Report (HDR) for Viet Nam is the result of the extensive collaboration, contribution and support of many people. In particular, UNDP would like to thank the Viet Nam Academy of Social Sciences (VASS), including Professor-Doctor Nguyen Xuan Thang, Professor-Doctor Do Hoai Nam, Ms Tran Thi Lan Anh and Mr Nguyen Thanh Ha, for the strategic advice and strong support provided by VASS senior and academic staff throughout the research and writing of this report.

The principal author of the report was Ingrid FitzGerald, drawing on an earlier draft of the report prepared by James Chalmers. Other contributing authors include Pham Thi Lien Phuong (Chapter Three) and Jairo Acuña-Alfaro (Chapter Six). The report also draws significantly throughout on the excellent working papers prepared by experts from a variety of fields and institutions, listed below.

Setsuko Yamazaki and Patricia Barandun provided overall guidance and support for the finalization of this report. Sincere thanks and acknowledgement is also due to the many readers who provided guidance and comments on the initial concept and successive drafts of the report. These include: Nguyen Thang, Ho Si Quy, Dang Bich Thuy, Phan Sy Man, Pham Thanh Nghi, Tran My Hanh, Pham Thi Lien Phuong, Alex Warren-Rodriguez, Jairo Acuña-Alfaro, Jonathan London, Martin Painter, Jonathan Pincus, Stefan Liller, Christophe Bahuet, Nguyen Bui Linh, Peter Chaudry, Pernille Goodall, Amanda Tyrell, Graham Harrison, Filip Lenaerts and Toomas Palu. Special mention is due to Tran My Hanh for her tireless facilitation and support throughout the process of preparing the report, and to Pham Thi Lien Phuong and Lo Thi Duc of the General Statistics Office of Viet Nam (GSO) for their invaluable assistance in pioneering the development of the Multi-dimensional Poverty Index (MPI), which is introduced for the first time in this report. However, any errors or omissions remain the responsibility of the principal authors.

Multiple consultations were held between February 2009 and February 2010 to help inform the preparation of the report, involving key experts and practitioners. Background research for the 2011 National Human Development Report (NHDR) was commissioned on a range of thematic issues and is listed in the references. Intensive collaboration with the working paper authors was facilitated by Jim Benson and Nancy White, affiliated with Modus Cooperandi/Full Circle Associates in Washington, USA.

Intellectual advice and technical support were very generously provided throughout the preparation process by Aimee Gaye and Tim Scott from the Human Development Report Office (HDRO), Anuradha Rajivan from the regional Human Development Report Unit and Joachim Nahem from the Oslo Governance Centre. Paul Quarles Van Ufford and Geetanjali Narayan of UNICEF provided timely advice on the multi-dimensional poverty measures that UNICEF has pioneered in Viet Nam.

Special thanks is also owed to Nguyen Manh The, Nguyen Van Tien and Björn Surborg for the statistics used in this report. In particular, UNDP wishes to express its gratitude for the work done to prepare statistics used from successive years of the Viet Nam Household Living Standards Survey (VHLSS) and population census. Particular thanks are due to the Viet Nam General Statistical Office for their timely calculations of the Human Development Index (HDI), Gender Development Index (GDI), Human Poverty Index (HPI) and Multi-dimensional Poverty Index (MPI) and disaggregation into provincial categories.

Finally, sincere gratitude and appreciation is due to the authors and readers of the working papers that formed the basis for this report: Jairo Acuña-Alfaro (UNDP), Soma Chakrabarti (UNDP), Koos Neefjes (UNDP), Ta Thi Thanh Huong (UNDP), Saskia Blume (International Organization for Migration), Nguyen Duc Nhat (Development and Policies

Research Center), Nguyen Ngoc Anh (Development and Policies Research Center), Giang Thanh Long (Indochina Research & Consulting), Jonathan London (City University of Hong Kong), Nguyen Viet Cuong (Indochina Research & Consulting), Björn Surborg (independent consultant, University of British Columbia), Vu Hoang Linh (Indochina Research & Consulting), Dao Hoang Mai (Institute of Economics, VASS), Nicola Jones (Overseas Development Institute), Elizabeth Presler-Marshall (Overseas Development Institute), Le Thuc Duc (Center for Analysis and Forecasting, VASS), Dang Hoang Giang (Centre for Community Support Development Studies), Pham Thai Hung (Indochina Research & Consulting), Tran Thi Van Anh (Institute of Family and Gender, VASS), Nguyen Ngoc Thang (University of Economics and Business, Viet Nam National University), Dang Nguyen Anh (VASS), Tran Nguyet Minh Thu (Institute of Sociology, VASS), Dao The Son (Center for Economics and Community Development (VUSTA), Santosh Khatri (UNESCO, Viet Nam), Martin Gainsborough (Centre for East Asian Studies, University of Bristol), Jonathan Pincus (Fulbright Economics Teaching Program, Harvard Kennedy School), Duncan Green (Oxfam UK), Scott Fritzen (Lee Kuan Yew School of Public Policy, National University of Singapore), Mrs. Khuat Thi Hai Oanh (Social Health Department, Institute for

Social Development Studies, Viet Nam), Gouranga Dasvarma (School of the Environment, Flinders University, Australia), Pham Thanh Nghi (Institute of Human Studies, VASS), Nguyen Thi Kim Chung (Faculty of State and Law, National Academy of Public Administration), Nguyen Mai Chi (AusAID), David Koh (Institute of Southeast Asian Studies, Singapore), Nguyen Trong An (Ministry of Labour, Invalids and Social Affairs), Tran Ngoc Anh (School of Public and Environmental Affairs, Indiana University, USA), Brian Quinn (Boston College Law School, USA), Jim Taylor (School of Social Sciences, University of Adelaide, Australia), Pham Thu Hien (Department for Gender Studies, Ho Chi Minh; National Academy of Politics and Public Administration, Hanoi), Nguyen Thi Thanh Ha (Oxfam Hong Kong), Sidney Ruth Schuler (Empowerment of Women Research Program, Academy for Educational Development, Washington DC), Dang Kim Chung (Institute of Labour Science and Social Affairs, Ministry of Labour, Invalids and Social Affairs), Truong Quang (Maastricht School of Management, The Netherlands), Vu Thieu (Viet Nam-Netherlands Master's Program in Development Economics), Vu Manh Loi (Institute of Sociology, VASS), and Adam Fforde (Centre for Strategic Economic Studies, Victoria University, Australia).

ACRONYMS

ADB	Asian Development Bank
CECODES	Center for Community Support Development Studies
CIEM	Central Institute of Economic Management
CPHCSC	Central Population and Housing Census Steering Committee
CPR	Child Poverty Rate
DRG	Diagnosis Related Group
EU	European Union
FDI	Foreign Direct Investment
ESEA Region	East and Southeast Asian Region
FSWS	Female Sex Workers
GDI	Gender Development Index
GDP	Gross Domestic Product
GER	Gross Enrolment Ratio
GII	Gender Inequality Index
GNI	Gross National Income
GoV	Government of Viet Nam
GSO	General Statistics Office of Viet Nam
HCMC	Ho Chi Minh City
HD	Human Development
HDI	Human Development Index
HDR	Human Development Report
HDRO	Human Development Report Office, New York
HIV	Human Immunodeficiency Virus
HPI	Human Poverty Index
ICT	Information and Communications Technology
IDUs	Intravenous Drug Users
ILO	International Labour Organization
IPCC	Intergovernmental Panel on Climate Change
MDGs	Millennium Development Goals

MICS	Multiple Indicator Cluster Survey
MoET	Ministry of Education and Training
MoH	Ministry of Health
MOLISA	Ministry of Labour, Invalids and Social Affairs
MPI	Multi-dimensional Poverty Index
MRD	Mekong River Delta
MSM	Men who have Sex with Men
NA	National Assembly
NER	Net Enrolment Rate
NHDR	National Human Development Report
NTP	National Targeted Programme
NTPPR	National Targeted Programme for Poverty Reduction
ODA	Official Development Assistance
OOP	Out-of-pocket (payments)
P135-II	Government Poverty Programme 135 Phase II
PAPI	Public Administration Performance Index
PCI	Provincial Competitiveness Index
PPP	Purchasing Power Parity
SAVY	Survey Assessment of Vietnamese Youth
SEDP	Socio-Economic Development Plan
SEDS	Socio-Economic Development Strategy
SHI	Social Health Insurance
SOE	State-Owned Enterprise
SRV	Socialist Republic of Viet Nam
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USD	United States Dollar
VASS	Viet Nam Academy of Social Sciences
VDGs	Viet Nam Development Goals
VHLSS	Viet Nam Household Living Standards Survey
VND	Viet Nam Dong
WHO	World Health Organization
WTO	World Trade Organization

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EXECUTIVE SUMMARY

BACKGROUND TO THE REPORT

This National Human Development Report (NHDR) sets out to explore the relationship between human development and social service delivery. It takes as its focus health and education services, both of which are central to achieving higher levels of human development. The report uses the three main human development indexes, the Human Development Index (HDI), the Gender-related Development Index (GDI) and the Human Poverty Index (HPI), together with a new measure of non-monetary poverty and deprivation, the Multi-dimensional Poverty Index (MPI), to explore changes in income, life expectancy, education and living standards dimensions of human development at the sub-national level over the 1999 to 2008 period.

Where the first NHDR in 2001 focused on the *doi moi* (renovation) reforms and their impact on poverty reduction and human development, this report focuses on the challenges many Vietnamese people currently face in accessing basic social services. Now that the country has attained middle-income status and aspires to continue moving to higher levels of human development, the Government will need to address these challenges.

This current report examines factors that have contributed to changes in the human development indexes, in particular changes to the life expectancy and education indicators. It examines disparities in access to health and education services at the sub-national level and among specific socio-economic groups, which may be impacting on progress in the HDI at the national and provincial level. Finally, the report discusses the provision of social services and the way current financing and governance arrangements are impacting access to, and quality of, health and education services, as well as user satisfaction.

The report adopts the methodology used in the 2009 global Human Development Report (HDR) to

calculate the HDI, GDI and HPI at the regional and provincial level, together with a new and localized MPI. This data was generated for the report by the General Statistics Office (GSO) and the Viet Nam Academy of Social Sciences (VASS). While refinements to the indexes introduced in the 2010 global HDR allow for a more accurate assessment of progress on key dimensions such as educational attainment, the original indexes remain relevant for analysis of trends over time and are therefore used in this report. The discussion of human development indicators is complemented by national data sources, in particular the Viet Nam Household Living Standards Survey (VHLSS) and the 2009 Vietnam Population and Housing Census, to allow for disaggregation by socio-economic group. Data from other smaller scale surveys and studies conducted by the Government, the United Nations, and other partners is used to supplement and triangulate the data from these official sources.

KEY MESSAGES OF THE REPORT

1. VIET NAM'S RECENT PROGRESS IN THE HUMAN DEVELOPMENT INDEX IS PRIMARILY DUE TO ECONOMIC GROWTH

Viet Nam has continued to see improvements in the HDI and related indexes, and ranked 113 out of 193 countries on the HDI globally in 2010. Viet Nam's success in achieving rapid economic growth is reflected in its relatively high ranking in the HDI. Over the past decade however, income growth has made a more significant contribution to progress in the HDI than either life expectancy and/or education indicators. During this period, Viet Nam moved out of low income country status as a result of impressive economic growth. Progress in social development, including health and education, has been less rapid contributing to slower growth in the HDI at the national and sub-national level.

From 1992 to 1999, gains in the life expectancy index made the greatest contribution to overall growth in the HDI, while from 1999 to 2008 progress on the HDI has been largely due to the wealth dimension. Although life expectancy has continued to rise in Viet Nam, the rate of progress slowed in the 1999 to 2008 period. While it is to be expected that growth in years of life expectancy will begin to slow once a country reaches higher levels of life expectancy, some countries in the region, such as South Korea, have continued to see rising years of life expectancy, even at very high levels.

Income growth has made a more significant contribution to progress in the HDI than either life expectancy and/or education indicators.

Growth in Viet Nam's education index appears to have slowed over the past decade, in particular from 2004 to 2008. This may indicate cause for concern, given the importance of education for human development and the prominence attached to education in the development priorities identified by the Socio-Economic Development Plan 2011-2015 and the Socio-Economic Development Strategy 2011-2020.

Thus since 2000, compared to some other countries in the region such as Indonesia and South Korea that have seen steady progress in both the income and non-income dimensions of the HDI, Viet Nam has seen slower progress in the non-income indicators. In that sense, Viet Nam's development pattern is closer to countries such as China, which have seen very rapid economic growth, but show slower improvements in the life expectancy and education indexes.

2. ECONOMIC GROWTH ALONE DOES NOT ALWAYS LEAD TO HIGHER LEVELS OF HUMAN DEVELOPMENT

This report echoes the first global Human Development Report in 1990: economic growth, while undoubtedly important in improving living standards and opportunities, does not always translate into improved living standards and quality of life for all a country's people. Inclusive and broad-based economic growth is required to ensure all people can benefit from the process of development, including through access to affordable, quality health and education services.

Health and education are the building blocks of human development. They are important in their own right, as a means to a good life, and to develop people's choices and capabilities. They are also a prerequisite to achieving more traditional development goals, including improved economic prosperity. The importance of improving people's living standards and well-being and ensuring access to social services and social protection for all citizens is highlighted in the Vietnamese government's key planning documents, the Socio-Economic Development Plan and the Socio-Economic Development Strategy, as well as in various governmental sectoral strategies and policy frameworks. However, government policies and expenditure have, at times, tended to prioritize achieving higher rates of economic growth over broader human development outcomes.

Viet Nam's development pattern is closer to countries such as China, which have seen very rapid economic growth, but show slower improvements in the life expectancy and education indexes.

Viet Nam's rate of return on investment in economic growth is low in comparison to other countries in the region. A very high ratio of annual investment to annual increase in GDP (Incremental Capital Output Ratio) suggests that current investment is not efficient. Ensuring greater efficiency of investment relies in part on a healthy, well educated population. Therefore Viet Nam should prioritize human development and invest in its people to achieve this, and move to the higher skills, high-tech, knowledge-based economy and society it aspires to become. Viet Nam has comparable levels of overall investment, from both public and private sources in health and education as a proportion of GDP, to other countries in the region. Yet Viet Nam has higher levels of private expenditure in both health and education than other countries. Other Asian countries that have achieved higher levels of human development also have higher overall levels of public investment in health, education and social protection than Viet Nam does. South Korea and Thailand are examples: South Korea spends more on social protection and health, while Thailand spends more on education, than Viet Nam does.

Viet Nam will need to accelerate improvements in health and education outcomes in order to attain higher levels of human development and achieve its broader economic and social development goals.

This is all the more critical given the new challenges Viet Nam is facing. The structure of the economy is changing, opening up new employment opportunities; and a shift to a more productive, high skilled, high-tech economy is required if Viet Nam is to continue to post high rates of economic growth and avoid the middle-income trap. The country's demographic profile is shifting, with a current demographic bonus in the working age population, which will be followed by rapid population ageing by 2050. Accelerating urbanization and migration are swelling Viet Nam's cities and putting pressure on social services. Viet Nam is one of the countries most affected by climate change globally and needs to act now to ensure social services are climate-proofed and can support resilience and recovery.

3. DESPITE PROGRESS SLOWER GROWTH IN THE HDI IS EVIDENT AT THE SUB-NATIONAL LEVEL

Signs of a slowdown in Viet Nam's HDI at a national level, as signaled by slowing progress in the life expectancy and education indexes, are also evident at the sub-national level. Persistent disparities in health and education indicators between provinces and among specific socio-economic groups are linked to these trends.

Significant disparities between regions, provinces, ethnic minorities and the Kinh/Hoa majority¹, and better off and poorer households are evident in the HDI and related indicators. Not only are these disparities persistent, they are also widening in some specific instances—in relation to the education indicators in the HDI, and access to water and sanitation in the HPI. While poorer provinces have seen some improvement in the HDI, a significant gap remains between poor and better off provinces. At the same time, growth in the HDI appears to have slowed in some of Viet Nam's wealthier provinces due to slowing progress in the education index, in particular gross enrolment ratios. In relation to the GDI, which measures gender inequality, while overall gender gaps have been steadily narrowing, some poorer provinces appear to be experiencing widening gender gaps in education. At the same time, some of Viet Nam's more dynamic provinces have seen widening gender gaps in income. Progress over time is evident in the HPI, but persistent disparities remain, with some provinces having very high rates of deprivation, largely due to lack of access to clean water. The new Multi-dimensional Poverty Index (MPI) introduced in this report shows

very high levels of non-monetary deprivation in Viet Nam's poorer provinces and regions.

Disparities in health and education outcomes are both a sign of, and a potential contributing factor to, economic inequality. Income inequality has been rising at the national and regional level in Viet Nam over the past decade. This is particularly apparent in those regions with low poverty rates, but which have seen higher levels of economic growth. At the provincial level the picture is more uneven, as lower poverty rates are not neatly correlated with higher income inequality in all provinces. From a human development perspective, economic inequality should not be tolerated or viewed as a normal side effect of rapid economic growth. In Viet Nam's case, where rising economic inequality is accompanied by persistent disparities in key education and health indicators, inequality is likely to exacerbate existing disparities. This has the potential to slow progress towards higher levels of human development.

While poorer provinces have seen some improvement in the HDI, a significant gap remains between poor and better off provinces.

4. CURRENT FUNDING AND PROVISION OF SOCIAL SERVICES PRESENTS A CHALLENGE TO VIET NAM'S HUMAN DEVELOPMENT ASPIRATIONS AND GOALS

As is well known in Viet Nam, access to health and education services is strongly correlated with differences in geographic location, ethnicity and income: people in urban areas, from the Kinh/Hoa majority and in higher income groups have considerably higher levels of access to health and education than their rural, ethnic minority and poor counterparts. Gender inequality also plays a role, for example in differential access to secondary and higher education between boys and girls in some ethnic minority groups. Other forms of vulnerability and disadvantage, such as disability and migrant status, also impact on access to health and education services. In some specific instances, gaps appear to be widening, for example in gross enrolment ratios in some provinces.

At present, the financing, delivery and governance of social services in Viet Nam appears to be contributing to inequities in access to social

services and in health and education outcomes. This presents a challenge to Viet Nam's development goals and is not conducive to moving to higher levels of human development. There is a tension evident between Viet Nam's strong in-principle commitment to universal access to quality social services for all its citizens on the one hand, and targeting of the most vulnerable and disadvantaged via a complex system of programmes and interventions designed to ensure access to social services and protection, on the other. The system of subsidies and benefits available to the poor and disadvantaged is not yet sufficient to ensure universal access to social services. While intended to ensure sustainability of social service funding, the socialization policy has in effect led to the increasing commercialization of public social services, and over-reliance on user fees by service delivery organizations. Both public and private health and education services are increasingly provided on a commercial basis. The non-state, not-for-profit sector is not yet sufficiently involved in social service delivery, including delivery of health and education services to those most in need.

Households bear a disproportionate proportion of the cost of health and education services, well above the 30 percent considered optimal for equity and human development, with negative impacts on poor and disadvantaged households that cannot afford these costs. Health and education costs are rising and represent a significant proportion of household expenditure, in particular in inpatient health services and at higher levels of education. Informal payments are significant and highly normalized in both health and education. As a result, a two-tier system of services appears to be evolving whereby those who can afford to pay receive a better quality of service, whether it is better care and equipment in hospitals or extra classes in school. This also contributes to inefficient allocation and use of resources. Low quality of local health services in terms of facilities and staff drives consumers to

use more expensive services offered by provincial and national hospitals. The quality of health and education services is undermined by these trends.

From a human development perspective, economic inequality should not be tolerated or viewed as a normal side effect of rapid economic growth.

In addition, the governance of health and education services has been significantly affected by decentralization of financing and management to the level of the service delivery organization. Private sector involvement in delivery of health and education services is growing in importance, and both public and private services are largely unregulated, posing significant risks to individuals and to society as a whole.

The equitable provision of quality, affordable basic social services—health and education—to all citizens has the potential to improve the lives of Vietnamese people. Equitable access to quality health and education services can develop people's capabilities and choices, lift families out of poverty, break persistent cycles of poverty and disadvantage and improve Viet Nam's overall human development outcomes, while also contributing to the achievement of economic goals. Yet, at present, this potential is not fully realized. As a result, some regions and socio-economic groups are at risk of being left even further behind, undermining Viet Nam's progress towards higher levels of human development.

This is a critical issue for Viet Nam and deserves greater priority from policymakers and decisionmakers than it currently receives. Human development, and in particular improved health and education outcomes, must be at the heart of Viet Nam's future progress, in its own right and not only as an instrument to achieving greater wealth and economic growth.

POLICY DIRECTIONS

The report identifies the following broad policy directions:

- **Valuing and investing in people over economic development:** The same level of priority and investment now needs to be given to building people's capacities, capabilities and choices, and improving human development outcomes as is accorded to generating higher levels of GDP per capita.
- **Access to quality, affordable social services can play a role in reducing disparities and containing rising inequality:** By providing opportunities for people to develop their capabilities and capacities and improve their well-being and by ensuring more equitable outcomes between different socio-economic groups and regions over time universal access to quality social services can help to limit rising inequalities and disparities.
- **A new approach to welfare is needed:** Quality, affordable social services and a comprehensive social protection system are the foundation of a prosperous, stable society and a prerequisite for improvements in human development and well-being. Ensuring universal social protection and access to quality social services as a right of all citizens is a hallmark of successful societies and economies.
- **A more coherent system of benefits is required to support universal access to quality social services:** The current system of programmes and initiatives that support access to health and education services is complex, overlapping, and not able to reach everyone in need.
- **It is timely to revisit and revitalize the socialization policy:** A more enabling environment for involvement of non-state, not-for-profit actors in service delivery, and greater engagement of citizens in planning and monitoring of social services is required.
- **A more equitable distribution of the costs of social services between households and the State:** At present, households pay a disproportionate share in an area where costs are rapidly increasing. These costs are already well above levels considered optimum to promote equity and improved human development outcomes.
- **Addressing the emergence of a 'two-tier' system of service delivery in health and education:** Where the better off pay more and receive a better quality of social services. An open and robust policy debate is needed about how much differentiation is acceptable, and what a minimum standard of services should involve, in line with Viet Nam's social equity goals.
- **Strengthening governance and improving quality of services:** At the administrative level and in service delivery organizations. Stronger governance, oversight and accountability of public services and service delivery organizations are critical; particularly in light of the impact of decentralization of funding and management of social services.
- **More effective regulation of both the public and the private sector:** Viet Nam's government needs to act more decisively to manage tensions between market incentives and egalitarian principles, and should enforce consequences for improper practices and substandard service quality.
- **Planning for the future:** Viet Nam's government should proactively plan for the kinds of social services a rapidly changing country needs, in order to cope with demographic, environmental and socio-economic changes, and meet the changing expectations and aspirations of the Vietnamese people, while continuing on the path to higher human development.

SECTION ONE

OVERVIEW OF KEY CONCEPTS AND HUMAN DEVELOPMENT TRENDS

THE HUMAN DEVELOPMENT CONCEPT

PEOPLE ARE THE REAL WEALTH OF NATIONS

People are at the heart of development. This is the basic tenet established in the first global Human Development Report (HDR) in 1990, which set out the case for a fundamental reorientation in development priorities. As the 1990 global HDR states:

People are the real wealth of a nation. The basic objective of development is to create an enabling environment for people to live long, healthy and creative lives. This may appear to be a simple truth. But it is often forgotten in the immediate concern with the accumulation of commodities and financial wealth.¹

The human development concept has a long history and has evolved over time, but the basic principle remains the same: people are the wealth of nations, and their development, freedom, capabilities and choices are the ultimate aim of the development process. The true test of a nation's progress is not GDP growth or rising aggregate incomes but rather human development. That is the extent to which all people are able to develop and exercise capacities and choices and have a say in the decisions that shape their lives. A country's stage of development is to be judged by the extent to which it is able to improve the health, education levels, well-being and living standards of all its citizens. It is also judged on how it creates opportunities for people to make choices about how to live in accordance with what they value and aspire to.

BOX 1.1: DEFINING HUMAN DEVELOPMENT

A review of the evolution of the human development concept for the global HDR 2010² summarizes the key elements of the concept as follows:

Firstly, human development aims to expand people's freedoms to do and be what they value and have reason to value. Human development is primarily concerned with essential freedoms and choices, including choices to have a long and healthy life, to gain an education, to be able to enjoy a decent standard of living, and to enjoy political freedoms, human rights and self-respect. The concept of human development also includes other important choices that lead to improved well-being, such as security, participation in cultural life, safe and meaningful livelihoods and emotional well-being.

Secondly, the concept views development as both a process of widening choices and as a set of outcomes by which to measure the level of achieved well-being among individuals and across society as a whole. Critically, it also refers to the process of developing people's capabilities, as well as their actual use: whether or not, and the extent to which, people actually exercise the capabilities they develop.

Finally, human development is concerned with agency. It considers people as active agents in the development process rather than as passive beneficiaries. Human development is concerned not only with the satisfaction of basic needs, but also with the extent to which people are able to actively participate in the development process. In other words it is concerned with human freedom and choice in opportunities, as well as in processes.³

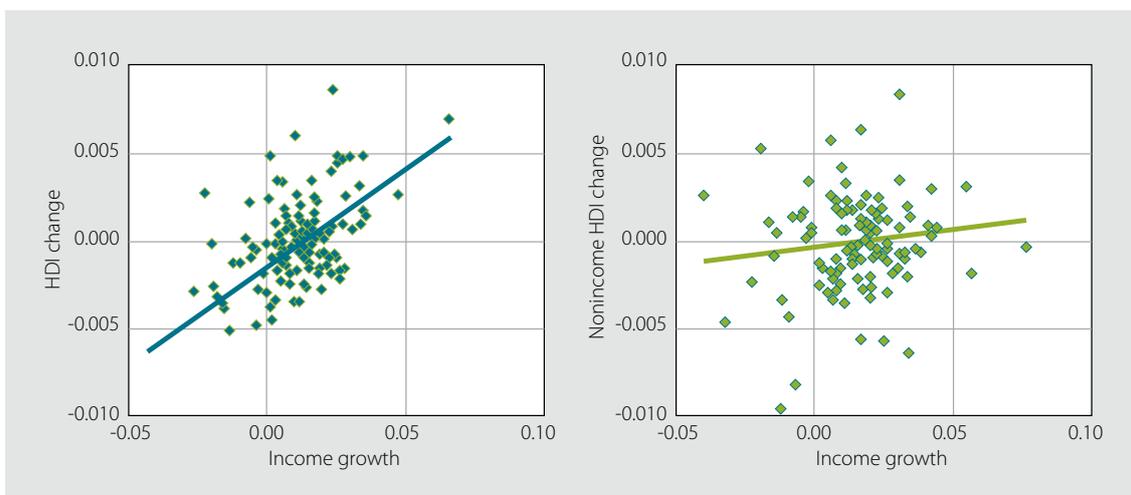
GROWTH AND WELL-BEING ARE NOT ALWAYS CORRELATED

The human development concept remains as relevant today as when it was first articulated in 1990. The experience of the past four decades shows that rising incomes do not always deliver better human development outcomes. At the same time, significant improvements are possible in human development, in countries with slow gains in GDP per capita.

When reviewing global Human Development Index (HDI) trends from 1970 to 2010, the 2010 global HDR shows that there is not always a direct correlation

between rising incomes and improved outcomes in non-monetary dimensions of well-being and human development (Figure 1.1).⁴ While rising incomes are important—for example to enable increased access to social services—they may also reflect an increase in the wealth of those who are already better off, rather than across the population as a whole. Thus in those countries which have achieved rapid economic growth, inequalities and disparities have often risen as well. In these countries, the benefits of growth have not always been evenly distributed, acting as a brake on broader human development by limiting the capacity of those left behind to access goods and services, including basic social services such as health and education.

Figure 1.1: Weak Relationship between Economic Growth and Changes in Health and Education, Worldwide, 1970-2010



Source: Global HDR 2010

BALANCING HUMAN AND ECONOMIC DEVELOPMENT

The analysis presented in the 2010 global HDR lends weight to the argument that has gained ground in the wake of the 2008 economic crisis and which underpins this report. Governments must pursue a much broader development agenda, one that is focused not only on wealth generation but also on improving people's well-being and living standards. This perspective is encapsulated in the 2009 report of the Stiglitz-Sen-Fitoussi Commission, which was established by French President Nicolas Sarkozy to develop new ways of measuring well-being and improvements in living standards. The report has the explicit aim of resetting the focus of policymakers and decisionmakers towards a broader set of social and welfare-oriented goals. In their overview report Stiglitz-Sen-Fitoussi stress that: 'Policies should be aimed at increasing social welfare, not GDP',⁵ and that new measures are needed to inform and influence policymaking:

Quality of life includes the full range of factors that make life worth living, including those that are not traded in markets and not captured by monetary measures...the Commission considers that the time has come to make a clear move from measuring production to measuring welfare, to try to close the gap between our measures of economic performance and widespread perceptions of well-being.⁶

Human development and improvements in people's well-being and quality of life are important in their own right. At the same time, they also have the potential to contribute to more traditional development goals.

Rising incomes do not always deliver better human development outcomes. At the same time, significant improvements are possible in human development, in countries with slow gains in GDP per capita.

For example, a healthy, well-educated population is more productive.⁷ Societies which invest in gender equality and empowerment of women and girls, for example by closing the gender gap in education, typically post higher rates of economic growth.⁸ Generating decent, better-paid jobs can help to lower poverty rates and also reduce pressure on natural resources.⁹

While economic growth is an important outcome of the development process, it is not sufficient to ensure happiness and well-being, and should be balanced against other development priorities that have the potential to contribute to improved well-being and quality of life.¹⁰ These include health status and outcomes; educational attainment; political voice and the ability to participate as full citizens; social connectedness and social capital; environmental conditions such as access to clean water and sanitation; personal security and physical integrity; and decent and satisfying work, among others.¹¹

BOX 1.2: MEASURING HUMAN DEVELOPMENT

In order to measure development progress in a way that does not rely on income or GDP growth alone, successive HDRs have introduced indexes which aggregate different indicators of human development. Three key indexes, which are used as the basis for the analysis in this report, are the Human Development Index (HDI), the Gender-related Development Index (GDI) and the Human Poverty Index (HPI).

The Human Development Index is a composite measure of health, education and income, designed to assess levels of, and progress towards, human development more broadly than is possible using income-based measures alone. As used in this report and in global HDRs until 2009, it combines four key indicators: life expectancy at birth, the gross enrolment ratio, adult literacy rates and GDP per capita, adjusted for Purchasing Power Parity (PPP).

The Gender-related Development Index uses the same four indicators as the HDI but measures the gap between male and female attainment of each indicator: countries are 'penalized' according to the extent to which women lag behind men in attaining health, accessing knowledge and earning an equitable income.

Finally, the Human Poverty Index measures severe deprivations in relation to health, education and income (living standards) by measuring the proportion of people who are most severely disadvantaged. These include the percentage of people not expected to live to age 40, the adult illiteracy rate, the proportion of the population which does not have access to clean water and the rate of children under 5 who are malnourished.

The refined HDI and other new indexes introduced in the 2010 global HDR aim to more accurately reflect attainments in education and other key dimensions of human development. However, the original indexes are more reliable in analyzing trends over time, and for this reason they are used in the present report.

HUMAN DEVELOPMENT IN THE VIETNAMESE POLICY CONTEXT

THE HUMAN DEVELOPMENT CONCEPT IN VIET NAM

The human development concept is enshrined in the Vietnamese constitution, as well as in successive national socio-economic development strategies and plans. The 1992 Constitution, revised in 2001, sets out the State's responsibility to ensure and constantly foster "the people's rights as masters in all spheres, [and] realize the targets of building a prosperous life for its people, a strong country and an equitable, democratic and civilized society, ensuring the well-being, freedom and happiness of all citizens as well as conditions for their all-round development."¹²

Viet Nam has localized the Millennium Development Goals (MDGs) by including related Viet Nam Development Goals (VDGs) in the Comprehensive Poverty Reduction and Growth Strategy (CPRGS) of 2002 and the Socio-Economic Development Plan (SEDP) 2006-2010.¹³ The VDGs set specific targets for human development in primary and secondary education, maternal and child health, and communicable diseases and water and sanitation.

The Socio-Economic Development Strategy (SEDS) 2011-2020 and Socio-Economic Development Plan (SEDP) 2011-2015 explicitly set out the priority and importance of promoting people's well-being and quality of life, as well as ensuring economic growth and stability. The SEDS 2011-2020 states the commitment of the Government of Viet Nam to: "Harmonize economic growth with social progress

and equity; improve constantly the quality of life for the people, develop vigorously culture, and promote democracy."¹⁴ It also commits to "enhance capacity and establish mechanisms for the people to exercise adequately their right as the master, especially direct democracy, so as to promote vigorously all creative capabilities and guarantee high-degree consensus in society, generating thereby a driving force for national development."¹⁵

The SEDP 2011-2015 explicitly recognizes the need to ensure the benefits of development are widely shared and to narrow the gap between regions, and between rich and poor people across the country.

Similarly the SEDP 2011-2015 explicitly recognizes the need to ensure the benefits of development are widely shared and to narrow the gap between regions, and between rich and poor people across the country. The SEDP states that "[e]conomic growth must be combined in harmony with social progress and justice, and continuous improvement of people's living quality. Socio-economic development must always go along with environmental protection and improvement."¹⁶ Both the SEDP and SEDS identify key 'breakthroughs' to be achieved over the next 5- to 10-year period, including the development of a healthy, well-educated population, and promotion of social equality and inclusion.¹⁷

USE OF HUMAN DEVELOPMENT INDEXES IN VIET NAM

The human development indexes used in this report have gained currency in Viet Nam in recent years. The Government of Viet Nam uses changes

in the HDI and GDI over time as an indicator of progress towards human development and gender equality. Improvement in the HDI rank and value was included as a target in the current SEDS 2001-2010. The SEDP 2011-2015 refers to improvements in the HDI as an indication of progress towards development goals, while the 2010 national MDG report cites positive change in the GDI as a sign of progress towards achieving gender equality and women's empowerment.

Key human development indexes have also been localized. While the 2010 HDR introduces the Multi-dimensional Poverty Index (MPI), in 2008 the General Statistics Office of Viet Nam (GSO), MOLISA and UNICEF developed a multi-dimensional Child Poverty Rate (CPR) for Viet Nam. The CPR aggregates indicators across different domains of human development including education, nutrition, health, shelter, water and sanitation, child labour, recreation, social inclusion and protection, and was included in the 2008 Viet Nam Household Living Standards Survey (VHLSS).¹⁸ Similarly, the 2010 Urban Poverty Survey by the GSO and UNDP introduces a multi-dimensional poverty index which includes the following dimensions: income, education, health, access to social security, housing, participation in social activities and safety.¹⁹ Such non-monetary measurements of poverty and deprivation are more widely used in Viet Nam than in the past, indicating greater awareness and acceptance of non-wealth-based indicators of deprivation and disadvantage among policymakers.

NATIONAL POLICY FRAMEWORKS STILL PRIORITIZE ECONOMIC GROWTH

Viet Nam has a strong history and tradition of equitable, inclusive development, and has been successful in raising general living standards and improving health and education outcomes. Even prior to *doi moi* (renovation), when incomes were low and income poverty was widespread, Viet Nam recorded achievements in terms of literacy, access to education and availability of health services at the commune level.²⁰ Over the past two decades strong economic growth and progressive elements of Viet Nam's education and health policies have generated improvements in the health and education status of Viet Nam's people.

Viet Nam also has a notable advantage over many other countries: the State has demonstrated strong and continued political commitment to ensuring a basic level of social services for all its citizens.²¹

This commitment is evident in Viet Nam's social and development policies. Examples are the recent commitment to universal health insurance coverage by 2014 and the focus on social protection initiatives in Resolution 11 designed to respond to macro-economic instability and high inflation.

Yet the Government of Viet Nam tends to give greater weight to ensuring continued rapid economic growth than to improving social and human development. For example, while human resource development is identified as a key breakthrough in the SEDS and SEDP, priority is given to fostering economic growth by creating more equitable conditions for competition. Ensuring skilled human resources and a more robust and sophisticated transport and infrastructure system are available to support this is also deemed to be important. State investment in generating economic growth was estimated at 24.7 percent of state expenditure or 7.9 percent of GDP in 2008.²²

Generating greater wealth, while important to improve living standards and create opportunities, does not always lead to higher levels of well-being, better quality of life, and increased satisfaction with government for all citizens.

At the same time, public expenditure on health and education accounted for an estimated 2.8 percent and 5.3 percent of GDP respectively (see Figure 1.2). However, investment in economic growth is less efficient than other countries in the region.²³ Public expenditure accounts for a lower proportion of overall expenditure on health and education from both public and private sources than in other neighbouring countries that have achieved higher levels of human development than Viet Nam, such as Thailand and South Korea. Greater efficiency of investment could help to free up resources for social spending.

The risk is that, as other countries have found, generating greater wealth, while important to improve living standards and create opportunities, does not always lead to higher levels of well-being, better quality of life, and increased satisfaction with government for all citizens. Societal problems that negatively affect ordinary people include significant and persistent disparities between different socio-economic groups and regions, poor quality basic social services such as health and education, weak

governance and rule of law, and systemic corruption. These issues have the potential to undermine the benefits of economic growth, erode social cohesion and eventually undermine political legitimacy, if they are not addressed and contained.

As this report will show, the Vietnamese government now faces challenges both at a policy and practical level in translating its strong commitment to human development into reality. Addressing these challenges over the coming period of the

SEDS and SEDP will be critical to realize Viet Nam's ambition to continue on a path of sustained human development and growth, and by doing so ensure that all Vietnamese people can enjoy healthy and prosperous lives. This report aims to contribute to the policy debate concerning these issues with an analysis of the current situation of social service delivery in Viet Nam, and how policy changes in specific areas of service delivery can help to address some of these challenges and constraints.

BOX 1.3: COMPARING HUMAN DEVELOPMENT IN BANGLADESH AND INDIA

In a recent article in *The New York Review of Books*, Amartya Sen noted that while India ranks substantially higher than Bangladesh in the HDI, this is largely due to India's faster rate of recent economic growth. However, while India has a GNP per capita PPP of US\$1,170 compared to US\$590 in Bangladesh, Bangladesh has consistently outperformed India on key human development indicators in health and education. Life expectancy in Bangladesh is 66.9 years compared to 64.4 in India. Mean years of schooling are 4.8 in Bangladesh compared to 4.4 years in India. The literacy rate is higher for girls than boys in Bangladesh, while it remains substantially lower for girls than boys in India. In health, the infant mortality rate is 50 per 1,000 in India and 41 per 1,000 in Bangladesh and the under-5 mortality rate is 66 per 1,000 in India compared to 52 in Bangladesh. As Mr. Sen notes, one reason for poorer health outcomes in India is the large reliance of the population on private health care and relatively low levels of public health funding.

Despite its low income, Bangladesh has been able to improve the living standards of its people faster than its neighbor India. As Mr. Sen points out, while "economic growth can make a very large contribution to improving people's lives...single minded-emphasis on growth has limitations that need to be clearly understood."²⁴

HUMAN DEVELOPMENT IN VIET NAM AND THE REGION

ECONOMIC GROWTH DRIVES VIET NAM'S PROGRESS IN THE HUMAN DEVELOPMENT INDEX (HDI)

Since the 2001 National Human Development Report (NHDR) was published, Viet Nam has seen significant change, having achieved medium human development, and reached middle-income country status, with an annual GNI per capita of US\$1,110 in 2010. Over the past 10 years, Viet Nam has seen high rates of annual GDP growth, even in the period following the 2008 global economic crisis. It has succeeded in lifting many hundreds of thousands of

people out of poverty and at a faster rate than almost any other country globally. Viet Nam's poverty rate fell from 37.8 percent in 1998 to 14.5 percent in 2008. Viet Nam's success in poverty reduction has been recognized around the world and the government has been asked to share lessons learned from these achievements with other developing countries.²⁵

Viet Nam has seen steady improvements in human development, as shown by increases in the HDI over time. Viet Nam's HDI value increased 19 percent between 1992 and 2008.²⁶ Yet there has been variation in progress over time for each of the different HDI indexes. The income index increased by 45 percent between 1992 and 2008, reflecting strong GDP growth. The life expectancy index also saw significant gains, rising by 19 percent between 1992 and 2008. This reflected steady improvements in average life expectancy from 65.2 years in 1992

to 72.7 years in 2008. The education index, which started from a relatively higher base in 1992, saw a slower rate of increase, rising by only 7 percent by 2008. Thus, since 1992, rising GDP, together with increased life expectancy, have been the main drivers of improvement in Viet Nam's HDI.

Since 1992, rising GDP, together with increased life expectancy, have been the main drivers of improvement in Viet Nam's HDI.

Table 1.1 shows the contribution to each of the indexes to change in the HDI for the period from 1992 to 2008. The contribution of the income

index was highest at 48.9 percent; followed by the life expectancy and education indexes. During the period from 1992 to 1999, however, the life expectancy index made the greatest contribution, at 41.8 percent compared to 36.1 percent for the income index, and 22.1 percent for the education index. During the years 1999 to 2008 the income index contributed 55.7 percent compared to 31.8 percent for the life expectancy index and 12.6 percent for the education index. In the period from 2004 to 2008, the income index contributed 79.1 percent compared to just 15.2 percent for the life expectancy index and 5.1 percent for the education index. This shows that income growth has become a more important factor in progress in the HDI over time.

Table 1.1: Contribution of HDI Components to HDI Growth, Viet Nam, 1992-2008

Year	HDI	Life Expectancy Index	Contribution of life expectancy index to HDI since previous period (%)	Education Index	Contribution of education index to HDI growth since previous period (%)	Income Index	Contribution of income index to growth since previous period (%)
1992	0.611	0.670	-	0.776	-	0.386	-
1995	0.639	0.690	18.8%	0.808	25.9%	0.420	55.3%
1999	0.651	0.721	86.1%	0.803	-13.9%	0.430	27.8%
2004	0.701	0.782	40.7%	0.826	15.3%	0.496	44.0%
2008	0.728	0.794	15.2%	0.830	5.1%	0.559	79.7%
Contribution to total change in HDI 1992-2008			35.2%		15.9%		48.95%

Source: NHDR 2001; HDI 1999, 2004, 2008

Viet Nam's strong progress in the HDI is testament to the rapid economic growth and progress the country has experienced. However the rate of progress in the education index has been slow in comparison to the other sub-indices. The contribution of the education index to overall growth in the HDI decreased from around 25.9 percent from 1992 to 1995 to 5.1 percent from 2004 to 2008. Most recently, while progress in the income index has remained steady, growth in both the life expectancy and education indexes has slowed. During the period from 2004 to 2008, the income index rose by 13 percent compared to 15 percent between 1999 and 2004, the life expectancy index increased by 2 percent compared to 8 percent between 1999 and 2004, and the education index by 1 percent between 2004 and 2008, compared to 3 percent between 1999 and 2004.²⁷

Slowing gains in life expectancy are to be expected once years of life expectancy reach higher levels, although it is worth noting that some countries in the region have continued to increase life expectancy rates at even higher levels than Viet Nam. Korea is one example. However, slowing gains in the education index are cause for concern. Adult literacy rates are already high in Viet Nam; however limited improvement is evident in gross enrolment ratios, as discussed in Chapter Three. Thus, it appears that Viet Nam's steady improvement in the HDI may now be slowing down due to relatively smaller increases in the life expectancy and education indexes than in the past. Overall, the improvement in the HDI from 1999 to 2008 is primarily due to rising incomes.

REGIONAL HDI COMPARISONS

Table 1.2: HDI Rank and Value, Selected Asian Countries, 1990-2007

Country	HDI Value 1990	HDI Value 2000	HDI Value 2007	HDI Rank 2007	Change 1990-2000	Change 2000-2007	Change 1999-2007
Korea (Republic of)	0.802	0.869	0.937	26	8%	8%	17%
Malaysia	0.737	0.797	0.829	66	8%	4%	12%
Thailand	0.706	0.753	0.783	87	7%	4%	11%
China	0.608	0.719	0.772	92	18%	7%	27%
Philippines	0.697	0.726	0.751	105	4%	3%	8%
Indonesia	0.624	0.673	0.734	111	8%	9%	18%
Viet Nam	0.599	0.690	0.725	116	15%	5%	21%
Lao People's Democratic Republic	-	0.566	0.619	133	-	9%	-
Cambodia	-	0.515	0.593	137	-	15%	-

Source: Global HDR 2009

Viet Nam ranked 116 out of 182 countries in the 2009 HDR and 113 out of 169 countries in the 2010 HDR, which introduced a new methodology for calculating the HDI as discussed later in this report. Viet Nam's HDI is lower than that of neighbouring countries such as Indonesia, the Philippines and Thailand, but remains higher than that of Cambodia and Laos.

Viet Nam's steady improvement in the HDI may now be slowing down due to relatively smaller increases in the life expectancy and education indexes.

Compared to some other countries in the region that have seen steady progress in all the dimensions of the HDI, Viet Nam's progress in the non-income indicators has been slower in the period since 2000. For example, Indonesia and South Korea, countries at quite different levels of human development, have both seen continued improvement in income and non-income indexes over time. Notably, these were the only two countries included in the top-10 'movers' for both income and non-income dimensions of the HDI in the 2010 global HDR. While Viet Nam saw a faster increase in the HDI between 1990 and 2000 than Indonesia and South Korea, this was not the case between 2000 and 2007, as shown in Table 1.2.

In this respect, Viet Nam's pattern of progress on the HDI is similar to that of countries such as China, which have also seen rapid economic growth. According to the 2008 NHDR for China, China's income index contributed 52.2 percent, the education index 29.8

percent and the life expectancy index 18 percent to overall growth in the HDI between 1980 and 2005.²⁸ Both Viet Nam and China saw slower growth in the HDI in the years between 2000 and 2007 than countries that experienced more balanced growth in both the income and non-income dimensions of the HDI.

IMPROVEMENTS IN HEALTH AND EDUCATION ARE KEY TO HUMAN DEVELOPMENT

TOWARDS A HEALTHY, WELL-EDUCATED POPULATION

In this regard, it is important to stress that Viet Nam's economic and social development goals are to a large extent dependent on having a healthy, well-educated population. For instance the MDGs where Viet Nam is not currently on track to meet its targets by 2015 are mostly health related, such as HIV, and water and sanitation.²⁹ In this sense, protection from health, income and environmental shocks, and from the impact of catastrophic health spending, which act to push households back below the poverty line or even further into poverty, together with affordable and accessible preventative and curative health services, are key to achieving the MDG targets where Viet Nam is lagging behind. Health and education are the building blocks of human development, fundamental to developing capacities and choices,

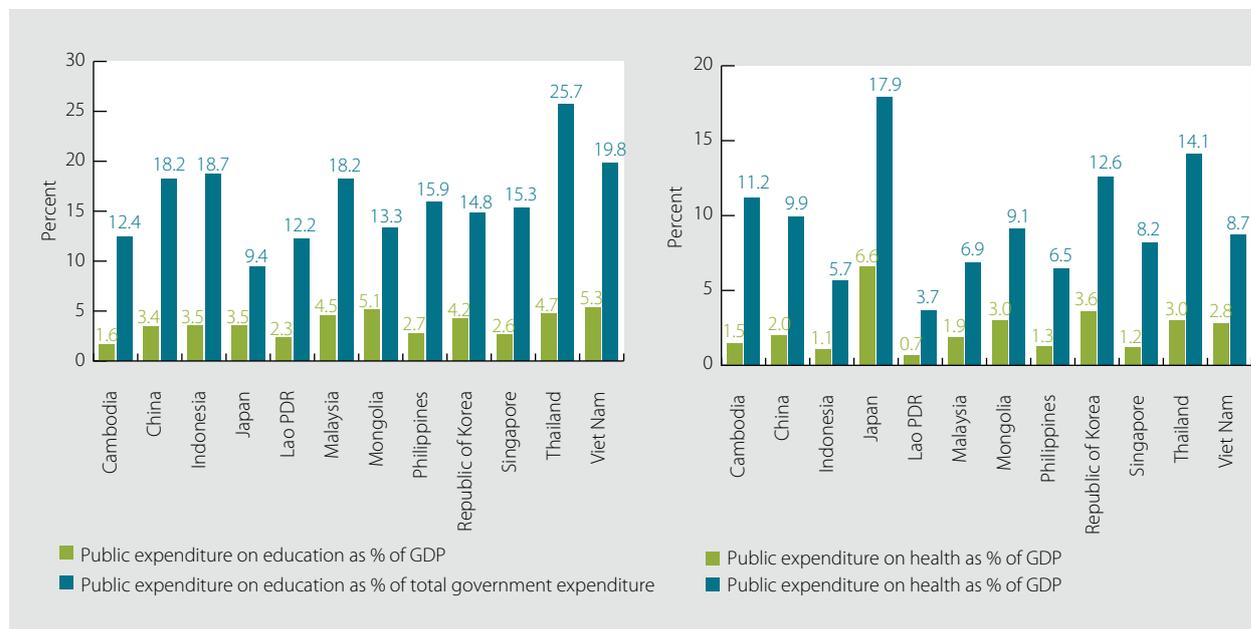
and enabling people to exercise their capabilities in line with what they value and aspire to. As the global 2010 HDR argues, and the brief analysis of Viet Nam's current HDI trajectory presented above suggests, improvements in health and education outcomes are not always neatly correlated with rising incomes. A range of intersecting factors contributes to better health and education outcomes. These include international cooperation to fight specific diseases and health problems, the spread of new knowledge and technology, the support and investment of households, and governments giving priority to and investing in quality, affordable and accessible health and education services.³⁰ In light of significant regional and population-based discrepancies in achievement of key health and education targets, improving health and education services is essential to improving human development

outcomes. This is also important when addressing the unfinished MDG agenda, including MDG 6 targets on HIV, and achieving the MDGs at a sub-national level and for all Vietnamese people. Indeed, improved health and education outcomes are a prerequisite if Viet Nam is to achieve the key 'breakthroughs' set out in the SEDP and SEDS, to move to a higher skill, high-tech economy and ensure the inclusive, broad-based economic growth the country aspires to. This NHDR therefore takes as its primary focus health and education, with a particular focus on access to, as well as funding and delivery of, health and education services.

Improvements in health and education outcomes are not always neatly correlated with rising incomes.

VIET NAM'S PUBLIC HEALTH AND EDUCATION EXPENDITURE

Figure 1.2: Health and Education Expenditure, Selected East and South-East Asian Countries, 2007-2008



Source: UNESCO Institute for Statistics <http://stats.uis.unesco.org>; WHO National Health Accounts, <http://www.who.int/gho/en/index.html>, ADB Key Indicators for the Asia Pacific 2010; http://www.adb.org/Documents/Books/Key_Indicators/2010/Country.asp

Viet Nam has lower levels of public health expenditure and higher levels of public education spending than other countries in the region. Although total health care spending has been increasing, and Viet Nam spends a relatively higher share of overall GDP than other countries at a similar income level, Viet

Nam invests a lower proportion of public resources in health care than many countries in the region. In 2008, Viet Nam's total health expenditure from all sources, including private expenditure, was equivalent to 7.3 percent of GDP. Government expenditure in 2008 was equivalent to just

2.8 percent of GDP. More than 50 percent of health spending is private, out-of-pocket expenditure.

Public expenditure on health represents about 8.7 percent of total public expenditure in Viet Nam, compared to 14.1 percent in Thailand and 9.9 percent in China. While Viet Nam invests a higher proportion of state resources in health than other countries such as Indonesia and Malaysia, the value of health spending is lower in real terms. Public health expenditure in Viet Nam is estimated to be US\$77 per capita PPP, above public expenditure in Indonesia, Cambodia, the Philippines and Laos, but well below countries such as Thailand at US\$242 per capita PPP, Malaysia at US\$273 per capita PPP and China at US\$121 per capita PPP.³¹ Part of the reason for relatively higher overall spending on health, including private out-of-pocket expenditure, is the rapid increase in health care costs.

Viet Nam's education expenditure is higher than that of other countries in the region, as public expenditure on education is equivalent to about 5.3 percent of GDP. Viet Nam spends about 19.8 percent of the state budget on education, which is comparable to many other countries in the region, though lower than Thailand. However, private expenditure on education is also high, due in part to rising fees and out-of-pocket costs, as Chapter Five shows. Figure 1.2 shows health and education expenditure for selected East and South-East Asian countries from 2007 to 2008.

South Korea's public expenditure on health is higher, and on education lower, as a proportion of total public expenditure than that of Viet Nam, while Indonesia's proportion of public expenditure on health and education is lower than that of Viet Nam. Yet both countries have continued to see steady progress in their HDI, including in the non-income indexes. China on the other hand has similar levels of public health expenditure but spends slightly more on education as a proportion of total public spending. It is one of few countries that saw a fall in gross enrolment ratios in the 1990s, though it has recovered more recently.³² Thus, although important, public investment is only one of several critical factors determining progress on health and education outcomes.³³ Efficiency of public investment, together with factors such as the cost of health and education to the household, the quality of service provision, and accessibility and availability of services that are responsive to the needs of the

end user are also important, as is governance of service delivery organizations. For example, despite the investment drive of the last decade to build new schools, colleges and universities, Viet Nam needs to significantly reform and upgrade its education system, in particular higher education. These reforms are essential if Viet Nam is to compete effectively in the global economy, achieve its economic goals and continue to generate economic growth.³⁴

The extensive commercialization of social service delivery, with individual households contributing the bulk of health and education costs, magnifies questions of affordability and access to social services for those most in need.

As this report will show, while Viet Nam strongly supports principles of universal access, supplemented by policies targeting specific population groups, a number of factors are combining to undermine access to the quality, affordable social services needed in order for people to secure a decent standard of living and realize their aspirations.³⁵ These include current funding and delivery arrangements, poor quality of services, and insufficient regulation of both public and private services. Critically, the extensive commercialization of social service delivery, with individual households contributing the bulk of health and education costs, magnifies questions of affordability and access to social services for those most in need. At the same time, examination of these issues raises concerns over how best to ensure the quality of social service delivery. In this sense, Viet Nam has yet to fully embed the strong oversight and accountability mechanisms required to make public-private funding and delivery of social services work in the interests of the consumer, and ultimately of Vietnamese society. The role of the State in economic and social sectors is undoubtedly changing, and in the area of social services, among others, the State is "becoming more of a 'steward' that facilitates, regulates and monitors the provision of a range of services rather than acting as a service provider itself, thus also generating the need for new and expanded policy, regulatory and enforcement capacity."³⁶ The challenge ahead is to ensure the State can progressively shift its role to more effectively protect citizens from the negative effects, while also maximizing the benefits, of a market economy.

THE PATH TO HIGHER LEVELS OF HUMAN DEVELOPMENT

HEALTH AND EDUCATION ARE KEY TO VIET NAM'S FUTURE SUCCESS

Over the past two decades Viet Nam has steadily increased overall incomes and reduced poverty, raising the living standards of the Vietnamese people. These achievements are due, at least in part, to Viet Nam's relatively equitable development process, and past history of investment in social service provision: as "the government's significant efforts to promote a degree of social equity through its policies have had tangible positive effects."³⁷ Now, as it settles into the ranks of lower middle-income countries, Viet Nam needs to lay strong foundations for sustained economic growth and human development and social equity. Viet Nam is changing rapidly: income inequality is rising, and inequities in access to health and education persist. And, as Chapter Five shows, costs to individual households of both health and education services are escalating. The early, relatively easier gains in poverty reduction and human development have largely been made, and remaining persistent poverty and disparity will be harder to address.³⁸ At the same time, existing poverty reduction and social protection programmes are complex, overlapping and face challenges in reaching those most in need of assistance and support.³⁹

Viet Nam now faces the possibility that rising inequality on the one hand, and persistent poverty and disparities among specific communities and regions on the other, may stall or even reverse Viet Nam's hard-won progress. As Chapter Two of this report discusses, Viet Nam is undergoing a series of socio-economic transformations. New and emerging pressures associated with demographic change, population mobility, and environmental stresses, including climate change, have the potential to exacerbate existing forms of poverty and inequality unless they are planned for and carefully managed. Rapid economic growth should not be the main policy goal as it overlooks unequal distribution of income and neglects sustainability of growth.

At a national level, Viet Nam continues to see progress on many health indicators including infant and maternal mortality. There are some notable exceptions however, for example rates of stunting and the proportion of the population without

access to clean water and sanitation remain high. Progress at the sub-national level and among ethnic minority and remote populations remains uneven.⁴⁰ Viet Nam has achieved high literacy rates, with near-universal enrolment in primary education, and has closed the gender gap at the primary and lower secondary level. However, other key education indicators have seen little progress since the early 2000s. An example is that although adult literacy rates continued to rise between 2000 and 2008, Viet Nam's gross enrolment ratios have remained static. Over the past decade expected years of schooling have increased only marginally; and while mean years of schooling have increased, progress is slower than in some other countries in the South-East Asian region. At the sub-national level progress is more uneven. Significant disparities in both health and education persist between regions, provinces and socio-economic groups.

Rapid economic growth should not be the main policy goal as it overlooks unequal distribution of income and neglects sustainability of growth.

This report suggests that renewed commitment and a re-orientation of overall development priorities is needed to ensure broad-based, inclusive growth and human development and universal, equitable access to quality, affordable health and education services are available for all Vietnamese citizens. Such an effort should encompass a careful review of the impact of policy approaches to the funding and provision of social services. This review should also examine the design and delivery of poverty reduction and social protection initiatives that subsidise access to social services, as well as overall priorities for, and efficiency of, public investment in order to increase social spending.

ABOUT THIS REPORT

AN OVERVIEW OF VIET NAM'S HUMAN DEVELOPMENT PROGRESS, WITH A FOCUS ON HEALTH AND EDUCATION

This report sets out to analyse the current situation of human development at the sub-national level, with a specific focus on health and education, using the three main human development indexes, the HDI, GDI and HPI, together with a localized MPI introduced in this report. Based on an analysis of trends in the human development indexes at

the provincial and regional level over the past decade, the report examines factors that may have contributed to a slowdown in the life expectancy and education indexes. In particular it examines disparities in health and education outcomes at the sub-national level and among different population groups, which may be contributing to changes in the HDI at the national level.

The report also investigates access to health and education services, funding and provision

of health and education services nationally, and issues to do with delivery on the ground which impact on access to and quality of services. Where the first NHDR in 2001 focused on the *doi moi* reforms and their impact on poverty reduction and human development (see Box 1.4), this second report explores the challenges many Vietnamese people now face in accessing basic social services, which the Government will need to address in the context of the country's recent ascension to middle-income status.

BOX 1.4: FIRST NATIONAL HUMAN DEVELOPMENT REPORT 2001: DOI MOI AND HUMAN DEVELOPMENT IN VIET NAM

The first NHDR was published in 2001 and showed an overall picture of strong progress on the key human development indicators. The report analysed the impact of the *doi moi* (renovation) process on human development outcomes, arguing that the series of reforms introduced by *doi moi*, most notably transition from central planning to a market economy 'with a socialist orientation' and integration of Viet Nam into regional and global communities, resulted in improvements in human development and had expanded people's choices and reduced human poverty.⁴¹ The success of *doi moi* was in creating an enabling environment for people to participate in the economy, as demonstrated by the strong performance on the HDI at a national level, in particular in rising GDP per capita PPP.

However, the report also found significant regional disparities for all the human development indicators: some provinces in the South East and Red River Delta had levels of development comparable with countries such as Hungary and Estonia, while others, notably in the North East, North West and Central Highlands were at a similar level of development to Laos, Nepal and Bhutan. Using General Statistics Office of Viet Nam (GSO) income data to generate Gini coefficients, which measure income inequality, the report also found a significant increase in inequality, in particular during the latter part of the decade. There also appeared to be a correlation between positive human development outcomes and lower levels of income inequality. Provinces with low income but high HDI seemed to fare better in terms of inequality than provinces with high income per capita but which were left behind in terms of human development.

The report recommended five key components of a comprehensive strategy to enhance human development in Viet Nam: (i) accelerating institutional reforms, especially for the more effective implementation of sound policies and laws; (ii) furthering economic restructuring; (iii) promoting rural development; (iv) reforming education and training, science and technology; and (v) expanding and improving public services.⁴²

ABOUT THE SECTIONS OF THIS REPORT

Section One of the report outlines the overall context for the analysis. This first chapter has set out the framework for and purpose of the report, giving an overview of the human development concept and key human development indicators and overall trends in Viet Nam's HDI performance.

Chapter Two outlines the complex socio-economic transformations Viet Nam is currently undergoing as it settles into middle-income country status, including economic, labour market, social and demographic, and environmental trends and challenges that impact on human development. Chapter Three examines in detail trends in human development at the sub-national level between

1999 and 2008, and what this reveals about progress as well as disparities between different regions and provinces across the country.

Section Two focuses more specifically on the challenges people now face in accessing basic social services, in particular health and education. Chapter Four discusses access to health and education services and identifies persistent disparities, as well as emerging signs of rising inequality, between regions and provinces and among socio-economic groups. Chapter Five discusses current policy approaches to social service provision, including tensions between Viet Nam's policy-level commitment to universal access versus targeting via specific poverty reduction and social protection initiatives; the history and impact of the 'socialization' policy; and financing of health and education services. Finally, Chapter Six discusses availability and quality of services and briefly assesses key issues relating to improving service delivery, including organizational culture and incentives, user participation and feedback in planning and delivery of services, use of modern planning and monitoring methods, and the professional development of staff. The report closes with a discussion of broad policy directions emerging from the analysis.

HUMAN DEVELOPMENT INDEXES USED IN THIS REPORT

This report uses the original family of human development indexes, the HDI, GDI and HPI, as calculated in the 2009 global HDR and defined in Box 1.2. It draws on analysis at the regional and provincial level using data generated for the report by the GSO and the Viet Nam Academy of Social Sciences (VASS) using the calculation methodology adopted in global HDRs to 2009. It also draws on successive global HDRs to compare Viet Nam with other countries in the region, using the original HDI and its three component indexes: education (adult literacy levels and gross enrolment ratios), life expectancy and income (GDP per capita PPP).

Each of the three human development indexes used in the 2009 global HDR has its limitations. In relation to the HDI for example, gross enrolment ratios do not reflect the quality of schooling and can "hide important differences among countries because of differences in the age range corresponding to a level of education and in the duration of education programmes".⁴³ Literacy rates also become less meaningful at higher levels of progress.⁴⁴ The GDI

was based on estimates for most countries rather than actual data, in particular for the income dimension.⁴⁵ The HPI measures deprivations at an aggregate level and cannot identify specific groups or households that are jointly deprived.⁴⁶

In order to address these limitations the 2010 global HDR introduced a new method for calculating the HDI. The education indicators were replaced with expected years of schooling and mean years of schooling in order to provide a more accurate measure of educational attainment. GDP per capita was replaced with gross national income. In addition, the global HDR introduced three new indexes: the Multi-dimensional Poverty Index (MPI), the Gender Inequality Index (GII) and the Inequality-adjusted HDI (IHDI).⁴⁷

The MPI, which is adapted to the Vietnamese context, is used in this report. However, the refined HDI, and the new IHDI and GI, which have been calculated for Viet Nam at the national level in the global HDR, are not used in the current report. This is for a number of reasons.

Firstly, as the 2010 global HDR acknowledges, the original indicators used in the HDI—life expectancy, literacy rate, gross enrolment and per capita GDP—are more broadly available and remain meaningful for historical analysis.⁴⁸ This report aims to analyse trends over time at the national, regional and provincial level. The new 2010 indexes are yet to be calculated by the GSO at the regional and provincial level. Nor have they been calculated retrospectively to show changes over time. Thus, this report does not use the new methodology for the HDI or the associated IHDI. Nevertheless, the limitations of the original HDI, especially in respect of educational attainment should be considered when reading this report.

This report introduces a new MPI, which is localized for Viet Nam, based on nine indicators drawn from the 2008 VHLSS.

Secondly, the 2010 global HDR calculated the MPI for Viet Nam using data from the 2002 Demographic Health Survey. This survey was used in order to be able to provide comparable data with other countries as no other more recent Vietnamese survey contains all the indicators used in the global MPI. However, as conditions have changed significantly within Viet Nam over the past decade, the global MPI for Viet Nam should be interpreted with some caution. It is less up to date than other available multi-dimensional poverty measures, including the HPI,

the Child Poverty Rate (CPR) developed by MOLISA and UNICEF, and the MPI used in the Urban Poverty Survey, all of which use more recent data.

This report therefore introduces a new MPI, which is localized for Viet Nam, based on nine indicators drawn from the 2008 VHLSS. This new MPI provides a baseline for measurement of non-monetary poverty in future NHDRs using available national indicators that are collected on a regular basis in the VHLSS. A technical note outlining the calculation of this index is included at Annex 3. The HPI is also used as it remains a relevant index for measuring severe deprivation in non-income dimensions of people's experience over time.

Finally, the Gender Inequality Index (GII) introduced by the 2010 HDR includes reproductive health indicators, such as maternal mortality and the adolescent fertility rate, as well as women's labour market participation, representation in national parliament and years of schooling. Viet Nam's performance on the new GII is equivalent to high human development, ranking it 58 out of 137 countries in 2010. However these indicators are not the most accurate measures of progress towards gender equality in Viet Nam, which has had high rates of women's political and labour market participation for some time. Although women's workforce participation rates are high, the majority of women are concentrated in informal work. While the gender wage gap is about 12 percent nationally, it rises to around 50 percent in the informal sector. These and other indicators, such as the rapidly rising sex ratio at birth at 110.5 boys to 100 girls nationally, and incidence of domestic violence at around 34 percent in a woman's lifetime, are more telling in the Vietnamese context.⁴⁹

OTHER DATA SOURCES

This report complements the discussion of human development indexes by drawing on national data sources, in particular the VHLSS and the national population and housing census, to present relevant data which is not captured in the human

development family of indicators, such as infant mortality, school completion rates, and poverty and inequality rates nationally and at the regional and provincial level. Use of the VHLSS and the population census also enables disaggregation by socio-economic groups, including ethnic minorities, women, the elderly and those with different levels of education and income. Data from other sources, including small-scale surveys conducted by the Government, the United Nations and development partners are used to supplement and triangulate the data from these official sources.

The human development indexes, census data and VHLSS provide a reasonably robust picture of key health, education and living standards dimensions as these have changed over time in Viet Nam.

The census and the VHLSS each have their strengths and weaknesses: for example the 2009 census covers a representative sample of 15 percent of the entire Vietnamese population but is only conducted every 10 years and generates a limited amount of information on the socio-economic characteristics of the population. This provides only a broad-brush picture of changing trends in health, education and living standards. The VHLSS is conducted every two years, so it can capture short-term changes over time. It has a small sampling frame based on simple random sampling, which means it is representative of the population but its data is less accurate at the sub-sample level, for example among small population groups such as ethnic minority populations. However, the census and the VHLSS also exclude some population groups who are likely to be among the poor and deprived, such as temporary and seasonal migrant workers.⁵⁰ Nevertheless, when used together, the human development indexes, census data and VHLSS do provide a reasonably robust picture of key health, education and living standards dimensions as these have changed over time in Viet Nam. Multi-dimensional measures of poverty and deprivation such as the HPI also provide important clues.

VIET NAM'S SOCIO-ECONOMIC TRANSFORMATIONS

A TRACK RECORD OF ECONOMIC GROWTH AND PROGRESS

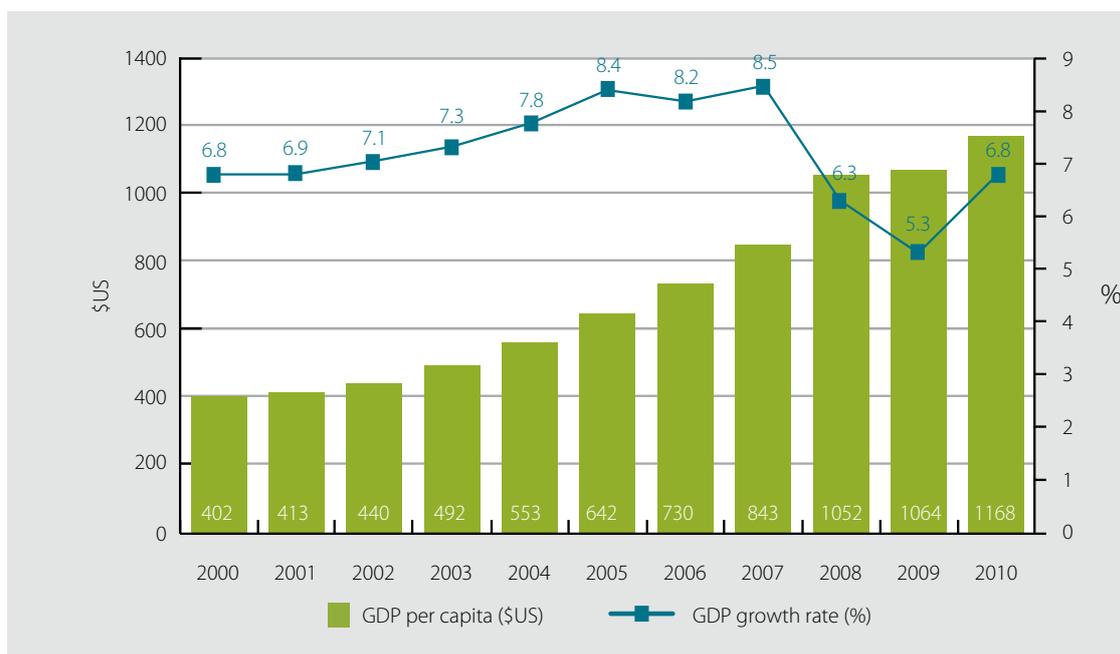
VIET NAM'S STRONG ECONOMIC GROWTH AND RAPID POVERTY REDUCTION

In 2009, Viet Nam officially attained middle-income country status, achieving annual Gross National Income (GNI) per capita of US\$1,020 in 2009 and US\$1,110 in 2010.¹ The country is well established in the ranks of countries that have attained 'medium human development'. These milestones in Viet Nam's development are testament to the country's achievements in both income and non-income

dimensions of human development—though, as the previous chapter showed, income growth has been the main driver of Viet Nam's gains in the HDI, in particular between 1999 and 2008.

Between 2000 and 2010 Viet Nam continued to achieve high levels of economic growth. GDP grew by 6 to 8 percent annually over the decade with the exception of the years immediately following the economic crisis: GDP growth rates dipped to 6.31 percent in 2008 and 5.32 percent in 2009, recovering in 2010 to 6.8 percent (Figure 2.1)². GDP per capita rose rapidly over the same period from US\$402 in 2000 to US\$1,168 in 2010. Nevertheless, Viet Nam's GDP per capita remains below most countries in the region with the exception of Laos and Cambodia.³

Figure 2.1: GDP Growth and GDP per capita \$US, Viet Nam, 2000-2010



Source: GSO accessed, www.gso.gov.vn

Consumption-based poverty rates also fell significantly during this period, from 37.4 percent in 1998 to 14.5 percent in 2008. Rural poverty fell from 44.9 percent to 18.7 percent, while urban poverty fell from 9.5 to 3.3 percent.⁴ While poverty rates are likely to be underestimated due to relatively low poverty thresholds by international standards⁵, and the exclusion of key vulnerable groups from national surveys, this nevertheless represents a significant achievement. In this regard, Viet Nam has made notable progress in this area, as was recognized at the September 2010 Millennium Summit.⁶

However, despite these gains, poverty reduction remains uneven across regions and among different population groups. Poverty is strongly correlated with geographic location and ethnicity as well as with non-monetary deprivations, including lower living standards and poorer health and education status. Poverty is highest in the Northern Midlands

and Mountainous Areas and lowest in the South East.⁷ One in two ethnic minority people lives in poverty compared to one in eleven Kinh majority people. In 2008 the poverty rate for the Kinh majority was 8.9 percent, compared to 50.3 percent for ethnic minority groups. The rate of poverty reduction has been faster in urban areas, and among the Kinh majority as well as in the Red River Delta and the South East. At the same time, income inequality appears to be rising, albeit relatively slowly over time compared to other countries in the region. The Gini coefficient for income rose from 0.418 in 2002 to 0.434 in 2008. The gap between the incomes of the richest and poorest quintiles was 8.94 times in 2008, up from 8.1 times in 2002.⁸

Poverty reduction remains uneven across regions and among different population groups.

Table 2.1: Poverty Rates and Poverty Reduction by Ethnicity and Region, Viet Nam, 1998-2008 (percent)⁹

	1998	2002	2004	2006	2008	Poverty reduction (%) 1998-2008
Viet Nam	34.7	28.9	19.5	16	14.5	58
Urban	9.5	6.6	3.6	3.9	3.3	65
Rural	44.9	35.6	25	20.4	18.7	58
Red River Delta	30.7	21.5	11.8	8.9	8.0	74
Northern Midlands and Mountainous Areas	64.5	47.9	38.3	32.3	31.6	51
North Central Area and Central Coastal Area	42.5	35.7	25.9	22.3	18.4	57
Central Highlands	52.4	51.8	33.1	28.6	24.1	54
South East	7.6	8.2	3.6	3.8	2.3	70
Mekong River Delta	36.9	23.4	15.9	10.3	12.3	67
Kinh majority	31.1	23.1	13.5	10.3	8.9	71
Other ethnic groups	75.2	69.3	60.7	52.5	50.3	33

Source: VHLSS 2008; Viet Nam MDG Report 2010

VIET NAM ON TRACK TO REACH THE MILLENNIUM DEVELOPMENT GOALS

Viet Nam has made important progress in relation to many of the key Millennium Development Goal (MDG) indicators during this period, including key health and education targets and is on track to reach the MDGs at a national level. Literacy rates for people

over 10 years of age rose from 89.5 percent in 1998 to 93.1 percent in 2008. Net enrolment rates in primary and lower secondary education on the other hand reached 97 percent and 83 percent respectively in 2008/09. The gender gap at lower levels of education has steadily narrowed, with 94 percent of both male and females aged 6 to 14 enrolled in school in 2008. Girls now outnumber boys in upper-secondary and college education.¹⁰

With regard to health-related indicators, the under-5 mortality rate fell from 58 per 1,000 deaths in 1999 to 24.4 per 1,000 deaths in 2009, while the infant mortality rate fell from 44.4 per 1,000 deaths to 16 per 1,000 deaths over the same period. Maternal mortality rates, on the other hand, are currently 69 per 100,000 live births according to the Ministry of Health, with 94.8 percent of births attended by a skilled health worker in 2008. Moreover, 83 percent of the rural population now has access to safe drinking water, up from just 30 percent in 2000, while 63 percent of rural households have sanitary toilets. However, Viet Nam is not on track to meet MDG 6 targets for HIV, and it appears that progress in reducing maternal mortality rates has plateaued in recent years.¹¹

Indeed, as Chapter Three shows, these positive results at a national level disguise significant and persistent disparities across different regions and provinces and among different population groups. In addition, Viet Nam now faces complex socio-economic challenges and changes which have the potential to reverse these gains and undermine future human development outcomes if they are not well managed and addressed. These challenges to human development are discussed briefly in the following sections.

A VOLATILE MACROECONOMIC ENVIRONMENT

THE MACROECONOMIC ENVIRONMENT AND CHALLENGES FOR HUMAN DEVELOPMENT

Despite steady gains in GDP growth and poverty reduction over the last decade, Viet Nam has experienced periods of macroeconomic instability in recent years. Viet Nam has the highest inflation rate in the region with Consumer Price Index (CPI) levels averaging 10.2 from 2004 to 2009 compared to 2.9 in China and 3.1 in Thailand.¹² Inflation has continued to be high and volatile in 2010 and 2011.¹³ In addition, during the past decade, the Vietnamese economy has persisted in presenting a current account deficit in its balance of payments, of around 12 percent of GDP in 2010.¹⁴ This deficit reflects a mismatch between domestic and foreign investment in the Vietnamese economy, the so-called 'investment gap'. This 'gap' has been driven in part by an economic model that has prioritized investment-led growth, with the ratio of investment to GDP at 42 percent

in 2010.¹⁵ At the same time, the rate of return on investment has been steadily declining, suggesting that investment has become less efficient in Viet Nam.¹⁶ This has added unnecessary pressures on Viet Nam's current account deficit, leading to a higher level of dependency on external sources of development financing, while making Viet Nam more vulnerable to global economic shocks such as the recent financial crisis.¹⁷ While Viet Nam was able to maintain GDP growth during the economic downturn, the impact of the crisis on the livelihoods and well-being of many Vietnamese people was nevertheless severe. Employment in export-oriented sectors and in craft villages contracted and many migrant workers were forced to return home. Unstable jobs and low incomes affected many households, while prices for food and other essential needs remained high.¹⁸ Many households cut their education spending and, in some cases, pulled their children out of school. Many families also reduced their food expenditure with impacts on the health and nutrition of women and children in particular.¹⁹

While Viet Nam was able to maintain GDP growth during the economic downturn, the impact of the crisis on the livelihoods and well-being of many Vietnamese people was nevertheless severe.

Macroeconomic instability makes Viet Nam a less attractive destination for investors: Viet Nam ranks lower on international comparisons of competitiveness than most other countries in the South-Eastern Asia region, ahead of Cambodia and the Philippines, but behind Indonesia, Thailand and Malaysia.²⁰ It also undermines people's living standards by eroding consumer purchasing power and increasing the cost of social services, including health and education. In addition, weak infrastructure, including regular power shortages, low skill and productivity levels, and an insufficiently transparent and stable regulatory environment deter investors, both foreign and national.²¹ It also undermines domestic enterprise growth, including the development of a strong micro- and small- and medium-sized enterprise sector.²² Viet Nam's current macroeconomic outlook poses specific challenges, given the wider pattern of intersecting economic and social transformations that the country is experiencing. These transformations will determine its future development and ability to realize improved human development levels and outcomes for all Vietnamese people.

A HEALTHY, EDUCATED POPULATION IS KEY TO CONTINUED ECONOMIC GROWTH

In the context of this discussion of human development and its income and non-income dimensions, there are several key issues that emerge from recent analyses. Firstly, there is an emerging consensus among analysts of Viet Nam's economy that the current growth model is rapidly exhausting its potential, and that strong economic growth is unlikely to continue in the current macroeconomic environment over the longer term. Indeed, a key contributing factor to macroeconomic instability has been a tendency among policymakers and decisionmakers to prioritize large-scale, and often inefficient, investment as a source of economic growth.²³ More recently, there have been signs that the Government recognises the importance of focusing on the quality of growth and ensuing economic stability in the longer term.²⁴ Secondly, and critically, given the subject of this report, there is a consensus among policymakers and analysts that Viet Nam needs to develop a highly skilled, technologically and intellectually sophisticated workforce in order to improve productivity levels. Viet Nam also needs to make the shift to higher-skill-level industries required to avoid the so-called

'middle income trap' (Box 2.1).²⁵ As the 2010 Viet Nam Competitiveness Report states:

... Viet Nam faces a serious shortage of high quality human resources, a major obstacle to productivity growth. If Viet Nam were to be satisfied with its achievements on basic human capacity indicators, it would hardly move beyond the current level and climb the competitiveness ladder.²⁶

Given Viet Nam's vulnerability to the impact of global financial shocks, and the present weakness of foreign investment in Viet Nam and of external demand for Viet Nam's exports, domestic demand and markets are emerging as an important source of economic growth. Yet increasing domestic demand requires availability of locally produced, high quality goods and services that satisfy people's needs and expectations, and which can compete with offerings from other countries. Increased domestic demand also requires an increasingly wealthy, educated and healthy population.²⁷ Thus improvements in health and education outcomes, including those measured by the Human Development Index (HDI), are fundamental to achieving continued economic growth and enabling Viet Nam to continue to move to higher living standards and income levels.

BOX 2.1: MIDDLE-INCOME COUNTRY STATUS, MEDIUM HUMAN DEVELOPMENT LEVELS AND THE 'MIDDLE-INCOME TRAP'

Middle-Income Country (MIC) status refers to the World Bank's classification of countries' economies using annual Gross National Income (GNI) per capita: lower middle-income countries such as Viet Nam were those that had a GNI per capita of US\$996 to US\$3,945 in 2009.²⁸

Medium Human Development is a classification adopted by the HDR and refers to countries that fall into the third quartile of countries based on progress in the three key dimensions of health (life expectancy), education (adult literacy levels and gross enrolment ratios), and living standards (GDP per capita Purchasing Power Parity [PPP]) measured by the HDI.²⁹

As a multi-dimensional index, the HDI provides a more rounded appraisal of human development than GNI per capita alone. However, the World Bank's classification system is used to determine the level and conditions of Official Development Assistance (ODA) a country receives. As Viet Nam has now reached MIC status, aid levels are expected to fall, with lower levels of concessionality to be expected in the aid Viet Nam receives in future.³⁰ The shift to MIC status therefore has important implications for human development, affecting development assistance for education, health and social protection initiatives.

The middle-income trap refers to the experience of developing countries which reach a certain level of income, but are not able to achieve the level of growth that would take them into the ranks of high income countries. Countries in this situation have successfully leveraged low labour costs and underutilized land and capital resources to attract investment. This also enables them to move from lower skill agricultural production into higher level agricultural production and lower-skilled manufacturing, raising incomes and generating rapid economic growth along the way.

But, as incomes rise, labour is no longer cheap as workers demand and secure higher wages, underused land and capital is no longer available and costs begin to rise, undermining the competitiveness of low-tech manufacturing industries. The solution to the so-called ‘trap’ is to move up the value chain into higher skilled, high-tech industries, but also and as importantly, to innovate, and invest in research and development. It is also important to ensure a highly educated, skilled and sophisticated labour force is available domestically to support this change. It is a difficult transition to make.³¹

For example, MICs such as Thailand, the Philippines and Malaysia have experienced slowing growth rates and stagnant competitiveness rankings over the past decade. While all three countries saw recovery in their GDP growth rates after the economic crisis, only in the Philippines has employment in manufacturing recovered to pre-crisis levels. These countries have remained stuck in the ranks of MICs over the past several decades. The Philippines and Malaysia have investment rates that are among the lowest in MICs globally, and critically, all three countries face constraints in terms of entrepreneurial abilities and skills and capabilities to innovate and produce new products.³²

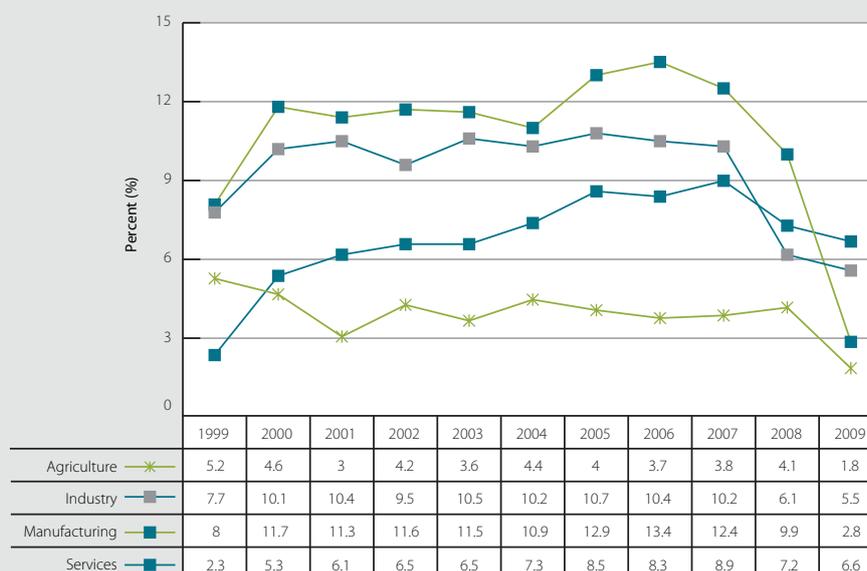
STRUCTURAL CHANGES IN THE ECONOMY AND LABOUR MARKET

A CHANGING LABOUR MARKET

Since the *doi moi* reforms were introduced in 1986, Viet Nam has undergone a transition from a centrally planned economy to a market economy ‘with a socialist orientation’ and has been gradually opening up to international markets for investment and trade. This process was accelerated with Viet Nam’s accession to the World Trade Organization (WTO) in 2007.

Viet Nam’s economic success rests on high levels of agricultural productivity, export growth, in particular in oil and in sectors such as garments and footwear, and Foreign Direct Investment (FDI). Over time, the structure of the economy has changed markedly—industry and construction have increased in value as a proportion of GDP and the value of agriculture has declined, while services remained steady over the 2000 to 2009 period.³³ All three sectors saw steady growth rates from 2000, fell in 2008 and 2009 as a result of the financial crisis, but had bounced back by 2010, though not to pre-crisis levels.³⁴ Manufacturing was hardest hit, dropping from growth rates of 12.4 in 2007 to 2.8 in 2009 (Figure 2.2).³⁵

Figure 2.2: Annual GDP Real Growth Rates by Aggregated Economic Sectors, Viet Nam (constant prices 1994)



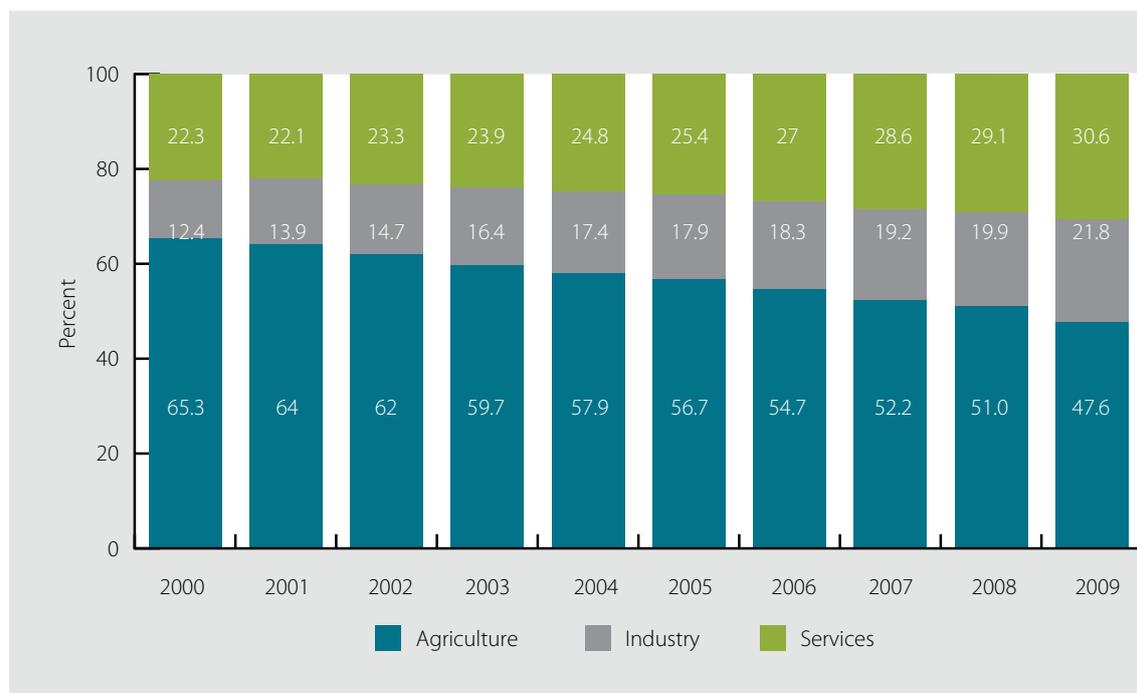
With the opening up and liberalization of Viet Nam's economy has also come a proliferation of enterprises, predominantly small, family-owned businesses: of the 355,000 private firms currently registered, 98.4 percent are small or medium enterprises.³⁶ As the overall investment environment has improved, in particular in the wake of WTO accession, and despite the challenges at a macroeconomic level discussed above, Viet Nam is still viewed as an attractive destination for overseas investors.

As a result, over time, the importance of FDI and the private sector in the economy have increased. FDI and the private sector have generated the bulk of new jobs as employment generation has been much faster in these sectors than in State-Owned Enterprises (SOEs).³⁷ The proportion of jobs in private sector enterprises increased from 29 to 50 percent from 2000 and 2009, from 16 to 33 percent in FDI enterprises, and fell from 55 percent to just 15 percent of jobs in SOEs.³⁸ This has important implications for employees' working conditions and job security, as well as for the gender wage gap as shown in Box 2.2. Two key points help to illustrate this: firstly, it is notable that in the 2007 to 2009 period which coincided with the economic downturn,

the number of workers on formal and permanent contracts fell, while the number of fixed-term, verbal contracts rose, reflecting greater job insecurity as a result of the financial crisis.³⁹ As noted earlier, jobs in sectors such as export-oriented manufacturing were hardest hit. Secondly, the bulk of industrial action in Viet Nam has been in relation to FDIs, the main causes of strikes include businesses not following labour regulations, low salaries, excessive overtime and hazardous working conditions.⁴⁰

In addition to driving GDP growth and raising incomes, these changes have had a profound effect on Viet Nam's labour market and available employment opportunities. Viet Nam's labour market is increasingly industrialized and urbanised. While a majority of the workforce continues to be employed in agriculture, the proportion employed in industry and construction has increased markedly. Thus, the proportion of the workforce employed in agriculture dropped from 65.3 percent in 2000 to 47.6 percent in 2009, while the proportion employed in industry rose from 12.4 percent to 21.8 percent over the same period. Employment in services rose from 22.3 percent in 2000 to 30.6 percent in 2009 (Figure 2.3).⁴¹

Figure 2.3: Distribution of Employment by Sector, Viet Nam, 2000-2009 (%)



Source: MOLISA, Labour and Employment Surveys (various years) cited in MOLISA and ILO 2010; GSO Report on the Labour Force 2010; Survey of Viet Nam 1 September 2009

Employment growth has been steady, averaging 2.6 percent per year in line with steady income per capita growth.⁴² Even in the wake of the economic crisis Viet Nam has continued to post strong job growth, with more than 2.2 percent employment growth annually between 2007 and 2009. Most of these new jobs were in industry and services.⁴³ Between 1997 and 2007 the proportion of jobs in urban areas increased from 20.9 percent to 24.7 percent, rising to 27.8 percent in 2009.⁴⁴

Despite these ongoing structural changes in the economy, the proportion of workers in paid employment remains small and the majority of Viet Nam's workforce continues to be concentrated in agriculture and in informal employment. According to the International Labour Organization (ILO), 65.1 percent of Viet Nam's workforce is concentrated in informal employment, while only 33.4 percent are waged or salaried workers. Of these workers, however, 44.7 percent worked with verbal contract arrangements or no contract at all.⁴⁵ Informal workers typically lack access to benefits and training, face insecure and often difficult working conditions, and earn significantly lower incomes than those in formal work.⁴⁶

A SKILLED AND PRODUCTIVE WORKFORCE AND ACCESS TO DECENT WORK

Education is vital to ensure a skilled and productive workforce and access to decent work, yet Viet Nam's workforce is still largely unskilled with low levels of education. Of those workers who were employed in 2007, only 24 percent had completed high school, while 35 percent of workers had some form of technical or advanced education: 29 percent of women and 40 percent of men.⁴⁷ Although unemployment rates are low at about 2.8

percent, they are higher among the 5- to 24-year-old age group: more than half of the unemployed population in 2009 were young people aged 15 to 24 and those aged 15 to 29 accounted for 65 percent of the unemployed.⁴⁸ Those who were unemployed typically lacked any kind of qualifications, 70.5 percent had no formal qualifications above the secondary level, 67 percent of men and 74 percent of women.⁴⁹

Informal workers typically lack access to benefits and training, face insecure and often difficult working conditions, and earn significantly lower incomes than those in formal work.

Furthermore, underemployment, a more useful indicator than unemployment to understand labour market constraints in developing countries, is also significant in Viet Nam, at about 5.4 percent in 2009; and at 6.3 percent in rural areas compared to 3.2 percent in urban areas⁵⁰, posing important challenges as many workers have seasonal or casual jobs that do not offer a sufficient income to maintain a decent standard of living.

Indeed, Viet Nam faces significant challenges in generating sufficient decent jobs that give workers access to labour protection and social services, and in developing a highly skilled, well educated workforce, which can support the desired transition to a higher skilled, high-tech economy.⁵¹ Continued human development, in particular in education and vocational training, is critical to enable people to move out of vulnerable employment and secure decent work. As Box 2.2 shows, it is particularly vital for women who are mostly concentrated in informal employment and often do not earn a wage.

BOX 2.2: A GENDER-SEGREGATED LABOUR MARKET

A great deal of Viet Nam's export success is arguably owed to the hundreds of thousands of young women who have flowed into the garment and footwear sectors.⁵² However, despite new opportunities opening up for women as Viet Nam's economy changes, the labour market remains gender-segregated. Women predominate in manufacturing, retail and trade, accommodation and food services and education; while men predominate in construction, transport and storage and socio-political organizations. Gender segregation in the labour market is both based on, and reinforces, gender inequalities within the broader society and acts as a constraint to women's human development.

When it comes to employment conditions, men are better off than women and the gap appears to be increasing. A higher proportion of men are in waged employment: 38.9 percent of men earn a wage compared to 27.5 percent of women; and men's waged employment also grew more than women's by 3.1 percent, compared to 2.5 percent between 2007 and 2009. Women are concentrated in vulnerable employment including as own-account and unpaid family workers: 69.1 percent of women compared to 54.4 percent of men fall into this category. However, a much higher proportion of women are unpaid family workers: 22.2 percent compared to 11.8 percent of men. Between 2007 and 2009 more men moved into paid employment in industry, while more women became unpaid family workers in agriculture and services. The proportion of women who were unpaid family workers increased by 8.2 percent between 2007 and 2009, while the proportion of women who were own-account workers, and therefore earning an income, fell by 11.2 percent. This suggests that women may have been more disadvantaged by the economic crisis, moving out of micro-businesses and trading and back into family-based businesses where they do not receive any paid income.

VHLSS 2008 data shows that, at an aggregate level, the gender wage gap has steadily narrowed, but has widened slightly in urban areas since 2006. Nationally, women earned 90 percent of male wages, 85 percent in urban areas and 91 percent in rural areas, compared to 87 percent in urban areas and 88 percent in rural areas in 2006.⁵³ While reliable data is not available for the informal sector, studies estimate women who earn an income in informal sector employment earn as little as 50 percent of male wages.⁵⁴

In some specific sectors and occupations women earn more than men, including in government jobs in rural areas, in administrative and management positions, and in trades in rural areas. Notably, however, in FDI enterprises and in particular in manufacturing where women predominate, they earn around two thirds of male wages.⁵⁵ In effect, gender-based wage differentials have helped to subsidise Viet Nam's investment and export success as, "especially in urban areas, manufacturing sector employers have been squeezing women's wages relative to men's wages in order to maintain their competitive edge in global markets".⁵⁶ This approach is not sustainable in the longer term if Viet Nam is to be successful in moving into higher skilled, high-tech industries.

A PERIOD OF DEMOGRAPHIC TRANSITION

DEMOGRAPHIC TRENDS WILL INFLUENCE VIET NAM'S FUTURE

At the same time as structural changes are gaining pace in Viet Nam's economy, demographic change and population mobility is putting pressure on the labour market, and fuelling an acceleration in migration and urbanization rates. In 2009, Viet Nam's population was over 85 million, having grown by a relatively modest 1.2 percent on average each year since 1999. Population growth was highest in the Central Highlands (3.2 percent) and the South East (2.3 percent), and lowest in the Red River Delta (0.9 percent) and Mekong River Delta (0.6 percent).⁵⁷ Low levels of population growth are explained in part by declining total fertility rates, which dropped from 2.33 children per woman in 1999 to below replacement levels at 2.03 children per women in 2009. Regional variations are evident in this data, as are urban-rural differences.⁵⁸ Fewer children being born has contributed to lower dependency rates, (the rate of dependents to workers in the household). Viet Nam's dependency ratio dropped to 46.3 percent in 2009 from 63.6 percent in 1999.

Underlying these lower fertility rates are three significant demographic trends, which are set to influence Viet Nam's future development, prosperity and ability to raise living standards. Firstly, Viet Nam is entering the period of the so-called demographic bonus. As a result of declining fertility and mortality the largest age cohort is currently the 15- to 24-year-old age group.⁵⁹ This age group makes up 19 percent of the labour force, with hundreds of thousands of young people entering the workforce each year.⁶⁰ As a result there will be two or more people of working age for every person aged under 15 or over 65 from around 2010 to 2049. This is a potential windfall but also a potential threat, depending on how it is managed. Viet Nam will need to develop the skills and capabilities of these young people, generate sufficient decent jobs for new labour market entrants, and ensure they have a stake in the future of the country by offering opportunities for meaningful participation and engagement in social and political life.⁶¹

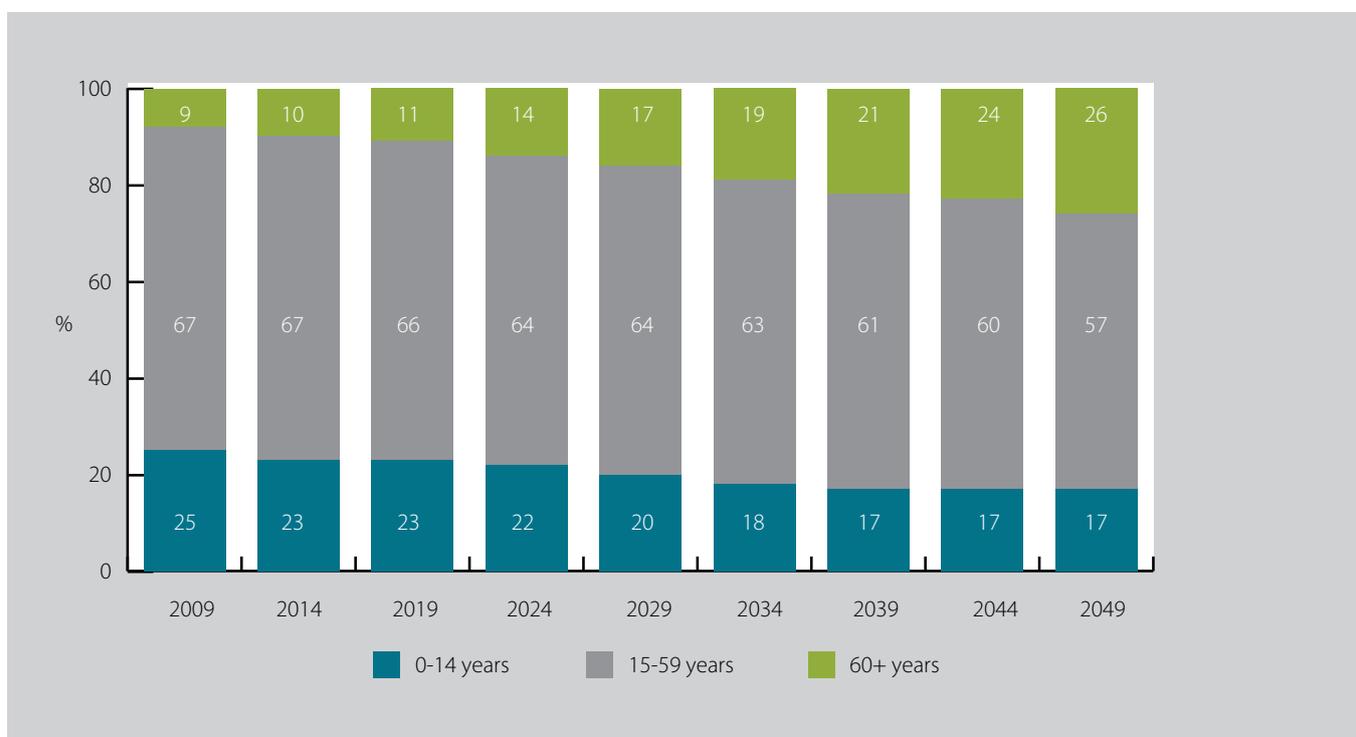
Failure to do so will not only consign a generation of Vietnamese people to the risk of unemployment and lost opportunities, it may also generate social problems. Young people's aspirations are changing rapidly, and today they have quite different expectations of the level of material prosperity they can attain than those of their parents' generation. Already there are signs of a generation gap emerging in Viet Nam between young people and their parents' generation, with young people finding they do not share common values or aspirations with their elders (See Box 2.5). Risk-taking behaviour is on the rise among young people with higher rates of drug and alcohol use, in particular among young men, high abortion rates among young unmarried women and increasing rates of HIV infection among young people.⁶² All of these changes have important implications for social services, in particular health services, as well as social protection and social welfare services to support this generation of young people. For example, health services targeting young people of reproductive age, together with social welfare services including mental health and drug and alcohol services will need to be scaled up.⁶³ Schools and training institutions will need to be much more attuned to the changing situation and needs of young people; this could be facilitated by developing their life skills and providing effective reproductive health education.⁶⁴

Demographic change and population mobility is putting pressure on the labour market, and fuelling an acceleration in migration and urbanization rates.

AN AGEING POPULATION

At the other end of the life cycle, Viet Nam's population is ageing, and as discussed in Box 2.3, an ageing population needs expanded health care and social protection. By 2049, more than 26 percent of Viet Nam's population will be 60 or over; a threefold increase from 2009 (Figure 2.4).⁶⁵ Life expectancy rates are continuing to rise, and are currently at 70.2 years for men and 75.6 years for women.⁶⁶ As family structures change and people live longer, Viet Nam can expect to see more and more elderly people living alone, and a majority of them will be women.

Figure 2.4: Projected Population by Age, Viet Nam, 2009-2049 (%)



Source: UNFPA cited in Giang Thang Long 2010

BOX 2.3: AN AGEING POPULATION⁶⁷

Over the same period as the demographic bonus, Viet Nam can expect to see a steady ageing of its population. As Figure 2.4 shows, the old-age population (those over 60) will increase from 9 percent in 2009 to 14 percent in 2024 and 26 percent in 2049. The ageing index (the number of persons over 60 to every 100 people under 15) will rise to 100 from 2035, with population ageing in Viet Nam occurring over a 35-year period, at a much faster pace than countries such as France (115 years) but slower than Japan, which reached an ageing population in just 26 years. The percentage of people aged 80 and over, who are most in need of care and support, will increase more quickly than at younger age groups. Viet Nam is at risk of 'becoming old before becoming rich', with income levels well below those of other countries, such as Japan, which are currently coping with population ageing.

In addition, the pace of ageing and distribution of older people will vary across different regions and provinces, as most older-age people are living in rural areas and in agricultural regions. The causes and types of illness that older people experience are also changing, from communicable to non-communicable diseases, with increased incidence of lifestyle-related health problems such as depression and high blood pressure.

These changes have significant implications for health services and social protection. More older people are using outpatient services, in particular hospitals and health services; and they are visiting outpatient services more often. They are also paying more for these services, as the out-of-pocket costs they pay per outpatient service increased by 17 percent from 152,400 VND in 2004 to 178,400 VND in 2008 (at 2004 constant prices). The costs of inpatient visits are considerably higher and

increased by 12 percent from 1,433,300 VND in 2004 to 1,606,800 VND in 2008 (at 2004 constant prices). This may account for the slight fall in older people using inpatient health services between 2004 and 2008 and the lower average number of inpatient visits in 2008.

Worryingly, given their rising health expenditure, many older people lack health insurance. According to 2008 VHLSS data, around 40 percent of older people aged 60 and over had no health insurance in 2008, though there has been a marked improvement since 2004 when 67 percent were not covered. The proportion of the elderly with free health insurance also increased from 28.4 percent to 37 percent between 2004 and 2008. Those aged 80 and over have higher coverage rates; as do those who are poor, from an ethnic minority group, and women, as these groups benefit from free or subsidised health insurance through various targeted programmes and social protection schemes. Twenty-two percent of older people receive a pension and 18.5 percent receive some type of aged care allowance.

Given the rising costs of health care, coupled with population ageing, it is evident that social protection, in particular health insurance and pension benefits, needs to be extended to cover all older people. Old-age pensions have helped to prevent a 50 percent increase in the poverty rate among those aged 60 and over. A social pension scheme providing a universal benefit of 60 percent of the 2004 official poverty line to all old-age people in rural areas would reduce the old-age poverty gap by 59.7 percent and reduce the severity of poverty, by 65.5 percent. Such a scheme would cost about 7,197.2 billion VND or 1 percent of GDP at 2004 levels—a fraction of the 42 percent of GDP Viet Nam currently invests to generate economic growth.

A CHANGING BURDEN OF DISEASE

Demographic and social transformations are also contributing to a changing disease burden in Viet Nam.⁶⁸ The burden of non-communicable, lifestyle-related diseases has been steadily increasing. According to a 2008 study, the leading cause of death for both men and women was stroke, while liver cancer and road traffic accidents were the second and third leading cause of death in men. In women, the second and third leading causes of death were, respectively, chronic obstructive pulmonary disease and pneumonia. Notably, 6 percent of male deaths were as a result of road traffic accidents and 3 percent were due to HIV/AIDS. Two thirds of years of life lost were due to non-communicable diseases. Cardiovascular disease, cancer and unintentional injuries were the leading cause of premature death in both men and women. Non-communicable diseases also account for around three quarters of the disability burden in Viet Nam. Significantly, the leading specific cause of years lost due to disability in men was alcohol use disorders, followed by depression and road traffic accidents; in women it was depression, loss of vision, osteoarthritis and anxiety disorders. While measures to control infectious diseases remain important, greater effort is required to prevent newly emerging non-communicable diseases.

'NATALITY INEQUALITY' IN VIET NAM

A third key demographic trend affecting Viet Nam is the rapidly rising sex ratio at birth. Viet Nam's sex ratio at birth is currently at 110.5 boys to every 100 girls, a comparable rate to countries such as India, though still lower than China at 120 boys to 100 girls. But Viet Nam has reached this current sex ratio at birth much more quickly than any other country in the region, with the sex ratio at birth rising from 107 boys to 100 girls in 2003 to current levels. Three key factors are at play—the widespread availability of sex-selection technology, the two-child policy (now renamed 'the small family norm') and persistent son preference, which leads to families wanting and valuing boys over girls. There is considerable variation in the sex ratio at birth in different regions and provinces and among different socio-economic groups. The sex ratio at birth is at 115.3 boys to girls in the Red River Delta compared to 105.6 boys to 100 girls (normal levels) in the Central Highlands and ranges from 100.5 to 130.7 boys per 100 girls in different provinces.⁶⁹

The burden of non-communicable, lifestyle-related diseases has been steadily increasing.

Higher sex ratio at birth values are found among better off households and among the Kinh majority than in poor and ethnic minority families.⁷⁰ Part of the explanation for this variation relates to the cost of conducting sex selection which is more readily available in urban areas and more affordable for those at higher income levels. Powerful commercial incentives for health professionals to perform pre-natal scans and conduct terminations, in contravention of the law, also contribute. However, values play a part as well, as sex-selection is more prevalent in households with a traditional patrilineal structure, and having sons is seen a sign of status among better off families. Couples experience intense social pressure to produce sons and sex-selection is undoubtedly contributing to Viet Nam's high rate of abortion compared to other countries in the region. The sex ratio at birth is predicted to rise to 115 by 2025 if no intervention occurs, resulting in a 12 percent surplus of men aged 50 and under by 2049—and millions of 'missing' Vietnamese women.⁷¹ As Amartya Sen has noted, "this is high-tech sexism."⁷² 'Natality inequality' both reflects and perpetuates deep-rooted gender inequality and discrimination at the household level. As countries with very high sex ratios at birth, such as India and China, have experienced, a scarcity of women increases pressure for early marriage, and can create rising demand for sex work, as well as an expansion in trafficking of women and girls.⁷³ As gender equality and women's empowerment is strongly correlated with higher levels of human development, Viet Nam's very rapid change in the sex ratio at birth is a significant concern.

'Natality inequality' both reflects and perpetuates deep-rooted gender inequality and discrimination at the household level.

FAST-PACED URBANIZATION AND INTERNAL MIGRATION

VIET NAM'S INCREASING URBANIZATION

Changing economic and labour market opportunities, together with less restrictive controls over population mobility have contributed to rapid urbanization and increased internal and overseas migration, as millions of Vietnamese people move in order to access income generation opportunities. In

the 10 years between the 1999 and 2009 census, Viet Nam's urban population grew by 3.4 percent a year, while in rural areas population growth was only 0.4 percent a year. By 2009, 29.6 percent of the population was living in urban areas, compared to 23.7 percent in 1999. This is an increase of 7.3 million people over the decade, compared to an increase in the rural population of 2.17 million people.⁷⁴ However, these figures are likely to significantly underestimate urban population growth, given that temporary migrants are not included, and many neighbourhoods on the outskirts of Viet Nam's two largest cities, Ho Chi Minh City and Ha Noi, are still classified as rural, despite a clearly urban countenance. In this sense, around 33 to 40 percent of the Vietnamese population is likely to already be living in urban areas.⁷⁵ Estimated population projections suggest that the population growth rate will be 2.91 percent each year for urban areas from 2015 to 2050; and only 0.13 percent each year for the rural population.⁷⁶ As Figure 2.5 shows, the urban population will outstrip the rural population from around 2045.

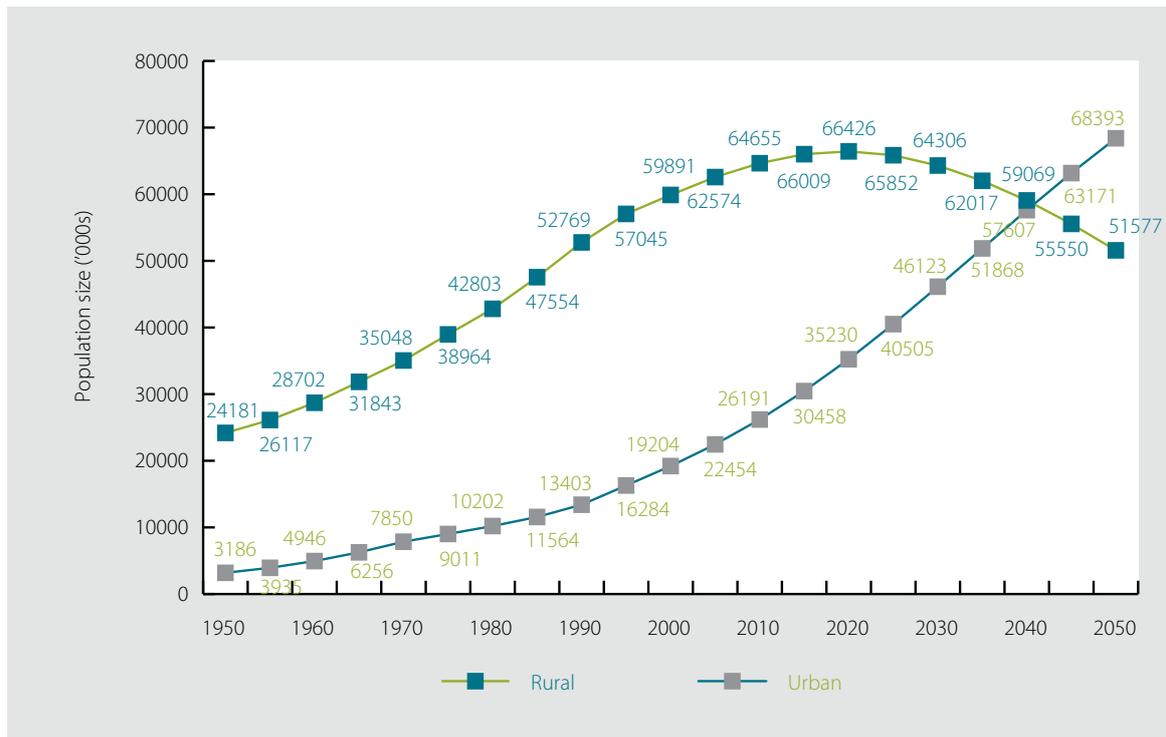
NEGATIVE EFFECTS OF RAPID URBANIZATION

Rapid urbanization poses significant challenges for Viet Nam. Viet Nam already has one of the highest levels of population density in Southeast Asia at 259 persons per kilometre, behind only the Philippines and Singapore.⁷⁷ Unsurprisingly, population density is greatest in the major cities, Ha Noi and Ho Chi Minh City. Increasingly these cities are experiencing the symptoms of rapid urbanization and congestion, with traffic jams and noise and air pollution levels already at unpleasant levels.⁷⁸ Water and air quality have been steadily declining, with contamination already above acceptable levels in both cities.⁷⁹ Infrastructure is also failing to keep pace with population growth and is proving inadequate to cope with increasing traffic. Flooding is common in urban areas in Ha Noi during the rainy season due to insufficient upgrading of drainage and storm water systems. Poor urban planning and enforcement is evident in failures to control industrial and construction pollution, approval of large-scale residential, retail and office buildings, which places a major burden on surrounding infrastructure. In addition, insufficient public services, including schools and health facilities, fail to meet the needs of an expanding urban population.⁸⁰ In common with other major Asian cities and of particular concern from a public health and safety perspective is the growth of urban slum areas, which contribute to waste and water pollution,

and increase the risk of transmission of communicable diseases. UN-Habitat estimates that around 40 percent of urban residents in Viet Nam are living in slums.⁸¹

Overcrowding in urban areas has also contributed to rising property prices and real estate speculation, with the result that housing in Viet Nam's cities is increasingly unaffordable for the poor.⁸²

Figure 2.5: Urban and Rural Population Estimates and Projections, Viet Nam, 1950-2050



Source: Van Arkadie and others. 2010 citing UNFPA population data

A PROFILE OF VIET NAM'S MIGRANTS

Migration is the single most significant factor in Viet Nam's rapid urbanization, contributing an estimated 57 percent to overall urban population growth. Migration data must be treated with caution in Viet Nam as migration rates are significantly underestimated in national surveys: the census, for example, captures permanent migrants but excludes temporary and seasonal migrants.⁸³ According to the latest census, overall internal migration rates rose from 4.5 million people in 1999 to 6.6 million people in 2009. Both urban-urban and rural-urban migration rates doubled between 1999 and 2009: with 1,719,056 million urban-urban migrants in 2009 compared to 971,468 in 1999; and 2,062,171 million rural-urban migrants in 2009 compared to 855,943 in 1999.⁸⁴ While census data does not reveal the extent of overseas migration, an estimated 400-500,000 Vietnamese people also work overseas as temporary migrants within the region and in the Middle East.⁸⁵

Migration is the single most significant factor in Viet Nam's rapid urbanization.

Census data shows a trend towards the feminization of migration, with women accounting for half the internal migrant population in 2009, and rates of female migration steadily increasing over the past two decades since the 1989 census.⁸⁶ Most migrants are also young, the average age is 25 years—23 years for rural to urban migrants. Population estimates suggest an increase in the total numbers and proportion of internal migrants by 2019 to around 10.4 million migrants, or 12 percent of Viet Nam's population.⁸⁷ The share of rural to urban migrants as a proportion of the urban population will increase from around 9 percent in 2009 to 11 percent in 2019. Migrants in the 2009 census were more likely to have received some training than non-migrants, had higher living standards, better housing and were more likely to have completed primary education.

This is in stark contrast to other studies, such as the Urban Poverty Survey conducted in 2009, which found significant diversity in terms of living standards, working conditions, and incomes among migrant workers studied. In particular, this survey found that, while migrants had similar income levels to non-migrants and were only slightly more likely to be poor than non-migrants, they had much higher levels of non-monetary poverty and, in particular, lacked social inclusion relative to residents.⁸⁸

CHALLENGES FACED BY MIGRANTS

Viet Nam's migrants face unequal access to opportunities to develop their capacities and improve their well-being. Temporary, seasonal and returning (circular) migrants are more likely to be among the poor and vulnerable than are permanent migrants who are captured by the census.⁸⁹ Non-permanent and unregistered migrants typically lack access to social services and social protection. They are also concentrated in vulnerable employment with low wages and lack access to labour protection. Even permanent migrants can have their access to social services disrupted as a result of migrating across administrative borders. Census data shows that migration disrupts schooling, with higher rates of non-attendance among migrants than non-migrants at primary and secondary levels. Rates of non-attendance were highest for inter-provincial migrants: 9 percent of 6- to 10-year-olds and 56 percent of 11- to 18-year-olds were not attending school, compared to 3 percent of non-migrants not attending primary, and 26 percent of non-migrants not attending secondary schooling.⁹⁰ The rates of non-attendance are likely to be significantly higher for temporary, seasonal and circular migrants. The Urban Poverty Survey found that migrants are less likely to be attending public schools or benefiting from school exemptions than are non-migrants. Migrants were also less likely to seek medical care when ill than were residents: lack of time and money were among the main reasons cited.⁹¹

Since the mid-2000s, new regulations aimed at improving the living conditions for internal migrants have been put in place; most notably, the 2007 Law on Residence lessens the requirements on temporary migrants seeking to gain permanent residence.⁹² This represents a significant change to Viet Nam's household registration system, which was established in the 1950s to limit population mobility and urbanization and support rationing under central planning.⁹³ However, in practice, many

migrants still lack access to key social services, in particular health and education. Many are unable to take advantage of the new regulatory environment to formalise their status in order to access these services.⁹⁴ This leads to a paradoxical situation where internal migrants, who have been, in many ways, the backbone of Viet Nam's rapid growth trajectory, and who support an estimated 50 percent of Vietnamese households via remittances⁹⁵, are in effect unable to access the full benefits of Vietnamese citizenship. This situation affects millions of Vietnamese men, women and children as discussed in Box 4.4 in Chapter Four.

CLIMATE CHANGE AND NATURAL DISASTERS

VIET NAM'S VULNERABILITY TO CLIMATE CHANGE AND NATURAL DISASTERS

One of the most significant challenges to Viet Nam's continued growth and development over the coming decades is likely to be climate change and climate-related disasters. Viet Nam is one of the countries that are most vulnerable to the effects of climate change globally, ranking sixth in the world out of countries with the highest proportion of people living in Low Elevation Coastal Zones. The Intergovernmental Panel on Climate Change (IPCC) has identified the Mekong Delta as one of three global hot spots in terms of potential population displacement as a result of sea level rises.⁹⁶ Already, Viet Nam ranks fifth globally as one of the countries in the world most affected by climate-related shocks and disasters over the past two decades, and ranks second in terms of the economic impact of these events, worth an estimated US\$1,861,000 PPP, or 1.31 percent of GDP annually.⁹⁷

Viet Nam is increasingly exposed to climate-related stresses and hazards. Climate change is resulting in more extreme natural disasters and shocks, while at the same time it is also increasing the incidence of gradual and accumulative stresses on people's lives and livelihoods. Already Viet Nam experiences more natural disasters and shocks than most other countries rated at high risk of climate change effects. Of the top-10 most affected countries from 1990 to 2009, Viet Nam experienced an average of 203 events annually, less only than the Philippines and Bangladesh. In 2009 alone, Viet Nam experienced 113 such events, causing 334

deaths and losses of 1.15 percent of GDP.⁹⁸ The impacts of climate change and natural disasters are not felt equally across Viet Nam. Not only do disaster risks, floods and droughts vary in different locations, natural disasters are more likely to affect poorer, rural households and women, who tend to rely more on natural resources and climate-sensitive activities to generate an income and are therefore particularly vulnerable to climate change stresses.⁹⁹ Typhoons account for 80 percent of disasters affecting Viet Nam, with central Viet Nam most affected, while the Mekong River Delta is particularly subject to river floods, and southern areas including the Central Highlands are regularly affected by drought and the associated risk of forest fires.¹⁰⁰

*Climate change poses specific challenges
in planning and delivery
of social services.*

Natural disasters also impact on urban communities, for example the 2010 droughts in South-East Asia affected hydroelectricity supply, bringing rolling blackouts to major centres, including Ho Chi Minh City and Ha Noi.¹⁰¹ Over the past two decades, an estimated 9,743,000 people have been killed, more than 100,000 people have been injured and 8,243,226 million people have been affected by natural disasters. Climate change poses specific challenges in planning and delivery of social services, including health and education, which are discussed in more detail in Box 2.4.

BOX 2.4: RESILIENT SOCIAL SERVICES TO COPE WITH CLIMATE CHANGE¹⁰²

Building climate change resilience in health and education requires social services to understand and cope with additional stresses from climate change. Most critical will be ‘no-regret’ measures that are beneficial regardless of whether climate change stresses are extreme or mild. Planning for climate change means that health facilities, including commune health stations, are accessible even during floods. Health professionals also need to understand the potential impacts of climatic stresses on health. Climate change has direct impacts on health and education, for example via natural disasters which cause death, injuries and infectious diseases, and disruption of access to schooling. It also causes increased demand on health services and requires more facilities to meet the needs of greater numbers of vulnerable patients.

Resilience in the context of health and education services is particularly related to continuity of services under stress, without compromising service quality. Measures are required to protect staff, and key assets such as equipment, to maintain essential functions, minimize or prevent service interruptions and provide for an effective recovery.

Between 1990 and 2009, an estimated 23,831 rooms in clinics and hospitals, and an estimated 142,206 classrooms, were damaged or destroyed as a result of natural disasters. In order to effectively plan for and adapt to climate change, service delivery organizations need to ensure infrastructure is climate proof, including both structural and non-structural elements. Ensuring continuity of services, for example, access to health facilities for the most vulnerable people in remote areas, or for the frail elderly who are not mobile, is critical. Similarly, small children need safe education and care facilities during and after floods, and special transport may be needed to get them there. Mobile services, such as ‘medical boats’ used during floods in the Mekong Delta, can help to ensure continuity of services.

Not only do services need to be ready to cope with, and adapt to, climate change and disaster risks, they can also be part of the solution. For example, use of solar energy on or near local health stations can help to minimize service disruption if public electricity is cut off during disasters. It can also be used to generate income by feeding excess power into the public electricity supply system. Strengthening innovation and high-tech research and vocational training are also central to adaptation efforts and building local and national resistance. Boosting investment in technical and science education is critical to respond to climate change and develop socio-economic opportunities from climate action.

NEW VALUES, NEW INSTITUTIONS

CHANGING EXPECTATIONS OF WELL-BEING AND QUALITY OF LIFE

The changes Viet Nam is experiencing include economic and labour market restructuring, demographic and population changes, urbanization and migration, and the emerging challenge of climate change. These changes require new kinds of responses from policymakers and decisionmakers and pose specific challenges to Viet Nam's governance system and institutions. As many of the challenges associated with Viet Nam's transformations are cross-sectoral in nature, they require a multi-sectoral Government response. They also require greater transparency, accountability and technical sophistication of Viet Nam's institutions.

Underpinning and reinforced by these changes are rapidly shifting and evolving value and attitude changes, as people's expectations and aspirations, including their expectations of government and political leaders, evolve in response to changing socio-economic circumstances. Vietnamese people are increasingly better informed: more and more Vietnamese people now access the internet and media. Around 25 percent of people use the Internet¹⁰³, and the number of households with a telephone doubled between 2006 and 2008 from 33.5 percent to 61.7 percent. Eighty-seven percent of households have a television—84 percent of rural households and 94 percent of urban households.¹⁰⁴ Changing attitudes and values are also evident among Vietnamese youth, as Box 2.5 illustrates.

BOX 2.5: CHANGING YOUTH VALUES AND EXPECTATIONS

Viet Nam's young people's life experiences and values are changing rapidly, although many still continue to adhere to traditional norms. Significant changes in attitudes and behaviours are observable over quite short periods of time, according to the Survey Assessment of Vietnamese Youth (SAVY II) conducted in 2003 and 2008.¹⁰⁵ The proportion of young Vietnamese people consuming various forms of media has increased rapidly: almost all young people watch television; 77.8 percent listen to the radio, and 79.3 percent read newspapers, up from 86.5 percent watching TV, 66.5 percent listening to the radio, and 63 percent reading newspapers in 2003. Sixty-one percent are using the Internet, up from 17 percent in the previous survey. More young people see premarital sex as acceptable than in the past—44 percent compared to 36 percent. The proportion of young people drinking alcohol has also increased, 60 percent have ever had a drink—80 percent of young men and 36 percent of young women, compared to 69 percent of young men and 28 percent of young women in the previous survey. Rates of smoking have decreased slightly, though 40 percent of young men still smoke.¹⁰⁶

Many young people in SAVY II reported feeling significant pressures, including not being able to get a job and difficulties at school and at home. While many young people expressed high hopes and expectations for the future, a significant proportion said they did not believe they would have a good income to live on; and around 59 percent reported that it is difficult to get a job. Worryingly, one in five respondents said that teachers at their school threatened or punished students and 35 percent reported that they don't want to go to school. More young people than in the past said that they found it difficult to discuss difficult issues with a family member, up to 41 percent from 32 percent in the previous survey. Forty percent reported experiencing some form of conflict in the family. More young people appear to be experiencing mental health problems as a result of these pressures: a significant proportion (around one third) reported that they "sometimes feel they are no good at all"; a majority (73 percent) reported feeling sad (more than double the 33 percent who said they felt sad in the previous survey), and 4 percent admitted to having suicidal thoughts. New services and forms of social support beyond the extended family are required to support this generation of Viet Nam's young people.

GROWING EXPECTATIONS OF GOVERNMENT

People's expectations of government and of social services are also shifting as Viet Nam develops—Vietnamese people expect government to do more than just deliver economic growth. The 2008 VHLSS governance module found that while people report improvements in administrative and social service delivery over time, they also express dissatisfaction with aspects of delivery, including corruption costs, service quality, and difficulty of administrative procedures.¹⁰⁷ As Acuña and others point out in a working paper for the National Human Development Report (NHDR):

Better fed and educated citizens demand better and more efficient administrative services from their government, less bureaucracy, corruption, patronage, nepotism and diversion or theft of public funds. They demand a public administration system that promotes development, equality and allows more participation in the decision-making processes and the implementation and monitoring of public policies.¹⁰⁸

While people report improvements in administrative and social service delivery over time, they also express dissatisfaction with aspects of delivery including corruption costs, service quality, and difficulty of administrative procedures.

There are some positive signs of change in this regard. The media and the National Assembly have increasingly been playing a strong oversight role, and both institutions have shown increasing willingness to stimulate and engage in public debate in relation to national policy decisions.¹⁰⁹ Local decisionmaking and people's participation in their communities has been strengthened. The 'grassroots democracy' initiative introduced in the late-1990s was deliberately designed to enhance people's participation, increase access to information and combat corruption at local levels, in line with the dictum: "people know, people discuss, people act and people monitor."¹¹⁰ Administrative and fiscal decentralization has included assigning an increasing proportion of taxes to local governments, and assigning spending powers over a wide range of activities to sub-national governments. These include the capacity to prioritize resources,

determine budget allocations and decide which public investment projects to pursue.¹¹¹ Provinces with higher poverty headcounts receive larger per capita transfers, so decentralization has a redistributive effect. Devolution has empowered provinces to better meet the needs of their citizens and has also encouraged competition between provinces, enabling top-performing provinces to attract investment and boost the living standards of their citizens.¹¹²

MODERNIZING VIET NAM'S INSTITUTIONS

Viet Nam does, however, face significant challenges in the governance arena, as acknowledged in the Socio-Economic Development Strategy (SEDS) 2011-2020, which identifies the need to "improve the State apparatus, generate vigorous progress in administrative reform [and] focus on building a clean and strong State administrative system ensuring unified, smooth, effective and efficient governance."¹¹³ Viet Nam is yet to fully embed the modern, sophisticated institutions and a culture of professionalism and public service required to respond to the complex challenges associated with the country's shift to medium human development and middle-income status. Continued reform of public administration and local governance systems to provide better quality public, administrative and social services to Viet Nam's people is required to support this transition. Also important are the implementation of improved, evidence-based planning and policy development processes. Increasing the participation and engagement of all Vietnamese citizens, and providing an enabling space for greater engagement by civil society organizations in the decisionmaking process as well as in service delivery are also critical to promote continued progress towards higher levels of human development.¹¹⁴

In light of the focus of this report on health and education, continued concerted effort to tackle corruption, which is recognized to be widespread in Viet Nam and which affects people's access to basic services, is particularly critical, as has been acknowledged by the Government of Viet Nam. The SEDS stresses the need to "carry out persistently, resolutely and efficiently the struggle against corruption and wastefulness as an important, pressing and long-term task."¹¹⁵ Corruption appears to be endemic in both health and education services; and is highly normalized among both service providers and clients. For example, a 2009 study by the Medical

University of Ha Noi found that over 70 percent of medical staff interviewed admitted to having breached medical ethics: requesting bribes was the most common breach.¹¹⁶ Similarly, a survey by the Government Inspectorate found that 67 percent of parents viewed it as acceptable and normal to pay for help to get their children enrolled in school.¹¹⁷ Not only does corruption hit the poor and vulnerable hardest, it has the potential to act as a brake on human development and economic progress.

Responding to people's changing values and increasingly sophisticated expectations of government and of social service delivery is key to improving human development outcomes. Improved governance and participation in social service planning, monitoring and delivery are also important. Reorienting social services to be more client focused, ensuring accountability and transparency in the way services are funded and delivered, promoting participation of non-state actors in service delivery, and countering the incentives which promote rent-seeking and corruption are among the key priorities going forward, as Section Two of this report shows.

THE PATH TO CONTINUED HUMAN DEVELOPMENT

Looking forward over the next decade as Viet Nam continues to negotiate the complex socio-economic transformations outlined in this chapter, it is evident that, as suggested in Chapter One, a renewed focus and commitment is required to ensure broad-based, inclusive economic growth and a better balance between social, human, economic and sustainable development goals. The path to economic growth

and prosperity which has served Viet Nam so well in the past now appears to be less viable: if Viet Nam is to continue to post high rates of economic growth, a fundamental shift to higher skill, high-tech industries and significantly improved productivity is required. The pressures associated with demographic change make it ever more imperative that Viet Nam continues to generate growth and create new jobs for the hundreds of thousands of young people entering the labour market each year. Population mobility, urbanization, demographic change and climatic shocks and pressures are putting pressure on existing infrastructure and services and creating new demands for social services and support.

Improved governance of social services is a fundamental requirement of the modern, technologically sophisticated society Viet Nam is fast becoming.

Accelerated governance reforms are needed to ensure Viet Nam has the capacity and the robust and sophisticated institutions in place to respond to these changes, as well as to the shifting expectations and demands of its citizens. Improved governance of social services is a fundamental requirement of the modern, technologically sophisticated society Viet Nam is fast becoming. As Section Two of this report will discuss, making the policy choices required to ensure universal access to quality health and education services and putting them into practice effectively is important if Viet Nam is to negotiate these pressures successfully, and continue on the path towards higher levels of human development.

HUMAN DEVELOPMENT IN VIET NAM— A PROVINCIAL PROFILE

HUMAN DEVELOPMENT 1999 TO 2008: KEY TRENDS

USING THE HUMAN DEVELOPMENT FAMILY OF INDEXES

Chapter One presented overall trends in human development using the Human Development Index (HDI) and its component indexes to discuss Viet Nam's progress over time, and to compare growth in Viet Nam's HDI to that of other countries in the region. This chapter focuses on changes in human development at the sub-national level over the decade from 1999 to 2008. The human development family of indexes, the HDI, Gender Development Index (GDI) and Human Poverty Index (HPI), together with their component indicators, are used to analyse progress at the national and provincial level. These indexes also analyse the extent to which income and non-income dimensions have contributed to human development. For the first time in Viet Nam, the report introduces the Multi-dimensional Poverty Index (MPI), which was localized for Viet Nam using data from the Viet Nam Household Living Standards Survey (VHLSS). While previous multi-dimensional poverty indexes have been developed specifically in relation to child poverty and urban poverty, this is the first time that the MPI has been applied to the sub-national level and for the general population. This chapter looks at those provinces that have made the greatest progress, as well as those that have seen slower growth. It examines the question of whether disparities are actually widening at a provincial level and, if so, in which specific dimensions of the

human development family of indexes these rising inequalities are evident.

At a national level, as discussed in Chapter One, Viet Nam has seen continued progress on the human development front. The HDI rose from 0.651 in 1999 to 0.728 in 2008, an increase of 11.8 percent. As noted in Chapter One, the greatest gains were seen in the income index, which rose from 0.430 in 1999 to 0.559 in 2008, an increase of 30 percent. The life expectancy index rose by 10 percent, while the education index rose by just 3.4 percent from 1999 to 2008. Most of this gain occurred in the 1999 to 2004 period, the HDI rose by 7.7 percent, the life expectancy index by 8.5 percent, the education index by 2.9 percent and the income index by 15.3 percent. Between 2004 and 2008, the income index rose by 12.6 percent, while the life expectancy index rose by 1.6 percent, and the education index saw a very slight increase. Thus, income gains have been faster and, as discussed in Chapter One, have made the primary contribution to overall improvement in the HDI over the past decade. This includes the period from 2004 to 2008 when progress in the non-income indexes slowed.

The GDI uses the same indicators as the HDI but compares male-female gaps to compose the overall index. The GDI rose from 0.650 in 1999 to 0.728 in 2008, an increase of 12 percent. In 2007, the last year for which comparable data was available for the GDI globally, Viet Nam had a GDI of 0.723, putting it ahead of Nepal, India, Cambodia and Laos, but behind Indonesia, the Philippines, China and Thailand.¹ The HPI, which reflects severity of deprivation in non-income dimensions, also

showed steady improvement, falling from 21.13 in 1999 to 10.93 in 2008. In 2007 the HPI was 12.4, again putting Viet Nam ahead of India, Nepal, Cambodia and Laos, but behind Indonesia, the Philippines, China and Thailand.² Progress in the HPI was largely a result of improved access to clean water and falling rates of child malnutrition over this period.

For the first time, this report presents the MPI for Viet Nam's provinces, using data from the 2008 VHLSS. The MPI uses nine indicators to measure deprivations in health, education and living standards. The MPI includes two different measures of deprivation: the share of people who are multi-dimensionally poor (the multi-dimensional poverty headcount) and the intensity of their poverty (the average number of deprivations that each multi-dimensionally poor household experiences). In 2008, the monetary (expenditure) poverty rate was 14.5 percent; however, the non-monetary poverty rate was 23.3 percent, suggesting a higher rate of other forms of deprivation. In addition, poverty intensity was much higher at 40.2 percent, reflecting multiple deprivations among poor households. A further 20.2 percent of the population was at risk of multi-dimensional poverty. As some of the indicators used in the localized MPI based on the VHLSS dataset differ from those used in the global HDR³, the results also differ: the 2010 HDR found a multi-dimensional poverty rate of 14.3 and intensity of deprivation of 52.5 percent for Viet Nam. The 2008 MPI for Viet Nam provides a baseline for future National Human Development Reports (NHDRs).

In Viet Nam, poverty and deprivation is concentrated in the highlands and remote and rural areas.

The human development family of indexes is acknowledged to have its limitations. For example, the HDI uses gross enrolment ratios, which are acknowledged to be a less reliable indicator of progress in education than other indicators, such as net enrolment, completion rates and average years of schooling. Nevertheless gross enrolment ratios that have traditionally been used as comparable data are available for a range of different countries. Similarly, life expectancy is used as a proxy indicator

for health. As noted in Chapter One, the original human development family of indexes are used in this report because they provide an important set of comparisons with countries in the region and globally, and enable an assessment of progress over time at the sub-national level in Viet Nam. However, this analysis of progress in human development in terms of the indexes and sub-indicators used in the human development family of indexes should be viewed with some caution, as it may not be consistent with all other key health and education indicators.

REGIONAL DISPARITIES AND INEQUALITY

Viet Nam's strong progress in the income index reflects continued economic growth and poverty reduction over the past decade, as discussed in Chapter Two. At the same time, more modest progress in the non-income dimensions of the HDI is due to slower growth in the education index in particular. However, overall progress in the HDI at the national level masks large disparities at a sub-national level. Together with economic status and ethnicity, regional and geographic disparities are among the most important determinants of inequality in Viet Nam. Geographic location plays a key role in access to services and opportunities: for example, residence has been shown to significantly reduce or increase the likelihood of dropping out of school among 11- to 18-year-olds.⁴ Geographic location is also correlated with income inequality, with very significant differences evident between regions and provinces.

In Viet Nam, poverty and deprivation is concentrated in the highlands and remote and rural areas, in particular the Northern Midlands and Mountainous Areas, the North Central Coast and the Central Highlands. Prosperity is centred in the Red River Delta, the South East, and to a lesser extent, the Mekong River Delta. These regional dynamics are evident in the analysis of the four human development indexes that follows. Before moving to this discussion, a brief overview of Viet Nam's regions is included in Box 3.1.

BOX 3.1: VIET NAM'S REGIONS—A SNAPSHOT⁵

The **Red River Delta** has a population of 19.5 million, making it Viet Nam's most populous region. People in this region score highest in terms of literacy and have the highest rates of completion of higher level schooling in the country. The region is experiencing rapid urbanization, largely focused on Hanoi. The country's formal institutions and central planning systems are based here, and the education and health systems have a long history in this region. Social infrastructure is relatively well developed; and the State remains predominant in provision of social services. This is changing however, even in Hanoi, where an increased proportion of upper-secondary students (over 40 percent in 2007⁶) now study in non-state schools. Transition to a market economy has transformed education and health policy and its implementation.

The **North and South Central Coast** have a combined population of 18.8 million people. The South Central Coast (SCC) is wealthier than the North Central Coast (NCC), which remains among the relatively poorer regions of Viet Nam. Physical ecology and social history have constrained economic development and well-being in this region. The concentrated settlements along Route 1 (the major North-South highway) give the South Central region a peri-urban character in many areas. Large cities, in particular Da Nang, Nha Trang and Quy Nhon are adding to the economic growth and vitality of the region due to their natural advantages as tourist attractions, though it also contains remote areas where economic growth has been relatively slower. Like other regions in the South, the SCC has had a relatively briefer exposure to central planning when compared to the NCC and other northern regions. Market forces have therefore historically played a greater role in the SCC as a result.

The **Mekong Delta** has a population of 17.2 million people. Although predominantly rural, the region ranks third highest in terms of income, after the South East and Red River Delta regions that contain Viet Nam's major cities. Despite relatively higher incomes, the Mekong Delta compares less well on social indicators. Historically, landlessness and land concentration have been more prevalent in this region. The local climate and geographical features present distinctive problems in education and health, including difficulties in physical access and transport, and sanitation problems.

The **South East** is Viet Nam's next most populated region with 14 million people. Along with the Red River Delta it has the highest levels of educational attainment, with more than 27 percent of the adult population having completed upper secondary education. Home to the dynamic Ho Chi Minh City, it is Viet Nam's

Map 3.1: Viet Nam's Regions



Source: UNHCR cited at <http://www.nationsonline.org>

wealthiest region and the fastest growing nationally—both in economic and demographic terms. A full array of state and market institutions and Viet Nam’s rapidly expanding ties to both regional and global economies are observable here. Given its relatively higher wealth, urban centres, and proximity to poorer areas, the South East is a major destination for both rural-urban and urban-urban migration. Urbanization is accelerating rapidly, with uneven institutional support and infrastructure. Together with other regions, the South East faces challenges in ensuring provision of social services for all its citizens.

The **Northern Midlands and Mountainous Areas** has a population of 11 million people, living in two distinct subregions, the North East coastal midlands and the mountainous North West. This region has the highest income poverty and lowest literacy rates in the country, with literacy rates under 60 percent in some provinces. In the North West, many households continue to rely on subsistence agriculture. Market-based provision of social services is negligible and state services are not adequate to meet local needs. Ethnic diversity, geographical remoteness and depressed economic conditions pose significant challenges that are different to other parts of the country

The **Central Highlands** is Viet Nam’s least populated region, with just 5.1 million people. The region has a higher concentration of indigenous groups. Fertility rates are comparatively higher with a younger overall population as a result. Population growth is also contributing to inward migration, by both Kinh majority and ethnic minority groups. This region has been, and remains, among the poorest in the country: nearly 50 percent of household incomes are spent on food. While there are indications of significant improvements in living standards, these are taking place alongside increasingly uneven income distribution, owing in part to an influx of recent, comparatively wealthy, in-migrants. Local economies in this region have been transformed by several decades of mass in-migration, and more recently an explosion in non-traditional agriculture. Social transformations are also taking place as a result of economic changes and the introduction of new infrastructure. Social tensions are evident as ethnic minority groups from many different regions are living side by side, while the social and economic environment is transforming around them, changing their traditional livelihoods and value systems.

HUMAN DEVELOPMENT IN VIET NAM’S PROVINCES

PROVINCIAL COMPARISONS

The HDI varies widely in Viet Nam’s provinces, as does growth in the HDI over time. Most provinces in Viet Nam saw progress in the HDI between 1999 and 2008. Poorer provinces made more rapid progress, but remained at lower levels of human development, while most wealthier provinces continued to move ahead. In both 1999 and 2008 the poorest provinces were those with the lowest HDI values, including Ha Giang in the North East, and Lai Chau in the North West. The provinces with the highest HDI values in both 1999 and 2008 were among Viet Nam’s most dynamic, Ba Ria–Vung Tau and Ho Chi Minh in the

South East, Hanoi in the North and Da Nang in the South Central Coast (Map 3.2).

Comparing Viet Nam’s provinces to countries in the 2009 global HDI (the latest year to use comparable indexes), levels of human development in Lai Chau and Ha Giang are comparable to countries such as Papua New Guinea and Swaziland. In Hanoi and Ho Chi Minh, levels of human development are comparable to Jordan, Belize and China.

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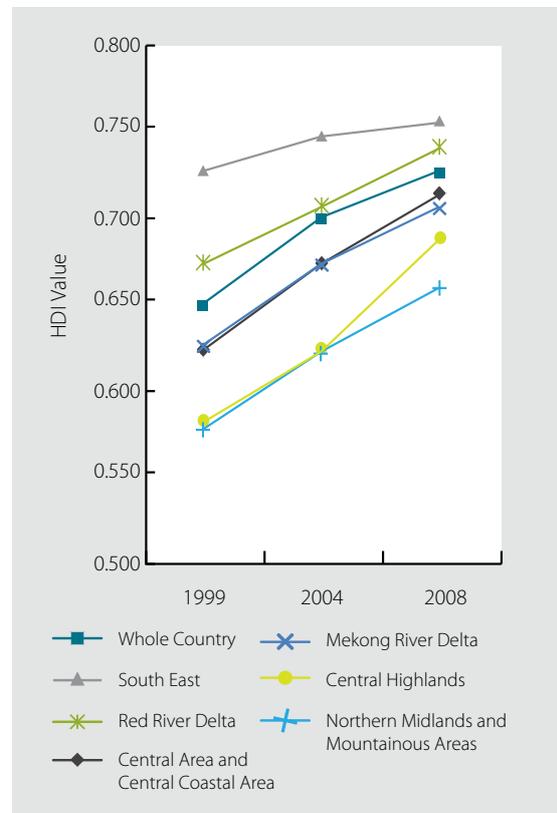
Map 3.2: Human Development Index (HDI), 2008



Source: B. Surborg for the NHDR 2011

Similarly, the most dynamic regions had the highest HDI values in both 1999 and 2008. In 2008, the HDI ranged from 0.756 in the South East to 0.660 in the Northern Midlands and Mountainous Areas. While some regions, most notably the Central Highlands and the Mekong River Delta, saw significant improvement in their HDI, the South East saw the slowest rate of growth, albeit from a much higher initial starting point (Figure 3.1).

Figure 3.1: HDI Values, Viet Nam and Six Regions, 1999-2008



Source: VASS/GSO; HDI 1999, 2004, 2008

See the Annexes for data tables

HDI GROWTH IN VIET NAM'S POOREST AND RICHEST PROVINCES

While they remained well behind the wealthier provinces, a number of Viet Nam's poorest provinces were able to achieve significant growth in their HDI values between 1999 and 2008. These included Gia Lai and Kon Tum in the Central Highlands, Son La in the North West and Lao Cai, Ha Giang, Cao Bang, and Bac Can in the North East. These provinces are among the poorest in the country and ranked in the bottom-10 provinces on the HDI in both 1999 and 2008. Despite strong improvements in human development, these provinces are still lagging behind Viet Nam's wealthier areas and were unable to significantly change their ranking over the decade. Some provinces, such as Ben Tre and Can Tho in the Mekong River Delta, were able to significantly improve their ranking.

Table 3.1: HDI Fast and Slow Growth, Viet Nam's Provinces, 1999-2008

	Province	HDI Rank 2008	HDI Rank 1999	HDI Value 2008	HDI Value 1999	Change 1999-2008 (%)
Faster HDI Growth	Gia Lai (CH)	53	59	0.667	0.519	28.5
	Lao Cai (NE)	57	57	0.644	0.527	22.3
	Son La (NW)	59	58	0.641	0.527	21.7
	Cao Bang (NE)	55	55	0.658	0.541	21.7
	Lang Son (NE)	35	52	0.702	0.581	20.8
	Kon Tum (CH)	58	56	0.641	0.535	19.8
	Ha Giang (NE)	62	60	0.570	0.477	19.4
	Ben Tre (MRD)	14	43	0.728	0.610	19.3
	Dac Lac (CH)	41	49	0.694	0.583	19.1
	Can Tho (MRD)	6	31	0.751	0.633	18.7
	Dong Thap (MRD)	43	50	0.691	0.582	18.7
Slower HDI Growth	Hung Yen (RRD)	24	13	0.718	0.661	8.7
	Binh Phuoc (SE)	38	18	0.701	0.649	8.0
	Tay Ninh (SE)	21	10	0.721	0.672	7.4
	Ba Ria-Vung Tau (SE)	1	2	0.805	0.759	6.0
	Dong Nai (SE)	9	7	0.744	0.702	6.0
	Hai Phong (RRD)	8	6	0.744	0.703	5.8
	Da Nang (SCC)	4	4	0.761	0.724	5.1
	HCM City (SE)	2	3	0.773	0.755	2.4
	Binh Duong (SE)	17	4	0.724	0.731	-0.9

Source: HDI 1999, 2008

*Oil and gas revenues are not included for Ba Ria-Vung Tau

RRD = Red River Delta, CH = Central Highlands, NE = North East, SE = South East, SCC = South Central Coast, NCC = North Central Coast, MRD = Mekong River Delta, NW = North West.

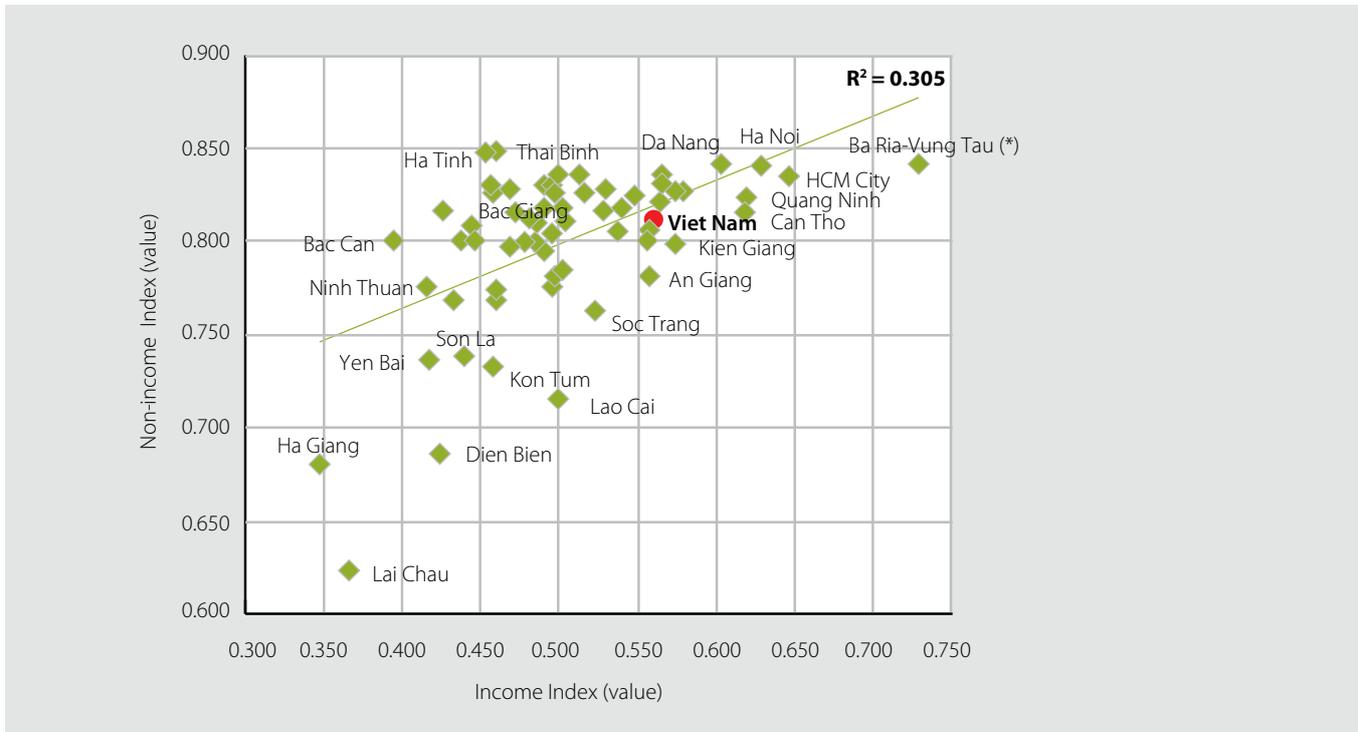
On the other hand, some of the country's wealthiest provinces, with the highest HDI values in both 1999 and 2008, saw slower growth in their HDI values over this period. These included Ho Chi Minh City, Da Nang, Hai Phong and Ba Ria-Vung Tau, which were among the top-ranking provinces in HDI value in both 1999 and 2008. These provinces already had high levels of human development in 1999 and continued to see modest gains in their HDI value between 1999 and 2008. Binh Duong, whose HDI ranking fell from 4th in 1999 to 17th in 2008, is an exception. One possible explanation may be that gross enrolment ratios in this province have fallen steadily, due in part to an increasing influx of migrants into this province. Binh Duong has the highest rate of in-migration nationally with one in three residents having migrated in, according to the 2009 census.⁷

Although growth in the HDI in some of Viet Nam's wealthier provinces slowed, a significant gap persists between the wealthier and poorer provinces.

Two trends are of concern. Firstly, while poorer provinces have been able to improve their HDI value and are closing the gap with the middle-ranking provinces, they have not been able to change their overall ranking on the HDI—poorer provinces are still unable to catch up. At the same time, although growth in the HDI in some of Viet Nam's wealthier provinces slowed, a significant gap persists between the wealthier and poorer provinces. As the following discussion will show, while economic growth has been evident in all provinces, slower growth in the life expectancy and education subindexes is slowing overall improvements in the HDI in both wealthier and poorer provinces.

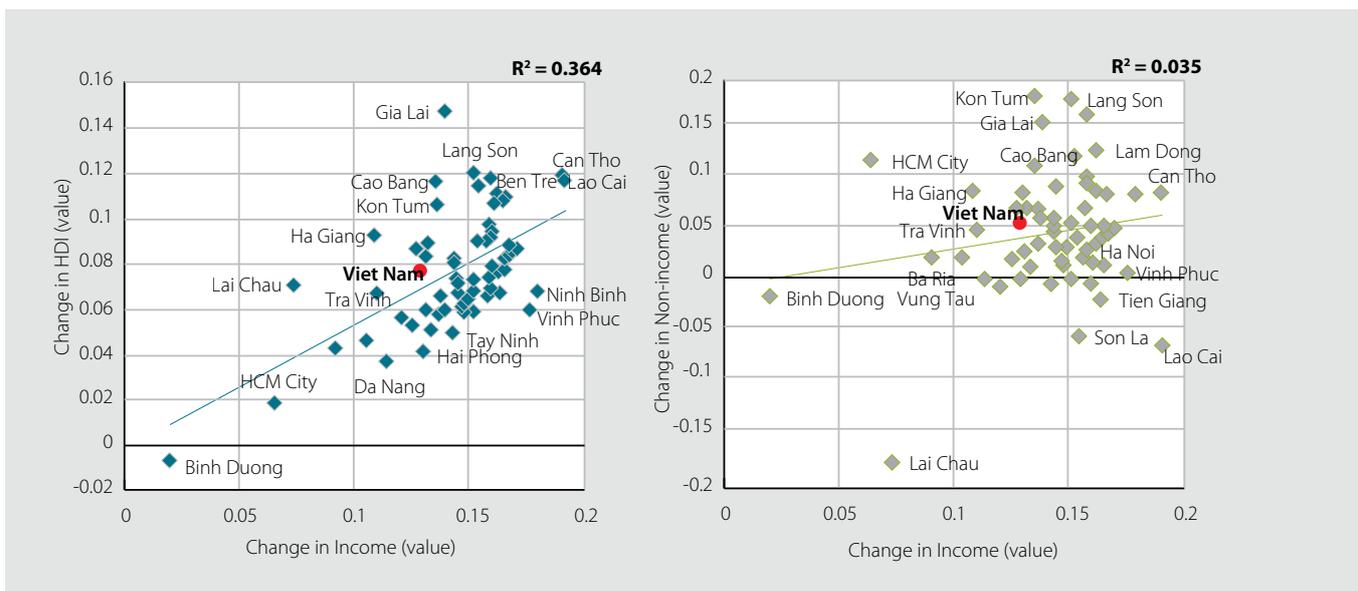
PROVINCIAL ANALYSIS USING THE HDI SUB-INDICATOR

Figure 3.2: HDI Income and Non-Income Index Values, Viet Nam's Provinces, 2008



Source: Own calculations, VASS/GSO, HDI Indexes 2008. Note that the life expectancy and education indexes have been combined to calculate a simple non-income index. $R = 0.55265$. See www.hdr.org for examples of combined indexes using the global HDR data.

Figure 3.3: Change in HDI Income and Non-Income Indexes, Viet Nam's Provinces, 1999-2008



Source: Own calculations; VASS/GSO; HDI 2008, 1999. $r=0.60393$; $r=0.18795$

Comparing the income and non-income dimensions of the HDI shows that, consistent with trends identified in the 2010 global HDR, progress on income and non-income dimensions of the HDI is not always correlated in Viet Nam's provinces. While provinces that performed strongly on the overall HDI were of course those which had higher values on the non-income (life expectancy and education) and income indexes, there was significant variation. Some provinces had relatively high income values, but below-average, non-income values. These included provinces in the Mekong River Delta such as Soc Trang and An Giang. Other provinces had lower-than-average income values, but were nevertheless able to achieve relatively higher levels of non-income human development. These included provinces such as Ha Tinh on the North Central Coast and Thai Binh in the Red River Delta. These two provinces had higher levels of non-income human development than Hanoi, Da Nang and Ho Chi Minh City.

In order to understand these dynamics, it is helpful to also examine changes over time in the non-income and income dimensions of the HDI. Obviously, those provinces that saw the greatest overall improvement in the HDI between 1999 and 2008 (the poorer provinces listed in Table 3.1) were those that were able to achieve progress in both the income and non-income dimensions of the HDI, albeit, often from a very low starting point. However, in many cases provinces saw improvements in the income index, but only modest progress on the non-income dimensions of the HDI, thus slowing their overall HDI growth. Figure 3.3 illustrates this point, in line with analysis presented in the 2010 global HDR (see Figure 1.1), showing that positive change in the value of the income index is correlated with progress in the overall HDI, but weakly correlated with progress in the non-income indexes. In other words, economic growth has driven improvements in the HDI at the provincial level, but this is not always correlated with improvements in the life expectancy and education subindexes.

Indeed, some provinces which experienced income growth between 1999 and 2008 actually experienced declining non-income values over the same period; these included Lao Cai, Son La and Tien Giang. While a majority of provinces saw increases of more than 30 percent in their income index during this period, increases in the life expectancy and education indexes were more modest, and a few provinces actually experienced a slight drop in

their life expectancy and education indexes. A third of provinces experienced falling gross enrolment ratios: however, in most of these cases rising literacy levels balanced out this effect, resulting in an overall gain in the education index. In other words, many provinces that saw a moderate improvement in their HDI value experienced a pattern of rapid GDP per capita Purchasing Power Parity (PPP) income growth but falling gross enrolment ratios: in effect their gains masked their losses. Around one third of the 63 provinces for which there is data in both 1999 and 2008 experienced this trend.

While Viet Nam is experiencing rising incomes, progress in the education dimension of the HDI is slowing.

Nationally, while GDP per capita income rose by 115.7 percent between 1999 and 2008, gross enrolment ratios increased by just 2.4 percent. Most of the gains in the life expectancy and education indexes occurred in the earlier part of the decade, from 1999 to 2004. Between 2004 and 2008, gross enrolment ratios rose by less than one percent at the national level, while GDP per capita PPP rose sharply by 45 percent. Thus, and consistent with the analysis presented in Chapter One, while Viet Nam is experiencing rising incomes, progress in the education dimension of the HDI is slowing. One possible explanation for the trend of slower growth in gross enrolment ratios may be increased commercialization of education services and exclusion of a proportion of the population who were previously able to access subsidised education services, as discussed in the following chapters. However, these trends should be interpreted with some caution given limitations associated with using gross enrolment ratios as an indicator of progress in education.

Although GDP per capita PPP rose significantly in most provinces between 1999 and 2008, there continues to be a marked income gap between the wealthiest and the poorest provinces. Ho Chi Minh province had an income of US\$4,834 GDP per capita PPP in 2008, almost six times that of Ha Giang province, which had GDP per capita of just US\$801 in PPP terms. The gap has, however, narrowed from 9.6 times in 1999, reflecting strong economic growth across Viet Nam.

Similarly, between 1999 and 2008, there was a slight fall in the gap in life expectancy and literacy rates between the provinces, with the highest and lowest rates for these two indicators. In 2008 there was a gap in life expectancy of 12 percent and 36 percent in literacy

rates between the provinces with the highest and lowest levels. However, the gap in gross enrolment ratios between the provinces with the highest and lowest ratio rose from 33 percent in 1999 to 40 percent in 2008.

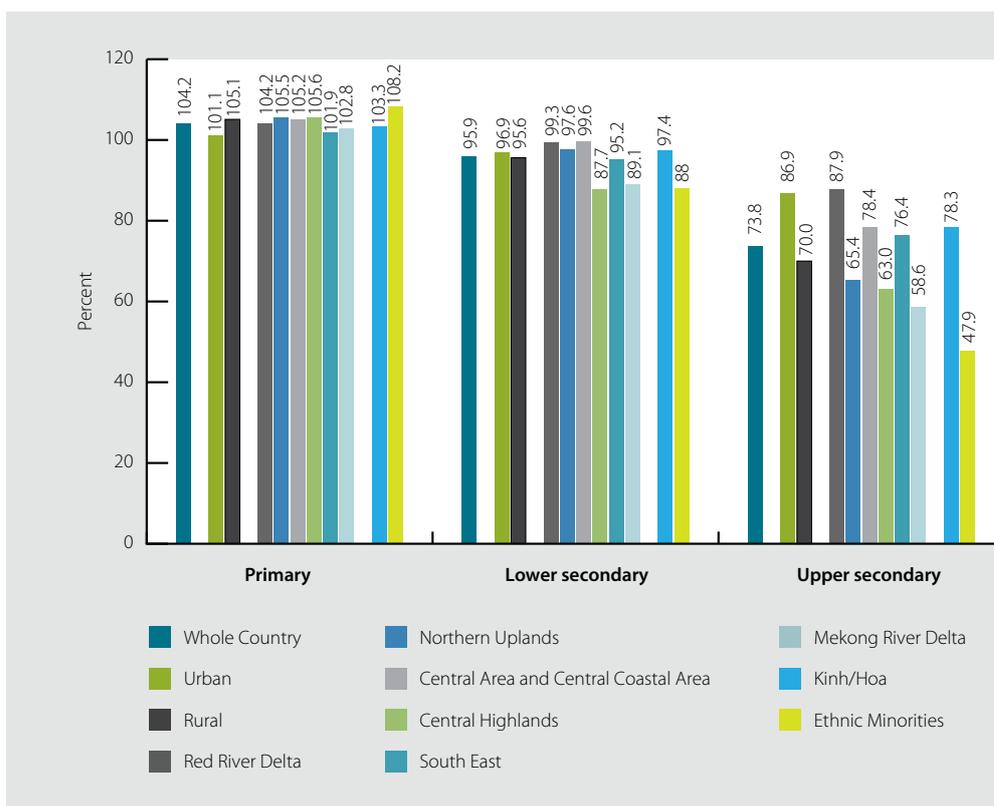
Notably, some of Viet Nam's wealthiest provinces, including Ho Chi Minh and Hai Phong (both provinces with high net in-migration), had gross enrolment ratios well below the national average in 2008. Gross enrolment ratios fell in Binh Duong (by 31 percent), Hai Phong (by 13.4 percent) and Da Nang (by 12 percent) between 1999 and 2008, as well as in some poorer provinces such as Kon Tum and Ha Giang. This decline largely took place between 2004 and 2008 in some wealthier provinces as gross enrolment ratios fell by 14 percent in Ho Chi Minh City, 12 percent in Hai Phong, 12 percent in Da Nang and 3 percent in Hanoi during this period. This is compared to little decline or even improvements in these provinces between 1999 and 2004. There are several possible explanations for this trend: firstly, these are areas which have seen a significant influx of migrants and children of migrants are more likely to be out of school as discussed in Chapter Two. Secondly, as the following chapters will show, the cost of education has risen significantly, in particular in urban areas, which may restrict poor migrant children's access

to education. Notably, 2009 census data shows high drop-out rates among the population aged 5 to 18 in some of these provinces. For example, Binh Duong province had a drop-out rate of 30.8 percent in 2009.⁸

EDUCATION GAPS IN ETHNIC MINORITY GROUPS AND REGIONS

Significant gaps in gross enrolment ratios persist between ethnic minorities and the Kinh majority, as well as between regions, and may help to explain slow progress on the education index across the country. According to the 2008 VHLSS, ethnic minority groups had gross enrolment ratios of 88 percent compared to 97.4 percent for the Kinh majority at the lower secondary level, and 47.9 percent compared to 78.3 percent at the lower secondary level. Similar gaps are apparent in some of Viet Nam's regions: low gross enrolment ratios for upper secondary education are evident in the Mekong River Delta, the Central Highlands and the Northern Uplands (Figure 3.4). Thus, part of the explanation for limited progress in overall gross enrolment ratios may be that specific population groups are lagging behind, while the wealthier, Kinh majority population continues to achieve higher educational attainment.

Figure 3.4: Gross Enrolment Ratios by Ethnicity and Region, Viet Nam, 2008



Source: VHLSS 2008

LAGGING EDUCATION OUTCOMES AFFECT SUB-NATIONAL HUMAN DEVELOPMENT

As this discussion has shown, economic growth, represented by GDP per capita PPP, has been the main contributor to progress in the HDI at both the national and the provincial level. However, rising incomes are not always correlated with progress in non-income dimensions of the HDI and, in the case of Viet Nam, have masked limited improvements in the education index in some provinces. Slow progress in the education index at the sub-national level as a result of lagging gross enrolment ratios is evident in both wealthy and poorer provinces. This slow progress is now hindering Viet Nam's continued progress in the HDI at a provincial and national level. Gross enrolment ratios are lagging among specific regions, socio-economic groups and ethnic minority communities, and declined in a third of provinces between 2004 and 2008. Notably these deprivations are evident in some of Viet Nam's more dynamic regions such as the Red River Delta and the South East. Although some of the country's poorest provinces have been able to achieve progress in both income and non-income dimensions of the HDI, some wealthier provinces have seen slower progress due to lagging or declining education outcomes in particular. As Chapter One noted, given the priority accorded to education in Viet Nam's development goals for the 2011 to 2020 period, this is cause for concern and should be a priority for policymakers.

Slow progress in the education index at the sub-national level as a result of lagging gross enrolment ratios is evident in both wealthy and poorer provinces.

GENDER DISPARITIES PERSIST IN THE HOUSEHOLD AND LABOUR MARKET

Viet Nam is a strong performer on gender equality within the region, but gender disparities persist, especially in the household and labour market. High rates of economic participation of women, strong representation in national parliament, and gender parity in education at primary and lower secondary levels are among Viet Nam's achievements. Still, there are significant continuing disparities, with lower levels of women's representation in sub-national government, continuing wage disparities in formal and informal work, and a concentration of women in vulnerable, informal jobs.⁹

GENDER INEQUALITY AT THE SUB-NATIONAL LEVEL

Map 3.3: Gender-related Development Index (GDI), 2008



Source: B. Surborg for the NHDR 2011

Recent studies also show signs of persistent gender inequality within the household. Nationally, 34 percent of women have experienced physical or sexual violence from their husband or spouse in their lifetime, the number rises to 58 percent when emotional abuse is included. More than half of these women did not seek any help.¹⁰ Rising sex ratios at birth in some provinces, discussed in Chapter Two, reflect a strong and persistent preference for sons. Evidence suggests that families invest more in the health of their boys than of their girls. Although health care for children under 6 is free, a 2008 Ministry of Health study found 39 percent of girls to 61 percent of boys were being treated in three national hospitals.¹¹ In poorer households girls are more likely to be pulled out of school in times of hardship. This is often also the case in ethnic minority communities.¹²

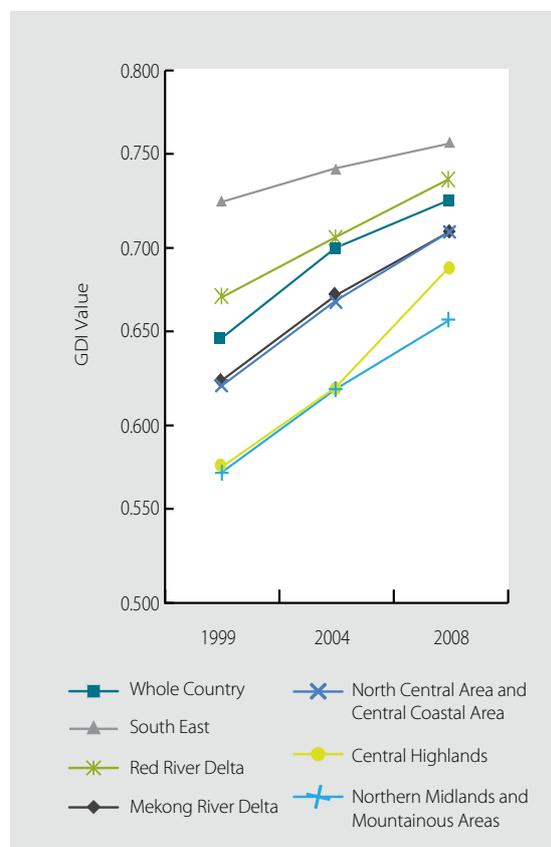
Viet Nam is a strong performer on gender equality within the region, but gender disparities persist, especially in the household and labour market.

THE GENDER GAP IN PROVINCES AND REGIONS

The Gender-related Development Index (GDI) measures the gender gap in human development, showing gender differentials in the four indicators and three indexes that make up the HDI. In Viet Nam, high female life expectancy rates, and gender parity in education, together with a steadily narrowing wage gap, have contributed to improvements in the GDI at both national and provincial levels. These improvements in the GDI have narrowed the gender gap between provinces and regions.

Not only have GDI values risen over time in all provinces, the gap between the provinces with the highest and lowest values has steadily narrowed, from 65 percent in 1999 to 62 percent in 2004 and 51 percent in 2008. The gap has also narrowed between Viet Nam's regions over time, with the highest GDI values in the South East and Red River Delta. Figure 3.5 shows the national and regional GDI trends. The GDI rose in all regions between 1999 and 2008, though progress in the South East was slower between 2004 and 2008 than other regions.

Figure 3.5: GDI values, Viet Nam and Six Regions, 1999-2008



Source: VASS/GSO; GDI 1999, 2004, 2008
See the Annexes for data tables

GENDER GAPS IN INCOME AND EDUCATION

In 2008, the top-ranking provinces were the same for the GDI and HDI, Viet Nam's wealthiest and most dynamic provinces: Ba Ria-Vung Tau, Ho Chi Minh, Hanoi and Da Nang had the highest GDI values in 2008. The bottom-ranking provinces were among the country's poorest: Dien Bien and Lai Chau in the North West and Ha Giang in the North East. Map 3.3 shows the range of GDI values in 2008.

However, in terms of overall improvements in the GDI between 1999 and 2008, while gender gaps are worst in the poorest provinces, these provinces saw greater improvement over time. These include Gia Lai and Kon Tum in the Central Highlands, Son La and Lao Cai in the North West and Lang Son and Cao Bang in the North East, which were all in the bottom-10 provinces in 1999 and in 2008 (see Table 3.2). Conversely, provinces that saw slower progress in the GDI during the 1999 to 2008 period were better off provinces such as Ba Ria-Vung Tau, Ho Chi

Minh City, Binh Duong, Da Nang and Hai Phong, which already had high GDI values in 1999.

As with the HDI, improvements in the GDI have been primarily driven by income change—both rising incomes overall, and greater gender equity in their distribution. From 1999 to 2008 the equally distributed income index increased by 31 percent, the equally distributed life expectancy index increased by 10 percent, and the equally distributed education index increased by 3 percent. While income growth and the narrowing of gender

gaps in income between men and women have largely been responsible for improvements in the GDI, it is useful to look at the gender gap in the different indicators in 2008 and the extent to which this is narrowing or widening over time.

Significant gender disparities in income are evident in some of Viet Nam's most dynamic provinces, where incomes are rising rapidly.

Table 3.2: GDI Fast and Slow Growth, Viet Nam's Provinces, 1999-2008

	Province	GDI Rank 2008	GDI Rank 1999	GDI Value 2008	GDI Value 1999	Change 1999-2008 (%)
Fast GDI Growth	Gia Lai (CH)	52	58	0.667	0.512	30.41
	Lao Cai (NE)	57	57	0.643	0.520	23.59
	Cao Bang (NE)	55	54	0.658	0.536	22.69
	Son La (NW)	59	56	0.637	0.521	22.28
	Lang Son (NE)	35	50	0.702	0.578	21.51
	Ha Giang (NE)	62	59	0.566	0.467	21.25
	Kon Tum (CH)	58	55	0.641	0.530	20.94
	Dac Lac (CH)	40	51	0.694	0.578	20.13
	Ben Tre (MRD)	14	41	0.728	0.609	19.55
	Quang Ngai (SCC)	44	49	0.689	0.579	19.04
Slow GDI Growth	Hai Duong (RRD)	15	11	0.723	0.663	9.06
	Hung Yen (RRD)	25	12	0.718	0.661	8.69
	Binh Phuoc (SE)	37	18	0.702	0.648	8.33
	Tay Ninh (SE)	19	10	0.720	0.670	7.45
	Dong Nai (SE)	8	6	0.744	0.701	6.11
	Ba Ria-Vung Tau (SE)	1	1	0.803	0.759	5.82
	Hai Phong (RRD)	9	5	0.744	0.703	5.76
	Da Nang (SCC)	4	4	0.760	0.721	5.46
	HCM City (SE)	2	2	0.771	0.753	2.35
	Binh Duong (SE)	17	3	0.723	0.729	-0.94

Source: GDI 1999, 2008

RRD = Red River Delta, CH = Central Highlands, NE = North East, SE = South East, SCC = South Central Coast, NCC = North Central Coast, MRD = Mekong River Delta, NW = North West.

Those provinces with the greatest gender gap in education in 2008 included some of the poorest nationally, Lai Chau, Dien Bien, and Son La in the North West, Ha Giang, Lao Cai and Yen Bai in the North East, as well as Tra Vinh in the Mekong River Delta. This is because gender gaps in literacy of up to 20 to 30 percent persist in some of Viet Nam's poorest provinces. In Lai Chau, for example, female literacy rates were 48 percent compared to 75.5 percent for men, in Dien Bien they were 60.5 percent to 83.4 percent, and in Ha Giang they were 62.7 percent compared to 84.1 percent for men. Similarly, in some provinces the gender gap in combined gross enrolment ratios was as high as 30 percent. In Dien Bien, female gross enrolment ratios were 55.3 percent compared to 78.5 percent for males, in Son La they were 55 percent for females compared to 71.3 percent for men and in Lai Chau they were 51.4 percent compared to 65.6 percent for males.

On the other hand, those provinces with the greatest gender gap in the income index were in the South. These included Cau Mau, Soc Trang, Bac Lieu, Tra Vinh, Anh Giang, Kien Giang and Tien Giang in the Mekong River Delta, together with Binh Duong, Ba Ria-Vung Tau and Ho Chi Minh in the South East. In some provinces female GDP per capita PPP is 50 to 60 percent that of male GDP per capita PPP including in Ca Mau (51 percent), Soc Trang (58 percent), Ba Ria-Vung Tau, Bac Lieu and Tra Vinh (all 59 percent).

Again, these trends are influenced by regional disparities as well as income and ethnic differences. Table 3.3 shows the differential achievements in adult literacy, combined gross enrolment ratios and GDP per capita between men and women in 2008 in Viet Nam's regions.

Table 3.3: GDI Indicators, Viet Nam's Six Regions, 2008

	Life expectancy at birth (male–years)	Life expectancy at birth (female–years)	Adult literacy rate (male–%)	Adult literacy rate (female–%)	Combined gross enrolment ratio for male (%)	Combined gross enrolment ratio for female (%)	GDP per capita for male (PPP US\$)	GDP per capita for female (PPP US\$)	GDI Value
Northern Midlands and Mountainous Areas	67.17	72.88	92.85	83.47	64.41	59.61	1349.1	1493.0	0.660
Red River Delta	71.55	76.68	98.56	94.64	63.25	61.91	3265.4	2759.1	0.741
North Central Area and Central Coastal Area	68.93	74.46	96.67	91.84	66.73	70.60	2040.6	1768.5	0.707
Central Highlands	67.54	73.25	92.74	87.06	66.23	69.08	1940.0	1766.4	0.689
South East	72.68	77.68	97.52	94.94	52.97	54.53	5064.7	3350.6	0.755
Mekong River Delta	70.87	76.13	94.22	89.34	55.76	57.04	3092.1	2004.1	0.712

Source: GDI 2008

At a national level, gender gaps in GDP per capita narrowed from 27 percent in 1999 to 17 percent in 2008, and the gender gap in gross enrolment ratios fell from 7 percent to no gender gap by 2008. The gap in adult literacy rates narrowed slightly from 7 to 5 percent. The life expectancy gap actually increased slightly; however, as in 1999 women lived an average

of 3.5 years longer than men, compared to just over 5 years in 2008.

However, while a majority of provinces saw narrowing gender gaps in education and were successfully moving towards gender equity, a few provinces saw widening gender gaps in gross

enrolment ratios between 1999 and 2008. These included Thai Nguyen, and Quang Ninh in the North East, Son La and Hoa Binh in the North West, Khanh Hoa in the South Central Coast and Ninh Binh in the Red River Delta. Also of note, Hanoi, Nam Dinh, Ninh Binh and Thai Binh, all of which are in the Red River Delta, together with Ninh Thuan in the South East and Thai Nguyen in the North East, all saw widening gender gaps in gross enrolment ratios in the 2004 to 2008 period.

In addition, while overall improvements in the GDI were driven by strong income growth, and a narrowing of the gender gap in GDP per capita was evident in most provinces between 1999 and 2008, a number of provinces in Viet Nam's wealthier regions did experience widening gender gaps in GDP per capita PPP for men and women over this period. These included Ho Chi Minh City and Ba Ria-Vung Tau in the South East; An Giang, Bac Lieu, Can Tho, Cau Mau, Kien Giang, Soc Trang, Tien Giang and Tra Vinh in the Mekong River Delta; Hanoi, Hai Phong, Ha Nam and Nam Dinh in the Red River Delta and Lam Dong in the Central Highlands.

Thus, two distinct patterns of gender inequality are evident in the GDI. Firstly, significant gender disparities in education persist in Viet Nam's poorest provinces. Secondly, significant gender disparities in income are evident in some of Viet Nam's most dynamic provinces, where incomes are rising rapidly, in particular in the South East and the Mekong River Delta. At the same time, greater gender equality in education is evident in the wealthier provinces, while greater gender parity in (lower overall) incomes appears to be the trend in some of the poorer provinces. Intersecting with these trends is a slight downward turn in education in terms of male-female gaps in gross enrolment ratios in some provinces. This has occurred in particular in poorer provinces in the north as well as some better off provinces in the Red River Delta. There is also a widening income gap in some of Viet Nam's more dynamic regions such as the Mekong River Delta, Red River Delta and the South East. This suggests a widening gap in access to education, with women

in some provinces falling further behind, and may also indicate that women in some provinces are gaining a less-than-equal share of Viet Nam's rapid economic growth, as noted in Chapter Two.

NON-MONETARY POVERTY AND DEPRIVATION

USING MULTI-DIMENSIONAL POVERTY INDEXES TO CAPTURE NON-MONETARY DIMENSIONS OF DEPRIVATION

The third main index in the human development family of indexes is the Human Poverty Index (HPI). This measures the extent of deprivations in living standards in the dimensions of life expectancy, adult illiteracy, access to clean water and child malnutrition. The HPI is therefore an important complement to poverty rankings based on income and consumption measures. As previously mentioned, this report introduces and discusses a multi-dimensional poverty index (MPI) that measures nine different forms of deprivation in health, education and living standards. However, as the MPI is only available for 2008, the HPI is used to discuss changes in non-monetary deprivation over the 1999 to 2008 period.

As noted in Chapter Two, Viet Nam's national expenditure poverty rate in 2008 was 14.5 percent. The HPI for Viet Nam in 2008 was 10.93 percent, suggesting a slightly lower level of non-material deprivation than monetary deprivation in Viet Nam. However, the national MPI non-monetary poverty rate for Viet Nam was much higher at 23.3 percent (the proportion of the total population who are multi-dimensionally poor).

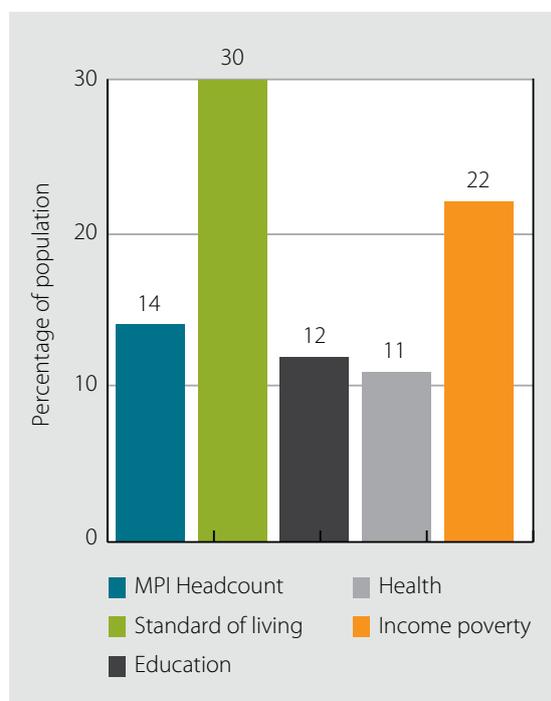
This is broadly consistent with the Child Poverty Rate (CPR) developed by MOLISA and UNICEF, which uses ten different indicators of poverty and deprivation. Viet Nam had a CPR of 20.7 percent for monetary poverty and 28.9 percent for multi-dimensional poverty in 2008.¹³

Map 3.4: Human Poverty Index (HPI), 2008



Source: B. Surborg for the NHDR 2011

Figure 3.6: 2010 Global HDR Multi-dimensional Poverty Index (MPI), Viet Nam, 2010



Source: Global HDR 2010

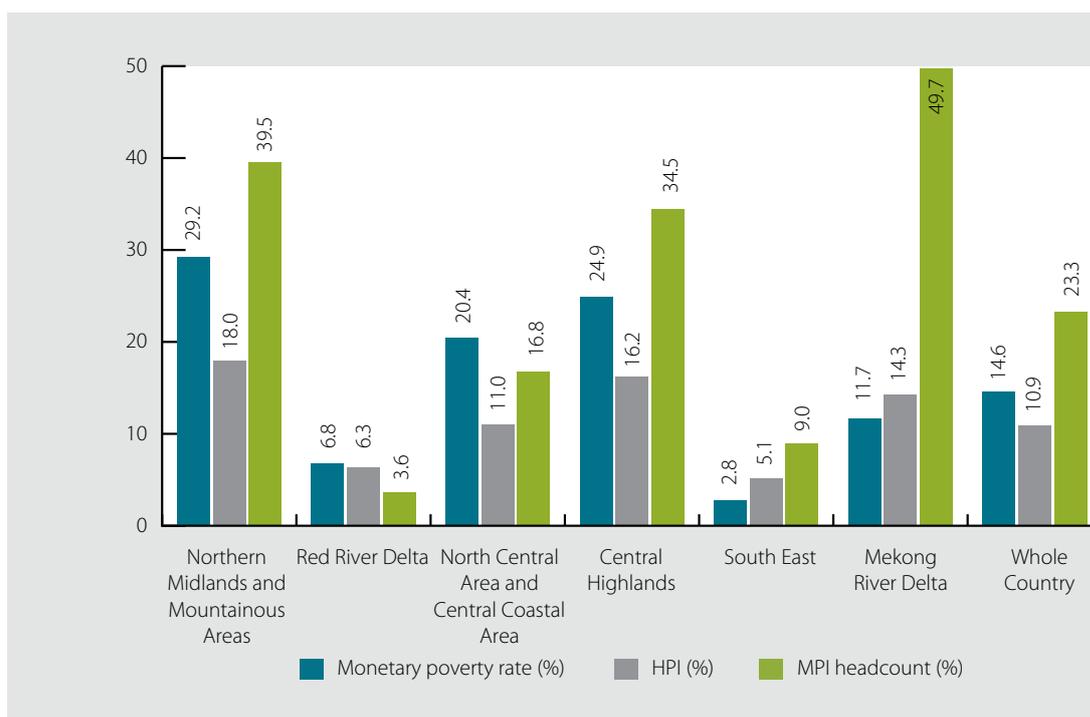
Higher rates of non-monetary poverty in the MPI compared to the HPI can be explained by the use of a higher number of more relevant indicators in the MPI; the HPI measures basic needs and deprivations and is a particularly relevant indicator for low-income countries. A wider definition of deprivation is relevant for Viet Nam as a middle-income country, and thus the MPI has been adopted for the 2011 national HDR.

Notably, the intensity of poverty was high at 40 percent in the 2008 localized MPI. This suggests that while a relatively small proportion of the population are multi-dimensionally poor, they experience multiple deprivations. In addition, the proportion of the population at risk of multi-dimensional poverty was 20 percent in the localized MPI. While most regions had higher expenditure poverty rates than HPI values, this was not the case in the South East and in the Mekong River Delta, which had a HPI of 5.1 percent and 14.3 percent respectively. This is a notable finding given the economic dynamism of the South East in particular, supporting the overall finding of this report that economic growth and poverty reduction are not always correlated with improvements in living standards and non-income human development outcomes.

However, the proportion of people who are multi-dimensionally poor according to the MPI was higher than that of people experiencing monetary poverty in four of the six regions in Viet Nam. The MPI headcount was highest in the country's poorest region, the Northern Midlands and Mountainous Areas, with a 40 percent rate of non-monetary poverty. However, the MPI headcount was also extremely high in the Mekong River Delta, with almost 50 percent experiencing non-monetary poverty, compared to just 11.7 percent experiencing monetary poverty, due to the high proportion of people experiencing both education and living standards deprivations in this region. Figure 3.7 shows the HPI, MPI and monetary poverty rates for Viet Nam's six regions in 2008.

In terms of different socio-economic groups, the MPI was five times higher in rural than in urban areas, at 29.9 percent compared to 5.9 percent, while 61.9 percent of ethnic minority groups experienced multi-dimensional poverty compared to 17.4 percent of the Kinh/Hoa majority. By income quintile, 49 percent of the poorest quintile are multi-dimensionally poor according to the MPI; however it should be noted that 5.7 percent of the richest quintile, 12.8 percent of the second richest quintile and 21.9 percent of the middle quintile are also multi-dimensionally poor, as they experience non-monetary forms of deprivation. As is the case with monetary poverty, there is a slight difference between men and women, 24.3 percent of women are multi-dimensionally poor, compared to 22.3 percent of men.

Figure 3.7: HPI, MPI Headcount and Monetary Poverty Rate, Viet Nam and Six Regions, 2008



Source: VASS/GSO; HPI and MPI 2008; VHLSS 2008

NON-MONETARY POVERTY IN VIET NAM'S POORER PROVINCES

MPI headcount rates were very high among the poorest provinces, at 82.3 percent in Lai Chau, 75 percent in Dien Bien, and 73 percent in Ha Giang. Indeed, 12 provinces had more than 50 percent of their population experiencing multi-dimensional poverty according to the MPI. Most of the provinces experiencing high rates of non-monetary poverty were among those provinces that had the highest monetary

poverty rates as well. Lai Chau had the highest monetary poverty rate nationally at 61.3 percent, Dien Bien had the second highest rate at 49 percent and Ha Giang at 43 percent was third.¹⁸² Notably however, Vinh Long had a much lower monetary poverty rate at 10 percent, compared to 30.2 percent for the HPI and 71.3 percent for the MPI. This is primarily due to a high proportion of the population experiencing deprivations in living standards, including lack of access to clean water and sanitation. Map 3.4 shows the distribution of HPI values in 2008 by province, while MPI data is shown in Table 3.4.

Table 3.4: Multi-dimensional Poverty, Viet Nam's Provinces, 2008

Rank	Province	MPI	Population in multi-dimensional poverty		Population at risk of multi-dimensional poverty*	Monetary poverty
		H*A	Headcount (H) (%)	Intensity of deprivation (A) (%)	(%)	National poverty line** (%)
1	Hanoi	0.0053	1.5	34.9	7.5	1.7
2	HCM	0.0071	2.1	34.1	4.6	0.5
3	Hai Duong	0.0087	2.5	35.0	11.4	8.9
4	Bac Ninh	0.0091	2.7	34.0	10.9	5.9
5	Hung Yen	0.0100	2.8	35.0	11.2	7.1
6	Hai Phong	0.0108	3.0	35.8	10.8	4.9
7	Da Nang	0.0110	3.0	36.3	5.0	3.0
8	Thai Binh	0.0137	3.9	35.1	16.7	8.5
9	Ba-Ria Vung Tau	0.0151	4.2	36.1	13.4	7.0
10	Nam Dinh	0.0185	5.0	36.7	16.7	7.7
11	Ha Nam	0.0197	5.5	36.1	22.6	8.4
12	Binh Duong	0.0211	5.9	35.8	17.4	0.5
13	Quang Ninh	0.0299	6.8	43.9	10.3	7.2
14	Vinh Phuc	0.0244	7.0	34.8	28.7	11.3
15	Ninh Binh	0.0324	9.2	35.3	31.8	12.9
16	Bac Giang	0.0392	10.5	37.4	22.4	17.5
17	Ha Tinh	0.0441	11.7	37.8	23.3	28.2
18	Nghe An	0.0534	12.8	41.6	23.7	24.9
19	Phu Tho	0.0549	14.8	37.1	24.2	17.4
20	Thanh Hoa	0.0570	15.0	38.0	23.5	26.3
21	Binh Dinh	0.0552	15.4	35.8	36.3	13.3
22	Quang Binh	0.0599	16.1	37.2	26.6	23.6
23	Dong Nai	0.0662	16.8	39.5	18.4	4.3
24	Khanh Hoa	0.0685	17.4	39.4	18.9	10.7
25	Lam Dong	0.0658	17.4	37.9	23.8	18.3
26	Phu Yen	0.0694	19.2	36.0	33.1	17.6
27	Thai Nguyen	0.0751	19.7	38.1	22.6	17.5
28	Binh Thuan	0.0784	20.2	38.8	21.1	9.3
29	Hue	0.0814	20.3	40.0	23.2	15.7
30	Quang Tri	0.0783	20.4	38.5	30.6	27.6
31	Quang Nam	0.0822	21.3	38.6	25.3	20.7
32	Binh Phuoc	0.0928	23.2	40.1	25.9	10.1
33	Quang Ngai	0.0881	23.4	37.6	27.2	21.7
34	Dak Nong	0.1009	27.0	37.4	36.4	26.7
35	Hoa Binh	0.1160	31.2	37.2	36.0	32.3
36	Tay Ninh	0.1210	31.9	37.9	26.1	5.6
37	Ninh Thuan	0.1373	33.5	41.0	21.2	21.2
38	Long An	0.1309	35.0	37.4	31.5	7.6
39	Dak Lak	0.1341	36.0	37.3	28.7	24.6

		MPI	Population in multi-dimensional poverty		Population at risk of multi-dimensional poverty*	Monetary poverty
			Headcount	Intensity of deprivation		National poverty line**
40	Tien Giang	0.1449	38.3	37.8	32.3	10.7
41	Can Tho	0.1676	39.3	42.6	19.5	6.9
42	Tuyen Quang	0.1577	41.2	38.2	29.0	23.3
43	An Giang	0.1899	45.0	42.2	23.1	8.5
44	Lang Son	0.1716	45.0	38.1	34.1	21.2
45	Bac Kan	0.1817	45.2	40.2	28.4	39.9
46	Yen Bai	0.1997	45.4	44.0	22.4	24.6
47	Bac Lieu	0.1773	46.1	38.4	24.2	12.4
48	Ca Mau	0.1806	46.2	39.1	26.2	13.7
49	Gia Lai	0.1916	46.3	41.4	24.9	29.1
50	Kien Giang	0.1987	49.2	40.4	23.8	9.5
51	Kon Tum	0.2074	50.1	41.4	23.2	32.0
52	Ben Tre	0.2006	51.0	39.3	29.2	15.5
53	Tra Vinh	0.2143	55.0	38.9	25.6	20.7
54	Lao Cai	0.2591	57.0	45.4	19.4	37.7
55	Soc Trang	0.2363	57.7	41.0	21.0	19.2
56	Son La	0.2513	60.1	41.8	25.3	42.4
57	Hau Giang	0.2379	60.6	39.3	26.9	13.8
58	Cao Bang	0.2819	60.9	46.3	22.0	42.0
59	Dong Thap	0.2800	65.6	42.7	19.4	10.3
60	Vinh Long	0.2898	71.3	40.7	14.8	10.0
61	Ha Giang	0.3325	73.0	45.6	11.4	43.0
62	Dien Bien	0.3622	75.0	48.3	11.3	49.0
63	Lai Chau	0.4119	82.3	50.0	7.8	61.3
Whole country		0.0936	23.3	40.2	20.2	14.6

Source: GSO based on VHLSS 2008.

*People at risk of suffering multiple deprivations—that is those suffering from overlapping deprivations in any two of nine indicators used.

**The national poverty line in 2008 was 290,000 VND per person per month in rural areas and 370,000 VND per person per month in urban areas.

Most provinces in the Red River Delta have a combination of a very low MPI headcount of less than 10 percent, with an average deprivation share between 40 and 45 percent, suggesting high poverty intensity. In contrast, most provinces in the Northern Midlands and Mountainous Areas region have both a high poverty headcount of over 30 percent and significant deprivation, ranging from 35 to 50 percent. Lai Chau has both the highest MPI headcount at 82.3 percent and highest poverty intensity at 50 percent. Provinces in the North and South Central Coast have an MPI headcount ranging from 10 to 30 percent and poverty intensity of 35 to 40 percent. There is considerable variation in the Central Highlands, with some provinces such as Lam Dong having a lower MPI headcount at 17.4 percent,

while Dak Lak and Kon Tum have relatively higher MPI headcounts at 36 percent and 50 percent respectively. Most provinces in the Mekong River Delta have a very high MPI headcount of 30 percent or more, with intensity of deprivation also high, in the range of 35 to 45 percent. Even in the wealthy South East, provinces such as Binh Phuoc and Tay Ninh have high MPI headcounts at 23 percent and 32 percent respectively. Thus, the MPI presents a more complex picture of poverty dynamics at the provincial level than monetary poverty rates alone.

A very persistent gap in living standards between the best off and worst off provinces is still evident.

THE HPI AND POORER PROVINCES

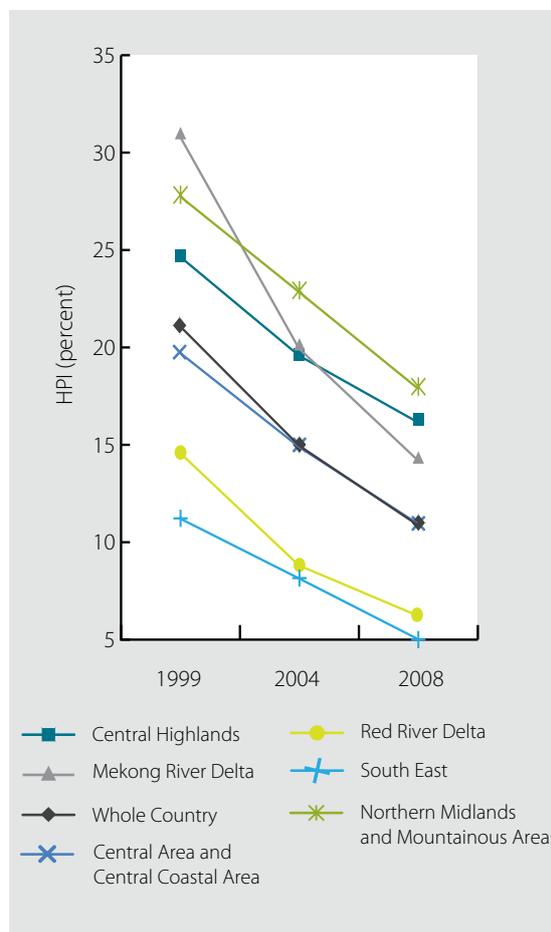
In 2008, the HPI varied considerably between provinces, ranging from just 2.84 in Ho Chi Minh to 38.63 in Lai Chau, having fallen from 7.37 in Ho Chi Minh in 1999 and 47.63 in Lai Chau in 1999. As this shows, the gap between the province with the greatest and least deprivation has fallen only slightly between 1999 and 2008. A very persistent gap in living standards between the best off and worst off provinces is still evident, with relatively limited change in the HPI in the poorest province, Lai Chau, between 1999 and 2008. In 2008, those provinces with the lowest poverty incidence according to the HPI were Ho Chi Minh, Hanoi, Da Nang and Hai Phong; these were also among the top 10-ranked provinces for the HDI and GDI. Similarly, Hanoi, Ho Chi Minh, Hai Phong and Da Nang all had low incidence of multi-dimensional poverty; as did Hai Duong, Bac Ninh and Hung Yen.

According to the HPI, all regions and provinces saw a reduction in poverty incidence between 1999 and 2008. The regions with the fastest percentage rate of poverty reduction were the Red River Delta, South East, and the Mekong River Delta. The Mekong River Delta saw the greatest fall in the HPI during this period (Figure 3.8).

Among provinces, those which saw the greatest progress in terms of the rate of poverty reduction were Hanoi and Hai Phong in the Red River Delta, Tien Giang, Ben Tre, Long An, Cau Mau, Can Tho and Bac Lieu in the Mekong River Delta, and Ho Chi Minh City and Ba Ria-Vung Tau in the South East. Those that saw the greatest fall in the HPI percentage were Ben Tre, Can Tho and Tien Giang in the Mekong River Delta, and Son La in the North West, provinces that were among those with the highest poverty rates in 1999.

While all provinces were able to reduce poverty incidence between 1999 and 2008, there were some that saw slower progress. Lai Chau in the North West, Yen Bai and Ha Giang in the North East, Kon Tum in the Central Highlands and Vinh Long in the Mekong River Delta all saw slower rates of poverty reduction between 1999 and 2008. Those provinces which experienced small reductions in the actual HPI percentage included provinces which already had low poverty rates in 1999, such as Ho Chi Minh and Da Nang, together with some provinces such as Yen Bai in the North East which had high poverty incidence in 1999 and which experienced little progress over the decade.

Figure 3.8: HPI, Viet Nam and Six Regions, 1999-2008



Source: VASS/GSO; HPI 1999, 2004, 2008
See the Annexes for data tables

As noted above, the gap between the poorest and the least poor province (Lai Chau and Ho Chi Minh) has narrowed only slightly over time. At an aggregate level, a fall in the proportion of people not expected to live to age 40 has been relatively modest; the same modest fall has been found for adult illiteracy. This is good progress, given lower initial rates of these deprivations in 1999. Reductions in the proportion of people living without clean water and in child malnutrition have been more substantial, given high initial levels in 1999. The gap between the worst-off provinces and those with lowest deprivation levels for each of the four indicators that makes up the HPI has also narrowed over time. These are encouraging signs.

The gap between the province with the lowest proportion of people not expected to live to 40 (Ho Chi Minh City—3.24 percent) and the province with the highest proportion (16.12 percent—Lai Chau), was moderate at just under 13 percent, or five times higher in Lai Chau. However, for the other three indicators the gap continues to be very significant, with markedly different deprivation levels evident in Viet Nam's wealthiest and poorest provinces. The proportion of undernourished children is 6.6 times higher in Dac Nong at 30.5 percent, than in Ho Chi Minh

at 4.6 percent. The adult literacy gap is 14 times higher in Lai Chau at 38.4 percent than in Ho Chi Minh at 2.77 percent. Most strikingly, 100 percent of people in Thai Binh have access to clean water, while 68 percent of those in Lai Chau do not.

The gap between the worst off provinces and those with lowest deprivation levels for each of the four indicators that makes up the HPI has also narrowed over time.

Table 3.5: HPI Fast and Slow Poverty Reduction, Viet Nam's Provinces, 1999-2008

	Province	HPI Rank 2008	HPI Rank 1999	HPI Value 2008 (%)	HPI Value 1999 (%)	Change 1999-2008 (%)
Faster poverty reduction	Tien Giang (MRD)	17	44	8.24	27.86	-70.41
	Hanoi (RRD)	2	3	3.75	11.73	-68.01
	Ben Tre (MRD)	41	55	12.70	39.54	-67.88
	Long An (MRD)	15	33	7.67	22.19	-65.45
	Ca Mau (MRD)	10	32	7.20	20.67	-65.18
	Bac Lieu (MRD)	12	30	7.25	20.40	-64.46
	Can Tho (MRD)	43	50	12.89	34.70	-62.84
	Hai Phong (RRD)	4	6	5.42	14.52	-62.65
	Ho Chi Minh City (SE)	1	1	2.84	7.37	-61.42
	Ba Ria-Vung Tau (SE)	5	5	5.64	14.47	-60.99
Slower poverty reduction	Cao Bang (NE)	57	54	25.59	38.94	-34.29
	Lao Cai (NE)	58	53	25.78	38.37	-32.81
	Dong Thap (MRD)	59	58	27.83	41.28	-32.56
	Tuyen Quang (NE)	48	39	16.20	23.86	-32.11
	Thai Nguyen (NE)	31	12	10.60	15.52	-31.75
	Ha Giang (NE)	60	59	29.26	41.78	-29.98
	Vinh Long (MRD)	61	57	30.02	40.73	-26.31
	Yen Bai (NE)	51	42	19.90	26.10	-23.75
	Kon Tum (CH)	56	47	23.92	31.16	-23.23
	Lai Chau (NW)	63	60	38.63	47.63	-18.88

Source: HPI 1999, 2008. RRD = Red River Delta, CH = Central Highlands, NE = North East, SE = South East, SCC = South Central Coast, NCC = North Central Coast, MRD = Mekong River Delta, NW = North West.

PROVINCIAL PROGRESS IN NON-MONETARY DEPRIVATIONS

A few provinces saw a rise in incidence of specific deprivations in the HPI from 1999 to 2008. These included Kon Tum, Dac Lac and Thai Nguyen, which saw a rise in the proportion of people without access to clean water, and Soc Trang which saw a slight rise in adult illiteracy rates. On the other hand, a number of provinces were able to substantially reduce the proportion of people without access to clean water, including those with fast rates of non-monetary poverty reduction, such as Ben Tre and Tien Giang. Child malnutrition rates fell in all provinces over this period.

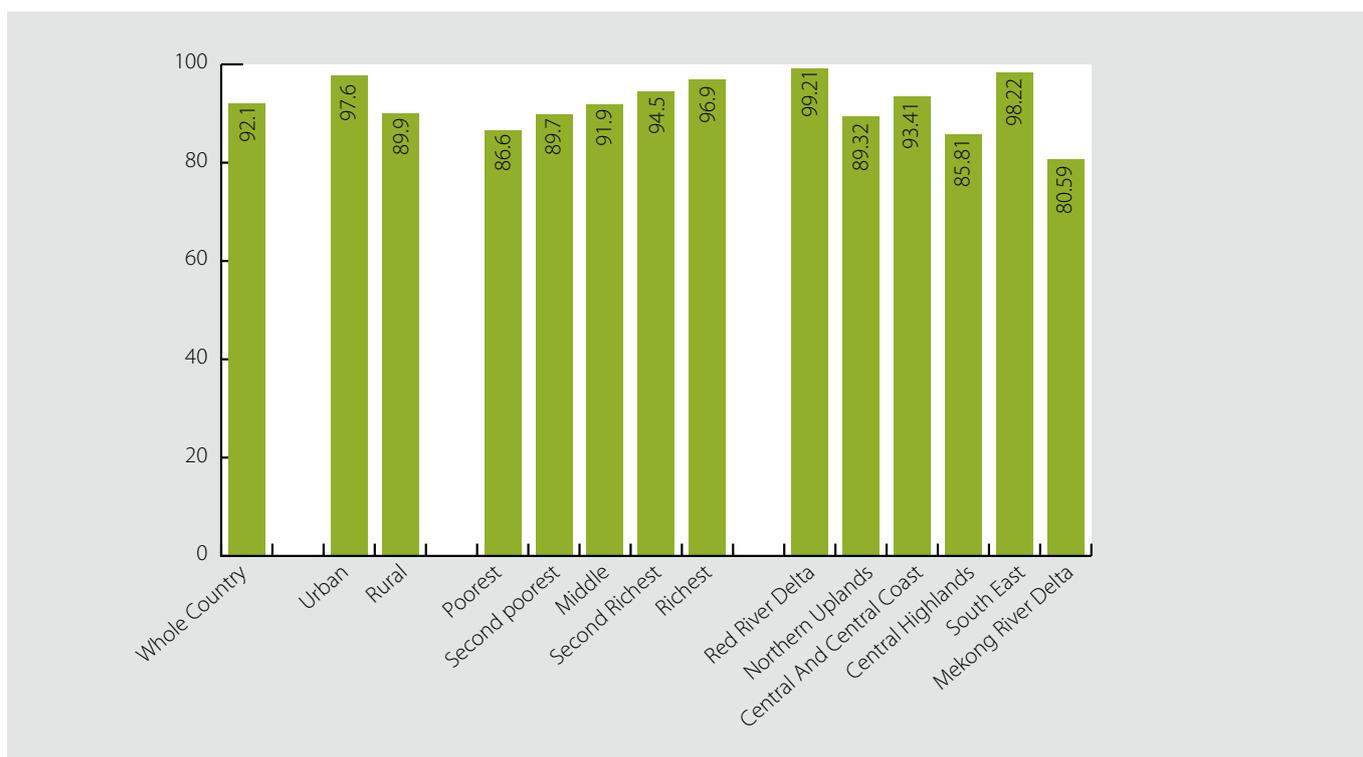
Looking to the briefer time period of 2004 to 2008, while all provinces saw continued improvements in child malnutrition rates, a number of provinces saw slight increases of 1-2 percentage points in adult illiteracy rates, and several saw increases in the proportion of the population without access to clean water. For example Da Nang, Hanoi, Gia Lai, Lai Chau, Phu Yen, Hue and Tuyen Quang all saw declines in the proportion of people accessing clean water. Again, this does suggest that disparities in health and education are rising in some provinces. On the other hand, a number of provinces were

able to make significant progress during this period. Son La, Can Tho, An Giang, Lai Chau, Dien Bien and Hau Giang all saw significant gains in non-monetary poverty reduction during this period, most notably due to improved access to safe water.¹⁵

A number of provinces were able to substantially reduce the proportion of people without access to clean water.

As noted above, the most significant and persistent disparity identified in the HPI is access to clean water. Access to clean water is a critical issue because contaminated water is a major cause of illness and death, and Viet Nam's MDG goal on safe drinking water is yet to be met.¹⁶ VHLSS 2008 data shows that there continue to be significant disparities in access to clean water among socio-economic groups and regions. In 2008, 86.6 percent of the poorest quintile had access to clean water, compared to 97 percent of the wealthiest quintile, with significant differences also evident within regions. Almost 100 percent of households living in the Red River Delta had access to clean drinking water, compared to 80.6 percent in the Mekong River Delta (Figure 3.9). Similarly, child malnutrition rates remain higher in the Central Highlands, North East, North West and the North Central Coast than in other regions.¹⁷

Figure 3.9: Access to Clean Water by Wealth and Region, Viet Nam, 2008



Source: VHLSS 2008

In the MPI, deprivations in living standards are also significant, in particular in relation to water and sanitation. Lack of permanent housing and deprivations in access to education are also important factors. Figure 3.10 shows the contribution of the nine indicators to the MPI: deprivations in permanent housing, sanitation and access to clean water are most significant.

Access to clean water is a critical issue because contaminated water is a major cause of illness and death, and Viet Nam's MDG goal on safe drinking water is yet to be met.

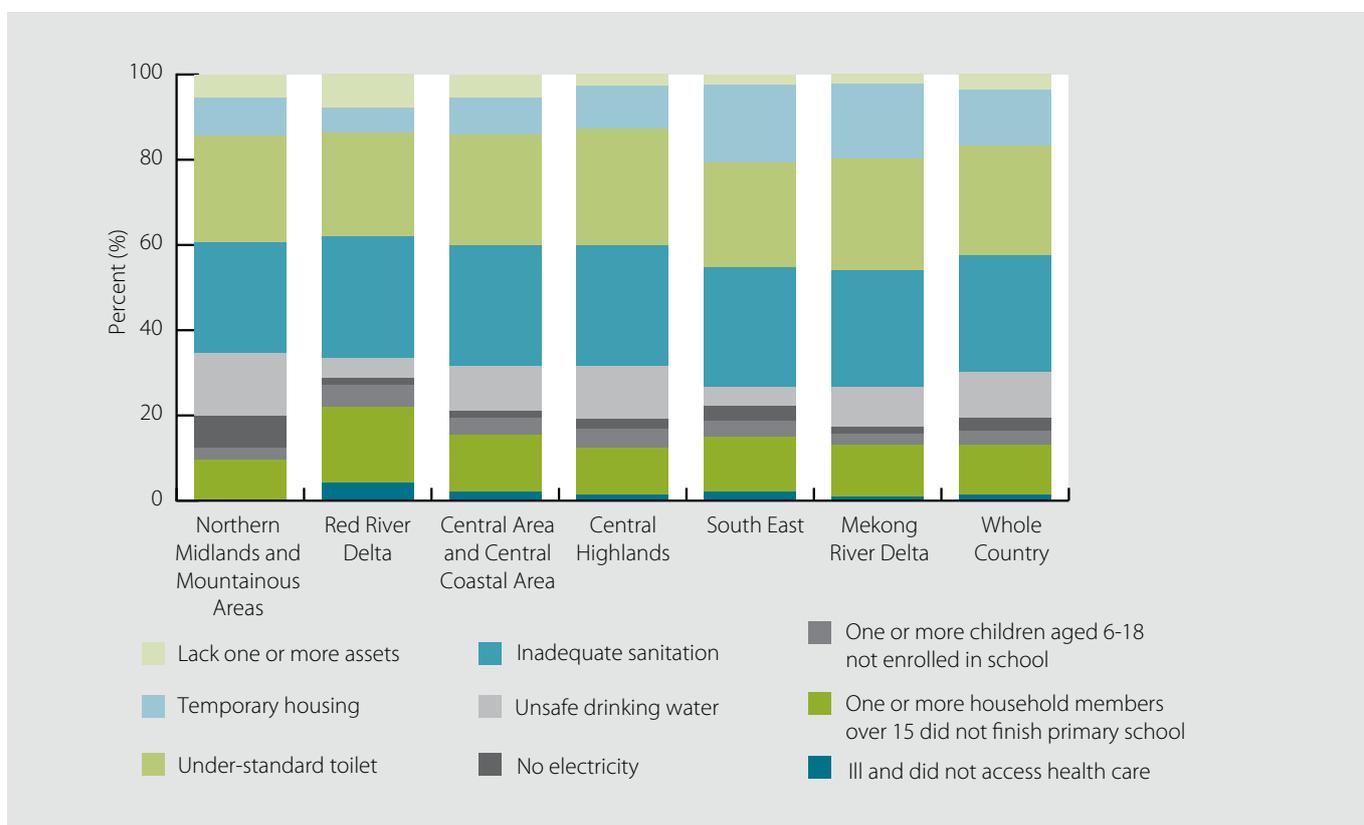
Other indicators not used in the HPI and MPI, such as infant mortality, also show significant variations between provinces, regions, and population groups. Consistently, the poorest provinces are those with the lowest HDI and GDI values and the highest HPI and MPI values, and have much higher rates of deprivation, including infant and child mortality rates, rates of stunting and wasting, and maternal mortality. For example, the infant mortality rate was 48 percent in Kon Tum, 40 percent in Ha Giang and 33 percent in Lai Chau in 2008, a rate five to six times that of Hanoi at 7 percent, and two to three times the national average of 15 percent (Map 3.5).

POVERTY AND INEQUALITY

MONETARY POVERTY FALLS, INCOME INEQUALITY RISES

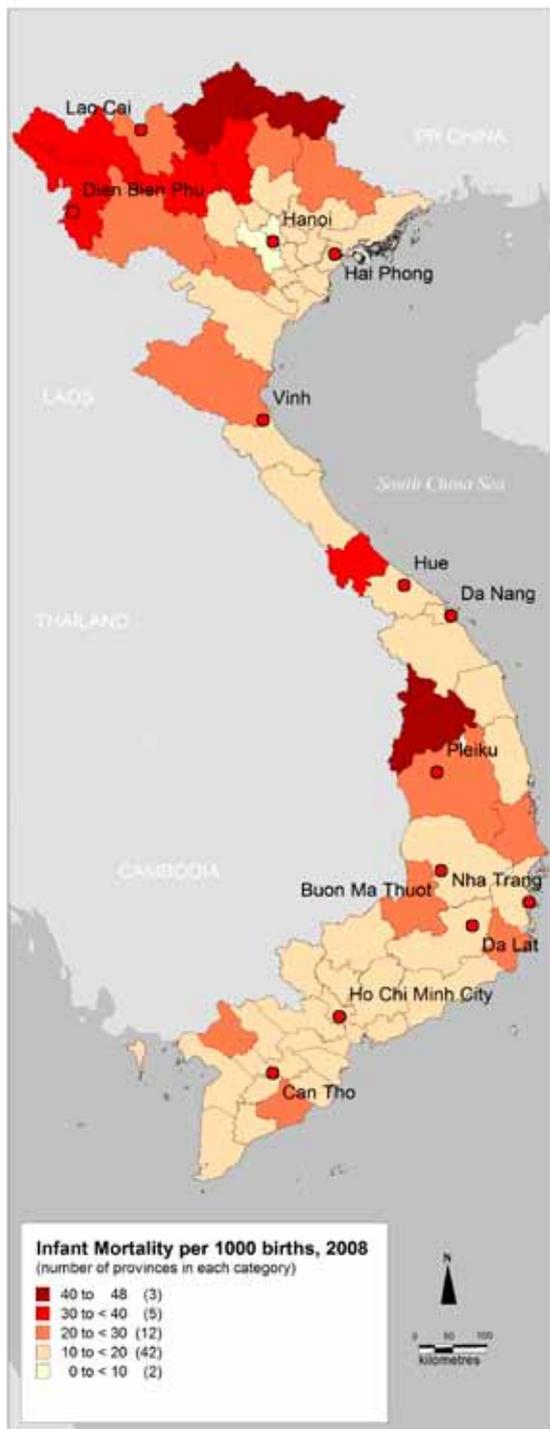
As this discussion has shown, inequalities in health, education and living standard indicators used in the human development family of indicators are correlated with ethnicity, geographical location and socio-economic status. Gender inequalities in the labour market and the household also persist, although steady progress has been made on some fronts, in particular women and girls' access to education.

Figure 3.10: Contribution of Nine Indicators to the MPI, Viet Nam and Six Regions, 2008



Source: MPI 2008, based on VHLSS 2008. See the Annexes for data tables

Map 3.5: Infant Mortality Rate, 2008



Source: B. Surborg for the NHDR 2011

As discussed in Chapter Two, Viet Nam has had a relatively equitable development process, has successfully reduced monetary poverty, and has been fairly successful in containing economic inequality in comparison to other countries in the region. However, there are signs that this is now changing. Apart from the anecdotal evidence, including signs of rising wealth disparities and a boom in conspicuous consumption in Viet Nam's major cities, data from the VHLSS shows that income inequality is rising across the country.

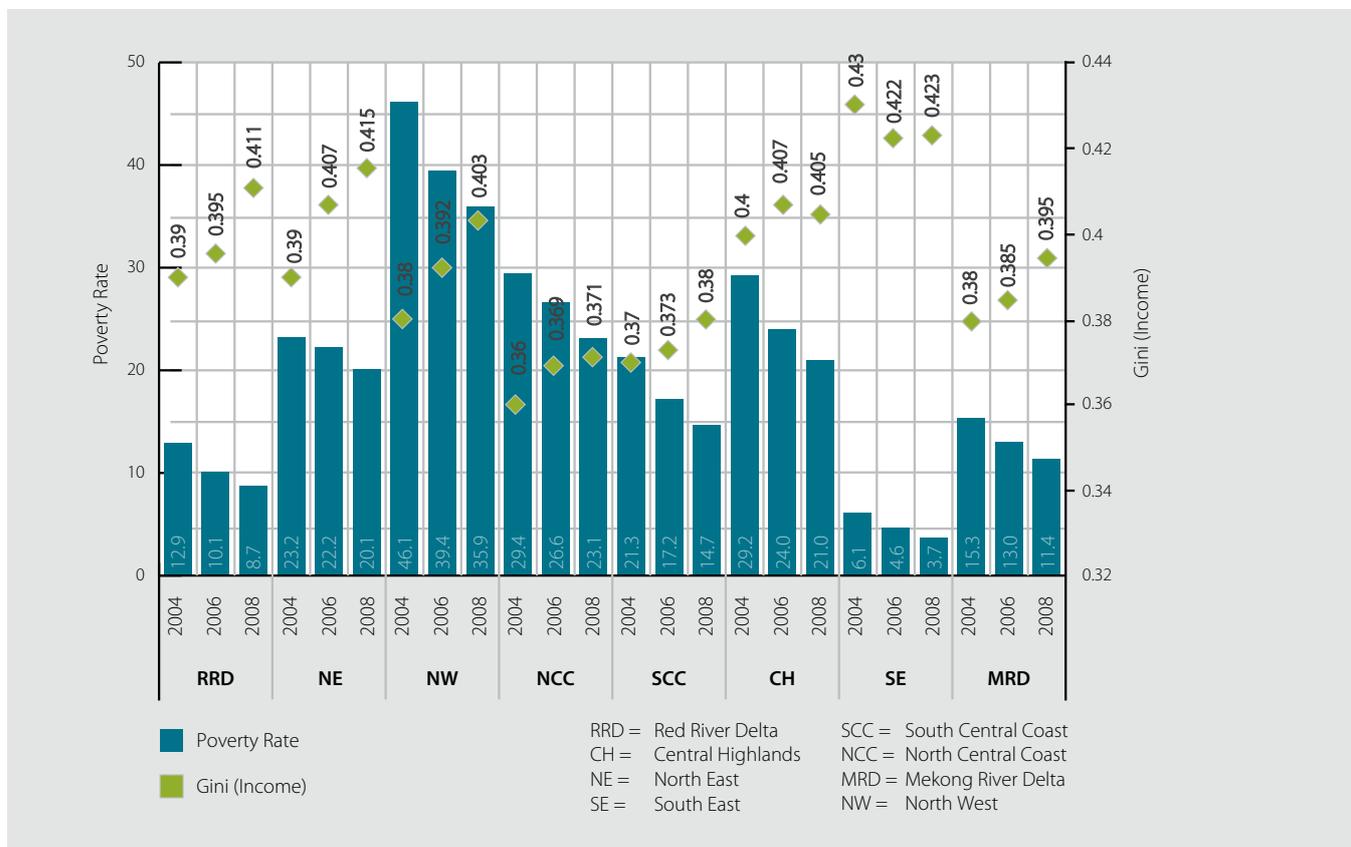
The ratio of the income of the richest quintile over the poorest quintile has risen in all regions between 2002 and 2010.

As income poverty has fallen—from 18.1 percent in 2004 to 15.5 percent in 2006 and 13.4 percent in 2008—income inequality has risen. The Gini coefficient shows income inequality rose from 0.420 in 2004 to 0.424 in 2006, 0.434 in 2008 and 0.433 in 2010. Admittedly these are slight increases, but it is likely that the very wealthy and very poor are not picked up in the VHLSS surveys. VHLSS data also shows that the income of the richest quintile over the poorest quintile has risen from 8.1 in 2002 and 8.3 in 2004 to 8.9 in 2008 and 9.2 in 2010. On this measure, Viet Nam has lower levels of wealth inequality than the Philippines and Singapore, but higher levels than Indonesia, Malaysia and Thailand.

At a regional level, similar trends are observable. Figure 3.11 shows poverty rates and Gini coefficients for Viet Nam's regions between 2004 and 2008. While poverty rates fell in all regions over this period, income inequality rose in all regions apart from the Central Highlands and the South East. The ratio of the income of the richest quintile over the poorest quintile has risen in all regions between 2002 and 2010.

The South East, which had the lowest poverty rates, also had the highest Gini coefficient for income inequality. Two distinct patterns are evident: lower poverty rates but higher inequality in the Red River Delta and the South East, and higher poverty rates but lower inequality in the North and South

Figure 3.11: Income Poverty and Income Inequality, Viet Nam's Eight Regions, 2004-2008



Source: VHLSS 2004, 2006, 2008

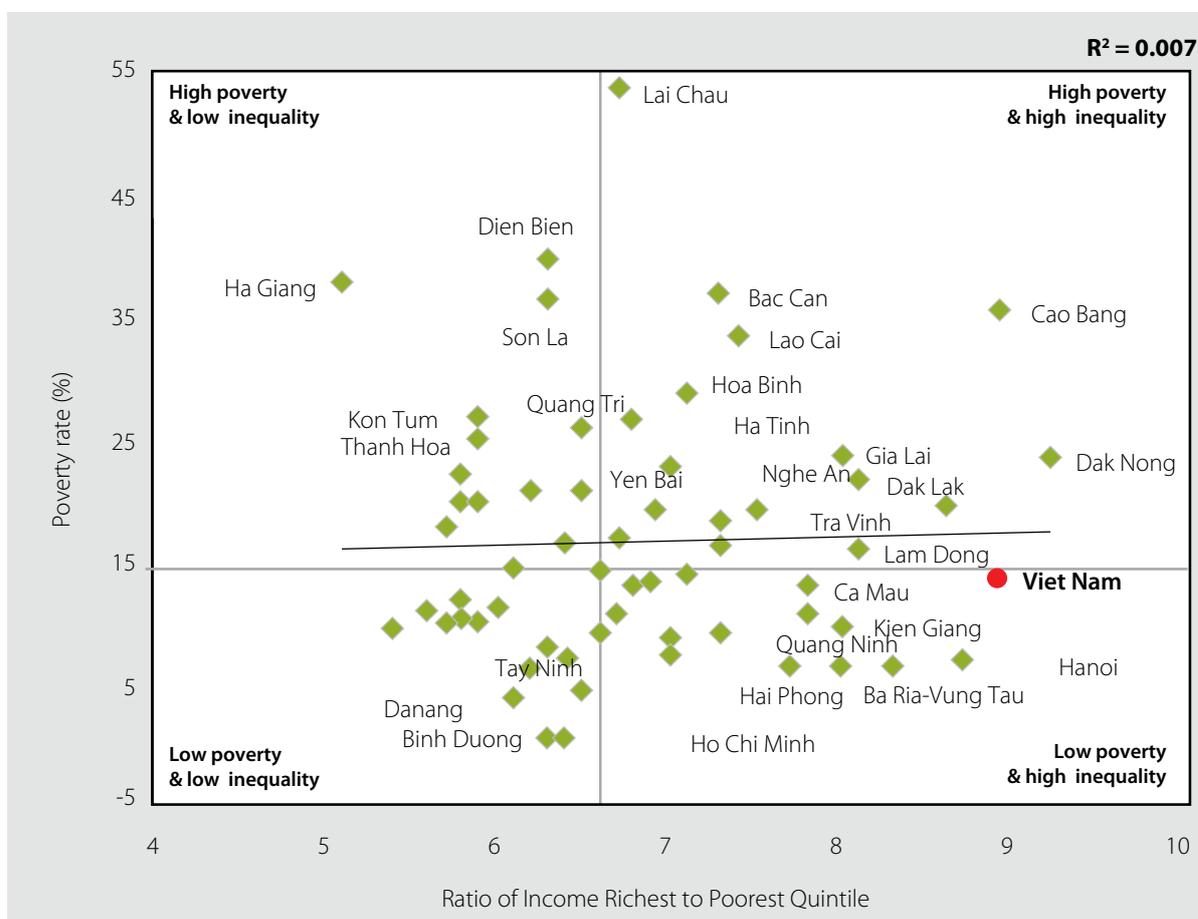
Central Coastal areas. The exception is the Central Highlands, which has both relatively higher income inequality and high poverty rates. This is likely to be a result of a large concentration of poorer ethnic minority groups in this region, coupled with a small Kinh/Hoa majority able to generate wealth through exploitation of natural resources. Overall however, these regional trends tend to suggest that rising inequality is a feature of Viet Nam's pattern of growth.

Regional trends tend to suggest that rising inequality is a feature of Viet Nam's pattern of growth.

POVERTY RATES AND INCOME INEQUALITY ARE NOT NEATLY CORRELATED

Comparing the poverty rate to the income inequality rate, in this case the ratio of the highest income quintile over the lowest income quintile shows a more mixed pattern. In 2008, some provinces with very high poverty rates had relatively lower levels of income inequality. These include Ha Giang, Lai Chau, Dien Bien and Son La. Others, such as Lao Cai, Cao Bang, Gia Lia, Dac Nong and Dac Lac had both high poverty rates and high rates of income inequality. On the other hand, some provinces, such as Kien Giang, Ba Ria-Vung Tau and Quang Ninh had low rates of poverty but relatively higher inequality. Others such as Da Nang, Can Tho and Ho Chi Minh City did not. Figure 3.12 shows the distribution of provinces according to these four patterns: high poverty/high inequality, high poverty/low inequality, low poverty/low inequality and low poverty/high inequality.

Figure 3.12: Poverty and Inequality, Viet Nam's Provinces, 2008



Source: VHLSS 2008

Thus there is no clear correlation between poverty rates and income inequality at the provincial level, in contrast to a more evident correlation at the regional level. However, although provincial patterns of income inequality are quite variable, and income inequality and poverty are not always neatly correlated, income inequality is on the rise in most of Viet Nam's regions, and is now at relatively high levels in a number of provinces, including both very poor and relatively wealthy provinces.

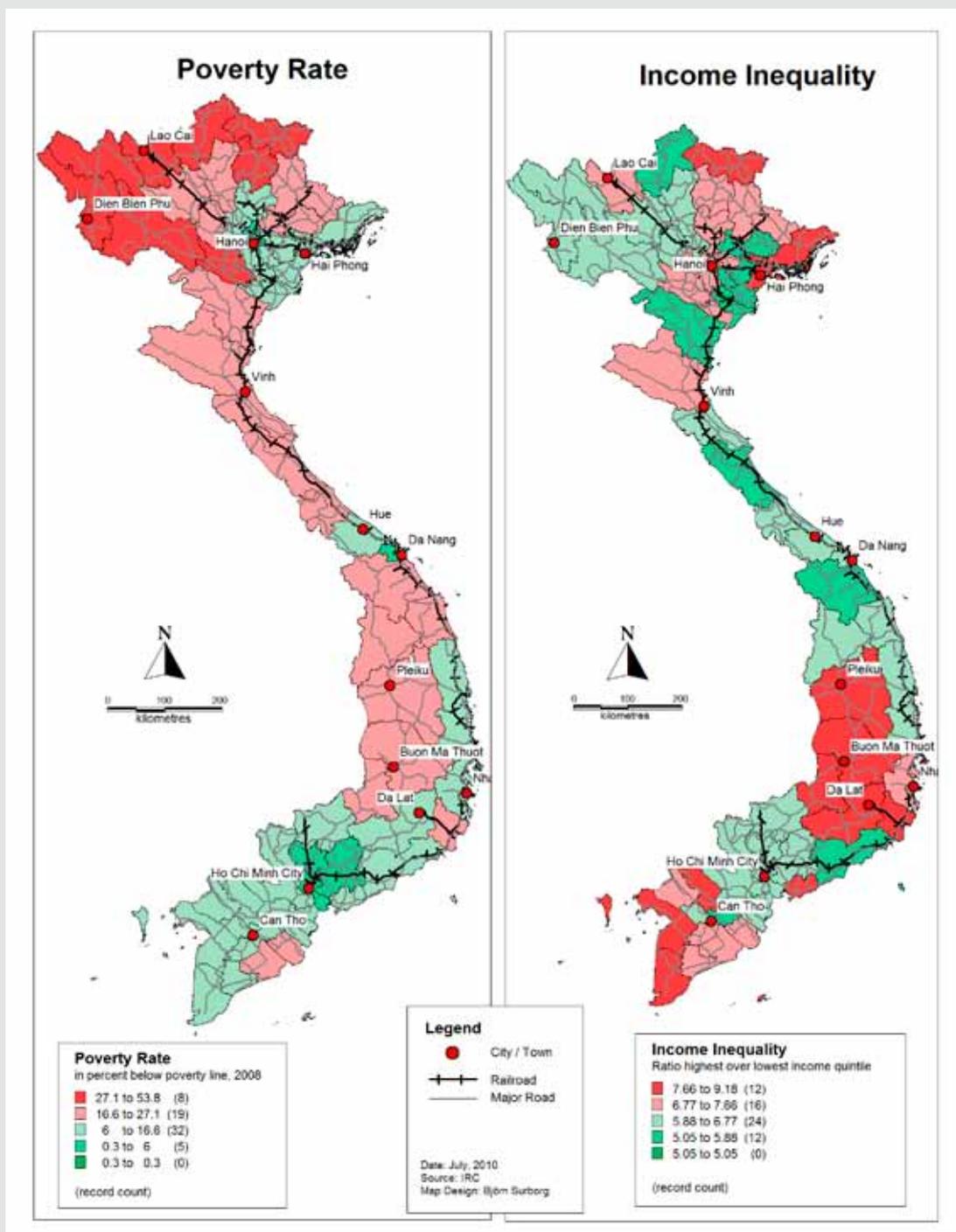
WIDENING DISPARITIES THREATEN VIET NAM'S HUMAN DEVELOPMENT PROGRESS

The analysis in this chapter has suggested that rising incomes have been responsible for Viet Nam's recent progress in the HDI and related human development indicators, while non-income dimensions of the HDI have been lagging behind. Together with this brief analysis of inequality and poverty, this shows that rising incomes do not always lead to improved human

development outcomes, and are not always correlated with improved living standards for all Vietnamese people. Progress on key health and education indicators, in particular gross enrolment ratios and access to clean water and sanitation, is lagging and is now acting as a brake on Viet Nam's progress towards higher levels of human development, as measured by the HDI and other key human development indexes. Non-monetary poverty and deprivations are significant in Viet Nam, in particular among more vulnerable groups. Gender gaps are narrowing in some dimensions, but widening in others.

Widening disparities and inequalities pose a risk to Viet Nam's continued human development. The costs of health and education services are continuing to rise in Viet Nam, as the following chapters will show. As wealth becomes less equitably distributed, so too does the purchasing power of many ordinary Vietnamese people to access essential social services become less equal. Disparities in human development indexes may widen in future as a result.

Map 3.6: Poverty and Inequality, Viet Nam's Provinces, 2008



Source: B. Surborg for the NHDR 2011

SECTION TWO

ACCESS TO HEALTH AND EDUCATION SERVICES

DISPARITIES IN HEALTH AND EDUCATION PERSIST

DISPARITIES IN HEALTH AND EDUCATION OUTCOMES AND ACCESS TO SERVICES

Disparities in health and education outcomes are directly related to widely divergent levels of access to health and education services among different provinces and regions, ethnic minorities and socio-economic groups. This chapter discusses access to health and education services and the relationship between patterns of utilization, and differences in health and education outcomes. Access to health services is primarily reflected in data on health service utilization and number of patient visits. Meanwhile gross and net enrolment rates provide information on access to different levels of education. As discussed in Chapter Five, a range of government initiatives are in place that aim to increase access to health and education services among disadvantaged and vulnerable groups. These include health insurance (health cards), free health care for children under 6, and exemption from school fees and other costs for children. While these subsidies do appear to support increased access to health and education services, including among disadvantaged groups, divergent patterns of access to health and education continue to persist in Viet Nam. This raises questions about the overall effectiveness and level of coverage achieved by these programmes, as explored in Chapter Five.

ACCESS TO HEALTH SERVICES

HEALTH SERVICE UTILIZATION AMONG THE POOR AND ETHNIC MINORITIES

Use of health services is correlated with ethnicity, geographic location and socio-economic status. In 2008, according to health service utilization data from the Viet Nam Household Living Standards Survey (VHLSS), 51.6 percent of people experienced an illness. Ten percent needed to stay in bed and be cared for by another person,

Divergent patterns of access to health and education continue to persist in Viet Nam.

with those who had to take time off work averaging 4.5 days. Thirty-four percent of Vietnamese people accessed health care services, with 31 percent accessing outpatient health services, and a relatively smaller proportion accessed more expensive inpatient care at just 6.6 percent. An encouraging sign is that between 2002 and 2008, health care utilization increased significantly. In 2002, 19 percent of Vietnamese people accessed health care services, with 5.7 percent accessing inpatient services and 14 percent accessing outpatient services. Notably also, service utilization has increased among all income quintiles, and in urban and rural areas. Similarly, the frequency of visits to outpatient services increased between 2004 and 2008, though the frequency of visits to inpatient services fell slightly. Most health service utilization involves visits to government health services: private health services account for around 38 percent of outpatient service use and just 2 percent of inpatient service use.

While these figures are encouraging and suggest more people are accessing health services than in the past, there are nevertheless some variations. Unsurprisingly, health care utilization is directly related to the life cycle—people over 60 were the greatest users of both inpatient and outpatient care in 2008, and women were more likely than men to use both types of services, due to their maternity and reproductive health care needs.¹

Higher rates of access to health care are evident among people who have health insurance either on a compulsory or voluntary basis.

However, there are also significant differences between regions, and among ethnic and socio-economic groups. While urban-rural differences were minimal, health service utilization varied significantly by region, with the highest level of utilization in the Mekong River Delta and the lowest level in the North West. People in the North West have the lowest rate of outpatient utilization, but the highest rate of inpatient use; while those in the South East were less likely to use inpatient services but more likely to use outpatient services. This was also the case in the Mekong River Delta and the Central Highlands. Health care services are more available and accessible in urban areas and the South than in the North West. However, lower rates of utilization of outpatient services may also reflect a tendency among poorer and more remote population groups to delay treatment until health problems are serious, as a way of minimizing the costs of accessing health care in the short term.²

Ethnic minority groups were less likely to use outpatient services than the Kinh/Hoa majority, but slightly more likely to use inpatient services in 2008, in contrast to 2004. The PII 135 baseline survey found that ethnic minority groups often avoided using health services, delayed treatment until their health conditions were serious, and were more likely to use traditional healing methods and self-medicate than were the Kinh/Hoa majority.³ Among income groups, the poor showed lower levels of health care

utilization than other population groups for both inpatient and outpatient care. Interestingly, use of health services among the Kinh/Hoa majority and the richest quintile appears to have declined slightly between 2004 and 2008.⁴

Certain groups are also using outpatient services on a more regular basis: these include people over 60, women, the Kinh/Hoa majority, the non-poor and those in urban areas. Frequency of outpatient visits also varies considerably between regions, with those in the South East and Mekong River Delta having more visits, and those in the North West, North Central Coast and North East having fewer visits. On the other hand, the number of inpatient visits fell slightly among most population groups, in particular people over 60, rising slightly for those below 15, the poor and those in the South East.

Not surprisingly, people over 60 averaged a much higher number of sick days, with 12.76 days not working and 8.82 days spent in bed in 2008, as did women, due to their reproductive health needs. The Kinh/Hoa majority and the non-poor also spent more days not working and in bed.⁵ One possible explanation for this may be that the poor and ethnic minorities, with lower incomes, are less able to afford lost days at work.

Notably, of those who reported an illness within the past year, 61 percent of men and 65 percent of women visited a health care worker or service, down from the 2006 VHLSS where 77 percent of men and 78 percent of women visited a health worker or service.⁶ Not surprisingly, health insurance is a factor in whether or not people seek health care. Higher rates of access to health care are evident among people who have health insurance either on a compulsory or voluntary basis. As the proportion of people who have health insurance has been steadily rising, as discussed in Chapter Five, this may help to account for the rising proportion of the population that is accessing health services. However it does not account for the significantly lower proportion of the population who sought health care when they were ill in 2008, compared to 2006.

Table 4.1: Proportion of Population Utilizing Health Services, Viet Nam, 2004-2008 (%)

		Outpatient services		Inpatient services	
		2004	2008	2004	2008
	All Viet Nam	31.1	31.76	6.88	6.61
Age	Below 15	29.49	33.09	4.17	5.02
	16-60	28.49	27.87	6.65	5.95
	Above 60	53.61	54.65	16.11	14.7
Sex	Male	27.42	28.36	6.24	5.97
	Female	34.71	35.02	7.49	7.23
Ethnicity	Kinh/Hoa	32.04	32.68	6.88	6.54
	Ethnic minorities	24.65	25.76	6.82	7.13
Poverty	Non-Poor	32.39	32.5	7.1	6.72
	Poor	25.78	27.38	5.93	5.98
Urban-rural	Urban	34.58	31.83	6.76	5.97
	Rural	29.9	31.73	6.92	6.86
Region	Red River Delta	29.2	27.27	7.03	6.52
	North East	21.28	24.77	6.82	7.73
	North West	23.57	21.87	6.98	8.42
	North Central Coast	21.36	24.63	8.07	6.94
	South Central Coast	32.11	31.49	7.79	7.93
	Central Highlands	36.85	35.65	7.14	6.47
	South East	37.52	33.13	5.89	5.27
	Mekong River Delta	38.69	44.31	6.29	6.2

Source: VHLSS 2004, 2008, cited in Nguyen Viet Cuong 2010

ACCESS TO PREVENTATIVE HEALTH CARE

A major limitation of the data reported above on health service utilization is that it does not clearly differentiate access to preventative health care, including visits to health services for preventative treatment, which has a direct influence on health outcomes. Key examples of access to preventative care are child vaccinations and pre-natal health checks, as well as use of modern contraceptive methods for family planning.

Persistent disparities in health outcomes, together with new and emerging health problems, require improved responses from health services.

Gender analysis of the VHLSS 2008 found that women were more likely to undertake preventative health care visits including vaccinations: 27 percent compared to 20 percent for men. The higher

percentage for women was due to women's visits for pre-natal care and other reproductive health services. However, both men and women were more likely to undertake preventative care visits in urban than in rural areas.⁷ Data from the 2006 Multiple Indicator Cluster Survey shows considerable variation in children aged 2 to 4 who are not fully vaccinated against childhood diseases. These figures were at 31 percent nationally in 2006, and 20 percent in urban areas compared to 35 percent in rural areas, ranging from 17 percent in the Red River Delta to 59 percent in the North West and 53 percent in the North East. Twenty-five percent of Kinh/Hoa majority children were not fully vaccinated compared to 58.5 percent of ethnic minority children.⁸ Although 86.4 percent of women nationally receive more than three pre-natal checks, this ranges from 68 percent in the North West to 98.5 in the Red River Delta.⁹ In 2008, 69 percent of currently married women aged 15 to 49 were using modern contraceptive methods, ranging from 72.5 percent in the North Central and South Central Coast to 59.4 percent in the Central Highlands.¹⁰

A UNICEF study on health equity in Viet Nam identified the following trends in access to health services. While over time poor and rural women have become more likely to use modern methods of contraception, income inequality in favour of the rich continues to influence access to pre-natal care; and income, ethnicity and access to health services are still important determinants of access to child immunization.¹¹ Differential patterns of access to health services are also influenced by the rising costs of services, both in absolute value and as a proportion of household expenditure. Availability of health insurance which tends to increase use of health services and reduce out-of-pocket expenses, also influences differential patterns of access to health services, as discussed in Chapter Five.

DISPARITIES IN HEALTH OUTCOMES

UNEVEN IMPROVEMENTS IN HEALTH STATUS AND NEW HEALTH PROBLEMS

Consistent with increased access to health care evident in the above analysis of VHLSS data, Viet Nam has been relatively successful in closing significant health gaps. For example, the under-5 mortality rate fell from 58 per 1,000 deaths in 1999

to 24.4 per 1,000 deaths in 2009; while the infant mortality rate fell from 44.4 per 1,000 deaths in 1999 to 16 per 1,000 deaths in 2009. Maternal mortality fell from 233 deaths per 100,000 in 1990 to 69 in 2009. A majority of children received vaccinations, at 82 percent, while trained health workers attended 94.8 percent of births. Eighty-three percent of the rural population had access to safe drinking water in 2010 compared to 30 percent in 2000.¹²

Nevertheless, as shown in Chapter Three, significant disparities remain. While stunting remains severe at 31.9 percent nationally, rates of child stunting and malnutrition are two to three times higher in rural and mountainous areas than in lowland and urban areas. Provinces such as Kon Tum, Ha Giang and Lai Chau have infant mortality rates two to three times higher than the national average. The gap in child mortality rates widened between the richest and poorest quintile from a difference of 33 per 1,000 in 1993 to 39 per 1,000 in 2006. The under-5 malnutrition rate ranges from 16.7 percent in the Red River Delta to 28.5 percent in the Central Highlands.¹³ A trained health worker attends only 79.9 percent of women in the North West during childbirth compared to 100 percent in the Red River Delta and Mekong River Delta. Maternal mortality rates are twice as high in rural as in urban areas.¹⁴ HIV incidence is highest among people under 40 and men, while some provinces have higher than average rates of incidence among specific at-risk population groups (Box 4.1).¹⁵

BOX 4.1: DISPARITIES IN HIV INCIDENCE

HIV infection rates vary considerably across Viet Nam. About 20 provinces had more than 200 cases per 100,000 people in 2008, concentrated in the north, together with Ho Chi Minh City and Ba Ria-Vung Tau in the south. Per capita infection rates are highest in those provinces where the epidemic is relatively newer, and are above 600 cases per 100,000 people in Dien Bien and Son La in the North West and Quang Ninh in the North East. However, the largest concentrations of people living with HIV can be found in the big cities, in particular Ho Chi Minh, Hanoi and Hai Phong.¹⁶

According to Ministry of Health projections, the number of people living with HIV will increase from 220,000 in 2007 to 280,000 in 2012. At the same time, the rate of new infections has declined, from 67 per 100,000 in 2000 to 39 per 100,000 in 2007, resulting in a decline in incidence in some provinces such as Ho Chi Minh City and An Giang. While men continue to account for a major proportion of HIV infections, the number of pregnant women living with HIV will increase from 4,100 in 2007 to 4,800 in 2012. Meanwhile the ratio of male to female adults living with HIV is expected to fall from 3 to 1 in 2007 to 2.6 to 1 in 2012 as more women are infected by their regular sexual partners. The number of children living with HIV is expected to increase from 3,750 in 2007 to 5,100 in 2012.¹⁷ The epidemic is predicted to rise rapidly among injecting drug users (IDUs) in the North West, among female sex workers in the North West and the Red River Delta and among clients of female sex workers in the North West and Can Tho.¹⁸

As Viet Nam becomes increasingly urbanised, and as the population profile changes, new lifestyle-related diseases are emerging, together with an increasing incidence of non-communicable diseases, with varying impacts on different population groups. According to the 2009 Joint Annual Health Review, cardiovascular diseases, cancer and mental health diseases accounted for 34 percent of the disease burden in men and 43 percent in women.¹⁹ Incidence of traffic accidents, alcohol, tobacco and illicit drug use is also on the rise, in particular among men.²⁰

Persistent disparities in health outcomes, together with new and emerging health problems, require improved responses from health services. Not just increased availability of health services, but also quality, effective regulation and oversight. Participation by users in service design and delivery are also required, as discussed in the following chapters. Costs of health services to the household are a key issue, as Chapter Five will show.

BOX 4.2: PEOPLE WITH DISABILITIES STRUGGLE TO ACCESS BASIC SERVICES

People with disabilities in Viet Nam are significantly disadvantaged when it comes to accessing health and education services. A 2006 study on the experience of people with disabilities in three provinces²¹ found that one in three had never attended school in Thai Binh and Quang Nam/Da Nang, one in two in Dong Nai. Women were less likely to have attended than men. Between 70 and 80 percent of respondents aged 6 to 30 had experienced significant difficulties in attending school, in particular in relation to learning, communication with teachers and other students, and travel and participation in school activities. Harassment and exclusion by classmates were also cited as problems. High proportions of those surveyed did not enrol as a result of these barriers—and drop-out rates were extremely high at 60 percent in Thai Binh, 46 percent in Quang Nam/Da Nang and 54 percent in Dong Nai. Most students dropped out at the primary and lower secondary school level. Disability rather than economic or other reasons was the main factor, in particular as a result of the difficulties cited above. Worryingly, around 25 to 30 percent of respondents did nothing about the difficulties they experienced—in other words they gave up on getting an education. Others tried to cope with their situation by seeking help and advice from others, using instrumental aids to support their travel and learning, and trying to adapt. The support they said was most needed was improved teaching methods and skills, help with travelling, and waiving or reduction of school fees. Improved infrastructure and an end to stigma and discrimination were also cited as important.

While people with disabilities may need health care more often than others, they do not always receive appropriate care. While 70 to 80 percent of study respondents who experienced illness sought health care, and some in particular in Thai Binh received home visits, a significant proportion used self-treatment. About half of respondents said that they experienced difficulties in accessing health care. Overwhelmingly, the major problem cited was the cost of treatment. However, lack of suitable transport, the distances involved in getting to health services, bureaucracy, lack of appropriate services, physical inaccessibility of services, stigma and discrimination were also cited as factors. While a small proportion stopped seeking help, a majority sought help from others, or practised self-treatment at home. The most needed support was, in line with problems experienced, waiving or reducing fees, having policies and programmes in place specifically to meet the needs of people with disabilities, more accessible and user-friendly infrastructure and less bureaucracy. As a high proportion of respondents did not have health insurance, from 28 percent in Quang Nam-Da Nang to 60 percent of those in Dong Nai, health care costs were a specific barrier and disincentive to seeking treatment.

Viet Nam is a signatory to the *2008 UN Convention on the Rights of Persons with Disabilities*, and in 2010 enacted a new national law on disability which mandates equal participation in society, including access to health care and education. However, the onus is still largely on people with disabilities to cope with, and adapt to, available health and education services, rather than on service providers to ensure their services are accessible and provide appropriate support that would enable more equal access by people with differing needs.

ACCESS TO EDUCATION SERVICES

INEQUALITIES IN ACCESS TO EDUCATION

Gross and net enrolment ratios²² in primary education fell slightly from 105 percent in 2006 to 104.2 percent in 2008. This slight fall in gross enrolment ratios in primary education is a positive sign as it shows that more children are attending primary school at the right age. However, gross enrolment ratios for

primary education are still very high in the North West and among ethnic minority groups such as the Thai, Khmer, H'mong and Dao, meaning that more of these children are not attending at the correct age.²³ Gross enrolment ratios were 96 percent for lower secondary education and 73.8 percent for upper secondary education in 2008. In a working paper for the National Human Development Report (NHDR), Dr. Vu Hoang Linh estimates that gross enrolment ratios almost doubled in tertiary education from 18.3 percent to 30.2 percent between 2004 and 2008.²⁴

Table 4.2: Gross Enrolment Ratios, Viet Nam, 2006-2008 (%)

	Primary		Lower Secondary		Upper Secondary	
	2006	2008	2006	2008	2006	2008
Whole country	105.0	104.2	92.5	95.9	69.9	73.8
Rural	101.2	101.1	91.8	95.9	65.1	70.0
Urban	106.0	105.1	94.8	96.9	87.1	86.9
Kinh/Hoa	103.4	103.3	97.6	97.4	77.2	78.3
Ethnic minorities	112.3	108.2	88.4	88	53.9	47.9

Source: VHLSS 2006, 2008; Vu Hoang Linh 2010

Table 4.3: Net Enrolment Rates, Viet Nam, 2009 (%)

	Primary	Lower Secondary	Upper Secondary	Junior College	University
Whole Country	95.5	82.6	56.7	6.7	9.6
Urban	97.2	88.8	68.4	12.9	23.3
Rural	94.9	80.6	52.8	3.7	3.0
Poorest	88.9	59.0	23.2	0.3	0.3
Second poorest	95.3	78.7	44.2	1.8	1.0
Middle	97.0	86.7	56.1	7.8	5.5
Second richest	97.5	89.6	64.6	8.6	10.6
Richest	98.3	94.9	82.3	11.6	26.3

Source: 2009 Census, cited in GSO 2011a

2009 census data shows that Viet Nam had achieved near-universal primary education, with net enrolment rates of 95.5 percent nationally, 82.6 percent for lower secondary and 56.7 percent for upper secondary education. Around 16.3 percent of the population participates in tertiary education.

Participation in early childhood education—kindergarten and nursery school—remains relatively lower than other levels of education with 23 percent of 3-year-olds, 37 percent of 4-year-olds and 40 percent of 5-year-olds attending early childhood education in 2008.²⁵

However, despite this overall positive outlook, persistent inequalities continue to be evident in all levels of education between different socio-economic and population groups. For instance, while in 2006 an estimated 57 percent of children were attending early childhood education in Viet Nam, a type of education which is particularly critical for child development, this share was as high as 61 percent among Kinh/Hoa majority children, compared to only 40 percent for ethnic minority children; and 75 percent of urban children compared to 51 percent of rural children. Across

Viet Nam's regions, the rate varied from 40 percent in the Mekong River Delta to 80 percent in the Red River Delta.²⁶ Similar disparities are also evident in primary education, the most heavily subsidised level of education in Viet Nam. Net enrolment rates for the poorest quintile only reached 88.9 percent, compared to 98.3 percent for the richest quintile; 97 percent for the Kinh majority compared to as low as 72.6 percent for the H'mong; and ranged from 92 percent in the Northern Midlands and Mountainous Areas to 98 percent in the Red River Delta.²⁷

At higher levels the gap continues to widen: in lower secondary education the net enrolment rate is 59 percent for the poorest quintile compared to 95 percent for the richest quintile. In upper secondary education there is a 59.1 percent gap between the poorest quintile at 23.2 percent and the richest at 82.3 percent. Among ethnic minorities, the net enrolment rate in lower secondary education is 86.7 percent for the Kinh, and as low as 34.1 percent for the H'mong and 46.3 percent for the Khmer ethnic minority groups. In upper secondary education it is just 6.6 percent for the H'mong and 15.4 for the

Khmer, compared to 61.8 percent for the Kinh/Hoa majority. Between regions, the Mekong River Delta had a net enrolment rate of 71.5 percent for lower secondary education, while the Red River Delta had a rate of 93.9 percent; and in upper secondary education, there was a 34.5 percent gap between the Red River Delta at 74.9 percent, and the Mekong River Delta at 40.4 percent.

Households tend to value and prioritize investment in boys' education over that of girls'.

At the tertiary level on the other hand, education continues to be the preserve of the well off. In 2009 net enrolment rates were only 0.6 percent for the poorest quintile compared to 37.9 percent for the richest quintile. Among ethnic minorities, net enrolment rates were less than one percent for the H'mong and 2 percent for the Kinh/Hoa majority. Regionally, the Northern Midlands and Mountainous Areas net enrolment rates were 5.7 percent compared to 27.1 percent in the Red River Delta.

BOX 4.3: PERSISTENT DISPARITIES AMONG ETHNIC MINORITY COMMUNITIES²⁸

Ethnic minority groups continue to face significant barriers in accessing health and education services. The baseline survey conducted for the P135-II Programme in 2007 provides a snapshot of these difficulties and their impact on health and education outcomes. The P135-II communes are among Viet Nam's poorest: the poverty rate was 26 percent for Kinh/Hoa households compared to 51 percent for ethnic minorities, and 54 percent for those who spoke no Vietnamese. A high level of income inequality was also evident with an income Gini coefficient of 0.53—for ethnic minorities 0.43 and 0.59 for the Kinh/Hoa majority.

Almost all communes (97.7 percent) had local health care stations, 78.2 percent had primary schools and 66.9 percent had lower secondary schools; however, only 2.3 percent had upper secondary schools. Around 53 percent of households had access to clean drinking water and 13 percent had sanitary toilet facilities.

As a result, net enrolment rates were 77.46 percent for primary school, 56.1 percent for lower secondary school and 33.27 percent for upper secondary school. Enrolment rates for ethnic minorities in the poor communes surveyed were significantly lower than the average level across the country as a whole.²⁹ In addition, there were very low enrolment rates for specific groups, in particular those who spoke little Vietnamese at lower and secondary level, as well as among the H'mong, Bana, H're and Khmer.³⁰

Drop-out rates are significantly higher for ethnic minority children, with most drop-outs occurring during the transition from primary to lower secondary, and lower secondary to upper secondary

school.³¹ This is particularly so for ethnic minority girls who experience a range of gender-specific barriers to accessing education. Households tend to value and prioritize investment in boys' education over that of girls'. Reasons for higher drop-out rates for ethnic minority girls include economic barriers, the need for girls to help out in the home or by working, a perception among girls and their parents that education lacks value, the poor quality of teaching and learning in schools, and lack of suitable infrastructure such as single sex dormitories and toilets.³² While VHLSS 2008 data suggests that girls are catching up, with gender parity evident among ethnic minority groups at primary and lower secondary levels, gender differentials reappear at higher levels of education among some ethnic minority groups. Only 29 percent of Northern Mountain ethnic girls aged 15 to 17 are attending school compared to 53 percent of boys. For the Khmer/Cham, the proportion is 22 percent of girls, compared to 30 percent of boys in this age group attending school.³³

In the P135-II survey, the main reason for not attending school was being over the appropriate age to attend (38 percent), while 17 percent were working. The most serious obstacles to accessing primary education included insufficient physical facilities and equipment, limited school budgets and poor living conditions for teachers, which makes it more difficult to attract qualified staff. Most pupils were exempt from school fees and contributions—91 percent of primary school students, 81 percent of lower secondary and 69 percent of upper secondary students—a much higher rate than the average in the VHLSS 2006.³⁴ This may help to explain why some students were able to attend upper secondary school without an accessible school in their area. However, interventions to address the quality of education being provided are limited. In addition, many households still reported difficulties with school expenses—32.7 percent said they lacked cash for school fees—the rate was 37 percent for ethnic minority households.

Facilities at health centres in poor communes are typically equipped with only the most essential facilities and medicines, with conditions well below that of the average service.³⁵ Yet a majority of those who were ill or injured accessed the health centre at the hamlet or commune where they were living, travelling an average of 3.87 kilometres to do so. Treatment in better equipped hospitals occurred in 17 percent of cases and involved travelling an average distance of 39 kilometres or three hours by public transport, as district hospitals are an average of 27 kilometres and provincial hospitals an average of 91 kilometres away. Around 30 percent avoided using any available public health service, instead relying on other methods, such as self-treatment, private practitioners or traditional methods. However, the P135-II baseline survey found that far fewer people from ethnic minority groups accessed health care: only 53 percent used public health services and 47 percent avoided getting any treatment from these services. Around 84 percent of people surveyed had health insurance—90 percent for ethnic minorities. Despite high levels of health insurance coverage, 48 percent of households in targeted communes said they lacked enough medicines—the rate was 52.7 percent for ethnic minority households. As noted in the survey report, a relatively high percentage of health insurance coverage among this group, compared to low levels of health care utilization, suggests that barriers to accessing health services may be significant and require attention from policymakers.

Participants in the P135-II baseline survey were also asked about their perceptions of their current living standards. Fifty-one percent of ethnic minority households assessed themselves as being poor, while fewer (28 percent) Kinh/Hoa households reported they were poor. Fifty-three percent of respondents were unhappy with their current living standards, while a third reported that their current welfare level was 'so-so'. Unsurprisingly, given their considerably lower level of living standards, 56.6 percent of ethnic minority households were unhappy with their living standards, compared to 46 percent of Kinh/Hoa households.

DISPARITIES IN EDUCATION OUTCOMES

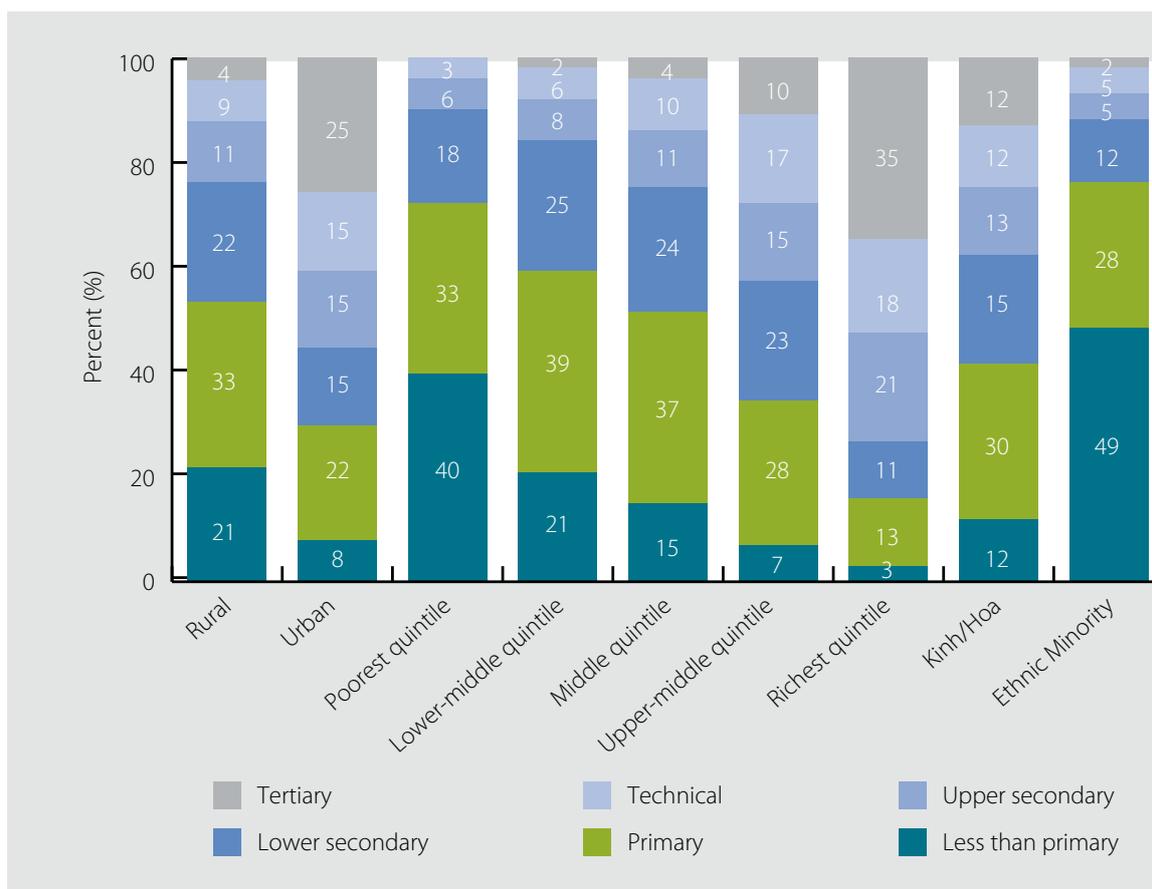
EDUCATION AND LITERACY IN POOR AND ETHNIC MINORITIES

Adult literacy rates are at 93.1 percent nationally, and among those aged 10 to 40 the male and female literacy rate is the same, at 96 percent.³⁶ According to the VHLSS 2008, although 21 percent of Vietnamese people have never attended school or gained even the most basic qualification, 23 percent completed primary education and 42 percent finished some form of secondary education. More and more Vietnamese people are attaining higher levels of

education: 14 percent had a technical or tertiary qualification in 2008.³⁷

Literacy rates among the richest quintile are 98 percent compared to 84.7 percent for the poorest quintile. In the poorest quintile, 80.2 percent of women and 89.8 percent of men are literate, compared to 96.9 percent of women and 99.2 percent of men in the richest quintile. In terms of educational attainment, there is significant variation between regions and population groups. In the poorest quintile, 36.7 percent had less than primary school education, while in 2008, 35.4 percent of people living in the Mekong River Delta had less than primary education compared to 10.3 percent in the Red River Delta.³⁸

Figure 4.1: Educational Attainment, 25- to 34-year-olds, Viet Nam, 2008



Source: Vu Hoang Linh 2010

While educational attainment is higher among younger generations, even among 25- to 34-year-olds there are significant differences between population groups (Figure 4.1). Among the poorest quintile, 40 percent have not completed primary education, while 53 percent of the richest quintile

has tertiary or technical qualifications. Similarly, 49 percent of ethnic minorities have not completed primary education, while 24 percent of the Kinh/Hoa majority have completed technical or tertiary qualifications. Divergence is also evident between regions, with 25- to 34-year-olds in the Red River

Delta the most educated, while those in the Central Highlands and the Mekong River Delta have the lowest education levels.³⁹

DROP-OUT AND COMPLETION RATES BY REGION

Drop-out and completion rates, which typically provide a more accurate assessment of gains from education than do enrolment rates alone, would seem to confirm the existence of considerable variations in educational attainment in Viet Nam for different groups of the population and across regions. Hence, primary school completion rates vary considerably by region, ranging from 80.3 percent in the North West to 93.9 percent in the South East in 2008/09.⁴⁰ Upper secondary completion rates show similar variation, with 91.9 percent completing upper secondary school in the Red River Delta, compared to 75.1 percent in the Mekong River Delta.⁴¹ Similarly, analysis of 2009 census data found significant variation in school drop-out rates across regions. The Red River Delta had seen the greatest fall in drop-out rates among 5-to-18-year-olds between the 1989 and 2009 census, and had the lowest rates in 2009. Regions in the south however, had seen less rapid declines and had higher drop-out rates in 2009, in particular in the South East and Mekong River Delta. High school and above completion rates were much higher in the Red River Delta, and significantly lower in the Mekong River Delta and the Central Highlands. While overall drop-out rates fell from 17.1 percent in 1999 to 15.5 percent in 2009, in urban areas the rate was 11.3 percent and in rural areas 16.9 percent in 2009, compared to 13.3 percent and 18 percent respectively in 1999.⁴² In rural areas the rate ranged from 10 percent for females and 11.1 percent for males in the Red River Delta to 22 percent for females and 24.3 percent for females in the Mekong River Delta, while in urban areas it ranged from 5.5 percent for males and 5.6 percent for females in the Red River Delta, to 17.6 percent for males and 16.4 percent for females in the Mekong River Delta.⁴³

GENDER GAPS IN EDUCATION

Gender parity was evident in primary education in 2008; and female net enrolment rates were slightly higher for all other levels, including tertiary education. In 2008, 22.4 percent of women were in tertiary education, compared to 19.8 percent of men.⁴⁴ This is a positive development. However distribution according to field of study continues to show significant gender segregation, which is linked to significant gender segregation in the labour market in terms of occupation and

industry. Men are more likely to specialise in engineering, manufacturing and construction, while women are more likely to specialise in social sciences, education, humanities and the arts.⁴⁵

Parents' school completion level has a significant positive effect on school enrolment.

While gender gaps among regions and ethnic minorities have generally closed in favour of girls and women, this is not the case in the North West where, for example, 53 percent of 15- to 17-year-old girls remain enrolled compared to 68 percent of boys. Among ethnic minorities, only the Khmer/Cham and Northern Mountain ethnic groups had lower enrolment rates for girls in 2008.⁴⁶ In addition, although gender gaps in education have steadily closed over time, gaps in adult literacy rates remain among older women and in ethnic minority groups as well as in the poorest quintile. In terms of educational attainment, women aged 25 to 34 are slightly more likely to have achieved less than primary education or primary education than are men. Fifty percent of women have primary education or lower compared to 43 percent of men. Men and women have equal levels of tertiary qualifications at 10.3 percent but more men have a technical qualification or some level of secondary education than women, at 13 compared to 8 percent (technical) and 33 compared to 30 percent (lower or upper secondary education).

ECONOMIC STATUS AND ETHNICITY IN ACCESS TO EDUCATION

Regression analysis conducted by Dr. Vu Hoang Linh for the 2011 NHDR provides insights into some of the determinants explaining disparities in school enrolment outcomes in 2008 at the post-primary level.⁴⁷ According to this analysis, parents' school completion level has a significant positive effect on school enrolment, with the father's completed education significant at the lower secondary level, while both parents' level of completed education was relevant for upper secondary and tertiary education. Household size is also relevant, with smaller households (those with fewer dependents) more likely to send their children to school as they have more resources to devote to their education. Unsurprisingly, per capita expenditure is strongly correlated with school enrolments at all levels, becoming more important at higher levels of education. Finally, ethnicity is a significant factor at higher levels, in particular at upper secondary and tertiary education, in part due to difficulties in

competing in entrance examinations as a result of poor quality of teaching at lower levels and language barriers, as will be discussed in Chapter Five.⁴⁸

As this discussion has shown, disparities in access to health and education services are strongly correlated with disparate health and education outcomes, including key indexes in the HDI and human development family of indicators. These disparities are persistent and prevalent between provinces and regions, among ethnic minorities and the Kinh/Hoa majority, and along wealth lines. Disparities are also gendered in particular in education, though gender gaps have been narrowing over time at the primary and lower secondary level. Inequities in access to health and education are not just a result of persistent inequalities and disparities; they also reinforce and perpetuate existing inequalities between different ethnic and socio-economic groups and geographical

areas. Over time, deficits in human development become entrenched and harder to change: this has, for example, been Viet Nam's experience with poverty reduction in remote and ethnic minority communities. Lack of access to basic social services effectively closes the door on pathways out of poverty and disadvantage towards higher levels of choice, capabilities and human development. It is therefore all the more critical that Viet Nam addresses the key barriers of variable availability, rising costs, and poor quality and responsiveness of social services, as Chapter Five will show.

Inequities in access to health and education... reinforce and perpetuate existing inequalities between different ethnic and socio-economic groups and geographical areas.

BOX 4.4: DISPARITIES IN ACCESS TO HEALTH AND EDUCATION AMONG RURAL-URBAN MIGRANTS

For rural-urban migrants, access to health and education services is, to a large extent, dependent on the household registration (*ho khau*) system, which establishes four categories of registration. These are local original residents (KT1); people registered in the same province but now living in a different district (KT2); people registered in one province but with permission to reside permanently in another (KT3); and seasonal workers and students living temporarily in a different province from their registration (KT4). Unregistered migrants are those who remain on household lists in their home communes and wards but actually live either temporarily or permanently in another district or province without registration. Once migrants lose their original registration records, it is very difficult to register in a different location: in effect they become undocumented.⁴⁹

Often migrants end up paying considerably more for health services, either because they don't have health insurance, or in order to avoid delays in accessing health services.

Children of KT1 and KT2 residents are given priority at qualified government schools, with children of KT3 and KT4 migrants only able to access places that are left over. These migrants, together with those who are unregistered, have two options: either apply for semi-public or private schools which typically charge higher fees, or pay extra to have their children admitted to public

schools. Similarly, unregistered migrants and those with KT3 and KT4 status are often not eligible for social services provided under national hunger eradication and poverty reduction programmes. These include low interest loans, free health care and exemption from school fees. Many migrant workers live in poor housing and low income settlements and face considerable hurdles in gaining access to secure land and housing tenure, as well as to electricity, water and sanitation services.

For migrants working in Industrial Parks and Export Processing Zones—who make up 70 percent of the workforce in these areas, are typically unregistered, and move jobs frequently—the main difficulties they encounter are not directly related to the *ho khau* system. Instead, low wages, poor housing and the high cost of living directly impact their ability to look after their health and well-being. Often these workers agree with their employers not to deduct the social insurance payment

from their salary, they spend very little on food and health care and pay higher-than-average costs for housing and electricity. They often face vulnerabilities associated with unstable income, unsafe work and poor living conditions.

Informal workers in urban areas working in sectors such as construction are rarely registered and are highly mobile. Most are unable to fulfil the criteria to access residency and therefore face problems getting their children into school. As a representative of the HCMC People's Committee said: "Without birth certificates, the children are not eligible for free health care (for children under 6 years of age) or able to enrol for admission to the primary schools. Private schools with lower quality standards may accept these children without birth certificates, at a higher charge. These children are Vietnamese citizens but not (treated as) nationals of Viet Nam. They account for 5 to 10 percent of migrant children in this city."

Typically urban migrants will either pay the higher fees for private schools or try to use social networks and pay additional costs to access public education. Often migrants leave their children with their extended family or neighbours in their area of origin, and use the money they remit to support their education and care. These arrangements put enormous emotional strain on migrants and their children. As a 34-year-old female street vendor said: "I send some money to my parents for school fees and living expenses of my child and some to support my parents taking care of my child. Sometimes I feel sorry for my child having to be away from me, but if I do not work here I will not have any money for him. We will not have money enough for meals, let alone for better meals with meat and milk..."

Migrants who have good jobs, contacts and living conditions are able to benefit from the KT3 status to become permanent residents. These migrants are better off and are able to afford to pay additional fees to access social services. However, even those with permanent status often do not use their health care cards to access health services. According to a representative of

Many migrant workers live in poor housing and low income settlements and face considerable hurdles in gaining access to secure land and housing tenure, as well as to electricity, water and sanitation services.

the Central Party Department for Propaganda and Education: "People, regardless of migrant status, rarely utilize health insurance cards for health care and treatment, due to the very poor quality of services with health insurance. In the central city hospitals, over 50 percent of the patients come from the provinces, and a majority of them use the uninsured health channel for better quality treatment."

Migrants in urban areas typically have worse health and their health deteriorates more rapidly than non-migrants. Health problems impose a substantial burden on migrants, in particular those working in the informal sector for low wages. Many avoid using health care providers due to the high cost of services. Female factory workers who participated in a group discussion in Ho Chi Minh City reported that: "It is very costly to go to the hospitals. We only go to hospital if we feel very ill or worried. For normal illness we just buy drugs at pharmacies. The drug sellers can also give us advice on which drugs to use."

Often migrants end up paying considerably more for health services, either because they don't have health insurance, or in order to avoid delays in accessing health services. Those with KT4 status, or who are unregistered, lack health insurance cards for their children and do not receive vitamin or vaccine information or programmes. Poor attitudes among health workers in insurance-based hospital services were also cited as a reason for using un-insured services. In a mixed gender discussion group of factory workers in Ho Chi Minh City participants observed: "If we use insured hospital services we not only have long waits, but the attitude of the hospital staff is also not nice. They tend to ignore us, keep us waiting, and sometimes they are not very polite. It is totally different if we use the basic, non-insured services or private clinics. We can only get poor treatment or be provided with cheap medicines if we use the health insurance card."

SOCIAL SERVICES POLICY AND FINANCING

POLICY FRAMEWORKS

SOCIAL POLICY COMMITMENTS TO UNIVERSAL ACCESS

As Chapter Four has shown, disparities persist in access to health services and in education in particular at higher levels. This chapter analyses key factors that contribute to these disparities, including overarching policy frameworks and approaches, financing of health and education, and provision and quality of basic social services in Viet Nam. The chapter finds that, despite the stated intent of Viet Nam's policy frameworks to provide universal access to social services to all Vietnamese people, the current situation of social service provision in Viet Nam appears to be contributing to persistent and widening disparities. This presents a challenge to Viet Nam's aspirations for higher human development.

At a policy level, Viet Nam is committed to ensuring universal access to social services, in particular education and health, in order to achieve higher levels of human development and attain Viet Nam's development goals. Viet Nam's strong policy commitment to universal access is evident in many of its key social policy documents and frameworks. For example under Decree 26/2005/ND-PC and the 2005 Law for Protection, Health Care and Education to Children, health care is considered as a basic right and children under 6 are entitled to free health services. The Law on Health Insurance passed in 2009 aims to ensure universal access to health services by extending health insurance coverage to the entire population by 2014. The National Education Targeted Programme commits Viet Nam to providing universal basic education, including early childhood education, primary, lower secondary and non-formal education.

However, while policy frameworks outline Viet Nam's continued commitment to universal access to education

and health services, in practice the Government has relied on targeting to ensure that the most vulnerable and disadvantaged are able to access basic services, including via major poverty reduction programmes. In particular these are the National Targeted Programme on Poverty Reduction (NTPPR) and the Programme for Socio-Economic Development in Communes Facing Extreme Hardship in Ethnic Minority and Mountainous Areas (P135-I and P135-II). In addition, a key feature of Viet Nam's policy approach to social service delivery has been the socialization policy, which was introduced to ensure sustainability of funding and provision of social services. A third key policy intervention has been the decentralization of social service governance to service delivery organizations. As this chapter shows, each of these approaches has, in practice, created challenges in ensuring universal access to quality social services for all Vietnamese people.

At a policy level, Viet Nam is committed to ensuring universal access to social services, in particular education and health.

UNIVERSALISM VERSUS TARGETING

Since the *doi moi* reforms, and despite its political and policy-level commitment to universal access, the Government has increasingly shifted responsibility for provision and funding of health and education services from the state and public providers to the private sector and households. In practice this represents a shift from universalism to provision of safety nets with the Government primarily supporting those most in need, while market-based provision and household payment play a greater role.¹

In principle, there is nothing problematic about combining principles of universalism and targeting by ensuring access to a basic floor of health and education services for all citizens, while also targeting specific population groups to address inequality and disadvantage and ensure they can access services

in practice. Targeting can also help to maximize return on investment, for example by ensuring prevention and early intervention initiatives reach specific population groups. Most countries feature a combination of targeted and universal social policies², and “the social policy literature does not reach firm conclusions on the question of whether universalism or targeting is the more efficient option”³.

Universal access to social services is a key human rights principle, and a prerequisite for promoting equitable human development.

Efficiency notwithstanding, universal access to social services is a key human rights principle, and a prerequisite for promoting equitable human development. At the same time, there is a place in any health and education system for targeted initiatives, such as teaching ethnic minority children in their mother tongue, training midwives from ethnic minority communities to ensure skilled midwife delivery in remote communities, providing vaccinations to infants and young children and ensuring pregnant women can access ante-natal care in the communities where they live.

However, in today's Viet Nam, the health and education system does not in practice provide a basic floor of education and health services to all citizens supplemented by targeting for specific groups. In reality, access to services is increasingly dependent on user-fees, imposing a significant burden on those who are disadvantaged, unable to access services in their local area, or on low incomes.⁴ While subsidies are provided to those who are most in need via a range of government programmes, there are overlaps and gaps in current coverage under these initiatives. In addition, the kind of targeting that is taking place, for example via the major poverty reduction programmes, is contributing to the emergence of a two-tier system of services. In effect, a different level of education and health care is available to those who can afford user fees than that which is available to the poor and disadvantaged via subsidies and fee exemptions. Thus, in order to ensure equitable access to social services, Viet Nam now needs to move away from highly targeted and specific programmes towards development of a universal social protection system. This system would offer support to people in a variety of different circumstances and be able to cushion ordinary people from economic, environmental and health shocks, as well as providing support and protection to the most vulnerable and disadvantaged.⁵

In doing so, Viet Nam can learn from other countries in the South-Eastern and Eastern Asia region which have higher levels of social protection and which have moved towards universalism, such as Japan, Taiwan, Korea and Thailand. These countries typically also have higher levels of human development as measured by the Human Development Index (HDI) and other human development indicators.⁶

A COMPLEX SYSTEM OF BENEFITS AND SUBSIDIES

Viet Nam's policy commitments and frameworks set out the country's continued strong commitment to universal access to social services. However, there is a significant gap between policy and practice. The system of benefits available under Viet Nam's various social protection and poverty reduction programmes, including those which subsidise access to health and education services, is complex and overlapping, and not always effective in reaching those who are most in need. For instance, a 2009 review by the Parliamentary Committee for Social Affairs of Viet Nam's poverty programmes found 75 key interventions across a variety of different sectors and approaches. The review found 14 projects and sub-components supporting access to education, most of which were outside mainstream education and the Education for All national programme. There were also an additional seven supporting access to vocational training. Five interventions were related to health, excluding those aimed at improving access to water and sanitation. Most interventions were focused on ensuring access for poor and ethnic minority populations, as well as infrastructure development in the health and education sectors.⁷

Although the Health Insurance Law has, to some extent, rationalized and simplified the subsidies available to support access to health care, problems of quality and affordability remain. Increased access to health insurance does appear to have helped to contain disparities in access to services that might otherwise have grown even more severe. Health insurance coverage has been steadily increasing, so that as of 2010 an estimated 61 percent of the population was covered by health insurance,⁸ However Viet Nam remains unlikely to achieve universal health insurance by 2014 (see Box 5.4). Given the limited depth of coverage currently available to those accessing the low benefits offered via the various poverty programmes, even universal health insurance coverage would not be sufficient to ensure universal access to health care for all. Subsidies offered via different programmes to support access to education, in particular at primary

and lower secondary level, do not appear to be sufficient to offset rising costs of schooling and other barriers. As discussed in Chapter Four, there are signs of persistent gaps between different

socio-economic groups and regions in enrolment and completion rates, in part as a result of rising costs of even basic education to households.

Table 5.1: Key National Policies with Provisions Affecting Access to Health and Education Services, Viet Nam

Policy/intervention	Policy or legislative framework	Target group/entitlements ⁹
Free health care services for children under 6	Decree No. 36/2005/ND-CP, Law on Child Protection, Care and Education; Law on Health Insurance	All children under 6 years are entitled to free health services in public facilities. Now included under Social Health Insurance.
Health Insurance	Health Care for the Poor (Decision 139/2002/QĐ-TTg on 15/10/2002); Law on Health Insurance 2008	People working in formal enterprise and state sectors are covered under the compulsory health insurance scheme as part of their compulsory social insurance. Specific population groups are covered by free or subsidised health insurance. This includes children under 6 (see above), poor people, pensioners, veterans etc. The new social health insurance policy under the Health Insurance Law incorporates the Health Care for the Poor and children under-6 initiatives. Voluntary health insurance covers those not eligible under 1 and 2 including students, farmers, and informal workers and so on. Coverage remains limited. Enrolment fees for non-students are 4.5-6 percent of the minimum wage. Financial incentives are offered to the near poor to join. Partial subsidies (50 percent) are available for near-poor households.
Compulsory social insurance	Law on Social Insurance 2006	Compulsory social insurance includes pension benefits as well as compulsory health insurance (see above), maternity benefits and workplace accident and disability insurance. Workers holding formal contracts are covered, including public servants and government employees, employees having labour contracts of more than 3 months, military and police officers and employees of the party.
National Targeted Programme for Poverty Reduction (NTPPR)	Decision 20/2007/QĐ-TTg on 05/02/2007	The MOLISA poverty line is used to identify beneficiaries. Under the National Targeted Programme, vocational training, health and education assistance are provided to targeted households. Health care cards, support in terms of cash or tuition fee exemptions and student loans and scholarships are also included, as well as infrastructure development (schools, hospitals and health clinics).
The Socio-Economic Programme for Extremely Difficult Communes in Ethnic Minority and Mountainous Areas (P-135 II)	Decision No. 07/2006/QĐ-TTg on 10/1/2006	Communes are selected on the basis of location, ethnicity, and poverty rates and so on. Also include infrastructure development (schools and health clinics); vocational training.
The Rapid and Sustainable Poverty Reduction Programme for the 62 Poorest Districts (62 Districts)	Resolution 30a	Direct support for education, cash and tuition fees exemption, vocational training for the poor, infrastructure development (schools, hospitals and health clinics).
Other	Circular 109/2009/TTLT-BTC-BGDDT on 29/5/2009; Circular No. 43/2007/TTLT-BTC-BGDDT on 2/5/2007	Support for students of boarding schools for ethnic minorities. Scholarships and social aid for ethnic minority students.

Source: Dao Thi Hoang Mai 2010; Jones and Nguyen Ngoc Anh 2010; Parliamentary Committee on Social Affairs 2009

SOCIAL PROTECTION IN VIET NAM

Viet Nam achieves an estimated rate of 71 percent of the poor receiving any form of social protection, well above the 56 percent average for Asia.

Viet Nam invests less in social protection than other countries in the region, yet is above average in the number of people receiving social protection. Although Viet Nam invests around 4.1 percent of GDP in social protection—more than Indonesia, the Philippines and Malaysia—this is still lower than the regional average for Asia of 4.8 percent, and below countries such as China at 4.6 percent, South Korea at 7.5 percent and Japan at 16 percent.¹⁰ Viet Nam achieves an estimated rate of 71 percent of the poor receiving any form of social protection, well above the 56 percent average for Asia.¹¹ Poverty reduction programmes are relatively successful in reaching intended beneficiaries, with 84 percent of poor households benefiting from health exemptions and 51 percent benefiting from education exemptions in 2008.¹² However, there remain issues with the way these programmes are targeted.

The various poverty programmes use the monetary poverty line to determine eligibility; for the 2006 to 2010 period, the government poverty line was just 200,000 VND a month for rural areas and 260,000 VND for urban areas. Many of the large numbers of Vietnamese people living near or just above the poverty line who are vulnerable to falling back into poverty as a result of shocks such as illness, economic downturn, disability or natural disasters were excluded from assistance.¹³ As noted in Chapter Two, Viet Nam's official poverty line is well below that of most other countries in the region, with the exception of China.

Viet Nam recently introduced a new poverty line that includes cut-offs for the poor and also for the near poor in order to respond to rising costs of living and to increase the level of coverage.¹⁴ However, certain groups, such as unregistered migrants, are still excluded from government assistance. In addition, use of more nuanced, multi-dimensional measures of poverty is relatively new and has not yet been adopted as a more effective way of targeting assistance to the poor and disadvantaged. These measures include the new Multi-dimensional Poverty Index (MPI) introduced in the 2010 global HDR, the Child Poverty Rate (CPR), and the Human Poverty Index (HPI), as discussed in Chapter Three.

Socialization in Viet Nam has meant greater involvement of the private sector in delivery of social services, and of households in financing health and education, as well as commercialization of both public health and state education services.

THE SOCIALIZATION POLICY

Prior to the *doi moi* reforms, the State was responsible for funding and delivery of health and education services. However, following the fiscal crisis that Viet Nam experienced in the late-1980s as a result of its transition from central planning to a market-oriented system, it became evident that the State could not afford to fund and deliver services to all Vietnamese people. A solution would have to be found. The so-called 'socialization policy' (Box 5.1) represents Viet Nam's attempt to find that solution. All sectors of society would be expected to contribute to financing and delivery of social services. However, in practice, socialization in Viet Nam has meant greater involvement of the private sector in delivery of social services, and of households in financing health and education, as well as commercialization of both public health and state education services.

BOX 5.1: THE SOCIALIZATION POLICY EXPLAINED¹⁵

Prior to the *doi moi* reforms in 1989, every citizen received free health and education services. The national health and education systems were solely public in terms of both provision and funding¹⁶, were financed via the central budget, and provided by local work-units including state-owned enterprises, administrative units and agricultural cooperatives. Although access to, and quality of, services were constrained by limited funding, Viet Nam was able to achieve impressive levels of access and higher health and education outcomes than other countries with comparable levels of wealth. These arrangements remained in effect until the late-1980s, when general conditions of economic shortage were followed by an acute fiscal crisis in 1989. The crisis undermined state functions including provision of health and education services, hastened market reforms, and heralded a shift from exclusive public provision and payment to more diverse institutional and funding arrangements.

Faced with a fiscal crisis, Viet Nam's state simply lacked the financial resources required to sustain the education and health systems based exclusively on public spending. Viet Nam's social policies underwent a critical realignment as a result. This process was facilitated by the adoption of the socialization policy. As early as 1989, state officials looking for a way to expand non-state payments for essential services began to advocate for the policy agenda that would be known as 'socialization'. Originally envisaged as a strategy for social mobilization, socialization calls on all sectors of society to contribute to education and health. It sets out the different responsibilities of actors in society as follows: the general population, mass organizations, the private sector are to be involved, with the State playing the role of policymaker, resource coordinator and enforcer to ensure quality, efficiency and equity.¹⁷ As a long-time health official and one of the architects of the socialization policy put it:

The concept of socialization should be understood as an effective and planned cooperation of activities of all social forces following a national direction and a strategy aiming to resolve a social problem... For each community, family, citizen, socialization is understood as a process of response to and participation in the leaders' mobilization movement; then becoming a process of active and conscious activities for the sake of improving their own quality of life... Socialization is understood as a 'social solution' of highly inter-sectoral characteristics, with the participation of many social forces.¹⁸

As the state budget was no longer able to sustain the health and education system, 'fees-for-service' were introduced as early as 1989 in public health and education services. Initially these measures were introduced as a cost-recovery mechanism and were labelled 'partial' collection of costs. Over time, the importance of fees-for-service has undoubtedly increased.

In spirit, the socialization policy was designed to fully engage different actors in addressing social issues. As stated at the 8th Party Congress: "Social policy problems must all be resolved with the spirit of social mobilization. The State holds the leading role and, at the same time, encourages the people, enterprises, social organizations, individuals and foreign organizations to work together to resolve social problems".¹⁹ In effect, however, the socialization policy has not so much engaged different sectors of society, including households, in the design, delivery and funding of health and education services. Rather it has shifted responsibility onto the public sector to generate additional revenues, increased the involvement of the private sector in delivery of services on a for-profit basis, and made individual households responsible for paying for them. Thus the understanding of 'socialization' in Viet Nam differs radically from its international meaning: the adoption of institutional responsibilities for providing and paying for services by the State.²⁰

The impact of the socialization policy has been profound. Modes of service provision have diversified, with greater involvement of the private or 'non-state' sector. However the public sector

remains predominant in both health and education, and non-state, not-for-profit provision of social services is largely undeveloped.²¹ But by far the greatest impact of socialization has been on the funding of services, including increasing commercialization and the expansion of both formal and informal payments.²² Informal payments include the practice of 'gift-giving' or envelope payments to medical staff and teachers, and the institutionalization of extra classes in the education system. These practices developed in response to low salaries and public spending in health and education in the 1990s and 2000s, which have continued until the present day. In addition, the mechanisms used to fund health services, mainly fees-for-service, have enabled both public and private providers to generate additional demand for unnecessary services and products such as pharmaceuticals.

As the socialization policy has shifted responsibility for paying for social services on to households, and as costs to households of health and education have risen, the Government has needed to put in place policies to ameliorate the impact of these costs on the poor and vulnerable.²³ In this sense, there is a direct link between commercialization of health and education services and targeting: targeting comes to be required as a result of privatization and commercialism to provide a safety net for those who cannot afford to pay.²⁴ Yet targeting cannot always ensure access effectively: under coverage and leakage are common problems in targeted interventions.²⁵ In Viet Nam, the use of a relatively low poverty line to determine eligibility is a key example: many people in Viet Nam live close to the poverty line but are excluded from accessing programmes and benefits.²⁶

There are evident tensions between political and policy-level commitments to universal access to health and education, and the reality of how these services are delivered and paid for in Viet Nam. Most countries have mixed modes of funding and delivery of social services: the issue is how the costs are distributed and the impact on broader human development and equity goals. These are critical policy issues for Viet Nam, and it is perhaps timely to revisit the spirit and intent of the socialization policy, namely to promote effective engagement of all sectors of society in the design, delivery and funding of health and education.

SOCIALIZATION AND THE COMMERCIALIZATION OF SOCIAL SERVICES

The opening of education and health sectors to market forces is not in and of itself a bad thing. Competition can improve both the quality of, and access to, services allowing private providers to deliver more popular and lucrative services. Meanwhile the State focuses on regulation

and oversight, funding of less profitable but nevertheless essential services including those for vulnerable groups, and ensuring social equity. In practice however, Viet Nam has seen not only increasing marketization and privatization of health and education services, but also rapidly increasing commercialization, much of which goes unregulated, regardless of whether it takes place in the public or private sector.

BOX 5.2: MARKETIZATION, PRIVATIZATION AND COMMERCIALIZATION OF SOCIAL SERVICE DELIVERY

Marketization of social services refers to the opening of social service delivery to markets, thereby improving competition and, at least in theory, offering greater choice to consumers. Privatization refers to the provision of social services by privately owned and managed businesses, in addition to services provided by the state and non-state, not-for-profit sectors. Commercialization, on the other hand, involves the delivery of social services on a fee-for-service basis, where the service delivery organization seeks to recoup the costs involved in service delivery direct from the consumer. In Viet Nam, both public and private health and education services charge user fees and operate on a commercial basis.

It appears that commercialization has had a number of negative effects. Firstly, it has driven up the costs of health and education beyond what many poor and disadvantaged people are reasonably able to bear. Secondly, it has, in many instances, actually depressed the quality and availability of services, as providers deliver only what is profitable and to those who can afford to pay. Thirdly, commercialization creates perverse incentives that undermine the professionalism and ethical behaviour of service providers, as discussed in Box 5.1. The State has largely focused on providing safety nets to the poorest and most disadvantaged, via a system of targeted poverty reduction and social protection programmes. These are widely acknowledged to be complex and overlapping, and often struggle to reach and support those who are most in need. The equitable and inclusive human development process that Viet Nam's leaders aspire to, and that its citizens expect, is undermined by these trends.

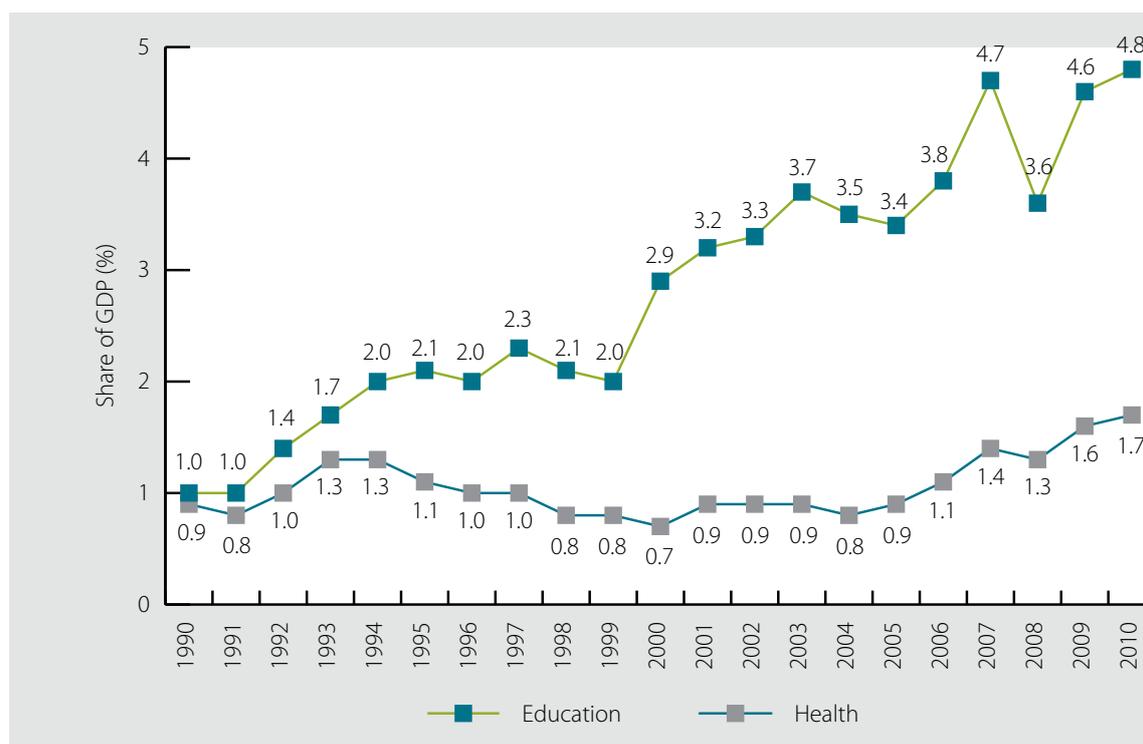
Viet Nam has seen not only increasing marketization and privatization of health and education services, but also rapidly increasing commercialization.

HEALTH AND EDUCATION FINANCING

RISING EXPENDITURE ON HEALTH AND EDUCATION

Total spending on health and education (from all sources including state and household expenditure) has steadily increased and shows no sign of slowing. As noted in Chapter One, Viet Nam has relatively high levels of public education expenditure and comparable public health care expenditure as a proportion of GDP compared to other countries in the region. However, private spending has accounted for the largest source of overall spending on health and education, with out-of-pocket payments constituting the bulk of this expenditure. Both public and private spending has continued to increase in real terms, although state spending on education has steadily outstripped state expenditure on health care. Figure 5.1 shows the proportion of recurrent public spending on health and education between 1990 and 2010 as a proportion of GDP.

Figure 5.1: Recurrent Public Expenditure on Health and Education as a Share of GDP, Viet Nam, 1990-2010



Source: Ministry of Finance cited in London 2010b

Vietnamese people pay among the highest out-of-pocket costs for health and education in the region. Not only do household contributions represent the largest source of payments in both education and health, these costs represent a significant proportion of household expenditure. Over time, private spending has accelerated faster than public expenditure in these two areas, though this is also rising steadily, as discussed below. Household spending varies considerably by region and socio-economic group, largely reflecting differences in available income. High costs of both health and education directly borne by end users tend to reinforce and even deepen existing disparities in access to social services, and thereby exacerbate inequalities in health and education outcomes.²⁷

High costs of both health and education directly borne by end users tend to reinforce and even deepen existing disparities in access to social services.

DECENTRALIZATION LEADS TO VARIABLE PROVINCIAL SPENDING

A key feature of the Vietnamese fiscal system has been increasing decentralization and devolution to the sub-national level. Over time, authority over expenditure has increasingly been decentralized, with a large majority of health and education spending now taking place at local levels of administration, as discussed in the following section.²⁸

Public expenditure in Viet Nam accounts for a lower proportion of health expenditure than in most neighbouring countries.

While this may help to channel resources where they are most needed, there is significant variation in the way resources are used at a sub-national level, and it is therefore more difficult for central government to ensure resources are used efficiently. Variable public spending on health and education at a provincial level is one of the factors that contribute to differential outcomes in human development discussed in Chapters Three and Four of this report.

HEALTH FINANCING

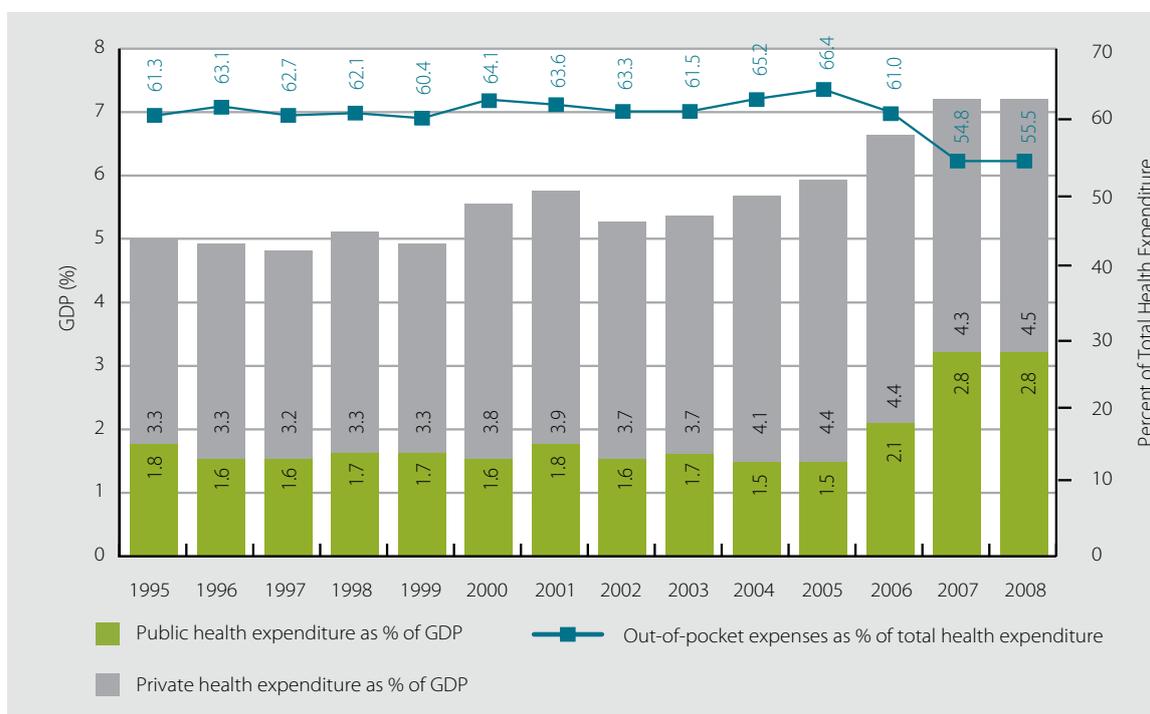
HEALTH EXPENDITURE

According to WHO National Health Accounts data, in 2008 Viet Nam spent 7.3 percent of GDP on health or US\$77 per capita Purchasing Power Parity (PPP). Of this, 38.5 percent was government expenditure and 61.5 percent was private expenditure, the majority of which was out-of-pocket expenses.²⁹ Out-of-pocket expenses represented about 90 percent of private expenses or 56 percent of total health expenditure.³⁰ Out-of-pocket expenditures reached a peak of around 66 to 67 percent of total health expenditure in 2005 but have since fallen, largely as a result of increased government expenditure on health, as well as the expansion of health insurance (Figure 5.2). External assistance accounts for less than 2 percent of health expenditure and around 10 percent of state budget spending.³¹ While Viet Nam's expenditure on health as a percentage of GDP outstrips many other countries in the region, many of these countries tend to have a higher proportion of government expenditure on health, as shown in Table 5.2. Public expenditure in Viet Nam accounts for a lower proportion of health expenditure than in most neighbouring countries, with the exception of the Philippines. Only Indonesia and the Philippines spend less in per capita terms. To sum up, Viet Nam has lower public health spending than other countries, with most expenditure from private sources.

RISING PUBLIC HEALTH SPENDING

While government spending has generally been lower than in other countries in the region, it has risen steadily from 4.8 percent to 10.2 percent of the state budget between 2002 and 2008.³² In 2008, the health budget was 43,048 billion VND, up from 5,098 billion VND in 2000 and far offsetting inflation during the same period.³³ The Government has committed to increase the annual budget for health care at a faster rate than the overall state budget.³⁴ Resolution 18 commits the Government to "increase the share of the annual state budget expenditure for health care, ensuring that the growth rate of health spending is higher than the growth rate of overall spending from the state budget, and reserving at least 30% of the state health budget for preventative medicine."³⁵

Figure 5.2: Health Expenditure, Viet Nam, 1995-2008



Source: WHO National Health Accounts <http://www.who.int/nha/en/>

Public expenditures on health care include allocations to different levels of health services and allocations via health insurance.³⁶ Capital investment costs, together with a portion of recurrent costs, in particular salaries, are paid for by the central government budget. Recurrent spending accounts for around 93 percent of the state budget, while investment spending is at 6 to 7 percent.³⁷ Despite increased state expenditure on health care, the bulk of the government health care budget goes to

services and supply-side subsidies, with significantly less going to health insurance, including subsidies for the poor and other disadvantaged groups.³⁸ However, the proportion of public health expenditure allocated to health insurance has been steadily increasing, rising from 7.9 percent in 2005 to 17.6 percent in 2008, and reflecting increasing coverage for these groups.³⁹ The difficulty in increasing health insurance coverage relates to voluntary membership, as discussed in Box 5.4.

Table 5.2: Total Health Expenditure and Public Health Expenditure, Selected Asian Countries, 2008

Country	Total health expenditure as a % of GDP	Public health expenditure as a % of total health expenditure	US\$ per capita PPP(\$)
Indonesia	2.0	55.3	45
Thailand	4.0	75.1	242
Philippines	3.8	32.9	44
China	4.3	46.7	121
Malaysia	4.3	44.1	279
South Korea	6.6	54.9	999
Viet Nam	7.3	38.5	77

Source: London 2010b, updated with data from WHO NHA 2008

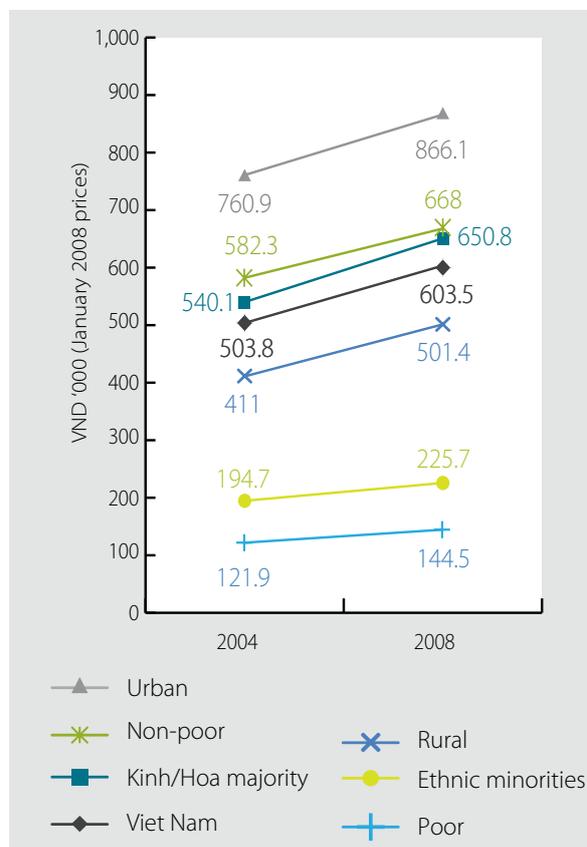
Public expenditure is not aligned with government priorities for preventative care, local-level care and support to disadvantaged areas.

State expenditure, while rising steadily, is not efficient or aligned with government priorities for improved health outcomes. For example, the 2008 Joint Annual Health Review on health financing suggests that public expenditure is not aligned with government priorities for preventative care, local level care and support to disadvantaged areas. This is because funding for development is focused on the national and provincial level, and expenditure is heavily weighted towards curative rather than preventative care.⁴⁰ The share of spending on preventative care has fluctuated over time, and was at around 28 percent nationally in 2007, short of the 30 percent target set by Resolution 18.⁴¹

SUB-NATIONAL LEVEL PUBLIC HEALTH SPENDING

The sub-national level accounts for a higher proportion of the state health budget, estimated at 63.2 percent in 2005. Different patterns of expenditure are evident at the sub-national level compared to the central level; for example, sub-national administrations spend less on preventative care, with most resources spent on curative care. Provincial spending on health care varies from 5.5 to 8 percent, with some localities spending almost nothing on preventative care at all.⁴² Low levels of spending at the district and commune level, which is responsible for commune health stations, help to account for low quality infrastructure, problems attracting and keeping staff, and low budgets for recurrent expenditure. All of these factors contribute to low quality of care in general.⁴³ Public spending on specific health care services also varies considerably by region and by provinces. For example, as shown in UNICEF's analysis of spending on child and maternal health services, average per capita spending in Ninh Thuan province was twice that of An Giang.⁴⁴

Figure 5.3: Per capita Out-of-pocket Expenditure on Health Care, Viet Nam, 2004-2008



Source VHLSS 2004, 2008 cited in Nguyen Viet Cuong 2010

OUT-OF-POCKET PAYMENTS BURDEN HOUSEHOLDS

Currently in Viet Nam, total private household expenditure accounts for around 60 percent of overall health expenditure, while out-of-pocket expenditure accounts for 56 percent of total health expenditure. This is considered very high for low- and middle-income countries. It is also well above the maximum of 30 percent considered to be optimal to achieve the goal of universal health care. Above this level households frequently face catastrophic health costs, that is, spending more than 40 percent of household expenditure on health care services. Levels of out-of-pocket expenditure in the Asia-Pacific region represent over 60 percent of total health expenditure, and rates of impoverishment due to health care costs in China and Viet Nam are among the highest in the world.⁴⁵ The cost of health care to Vietnamese households is rising. Overall average per capita out-of-pocket

expenditure on health care rose by 20 percent from 503,800 VND in 2004 to 603,500 VND in 2008 (at January 2008 prices), representing around 7 percent of household living expenses in 2008. Kinh/Hoa households, the non-poor, urban households, and those in the South East spend the most and poor households and ethnic minorities the least (Figure 5.3). Although health spending as a proportion of living expenditure stayed relatively constant between 2004 and 2008, in value terms all socio-economic groups and people in all regions are spending more than they did in the past. Ethnic minorities and the poor spend the lowest proportion of household expenditure on health, at 4.7 percent and 5.6 percent of per capita household expenditure respectively. While those in urban areas spent 1.7 times as much as did those in rural areas, the richest quintile, and the Kinh/Hoa majority spent three times as much as the poor and ethnic minorities.⁴⁶

Rates of impoverishment due to health care costs in China and Viet Nam are among the highest in the world.

Out-of-pocket spending on health services per contact visit rose by 20 percent from 189,100 VND in 2004 to 227,000 VND in 2008 for outpatient services, and by 16 percent from 1,909,000 VND in 2004 to 2,218,000 VND in 2008 for inpatient services (at January 2008 prices). Spending on outpatient services increased among all population groups and regions, with the exception of the North Central Coast and the North East. Spending on inpatient services also increased among all groups and regions between 2004 and 2008, except in the Mekong River Delta and the South Central Coast.⁴⁷ Spending also varied considerably between different socio-economic groups and regions.

Table 5.3: Expenditure on Health Care as a Percentage of per capita Expenditure, Viet Nam, 2004-2008 (%)

		Outpatient		Inpatient	
		2004	2008	2004	2008
	All Viet Nam	2.9	3	29.6	28.9
Age	Below 15	1.8	1.6	19.5	17.2
	Aged 16-60	3.2	3.2	30.2	30.2
	Above 60	3.2	3.6	31	32
Sex	Male	3	3.1	33.2	32.3
	Female	2.8	2.8	26.6	26.1
Ethnicity	Kinh/Hoa	2.9	2.9	30.1	29.3
	Ethnic minorities	3	3	21.6	26.1
Poverty	Non-Poor	2.8	2.9	29.6	28.9
	Poor	3.7	3.5	19.2	21.1
Urban-rural	Urban	2.3	2.5	24.9	24.3
	Rural	3.4	3.2	33.4	32.6
Region	Red River Delta	3.2	3.2	28.7	28.3
	North East	3.9	3.2	23.9	26.5
	North West	4.1	3.8	31.9	23.3
	North Central Coast	5.6	4.2	28.9	38.5
	South Central Coast	3.2	3.2	27.7	21.9
	Central Highlands	3.3	3.3	27.3	34.7
	South East	2.1	2.9	30.8	32.1
	Mekong River Delta	2.1	2.1	37.3	28.8

Source: VHLSS 2004, 2008 cited in Nguyen Viet Cuong 2010

People over 60, adults aged 16 to 60 and the non-poor, the Kinh/Hoa majority and men had higher levels of out-of-pocket expenditure than other socio-economic groups. The lowest levels of out-of-pocket expenditure were among the poor, ethnic minorities and children under 15. In terms of Viet Nam's regions, people in urban areas and in the South East spent the most. People in the Mekong River Delta and the North West spent least on outpatient services, while those in the Mekong River Delta and the South East spent least on inpatient services. One reason for considerably lower levels of expenditure among the poor, children and ethnic minorities is higher levels of health insurance coverage, discussed below. Lower out-of-pocket expenditure may also be due to lower rates of service utilization, which in turn indicates reduced financial access. Women have lower levels of spending than men, which is surprising given that they have higher levels of use of both inpatient and outpatient services, but lower levels of health insurance coverage.⁴⁸

While the value of health care spending rose between 2004 and 2008, the ratio of expenditure per out-of-pocket contact with a health service to per capita expenditure remained relatively stable between 2004 and 2008, averaging around 3 percent for outpatient care and as much as 29 percent for inpatient care (Table 5.3). The elderly, men, ethnic minorities, the poor and those in rural areas spent more per capita than average per outpatient visit, as did people in the North Central Coast and the North East. On the other hand, adults aged 16 to 60, men, the Kinh/Hoa majority, the non-poor and people in the North Central Coast and the Central Highlands spent more per capita than average per inpatient visit. Indeed, at 29 percent of per capita expenditure, spending per inpatient visit represents a significant proportion of per capita expenditure, including for low-income groups, reflecting the burden of health expenditure on poorer households.⁴⁹

HIGH LEVELS OF 'CATASTROPHIC' HEALTH EXPENDITURE

Out-of-pocket payments continue to pose a significant burden on households, in some cases leading to catastrophic health spending.⁵⁰ Viet Nam Household Living Standards Survey (VHLSS) data from 2008 shows that 8.1 percent of households spent more than 20 percent of their total household expenditure per

capita on health care. Non-poor and Kinh/Hoa majority households had a higher proportion of households spending more than 20 percent of expenditure on health, at 8.6 percent. Ethnic minorities and the poor on the other hand had around 4 percent of households spending more than 20 percent of their expenditure on health. However, if health spending is measured as a proportion of non-food consumption, the percentage of households with potentially catastrophic health expenditure is considerably higher. An estimated 12 percent of all households spent more than 25 percent of their non-food consumption on health in 2008, and around 5 percent spent more than 40 percent.⁵¹ A World Health Organization (WHO) and Hanoi Medical University study on the financial burden of health payments found 5.7 percent of households spent more than 40 percent of their income on health care, and 3.7 percent were impoverished.⁵²

Out-of-pocket payments continue to pose a significant burden on households, in some cases leading to catastrophic health spending.

INFORMAL PAYMENTS DRIVE UP HEALTH CARE COSTS

Informal payments play a significant role in driving up costs of health care to the household. The practice of making informal 'envelope' payments to health care staff is highly normalized. Staff have significant incentives to seek such payments as well, as some services, such as urban hospitals, are able to top up staff salaries, while others such as lower level hospitals and health care hospitals are not, with the result that staff seek opportunities to generate additional income.⁵³ In the 2010 Public Administration Performance Index (PAPI) survey, 28 percent of respondents reported paying bribes when receiving hospital services. A majority of households report corruption in the health sector, with one in four reporting that corruption is a very serious issue in central health services; and 22 percent reporting that corruption had got worse in central health services between 2006 and 2008.⁵⁴ Informal payments add an element of unpredictability to the cost of health care as the costs are not always known in advance, impose a disproportionate burden on those who can least afford it and

undermine people's trust in and respect for public health services and staff.

Cases have been reported in the media where individual staff have been given targets by hospitals for how many patients they must admit, how many drugs they should prescribe for each patient, and how many days patients should stay in hospital, regardless of any medical need for these services.⁵⁵ The predominant fee-for-service approach to paying for health care services creates powerful incentives for providers to deliver additional services. These may be services that are excessive in number or duration, as in the case of extra bed days in hospital, or medically unnecessary, as in the case of prescription of additional pharmaceuticals. Without clear accountability mechanisms such as complaints procedures, patients have no means of redress or way to have these practices fairly investigated.

The impact of the socialization policy and devolution of administrative responsibility to the level of the service provider, discussed below, has also enabled staff in public hospitals to provide the capital to purchase medical technology, in particular diagnostic equipment. These staff then have a very powerful incentive to refer all their patients for these services, whether or not they are necessary, because they are able to make a profit from the use of this technology, together with the hospital. This practice is usually not permitted in other countries. In addition, private companies often provide the technology in exchange for a proportion of the profit generated, which is shared with the hospitals. Under autonomous management, where hospitals are urged to generate as much revenue as possible for themselves, they take advantage of these opportunities to access technologies, which staff are then given targets for, in order to generate revenues.

BOX 5.3: OPTIONS FOR HEALTH FINANCING

Two options for health care financing currently under discussion in Viet Nam are capitation, where a pre-determined fixed rate is paid per patient and unit of time to the physician to deliver medical service, and diagnosis related group (DRG), a system of set payments to service providers and/or charges to patients based on average costs calculated for each 'product' (treatment for specific diseases and health conditions). In Viet Nam, a 2009 government decree states that capitation payments should be introduced in primary health care facilities. Capitation payments have been introduced via pilot initiatives since 2001, with 43 providers providing capitation to date, mostly in district hospitals. However, capitation funds have been overspent in most hospitals while average costs of care have actually risen.⁵⁶ Other neighbouring countries such as China and Thailand have been experimenting with DRGs, initially focusing on a core group of common diseases. DRGs have been found to reduce the average hospital stay and can help to prevent over-medication and unnecessary treatment.⁵⁷

A recent paper on health financing options for Viet Nam suggests that DRGs developed for neighbouring countries could be adopted in Viet Nam. The paper recommends that Viet Nam adopt a payment mix that includes capitation payments for primary care and DRG-style payments for hospital care, targeting high priority and preventative health services in the first instance.⁵⁸

HEALTH INSURANCE COVERAGE

On the other hand, health insurance is playing an increasingly important role in defraying health care costs. VHLSS data shows that coverage has increased rapidly; from 39 percent of people over 5 in 2004 to 53 percent in 2008 (children under 6 are automatically entitled to free health care). Of those who are covered, 21 percent receive free health

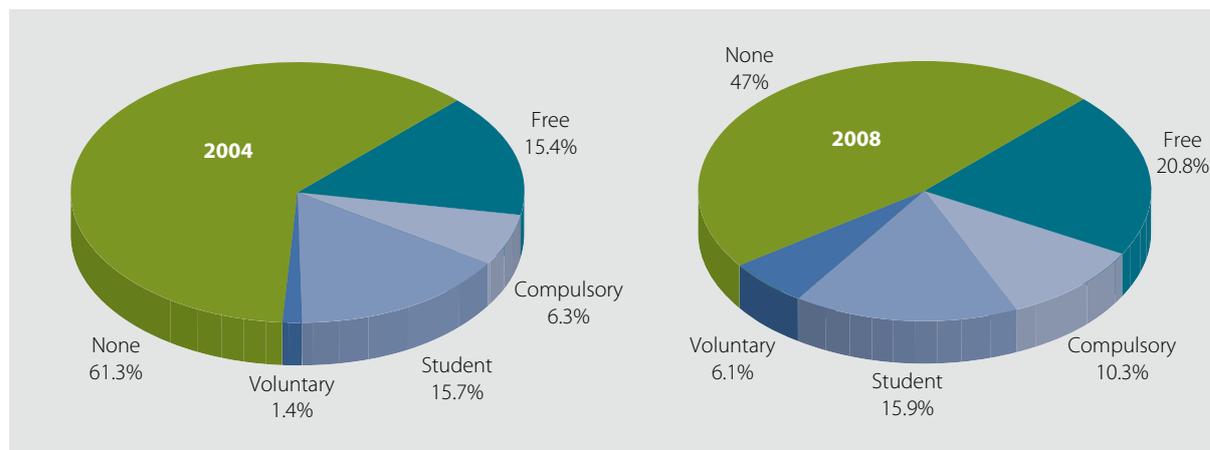
insurance, 10 percent are covered by compulsory insurance, 16 percent by student insurance and 6 percent by voluntary insurance. In 2008, 69 percent of the poor, 76.2 percent of ethnic minorities, and 59 percent of people aged 60 and over were covered by health insurance. Women were slightly less likely to be covered than men.⁵⁹ In 2009, coverage rose to an estimated 58.4 percent of the population while the remaining 35.7 million were not covered.⁶⁰

In a working paper for the National Human Development Report (NHDR), Mr. Nguyen Viet Cuong shows that health insurance plays a positive role in increasing access to health services and containing out-of-pocket payments. Enrolments in all types of health insurance are positively correlated with contacts with both inpatient and outpatient services. Health insurance also reduces out-of-pocket expenditure for health services, in particular free, compulsory and student health insurance.⁶¹ Increasing public expenditure on health insurance for the poor and disadvantaged and expanding coverage across different population groups does have the potential to further increase access to health services and reduce the costs of inpatient and outpatient care.

The Government has committed to universal health insurance coverage by 2014, yet the health insurance system faces significant challenges. From a user perspective, the quality of the services received,

delays in treatment, and attitudes of staff providing free or insured services, act as a barrier to purchasing and using health insurance.⁶² Those who can afford it will often choose to pay for non-insured services to avoid receiving inferior treatment. Those who cannot will often avoid addressing health problems unless their condition is serious. Often the level of benefit is low, in particular for those who receive coverage under Viet Nam's poverty and social protection initiatives. As a result, approximately 30 percent of people with health insurance for the poor still face catastrophic health spending.⁶³ Health insurance coverage remains an issue as two in five Vietnamese people still lack health insurance, including many poor and near poor households and individuals. Extending health insurance coverage and generating sufficient revenue to increase the benefit package and ensure the viability of the scheme are therefore critical policy priorities going forward (Box 5.4).

Figure 5.4: Health Insurance Held by People Over 5, Viet Nam, 2004-2008 (%)



Source: VHLSS 2004, 2008 cited in Nguyen Viet Cuong 2010

BOX 5.4: TOWARDS UNIVERSAL HEALTH INSURANCE

Three types of health insurance are currently available to Vietnamese citizens (see Table 5.1): mandatory health insurance offered to workers, free or subsidised health insurance provided to poor and disadvantaged groups, and voluntary health insurance which is available to farmers, students and informal workers. As of 2008, 53 percent of Vietnamese people had health insurance; this rose to an estimated 58.4 percent in 2009.⁶⁴ While health insurance is skewed to less advantaged population groups, a significant proportion of these people are still not covered. In 2008, 41 percent of people aged over 60, 24 percent of ethnic minorities and 31 percent of the poorest quintile were not covered by health insurance. Rates in some of Viet Nam's poorer regions were also low:

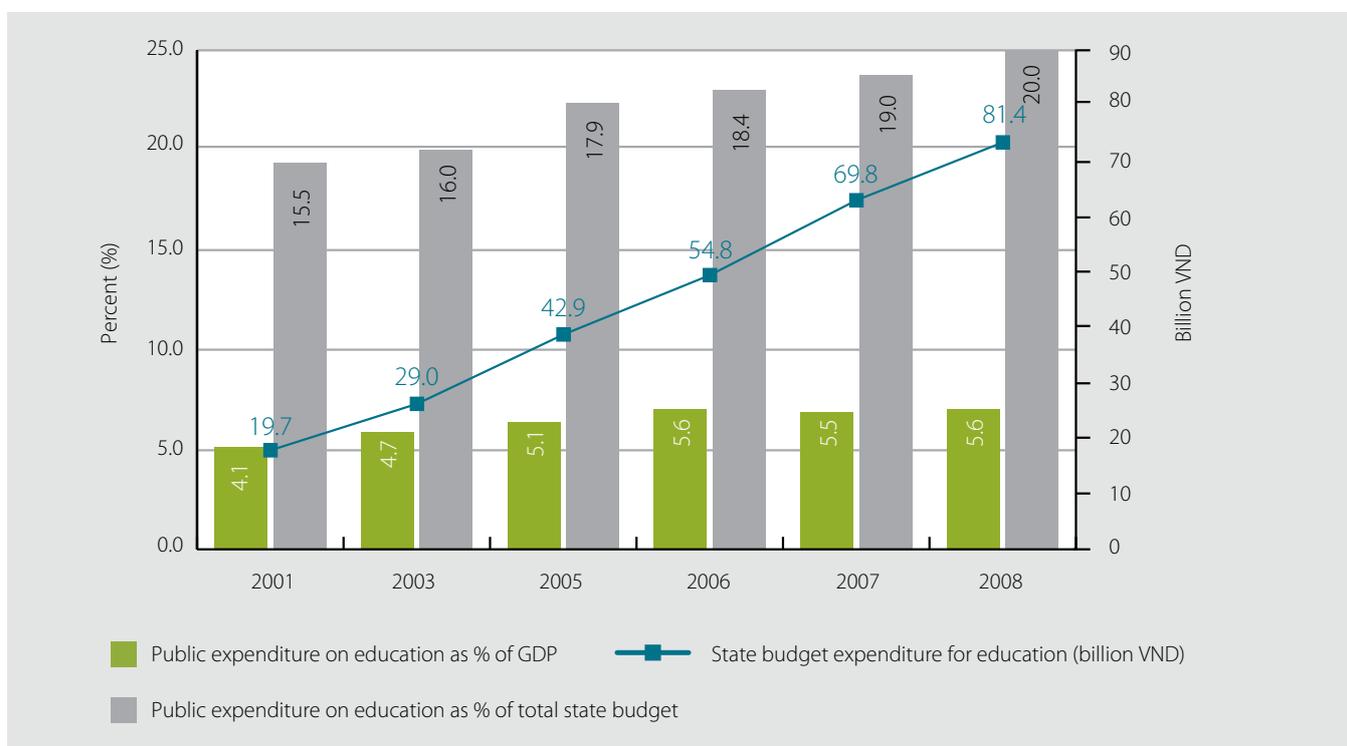
34 percent of those in the North East; 39 percent in the North Central Coast and 38.5 percent of people in the Central Highlands did not have health insurance. On the other hand, 50 percent of the richest quintile was covered in 2008.⁶⁵ While children under 6, people over 60, the poor, ethnic minorities and those in rural areas are more likely to have free health insurance; there are higher rates of compulsory, student and voluntary health insurance among the Kinh/Hoa and the non-poor. However, 14.6 percent of the non-poor had free health insurance in 2008.

A much higher proportion of some population groups, in particular workers who are not eligible for subsidies and are not covered by mandatory health insurance schemes (including via a direct relative) do not have health insurance. An estimated 23 million people fall into this category, and in 2008 only 11 percent had health insurance.⁶⁶ They are eligible for voluntary insurance but they are not joining the scheme: the majority of those who do hold voluntary insurance are students who can easily be recruited via schools. There are significant disincentives for non-students to join, including the cost of voluntary insurance (currently 4.5 to 6 percent of the minimum wage); the poor quality of health services received; low income levels; and lack of effective targeting and marketing.⁶⁷ Co-payments are set at 20 percent for most scheme participants for ordinary health services and as high as 50 to 80 percent for high cost services and laboratory tests. The exception is the poor, pensioners, recipients of social allowances and other groups who pay 5 percent and people from the army and the police, who together with children under 6, are exempt from co-payments.⁶⁸ As there is a ceiling on the maximum amount reimbursable by health insurance it does not provide comprehensive financial protection for households.

Critically the Social Health Insurance (SHI) fund is in debt, by an estimated 1,400 billion VND in 2008. The major deficits relate to the free health care for children under 6, and the voluntary health fund.⁶⁹ Part of the problem is 'adverse selection' whereby those who are most in need of health services are also most likely to take up health insurance, driving up costs. This is particularly the case in respect of voluntary health insurance in Viet Nam: most informal workers are not interested in joining, so only those who are sick or know they may face high levels of health expenditure are likely to buy health insurance.⁷⁰ If Viet Nam is to achieve universal health insurance and generate sufficient revenue for the SHI fund, it will have to capitalise on the current demographic bonus of people of working age, and attract millions of informal workers, the most difficult group to attract. Those who are on low incomes struggle with affordability, while those who earn more cannot see the benefit in enrolling.⁷¹ The SHI fund also needs to become a much more active purchaser of services to ensure that the care it is paying for is really necessary and is not excessive, including prescription of pharmaceuticals. It could also be much more proactive in monitoring and analyzing the performance of health care providers and making this information available to consumers.

Estimates based on 2006 VHLSS data suggest that in order to achieve universal coverage, the Government would need to significantly increase its health expenditure by between 0.7 percent and 1.6 percent of GDP. Increasing both revenues from compulsory insurance from formal sector workers, and demand-side subsidies to users could potentially cut out-of-pocket payments to 30 percent and provide the SHI fund with enough revenue to enable it to influence health providers, for example to improve the quality of services provided to the insured.⁷² Necessarily, this would require the Government to reconsider the priority given to human development vis-à-vis other priorities for public investment.

Figure 5.5: Public Expenditure on Education, Viet Nam, 2001-2008



Source: Ministry of Education and Training cited in Vu Hoang Linh 2010

EDUCATION FINANCING

EDUCATION EXPENDITURE

Viet Nam spends more on education than on health, with public spending having risen from 15.5 percent in 2001 to 20 percent of the state budget in 2008. Public expenditure on education was 5.6 percent of GDP in 2008, twice that for health. Figure 5.5 shows the change in education spending: while public expenditure increased fourfold as a proportion of the state budget between 2001 and 2008, it has remained relatively stable as a proportion of GDP. Viet Nam compares relatively well to other countries in the region in terms of education spending. According to UNESCO data⁷³, Viet Nam spent a higher proportion of its budget on education than most neighbouring countries, apart from Thailand. However, Viet Nam's educational performance is poorer than all of these countries, with lower average and expected years of schooling, suggesting Viet Nam's investment is less efficient (Table 5.4).

PUBLIC EDUCATION EXPENDITURE AT THE SUB-NATIONAL LEVEL

In 2008, the bulk of public expenditure in education was devoted to primary and secondary education, though spending on pre-primary, vocational and tertiary education has increased since 2001. Spending on basic (primary and lower secondary) education accounted for 52 percent, pre-primary for 7.5 percent, upper secondary for 11 percent and tertiary and vocational training for 24.4 percent of the education budget in 2008.⁷⁴ As is the case in health expenditure, there is considerable variation between regions and provinces, with a fourfold gap in spending between richer and poorer provinces.⁷⁵ Education spending is significantly devolved to the sub-national level, with 89 percent of total expenditure in education at the sub-national level. Only in tertiary education is national level spending significant.⁷⁶ External assistance to Viet Nam's education sector has been significant, in particular in terms of support to basic education. However this is likely to change, as Viet Nam is now a lower Middle-Income country (MIC) and this classification may result in a decline in education aid.⁷⁷

Table 5.4: Public Education Expenditure and Years of Schooling, Selected Asian Countries, 2007 and 2008

Country	Public education expenditure as a % of GDP	Public education expenditure as a % of total government expenditure	Average years of schooling	Expected years of schooling
Indonesia (2007)	3.5	18.7	5.7	12.7
Thailand (2008)	4.7	25.7	6.6	13.5
Philippines (2007)	2.7	15.9	8.7	11.5
Malaysia (2007)	4.5	18.2	9.5	12.5
South Korea (2007)	4.2	14.8	11.6	16.8
Viet Nam (2008)	5.3	19.8	5.5	10.4
China (2007)	3.4	18.2	7.5	11.4

Source: UNESCO Institute for Statistics <http://stats.uis.unesco.org>; ADB 2010; Global HDR

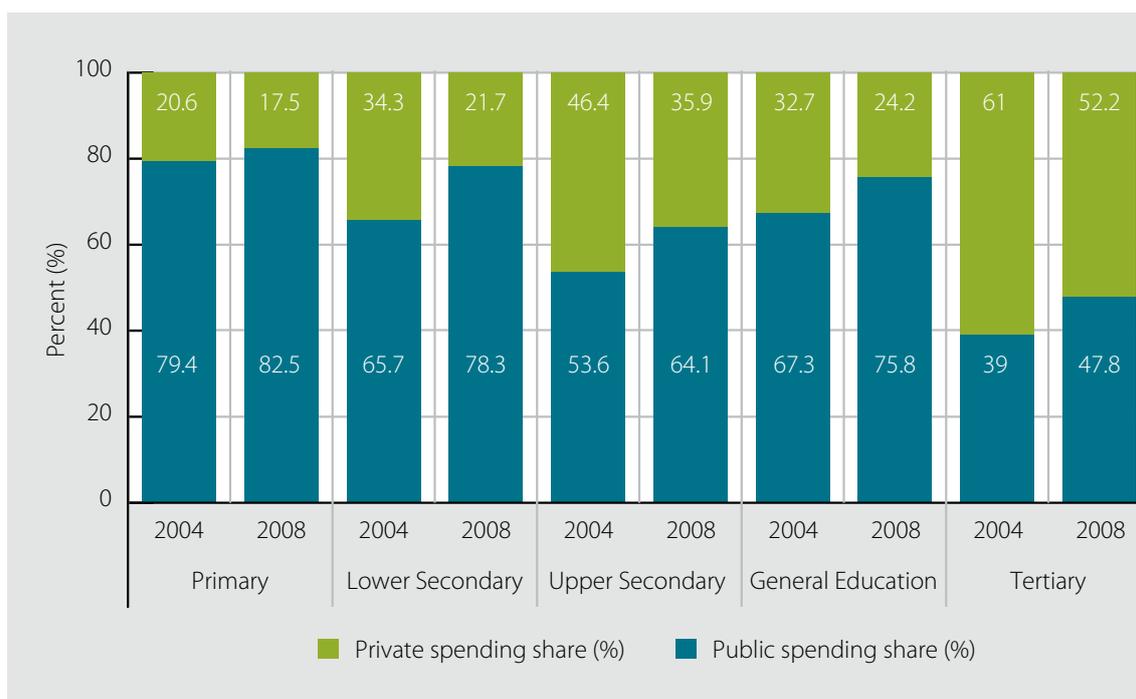
HOUSEHOLD SPENDING ON EDUCATION

Household spending on education has accelerated sharply across all regions and socio-economic groups and is estimated to account for up to 50 percent of overall education expenditure in Viet Nam, depending on the education level.⁷⁸ Public spending accounts for the majority of spending in primary and lower secondary education, while private spending accounts for more than half of tertiary-level spending (Figure 5.6). The share of

private spending has, however, decreased at all levels over time as, while household expenditure has increased, public expenditure on education has also risen, by more than overall levels of public spending and for all levels of education.⁷⁹

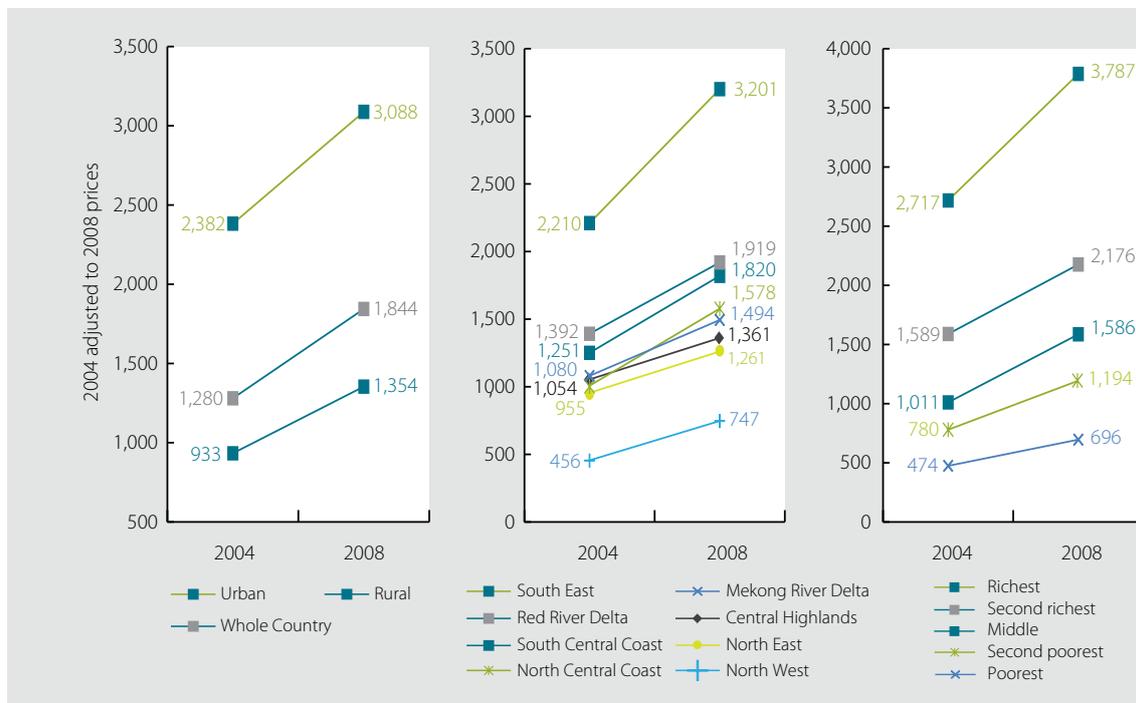
Viet Nam compares relatively well to other countries in the region in terms of education spending.

Figure 5.6: Public and Private Education Spending, Viet Nam, 2004-2008



Source: VHLSS 2004, 2008; MOET cited in Vu Hoang Linh

Figure 5.7: Average Per Capita Expenditure on Education ('000 VND, 2008 prices), 2004-2008



Source: VHLSS 2004, 2008

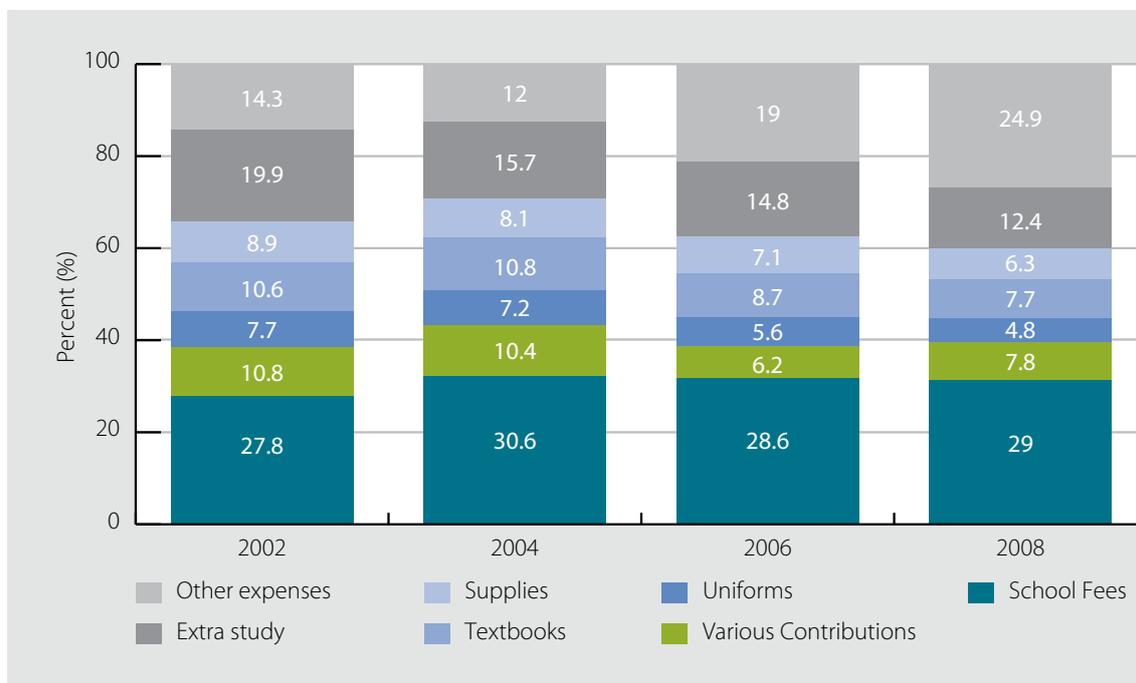
Public spending accounts for the majority of spending in primary and lower secondary education, while private spending accounts for more than half of tertiary-level spending.

However, actual household expenditure on education increased by 44 percent from 1,280,300 VND in 2004 to 1,844,000 VND in 2008 (at 2008 prices). While expenditure increased in all regions and socio-economic groups, as Figure 5.7 shows, the steepest rises have been in urban areas, among the richest quintile, and in the South East, largely reflecting greater capacity to pay. At the same time, the gap between urban and rural areas, the richest and poorest quintile, and the South East and North West has also increased significantly. In 2008, people in urban areas spent 2.3 times more than those in rural areas, people living in the South East spent 4.3 times as much as those in the North West, while those in the richest quintile spent 5.4 times as much as those in the poorest quintile.

What is notable, however, is that most spending in education is not on tuition and fees, but on associated costs. In 2008, tuition and fees accounted for 29 percent of education costs, while private tutoring accounted for 12 percent, and other costs accounted for 25 percent of costs, including transport, meals, gifts and payments to teachers. Figure 5.8 shows the distribution of these costs between 2002 and 2008.

In 2008, there were also significant differences in expenditure at different levels of education and among different socio-economic groups and regions. School fees represent an increasing proportion of expenses at higher levels of education, and private tutoring becomes particularly significant at upper secondary level. Urban households spend more on private tutoring while rural households spend more on textbooks and school supplies.⁸⁰ These costs are a significant burden to the poorest families, who spend more on school contributions and uniforms, while better off households spend more on private tutoring and other costs.

Figure 5.8: Estimated Share of Household Expenditure per item, Viet Nam, 2002-2008



Source: VHLSS 2008 cited in London 2010b

ADDITIONAL TUITION IS KEY TO ACADEMIC ATTAINMENT

In today's Viet Nam, academic attainment is increasingly dependent on access to extra classes. At the primary level where education is supposed to be free, an estimated 50 percent of households pay for extra classes prior to entry into grade one, rising to 70 percent from grade five as children prepare for entry into high school.⁸¹ Extra study courses are considered essential at the secondary level for students wanting to continue to post-secondary schooling. Critically, the best off households allocate more than a third of their education spending to private tutoring at the lower and upper secondary level. The poorest households spend 12 percent on private tuition in secondary level. This suggests a bias in access to high-quality education, and of course also influences access to tertiary education that is based on entrance exam results.⁸² Thus household wealth helps to explain the 26 percent gap in tertiary education attendance between the richest and poorest quintiles noted in Chapter Four. Richer households also spent more on tuition fees, in particular at primary level, which may indicate they are attending better and more expensive schools, whereas poor students are attending tuition-free public schools. Higher tuition costs may also include informal payments to teachers for extra classes.⁸³ On the other hand, poorer households, ethnic

minorities, and rural households tend to spend less on tuition and fees in particular at primary and lower secondary levels, due to fee exemptions.

INFORMAL PAYMENTS IN EDUCATION

As is the case in health care, the system of informal payments is pervasive and occurs regularly, and includes corruption in entrance admission, school charges and fees and private tutoring. A 2010 study by the Government Inspectorate found that parents surveyed in Hanoi, Ho Chi Minh City and Da Nang considered paying bribes to be a normal part of the process of accessing education services, including at the primary level. While only 10 percent of parents admitted to paying to get their children into school, 67 percent said this behaviour was acceptable.⁸⁴ Similarly, in the 2010 PAPI survey, 47 percent of respondents agreed that teachers favour students whose parents pay bribes, 61 percent said that informal payments in primary education are common, and 43 percent say that paying bribes to teachers is common.⁸⁵

At the tertiary level, corruption is acknowledged to be widespread in certain types of programmes, as graduate degrees, together with qualifications from in-service training, distance and alliance programmes can in some instances be purchased.⁸⁶

Education spending represents a significant burden to poor and disadvantaged households, especially at higher levels.

In the 2008 VHLSS, 15 to 16 percent of respondents reported corruption had worsened in vocational training and university education, 11 percent in secondary education and 9 percent in primary education between 2006 and 2008.⁸⁷

Table 5.5: Net Household's Educational Costs per Student per Education Level as a Percentage of Average per capita Expenditure, Viet Nam, 2008 (%)

		Primary	Lower secondary	Upper secondary	Tertiary
	Viet Nam	9.8	13.2	22.2	51.4
Urban-rural	Urban	14.1	16.7	24.4	43.1
	Rural	8.5	12.0	21.4	57.7
Region	Red River Delta	12.2	16.4	24.0	44.8
	North East	8.0	11.1	18.7	51.3
	North West	2.8	0.8	12.7	33.0
	North Central Coast	12.0	14.1	24.0	59.9
	South Central Coast	8.0	12.2	23.4	51.6
	Central Highlands	7.5	11.0	17.2	49.7
	South East	14.3	16.1	26.0	50.8
	Mekong River Delta	6.5	10.7	19.3	61.8
Ethnicity	Kinh/Hoa majority	11.0	14.4	23.4	51.5
	Ethnic minorities	4.2	5.7	11.3	49.9
Quintile	Poorest quintile	9.0	12.6	24.4	41.4
	Lower-middle quintile	9.1	13.1	23.9	78.5
	Middle quintile	10.5	12.7	22.4	63.5
	Upper-middle quintile	9.4	13.2	21.7	57.0
	Richest quintile	12.4	14.5	19.7	40.0

Source: VHLSS 2008 cited in Vu Hoang Linh 2010

PER CAPITA HOUSEHOLD EXPENDITURE ON EDUCATION HAS INCREASED

Finally, and critically, the overall share of household expenditure per capita on education increased between 2004 and 2008 at all levels of education, with the exception of lower secondary education. As a proportion of household per capita expenditure, education accounts for 6.4 percent nationally. However, in 2008 net education costs (minus all education benefits such as grants and scholarships) were 9.8 percent of household expenditure per capita for primary education, 13.2 percent for

lower secondary education, 22.2 percent for upper secondary education and a staggering 51.4 percent for tertiary education (Table 5.5). Urban households, Kinh/Hoa majority households and those in the richest quintile, as well as households in the Red River Delta, the South East and the North Central Coast spent the highest proportion of their expenditure on primary and lower secondary education.

At the upper secondary level, urban households, those in the South East, the Red River Delta, and the North Central Coast spent a higher proportion of household expenditure, as did those from the Kinh/

Hoa majority, but those in the lowest two quintiles spent a higher proportion of their expenditure than did better off households. At the tertiary level however, rural households, those in the North Central Coast and the Mekong River Delta, and the lower-middle quintile spent the most, partly due to the cost of travel and other expenses associated with tertiary education. Clearly, education spending represents a significant burden to poor and disadvantaged households, especially at higher levels, as reflected in higher drop-out rates in upper secondary education. Dr. Vu Hoang Linh estimates that a family with two children attending college would need to spend as much as 25.7 percent of their total household expenditure on their children's education.⁸⁸

Cost remains a significant barrier to accessing education, in particular at the post-primary level, for low-income and disadvantaged households.

EDUCATIONAL FEE AND COST EXEMPTIONS

On the other hand, school fee and other cost exemptions play a role in containing education costs borne directly by households, most significantly at the primary school level. VHLSS 2008 data shows that a substantial proportion of the student population are exempt from official school fees and payments: 35.5 percent of primary pupils were exempted in 2008. Of these students, 50 percent were exempt because they were primary pupils, while 17 percent were from poor households, 13 percent were from ethnic minorities, 12 percent lived in remote or mountainous areas, 4.5 percent had parents who were deceased or war veterans, and the remainder either lived in difficult circumstances or were exempt for other reasons.⁸⁹ Higher exemption rates are observable in rural areas, among regions such as the North West and the Central Highlands, and among the poorest quintile. Of the poorest quintile, 61.1 percent of pupils were exempt, predominantly due to being from poor households, from an ethnic minority or living in a remote or mountainous area. However, 17 percent of pupils in the richest quintile also were exempt, mostly because they were attending primary school, but a small percentage were also being targeted by various government programmes, suggesting some leakage in these initiatives.⁹⁰

The majority of exemptions in Viet Nam are applied at the primary level: 14 percent of kindergarten/

preschool students, 80 percent of primary students, 26 percent of lower secondary students, 17.5 percent of upper secondary student and 12.5 percent of professional secondary and vocational students were exempt in 2008. Primary students are mainly exempt because primary school is free, however in early childhood education, most children were exempt or had reduced fees because of their ethnicity or area of residence. Meanwhile, at higher levels, students were exempt due to poverty or their area of residence: in other words, exemptions and fee reductions were being provided via the major poverty programmes including P135-II, the 61 Poorest Districts Programme, and the National Targeted Poverty Programme. Importantly, 35.7 percent of registered students at all levels of education are able to access exemptions or fee reductions, compared to only 14 percent of non-registered (migrant) pupils, which attests to the difficulties children of migrants experience in gaining an education. The system of exemptions goes some way to explaining the differential costs of education discussed above, with the poorest quintile and ethnic minority groups spending less than other groups as a proportion of per capita expenditure.

RISING USER FEES KEEP EDUCATION COSTS HIGH

School fee exemptions and fee reductions reflect the commitment of the Government of Viet Nam to ensuring access to education for all its citizens in order to promote human development and a more equitable society. However, there is a significant and growing gap between policy and practice. For example, by law primary schools are not allowed to charge tuition fees, which should act as a leveller allowing children from poor and disadvantaged backgrounds to gain at least a basic education. In practice however, many primary schools do charge fees, apart from tuition fees, and importantly, in many cases these payments are well above the regulated levels. Despite political commitment to free primary education, household payments account for an estimated 17.5 percent of overall expenditure at the primary level.⁹¹

Exemptions are granted on a discretionary basis, and households increasingly contribute for extra study, in particular in urban areas. This explains the higher actual and net cost per capita of primary education among people in urban areas, and in the Red River Delta and the South East. The majority of exemptions are for full school fees—28.7 percent in 2008—but a small proportion of exemptions

are in fact partial for both fees and other costs; meaning households must make up the gap.⁹² At higher levels of education, as discussed above, costs escalate, and include not only school fees and other school expenses but also increasing household expenditure on fees for extra study courses. The

proportion of private provision also increases at higher levels, in particular from the upper secondary level, increasing the fees required to attend.⁹³ Cost therefore remains a significant barrier to accessing education, in particular at the post-primary level, for low-income and disadvantaged households.

BOX 5.5: CONDITIONAL CASH TRANSFERS IN HEALTH AND EDUCATION

Conditional cash transfers are an example of a demand-side strategy that is successful in increasing access to health and education services, often by targeting women. Many countries now have conditional cash transfer programmes in place. In some countries, including countries with high human development and upper middle-income status such as Brazil and Mexico, these programmes cover millions of households, providing transfers to the value of as much as 20 percent of median household consumption and are valued at about 0.5 percent of GDP. While these programmes vary, they transfer cash directly to the household, ask for compliance with conditions such as school enrolment and attendance, and attendance at appointments for preventative health care for young children and target the poor. They are intended to reduce consumption poverty, but also to promote improved human development outcomes. Many specifically target women thereby potentially increasing their bargaining power within the household.⁹⁴ Conditional cash transfers lead to significant and often substantial increases in service use, though their impact on longer term health and education outcomes is more mixed.

The Brazilian Bolsa Familia programme covers 12 million families. Families receive small amounts of money, around US\$12 a month, with payments dependent on children of the household remaining in school until they are 17, and attending at least 85 percent of classes up to the age of 14 years, and 75 percent from 14 to 17 years. Mothers are required to attend pre- and post-natal care and children under 5 must receive all the recommended vaccinations. In order to avoid leakage of public funds to those who are not eligible, members of the scheme are listed publicly on a website. Independent evaluations have found that 80 percent of funds are reaching the intended recipients. Since the scheme was established in 2003, the poverty rate has fallen from 42.7 percent to 28.8 percent and inequality has been cut by 17 percent.⁹⁵

Similarly, in Mexico, PROGRESA (now Oportunidades), a conditional cash transfer programme with national coverage, focuses on education, health and nutrition, reaching an estimated 5 million households. Benefits include direct cash transfers to mothers for improved nutrition, nutritional supplements, educational grants for children, incentives for students to finish high school, cash transfers for school expenses, medical services and health promotion for teenagers, cash transfers for people over 70 in a beneficiary family, and cash transfers to compensate for energy and food expenses. The programme provides specific incentives to counter higher drop-out rates among girls in lower and upper secondary education.

The programme has successfully reduced the poverty gap by 19 percent, and has decreased drop-out rates between primary and secondary school by 9 percent. Overall years of schooling increased among programme beneficiaries, while use of public sector health services in rural areas increased by 35 percent. The programme has also improved health outcomes among beneficiaries, for example by reducing rates of stunting, contributing to an overall reduction in national prevalence of stunting in the poorest two deciles. Overall, some outcomes, such as returns to education in terms of wages and performance in achievement tests, have not been as high as expected. Demand-side initiatives are not sufficient if the quality of services provided to the poor remains low.⁹⁶

HOUSEHOLD EXPENDITURE AND HUMAN DEVELOPMENT

RISING COSTS OF HEALTH AND EDUCATION UNDERMINE VIET NAM'S HUMAN DEVELOPMENT PROGRESS

Private spending continues to account for a very high proportion of both health and education expenditure. In health, households directly contribute more than 60 percent of total health expenditure, while in education they contribute 17.5 percent in primary education, rising to more than 50 percent for tertiary education.⁹⁷ High household contributions undermine the Vietnamese government's commitment to ensuring universal access to services, impose a significant cost on households, in particular poor and low-income households; and increase the vulnerability of poor and disadvantaged individuals and families. High out-of-pocket payments for health and education are at odds with a human development approach that seeks to develop individual capabilities and choices within a context of equitable distribution of opportunities and access to services.

Informal payments in health and education are driving up the costs to households, and also affect the quality of services received, as those who can afford to pay get a better, higher quality service than those who cannot. Critically, those who can afford to pay have limited incentives to use whatever political and social influence they have to improve the quality of services available to the poor and disadvantaged, as increasingly, they are not using, or relying on, these services. Indeed, the wealthiest Vietnamese are already increasingly educating their children and seeking medical treatment abroad, while the poor have no choice but to accept the quality of services available to them.⁹⁸

High out-of-pocket payments for health and education are at odds with a human development approach that seeks to develop individual capabilities and choices.

Rising costs of health and education thus have direct impacts on human development. Not only are health costs a significant burden to poor households, they can drive households further into poverty, as is the case when health shocks drive families into debt,

use up savings or result in the sale of assets such as land. Delaying health treatment also serves to drive up the eventual cost of health care, if for example hospitalization is required, and is also likely to increase the severity of the health problems people experience. Many people in Viet Nam typically delay treatment and self-medicate or use private clinics instead, which helps to explain the relatively high proportion of spending on medicines. Catastrophic health spending is a source of economic insecurity for many Vietnamese households.⁹⁹ Similarly the cost of keeping children in school imposes a significant burden on poorer households, in particular at higher levels of education. While missing out on an education may not have an immediate economic cost, it does impose significant opportunity costs in terms of lost future income and opportunities and can also help to perpetuate the intergenerational cycle of poverty.

Subsidies and benefits to the poor and disadvantaged do play a role in ensuring access to both health and education, and have been prioritized for that reason by the government of Viet Nam. Health care support includes free medical treatment for children under 6 and provision of health insurance cards, while in education, free primary school education and exemptions and discounts for school fees are designed to ensure poor and disadvantaged households can access a basic education. The Government has explicitly committed to reducing out-of-pocket payments for health via a combination of increased health care budget expenditure and universal coverage for health insurance, though this remains a challenge (see Box 5.4). In education, however, there has been a tendency to increase tuition fees at all levels of education above the primary level, based on estimates of household expenditure that exclude many of the costs associated with education, including voluntary contributions.¹⁰⁰ The system of subsidies also appears to be less effective in education than in health, and in any case excludes many people who should be eligible for assistance. While Viet Nam scores relatively well in terms of expenditure on education, and is catching up with its neighbours in terms of health expenditure, additional resources are needed, for example to expand health insurance coverage to all Vietnamese people. As important though is the efficiency of the allocation and use of resources, the way revenues are being generated and used in both the public and private sectors, and the role of government in regulating private and fee-for-service provision, as will be discussed in Chapter Six.

AVAILABILITY, QUALITY AND GOVERNANCE OF SOCIAL SERVICES

AVAILABILITY OF HEALTH AND EDUCATION SERVICES

PUBLIC AND PRIVATE SERVICE AVAILABILITY

Both supply-and-demand-side factors influence access to health and education services in Viet Nam. These include supply-side factors such as the availability and accessibility of services, the quality of services provided and the attitudes of staff. On the demand side, access to subsidies and benefits, together with perceptions and satisfaction levels are also key. In Viet Nam, as discussed in Chapter Five, the cost of health and education is undoubtedly a major factor influencing rising disparities in access to services and in health and education outcomes, with significant consequences for many Vietnamese families.

Over time, health and education services have become widely available in Viet Nam. Public provision remains predominant, though the rising involvement of the private sector has accelerated over the past decade in both health and education services. This has been particularly evident in outpatient and pharmaceutical services, and pre-primary, upper secondary and tertiary and vocational education

and training. Some services, such as commune health stations and hospitals, remain predominantly public in terms of provision, though recent policies on hospital autonomy have led to increasing private investment in public hospitals. Non-state, not-for-profit provision is still nascent in Viet Nam, a key policy issue discussed in this chapter. Any neat public-private division is however complicated by the commercialization of public sector services in both health and education.¹ Public service delivery is increasingly commercialized via fee-for-service arrangements in both health and education.

Public service delivery is increasingly commercialized via fee-for-service arrangements in both health and education.

Decentralization has given greater autonomy to both public health and education services to determine the way that they secure funding—and how they spend it (Box 6.1). As a result, both public financing arrangements and fee-for-services arrangements in public and private services have introduced powerful commercial incentives in health and education that undermine government policy commitments and human development outcomes.

BOX 6.1: DECENTRALIZATION

Viet Nam's public administration reforms have rapidly devolved power and authority over the provision and payment of health and education services. In doing so, these reforms have conferred unprecedented managerial and financial authority to public service delivery units. The intention has been to encourage services to mobilise economic resources, expand the range and improve the quality of services, and increase their responsiveness to local public needs. Decentralization has promoted a wide diversity of arrangements governing service delivery across regions. Services have been encouraged to embrace commercialism in order to take pressure off the central budget.²

Decree 10 (2004) and its replacement Decree 43 (2006) confer this financial and managerial autonomy, granting services greater discretion over service organization, management of staff and mobilization and allocation of financial resources. Service providers are encouraged to finance improvements, cover staff wages and expand the range of services they deliver by developing non-budgetary sources of revenue.³ While it is desirable that schools are able to upgrade their facilities, and hospitals are able to offer better incentives to their staff, there has undoubtedly been an impact in terms of creating powerful commercial incentives for staff. This has given rise to pronounced supplier-induced demand for services, and has increased the costs of both health and education to the end consumer.⁴ Importantly, this rapid transition to devolved and autonomous public services has not been accompanied by effective development and implementation of mechanisms required to ensure oversight and accountability, and to enable end users to give feedback on and influence the way services are delivered.

HEALTH CARE SERVICES

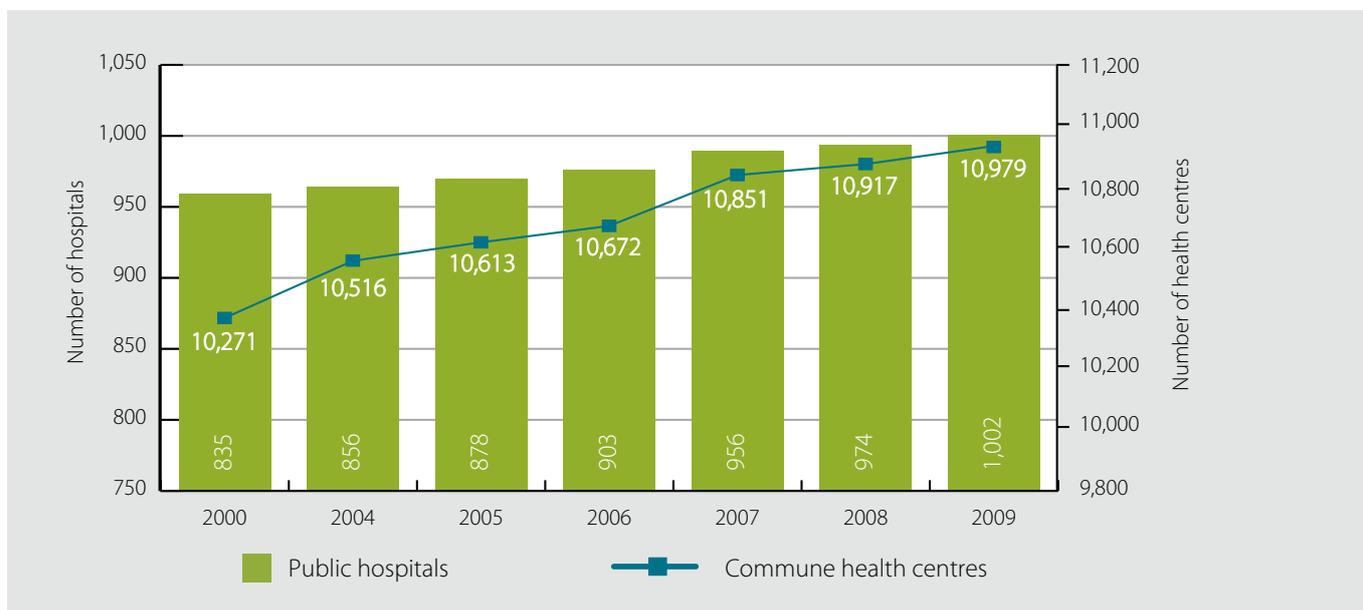
THE GROWING HEALTH SECTOR

Health care is predominantly provided by the public sector, with a rapidly growing private sector providing outpatient health services in particular. However, in practice, the distinction between public and private health services is not clear cut, as patients must pay for almost every service they receive, regardless of whether it is offered by a private or public provider. In 2008, health staff were available in 100 percent of communes and wards, including doctors in 65 percent of communes, a midwife or obstetric/paediatric doctor's assistant in 93.3 percent of communes, and health workers in 87 percent of villages.⁵ Public clinics include the more than 12,000 commune health centres (or commune health stations) that are available in every commune or precinct. These serve as the backbone of Viet Nam's preventative health system as preventative health care is primarily provided by public health services.⁶ However, non-state (private) clinics and hospitals are increasing in number, as are the range of services provided on a commercial (user-pays) basis in both public hospitals and clinics. There is also a proliferation of small, private pharmacies.⁷

Decentralization has promoted a wide diversity of arrangements governing service delivery across regions.

Figure 6.1 shows the rising availability of public hospitals and clinics between 2000 and 2009. The number of patient beds available in public hospitals in 2009 was 163,900. Similarly, the number of doctors and nurses in public hospitals and health centres has steadily increased, by 46 percent and 41 percent from 2000 to 2008 respectively.⁸ However, there is a major shortage of nurses, in particular those with higher qualification levels.⁹ Public health services account for around 13,500 public facilities, compared to 35,000 private facilities, mainly private clinics. In 2008, Viet Nam's 974 public hospitals with 151,800 hospital beds were supplemented by 85 private hospitals and 5,800 beds: on average Viet Nam has around 18 inpatient beds per 10,000 people.¹⁰ This is considerably less than the 140 beds available per 10,000 people in Japan, 86 in South Korea, and 22 per 10,000 in Thailand.¹¹ In addition, there is considerable variation in the availability of public health services and staff between different regions, with more services and staff available in regions with high population levels such as the Red River Delta and the Mekong River Delta (Table 6.1). However, given population pressure in these regions, they typically have fewer services and health staff per 100,000 people.

Figure 6.1: Public Health Services, Viet Nam, 2000 and 2004-2009 (number)



Source: Nguyen Viet Cuong 2010; Viet Nam Statistical Yearbook 2009

COMMERCIALIZATION OF HEALTH CARE

Many public hospitals in Viet Nam offer commercialized services within their premises, such as the provision of 'services on demand' including separate rooms, wings or entire facilities which offer higher priced services. Other commercialized services include 'add-ons' such as private rooms,

air conditioning and, in some cases, more modern equipment, for a price. As a result, there is considerable variety in the quality of services provided in the same hospital and between different hospitals offering the same levels of care.¹² Demand for these services has been rising, as more people are now able to afford to pay for more expensive services.

Table 6.1: Public Health Establishments and Medical Staff, Viet Nam and Eight Regions, 2008

Regions	Number of public health establishments and medical staff				Number of public health establishments and medical staff per 100,000 people			
	Commune centres	Hospitals	Doctors	Nurses	Commune centres	Hospitals	Doctors	Nurses
Red River Delta	2,546	170	9,764	23,621	13.7	0.92	52.6	127.4
North East	2,434	155	6,160	17,495	25.2	1.61	63.8	181.3
North West	736	46	1,329	6,263	27.6	1.73	49.9	235.0
North Central Coast	2,043	108	4,912	15,871	18.9	1.00	45.5	147.0
South Central Coast	1,023	88	3,930	10,741	14.1	1.21	54.2	148.1
Central Highlands	823	67	2,402	7,330	16.4	1.34	48.0	146.5
South East	1,259	127	8,288	20,349	8.6	0.87	56.8	139.4
Mekong River Delta	1,806	154	7,886	23,241	10.2	0.87	44.6	131.3
All Viet Nam	12,670	915	44,671	124,911	14.7	1.06	51.8	144.9

Source: GSO Statistical Yearbooks cited in Nguyen Viet Cuong 2010

In public health services, commercialization has tended to encourage overuse of medications, and over-prescription of unnecessary medical services. State funding is allocated according to the number of hospital beds. For preventative services, it is allocated by population. This encourages hospitals to overprescribe hospitalization for services that should be delivered on an outpatient basis, contributing to overcrowding, and does not take into account the quality of services provided or their performance.¹³ Health care providers receive income from the state budget, out-of-pocket payments and the health insurance fund.¹⁴ State budget funding accounts for about 29 percent of total hospital revenues—the main source is user fees at 59.4 percent of total revenues.¹⁵ National and provincial hospitals are overutilized and are able to charge higher fees for services than district hospitals, allowing them to generate sufficient revenue to offer state-of-the-art services and attract better qualified staff. Providers enjoy a great deal of latitude in terms of clinical decisionmaking, setting of drug prices, and the ability to benefit financially from higher hospital revenues. This will only increase with Decrees 10 and 43 (see Box 6.1). The risk is a race for medical technology and an even greater level of unnecessary care.¹⁶ Indeed, an estimated 180 million consultations, 205 million lab tests and over 10.6 million ultrasound scans were carried out in 2008.¹⁷

District hospitals, on the other hand, are underutilized, with lower levels of investment, and presumably, less qualified and competent staff, as it is less attractive to medical professionals to work in these facilities.¹⁸ Treatment, medicines and equipment available in commune health stations vary considerably depending on their location, as

noted in Chapter Four. Commune health stations could play a stronger role in preventative care, but often lack the staffing, resources, and equipment to do so. Use of private services directs resources away from the public health system, in particular at the primary level. Patient behaviour plays a part, with poorer people using self-medication or private health clinics for less serious conditions, and seeking public treatment, in particular in hospitals, only in cases of severe illness.¹⁹ All in all, the financing incentives in Viet Nam's health system do not favour the rational provision of health services based on medical need.

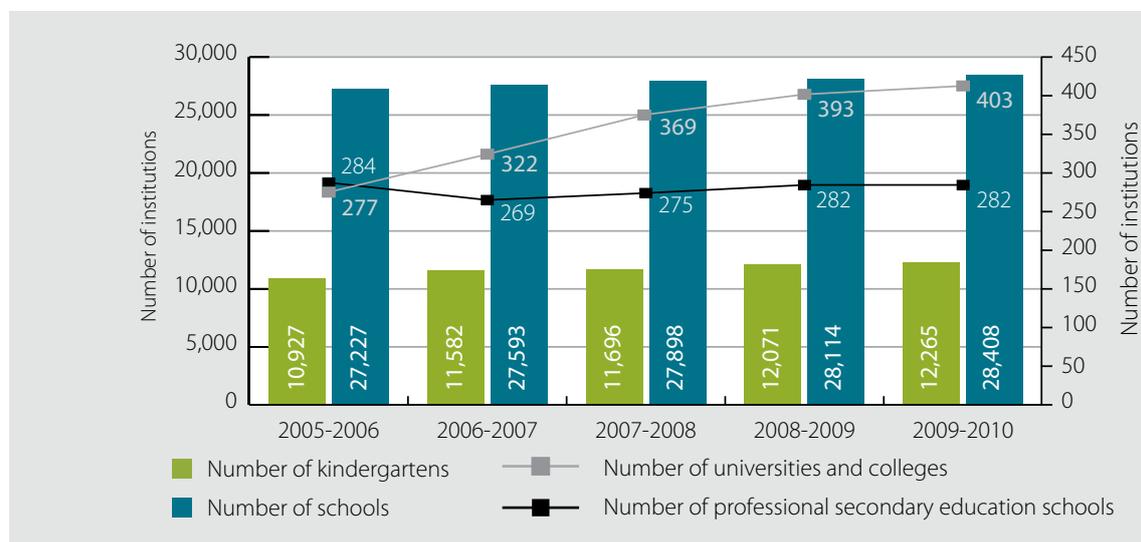
The financing incentives in Viet Nam's health system do not favour the rational provision of health services based on medical need.

EDUCATION SERVICES

PUBLIC AND PRIVATE EDUCATIONAL INSTITUTIONS

Both public and non-state institutions provide education services. The number of public and private educational institutions has been steadily increasing over time, as shown in Figure 6.2, with the exception of secondary professional schools. Tertiary institutions have proliferated particularly rapidly, from 277 in the 2005/06 school year to 403 in the 2009/10 school year. The number of teachers has similarly increased over time at all levels of education.²⁰

Figure 6.2: Education Services, Viet Nam, 2005-2010 (number)



Source: Viet Nam Statistical Yearbook 2009

As with the health sector, the public sector still dominates the provision of education in Viet Nam. However, the share of private provision has steadily increased, with the number of students enrolled in non-state education institutions increasing from 2.6 million in 2000 to 3.4 million in 2008, or 12 to 15 percent of overall enrolments during this period.²¹

Public providers dominate at primary and secondary levels, with private providers more heavily involved in preschool, university and college, and vocational

education and training. According to Ministry of Education figures, around 43 percent of preschool/ kindergarten providers, 19 percent of upper secondary schools, 20 percent of universities and colleges and 34 percent of vocational and professional institutions are non-public.²² By 2008, 49 percent of pre-primary students, 21 percent of upper secondary students, 37 percent of trainees, 18 percent of professional secondary students and almost 12 percent of tertiary students were attending private institutions (Table 6.2).

Table 6.2: Public and Private Share of School Enrolments by Education Level, Viet Nam, 2000 and 2005-2008

	2000	2005	2006	2007	2008
All levels					
State sector	88.16	85.12	84.34	84.6	84.94
Non-state sector	11.84	14.88	15.66	15.4	15.06
Pre-primary					
State sector	52.78	58.31	57.27	56.37	51.14
Non-state sector	47.22	41.69	42.73	43.63	48.86
Primary					
State sector	99.72	99.55	99.46	99.42	99.4
Non-state sector	0.28	0.45	0.54	0.58	0.6
Lower secondary					
State sector	96.82	98.2	98.59	98.83	98.91
Non-state sector	3.18	1.8	1.41	1.17	1.09
Upper secondary					
State sector	65.21	69.54	69.4	72.9	79.03
Non-state sector	34.79	30.46	30.6	27.1	20.97
Training programmes					
State sector	70.70	73.80	71.17	70.71	63.35
Non-state sector	29.30	26.20	28.83	29.29	36.65
Professional secondary					
State sector	97.1	84.49	81.78	81.57	81.33
Non-state sector	2.9	15.51	18.22	18.43	18.67
Tertiary					
State sector	88.64	88.43	87.13	88.22	88.4
Non-state sector	11.36	11.57	12.87	11.78	11.6

Source: MoET cited in Vu Hoang Linh 2010

The line between public and private provision of education is increasingly blurred, as most public schools depend on revenues other than state funding. Schools that received state funding included, until recently, public, semi-public and financially autonomous schools. Semi-public schools

that were state funded and managed, until they were recently deemed illegal, charged significantly higher fees than public schools, and often provided for students whose academic attainment was substandard. At the same time, some public sector schools had semi-public classrooms with higher fee

paying students, and sometimes even semi-public students attending public classes. Non-state schools include so-called 'people-founded' schools, which are independent but receive support in the form of infrastructure or subsidies, and wholly private for-profit schools, which receive no material support from the state.²³ To some extent, public schools providing education without significant additional informal payments have provided a measure of protection against commercialization of education, for example by offering fee exemptions in primary education to low-income households. However, the growth of extra classes that are increasingly required to ensure academic performance has largely negated these protective effects.²⁴

COMMERCIALIZATION DRIVES UP COSTS

Outside primary and lower secondary education, user payments are a predominant source of income for public education and training providers. In early childhood education, semi-public and people-founded preschools secured 50 percent of operational costs from donations, and in 2008 mobilized an estimated 600 billion VND for new construction, maintenance and equipment.²⁵

The line between public and private provision of education is increasingly blurred, as most public schools depend on revenues other than state funding.

Early childhood education is highly commodified and dependent on household spending: with limits on public funding and facilities local authorities are at times unable to meet local demand for services. Given that early childhood education effectively acts as a form of childcare for working parents, there are significant pressures on families to pay up even if the fees are high. With regard to primary education, despite the ban on fees, many public primary schools do charge fees, of up to 80,000 VND per month in some cities and, as discussed in Chapter 5, many also impose additional charges.²⁶ Primary schools justify these additional costs to households on the basis of the high cost of running classes. Elite public secondary schools charge as much as 3 million VND a month for fees, contributions and extra classes, well beyond what most Vietnamese households are able to pay. Lower-achieving students are forced to study in private or semi-private schools charging higher fees than equivalent public schools. Public vocational training and universities are also increasingly reliant on fees, which influences the kind of education and training they provide, towards more lucrative and popular offerings, rather than those which are in society's interest (Box 6.2).

BOX 6.2: HIGHER EDUCATION REFORM

Viet Nam's higher education system is the cornerstone of its development aspirations over the coming decade as, without a highly skilled and innovative working population, it will not be possible for Viet Nam to make the desired shift to a high-tech, higher skilled economy. Yet Viet Nam's higher education sector faces significant challenges. While Viet Nam spends a higher proportion of GDP on education than many other countries in the region, a relatively smaller proportion is spent on tertiary education, at around 10 percent of all education spending, 18 percent if all forms of vocational training are included. The sector has expanded extremely rapidly: student enrolments rose from 918,228 in 2000 to 1,719,499 in 2008 and the number of institutions rose from 178 to 369. Private provision has also increased, with an estimated 218,189 students attending 64 private universities and colleges in 2008.²⁷ Quality and accountability standards have not kept pace with this change.

Challenges include difficulties meeting targets for provision in areas that the government has identified as a priority, such as IT and engineering courses; lack of minimum academic and organizational standards and enforcement; the predominance of de facto planning, resulting in a proliferation of tertiary institutions at the sub-national level and a focus on current, rather than future, demand with insufficient enrolment in fields such as engineering, IT and natural

sciences, which are critical for Viet Nam's future economic development. Other challenges include growing reliance on household and private financing, commercialization of higher education and overly tight control of administration and management, rather than effective oversight of quality standards for consumers.²⁸

Commercialization has proceeded apace in higher education in Viet Nam, without a sufficient market regulatory framework to protect consumers, in this case students and their families. The proliferation of open in-service, distance and alliance programmes, where universities can charge higher fees, is just one example. These programmes typically have lower academic standards, operate without oversight and instances of qualifications being purchased are well-documented.²⁹ As a 2010 report by experts from the New School University in New York and Harvard University on higher education reform puts it: "A distinction can be drawn between...having a market in education—and de facto privatization in absence of system wide standards—the commercialization of education."³⁰

Non-state expenditure is estimated to be around 37 percent of overall education spending: this does not include the US\$1 billion spent by families on overseas study in 2007. However, in higher education, levels of private expenditure are considerably higher. Indeed, tuition has been steadily increasing, rising by 42 percent between 2008 and 2009 alone, and predicted to rise between 17 and 27 percent annually between 2009 and 2014. Average tuition was 383,000 VND a month per student in 2008 and 414,000 VND a month in 2009 (in 2008 prices); however some private universities charge between 7 and 20 million VND a year, or 700,000 to 2 million VND a month.³¹ Although middle-class Vietnamese families are willing to invest heavily in their children's education, the gap in access to tertiary education between the rich and those who are less well off is set to grow as tuition fees continue to rise. As noted in Chapter Four, less than 1 percent of the poorest quintile attended tertiary education in 2009, compared to 38 percent of the richest quintile, a failure of fairness which has the potential to affect people's perceptions of whether the government is delivering growth with equity.³²

QUALITY OF SOCIAL SERVICE DELIVERY

CHALLENGES IN PUBLIC HEALTH CARE

There are significant challenges related to providing health services on the ground in all communities, in particular in ethnic minority communities and remote areas, as households may be located 5 to 10 kilometres from the closest commune health station, which may only be accessible by foot. Distance and time help to explain difficulties accessing health services in remote areas. However, the quality of infrastructure and the skills and responsiveness of staff also play a part, as is also the case in urban areas. Many commune health stations lack basic infrastructure including electricity and clean water, in particular in the mountainous and hard-to-reach regions. Shortages of health providers, difficult working conditions, lack of training opportunities

and weak supervision also impact negatively on the quality of services available.³³ Severe shortages of health workers are evident in preventative medicine, in the grass roots health centres and clinics, and in remote areas. This is because, in part, these posts are less attractive to health professionals as the opportunities to earn an income are more limited. Over half of qualified doctors and nurses, and 82 percent of qualified pharmacists, work in urban areas.³⁴ In addition, few health care workers have higher qualifications—only 2.1 percent have postgraduate degrees—and most management and administrative staff have medical backgrounds and lack relevant management skills and experience.³⁵

District health care services tend to be underutilized, while provincial and national hospitals are seriously oversubscribed. This is, in part, due to perceptions of the inferiority of hospitals at lower levels, but also to the fact that provincial and central hospitals have better paid staff and equipment. Often hospitals at district and even provincial levels are unable to

treat patients with serious problems, with the result that people go to national hospitals, increasing their expenses for travel, accommodation and food. Demand for more sophisticated services is escalating in Viet Nam; partly driven by the growing commercialization of public health care leading to a tendency to overprescribe and conduct unnecessary medical procedures. This contributes to increased expenditure on health care. In addition, a great deal of primary care is provided on an inpatient basis that could be provided on an outpatient basis, at considerably less expense.³⁶

People using free and insured health services often report that medical staff do not treat them with the same level of respect or consideration they receive if they pay a fee.

This also has important equity considerations as increasing commercialization of services results in a better quality of service being available to those who can afford to pay. Indeed, people using free and insured health services often report that medical staff do not treat them with the same level of respect or consideration they receive if they pay a fee.³⁷ Although the Law on Examination and Treatment does provide accountability mechanisms for patients, including complaints mechanisms, it is yet to be effectively implemented, as discussed below.

CHALLENGES FOR PUBLIC EDUCATION

A similar situation prevails in education. People living in more remote and ethnic minority communities typically face difficulties in physically accessing education services, and are also often provided with poorer quality services than those available in urban and more densely populated areas. Public spending on early childhood education varies considerably across provinces, contributing to uneven availability and quality of early childhood education services. Barriers of distance and language are a major issue for those living in remote and ethnic minority communities. At the preschool level this can mean sending a child under 5 on a 30 minute trek over rough terrain to a class where they will be expected to learn in another language. Understandably, many ethnic minority parents are reluctant to send their children to preschool. Preschool facilities often lack proper infrastructure, including lack of sanitation, with limited curriculum, learning tools and toys available for children. The quality of teaching

also varies considerably: often poorly paid and underqualified young people—primarily young women—and in some cases even unqualified volunteers work in understaffed preschool facilities.

Physical barriers and infrastructure limitations remain significant at the primary level as well, in particular in remote and rural localities where transport is difficult. Disparities in the quality of facilities and teaching, in classroom time, and specific barriers as a result of language and social exclusion also affect school attendance. Again, at higher levels of education, lower availability of services in poor and remote districts, together with gaps in the quality of education infrastructure and teaching, combine to produce a two-tier system.³⁸ Barriers to access are particularly acute for low-income, ethnic minority children, in particular girls. These barriers include not only cost barriers discussed earlier, but also the need to earn an income, the poor quality of teaching and learning, the lack of perceived value of getting an education—again, in particular for girls—and inadequate school infrastructure. Linguistic differences and very limited provision of bilingual education are significant issues at all levels of education.³⁹ The quality of university and vocational training has been acknowledged as a major issue and an obstacle to Viet Nam's future development. The low level of teacher qualifications, poor subject knowledge, and limited pedagogical skills, together with shortages of experienced and qualified teachers in both rural and urban areas are persistent challenges. In particular in rural areas, schools are often understaffed, with teachers whose skills fall short of national teaching standards.⁴⁰

PRIVATE PROVIDERS

Private provision of health and education is gaining pace. There are several critical issues to do with private provision as it is currently occurring in Viet Nam. Firstly, private providers are not well regulated, and there is little oversight of the services they provide or their quality. In health care, this results in treatment that is unnecessary at best, and at worst, illegal and even harmful. For example, unsafe and irrational use of drugs is widely acknowledged to be a problem in Viet Nam, as noted in several recent Joint Annual Health Reviews.⁴¹ Pharmaceuticals are generally expensive in Viet Nam, accounting for a significant proportion of health spending and driving up health care costs. There are significant economic incentives to prescribe more expensive drugs.⁴² A large proportion of private providers in Viet Nam are drug vendors.⁴³ The prices they charge,

whether or not they are prescribing appropriately, or selling fake and out-of-date medications goes largely unregulated. Rates of self-medication are high and pharmacies often sell drugs without a prescription. Standard treatment guidelines are not yet available in either public or private hospitals.⁴⁴ Services such as ultrasound and sex-selective abortion, both of which are illegal under Vietnamese law, are widely available from private clinics at very low cost, in particular in urban areas. As the 2010 Joint Annual Health Review reports: "Monitoring and supervision of facilities providing population, family planning and reproductive services in the private sector remains weak, especially in relation to abortion in private facilities."⁴⁵

Private providers are not well regulated, and there is little oversight of the services they provide or their quality.

Unsurprisingly, private health and education providers concentrate in regions and on services where they can make a profit, rather than providing services to the less advantaged or those that are essential but not lucrative. Thus, while the private health sector is developing, it tends to be concentrated in economically better off regions and in urban areas, thereby ensuring more choice for better off people living in these areas. This forces the poor and disadvantaged, and those in remote locations, to rely on the public health system.⁴⁶ Similarly, private providers have tended to focus on delivery of higher level education, in particular vocational training and tertiary education, and on courses where they can make a profit, such as IT and language studies. While there is a place for for-profit delivery: "...for-profit private education cannot fill two essential tasks. First, for-profits will not invest in money-losing disciplines in the social sciences, natural sciences, engineering and the humanities. Second, for-profits will accept students based on their ability to pay and not on merit."⁴⁷ This is not in society's interests and nor does it serve broader human development objectives. This report suggests that government should play a stronger regulatory and oversight role, and deliver services which the private sector won't provide because profits are too low or the incentives are wrong. These include services for the most disadvantaged and vulnerable. Opening up non-state, not-for-profit service delivery will be key to spreading the burden and allowing the state to focus on its policy-making, oversight and regulatory role.

THE NOT-FOR-PROFIT SECTOR

While the socialization policy calls upon all sectors of society to play their part in the design and delivery of social services, to date in Viet Nam the non-state, not-for-profit sector has been largely absent from health and education service provision. Government caution about the motives and political affiliations of NGOs, charity and religious organizations has to date limited scope for their involvement. An enabling space that would allow not-for-profit community organizations to operate is yet to be fully established: the regulatory and administrative environment is not supportive, and efforts to establish not-for-profit institutions, for example in the tertiary education sector, have been blocked.⁴⁸ As a result:

Viet Nam lacks a tradition of non-state, not-for-profit provision of social services... Lacking workable models of quasi-public and civil society institutions, the system has been drawn towards the two poles of direct delivery by state agencies and commercialization of both public and private institutions.⁴⁹

Yet not-for-profit, non-state institutions could potentially play a key role in delivery of health and education services, including by expanding delivery to, and access by, vulnerable and disadvantaged groups. The not-for-profit sector could also develop and model more transparent and accountable management and administrative systems. And a strong community sector could develop professional associations and standards, thus taking the weight off government to supervise and monitor service provider behaviour.

A TWO-TIER SYSTEM OF HEALTH AND EDUCATION

As this discussion shows, health and education services in Viet Nam are both increasingly privatised, (delivered by non-state, for-profit institutions) and commercialized (delivered on a fee-for-service basis by both private and public or publicly subsidised services). While there is undoubtedly a role for non-state delivery of social services, in practice the marketization of health and education in Viet Nam is undermining the government's commitment to equitable access to social services, and contributing significantly to disparities in access and outcomes. And it is driving up the cost of services for Vietnamese families, whose contributions represent the bulk of health and education funding.

As a result, a 'two-tier' system of health and education is evolving in Viet Nam, where people who can afford to pay can access a significantly better level of service than those who are dependent on subsidies and rely on services available at the local level. Problems with the quality of both health and education services are increasingly underscored by the rising number of Vietnamese families who prefer to access university education and health care outside the country. In effect they are voting with their feet—and their wallets. Low-income families do not have this luxury. Greater divergence in future health and education outcomes is the inevitable result of this trend.

REVITALIZING THE SOCIALIZATION POLICY

The socialization policy represents Viet Nam's strategy for managing what was an inevitable shift away from public provision and funding of social services, given that the state could no longer afford to pay for 100 percent of public provision. That the intent of the policy—greater engagement of all sectors of society in the design, delivery and monitoring of social services—has not been matched by the reality of its implementation is evident from this discussion of current financing and delivery arrangements for health and education services. There are a series of policy 'decision points' ahead for Viet Nam. These include, in particular, the need for better enforcement of existing policies and regulations to counter the negative effects of commercialization of health and education services, the role of the state in regulating the market and how to live up to the commitment and promise of universalism. Another key decision point is how to use targeting to lift up those being left behind, rather than creating a two-tier system of services where people's access, and eventually their health and education status, depends on their capacity to pay.

Unfortunately there are signs that a two-tier system is already a reality in Viet Nam, and that health and education are in practice no longer a universal right, but are becoming a commodity. Confronting this reality is not comfortable in a political context where government policies and public perceptions strongly endorse the right of every citizen to access health and education. But an open and informed policy debate about what is happening is required,

as the government will face significant challenges and require significant support, including from development partners, if it is to successfully subordinate market forces to public needs and interests.⁵⁰ Institutions and regulatory capacity will need to be built and strengthened, new professional associations and practices will need to be developed, and new actors including non-state, not-for-profit organizations and end users will need to be much more actively engaged.

USER SATISFACTION WITH SERVICES

LOW LEVELS OF SATISFACTION WITH HEALTH AND EDUCATION

As noted in Chapter Two, the expectations and aspirations of Vietnamese people are changing; with the result that their levels of satisfaction with the health and education services they receive is also likely to change, affecting their acceptance and use of poorer quality services. The 2008 Viet Nam Household Living Standards Survey (VHLSS) asked respondents about whether they were satisfied with health and education services, to what extent they thought services had improved and whether they thought corruption had become worse or better between 2006 and 2008. Overall, respondents were most satisfied with public primary education, and least satisfied with local health services and public vocational training. A majority also thought that services were improving, in particular primary and secondary education, though the response was slightly less positive regarding universities, vocational training and local health services. In general men were more likely to be positive than women, and urban and better off respondents were more critical, suggesting greater choice and capacity to pay is influencing satisfaction levels.⁵¹

Government will face significant challenges and require significant support... if it is to successfully subordinate market forces to public needs and interests.

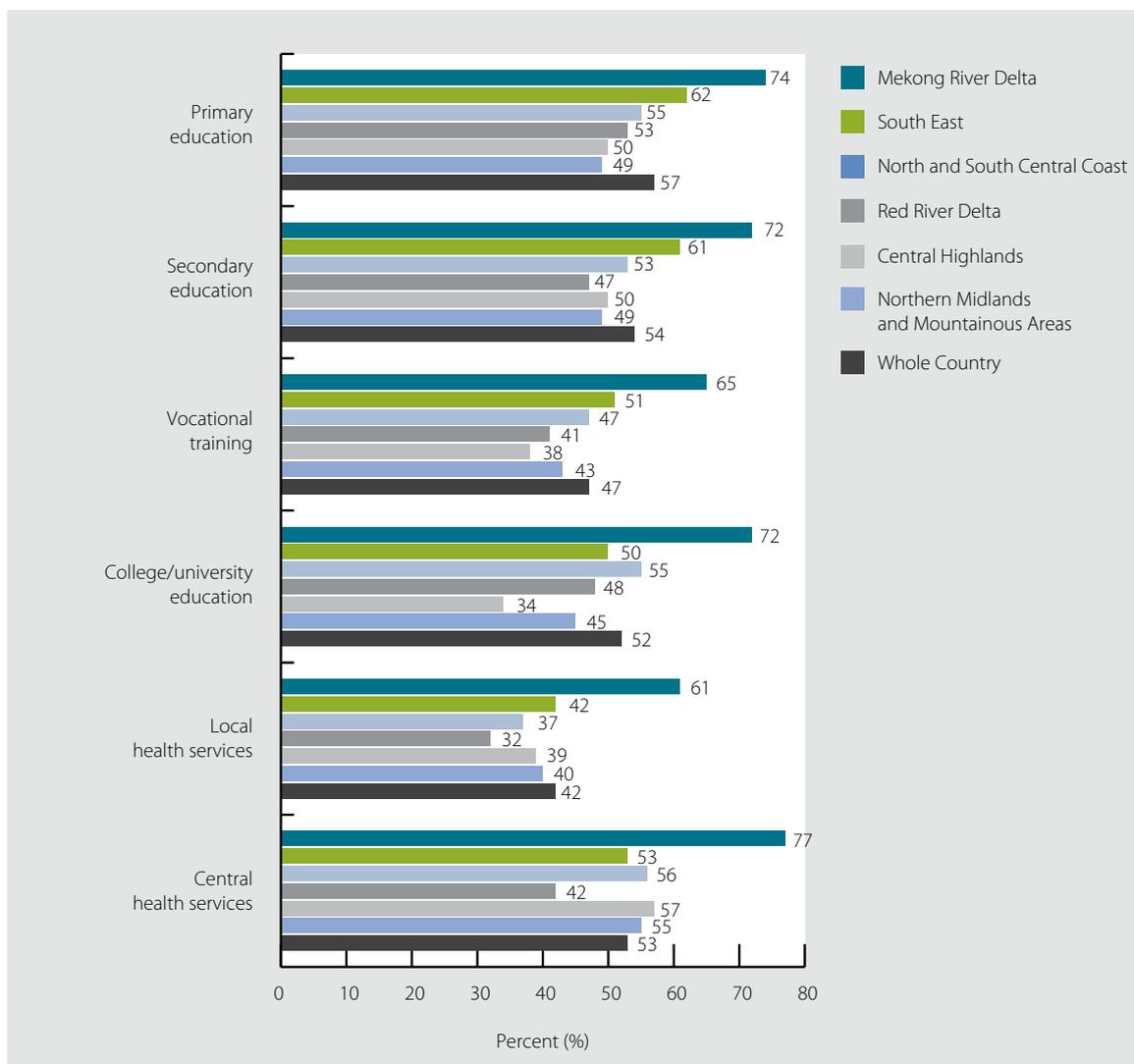
At the regional level, similar trends were evident. In education, the highest levels of satisfaction with primary, secondary and vocational education and training education were evident in the Mekong River Delta and the South East. For university education they were highest in the Mekong River Delta and the North and South Central Coast.

Levels of satisfaction were lowest in the Northern Midlands and Mountainous Areas for primary education, in the Red River Delta for secondary education, and in the Central Highlands for vocational training and university education. Respondents in the Mekong River Delta were also the most satisfied with local and central health services. However, respondents in the Central Highlands, the North and South Central Coast, and the Red River Delta were less satisfied with local health services, while those

in the South East and the Red River Delta were less satisfied with central health services.

The 2010 Viet Nam Provincial Governance and Public Administration Performance Index (PAPI) survey conducted in 30 provinces also asked respondents about their experience of health and education services.⁵² Around 53 percent of respondents said they had health insurance, and 52 percent had had direct contact with a public hospital in the past year. Seventy-four percent said that poor households received subsidized health insurance, while 87.4 percent said children under 6 were able to access free health check-ups, in line with government policy. When asked about the quality of public hospitals at the district/ward level, it was evident that patients were frequently expected to share beds, and health care expenses and waiting

Figure 6.3: Proportion of Respondents Satisfied or Very Satisfied with Health and Education Services, Viet Nam and Six Regions, 2008



Source: VHLSS 2008

times were not perceived to be reasonable. The quality of school sickrooms also remains poor. In relation to the quality of public primary education, infrastructure in public primary schools, together with the quality of teaching, was generally perceived to be good. However, teachers were viewed as favouring children participating in extra classes and classes remain crowded. Respondents in all the provinces studied also identified problems of informal payments and bribery.⁵³

GOVERNANCE AND HUMAN DEVELOPMENT

GOVERNANCE AND PUBLIC ADMINISTRATION

The ultimate objective of the reform and modernization of public sector institutions is to provide better quality public services to citizens. In this regard, the transition towards higher levels of development in a country's governance and public administration system has to create opportunities for citizens to engage effectively in the realization of their full potential and capabilities. This implies that there are differentiated roles for economic development that go beyond simply putting efforts into reducing poverty, to enlarging people's potential to play an increasingly dynamic role that is not fulfilled by economic growth alone.

When asked about the quality of public hospitals... it was evident that patients were frequently expected to share beds.

Governance and public administration are driving forces that enhance human development. Governance is the process by which authorities exercise power and enhance the framework for individuals to develop their potential, and public administration is the vehicle by which the State and citizens interact. The State provides not only public services, but also the framework for the enhancement of individual and collective capabilities. Citizens are not only beneficiaries of public services, but also promoters and drivers of social changes.

Strong governance institutions and effective public administration are critical elements of success for not only economic growth, but also human development. Increasingly, people are recognizing that governance matters for development: institutions, rules and political processes play an important role in whether economies grow, and human development is improved.⁵⁴

Nowadays, it is increasingly recognized that governance and public administration play major roles in enhancing development opportunities. Public administration reform aims to support and operate as the backbone to ensure that children go to school, life expectancy is raised, individuals have adequate access to basic infrastructure, and citizens' security is safeguarded, among others. Promoting human development is not only a social, economic and technological challenge, but also a governance and public administration challenge.⁵⁵ Good governance and public administration goes hand in hand with human development, and with the goal of providing public services.

The provision of public services is not only left to the public administration system. However, it has the mandate to provide the framework for the enhancement of individual and collective capabilities. While governance can be understood as the process by which authorities exercise power and enhance the framework for individuals to develop their potential, public administration must be viewed as the vehicle that provides these opportunities in a fair, equal and consistent manner.

As outlined in Chapter One, Viet Nam's policy frameworks and commitments put people at the centre of the country's social policy with an aim to foster people's happiness, considering that proper social policy will be a driving force to bring into full play the creative potential of people.⁵⁶ That is the primary reason why human development has traditionally emphasized investment in education and health and the promotion of equitable economic growth. However, a third pillar of human development has been recently highlighted: the promotion of participation through governance and public administration systems. In this regard, enjoying opportunities for participation, being knowledgeable and enjoying good health, and enjoying a decent standard of living are all three mutually reinforcing capabilities.

Promoting human development is not only a social, economic and technological challenge, but also a governance and public administration challenge.

As a socialist-oriented state, Viet Nam has by definition committed itself to provide basic services to its citizens. Health care, education, basic infrastructure and public security are state priorities, since they are sectors

that involve the most frequent and direct interaction between the State and citizens. Since economic reforms in the early 1990s, public service providers have received increasing autonomy in finance and managerial aspects through increasing delegation of administration tasks, as noted in Box 6.1.⁵⁷ Although improvements resulting from greater autonomy in service provision have been noted⁵⁸, these are unevenly distributed across provinces, administrative units and different socio-economic groups.⁵⁹

BOX 6.3: PAPI—ENGAGING CITIZENS IN SOCIAL AND ADMINISTRATIVE SERVICES⁶⁰

The socialization policy calls upon ordinary citizens to be involved in social services—and not just as users paying for the services they consume. Greater citizen engagement, and input into the way services are designed and delivered, is critical to improve the overall quality and responsiveness of health and education services at all levels. Citizen scorecards are a relatively new phenomenon in Viet Nam, yet citizen perception surveys can provide important feedback to leaders and administrators at the sub-national level, increase accountability and transparency and provide a basis for demanding real improvements.⁶¹

The Viet Nam Governance and Public Administration Performance Index (PAPI) measures citizens' direct experiences when interacting with local authorities on different issues. PAPI was developed in the context of increasing demand for citizen engagement in monitoring and evaluating policy implementation to feed evidence for subsequent policymaking. PAPI provides objective and evidence-based measures of the standard of provincial-level governance, public administration and public service performance. PAPI also provides objective information to help provincial and national policymakers understand the impact of their decisions and draw concrete lessons, in order to improve the efficiency and effectiveness of governance and citizen satisfaction with public administration and public service delivery.

Drawing from international experiences and specific reflections in the national context, PAPI captures performance levels in six dimensions: (i) participation at local levels, (ii) transparency, (iii) vertical accountability, (iv) control of corruption, (v) public administrative procedures and (vi) public service delivery. Each dimension consists of several sub-dimensions that reflect some of the most relevant areas of public administration and service delivery in contemporary Viet Nam.

Examples such as PAPI can build on and complement other efforts to assess end users experiences, perception and satisfaction with social services. Other examples include the Provincial Competitiveness Index (PCI) which asks businesses about whether there is a conducive environment for doing business in Viet Nam's provinces, and provincial-level surveys such as the 2008 Ho Chi Minh City's Survey on Citizen's Satisfaction with Public Services or citizen report cards at the provincial level. PAPI was carried out in 30 provinces for the first time in 2010, following an earlier pilot study in 2009, and is set to expand to all 63 provinces from 2011 onwards.

In addition to expanding capabilities and choices, the human development concept stresses the importance of participation, including in governance processes and administrative systems. PAPI uses the Ordinance on Grassroots Democracy as the framework for assessing the degree of participation of citizens in public administration, together with satisfaction levels with public services such as health and education, as discussed in Chapter Four. Importantly, PAPI tests the extent to which people are aware of benefits which are available to them, as well as whether they actually have a say in the decisions that affect their lives.⁶² Unsurprisingly, access to information about benefits and entitlements was widely available in urban areas, in particular Ho Chi Minh City, Da Nang and Hue, while people in border and mountainous provinces such as Dak Lak, Quang Tri, Lai Chau and Kon Tum had much lower levels of awareness. Similarly, the quality of public service delivery was generally assessed as much better in municipalities such as Hai Phong, Da Nang and Ho Chi Minh City. Hanoi lags significantly behind however. Poor provinces and those further from major urban centres ranked poorly, largely due to weak infrastructure.⁶³ Initiatives such as PAPI have an important role to play in human development both by directly involving citizens in monitoring and giving feedback on public administration and services, and by improving delivery of public services, via a demand-side perspective.

GOOD GOVERNANCE AND HUMAN DEVELOPMENT AT THE PROVINCIAL LEVEL

In light of the focus of PAPI, it is worth exploring the relationship between PAPI and its dimensions, and provincial performance on the HDI in order to

better understand the relationship between overall human development and different elements of governance. Table 6.3 and Figure 6.4 do precisely that by looking at the correlations between PAPI dimensions and the Human Development Index (HDI) at the provincial level.

Table 6.3: Correlation between PAPI Dimensions and the HDI at the Provincial Level, Viet Nam, 2010

	Participation	Transparency	Accountability	Corrupt Control	Administrative Procedures	Public Services	Composite PAPI (unweighted)
Human Development Index	0.4763***	0.5402***	0.4660***	0.3588**	0.1805	0.6262***	0.6799***
Composite PAPI (unweighted)	0.7507***	0.7149***	0.7513***	0.6614***	0.4099**	0.5047***	
Public Services	0.4007**	0.5327***	0.2323	-0.0900	0.2643		
Public Administrative Procedures	0.3284*	0.1701	0.2106	0.0541			
Control Corruption	0.2708	0.3045	0.4619**				
Accountability	0.5055***	0.3480*					
Transparency	0.4908***						

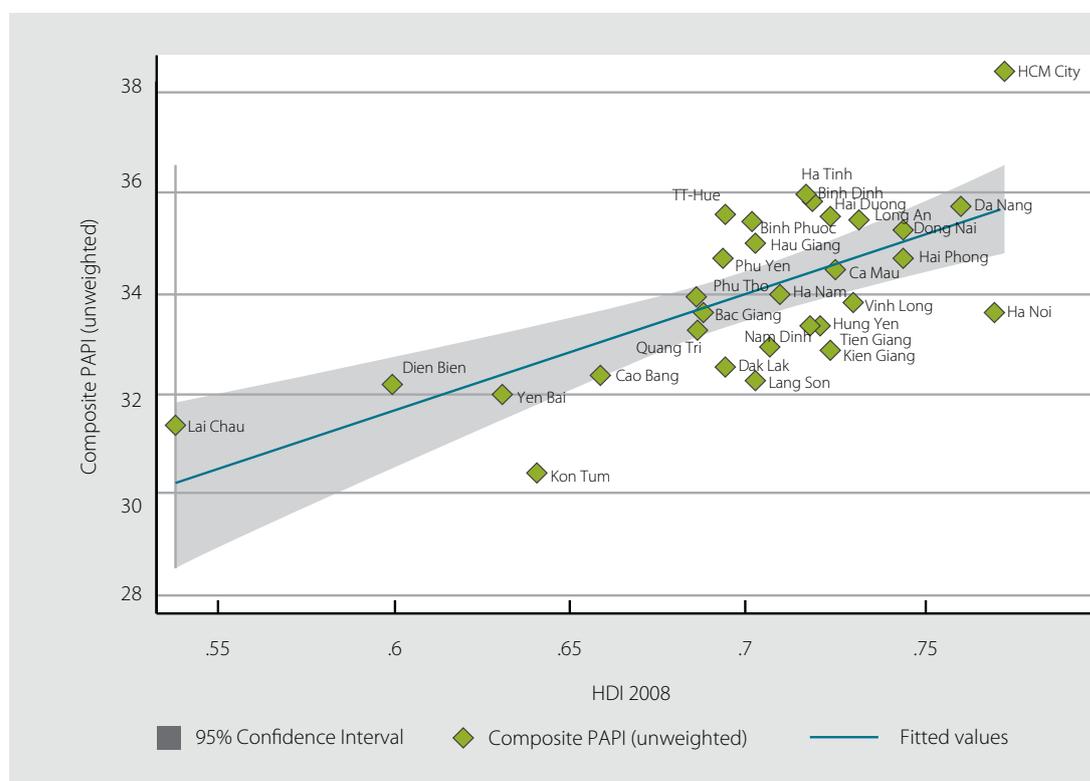
Notes: Pairwise correlations, * significant at 0.1 level, ** significant at 0.05 level, *** significant at 0.01 level.
Source: PAPI data available at www.papi.vn and HDI 2008.

Table 6.3 shows that public service delivery, perhaps unsurprisingly, is the dimension with the highest level of correlation (0.6262), followed by transparency (0.5402), participation at local levels (0.4763) and vertical accountability (0.4660); all statistically significant at the 0.01 level. The dimension relating to control of corruption is also highly correlated (0.3588) at the 0.05 significance level. In addition, contrary to all other five dimensions included in PAPI, it is noted that there is no statistical association between measured

aspects of public administrative procedures and overall provincial human development levels. As this shows, there is indeed a strong correlation between elements of good governance and higher levels of human development.

There is indeed a strong correlation between elements of good governance and higher levels of human development.

Figure 6.4: Association between the Composite PAPI and the HDI at the Provincial Level, Viet Nam, 2008

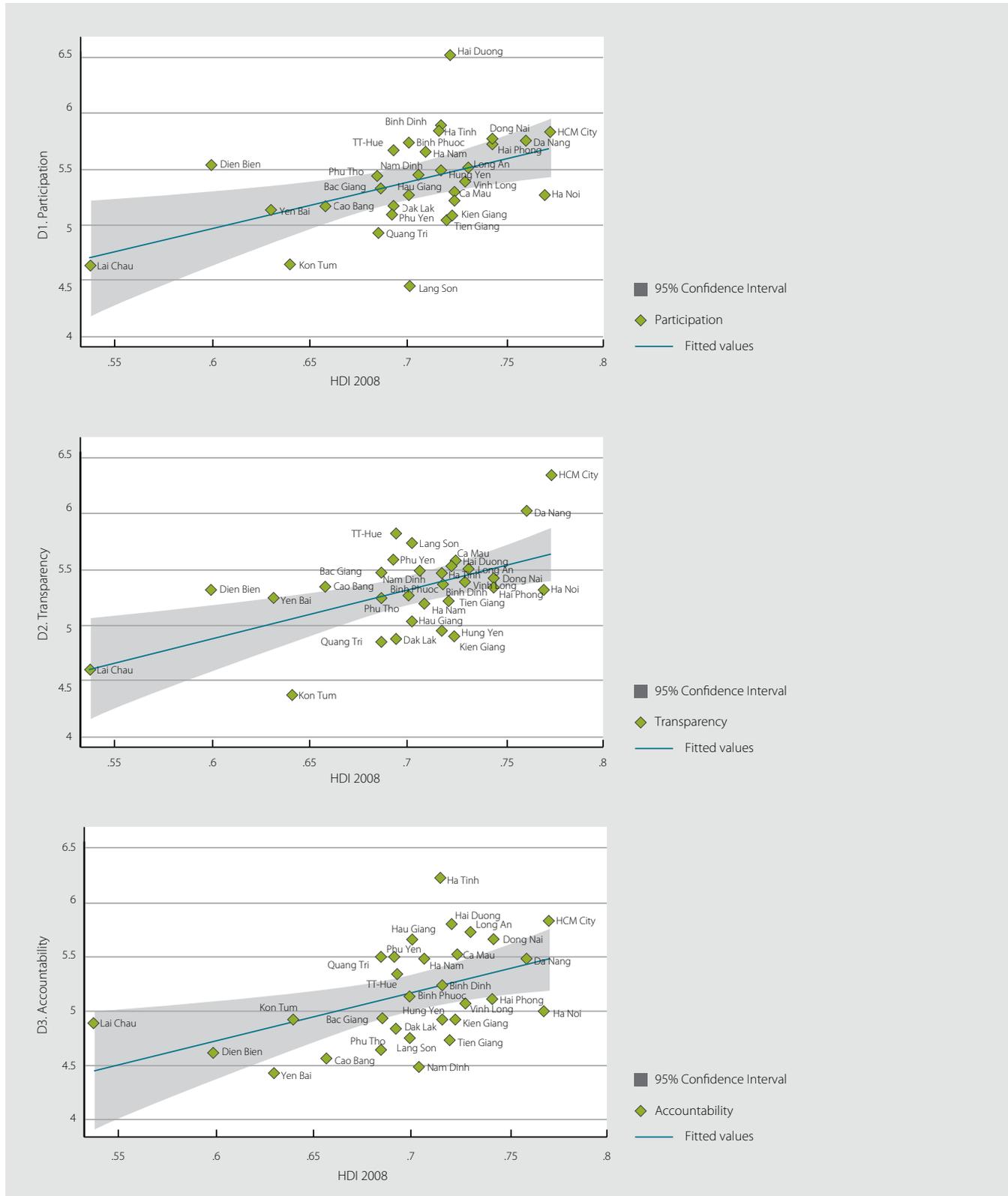


Source: PAPI 2010; HDI 2008

Another way to look at the association between the composite PAPI and its composite dimensions and the HDI at the provincial level is shown in the figures below. Figure 6.4 shows that the composite PAPI is strongly associated with the HDI ($r=0.6799$). In other words, overall, provinces with higher levels of performance in PAPI also tend to have higher levels of human development. However, an important point to stress here is that while the association is positive and strong, correlation does not mean causality. The relationship can run either

way. But, nevertheless, this provides significant evidence that good governance in terms of public administration and service delivery appears to go hand in hand with higher levels of human development at the provincial level in Viet Nam. Figure 6.5 shows the correlation between different components of PAPI and the HDI at the provincial level; and, as noted above, the relationship between service delivery and the HDI is particularly strong.

Figure 6.5: Associations between PAPI's Dimensions and the HDI at the Provincial Level, Viet Nam, 2008



GOVERNANCE OF SERVICE DELIVERY ORGANIZATIONS

CHALLENGES FOR SERVICE DELIVERY ORGANIZATIONS

Changing the way that social services are delivered in Viet Nam involves not only a shift in the policy orientations discussed in Chapter Five, it also involves changes in the norms and practices of the organizations that deliver social services and of the people who work in them. The organizational culture and 'rules of the game', professional standards and behaviours, and management and administrative structures of Viet Nam's health and education system require reform if they are to deliver higher levels of human development to all Viet Nam's citizens. These changes are no less significant or challenging than those at a policy level. Indeed, Viet Nam's experience has been that while it is possible, though not always easy, to change policy and legislative frameworks, changing implementation and practices on the ground often proves to be considerably more difficult.

Three broad sets of arrangements for service delivery can be identified at the organizational level, where service delivery organizations are understood to be institutions which are bound by complex formal and informal sets of rules and practices that shape their culture and behaviour, and service delivery units are subsidiary parts of larger service delivery organizations.⁶⁴ They are:

- Public sector or state service delivery organizations are generally understood to be state-owned and operated organizations, subject to hierarchical state control and regulation. These agencies are established to provide a public service whose goals or mission is established by the State. Typically they are managed in a top-down, hierarchical way, and in principle they are accountable to state institutions, the government and to citizens.
- Private service delivery organizations are independently and privately owned and controlled and thus operate autonomously, or relatively so, from the State. They come in two types: commercial service delivery organizations which are established and operated to provide services on a for-profit basis. Not-for-profit service

delivery organizations, on the other hand, provide services for civic reasons and purposes other than direct profit generation. Many private not-for-profit service delivery organizations receive full or substantial subsidies and other forms of support (such as tax exemptions) from the state. Private commercial organizations are accountable to their owners and/or shareholders, while not-for-profit organizations are also accountable to their 'owners' or 'shareholders', though these may include state authorities, or even communities.

- Hybrid service delivery organizations combine aspects of public and private ownership and service delivery, including as public-private partnerships and 'social enterprises' and feature mixed forms of ownership and control. Their goals and operations are often jointly governed by multiple organizations, with hybrid ownership arrangements exhibiting typically very complex accountability relations.

MANAGEMENT AND ACCOUNTABILITY ARRANGEMENTS FOR PUBLIC AND PRIVATE SERVICES

In Viet Nam, the muddying of public and private service provision discussed earlier, whereby both state and private health and education services operate on a commercial basis, undermines these clear-cut categories of service provisions, and with it, the management and accountability arrangements that would usually apply. In effect, many so-called public sector services are in fact hybrid service organizations in the way they operate, and accountability arrangements are often unclear and complex. Examples include the so-called 'semi-public' and 'people-founded' schools that receive subsidies and support from the State. At the same time, decentralization has also changed governance arrangements in the provision of public services, with increasing autonomy and independence apparent in the way service delivery organizations, such as hospitals, function. Market forces have had a powerful impact on the way that public services operate and the kinds of incentives that are available to their staff.

The hybridization of service delivery in Viet Nam has occurred in a relatively ad hoc manner and without the development of strong transparency and accountability mechanisms. In effect, public sector accountability relations and transparency

remain weak and underdeveloped, while the kinds of accountability mechanisms typically in place in larger commercial organizations, such as boards of management, are not always in place in the Vietnamese context. In the absence of these mechanisms, public services in particular are facing challenges in adapting to the rapid social and economic changes that are unfolding around them, and also within their own institutions.⁶⁵

PUBLIC ADMINISTRATIVE REFORM AND SOCIAL SERVICES

There is clearly a need for institutional strengthening of both public and private service delivery organizations to improve governance and accountability in the health and education sectors. In framing this discussion, it is useful to briefly outline different models for achieving good governance in service delivery, drawn from discussions on public administrative reform, new public management theory, and governance in the not-for-profit sector. Unsurprisingly, there is considerable overlap between these approaches.

The purpose of public administrative reform is to deliver better quality public services to citizens, especially the poor. There is no single perfect institutional design; however, a modern, efficient and meritocratic public administrative system with skilled, motivated and capable staff is required if Viet Nam is to manage the complex challenges it faces as a medium human development, lower middle-income country, as discussed in Chapter Two.⁶⁶ In a paper on public administrative reform and achieving excellence in service delivery in Viet Nam, Koh and others outline three key principles for public administrative reform in terms of service delivery. Firstly, client focus, taking the public's satisfaction as the ultimate measure of the effectiveness of public administration and service delivery. Secondly, ensuring adaptation to local circumstances given that there is no single 'best' model for delivery of public services. Thirdly, government structural reform to ensure specialization in the arrangement and delegation of work, and ensure agencies are able to improve public welfare across the whole of government, rather than engage in direct service delivery. In addition, the authors recommend that independent regulatory authorities be established in specific industries and sectors to represent and enforce government oversight, and at the same time develop and set independent standards in order to promote excellence in service provision.⁶⁷

PRIVATE SECTOR PRINCIPLES AND GOVERNMENT SERVICE DELIVERY

Corporate governance models also offer lessons for improving the way government services are delivered, given that bureaucracies can often be rigid, insensitive to costs, and not responsive to clients needs and interests. One solution is to draw on market-like incentives to improve public service delivery, based on the assumption that private sector entities are inherently more efficient because they must be so in order to survive. In order to ensure transparency and accountability, an engaged citizenry and appropriate supporting institutions are a prerequisite—citizens must be active in the governance of service organizations, rather than passive recipients.

Citizens must be active in the governance of service organizations, rather than passive recipients.

As London outlines in a working paper for the National Human Development Report (NHDR), five principles are associated with this approach to service delivery: firstly, government remains responsible for steering delivery of public services, though not necessarily for actual delivery; secondly, governments and their local 'units' should be owned by citizens, and empower them to govern their own communities; thirdly, competition between service delivery organizations is key to lowering costs, and ensuring more responsive service delivery to clients; fourthly, agencies' performance should be assessed based on their mission—the goals and objectives they are charged to carry out; and fifthly, as noted above, citizens are not passive customers but active participants exercising their right to choose between different services and have a say in the way they are delivered and assessed.⁶⁸

There are evident weaknesses to this approach—it is not sensitive to the local conditions and context in which services are delivered, and does not recognize the inherent weaknesses of markets or difficulties that arise when markets fail. Nor does it acknowledge the political context in which services are delivered, including power differentials between different groups. Nevertheless, the approach does underscore some of the practical issues involved in governance of public service delivery organizations.⁶⁹

LEARNING FROM THE NOT-FOR-PROFIT SECTOR

Although the non-state, not-for-profit sector is relatively underdeveloped in Viet Nam, governance of not-for-profit service delivery in other countries may offer some useful lessons for service delivery organizations in Viet Nam. For example, a recent review by the Australian Productivity Commission of the contribution of not-for-profits in Australia, including in the health and education sectors, clearly identifies the specific role of not-for-profits and the potential value they add. Not-for-profits are typically established for a community purpose and members' control over how this purpose is achieved is an important feature of the way they operate. Many not-for-profits add value by the way they work, including how they are organized, engage people, make decisions and go about delivering services. Many of the activities they undertake would not be performed by the public or the private sector, because of lack of financial return, high risk (including political risk) and the chance activities may not be effective, or because government and business lack trust or client relationships required to deliver services effectively. Their activities often generate benefits beyond those experienced by direct beneficiaries, for example by building social capital and social inclusion by including families and community members in direct delivery of services to vulnerable people.⁷⁰

In terms of improving the way not-for-profits work, the Commission identified five key elements: building knowledge systems that support understanding of the way the sector operates, as well as establishing and building an evidence base about what makes for effective innovation; ensuring clear governance and accountability via a single consolidated regulatory framework for not-for-profit organizations; ensuring more effective sector development, including skills in governance, business planning and evaluation; stimulating social innovation to develop new and better ways of solving social problems where the main benefit is to the community rather than financial returns; and relationship and partnership building between not-for-profits and government, in particular where not-for-profits are delivering government-funded services.⁷¹

Each of these approaches offers a way of thinking about how service delivery organizations in Viet Nam might develop in future. As service delivery organizations themselves are increasingly

hybridised, a hybrid response to improving their performance and effectiveness may well be most appropriate. Clearly oversight and accountability arrangements are key. But so is client focus, and responsiveness to the needs and interests of users and communities, engaging citizens in the way that services are planned and delivered. Boosting a sense of mission and strengthening professional culture and ethics, while also offering appropriate incentives that recognize the reality of the pressures currently operating on service delivery organizations and their staff, is critical. Finally, improving evaluation, monitoring and the evidence base for decision-making and planning, including by using new technology, is crucial to help service delivery organizations and policymakers understand what kinds of interventions are working, and plan for the needs of a rapidly changing society and population. Each of these dimensions is briefly discussed in turn in the following sections.

Improving evaluation, monitoring and the evidence base for decision-making and planning, is crucial to help service delivery organizations and policymakers understand what kinds of interventions are working, and plan for the needs of a rapidly changing society and population.

OVERSIGHT AND ACCOUNTABILITY

CHALLENGES FOR IMPROVING GOVERNANCE

Improved governance is key to ensure public accountability and performance and to regulate private provision in health and education service delivery organizations. Developing governance mechanisms to ensure accountability of public health and education service delivery organizations and units to higher levels of government and to their constituents is undoubtedly one of the key challenges currently confronting the health and education system in Viet Nam. Another key challenge is ensuring private service delivery organizations are effectively regulated and monitored. In the context of decentralization, it is particularly challenging for higher level authorities to hold service delivery organizations accountable, given the high level of autonomy they have been

granted over the income generation and use of financial resources, together with other aspects of their management. The situation in Viet Nam's hospitals is a case in point. A significant degree of autonomy is now evident, in particular in the larger and more central hospitals that are able to generate significant fee-for-service income, and therefore have greater discretionary space in terms of how to spend what they earn.⁷² While hospitals have been quite successful in using revenue generated to attract highly qualified staff and offer state-of-the-art services, there is evidence that accountability has suffered. For example, it is difficult for central-level authorities to monitor and restrict delivery of 'private' services in hospitals.⁷³

STRENGTHENING ACCOUNTABILITY IN HEALTH AND EDUCATION

Efforts have, however, been made to strengthen accountability arrangements, at least in principle, in respect of both health and education. For example, the new Law on Examination and Treatment, which was passed in 2009, sets out how Viet Nam will license medical facilities and certify health care practitioners in both the public and private sector. Best practice principles would suggest a national certification system is preferable, so that, for example, practitioners who have been disbarred from practising in one province are not able to practise in other parts of the country. However, Viet Nam has adopted a dual approach whereby foreign practitioners and those working in central-level facilities will be certified by the Ministry of Health, while certification of other practitioners takes place at the provincial level, making it difficult for government to monitor practitioners effectively. Nor is there a national-level mechanism in place to deal with complaints and impose disciplinary measures on health care practitioners who violate the law. In addition, while the law provides for licensing of both public and private providers, to date a large number of private providers are unlicensed and therefore unregulated.⁷⁴

Another example is the development and implementation of quality assurance systems in the education sector. Minimum quality standards for primary schools were adopted in 2004, and cover a wide range of aspects, including expected quality and outcomes. Standards have also been established for school principals. However, control over non-state school services remains weak with little actual monitoring of whether schools are complying with government regulations, although in practice there does not appear to be a problem with compliance,

but rather with very high tuition fees being charged to parents.⁷⁵ The Ministry of Education has limited capacity to monitor the higher education system and there is therefore limited oversight of higher education in Viet Nam and capacity to enforce standards. For example, only 50 percent of universities and colleges complied with reporting requirements in the 2008/09 academic years. A self-accreditation process has been established for universities, while a national council on quality assurance has been established to provide an independent accreditation system. Around 100 universities have established internal quality assurance centres, and around half have undertaken self-evaluations; however, only 20 universities have been assessed independently to date. There is a general consensus that a strong, independent accreditation agency is required to ensure the process is meaningful and effective. In addition, voluntary uptake of international accreditation would not only provide an independent 'stamp' of quality but would also help to lift standards across the board.⁷⁶

Altogether these examples underscore the need for Viet Nam to consider establishing independent authorities at a sectoral level. These would be appointed outside the executive and responsible line ministries and would have quality, accreditation and monitoring functions. An independent national health authority is eminently preferable to devolution of licensing and certification functions to provincial-level health authorities, which would potentially open avenues for rent-seeking and corruption. This is highly undesirable given the vulnerability of patients if, for example, disbarred or unqualified practitioners are able to bribe their way into medical practice. An independent complaints mechanism should be directly linked to certification and licensing arrangements, and should be managed at a national level by an independent institution with broad representation, including from civil society and patient representatives.⁷⁷ Similarly, in education, school and ministry initiatives to ensure quality assurance could be supplemented by establishing an independent body such as a school's authority to provide an independent assessment of the quality of teaching and learning, and monitor and make public information about school performance. Independent professional associations can also play a role in quality assurance of individual professional staff as discussed below.

CITIZEN ENGAGEMENT AND AWARENESS

Citizen engagement in the planning and delivery of health and education services is one of the principles of the socialization policy, as discussed above. In

order to improve 'downward' accountability to the end users of their services, service delivery organizations need to have in place processes for involving clients and seeking their feedback, as well as to ensure they have the information required to make well-informed choices about service use.

This is a critical issue in health care where there is a clear 'information asymmetry', as users are not well informed about medical treatment, health care options or medications and their effects. The Law on Examination and Treatment clearly sets out the rights of patients, including information about their health status, treatment options and treatment costs. The Law also affords to patients the right to be treated with respect, to confidentiality, to non-discrimination and to refuse treatment.⁷⁸ However, in practice, levels

of awareness about health entitlements are low; for example, people are not well informed about the voluntary health insurance scheme. As well, irrational use of medicines is, in part, fuelled by a lack of understanding about possible side effects of medications and a belief that foreign drugs are better.⁷⁹ The Government of Viet Nam has invested significantly in communication and awareness-raising campaigns about specific health conditions and preventative health practices such as wearing helmets, HIV prevention and the like. Similar investment is required in awareness-raising about patient rights and entitlements under the new law.

Service delivery organizations need to have in place processes for involving clients and seeking their feedback.

BOX 6.4: THE LAW ON EXAMINATION AND TREATMENT⁸⁰

The 2009 Law on Examination and Treatment provides for patient feedback and complaints. It entitles patients to exercise the right to choose medical examination and treatment, to be provided with information about medical records and expenses of examination and treatment, and to refuse or end treatment. Chapter VII provides for complaints mechanisms, including establishment of a professional council to hear complaints and determine their cause; and provides for direct complaints about medical examination and treatment by patients and their representatives. As part of the implementation of the Law, a patient feedback mechanism is to be implemented through which patients should be able to make complaints about services, and which would provide systematic information on service quality. However, this mechanism is yet to be implemented, and at present facilities continue to assess themselves, leaving little room for objectivity.

Similarly, in education, parents and students should be entitled to information about school performance, financing and management arrangements. This is, to some extent, the case in higher education, as higher education institutions are required to make public information about their students, faculty, resources and finances. Some universities are also making feedback available on teachers, which should help students and their families to make more informed choices about tertiary education.⁸¹

SEEKING AND ADDRESSING CLIENT FEEDBACK

A second key responsibility of service providers is to seek feedback at the level of the service delivery organization or unit on client needs and expectations, as well as feedback on user

satisfaction with services provided. This feedback is needed in order to inform service providers about how to tailor their services to the specific needs of the communities they serve. This is a relatively new concept in Viet Nam, given its history of using central planning to determine the need for health and education services at the local level. Although decentralization has allowed hospitals much greater flexibility in determining what services to provide, they are still funded according to the number of beds and population size, and the incentives in place tend to privilege providing services that are lucrative, rather than those which may be most needed by individuals or communities.⁸²

In education, on the other hand, the curriculum is developed nationally. In order to ensure it is both accessible and relevant, greater diversification and flexibility is required in terms of how schools actually

deliver the curriculum. This also requires a higher level of teaching skills. Vocational training and university education are often out of step with labour market trends and requirements, with limited linkages to market information and employer requirements. It is also recognized across the education system that more flexible, participatory and up-to-date teaching methods are required to encourage active learning and foster life skills development, as well as academic attainment.⁸³

Some service delivery organizations in Viet Nam are beginning to experiment with obtaining user feedback. For example, universities are collecting information on student satisfaction with teaching quality, and some hospitals have also undertaken client satisfaction surveys. The National Hospital of Paediatrics is collecting baseline data on parents' satisfaction with the care their children receive, in order to improve communication between hospital staff and parents.⁸⁴ According to the 2010 Joint Annual Health Review, end users are also involved via hotlines established in hospitals, patient committees that meet on a weekly basis, and feedback letterboxes set up in hospitals.⁸⁵ Examples of this were found in a 2009 study of the health system in two provinces: provincial- and district-level hospitals in Can Tho and Ninh Binh were holding regular discussions with patients and their families to seek feedback, and patient committees met once a month. However, citizens and civil society organizations did not play any formal role in monitoring whether service delivery organizations were complying with standards, and following relevant protocols and codes of conduct.⁸⁶ Thus, while there are encouraging signs, soliciting—and more importantly acting on—user feedback is not yet fully institutionalized in many service delivery organizations.

LEARNING FROM NOT-FOR-PROFITS

This is an area where Viet Nam's health and education service delivery organizations can draw from the experience of not-for-profit organizations. In addition to larger-scale satisfaction surveys, such as PAPI, that provide feedback at the provincial level, and surveys and other consultative mechanisms at the level of the individual institution, public and private service delivery organizations could look to participatory practices such as those employed by not-for-profit organizations to engage their

clients and communities. Strategies service delivery organizations can employ to increase participation and engagement include involving clients and community members as volunteers, in boards of management and user advisory committees, conducting extensive consultations with stakeholders as an input to planning and decision-making and making service performance data, including outcomes of satisfaction surveys, publicly available. For example, in the state of Andhra Pradesh in India, mother's committees oversee health and education services provided to children. These committees were established to develop a sense of ownership, increase service uptake and encourage demand-led service provision.⁸⁷ User committees and other participatory mechanisms can act as part of a specific strategy to give those in a community who traditionally have less voice a say in how services are delivered, and an opportunity to provide direct feedback to service providers.

Service delivery organizations could look to participatory practices such as those employed by not-for-profit organizations to engage their clients and communities.

Viet Nam's Grassroots Democracy Decree provides a framework for involving citizens in the decisions that affect their lives. Designed to increase the participation of people in village and commune level decisionmaking, the framework could usefully be extended to promote greater citizen participation and engagement in service delivery organizations. The right to be informed, the right to be consulted, the right to decide and the right to supervise (monitor) have clear parallels in relation to service delivery organizations. That is, people have the right to be informed about the services they receive, their quality, and the options open to them when choosing which service to use; to be consulted when plans are afoot to change these services and the way they are delivered; and the right to be involved in decisionmaking, for example as members of school and hospital boards. They also have the right to give feedback on the quality of services and the way they are delivered, and have that feedback taken seriously and acted upon. These rights should undoubtedly apply in respect of government-funded or subsidised health and education services, but private service delivery organizations should also be engaging with and seeking feedback from their clients.

PROFESSIONAL CULTURE AND ETHICS

POWERFUL MARKET INCENTIVES THREATEN PROFESSIONALISM

People have the right to be informed about the services they receive, their quality, and the options open to them when choosing which service to use.

Each of the approaches to governance of service delivery organizations discussed stresses the importance of having a guiding mission, and using the mission as the benchmark for assessing service delivery organization and staff performance. In public service delivery organizations (including those which receive government subsidies), this should be public or common welfare, measured by “a level of satisfaction on the part of users of public services...based on a collection of criteria such as service excellence, affordability, and whether different sections of the population who have different needs are taken care of.”⁸⁸ However, in Viet Nam’s health and education service delivery organizations hybridization has arguably resulted in public service delivery organizations veering from this core mission, and enhancing their responsiveness to commercial rather than human development imperatives.⁸⁹

Powerful market incentives that significantly undermine professional behaviour, and which are not in the interests of human development, affect the staff of service delivery organizations. There are significant pressures on staff to prioritize treatment and/or teaching of those who can pay, and provide a second-tier service to those who cannot, which undermines principles of non-discrimination on the basis of income and socio-economic status. Informal payments are widely accepted in both health and education, as previously discussed. This is a direct result of the inadequate wages available to medical staff and teachers in public service delivery organizations. It is highly normalized behaviour that is likely to be difficult to change and it directly impacts on access to services and client satisfaction with service delivery.

Nevertheless, significant efforts are being made in both the health and education sectors to increase

the skills, qualification levels and professionalism of staff. In education, for example, performance standards for teachers have been established nationwide since 2007, and the Ministry of Education and Training has introduced performance criteria for principals of secondary schools. Another example is the ethical and professional standards and behavioural standards that are included in the criteria for principals.

The Law on Examination and Treatment establishes the framework for certification of health care practitioners. The Law requires health workers to meet standards in terms of medical theory and practice, but to date national standards for professional competency have yet to be developed. The Law also requires health workers to undertake continuing medical education. In the absence of national professional standards (and a national body to monitor them), there are some existing guidelines and protocols for health workers that provide some guidance. However, these tend to be technical (that is, they are related to management of specific diseases, regulation of drug use and treatment regimes and so on) and are far from comprehensive, as clinical standards and treatment guidelines are not available for all conditions.⁹⁰ Codes of conduct do exist for medical staff including for treatment of patients. However, they are not effectively monitored or enforced. Nor are mechanisms for clinical supervision, performance assessment, or incentives for improved performance and productivity in place.

Increasing the skill level, capacity and levels of professional qualifications of staff in both the health and education sectors has been identified as a critical issue by the Government of Viet Nam.

Increasing the skill level, capacity and levels of professional qualifications of staff in both the health and education sectors has been identified as a critical issue by the Government of Viet Nam and has been given priority within sectoral health and education sectoral strategies. Distribution of skilled staff is also a key issue, as health professionals and teachers are often reluctant to work in remote and rural areas where their skills are needed. The impact of decentralization and fee-for-service arrangements in hospitals has already been discussed: one of the main impacts has been a concentration of more qualified staff in central and provincial hospitals that can generate higher revenues and pay their staff more. Doctors typically are reluctant to work in rural areas, and

the financial incentives currently on offer are not sufficient to enable them to earn a comparable income to those in urban areas.⁹¹ Similar problems prevail in the education sector, where there are considerable difficulties recruiting teachers who are willing to work in rural and remote schools.

PROFESSIONAL ETHICS AND POSITIVE INCENTIVES

Establishing a culture of ethics in service delivery organizations is not an easy task. It includes clear performance management frameworks, dismissal policies for staff not adhering to performance and ethical standards, training on the expected standards and what to do when they are breached, and a supportive environment within the service delivery organization, and also in the broader community, for individual responsibility and accountability and ethical behaviour. Critically, there should be consequences for undesirable behaviours and these consequences should be (and be seen to be) enforced, up to and including dismissal and revocation of professional status and accreditation. Issuing health workers and medical professionals with a single, lifetime licence under the new Law on Examination and Treatment should be reviewed in light of international experience that shows that lifetime licensing can act as a disincentive to medical staff to engage in continuous learning, isolating staff from their peers and exposure to new ideas and methods, including about ethical behaviour and practices. In China, for example, lifetime licensing has been replaced with a stipulated review of licenses every three years, with health professionals either undertaking an exam or engaging in a programme of continuous learning in order to maintain their

professional standing. Independent and robust complaints mechanisms, in particular in health care, are also an obvious requirement to maintain professional standards and protect patients from exploitation, abuse and malpractice. Professional associations have a role to play in establishing and maintaining standards, and educating their members about appropriate behaviours. They can also facilitate rewarding and sharing good practice, and can play a role in certification and accreditation of members.

In addition to instilling ethics and a culture of public service in the teaching and health professions, it is also important to recognize that these must be balanced with practical and positive incentives for changed behaviour. Both monetary and non-monetary incentives are required. A plethora of possible options are available, including direct pay increases, opportunities for further education and skill development, fast tracking to promotion, and rewards and recognition for excellence in service provision. The point is that these incentives need to be tailored to the specific culture and attitudes of medical and teaching staff working in Viet Nam, and a deeper understanding of the attitudes and incentives in play is required to design effective strategies. For example, a recent study on incentives for doctors and medical students to work in rural areas found that pay-based incentives alone were not sufficient to attract doctors, as they could earn significantly more in urban areas. The study also found that newly qualified doctors would often avoid the compulsory two years of service in rural areas by moving into private practice or returning to urban areas. Medical students were much more concerned with non-financial incentives such as long-term career prospects, while practising doctors were primarily concerned with current earnings.⁹²

BOX 6.5: WORLD HEALTH ORGANIZATION (WHO) GUIDELINES FOR RETENTION OF RURAL HEALTH WORKERS⁹³

In 2010, the WHO-issued guidelines for retention of health workers in remote and rural settings. While recognizing that incentives must be tailored to local needs and circumstances, the guidelines suggest a combination of educational, regulatory and financial incentives, together with professional and personal support.

The guidelines recommend targeting of rural students for health and medical education, location of medical schools outside major cities, exposure of undergraduate students to rural settings via community experiences and clinical rotation, inclusion of rural health topics in curricula, and accessible continuing education for rural health workers. In addition, compulsory service requirements for rural and remote areas should be accompanied by incentives and support,

and scholarships, bursaries and other education subsidies should include enforceable agreements for service in rural and remote areas.

Financial incentives recommended include hardship allowances, housing grants, free transport, and paid vacations, which should be sufficient to outweigh opportunity costs associated with working in rural areas. As living conditions are a major barrier for health workers in countries such as Viet Nam, improved living conditions, infrastructure and services are critical to attract and retain rural health workers, as are good and safe working environments. Professional networks, outreach activities, placement of senior health posts in rural locations and a system of rewards and recognition are also key.

MODERN SYSTEMS

MODERN PERFORMANCE MANAGEMENT SYSTEMS

In order to improve the responsiveness of health and education service delivery organizations to the changing needs and expectations of clients, and to support improved accountability and transparency, modern systems for monitoring, reporting on and evaluating performance need to be adopted and scaled up. Two key approaches are discussed briefly here: performance-based funding and use of information technology.

The health sector has recognized the need to shift to performance-based funding, and a draft decree has been developed to support performance-based budget allocation.⁹⁴ This represents an important step towards measuring and funding health service delivery organizations on the basis of whether they are fulfilling their mission, rather than the number of patients they treat or the number of hospital beds per facility. The *WHO 2010 Global Health Report on health financing* argues that performance-based funding can be an effective strategy for “rewarding the delivery of specific services to encourage higher coverage, better quality or improved health outcomes.”⁹⁵ In order to be successful, results must be strictly verified to ensure intended outcomes are realized: balancing quantitative indicators with measurements of quality of care is key. Engaging clients and civil society organizations in providing oversight and feedback on service quality, and in setting norms for delivery such as fee levels, also helps to ensure participation and voice. In countries such as Rwanda, performance-based funding has been shown to increase the use of health services, improve financial accessibility and motivation of

health staff, and has helped to incorporate private sector providers.⁹⁶

Similarly, in education, state budgets could be used to encourage institutions to fulfil their mission and implement good institutional practices. In higher education, performance-based funding has commonly been introduced to generate competition between institutions and improve the overall quality and performance of the tertiary sector. The goals or mission of the institution are agreed upon between the government as funder and the university or college as provider, and funding is then based on the degree to which the organization achieves its mission. For example, in Hong Kong, the University Grants Committee has worked with the administration of Hong Kong’s eight universities to develop specific goals or missions for each institution, which fit within the broader objectives of the higher education system. A percentage of the recurrent grant given to universities is tied to periodic review of the extent to which these institutions have fulfilled their agreed role.⁹⁷

In the Vietnamese context, funding could be tied to improving performance and development by “offering grants to institutions with strategic plans to improve academic performance, increase community relevance of their programs or improve their management structures”.⁹⁸ Funding can also be used as an incentive to improve the quality and responsiveness of private tertiary institutions, by making them compete for public support. By changing the incentives to focus on results (satisfaction of users, increased coverage, lower disease rates), rather than inputs (number of beds), performance-based funding realigns the role of service delivery organizations with human development goals and objectives, and could act as an important corrective to the commercialization of health and education services in Viet Nam.

GOOD INFORMATION SYSTEMS ARE ESSENTIAL

Measuring and reporting on results also requires having good systems in place, including use of Information and Communications Technology (ICT) to gather and share data and information. The 2010 Joint Annual Health Review identifies health information systems as one of the six essential building blocks of the health system. Good information systems are important not only for effective sectorwide planning and decisionmaking, but also for effective management and monitoring of service delivery organizations. For example, centralized patient records are an important way to monitor disease and treatment trends nationally, but can also help central and provincial hospitals to plan for service delivery that is effective in meeting local-level needs. At present, data management and storage is implemented at all levels of the health system, from the commune to the central level. However, at the commune level it remains largely paper based.⁹⁹ At the service delivery organization-level information and data management systems are therefore underdeveloped. Such systems have enormous potential not only for tracking disease trends and treatment, but also for measuring hospital and health facility performance—and feeding this information back to users.

The Ministry of Education and Training has committed to the use of ICT in schools and has entered into a partnership with telecommunications provider Viettel to provide free Internet access to 39,000 schools around the country. Viet Nam aims to not only increase training in IT skills, but also to ensure all schools have an Internet connection and are equipped with computers, not only to facilitate development of IT skills but also to promote innovative approaches to teaching and learning.¹⁰⁰ Directive 55 (2008) sets out the priority given to enhancing use of ICT for teaching and training. Provincial departments of education are tasked with

working with Viettel to make the education network a reality. As in health, ICT has an important role to play in enabling service delivery organizations to improve and modernise education management, evaluation, and reporting, for example by storing enrolment information and student results.¹⁰¹ The risk is that better off schools and students will take up new technology faster, widening the gap between the haves and have-nots even further. Nevertheless, ICT has a role to play in improving service delivery organizations' effectiveness and responsiveness to clients. While many of Viet Nam's citizens are not yet connected, uptake of the Internet is rising rapidly, in particular among young people, and mobile telephony has increased exponentially across the population. Such technology can not only be used to share information about services and their performance, but also to gather data on user expectations and preferences in a confidential way.

Critically, using modern systems for planning, reporting and monitoring can help service delivery organizations to be more responsive to the needs and expectations of clients and communities, as well as to prepare more effectively for future needs and the many challenges Viet Nam faces in a rapidly changing environment. However, building modern service delivery organizations, with professional staff, high standards, strong accountability mechanisms and a strong client orientation is not an easy task. Viet Nam will require continued support from its development partners to do so, together with strong institutions and accountability mechanisms at a national and sub-national level, and a more supportive enabling environment in which different kinds of organizations, such as non-state not-for-profits, can engage in delivery of services, and ordinary people can have a say about the way services are planned and delivered. If Viet Nam is to reach its development goals, and ensure a prosperous and healthy future for all its citizens, it is a task that cannot be avoided. Indeed, Viet Nam's progress and the human development of all its citizens depend on it.

POLICY DIRECTIONS

VALUING PEOPLE OVER ECONOMIC DEVELOPMENT

People are the real wealth of nations. The same level of priority and investment should be given to building people's capacities, capabilities and choices, and improving human development outcomes as is currently accorded to generating higher levels of GDP per capita each year. Health and education are the building blocks of human development, and ensuring equitable access to quality health and education services for all citizens is fundamental to moving to higher levels of human development. In Viet Nam, public investment in education is comparable to most countries in the region, public investment in health care is rising, and policy frameworks and political commitments, which support universal access to quality social services and social protection, are in place. Yet over the past decade progress on key health and education indicators, including those used in the Human Development Index (HDI), and other human development indexes has been lagging behind rapid economic growth. Access to health and services has become more costly for households and is likely to become more inequitable as a result. In consequence, Viet Nam's progress towards higher levels of human development as measured by the HDI has slowed, both at a national and a sub-national level. Arresting this trend is no easy feat and requires the concerted attention and effort of policymakers and decisionmakers, and the support of the development community.

The following broad policy implications and directions are highlighted by this report.

SOCIAL SERVICES HAVE A KEY ROLE TO PLAY IN REDUCING DISPARITIES AND CONTAINING RISING INEQUALITY

As this report has shown, disparities in access to health and education services, together with inequities in health and education outcomes are persistent, and in some specific cases appear to be widening. These include disparities among different regions and provinces, ethnic minorities and the Kinh/Hoa majority, and in some provinces,

between women and men. If not checked, rising inequalities and disparities have the potential to constrain Viet Nam's progress to higher levels of human development and may also create social instability and undermine social cohesion in the longer term. Social services such as health and education have the potential to play a critical role in reducing and containing disparities, by providing opportunities for people to develop their capabilities and capacities and improve their well-being, and by ensuring more equitable outcomes between different socio-economic groups over time. However, in Viet Nam, despite many significant achievements in improving health and education and lifting overall living standards, this potential is not yet fully realized. In contrast, current financing and delivery arrangements for health and education services appear to be reinforcing, and in some instances even exacerbating, existing disparities and inequalities. Addressing this is now a key policy imperative in light of Viet Nam's development aspirations and in order to reach higher levels of human development. Policy frameworks are in place to support universal and equitable access to quality social services. Examples include the 2009 Health Insurance Law, the draft Social Protection Strategy and Resolution 80 on Sustainable Poverty Reduction. However, ensuring policy coherence and effective implementation remain significant challenges.

The same level of priority and investment should be given to building people's capacities, capabilities and choices, and improving human development outcomes as is currently accorded to generating higher levels of GDP per capita each year.

A NEW APPROACH TO WELFARE

As these key policy instruments recognize, the main purpose of investing in social services and social protection is not primarily to provide safety nets or charity to those who are most vulnerable and disadvantaged. Quality, affordable social services and a comprehensive social protection system are the foundation of a prosperous, stable society and a prerequisite for improvements in human

development and well-being. Access to social services and social protection are vital to cushion a society and its citizens from various kinds of shocks, whether they are environmental, social, economic or health-related, as well as to promote recovery and resilience. It is increasingly recognized around the world that a shift to viewing social protection and access to social services as a universal right of all citizens rather than as a set of 'safety nets' for the most vulnerable and disadvantaged is a hallmark of successful societies and economies. In Viet Nam there are signs that this shift is under way, but it is far from complete. Commitments to universal social protection in support of a healthy and robust society must be strengthened and more effective implementation ensured.

A MORE COHERENT SYSTEM OF BENEFITS TO SUPPORT UNIVERSAL ACCESS TO SERVICES

The current system of programmes and initiatives which support people to access social services is complex, overlapping, and not yet able to reach everyone who is in need of support: internal migrants who remain unregistered are just one example. The Health Insurance Law sets out the principles for a more coherent and universal approach to providing health coverage. Implementation remains a challenge, as many people don't yet have health insurance cards or don't use them. The benefit package is limited and the services provided to users of the health card are often of lower quality than those available to fee-paying clients. Financing arrangements in health care also need reconsideration in order to reduce incentives for over-treatment and over-prescription. Exploration of alternatives to user fees such as capitation and Diagnosis Related Group (DRG) approaches should be accelerated. In education at present, with costs escalating rapidly, in particular at higher levels, subsidies are failing to keep up. More innovative ways of ensuring access, such as voucher systems, a broader approach to conditional cash transfers, and better integration of different benefit systems also need to be considered.

REVISITING THE SOCIALIZATION POLICY

In line with renewed commitment to universal provision of quality social services and social protection, it is now timely to revisit and revitalise the socialization policy. The original intent of the socialization policy was to involve all actors in planning for, delivering and monitoring of social services. This is now urgent. A more enabling environment for non-state, not-for-profit service

delivery needs to be fostered as a key priority. Development partners are well placed to support the Government of Viet Nam in this regard, as well as to work closely with non-state, not-for-profit organizations to build their capacity to deliver social services in Viet Nam. Much greater engagement of citizens in planning for and monitoring of social services—rather than just paying for them—is also critical. Both participation at the level of service planning and administration via engagement with local authorities and citizen scorecard processes, as well as direct involvement with service delivery organizations via users committees, are required. Other mechanisms for providing direct feedback to service management and staff are also required.

More equitable distribution of the cost burden of paying for social services is required between the State and households, and between the better off and the poor.

A MORE EQUITABLE FUNDING BURDEN

One of the most pernicious aspects of the current financing system in both health and education is heavy reliance on household contributions in both sectors, in an environment where costs are rapidly escalating. More equitable distribution of the cost burden of paying for social services is required between the State and households, and between the better off and the poor. At present households pay an estimated 60 percent of health costs and around 37 percent of education costs—rising to more than 50 percent for tertiary education—well above levels considered optimum to promote equity and improved human development. Even in primary education, which is supposed to be free, households are paying additional costs of around 17 percent. Informal payments only increase the cost burden on households. A better balance is needed between economic and human development goals and investment in social services and social protection; however, increased funding alone is not the answer, rather, more efficient investment, attention to quality, and more effective governance of service delivery is required.

ADDRESSING THE EMERGING TWO-TIER SYSTEM OF SERVICE DELIVERY

At present in Viet Nam, the better off pay more for social services, and receive a better quality of services as a result. As result, they do not invest in, or care about the quality of the services available to the poor. On the other hand, poor and disadvantaged

people have little choice but to accept the services that are available to them, even if these services are of substandard quality. This leads to a downgrading of publicly available services that is apparent in district hospitals and commune health stations, for example. Some level of differentiation in the quality of social services is inevitable in any country, based on the varying capacity of individuals and households to pay. However, there needs to be a much greater debate about how much differentiation is acceptable, given Viet Nam's social equity goals, as well as a robust policy discussion regarding developing a minimum standard of service that is available to all citizens as well as what this should include.

Stronger governance is all the more critical in light of decentralization of funding and management of social services to the level of service delivery organizations.

STRENGTHENING GOVERNANCE AND IMPROVING QUALITY OF SERVICES

A key theme of this report has been the importance of improving governance, oversight and management of social services at the administrative level, as well as in service delivery organizations. Stronger governance is all the more critical in light of decentralization of funding and management of social services to the level of service delivery organizations. Development partners are well placed to assist the Government of Viet Nam to improve oversight and accountability of public services, and to support strengthening of the management practices, workplace culture and professional standards of public service delivery organizations. It should, however, be recognized that creating incentives for service providers to act in the best interests of clients is likely to be difficult, and that financial incentives must be put in place alongside professional and normative ones. Complex and entrenched vested interests will need to be recognized, challenged and addressed.

Participation and feedback from users is key to this effort. Provincial-level indexes such as the Public Administration Performance Index (PAPI) are a valuable tool to help government at the sub-national level improve planning and delivery of social services, as well as to better engage stakeholders and communities in decisionmaking. The HDI and human development family of indexes presented in this report show which provinces have been able to lift their performance on health and education indicators, even in cases where economic growth has been less rapid. These indexes also show which

provinces have experienced rising levels of disparity, even as they have become more prosperous. The HDI and human development family of indexes show which provinces are doing less well and which are succeeding, in raising the living standards, well-being and quality of life of their citizens, and improving human development outcomes. As such they are valuable tools and sources of information for decisionmakers.

MORE EFFECTIVE REGULATION OF THE PUBLIC AND PRIVATE SECTOR

Government needs to more actively manage tensions between market incentives and egalitarian principles. More effective regulation of both the public and the private sector is critical. Public sector services are increasingly engaging in fee-for-service delivery and, in the case of health care, are providing services which are often not needed and, in the worst case, actively harmful. At present, private sector involvement in health and education services is proliferating, including in pharmacies and private health clinics, early childhood education, and vocational training and university education. Often both public and private sector service providers operate with little oversight and limited consequences for delivering low quality services, or even for fraud or malpractice—even though the consequences may be very serious for individuals and households when this occurs. If Viet Nam wants to achieve its aim of building a world-class university system, to ensure young children get a good start in life, and to prevent over-prescription and over-medicalization in health care services at best—and illegal, unethical practices at worst—it must act now to impose consequences for improper practices and substandard quality of service delivery.

PLANNING FOR THE FUTURE

Finally, and critically, Viet Nam needs to be more actively thinking ahead and planning for the future. For the kinds of services and social protection system a rapidly changing country and context will need, for emerging issues and challenges such as an ageing population and the challenge of climate change, and for the changing aspirations and expectations of its citizens. Use of more modern systems and approaches, including information and communications technology and results-focused funding of services, together with better use of evidence for planning, are key to ensure Viet Nam is able to meet emerging needs and demands and cope with rapid social and economic change, while continuing on the path to higher human development.

NOTES AND REFERENCES

NOTES

- 1 The Kinh or Viet are the main ethnic group in Viet Nam and account for the majority of the population, at 76 percent. The Hoa ethnic group or the ethnic Chinese account for around 1 percent; however this group is not usually considered as an ethnic minority group in Viet Nam because of their high level of assimilation with the Kinh majority and their relative wealth. This report defines the ethnic majority group as consisting of the Kinh and Hoa ethnic groups and ethnic minority groups as the remaining ethnic groups, which account for the remaining 13 percent of the population.

CHAPTER ONE

- 1 UNDP 1990: 9.
- 2 Alkire 2010.
- 3 Alkire 2010.
- 4 UNDP 2010.
- 5 Stiglitz, Sen, and Fitoussi 2009: 4.
- 6 Stiglitz, Sen, and Fitoussi 2009: 63.
- 7 Bloom and Canning 2008.
- 8 UNDP Asia-Pacific Regional Centre in Colombo 2008.
- 9 National Centre for Social Sciences and Humanities 2001.
- 10 UNDP 2010.
- 11 Stiglitz, Sen, and Fitoussi 2009.
- 12 GoV 2001.
- 13 GoV 2010b: 15.
- 14 GoV 2010d: 4.
- 15 GoV 2010d: 5.
- 16 GoV 2010c: 4.
- 17 GoV 2010c: 4-5.
- 18 MOLISA and UNICEF 2008.
- 19 Hanoi People's Committee and Ho Chi Minh People's Committee 2010.
- 20 National Centre for Social Sciences and Humanities 2001: 19
- 21 London 2010a: 39.
- 22 Central Institute for Economic Management (CIEM) and Asia Competitiveness Institute 2010.
- 23 Central Institute for Economic Management (CIEM) and Asia Competitiveness Institute 2010: 8.
- 24 Sen 2011.
- 25 For example, the second Viet Nam-Africa International Forum, which took place in Hanoi in August 2010, was explicitly designed to share lessons learned in MDG attainment and sustainable development.
- 26 The source for data prior to 1999 is the 2001 National Human Development Report.
- 27 See the annexes for details of changes in the different indexes over time.
- 28 China Institute for Reform and Development 2008: 13.
- 29 GoV 2010b.
- 30 UNDP 2010: 50, 51.
- 31 WHO National Health Accounts 2008.
- 32 UNDP 2010: 30.
- 33 Harvard Viet Nam Program 2008: 22.
- 34 Harvard Viet Nam Program 2008: 22; Van Arkardie and others 2010; Central Institute for Economic Management (CIEM) and Asia Competitiveness Institute 2010.

- 35 London 2010a; Van Arkardie and others 2010.
- 36 UN in Viet Nam 2011: 3, 4.
- 37 Van Arkardie and others 2010: 19; see also London 2010a.
- 38 GoV 2010a: 32.
- 39 Parliamentary Committee on Social Affairs and UNDP 2009.
- 40 GoV 2010b.
- 41 National Centre for Social Sciences and Humanities 2001: 28.
- 42 National Centre for Social Sciences and Humanities 2001: 9.
- 43 UNDP 2009.
- 44 UNDP 2010: 28.
- 45 UNDP 2010: 90.
- 46 UNDP 2010: 95.
- 47 Further information about these new indexes and what they measure is available at www.hdr.undp.org.
- 48 UNDP 2010: 26.
- 49 The new GII is already the subject of global debate. See Permanyer (no date).
- 50 Pincus and Sender 2007: 108-150.
- 4 GSO 2010d. These poverty rates are based on expenditure levels using the WB and GSO poverty line. The poverty rate is slightly lower if it is calculated based on average monthly income per capita using VHLSS data and the new Government poverty line for the 2006 to 2010 period.
- 5 Viet Nam's poverty line is low by international standards: in 2008 the official poverty line was PPP US\$1.09 per day lower than all other countries in the region apart from China, and considerably lower than countries such as Thailand at PPP US\$2.49 a day. (Poverty in East Asia and the Pacific: Are we measuring the right thing(s)? World Bank: 2010a).
- 6 Hence, according to the 2010 MDG Report Card produced for the summit, Viet Nam ranked sixth globally for both absolute and relative progress towards achieving the MDGs. Overseas Development Institute (ODI) 2010: 9.
- 7 GSO 2010d.
- 8 GSO 2010d.
- 9 Note these figures are based on expenditure and a relatively low poverty line in Viet Nam as noted above.

CHAPTER TWO

- 1 The World Bank's main criterion for classifying economies is Gross National Income (GNI) per capita. Economies are divided according to 2010 GNI per capita, calculated using the World Bank Atlas method. The groups are: low income, US\$1,005 or less; lower middle income, US\$1,006 to US\$3,975; upper middle income, US\$3,976 to US\$12,275; and high income, US\$12,276 or more. See <http://data.worldbank.org/about/country-classifications> and <http://data.worldbank.org/indicator/NY.GNP.PCAP.CD> last accessed September 2011
- 2 GSO data available online at www.gso.gov.vn.
- 3 Central Institute for Economic Management (CIEM) and Asia Competitiveness Institute 2010.
- 10 GoV 2010b: 43.
- 11 GoV 2010b: 43.
- 12 Central Institute for Economic Management (CIEM) and Asia Competitiveness Institute 2010: 69.
- 13 See World Bank 2011.
- 14 World Bank 2010c: 5, 13.
- 15 World Bank 2010c: 8.
- 16 Hence, Viet Nam's Incremental Capital Output Ratio (ICOR) is currently at close to 7, meaning that Viet Nam must invest seven units per one unit of GDP generated—a much higher ratio than countries such as China and India. Central Institute for Economic Management (CIEM) and Asia Competitiveness Institute 2010: 40.
- 17 Pincus 2010.
- 18 Hanoi People's Committee and Ho Chi Minh People's Committee 2010: 106.

- 19 Hanoi People's Committee and Ho Chi Minh People's Committee 2010: 106; Viet Nam Academy of Social Sciences (VASS) Center for Analysis and Forecasting 2009.
- 20 Central Institute for Economic Management (CIEM) and Asia Competitiveness Institute 2010: 61.
- 21 Central Institute for Economic Management (CIEM) and Asia Competitiveness Institute 2010: 61; Pincus 2010.
- 22 For a detailed discussion of current economic trends the reader is referred to the various World Bank, UN and independent papers referred to in this chapter.
- 23 Central Institute for Economic Management (CIEM) and Asia Competitiveness Institute 2010: 97; UN in Viet Nam 2009.
- 24 For example, Resolution 11/NQ-CP represents a turnaround in policy thinking, as it prioritises 'quality' of growth and development, rather than short-term growth alone.
- 25 Harvard Viet Nam Program 2010; Central Institute for Economic Management (CIEM) and Asia Competitiveness Institute 2010.
- 26 Central Institute for Economic Management (CIEM) and Asia Competitiveness Institute 2010: 63.
- 27 Central Institute for Economic Management (CIEM) and Asia Competitiveness Institute 2010: 90.
- 28 <http://data.worldbank.org/about/country-classifications>
- 29 UNDP 2010: 139
- 30 UN in Viet Nam 2010a: 15
- 31 For more on the middle-income trap see Van Arkadie and others 2010; Central Institute for Economic Management (CIEM) and Asia Competitiveness Institute 2010.
- 32 World Bank 2010a.
- 33 Industry and construction were worth 42 percent of GDP in 2009, compared to 36 percent in 2000, and 25 percent in 1990, while the value of agriculture has declined to 17 percent of GDP from 31 percent in 1990 and services have remained at around 40 to 43 percent over the 1990 to 2009 period. Figures at 1994 constant prices, GSO, www.gso.gov.vn, last accessed September 2011.
- 34 Growth in industry and construction fell from 10.2 in 2007 to 5.5 percent in 2009, from 8.9 to 6.6 percent in services and 3.8 to 1.8 percent in agriculture during the same period. World Bank 2010c: 7.
- 35 MOLISA, ILO and EU 2011: 5.
- 36 Central Institute for Economic Management (CIEM) and Asia Competitiveness Institute 2010: 55.
- 37 Central Institute for Economic Management (CIEM) and Asia Competitiveness Institute 2010: 93.
- 38 GSO 2010a.
- 39 MOLISA, ILO and EU 2011.
- 40 Better employment conditions needed to curb labour disputes 2011; Meissner and Ho Sy Hung 2008.
- 41 MOLISA and ILO 2010; GSO 2010d.
- 42 Nguyen Ngoc Thang 2010.
- 43 MOLISA, ILO and EU 2011: 21.
- 44 MOLISA and ILO 2010: 15; GSO 2010d.
- 45 MOLISA and ILO 2010: 14
- 46 Cling and others 2010.
- 47 MOLISA, ILO and EU 2010. Note that education data for the entire workforce is not available in the 2009 Labour Force Survey.
- 48 GSO 2010c: 43.
- 49 GSO 2010c: 38.
- 50 Underemployment is calculated by using data related to the hours of work in the primary job and the readiness of the employed person to work additional hours. MOLISA, ILO and EU 2011: 19.
- 51 Nguyen Ngoc Anh and Nguyen Duc Nhat 2010.
- 52 Pincus 2010.

- 53 Rodgers and Menon 2010; Lee 2008.
- 54 Cling and others 2010.
- 55 Rodgers and Menon: 2010.
- 56 Rodgers and Menon: 39.
- 57 Central Population and Housing Census Steering Committee 2010: 34.
- 58 Central Population and Housing Census Steering Committee 2010: 53.
- 59 Central Population and Housing Census Steering Committee 2010: 41.
- 60 MOLISA, ILO, EU 2011: 47.
- 61 Van Arkadie and others 2010.
- 62 GSO 2010b.
- 63 Van Arkadie and others 2010.
- 64 UNFPA 2011.
- 65 Giang Thanh Long 2010: 4.
- 66 Central Population and Housing Census Steering Committee 2010: 70.
- 67 Based on Giang Thanh Long 2010.
- 68 This section is drawn from Hanoi School of Public Health and University of Queensland 2008.
- 69 Central Population and Housing Census Steering Committee 2010: 62, 63.
- 70 Guilмото 2010.
- 71 Guilмото 2010.
- 72 Sen 2001: 35.
- 73 Guilмото 2010.
- 74 Central Population and Housing Census Steering Committee 2010: 38.
- 75 Van Arkardie and others 2010: 218.
- 76 Van Arkardie and others 2010: 218.
- 77 Central Population and Housing Census Steering Committee 2010: 36
- 78 Dapice, Gomez-Ibanez and Nguyen Xuan Thanh 2010.
- 79 Van Arkardie and others 2010: 222, 223.
- 80 Van Arkardie and others 2010: 226.
- 81 UN-Habitat 2008: 178.
- 82 Dapice, Gomez-Ibanez and Nguyen Xuan Thanh 2010: 15.
- 83 The census excludes all temporary, seasonal and circular migrants numbers, who are estimated to be significant in Viet Nam. GSO 2011b.
- 84 GSO 2011b.
- 85 UNIAP 2008.
- 86 GSO 2011b: 9.
- 87 GSO 2011b: 9.
- 88 Hanoi People's Committee and Ho Chi Minh People's Committee 2010.
- 89 GSO 2011b; Hanoi People's Committee and Ho Chi Minh People's Committee 2010.
- 90 GSO 2011b.
- 91 Hanoi People's Committee and Ho Chi Minh People's Committee 2010: 23, 24.
- 92 IOM 2010.
- 93 Pincus and Sender 2007: 116.
- 94 IOM 2010.
- 95 Around 89 percent of Vietnamese households receive some form of remittance from international or internal migrants, and the value of these remittances was worth around US\$5.5 billion in 2007. The value of internal remittances has been increasing over time. United Nations in Viet Nam 2010b: 41.
- 96 Ta Thi Thanh Huong and Neefjes 2010.
- 97 Harmeling 2010.
- 98 Harmeling 2010: 7.
- 99 Ta Thi Thanh Huong and Neefjes 2010: 4.
- 100 Ta Thi Thanh Huong and Neefjes 2010: 9.
- 101 Ta Thi Thanh Huong and Neefjes 2010: 10.
- 102 Ta Thi Thanh Huong and Neefjes 2010.
- 103 GoV 2010b: 97.
- 104 GSO 2010d.
- 105 All data is from GSO 2010b.
- 106 Less than 1 percent of young women in Viet Nam smoke.
- 107 World Bank 2009.
- 108 Acuña-Alfaro, Giang Dang and Do Thanh Huyen 2010: 1.
- 109 UN in Viet Nam 2010a.

- 110 World Bank 2009: 30.
 111 World Bank 2009: 27.
 112 World Bank 2009: 133.
 113 GoV 2010d: 21.
 114 UN in Viet Nam 2010a.
 115 GoV 2010d: 22.
 116 Cited in Vian, Salomon, and Nguyen Thi Kieu Vien 2010: 7.
 117 Government Inspectorate 2010.

CHAPTER THREE

- 1 UNDP 2009.
 2 UNDP 2009.
 3 See Annex Three for information on how the Vietnamese MPI was constructed.
 4 Surborg 2010.
 5 London 2010b, Population data cited in Central Population and Housing Census Steering Committee 2010.
 6 London 2011: 1-56.
 7 GSO 2010; Central Population and Housing Census Steering Committee 2010: 85.
 8 GSO 2011b.
 9 Rodgers and Menon 2010; see also GoV 2010a.
 10 GSO and WHO 2010.
 11 Ministry of Health, National Hospital of Paediatrics and UNICEF 2008.
 12 UNICEF, MoET, and UNESCO 2008.
 13 GSO 2010d: Table 9.5.
 14 GSO 2010a: Table 9.4.
 15 See the data tables in Annex Four for changes in the HPI sub-indicators over time.
 16 GoV 2010b: 57.
- 3 Committee for Ethnic Minority Affairs and UNDP 2008.
 4 Nguyen Viet Cuong 2010: 23.
 5 Nguyen Viet Cuong 2010: 19.
 6 Rodgers and Menon 2010: 46.
 7 Rodgers and Menon 2010: 48.
 8 Cited by MOLISA and UNICEF 2010: 44.
 9 GoV 2010b: 60.
 10 GSO 2009a: 112.
 11 Knowles and others 2010: xiv.
 12 GoV 2010b.
 13 GoV 2010b: 55-57.
 14 GoV 2010b: 60-63.
 15 For IDUs, the epidemic is higher in Quang Ninh, Ho Chi Minh City, and Can Tho; for Female Sex Workers (FSWS) in Hai Phong, Ho Chi Minh City and Can Tho, for clients of FSWS in the North West and Can Tho and among MSM in Hanoi and Ho Chi Minh City. See Ministry of Health—Viet Nam Administration of HIV/AIDS Control 2009.
 16 Surborg 2010.
 17 Ministry of Health—Viet Nam Administration of HIV/AIDS Control 2009.
 18 Ministry of Health—Viet Nam Administration of HIV/AIDS Control 2009.
 19 Ministry of Health and Health Partnership Group 2009: 12.
 20 United Nations in Viet Nam 2010a; Ministry of Health and Health Partnership Group 2010.
 21 Le Bach Duong and others 2008
 22 Gross enrolment rates or ratios are the number of students enrolling in an education level, regardless of age, expressed as a percentage of the population of a certain age group. Net enrolment rates are the number of students in the theoretical age group for an education level, actually enrolled in that education level, that are expressed as a percentage of the population in that age group.
 23 Vu Hoang Linh 2010; GSO 2010d: Table 2.3.

CHAPTER FOUR

- 1 Rodgers and Menon 2010.
 2 Committee for Ethnic Minority Affairs and UNDP 2008.

- 24 Vu Hoang Linh 2010.
- 25 London 2010a: 41.
- 26 GSO and UNICEF 2007: 209.
- 27 GSO 2011a: 36; see also Central Population and Housing Census Steering Committee 2010: 91, Table 7.4.
- 28 Pham Thai Hung 2010; Committee for Ethnic Minority Affairs and UNDP 2008.
- 29 Pham Thai Hung 2010.
- 30 Pham Thai Hung 2010.
- 31 Pham Thai Hung 2010.
- 32 See UNICEF, MoET, and UNESCO: 2008.
- 33 Rodgers and Menon 2010: 81.
- 34 Pham Thai Hung 2010.
- 35 Pham Thai Hung 2010.
- 36 Pham Thai Hung 2010.
- 37 GSO 2010d: Table 2.2.
- 38 GSO 2010d: Table 2.1.
- 39 Vu Hoang Linh 2010.
- 40 GoV 2010b: 40.
- 41 GSO 2009b.
- 42 GSO 2011a: 38, 39.
- 43 GSO 2011a: 38, 39.
- 44 Vu Hoang Linh 2010.
- 45 Vu Hoang Linh 2010: 14.
- 46 Rodgers and Menon 2010: 16, 17.
- 47 As primary school education is compulsory this was not examined.
- 48 Vu Hoang Linh 2010.
- 49 IOM 2010.
- 8 Ministry of Health and Health Partnership Group 2010: 149.
- 9 Note that in order to receive any of the benefits listed in Table 5.1, recipients must be registered. Unregistered and temporary migrants are therefore excluded. Parliamentary Committee for Social Affairs and UNDP 2009.
- 10 Baluch and others 2008: 53.
- 11 Baluch and others 2008: 66.
- 12 GSO 2010d.
- 13 UN in Viet Nam 2010a: 49.
- 14 The new poverty line for 2011 to 2015 is 500,000 VND a month for urban areas and 400,000 VND a month for rural areas, with cut-offs for the near poor at 501,000 to 650,000 VND for urban areas and 401,000 to 520,000 VND for rural areas. However, many urban areas and richer regions have set their own poverty line at higher levels.
- 15 Based on London 2010b; Pincus 2010; and Van Arkadie and others 2010.
- 16 Nguyen Khanh Phuong 2009: 126.
- 17 Van Arkadie and others 2010: 135.
- 18 Cited in London 2010b: 23.
- 19 Cited in Ministry of Health and Health Partnership Group 2010: 142.
- 20 Cited in Ministry of Health and Health Partnership Group 2010: 142.
- 21 Pincus 2010: 26.
- 22 London 2010b: 24.
- 23 London 2010b: 25.
- 24 Pincus 2010: 27.
- 25 Fischer 2010.
- 26 It is for this reason that initiatives such as the new Health Insurance Law also offer subsidies to the near poor.
- 27 London 2010b: 33.
- 28 London 2010b: 34.
- 29 Note that international data may differ slightly from national data. According to the National Health Accounts, health expenditure was 6.4 percent of GDP in 2008. Ministry of Health and Health Partnership Group 2010: 144.

CHAPTER FIVE

- 1 London 2010b: 21.
- 2 Van Arkadie and others 2010: 85.
- 3 Pincus 2010: 27.
- 4 London 2010b: 27.
- 5 UN in Viet Nam 2010a: 50.
- 6 Cook 2009. Baluch and others 2008.
- 7 Parliamentary Committee on Social Affairs and UNDP 2009.

- 30 WHO National Health Accounts. <http://www.who.int/nha/en/> last accessed September 2011.
- 31 Ministry of Health and Health Partnership Group 2010: 150.
- 32 UN in Viet Nam 2010a: 53.
- 33 London 2010b: 38.
- 34 London 2010b: 38.
- 35 Cited in Ministry of Health Viet Nam and Health Partnership Group 2008: 15.
- 36 Ministry of Health Viet Nam and Health Partnership Group 2008: 36; Giang Thanh Long 2010: 11.
- 37 Ministry of Health Viet Nam and Health Partnership Group 2010: 152.
- 38 Giang Thanh Long 2010: 11.
- 39 Ministry of Health Viet Nam and Health Partnership Group 2010: 150.
- 40 Ministry of Health Viet Nam and Health Partnership Group 2008: 40.
- 41 Ministry of Health Viet Nam and Health Partnership Group 2010: 148.
- 42 Ministry of Health Viet Nam and Health Partnership Group 2010: 150.
- 43 London 2010b: 34.
- 44 Cited in London 2010b: 38.
- 45 WHO 2009: 5, 18.
- 46 GSO 2010d: Table 4.13
- 47 It is worth noting that the South Central Coast region appears to have adopted a more client-centred approach to encouraging people to purchase health insurance than other regions. The region achieved the highest enrolment rate for health insurance cards (15.8 percent), compared to the national average (11.1 percent). The insured in this region were more likely to be registered at hospitals (fewer registered at the commune level—18 percent compared to the national average of 32 percent), and paid less additional fees (9 percent compared to 12 percent nationally). Castel, Tran Thi Mai Oanh and Tran Ngo Thi Minh Tam, 2010.
- 48 Rodgers and Menon 2010.
- 49 Nguyen Viet Cuong 2010: 22.
- 50 Once households are spending more than 40 percent of their expenditure on health care or 25 percent of their non-food expenditure, they are not able to meet other necessary living expenses, in particular at the low-income end of the spectrum.
- 51 Ministry of Health Viet Nam and Health Partnership Group 2010: 62.
- 52 Hoang Van Minh and Phuong Nguyen 2011.
- 53 Ministry of Health Viet Nam and Health Partnership Group 2010: 65.
- 54 World Bank 2010: 77.
- 55 See for example 'Goal: Maximising profits from patients' illness' 2011.
- 56 Thompson, Wittner, and Nguyen Thi Thuy Nga 2011: 26.
- 57 Thompson, Wittner, and Nguyen Thi Thuy Nga 2011: 27.
- 58 Thompson, Wittner, and Nguyen Thi Thuy Nga 2011: 42.
- 59 Nguyen Viet Cuong 2010: 17.
- 60 Castel and Oanh 2010.
- 61 Nguyen Viet Cuong 2010: 32.
- 62 Castel and Oanh 2010.
- 63 Castel and Oanh 2010: 154.
- 64 Castel and Oanh 2010; Nguyen Viet Cuong 2010.
- 65 Nguyen Viet Cuong 2010: 17, 18.
- 66 Castel and Oanh 2010.
- 67 Castel and Oanh 2010; Giang Thanh Long 2010: 11.
- 68 Castel and Oanh 2010.
- 69 Giang Thanh Long 2010: 10.
- 70 Giang Thanh Long 2010: 10.
- 71 Giang Thanh Long 2010: 10.
- 72 Lieberman and Wagstaff 2009.
- 73 Note that global data may vary slightly from nationally available statistics.
- 74 Vu Hoang Linh 2010.
- 75 UNICEF 2010.
- 76 UNICEF 2010.

- 77 London 2010b: 36.
- 78 London 2010b: 34.
- 79 London 2010b: 34.
- 80 Vu Hoang Linh 2010.
- 81 London 2010b: 45.
- 82 London 2010b: 25.
- 83 London 2010b: 25.
- 84 Government Inspectorate 2010.
- 85 CECODES, VFF and UNDP 2011.
- 86 New School and Harvard University 2010: 40.
- 87 World Bank 2009: 79.
- 88 Vu Hoang Linh 2010.
- 89 GSO 2010d: Table 2.6.
- 90 GSO 2010d: Table 2.6.
- 91 London 2010b: 44.
- 92 GSO 2010d: Table 2.7.
- 93 London 2010b: 47.
- 94 Fizbein and Schady 2009.
- 95 Bunting 2011.
- 96 Bunting 2011.
- 97 The Ministry of Education and Training (MoET) estimates that households contribute 25 percent of overall education expenditures. MoET 2009.
- 98 London 2010b: 64. Recent media reports confirm this trend. "According to data from the Ministry of Health, currently about 40,000 Vietnamese go abroad every year for health services, spending more than \$US 1 billion. This is just the recorded number. The actual number might be many times higher." <http://vnexpress.net/gl/suc-khoe/2011/10/che-hang-noi-dan-do-ra-nuoc-ngoai-chua-benh/>
- 99 London 2010a: 54.
- 100 Vu Hoang Linh 2010.
- 5 Nguyen Viet Cuong 2010: 10.
- 6 Nguyen Viet Cuong 2010: 10.
- 7 London 2010b: 32.
- 8 Nguyen Viet Cuong 2010: 11.
- 9 Ministry of Health and Health Partnership Group 2009.
- 10 Ministry of Health and Health Partnership Group 2009: 14.
- 11 Economist Intelligence Unit 2011.
- 12 London 2010b: 33.
- 13 Ministry of Health Viet Nam and Health Partnership Group 2010: 151.
- 14 Lieberman and Wagstaff 2009: 121.
- 15 Ministry of Health Viet Nam and Health Partnership Group 2010: 64.
- 16 Lieberman and Wagstaff 2009: 125.
- 17 London 2010a: 28.
- 18 London 2010a: 28.
- 19 London 2010a: 54.
- 20 GSO 2009.
- 21 Vu Hoang Linh 2010.
- 22 MoET cited in London 2010b: 30.
- 23 London 2010b: 31, 32.
- 24 London 2010b: 31, 32.
- 25 London 2010b: 42.
- 26 London 2010b: 44.
- 27 New School and Harvard University 2010: 33.
- 28 New School and Harvard University 2010: 18, 19.
- 29 New School and Harvard University 2010: 40.
- 30 New School and Harvard University 2010: 27.
- 31 New School and Harvard University 2010: 61.
- 32 New School and Harvard University 2010: 16.
- 33 New School and Harvard University 2010: 52.
- 34 Ministry of Health Viet Nam and Health Partnership Group 2009: 19.
- 35 Ministry of Health Viet Nam and Health Partnership Group 2009: 20.
- 36 Ministry of Health Viet Nam and Health Partnership Group 2009: 53, 54.
- 37 Castel and Oanh 2010.

CHAPTER SIX

- 1 London 2010b: 33.
- 2 London 2010b: 28.
- 3 London 2010b: 28.
- 4 London 2010b: 28.

- 38 London 2010b: 48.
- 39 London 2010b: 48.
- 40 London 2010: 32.
- 41 Ministry of Health Viet Nam and Health Partnership Group 2010, 2009.
- 42 Ministry of Health Viet Nam and Health Partnership Group 2010: 126.
- 43 Lieberman and Wagstaff 2009: 112.
- 44 Ministry of Health Viet Nam and Health Partnership Group 2010: 119.
- 45 Ministry of Health Viet Nam and Health Partnership Group 2010: 76.
- 46 Ministry of Health Viet Nam and Health Partnership Group 2010: 67.
- 47 New School and Harvard University 2010: 17.
- 48 London 2010b: 61.
- 49 Pincus 2010: 26.
- 50 London 2010b; Pincus 2010.
- 51 World Bank 2010: 76, 77.
- 52 CECODES, VFF and UNDP 2011.
- 53 CECODES, VFF and UNDP 2011: 80-82.
- 54 See Acuña-Alfaro, Giang Dang, and Do Thanh Huyen 2010.
- 55 See UNDP 2002 and Acuña-Alfaro, Giang Dang, and Do Thanh Huyen 2010.
- 56 Viet Nam Communist Party Magazine (24/04/2006). Resolution of the Party Congress VII of the CPV approving "Political programme on building up the country in the transition towards socialism" dated June 27, 1991. URL: http://123.30.49.74:8080/tiengviet/tulieuvankien/vankiendang/details.asp?topic=191&subtopic=8&leader_topic=224&id=BT2440654662
- 57 See Resolution No. 08/2004/NQ-CP of the Government of Viet Nam on continued delegation of state management functions from the central government to provincial government.
- 58 A review of delegation of management tasks by Ha Noi People's Committee shows a mixed picture of what have and have not been achieved through the exercise (See Ha Noi Moi Online (17/11/2010), Delegation of Administration Tasks: Resolving problems, increasing synergy and effectiveness. URL: <http://www.hanoimoi.com.vn/newsdetail/Kinh-te/399693/phan-cap-quan-ly-khac-phuc-bat-cap-tang-dong-bo-hieu-qua.htm> [Accessed on 01/12/2010])
- 59 See World Bank 2009: 64, 65.
- 60 The Viet Nam Governance and Public Administration Performance Index (PAPI): Measuring citizens' experiences. Available at www.papi.vn
- 61 Acuña-Alfaro, Giang Dang, and Do Thanh Huyen 2010.
- 62 Acuña-Alfaro, Giang Dang, and Do Thanh Huyen 2010.
- 63 CECODES, VFF and UNDP 2011.
- 64 London 2010a.
- 65 London 2010a: 23.
- 66 Acuña-Alfaro 2009: 21-40.
- 67 Koh, Dang Duc Dam, and Nguyen Thi Kim Chung 2009: 252-319.
- 68 London 2010a: 10.
- 69 London 2010a: 12.
- 70 Australian Government Productivity Commission 2010: xxix.
- 71 Australian Government Productivity Commission 2010: xxxiii.
- 72 World Bank 2009: 64.
- 73 Ministry of Health and Health Partnership Group 2010: 64.
- 74 Lieberman and Wagstaff 2009: 112.
- 75 World Bank 2009: 65.
- 76 New School and Harvard University 2010: 49.
- 77 The draft Law on Examination and Treatment included provision for establishing an independent National Medical Council; however this was omitted in the final law.

- 78 Ministry of Health and Health Partnership Group 2010: 55.
- 79 Lieberman and Wagstaff 2009.
- 80 National Assembly Law No: 2009/QH12 Law on Examination and Treatment.
- 81 New School and Harvard University 2010: 47.
- 82 Ministry of Health and Health Partnership Group 2010.
- 83 UN in Viet Nam 2010a: 57.
- 84 World Bank 2009: 79.
- 85 Ministry of Health and Health Partnership Group 2010: 56.
- 86 USAID 2009.
- 87 Jones and others 2007.
- 88 Koh and others 2009: 260.
- 89 London 2010a: 17.
- 90 Ministry of Health and Health Partnership Group 2010.
- 91 Vujicic and others 2010.
- 92 Vujicic and others 2010.
- 93 WHO 2010a.
- 94 Ministry of Health and Health Partnership Group 2010: 208.
- 95 WHO 2010b.
- 96 Soeters and others 2006: 884-889.
- 97 New School and Harvard University 2010: 81.
- 98 New School and Harvard University 2010: 81.
- 99 Ministry of Health and Health Partnership Group 2010: 96.
- 100 Ministry of Education And Training 2009; Ministry Of Education And Training 2000.
- 101 Peeraer and Tran 2010.

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ANNEX 1: LIST OF NHDR WORKING PAPER AUTHORS AND CONTRIBUTORS

AUTHORS AND WORKING PAPERS:

Topic no.	Author	Working Paper
1	Giang Thanh Long	Reaching higher human development: Challenges of healthcare services and financing in Viet Nam, and the role of government
2	Jonathan London	Balancing Means with Ends: Institutional Responsibilities for the Provision and Payment for Education and Health Services
3	Jonathan London	Aligning Organizational Interests with Public Needs: Service Delivery Challenges in Viet Nam's Education and Health Sectors
4a	Nguyen Viet Cuong	Public Delivery of Health Services and People's Health Care Utilization in Viet Nam
4b	Björn Surborg	Mapping the reform process in the public delivery of health services in Vietnam: The spatial representation of wellbeing in Viet Nam
5	Vu Hoang Linh	Education Issues in Vietnam in the New Millennium: Access, Disparities and Financing
6a	Dao Hoang Mai	Mapping reforms in public social protection services in Viet Nam: Rethinking Poverty and Inequality Reduction
6b	Nicola Jones & Nguyen Ngoc Anh with Elizabeth Presler-Marshall	Mapping the reform process in the public delivery of social protection services in Viet Nam
6c	Giang Thanh Long	Toward an aging population: Mapping the reform process in the public delivery of social protection services in Vietnam
7	Le Thuc Duc	Early interventions: the most effective investments in human capital development in Vietnam
8	Jairo Acuña-Alfaro, Giang Dang and Do Thanh Huyen	Measuring Governance and Public Administration for Human Development: A Demand-Side Approach
9	Pham Thai Hung	Assessing access to health and education services among ethnic minorities in Viet Nam
10	Tran Thi Van Anh & Soma Chakrabarti	Assessing Gender Empowerment in Vietnam's Public Sector
11	Koos Neefjes & Ta Thi Thanh Huong	Climate change & social services
12	Nguyen Ngoc Thang	Assessing employment trends in Vietnam in the context of transition to higher-value economy
13a	Nguyen Duc Nhat & Nguyen Ngoc Anh	Labor employment trends in Vietnam in the context of transition to higher-value economy
13b	Saskia Blume, Dang Nguyen Anh, Tran Nguyet Minh Thu & Dao The Son	Legal developments relating to urban migrants in Viet Nam and social implications—access to basic public services

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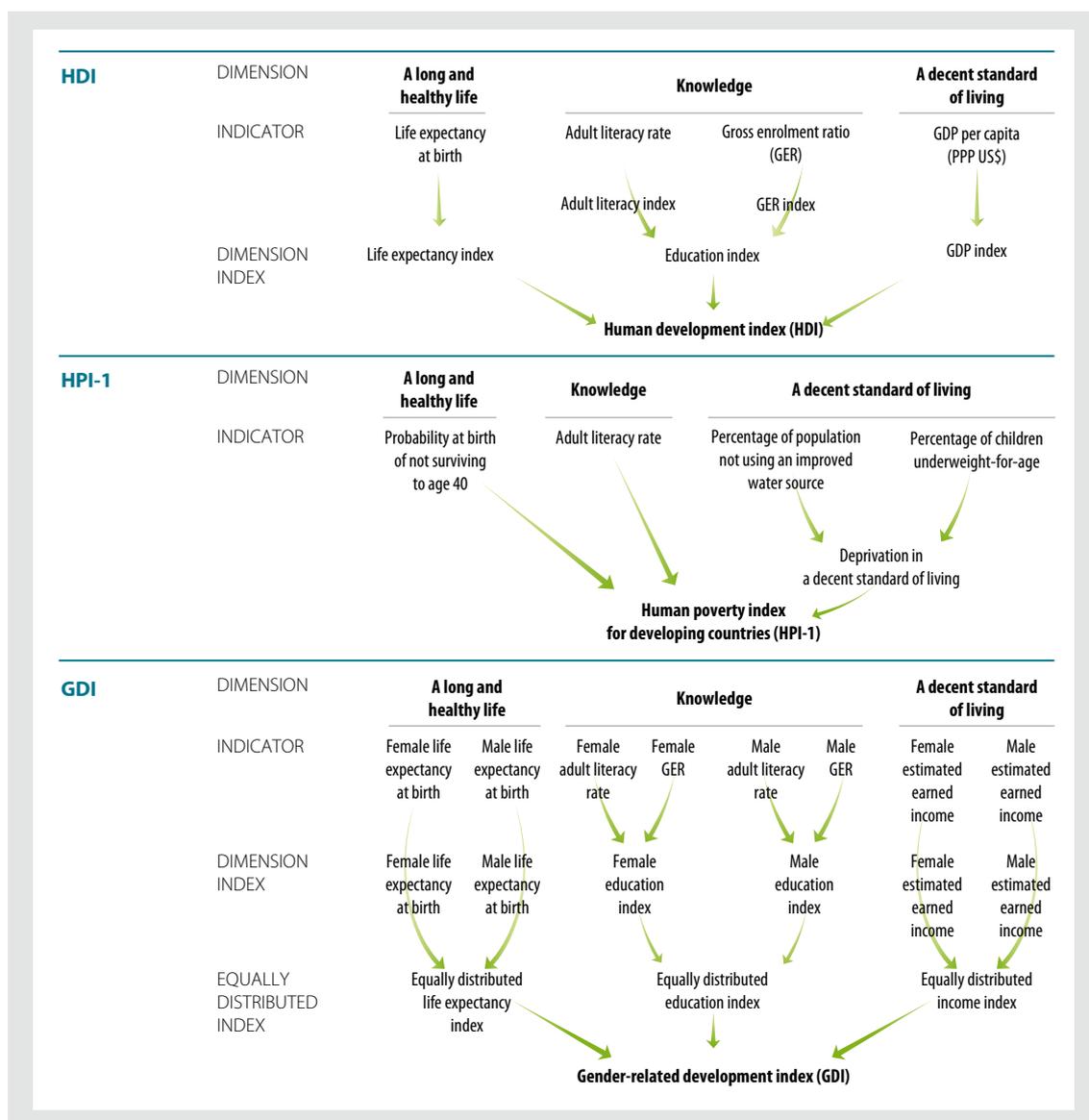
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ANNEX 2: TECHNICAL NOTE ON CALCULATION OF THE INDEXES

CALCULATING THE HUMAN DEVELOPMENT INDICES



1. CALCULATING THE HDI

Performance in each dimension is expressed as a value between 0 and 1 by applying the following general formula:

$$\text{Dimension index} = \frac{\text{actual value} - \text{minimum value}}{\text{maximum value} - \text{minimum value}}$$

The HDI is then calculated as a simple average of the dimension indices. The box on the following page illustrates the calculation of the HDI for a sample country.

GOALPOSTS FOR CALCULATING THE HDI

Indicator	Maximum value	Minimum value
Life expectancy at birth (years)	85	25
Adult literacy rate (%)*	100	0
Combined gross enrolment ratio (%)	100	0
GDP per capital (PPP US\$)	40,000	100

- The goalpost for calculating adult literacy implies the maximum literacy rate is 100%. In practice, the HDI is calculated using an upper bound of 99%.

Before the HDI itself is calculated, an index needs to be created for each of these dimensions. To calculate these indices – the life expectancy, education and GDP indices — minimum and maximum values (goalposts) are chosen for each underlying indicator.

2. CALCULATING THE HPI-1

The formula used to calculate the HPI-1 is as follows:

$$\text{HPI} - 1 = [1/3(P_1^a + P_2^a + P_3^a)]^{1/a}$$

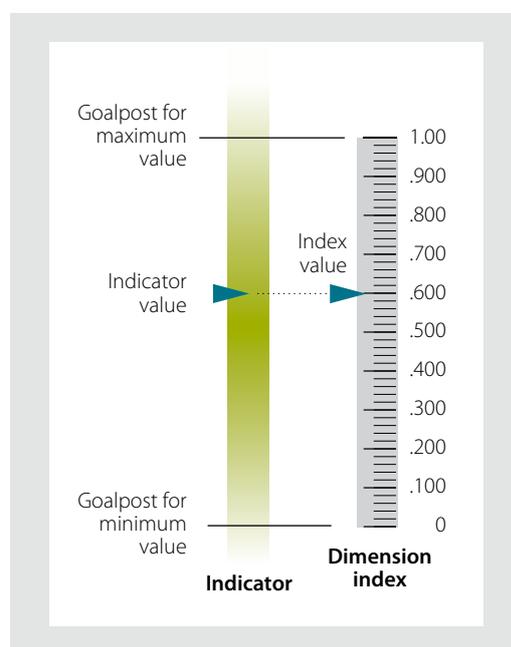
Where:

P1 = Probability at birth of not surviving to age 40 (times 100)

P2 = Adult illiteracy rate

P3 = Unweighted average of population not using an improved water source and children underweight-for-age

$\mu = 3$



3. CALCULATING THE GDI

The calculation of the GDI involves three steps. First, female and male indices in each dimension are calculated according to this general formula:

$$\text{Dimension index} = \frac{\text{actual value} - \text{minimum value}}{\text{maximum value} - \text{minimum value}}$$

Second, the female and male indices in each dimension are combined in a way that penalizes differences in achievement between men and women. The resulting index, referred to as the equally distributed index, is calculated according to this general formula:

$$\text{Equally distributed index} = \frac{\{[\text{female population share} (\text{female index}^{1-\epsilon})] + [\text{male population share} (\text{male index}^{1-\epsilon})]\}^{1/\epsilon}}$$

ϵ measures the aversion to inequality. In the GDI $\hat{\epsilon} = 2$. Thus the general equation becomes:

$$\text{Equally distributed index} = \frac{\{[\text{female population share} (\text{female index}^{-1})] + [\text{male population share} (\text{male index}^{-1})]\}^{-1}}$$

which gives the harmonic mean of the female and male indices.

Third, the GDI is calculated by combining the three equally distributed indices in an unweighted average.

GOALPOSTS FOR CALCULATING THE GDI

Indicator	Maximum value	Minimum value
Female life expectancy at birth (years)	87.5	27.5
Male life expectancy at birth (years)	82.5	22.5
Adult literacy rate (%)	100	0
Combined gross enrolment ratio (%)	100	0
Estimated earned income (US\$ PPP)	40,000	100

Note: The maximum and minimum values (goalposts) for life expectancy are five years higher for women to take into account their longer life expectancy. To preserve the relationship between female and male values of each indicator, scaled values are computed and used in place of figures where either the female or male value exceeds the threshold (in the case of Adult Literacy a practical threshold value of 99% is used). The scaling is achieved by multiplying the female and male values by the practical threshold values divided by the maximum reported value for either females or males.

ANNEX 3: TECHNICAL NOTE ON THE CALCULATION OF THE MULTI-DIMENSIONAL POVERTY INDEX FOR VIET NAM

TECHNICAL NOTE: CALCULATING THE MULTI-DIMENSIONAL POVERTY INDEX (MPI)

Global approach using Alkire and Foster's methodology

The MPI introduced in the 2010 global Human Development Report (HDR) is the product of the multi-dimensional poverty headcount (the share of people who are multi-dimensionally poor) and the intensity of their poverty (the average number of deprivations each multi-dimensionally poor household experiences). Unlike the Human Poverty Index (HPI), which uses country averages to reflect aggregate deprivations in health, education and standards of living without identifying specific individuals, households or specific sub-populations as jointly deprived, the MPI captures how many people experience overlapping deprivations and how many deprivations they face on average. In this regard, the measure requires that all data should come from one survey, and therefore the options for selecting dimensions for this index are limited in Viet Nam.

The MPI is considered as most appropriate for less developed countries, as it can capture the prevalent deprivations in these countries. However, it is also an effective indicator for measuring deprivation and non-income poverty intensity in middle-income countries such as Viet Nam.

Many countries, especially those in Africa, that have a high multi-dimensional poverty headcount tend to have more deprivations. Some countries, like Bangladesh, Cambodia and the Democratic Republic of Congo, have a high headcount ratio but low intensity. On the other hand, as cited in the global HDR 2010, Viet Nam, together with Myanmar and Philippines, has a low multi-dimensional poverty headcount (14.3%), but high intensity of poverty (52.5%), which identifies it as one of the most severely affected countries among the medium human development group in terms of intensity of deprivation. This implies that targeting of Vietnamese social policies for vulnerable groups needs to be more focused and will be more costly than in the past.

The national HDR 2011 uses the MPI, but adapts it to the local context, using the Vietnam Household Living Standard Survey (VHLSS) 2008 dataset that was previously used to calculate the Child Poverty Rate, together with the MPI in the Urban Poverty Survey (UPS) 2009. The MPI used in the 2010 global HDR was drawn from the 2002 Demographic Health Survey. This has not been updated with more recent surveys; and is therefore not the best data source for calculating the MPI in Viet Nam. In order to ensure that the MPI can be produced and compared over time, the MPI indicators have been adapted, so that the VHLSS dataset, which is available every two years, can be used to calculate the MPI. The two global health indicators have been replaced with just one health indicator. The education indicators have also been slightly amended, as has the assets indicator.

Methodology: The methodology used to calculate the MPI uses the following steps from the Alkire and Foster method cited in the 2010 global HDR:

Step 1: Choose Unit of Analysis. The MPI is calculated at the individual level.

Step 2: Choose Dimensions. Three dimensions have been selected in line with the global approach: health, education and living conditions.

Step 3: Choose Indicators. Based on the principles of accuracy and parsimony, it is best to choose those indicators that are not highly correlated. The MPI for Viet Nam uses nine indicators: one for the health dimension, two for the education dimension and six for the living conditions dimensions. Equal weight for these nine indicators is assumed for simplicity.

Step 4: Set Poverty Lines. A poverty cut-off is set for each dimension (see the following table). Every person can then be identified as deprived or non-deprived with respect to each dimension.

Step 5: Apply Poverty Lines. In this exercise, a cut-off of three, which means those deprived in any three indicators or more, or who are deprived in the health indicator and at least one education indicator, are considered to be multi-dimensionally poor.

If the household member's score is three or more for any of the nine indicators combined/or is equal to two for any combined health and education indicators, that household member is considered as multi-dimensionally poor.

If the score is between two and three, with the exception of those household members who have $k=2$ as a combination of health and education indicators, household members are considered vulnerable to, or at risk of, becoming multi-dimensionally poor.

Step 7: Calculate the Headcount ratio (H). Divide the number of poor people by the total number of people.

Step 8: Calculate the Intensity of Poverty (A). A is the average number of deprivations a poor person suffers. It is calculated by adding up the proportion of total deprivations each person suffers, divided by the total number of poor persons.

Step 9: Calculate the MPI (or $M0$) = $H \cdot A$. In sum, the MPI represents the share of the population that is multi-dimensionally poor, adjusted by the intensity of the deprivations suffered.

Dataset: As indicated in the global 2010 HDR, often health data are relatively weak especially for nutrition indicators, and this is the case in Viet Nam. Given the lack of similar indicators in terms of health

to those used in the global report, as well as limited information available from the VHLSS 2008 dataset, only one new health indicator is used and, to some extent, differs from that used in the UPS. Two education indicators have been adapted in line with the UPS. The remaining six indicators are basically the same as relevant targets set by the Millennium Development Goals (MDGs) and/or those used in the 2010 global HDR, with some changes introduced to reflect the local data source used.

TREATMENT OF THE NON-APPLICABLE POPULATION

The two education indicators are not applicable to the entire population, as child school attendance is only applicable for households with children of school age. Therefore, the procedure followed is to consider as non-deprived in each indicator those household members for whom the indicator is not relevant/who are not eligible. However, households for whom the indicator is applicable but that had missing values are considered as having missing information and were therefore excluded from the sample.

Table 1: Dimensions, Indicators, Cut-offs and Weights of the MPI

Dimension	Indicators	Poverty lines	Related to	Notes
Health	1. Household members who have sold their products/assets, taken loans to pay for health care services or quit treatment due because they did not have enough money to pay for health care expenses.	Household member is at risk or vulnerable due to constraints in their access to health services	New indicator used for the national MPI.	No data is available to apply MDG 1 or 4; however, this indicator is measured for all household members.
Education	2. Household members have not completed primary education	Household member aged 15 and above who has not completed primary education	MDG2	
	3. School-age children are not currently enrolled in school	School-age children from 6 to 18 are currently not enrolled in school	This indicator is consistent with the UPS	The threshold level for this indicator is higher than that in MDG2 (which counts those of school age who are currently not enrolled in school between years 1 to 8.)
Living conditions	4. Use electricity as the main source of lighting	No electricity used as the main lighting source	Global 2010 HDR	
	5. Access to clean drinking water	Access to unsafe or seriously polluted water source only	MDG7	
	6. Access to inadequate sanitation	Garbage is not collected, or serious pollution due to uncollected garbage	UPS	
	7. Access to standard toilet	Toilet directly over the water/no toilet	MDG7	
	8. Living in a permanent house	Living in a temporary house	MDG7	
	9. Durable assets owned	Do not have at least one of all three of the following asset types: 1. Transport: (Bicycle and/or motorcycle/motor boat /rowing boat, ferry) 2. Communications (Telephone and/or mobile phone) 3. Information (Colour TV and/or black/white TV and/or radio/cassette player).	MDG7	The threshold level is set higher than that used in the global HDR 2010, which uses DHS 2002 data that is no longer applicable in Viet Nam. Data from the VHLSS 2008 shows that no one is deprived when only taking into account just one asset owned. In other words no household has only one of the three asset types listed here. Three categories of assets that represent access to transport, communication and information are used to construct the assets indicator. Households with at least one asset in each group are not considered deprived.

A NOTE ON VIET NAM'S REGIONS

For the purposes of statistical analysis, Viet Nam is typically divided into either six or eight regions.

THE SIX REGIONS ARE AS FOLLOWS:

- Red River Delta
- Northern Midlands and Mountainous Areas (sometimes called Northern Uplands)
- Central Area and Central Coastal Area
- Central Highlands
- South East
- Mekong River Delta

THE EIGHT REGIONS ARE AS FOLLOWS:

- Red River Delta
- North East
- North West
- North Central Coast
- South Central Coast
- Central Highlands
- South East
- Mekong River Delta

A description of the six regions can be found in Box 3.1. Typically older surveys use the eight regions while newer data sets, including the 2008 and 2010 VHLSS, provide a breakdown for the six regions. Thus for the purposes of this report, while the six regions are used where possible, in some instances, in order to compare data sets over time, the eight regions are used.

STATISTICAL TABLES

Human Development Index 2008

HDI Rank	Province	Life Expectancy at Birth (years)	Adult Literacy Rate (% age 15 and above)	Combined Gross Enrolment Ratio (%)	GDP per capita (PPP US\$)	Life Expectancy Index	Education Index	Income Index	HDI	GDP and HDI Ranking Gap
	Whole Country	72.66	93.6	61.78	2840.4	0.794	0.83	0.559	0.728	
1	Ba Ria -Vung Tau	75.19	95.34	63.95	7911	0.836	0.849	0.73	0.805	0
2	Ho Chi Minh City	75.7	97.23	53.1	4834.1	0.845	0.825	0.647	0.773	0
3	Hanoi	74.78	97.13	60.96	4342.5	0.83	0.851	0.629	0.770	0
4	Da Nang	74.66	97	62.08	3710	0.828	0.854	0.603	0.761	2
5	Quang Ninh	72.64	95.83	63.74	4114.1	0.794	0.851	0.62	0.755	-1
6	Can Tho	75.38	94.59	48.96	4087.4	0.84	0.794	0.619	0.751	-1
7	Bac Ninh	73.73	96.14	65.05	2964.6	0.812	0.858	0.566	0.745	4
8	Hai Phong	74.32	96.66	56.35	3194.9	0.822	0.832	0.578	0.744	-1
9	Dong Nai	75.27	96.05	55.84	2996.2	0.838	0.826	0.567	0.744	1
10	Vinh Phuc	73.87	96.4	58.84	3091.2	0.815	0.839	0.573	0.742	-1
11	Khanh Hoa	72.46	95.53	64.26	2942.3	0.791	0.851	0.564	0.735	1
12	Long An	74.66	94.08	57.85	2677.8	0.828	0.82	0.549	0.732	4
13	Vinh Long	74.24	95.04	61.38	2402.7	0.821	0.838	0.531	0.730	6
14	Ben Tre	73.82	94.23	69.36	2133.2	0.814	0.859	0.511	0.728	9
15	Ca Mau	73.05	96.63	56.61	2553.2	0.801	0.833	0.541	0.725	2
16	Kien Giang	73.05	90.09	58.94	3139.6	0.801	0.797	0.575	0.724	-8
17	Binh Duong	75.27	96.46	39.66	2830.4	0.838	0.775	0.558	0.724	-4
18	Lam Dong	73.2	92.91	69.11	2208.8	0.803	0.85	0.517	0.723	4
19	Hai Duong	73.87	96.39	63.62	1992	0.815	0.855	0.499	0.723	9
20	Tien Giang	74.24	92.78	58.46	2393.6	0.821	0.813	0.53	0.721	0
21	Tay Ninh	73.42	92.43	54.48	2810.3	0.807	0.798	0.557	0.721	-6

HDI Rank	Province	Life Expectancy at Birth (years)	Adult Literacy Rate (% age 15 and above)	Combined Gross Enrolment Ratio (%)	GDP per capita (PPP US\$)	Life Expectancy Index	Education Index	Income Index	HDI	GDP and HDI Ranking Gap
22	Thai Binh	74.32	96.48	69.7	1575.8	0.822	0.876	0.46	0.719	24
23	Binh Dinh	71.74	95.36	73.57	1940.6	0.779	0.881	0.495	0.718	10
24	Hung Yen	73.73	95.84	60.8	1985.6	0.812	0.842	0.499	0.718	5
25	Ninh Binh	72.71	96.6	66.23	1913.6	0.795	0.865	0.493	0.717	9
26	Bac Lieu	73.42	94.96	51.75	2506.3	0.807	0.806	0.538	0.717	-8
27	Ha Tinh	71.83	97.43	79.65	1524.8	0.78	0.915	0.455	0.717	24
28	Binh Thuan	73.05	92.87	65.21	2021.8	0.801	0.836	0.502	0.713	-2
29	Quang Nam	70.89	95.6	66.17	2061.6	0.765	0.858	0.505	0.709	-5
30	Thai Nguyen	73.14	96.34	57.15	1896.2	0.802	0.833	0.491	0.709	6
31	Ha Nam	72.73	95.47	67.23	1665.9	0.795	0.861	0.469	0.709	12
32	An Giang	72.28	90.61	51.69	2814.7	0.788	0.776	0.557	0.707	-18
33	Nam Dinh	73.61	95.75	63.81	1545.1	0.81	0.851	0.457	0.706	17
34	Thanh Hoa	72.28	94.78	69.5	1559.5	0.788	0.864	0.458	0.703	15
35	Lang Son	71.3	93	68.41	1845.5	0.772	0.848	0.487	0.702	2
36	Hau Giang	74.24	91.78	57.28	1795.6	0.821	0.803	0.482	0.702	3
37	Quang Binh	70.91	96.11	67.57	1703.9	0.765	0.866	0.473	0.701	4
38	Binh Phuoc	71.56	93.24	63.15	1955.4	0.776	0.832	0.496	0.701	-6
39	Nghe An	71.74	94.26	66.5	1692.2	0.779	0.85	0.472	0.700	3
40	Thua Thien-Hue	70.2	91.12	68.76	1899.3	0.753	0.837	0.491	0.694	-5
41	Dak Lak	70.54	90.78	69.01	1842.8	0.759	0.835	0.486	0.694	-3
42	Phu Yen	70.89	94.13	62.34	1751.3	0.765	0.835	0.478	0.693	-2
43	Dong Thap	72.68	89.42	53.67	2028.3	0.795	0.775	0.502	0.691	-18
44	Quang Ngai	71.21	89.53	69.11	1663.9	0.77	0.827	0.469	0.689	0
45	Bac Giang	72.18	96.24	61.95	1295.9	0.786	0.848	0.428	0.687	12
46	Phu Tho	71.63	95.6	59.73	1440.2	0.777	0.836	0.445	0.686	7
47	Quang Tri	65.88	92.19	79.23	1975	0.681	0.879	0.498	0.686	-17
48	Soc Trang	72.28	83.63	54.34	2313.5	0.788	0.739	0.524	0.684	-27
49	Tuyen Quang	71.25	94.45	60.71	1461.3	0.771	0.832	0.448	0.684	3

HDI Rank	Province	Life Expectancy at Birth (years)	Adult Literacy Rate (% age 15 and above)	Combined Gross Enrolment Ratio (%)	GDP per capita (PPP US\$)	Life Expectancy Index	Education Index	Income Index	HDI	GDP and HDI Ranking Gap
50	Dak Nong	68.98	89.33	66.9	1968	0.733	0.819	0.497	0.683	-19
51	Hoa Binh	71.25	93.67	62.34	1384.1	0.771	0.832	0.439	0.681	4
52	Tra Vinh	72.28	86.42	53.85	1571.1	0.788	0.756	0.46	0.668	-5
53	Gia Lai	69.28	88	64.43	1586.7	0.738	0.801	0.461	0.667	-8
54	Bac Can	71.25	91.32	66.56	1074.6	0.771	0.831	0.396	0.666	7
55	Cao Bang	68.44	83.81	77.11	1340.7	0.724	0.816	0.433	0.658	1
56	Ninh Thuan	70.37	85.68	66.29	1221.4	0.756	0.792	0.418	0.655	4
57	Lao Cai	66.47	80.6	60.46	2006.9	0.691	0.739	0.501	0.644	-30
58	Kon Tum	65.84	83.38	68.14	1562.9	0.681	0.783	0.459	0.641	-10
59	Son La	68.8	81.19	63.24	1393	0.73	0.752	0.44	0.641	-5
60	Yen Bai	68.44	83.44	58.07	1221.7	0.724	0.75	0.418	0.631	-1
61	Dien Bien	65.44	71.55	66.9	1278.9	0.674	0.7	0.425	0.600	-3
62	Ha Giang	65.99	73.1	57.86	801	0.683	0.68	0.347	0.570	1
63	Lai Chau	63.38	61.59	58.65	901.7	0.64	0.606	0.367	0.538	-1

Region	Life Expectancy at Birth (years)	Adult Literacy Rate (% age 15 and above)	Combined Gross Enrolment Ratio (%)	GDP per capita (PPP US\$)	Life Expectancy Index	Education Index	Income Index	HDI
Northern Midlands and Mountainous Areas	69.94	88.03	62.02	1,421.6	0.749	0.794	0.439	0.660
Red River Delta	74.04	96.5	62.58	3,008.4	0.817	0.852	0.554	0.741
North Central Area and Central Coastal Area	71.61	94.14	68.58	1,903.0	0.777	0.856	0.487	0.707
Central Highlands	70.31	89.83	67.62	1,853.0	0.755	0.824	0.486	0.688
South East	75.11	96.18	53.73	4,185.8	0.835	0.82	0.613	0.756
Mekong River Delta	73.42	91.67	56.37	2,541.8	0.807	0.799	0.536	0.714

Source: Calculated for the NHDR by VASS and GSO 2011

Human Development Index 2004

HDI Rank	Province	Life Expectancy at Birth (years)	Adult Literacy Rate (% age 15 and above)	Combined Gross Enrolment Ratio (%)	GDP per capita (PPP US\$)	Life Expectancy Index	Education Index	Income Index	HDI
	Whole Country	71.90	93.30	61.18	1,954.0	0.782	0.826	0.496	0.701
1	Ba Ria-Vung Tau	75.04	95.29	60.70	7,134.5	0.834	0.838	0.712	0.795
2	Ho Chi Minh City	76.20	96.84	61.77	4,581.1	0.853	0.852	0.638	0.781
3	Da Nang	76.10	96.80	70.39	2,628.1	0.852	0.880	0.546	0.759
4	Hai Phong	74.20	96.74	64.04	2,151.9	0.820	0.858	0.512	0.730
5	Hanoi (including Ha Tay)	73.79	97.00	63.06	2,886.4	0.813	0.857	0.519	0.730
6	Dong Nai	72.48	95.83	59.87	2,508.0	0.791	0.838	0.538	0.723
7	Quang Ninh	72.08	95.92	62.61	2,435.3	0.785	0.848	0.533	0.722
8	Binh Duong	72.76	96.38	47.48	2,729.6	0.796	0.801	0.552	0.716
9	Khanh Hoa	73.16	94.21	62.91	1,964.4	0.803	0.838	0.497	0.712
10	Hai Duong	74.50	96.69	58.60	1,481.1	0.825	0.840	0.450	0.705
11	Can Tho	72.36	93.82	49.04	2,246.2	0.789	0.789	0.519	0.699
12	Bac Ninh	72.38	96.18	64.83	1,444.5	0.790	0.857	0.446	0.698
13	Vinh Phuc	73.08	96.72	57.94	1,399.0	0.801	0.838	0.440	0.693
14	Ca Mau	72.10	95.95	50.76	1,775.3	0.785	0.809	0.480	0.691
15	Vinh Long	74.10	95.28	54.26	1,372.3	0.818	0.816	0.437	0.691
16	Hung Yen	72.90	95.58	61.10	1,330.9	0.798	0.841	0.432	0.690
17	Kien Giang	72.98	89.28	56.77	1,775.2	0.800	0.784	0.480	0.688
18	Long An	73.06	94.55	53.93	1,463.2	0.801	0.810	0.448	0.686
19	Quang Nam	72.00	93.45	71.38	1,187.9	0.783	0.861	0.413	0.686
20	Ha Nam	74.77	95.77	60.99	993.8	0.830	0.842	0.383	0.685
21	Nam Dinh	72.66	96.44	67.89	1,014.6	0.794	0.869	0.387	0.683
22	Tien Giang	73.32	93.42	53.94	1,396.3	0.805	0.803	0.440	0.683
23	Thai Binh	72.90	96.72	64.35	1,028.5	0.798	0.859	0.389	0.682

HDI Rank	Province	Life Expectancy at Birth (years)	Adult Literacy Rate (% age 15 and above)	Combined Gross Enrollment Ratio (%)	GDP per capita (PPP US\$)	Life Expectancy Index	Education Index	Income Index	HDI
24	Bac Lieu	70.82	93.87	52.11	1,785.5	0.764	0.799	0.481	0.681
25	Ben Tre	71.10	94.73	57.44	1,448.7	0.768	0.823	0.446	0.679
26	Binh Dinh	71.10	94.77	67.36	1,163.4	0.768	0.856	0.410	0.678
27	Ha Tinh	71.10	96.66	73.92	934.9	0.768	0.891	0.373	0.677
28	Tay Ninh	71.30	91.78	52.81	1,646.7	0.772	0.788	0.468	0.676
29	Nghe An	71.15	94.31	68.02	1,101.2	0.769	0.855	0.400	0.675
30	Binh Thuan	71.70	93.51	62.36	1,193.9	0.778	0.831	0.414	0.675
31	Ninh Binh	72.38	96.87	63.19	903.6	0.790	0.856	0.367	0.671
32	Thua Thien Hue	71.25	90.89	68.36	1,154.2	0.771	0.834	0.408	0.671
33	Lam Dong	71.80	92.11	65.96	1,076.4	0.780	0.834	0.397	0.670
34	Phu Tho	71.98	96.04	61.65	983.5	0.783	0.846	0.382	0.670
35	Thai Nguyen	70.81	96.07	58.78	1,128.7	0.763	0.836	0.405	0.668
36	Thanh Hoa	70.63	95.20	66.92	976.7	0.760	0.858	0.380	0.666
37	Quang Binh	69.31	95.06	71.91	994.9	0.738	0.873	0.383	0.665
38	Dong Thap	72.62	90.57	54.64	1,098.8	0.794	0.786	0.400	0.660
39	An Giang	70.90	88.35	48.48	1,592.4	0.765	0.751	0.462	0.659
40	Hau Giang	71.02	90.35	49.85	1,293.8	0.767	0.768	0.427	0.654
41	Tra Vinh	71.05	84.77	53.40	1,467.5	0.768	0.743	0.448	0.653
42	Binh Phuoc	70.80	93.83	57.33	960.3	0.763	0.817	0.378	0.653
43	Tuyen Quang	68.36	94.74	69.25	902.9	0.723	0.862	0.367	0.651
44	Lang Son	66.96	93.08	65.42	1,171.4	0.699	0.839	0.411	0.650
45	Phu Yen	67.83	94.82	58.98	1,120.3	0.714	0.829	0.403	0.649
46	Quang Ngai	70.95	89.51	62.98	902.5	0.766	0.807	0.367	0.647
47	Soc Trang	70.72	86.02	51.91	1,321.5	0.762	0.747	0.431	0.646
48	Bac Giang	68.86	96.37	62.06	825.9	0.731	0.849	0.352	0.644
49	Quang Tri	66.01	90.64	71.14	995.7	0.683	0.841	0.384	0.636
50	Ninh Thuan	70.40	85.68	60.02	866.4	0.757	0.771	0.360	0.629
51	Hoa Binh	68.76	93.85	56.83	783.3	0.729	0.815	0.344	0.629

HDI Rank	Province	Life Expectancy at Birth (years)	Adult Literacy Rate (% age 15 and above)	Combined Gross Enrollment Ratio (%)	GDP per capita (PPP US\$)	Life Expectancy Index	Education Index	Income Index	HDI
52	Dak Nong	67.02	90.70	62.87	926.5	0.700	0.814	0.372	0.629
53	Dak Lak	67.52	88.37	68.29	857.4	0.709	0.817	0.359	0.628
54	Bac Can	68.35	90.40	66.26	694.2	0.723	0.824	0.323	0.623
55	Yen Bai	68.71	84.94	63.64	831.5	0.728	0.778	0.354	0.620
56	Lao Cai	67.85	80.09	61.61	926.3	0.714	0.739	0.372	0.608
57	Cao Bang	64.71	80.53	65.52	921.7	0.662	0.755	0.371	0.596
58	Son La	67.95	78.65	57.66	729.1	0.716	0.717	0.332	0.588
59	Gia Lai	64.16	82.67	57.56	843.1	0.653	0.743	0.356	0.584
60	Dien Bien	66.56	71.72	62.34	877.0	0.693	0.686	0.362	0.580
61	Kon Tum	59.70	81.71	71.56	890.8	0.578	0.783	0.365	0.576
62	Ha Giang	61.30	69.67	59.63	609.3	0.605	0.663	0.302	0.523
63	Lai Chau	64.86	59.18	45.93	511.3	0.664	0.548	0.272	0.495

Region	Life Expectancy at Birth (years)	Adult Literacy Rate (% age 15 and above)	Combined Gross Enrollment Ratio (%)	GDP per capita (PPP US\$)	Life Expectancy Index	Education Index	Income Index	HDI
Northern Midlands and Mountainous Areas	68.21	87.71	61.25	876.8	0.720	0.789	0.359	0.623
Red River Delta	73.40	96.60	62.91	1,873.2	0.807	0.854	0.461	0.707
North Central Area and Central Coastal Area	71.05	93.83	67.19	1,176.0	0.767	0.850	0.405	0.674
Central Highlands	67.04	87.52	64.89	914.4	0.701	0.800	0.369	0.623
South East	74.35	95.87	59.04	3,746.1	0.823	0.836	0.586	0.748
Mekong River Delta	72.07	91.44	52.87	1,533.2	0.785	0.786	0.453	0.674

Source: Calculated for the NHDR by VASS and GSO 2011

Human Development Index 1999

HDI Rank	Province	Life Expectancy at Birth (years)	Adult Literacy Rate (% age 15 and above)	Combined Gross Enrollment Ratio (%)	GDP per capita (PPP US\$)	Life Expectancy Index	Education Index	Income Index	HDI
	Whole Country	68.26	90.3	60.34	1,316.9	0.721	0.803	0.430	0.651
1	Ba Ria-Vung Tau	74.46	92.7	62.82	4,246.7	0.82	0.83	0.63	0.759
2	Ho Chi Minh City	78.07	94.4	50.71	3,271.2	0.88	0.80	0.58	0.755
3	Binh Duong	75.72	92.8	57.20	2,515.1	0.85	0.81	0.54	0.731
4	Da Nang	74.36	94.0	70.66	1,867.7	0.82	0.86	0.49	0.724
5	Hai Phong	73.69	95.1	65.05	1,464.8	0.81	0.85	0.45	0.703
6	Dong Nai	73.56	92.7	60.80	1,732.9	0.81	0.82	0.48	0.702
7	Ha Noi (including Ha Tay)	72.60	95.3	60.80	2,188.3	0.79	0.84	0.47	0.700
8	Quang Ninh	70.00	92.4	63.04	1,724.9	0.75	0.83	0.48	0.684
9	Vinh Phuc	73.23	93.9	66.06	1,076.1	0.80	0.85	0.40	0.682
10	Tay Ninh	74.81	88.9	53.16	1,198.8	0.83	0.77	0.41	0.672
11	Hai Duong	71.74	94.3	64.32	905.6	0.78	0.84	0.37	0.663
12	Bac Ninh	70.03	93.9	63.58	1,101.7	0.75	0.84	0.40	0.663
13	Hung Yen	71.82	93.8	64.33	875.6	0.78	0.84	0.36	0.661
14	Lam Dong	72.59	89.8	66.06	835.5	0.79	0.82	0.35	0.656
15	Long An	72.30	91.4	51.89	1,025.6	0.79	0.78	0.39	0.653
16	Khanh Hoa	67.78	91.5	59.87	1,340.2	0.71	0.81	0.43	0.652
17	Ninh Binh	71.66	94.1	68.62	653.5	0.78	0.86	0.31	0.649
18	Binh Phuoc	72.63	87.1	60.42	919.6	0.79	0.78	0.37	0.649
19	Binh Thuan	72.52	88.5	58.15	888.1	0.79	0.78	0.36	0.647
20	Thai Binh	72.00	94.8	61.35	662.6	0.78	0.84	0.32	0.645
21	Vinh Long	71.70	90.5	56.72	881.3	0.78	0.79	0.36	0.645
22	Tien Giang	72.19	90.7	52.05	892.0	0.79	0.78	0.37	0.643
23	Ha Nam	71.78	94.0	63.52	644.6	0.78	0.84	0.31	0.643
24	Nghe An	70.14	92.9	69.72	682.7	0.75	0.85	0.32	0.642
25	Nam Dinh	71.74	94.7	61.80	631.6	0.78	0.84	0.31	0.641

HDI Rank	Province	Life Expectancy at Birth (years)	Adult Literacy Rate (% age 15 and above)	Combined Gross Enrollment Ratio (%)	GDP per capita (PPP US\$)	Life Expectancy Index	Education Index	Income Index	HDI
26	Thai Nguyen	70.06	94.7	60.18	761.1	0.75	0.83	0.34	0.640
27	Ha Tinh	70.17	94.5	73.70	575.9	0.75	0.88	0.29	0.640
28	Ca Mau	66.96	92.5	54.94	1,158.1	0.70	0.80	0.41	0.636
29	Quang Nam	69.05	90.4	66.31	797.1	0.73	0.82	0.35	0.635
30	Kien Giang	68.04	87.7	53.97	1,214.0	0.72	0.76	0.42	0.633
31	Can Tho	67.51	89.2	49.84	1,300.5	0.71	0.76	0.43	0.633
32	Thua Thien Hue	70.26	85.8	67.17	780.4	0.75	0.80	0.34	0.631
33	Bac Lieu	67.71	88.7	53.40	1,167.7	0.71	0.77	0.41	0.630
34	Phu Tho	69.10	94.6	61.44	626.4	0.74	0.84	0.31	0.626
35	Tuyen Quang	69.86	88.8	69.71	605.2	0.75	0.82	0.30	0.624
36	Binh Dinh	67.36	92.3	61.62	753.5	0.71	0.82	0.34	0.621
37	Bac Giang	70.34	93.3	59.55	545.0	0.76	0.82	0.28	0.620
38	An Giang	69.66	84.7	46.76	1,039.6	0.74	0.72	0.39	0.618
39	Soc Trang	67.92	85.3	53.74	924.5	0.72	0.75	0.37	0.611
40	Quang Binh	65.63	91.9	67.23	676.2	0.68	0.84	0.32	0.611
41	Phu Yen	66.35	90.0	62.75	739.8	0.69	0.81	0.33	0.611
42	Ben Tre	67.02	90.3	52.85	826.4	0.70	0.78	0.35	0.610
43	Thanh Hoa	66.74	91.8	66.86	597.5	0.70	0.83	0.30	0.610
44	Tra Vinh	68.15	82.6	54.39	813.5	0.72	0.73	0.35	0.600
45	Quang Tri	64.16	87.0	71.31	712.7	0.65	0.82	0.33	0.599
46	Ninh Thuan	70.11	81.6	60.88	593.2	0.75	0.75	0.30	0.599
47	Bac Can	67.22	85.0	69.76	453.7	0.70	0.80	0.25	0.585
48	Dak Lak	62.31	87.1	66.77	695.2	0.62	0.80	0.32	0.583
49	Dong Thap	65.56	85.7	49.26	746.9	0.68	0.74	0.34	0.582
50	Quang Ngai	63.43	87.4	65.09	617.6	0.64	0.80	0.30	0.581
51	Lang Son	60.22	89.4	67.52	746.5	0.59	0.82	0.34	0.581
52	Yen Bai	66.74	83.2	61.30	549.9	0.70	0.76	0.28	0.580
53	Hoa Binh	62.23	91.9	63.54	529.7	0.62	0.82	0.28	0.574

HDI Rank	Province	Life Expectancy at Birth (years)	Adult Literacy Rate (% age 15 and above)	Combined Gross Enrolment Ratio (%)	GDP per capita (PPP US\$)	Life Expectancy Index	Education Index	Income Index	HDI
54	Cao Bang	60.99	75.0	67.57	594.3	0.60	0.73	0.30	0.541
55	Kon Tum	55.80	75.6	79.42	694.2	0.51	0.77	0.32	0.535
56	Lao Cai	63.33	65.0	59.50	638.0	0.64	0.63	0.31	0.527
57	Son La	63.40	69.1	57.90	554.5	0.64	0.65	0.29	0.527
58	Gia Lai	58.06	72.6	60.10	686.9	0.55	0.68	0.32	0.519
59	Ha Giang	60.02	61.0	61.01	417.2	0.58	0.61	0.24	0.477
60	Lai Chau	60.38	53.4	49.16	581.2	0.59	0.52	0.29	0.468
61	Dien Bien								
62	Dak Nong								
63	Hau Giang								

Region	Life Expectancy at Birth (years)	Adult Literacy Rate (% age 15 and above)	Combined Gross Enrolment Ratio (%)	GDP per capita (PPP US\$)	Life Expectancy Index	Education Index	Income Index	HDI
Northern Midlands and Mountainous Areas	65.79	83.05	61.52	595.8	0.68	0.76	0.30	0.578
Red River Delta	72.10	94.53	63.00	1309.6	0.78	0.84	0.40	0.674
North Central Area and Central Coastal Area	68.36	90.83	66.28	769.5	0.72	0.83	0.33	0.627
Central Highlands	63.31	83.39	65.98	727.6	0.64	0.78	0.33	0.582
South East	76.08	92.83	54.95	2645.5	0.85	0.80	0.53	0.728
Mekong River Delta	68.76	88.17	51.91	1005.9	0.73	0.76	0.38	0.624

Source: Calculated for the NHDR by VASS and GSO 2011

HDI Change 1999-2008

2008 HDI Rank	Province	HDI 2008	HDI 2004	HDI 1999	Change 1999-2004 (%)	Change 2004-2008 (%)	Change 1999-2008 (%)
	Whole Country	0.728	0.701	0.651	7.66	3.82	11.77
1	Ba Ria-Vung Tau	0.805	0.795	0.759	4.68	1.30	6.04
2	Ho Chi Minh City	0.773	0.781	0.755	3.45	-1.03	2.38
3	Hanoi (including Ha Tay)	0.770	0.730	0.700	4.18	5.53	9.94
4	Da Nang	0.761	0.759	0.724	4.79	0.25	5.06
5	Quang Ninh	0.755	0.722	0.684	5.58	4.58	10.42
6	Can Tho	0.751	0.699	0.633	10.54	7.40	18.72
7	Bac Ninh	0.745	0.698	0.663	5.23	6.80	12.39
8	Hai Phong	0.744	0.730	0.703	3.82	1.89	5.78
9	Dong Nai	0.744	0.723	0.702	2.93	2.97	5.99
10	Vinh Phuc	0.742	0.693	0.682	1.61	7.04	8.77
11	Khanh Hoa	0.735	0.712	0.652	9.27	3.16	12.73
12	Long An	0.732	0.686	0.653	5.09	6.66	12.08
13	Vinh Long	0.730	0.691	0.645	7.12	5.72	13.24
14	Ben Tre	0.728	0.679	0.610	11.29	7.19	19.29
15	Ca Mau	0.725	0.691	0.636	8.70	4.87	13.99
16	Kien Giang	0.724	0.688	0.633	8.74	5.22	14.42
17	Binh Duong	0.724	0.716	0.731	-2.01	1.08	-0.95
18	Lam Dong	0.723	0.670	0.656	2.24	7.88	10.29
19	Hai Duong	0.723	0.705	0.663	6.26	2.56	8.99
20	Tien Giang	0.721	0.683	0.643	6.12	5.62	12.08
21	Tay Ninh	0.721	0.676	0.672	0.61	6.70	7.36
22	Thai Binh	0.719	0.682	0.645	5.73	5.39	11.43
23	Binh Dinh	0.718	0.678	0.621	9.15	5.89	15.58
24	Hung Yen	0.718	0.690	0.661	4.48	3.99	8.66
25	Ninh Binh	0.717	0.671	0.649	3.43	6.83	10.49

2008 HDI Rank	Province	HDI 2008	HDI 2004	HDI 1999	Change 1999-2004 (%)	Change 2004-2008 (%)	Change 1999-2008 (%)
26	Bac Lieu	0.717	0.681	0.630	8.08	5.22	13.72
27	Ha Tinh	0.717	0.677	0.640	5.82	5.84	12.00
28	Binh Thuan	0.713	0.675	0.647	4.30	5.71	10.25
29	Quang Nam	0.709	0.686	0.635	8.02	3.39	11.69
30	Thai Nguyen	0.709	0.668	0.640	4.31	6.12	10.70
31	Ha Nam	0.709	0.685	0.643	6.50	3.53	10.26
32	An Giang	0.707	0.659	0.618	6.59	7.25	14.32
33	Nam Dinh	0.706	0.683	0.641	6.58	3.30	10.10
34	Thanh Hoa	0.703	0.666	0.610	9.28	5.53	15.32
35	Lang Son	0.702	0.650	0.581	11.75	8.08	20.78
36	Hau Giang	0.702	0.654			7.30	
37	Quang Binh	0.701	0.665	0.611	8.86	5.40	14.73
38	Binh Phuoc	0.701	0.653	0.649	0.57	7.43	8.04
39	Nghe An	0.700	0.675	0.642	5.21	3.70	9.11
40	Thua Thien-Hue	0.694	0.671	0.631	6.32	3.43	9.96
41	Dak Lak	0.694	0.628	0.583	7.74	10.51	19.06
42	Phu Yen	0.693	0.649	0.611	6.19	6.84	13.45
43	Dong Thap	0.691	0.660	0.582	13.31	4.72	18.66
44	Quang Ngai	0.689	0.647	0.581	11.22	6.56	18.52
45	Bac Giang	0.687	0.644	0.620	3.96	6.64	10.86
46	Phu Tho	0.686	0.670	0.626	7.11	2.37	9.65
47	Quang Tri	0.686	0.636	0.599	6.15	7.84	14.47
48	Soc Trang	0.684	0.646	0.611	5.74	5.81	11.87
49	Tuyen Quang	0.684	0.651	0.624	4.27	5.10	9.59
50	Dak Nong	0.683	0.629			8.64	
51	Hoa Binh	0.681	0.629	0.574	9.55	8.21	18.55
52	Tra Vinh	0.668	0.653	0.600	8.76	2.30	11.26
53	Gia Lai	0.667	0.584	0.519	12.52	14.24	28.55

2008 HDI Rank	Province	HDI 2008	HDI 2004	HDI 1999	Change 1999-2004 (%)	Change 2004-2008 (%)	Change 1999-2008 (%)
54	Bac Can	0.666	0.623	0.585	6.50	6.87	13.82
55	Cao Bang	0.658	0.596	0.541	10.20	10.41	21.67
56	Ninh Thuan	0.655	0.629	0.599	5.12	4.07	9.40
57	Lao Cai	0.644	0.608	0.527	15.52	5.86	22.29
58	Kon Tum	0.641	0.576	0.535	7.56	11.37	19.80
59	Son La	0.641	0.588	0.527	11.66	9.01	21.72
60	Yen Bai	0.631	0.620	0.580	6.96	1.75	8.84
61	Dien Bien	0.600	0.580			3.39	
62	Ha Giang	0.570	0.523	0.477	9.61	8.93	19.40
63	Lai Chau	0.538	0.495	0.468	5.80	8.74	15.04

Regions	HDI 2008	HDI 2004	HDI 1999	Change 1999-2004 (%)	Change 2004-2008 (%)	Change 1999-2008 (%)
Northern Midlands and Mountainous Areas	0.660	0.623	0.578	7.72	5.97	14.15
Red River Delta	0.741	0.707	0.674	4.92	4.79	9.95
North Central Area and Central Coastal Area	0.707	0.674	0.627	7.43	4.88	12.68
Central Highlands	0.688	0.623	0.582	7.10	10.44	18.28
South East	0.756	0.748	0.728	2.72	1.03	3.78
Mekong River Delta	0.714	0.674	0.624	8.04	5.86	14.37

Source: Calculated for the NHDR by VASS and GSO 2011

HDI change and contribution of each dimension to the HDI 1999-2008

	2008	2004	1999	Change 1999-2004 (%)	Change 2004-2008 (%)	Change 1999-2008 (%)	Contribution to change (% point) 1999-2004	Contribution to change (% point) 2004-2008	Contribution to change (% point) 1999-2008	Contribution (%) 1999-2004	Contribution (%) 2004-2008	Contribution (%) 1999-2008
Whole Country												
Life Expectancy Index	0.794	0.782	0.721	8.4	1.6	10.2	3.1	0.6	3.8	40.7	15.2	31.9
Education Index	0.830	0.826	0.803	2.9	0.5	3.4	1.2	0.2	1.4	15.3	5.1	11.8
Income Index	0.559	0.496	0.430	15.3	12.6	29.8	3.4	3.0	6.6	44.0	79.7	56.3
HDI	0.728	0.701	0.651	7.7	3.8	11.7	7.7	3.8	11.7	100.0	100.0	100.0
Northern Midlands and Mountainous Areas												
Life Expectancy Index	0.749	0.720	0.680	5.9	4.0	10.2	2.3	1.5	4.0	29.9	25.2	27.8
Education Index	0.794	0.789	0.759	4.0	0.6	4.6	1.7	0.3	2.0	22.3	4.1	14.0
Income Index	0.443	0.362	0.298	21.7	22.3	48.7	3.7	4.3	8.4	47.8	70.6	58.3
HDI	0.662	0.624	0.579	7.8	6.1	14.3	7.8	6.1	14.3	100.0	100.0	100.0
Red River Delta												
Life Expectancy Index	0.817	0.807	0.785	2.8	1.3	4.1	1.1	0.5	1.6	22.9	12.1	17.7
Education Index	0.852	0.854	0.840	1.6	-0.2	1.4	0.7	-0.1	0.6	14.2	-2.0	6.4
Income Index	0.568	0.489	0.429	13.9	16.2	32.3	2.9	3.7	6.8	62.9	90.0	75.9
HDI	0.746	0.717	0.685	4.6	4.1	8.9	4.6	4.1	8.9	100.0	100.0	100.0
North Central Area and Central Coastal Area												
Life Expectancy Index	0.777	0.767	0.723	6.2	1.2	7.5	2.4	0.5	2.9	32.3	9.7	23.1
Education Index	0.856	0.850	0.826	2.8	0.8	3.6	1.2%	0.3	1.6	16.6	6.9	12.7
Income Index	0.492	0.411	0.341	20.8	19.5	44.4	3.	4.0	8.0	51.0	83.4	64.3
HDI	0.708	0.676	0.630	7.3	4.7	12.4	7.3	4.7	12.4	100.0	100.0	100.0
Central Highlands												
Life Expectancy Index	0.755	0.701	0.639	9.7	7.8	18.3	3.6	2.9	6.7	50.0	27.7	36.3

	2008	2004	1999	Change 1999-2004 (%)	Change 2004-2008 (%)	Change 1999-2008 (%)	Contribution to change (% point) 1999-2004	Contribution to change (% point) 2004-2008	Contribution to change (% point) 1999-2008	Contribution (%) 1999-2004	Contribution (%) 2004-2008	Contribution (%) 1999-2008
Education Index	0.824	0.800	0.776	3.1	3.1	6.2	1.4	1.3	2.8	19.3	12.4	15.1
Income Index	0.487	0.369	0.331	11.5	31.9	47.1	2.2	6.3	8.9	30.7	59.9	48.6
HDI	0.689	0.623	0.582	7.1	10.5	18.4	7.1	10.5	18.4	100.0	100.0	100.0
South East												
Life Expectancy Index	0.835	0.823	0.851	-3.4	1.5	-1.9	-1.3	0.6	-0.7	-45.4	81.3	-20.5
Education Index	0.820	0.836	0.802	4.2	-1.9	2.3	1.5	-0.7	0.8	53.6	-100.9	23.2
Income Index	0.623	0.605	0.547	10.6	3.1	14.0	2.6	0.8	3.5	91.8	119.6	97.3
HDI	0.760	0.754	0.733	2.9	0.7	3.6	2.9	0.7	3.6	100.0	100.0	100.0
Mekong River Delta												
Life Expectancy Index	0.807	0.785	0.729	7.6	2.9	10.7	2.9	1.1	4.1	36.7	18.7	28.7
Education Index	0.799	0.786	0.761	3.3	1.7	5.0	1.3	0.7	2.0	16.6	11.0	14.1
Income Index	0.540	0.456	0.385	18.3	18.5	40.2	3.8	4.2	8.2	46.7	70.3	57.2
HDI	0.715	0.675	0.625	8.0	5.9	14.4	8.0	5.9	14.4	100.0	100.0	100.0

Source: Based on calculations for the NHDR by VASS and GSO 2011

Gender-related Development Index 2008

HDI Rank	GDI Rank	Province	Life Expectancy/Expectancy at Birth		Adult Literacy Rate (male)	Adult Literacy Rate (female)	Combined Gross Enrollment Ratio		GDP per capita (male) (PPP US\$)	GDP per capita (female) (PPP US\$)	Population Share		Life Expectancy/Expectancy Index		Equally Distributed Education Index		Income Index		Equally Distributed Income Index	GDI	
			(male)	(female)			(male)	(female)			(male)	(female)	(male)	(female)	(male)	(female)	(male)	(female)			(male)
		Whole Country	70.04	75.44	96.09	91.28	61.73	61.83	3,111.0	2,577.4	49.3	50.71	0.79	0.80	0.85	0.81	0.83	0.57	0.54	0.56	0.728
1	1	Ba Ria-Vung Tau	72.79	77.73	97.19	93.60	60.82	67.30	9,961.1	5,853.4	50.1	49.9	0.84	0.84	0.85	0.85	0.85	0.77	0.68	0.72	0.803
2	2	Ho Chi Minh City	73.31	78.24	98.23	96.28	52.32	53.92	6,003.4	3,742.0	48.3	51.7	0.85	0.85	0.83	0.82	0.83	0.68	0.60	0.64	0.771
3	3	Hanoi	72.38	77.32	98.77	95.62	61.52	60.35	4,700.4	3,999.1	49.0	51.0	0.83	0.83	0.86	0.84	0.85	0.64	0.62	0.63	0.770
4	4	Da Nang	72.25	77.23	98.75	95.38	61.16	63.04	4,488.0	2,957.7	49.2	50.8	0.83	0.83	0.86	0.85	0.85	0.63	0.57	0.60	0.760
5	5	Quang Ninh	70.03	75.40	98.06	93.65	63.41	64.09	4,644.1	3,564.4	50.9	49.1	0.79	0.80	0.87	0.84	0.85	0.64	0.60	0.62	0.755
6	6	Can Tho	72.99	77.92	96.14	93.12	48.18	49.79	4,846.7	3,345.5	49.4	50.6	0.84	0.84	0.80	0.79	0.79	0.65	0.59	0.61	0.750
7	7	Bac Ninh	71.18	76.44	98.63	93.95	66.30	63.84	3,310.1	2,633.8	48.9	51.1	0.81	0.82	0.88	0.84	0.86	0.58	0.55	0.56	0.745
8	9	Hai Phong	71.86	76.94	98.68	94.80	56.79	55.90	3,643.5	2,755.0	49.5	50.5	0.82	0.82	0.85	0.82	0.83	0.60	0.55	0.58	0.744
9	8	Dong Nai	72.88	77.81	97.74	94.50	55.27	56.42	3,274.0	2,721.9	49.7	50.3	0.84	0.84	0.84	0.82	0.83	0.58	0.55	0.57	0.744
10	10	Vinh Phuc	71.34	76.56	98.73	94.30	59.97	57.67	3,284.6	2,901.5	49.5	50.5	0.81	0.82	0.86	0.82	0.84	0.58	0.56	0.57	0.742
11	11	Khanh Hoa	69.82	75.25	97.15	94.05	60.92	67.87	3,470.2	2,422.2	49.6	50.4	0.79	0.80	0.85	0.85	0.85	0.59	0.53	0.56	0.735
12	12	Long An	72.25	77.23	96.55	91.88	55.14	60.67	2,963.8	2,395.5	49.7	50.3	0.83	0.83	0.83	0.81	0.82	0.57	0.53	0.55	0.732
13	13	Vinh Long	71.76	76.87	96.71	93.49	59.61	63.30	2,813.1	2,009.2	48.9	51.1	0.82	0.82	0.84	0.83	0.84	0.56	0.50	0.53	0.729
14	14	Ben Tre	71.28	76.51	96.90	91.89	65.63	73.43	2,497.2	1,785.3	48.9	51.1	0.81	0.82	0.86	0.86	0.86	0.54	0.48	0.51	0.728
15	20	Ca Mau	70.46	75.80	97.92	95.39	58.49	54.58	3,390.8	1,717.2	50.0	50.0	0.80	0.80	0.85	0.82	0.83	0.59	0.47	0.53	0.720
16	18	Kien Giang	70.46	75.80	93.07	87.34	58.46	59.46	3,876.7	2,406.1	49.9	50.1	0.80	0.80	0.82	0.78	0.80	0.61	0.53	0.57	0.722
17	17	Binh Duong	72.88	77.81	97.66	95.39	40.01	39.32	3,364.6	2,335.2	48.1	51.9	0.84	0.84	0.78	0.77	0.78	0.59	0.53	0.55	0.723
18	16	Lam Dong	70.61	75.94	95.60	90.37	68.00	70.27	2,495.0	1,921.2	50.1	49.9	0.80	0.81	0.86	0.84	0.85	0.54	0.49	0.51	0.723
19	15	Hai Duong	71.34	76.56	98.64	94.39	64.51	62.67	2,064.0	1,923.1	48.9	51.1	0.81	0.82	0.87	0.84	0.85	0.51	0.49	0.50	0.723

HDI Rank	GDI Rank	Province	Life Expectancy/Expectancy at Birth		Adult Literacy Rate		Combined Enrollment Ratio		GDP per capita		Population Share		Life Expectancy/Expectancy Index		Equally Distributed Education Index		Income Index		Equally Distributed Income Index	GDI
			(male)	(female)	(male)	(female)	(male)	(female)	(male)	(female)	(male)	(female)	(male)	(female)	(male)	(female)	(male)	(female)		
20	22	Tien Giang	71.76	76.87	95.48	90.39	56.26	60.83	2,977.9	1,835.8	48.8	51.2	0.82	0.82	0.82	0.81	0.57	0.49	0.52	0.719
21	19	Tay Ninh	70.84	76.16	94.34	90.70	53.31	55.70	3,195.4	2,432.8	49.5	50.5	0.81	0.81	0.81	0.79	0.58	0.53	0.55	0.720
22	21	Thai Binh	71.86	76.94	98.40	94.84	71.60	67.69	1,646.2	1,510.3	48.2	51.8	0.82	0.82	0.82	0.86	0.47	0.45	0.46	0.719
23	23	Binh Dinh	69.08	74.56	98.01	93.02	72.32	74.91	2,178.0	1,714.1	48.8	51.2	0.78	0.78	0.89	0.87	0.51	0.47	0.49	0.718
24	25	Hung Yen	71.18	76.44	98.54	93.45	60.43	61.17	2,061.4	1,914.7	48.3	51.7	0.81	0.82	0.86	0.83	0.51	0.49	0.50	0.718
25	24	Ninh Binh	70.10	75.47	98.57	94.88	71.19	61.67	1,890.8	1,936.0	49.5	50.5	0.79	0.80	0.89	0.84	0.49	0.49	0.49	0.718
26	27	Bac Lieu	70.84	76.16	96.32	93.71	52.30	51.18	3,174.7	1,871.0	48.7	51.3	0.81	0.81	0.82	0.80	0.58	0.49	0.53	0.714
27	26	Ha Tinh	69.18	74.64	98.89	96.15	78.33	81.09	1,429.4	1,612.9	48.0	52.0	0.78	0.79	0.92	0.91	0.44	0.46	0.45	0.717
28	28	Binh Thuan	70.46	75.80	94.50	91.35	65.57	64.85	2,357.0	1,683.8	50.2	49.8	0.80	0.80	0.85	0.83	0.53	0.47	0.50	0.712
29	29	Quang Nam	68.13	73.81	98.24	93.20	63.52	69.14	2,196.1	1,934.4	48.6	51.4	0.76	0.77	0.87	0.85	0.52	0.49	0.50	0.710
30	30	Thai Nguyen	70.55	75.88	98.09	94.72	58.92	55.34	1,844.4	1,947.7	49.8	50.2	0.80	0.81	0.85	0.82	0.49	0.50	0.49	0.709
31	31	Ha Nam	70.12	75.49	98.51	92.83	64.13	70.57	1,857.4	1,484.8	48.6	51.4	0.79	0.80	0.87	0.85	0.49	0.45	0.47	0.709
32	33	An Giang	69.64	75.08	92.88	88.49	51.19	52.23	3,503.9	2,140.3	49.5	50.5	0.79	0.79	0.79	0.76	0.59	0.51	0.55	0.705
33	32	Nam Dinh	71.04	76.33	97.96	93.72	63.91	63.70	1,705.1	1,394.0	48.6	51.4	0.81	0.81	0.87	0.84	0.47	0.44	0.46	0.706
34	34	Thanh Hoa	69.64	75.08	97.34	92.47	66.90	72.34	1,511.4	1,606.7	49.5	50.5	0.79	0.79	0.87	0.86	0.45	0.46	0.46	0.704
35	35	Lang Son	68.58	74.18	96.03	90.17	68.31	68.52	1,680.3	2,009.3	49.8	50.2	0.77	0.78	0.87	0.83	0.47	0.50	0.49	0.702
36	39	Hau Giang	71.76	76.87	94.49	89.23	57.30	57.27	2,201.7	1,390.9	49.9	50.1	0.82	0.82	0.82	0.79	0.52	0.44	0.47	0.700
37	36	Quang Binh	68.16	73.83	97.64	94.71	67.40	67.76	1,696.7	1,711.1	50.0	50.0	0.76	0.77	0.88	0.86	0.47	0.47	0.47	0.702
38	37	Binh Phuoc	68.87	74.40	95.21	91.36	63.42	62.87	2,018.5	1,890.2	50.8	49.2	0.77	0.78	0.85	0.82	0.50	0.49	0.50	0.702
39	38	Nghe An	69.08	74.56	96.34	92.41	64.13	69.18	1,655.9	1,727.7	49.4	50.6	0.78	0.78	0.86	0.85	0.47	0.48	0.47	0.701

HDI Rank	GDI Rank	Province	Life Expectancy		Adult Literacy		Combined Enrollment Ratio		GDP per capita		Population Share		Life Expectancy		Equally Distributed		Income Index		
			(male)	(female)	(male)	(female)	(male)	(female)	(male)	(female)	(male)	(female)	(male)	(female)	(male)	(female)	(male)	(female)	(male)
40	41	Thua Thien-Hue	67.37	73.21	95.12	87.39	65.66	72.07	2,176.7	1,630.6	49.2	50.8	0.75	0.76	0.75	0.85	0.82	0.51	0.47
41	40	Dak Lak	67.77	73.48	93.10	88.54	67.87	70.18	1,750.2	1,937.2	50.5	49.5	0.75	0.77	0.76	0.85	0.82	0.48	0.49
42	42	Phu Yen	68.13	73.81	96.53	91.91	60.46	64.35	1,923.6	1,580.0	49.9	50.1	0.76	0.77	0.77	0.85	0.83	0.49	0.46
43	43	Dong Thap	70.07	75.44	92.19	86.83	53.93	53.41	2,304.4	1,753.4	49.9	50.1	0.79	0.80	0.80	0.79	0.76	0.52	0.48
44	44	Quang Ngai	68.48	74.10	93.99	85.45	67.35	71.02	1,885.1	1,449.8	49.2	50.8	0.77	0.78	0.77	0.85	0.81	0.49	0.45
45	45	Bac Giang	69.55	74.96	98.36	94.32	64.52	59.36	1,284.5	1,307.1	49.7	50.3	0.78	0.79	0.79	0.87	0.83	0.43	0.43
46	46	Phu Tho	68.96	74.47	97.79	93.66	62.48	56.95	1,430.2	1,449.9	49.3	50.7	0.77	0.78	0.78	0.86	0.81	0.44	0.45
47	47	Quang Tri	62.93	69.00	96.35	88.44	78.66	79.83	1,851.2	2,096.8	49.6	50.4	0.67	0.69	0.68	0.90	0.86	0.49	0.51
48	51	Soc Trang	69.64	75.08	87.22	80.31	55.85	52.71	2,946.1	1,702.6	49.1	50.9	0.79	0.79	0.79	0.77	0.71	0.56	0.47
49	48	Tuyen Quang	68.53	74.14	96.66	92.35	56.64	65.19	1,306.9	1,612.1	49.4	50.6	0.77	0.78	0.77	0.83	0.83	0.43	0.46
50	49	Dak Nong	66.10	72.04	91.45	87.26	65.97	67.84	2,141.0	1,795.0	50.0	50.0	0.73	0.74	0.73	0.83	0.81	0.51	0.48
51	50	Hoa Binh	68.53	74.14	96.21	91.35	60.85	63.89	1,313.8	1,451.1	48.8	51.2	0.77	0.78	0.77	0.84	0.82	0.43	0.45
52	54	Tra Vinh	69.64	75.08	91.39	82.08	55.04	52.63	1,977.3	1,173.6	49.5	50.5	0.79	0.79	0.79	0.79	0.72	0.50	0.41
53	52	Gia Lai	66.43	72.31	91.24	84.93	62.04	67.00	1,741.6	1,432.2	49.9	50.1	0.73	0.75	0.74	0.82	0.79	0.48	0.44
54	53	Bac Can	68.53	74.14	94.31	88.45	64.85	68.41	965.5	1,185.0	50.3	49.7	0.77	0.78	0.77	0.84	0.82	0.38	0.41
55	55	Cao Bang	65.53	71.53	88.44	79.55	77.96	76.23	1,284.7	1,394.7	49.1	50.9	0.72	0.73	0.73	0.85	0.78	0.43	0.44
56	56	Ninh Thuan	67.59	73.32	89.97	81.73	66.58	66.00	1,437.1	1,008.7	49.7	50.3	0.75	0.76	0.76	0.82	0.76	0.44	0.39
57	57	Lao Cai	63.55	69.56	86.73	74.58	61.47	59.35	2,020.0	1,993.7	50.2	49.8	0.68	0.70	0.69	0.78	0.70	0.50	0.50
58	58	Kon Tum	62.89	68.96	89.17	77.90	67.40	68.90	1,525.9	1,599.7	49.8	50.2	0.67	0.69	0.68	0.82	0.75	0.45	0.46
59	59	Son La	65.90	71.87	90.45	72.33	71.27	55.01	1,243.2	1,540.7	49.6	50.4	0.72	0.74	0.73	0.84	0.67	0.42	0.46
60	60	Yen Bai	65.53	71.53	88.40	78.74	59.74	56.31	1,158.1	1,285.0	49.9	50.1	0.72	0.73	0.73	0.79	0.71	0.41	0.43
61	61	Dien Bien	62.48	68.58	83.41	60.47	78.48	55.33	1,071.3	1,488.0	50.2	49.8	0.67	0.68	0.68	0.82	0.59	0.40	0.45
62	62	Ha Giang	63.06	69.11	84.05	62.71	61.23	54.39	681.2	918.4	49.5	50.5	0.68	0.69	0.68	0.76	0.60	0.32	0.37
63	63	Lai Chau	60.38	66.57	75.50	48.05	65.59	51.42	965.4	836.2	50.7	49.3	0.63	0.65	0.64	0.72	0.49	0.38	0.35

Region	Life Expectancy at Birth (male)	Life Expectancy at birth (female)	Adult Literacy Rate (male)	Adult Literacy Rate (female)	Combined Gross Enrolment Ratio (male) (%)	Combined gross enrolment ratio (female) (%)	GDP per capita (male) (PPP US\$)	GDP per capita (female) (PPP US\$)	GDI
Northern Midlands and Mountainous Areas	67.17	72.88	92.85	83.47	64.41	59.61	1,349.10	1,493.00	0.660
Red River Delta	71.55	76.68	98.56	94.64	63.25	61.91	3,265.40	2,759.10	0.741
North Central Area and Central Coastal Area	68.93	74.46	96.67	91.84	66.73	70.60	2,040.60	1,768.50	0.707
Central Highlands	67.54	73.25	92.74	87.06	66.23	69.08	1,940.00	1,766.40	0.689
South East	72.68	77.68	97.52	94.94	52.97	54.53	5,064.70	3,350.60	0.755
Mekong River Delta	70.87	76.13	94.22	89.34	55.76	57.04	3,092.10	2,004.10	0.712

Source: Calculated for the NHDR by VASS and GSO 2011

Gender-related Development Index 2004

HDI Rank	GDI Rank	Province	Life Expectancy at Birth (male)	Life Expectancy at Birth (female)	Adult Literacy Rate (male) (% age 15 and above)	Adult Literacy Rate (female) (% age 15 and above)	Combined Gross Enrolment Ratio (male) (%)	Combined Gross Enrolment Ratio (female) (%)	GDP per capita (male) (PPP US\$)	GDP per capita (female) (PPP US\$)	Population Share (female)	Equally Distributed Life Expectancy Index	Equally Distributed Education Index	Equally Distributed Income Index	GDI
		Whole Country	69.10	74.90	94.84	91.81	62.12	60.20	2,171.1	1,744.0	50.83	0.78	0.83	0.49	0.701
1	1	Ba Ria-Vung Tau	72.48	77.76	95.46	95.13	60.35	61.07	9,587.8	4,668.9	49.87	0.84	0.84	0.70	0.790
2	2	Ho Chi Minh City	73.58	78.98	96.30	97.35	64.14	59.40	5,785.4	3,461.7	51.83	0.85	0.85	0.63	0.779
3	3	Da Nang	73.52	78.84	99.75	94.04	71.71	69.05	3,133.2	2,154.9	51.63	0.85	0.88	0.54	0.758
4	5	Hai Phong	71.61	76.95	97.39	96.11	64.80	63.23	2,458.3	1,852.5	50.57	0.82	0.86	0.51	0.730
5	4	Hanoi (including Ha Tay)	71.08	76.67	98.69	95.41	61.01	65.66	3,145.7	2,629.6	50.77	0.81	0.86	0.52	0.730
6	6	Dong Nai	69.91	75.21	96.97	94.71	60.42	59.31	2,896.6	2,125.5	50.40	0.79	0.84	0.53	0.722
7	7	Quang Ninh	69.07	75.27	99.35	92.41	62.10	63.16	2,779.9	2,081.6	49.35	0.79	0.85	0.53	0.721
8	8	Binh Duong	70.34	75.32	96.63	96.15	48.77	46.18	3,128.3	2,363.3	52.12	0.80	0.80	0.55	0.716
9	9	Khanh Hoa	70.45	76.04	95.36	93.07	64.02	61.77	2,416.7	1,518.4	50.35	0.80	0.84	0.49	0.710
10	10	Hai Duong	71.74	77.42	97.52	95.91	59.12	58.04	1,564.7	1,402.7	51.62	0.83	0.84	0.45	0.705
11	12	Can Tho	69.40	75.50	94.79	92.89	47.98	50.20	2,952.7	1,562.6	50.82	0.79	0.79	0.51	0.695
12	11	Bac Ninh	69.63	75.30	96.79	95.60	66.43	63.19	1,639.2	1,259.7	51.31	0.79	0.86	0.44	0.697
13	13	Vinh Phuc	70.28	76.06	96.29	97.13	61.08	54.97	1,454.0	1,345.1	50.48	0.80	0.84	0.44	0.694
14	22	Ca Mau	69.70	74.64	95.87	96.04	52.84	48.63	2,560.0	1,011.7	50.68	0.79	0.81	0.45	0.682
15	15	Vinh Long	71.49	76.86	96.27	94.35	55.54	52.95	1,651.0	1,108.6	51.39	0.82	0.82	0.43	0.689
16	14	Hung Yen	70.14	75.84	96.42	94.80	60.86	61.36	1,276.7	1,381.6	51.65	0.80	0.84	0.43	0.691
17	20	Kien Giang	70.41	75.70	89.97	88.61	59.90	53.52	2,332.5	1,233.1	50.69	0.80	0.78	0.47	0.684
18	17	Long An	70.49	75.79	96.13	93.02	54.76	53.08	1,657.4	1,275.3	50.83	0.80	0.81	0.45	0.686
19	16	Quang Nam	69.38	74.78	96.11	90.95	69.63	73.25	1,235.1	1,143.6	51.58	0.78	0.86	0.41	0.686

HDI Rank	GDI Rank	Province	Life Expectancy at Birth (male)	Life Expectancy at Birth (female)	Adult Literacy Rate (male) (% age 15 and above)	Adult Literacy Rate (female) (% age 15 and above)	Combined Gross Enrolment Ratio (male) (%)	Combined Gross Enrolment Ratio (female) (%)	GDP per capita (male) (PPP US\$)	GDP per capita (female) (PPP US\$)	Population Share (female)	Equally Distributed Life Expectancy Index	Equally Distributed Education Index	Equally Distributed Income Index	GDI
20	18	Ha Nam	72.04	77.66	97.69	93.96	61.29	60.67	1,113.6	881.2	51.56	0.83	0.84	0.38	0.685
21	19	Nam Dinh	70.02	75.47	96.44	96.45	63.93	72.07	1,026.8	1,003.0	51.21	0.80	0.87	0.39	0.684
22	23	Tien Giang	70.72	76.08	94.80	92.12	54.61	53.25	1,700.7	1,109.1	51.45	0.81	0.80	0.43	0.681
23	21	Thai Binh	70.31	75.64	96.18	97.23	61.08	67.79	1,096.3	965.8	51.95	0.80	0.86	0.39	0.683
24	27	Bac Lieu	68.36	73.43	94.81	92.98	60.21	43.82	2,382.3	1,220.7	51.38	0.76	0.80	0.47	0.676
25	26	Ben Tre	68.32	74.06	96.20	93.33	56.86	58.07	1,775.1	1,140.4	51.42	0.77	0.82	0.44	0.677
26	25	Binh Dinh	68.39	73.98	95.53	94.04	69.61	65.03	1,322.9	1,011.9	51.29	0.77	0.86	0.41	0.677
27	24	Ha Tinh	68.62	73.73	96.07	97.25	72.00	76.07	946.4	923.5	50.34	0.77	0.89	0.37	0.678
28	29	Tay Ninh	68.88	73.86	92.10	91.47	54.03	51.52	1,932.5	1,369.8	50.79	0.77	0.79	0.46	0.675
29	28	Nghe An	68.40	74.07	95.21	93.44	71.99	63.85	1,068.9	1,132.4	50.85	0.77	0.85	0.40	0.675
30	30	Binh Thuan	68.93	74.64	95.10	91.93	61.61	63.15	1,475.5	913.7	50.12	0.78	0.83	0.41	0.672
31	31	Ninh Binh	69.63	75.30	98.74	95.09	64.60	61.77	895.7	911.2	51.13	0.79	0.86	0.37	0.672
32	33	Thua Thien Hue	68.50	74.17	95.66	86.29	71.14	65.56	1,274.6	1,037.9	50.88	0.77	0.83	0.41	0.670
33	34	Lam Dong	68.79	75.00	95.39	88.83	67.62	64.29	1,240.1	912.6	49.98	0.78	0.83	0.39	0.669
34	32	Phu Tho	68.88	75.26	96.61	95.48	63.78	59.43	990.4	976.8	50.84	0.78	0.85	0.38	0.670
35	35	Thai Nguyen	67.93	73.86	97.22	94.93	57.68	59.95	1,118.6	1,138.8	50.02	0.76	0.84	0.40	0.669
36	36	Thanh Hoa	67.92	73.49	96.11	94.33	64.47	69.54	920.1	1,031.1	51.01	0.76	0.86	0.38	0.667
37	37	Quang Binh	66.57	72.21	96.60	93.56	73.63	70.09	1,033.1	957.6	50.55	0.74	0.87	0.38	0.665
38	39	Dong Thap	69.77	75.65	92.56	88.66	55.89	53.35	1,474.9	740.3	51.20	0.80	0.79	0.38	0.654
39	38	An Giang	68.21	73.75	89.05	87.66	49.17	47.75	2,089.6	1,111.8	50.84	0.77	0.75	0.45	0.655
40	42	Hau Giang	68.20	74.00	91.23	89.49	53.58	45.99	1,662.1	937.1	50.80	0.77	0.77	0.42	0.650
41	41	Tra Vinh	68.37	73.90	86.36	83.20	55.11	51.57	1,780.7	1,157.0	50.22	0.77	0.74	0.44	0.651
42	40	Binh Phuoc	68.22	73.55	98.87	88.61	57.51	57.14	1,039.0	878.8	49.11	0.76	0.82	0.38	0.652
43	43	Tuyen Quang	65.63	71.26	98.56	91.00	71.27	67.10	809.5	994.4	50.49	0.72	0.86	0.37	0.650

HDI Rank	GDI Rank	Province	Life Expectancy at Birth (male)	Life Expectancy at Birth (female)	Adult Literacy Rate (male) (% age 15 and above)	Adult Literacy Rate (female) (% age 15 and above)	Combined Gross Enrolment Ratio (male) (%)	Combined Gross Enrolment Ratio (female) (%)	GDP per capita (male) (PPP US\$)	GDP per capita (female) (PPP US\$)	Population Share (female)	Equally Distributed Life Expectancy Index	Equally Distributed Education Index	Equally Distributed Income Index	GDI
44	44	Lang Son	63.91	70.19	95.21	90.98	65.79	65.04	1,104.8	1,237.3	50.28	0.70	0.84	0.41	0.650
45	45	Phu Yen	65.29	70.52	96.89	92.79	60.56	57.31	1,250.7	991.8	50.37	0.72	0.83	0.40	0.648
46	46	Quang Ngai	68.17	73.91	91.07	88.01	64.14	61.75	966.9	840.9	51.12	0.77	0.81	0.37	0.647
47	48	Soc Trang	68.12	73.49	87.27	84.85	54.03	49.68	1,732.4	930.9	51.26	0.76	0.75	0.42	0.642
48	47	Bac Giang	66.10	71.77	97.86	94.91	67.11	56.77	723.6	926.0	50.56	0.73	0.85	0.35	0.643
49	49	Quang Tri	63.11	69.07	94.22	87.14	72.63	69.55	1,041.0	951.4	50.56	0.68	0.84	0.38	0.636
50	53	Ninh Thuan	67.72	73.23	88.35	83.07	54.36	65.99	1,053.4	683.4	50.54	0.76	0.77	0.35	0.628
51	50	Hoa Binh(2)	65.96	71.73	95.25	92.47	57.26	56.37	773.2	793.2	50.30	0.73	0.81	0.34	0.630
52	51	Dak Nong	64.20	70.00	95.29	86.18	66.66	59.08	972.6	881.2	50.40	0.70	0.81	0.37	0.628
53	52	Dak Lak	64.70	70.50	91.28	85.42	68.42	68.15	888.8	825.4	49.56	0.71	0.82	0.36	0.628
54	54	Bac Can	65.37	71.52	94.31	86.48	66.09	66.45	579.7	809.1	49.91	0.72	0.82	0.32	0.622
55	55	Yen Bai	65.96	71.63	88.70	81.21	65.25	61.93	795.6	867.2	50.18	0.73	0.78	0.35	0.620
56	56	Lao Cai	64.72	71.17	87.17	73.07	65.95	57.17	889.1	963.2	50.22	0.72	0.73	0.37	0.607
57	57	Cao Bang	61.47	68.14	84.77	76.45	66.98	64.00	801.1	1,038.0	50.91	0.66	0.75	0.37	0.595
58	58	Son La	64.97	71.12	90.87	66.28	64.19	50.76	703.0	755.5	49.72	0.72	0.70	0.33	0.583
59	59	Gia Lai	61.00	67.52	90.23	74.83	57.55	57.58	943.0	739.6	49.11	0.65	0.74	0.35	0.582
60	61	Dien Bien	63.40	69.90	86.89	56.41	73.05	51.08	689.6	1,066.0	49.80	0.69	0.66	0.35	0.569
61	60	Kon Tum	56.39	63.20	89.67	73.68	71.35	71.77	991.8	788.8	49.77	0.58	0.78	0.36	0.574
62	62	Ha Giang	57.99	64.80	78.98	60.55	64.67	54.47	584.8	633.3	50.49	0.61	0.65	0.30	0.520
63	63	Lai Chau	61.90	68.00	71.64	46.59	51.07	40.16	522.6	499.9	49.76	0.67	0.53	0.27	0.489

Region	Life Expectancy at Birth (male)	Life Expectancy at Birth (female)	Adult Literacy Rate (male) (% age 15 and above)	Adult Literacy Rate (female) (% age 15 and above)	Combined Gross Enrolment Ratio (male) (%)	Combined Gross Enrolment Ratio (female) (%)	GDP per capita (male) (PPP US\$)	GDP per capita (female) (PPP US\$)	Population Share (female)	Equally Distributed Life Expectancy Index	Equally Distributed Education Index	Equally Distributed Income Index	GDI
Northern Midlands and Mountainous Areas	65.25	71.35	92.28	83.15	64.23	58.12	826.3	926.6	50.31	0.72	0.78	0.36	0.621
Red River Delta	70.68	76.29	97.62	95.62	62.01	64.02	2030.7	1718.3	51.01	0.81	0.85	0.46	0.707
North Central Area and Central Coastal Area	68.35	73.91	95.38	92.34	67.61	66.78	1268.5	1086.4	50.86	0.77	0.85	0.40	0.674
Central Highlands	64.05	70.20	92.21	82.75	65.64	64.14	1000.8	826.9	49.64	0.70	0.80	0.37	0.622
South East	71.78	77.08	96.19	95.52	60.53	57.54	4673.6	2864.8	51.17	0.82	0.84	0.58	0.746
Mekong River Delta	69.41	74.90	92.56	90.37	54.43	51.26	1970.3	1112.7	51.01	0.79	0.79	0.44	0.671

Source: Calculated for the NHDR by VASS and GSO 2011

Gender-related Development Index 1999

HDI Rank	GDI Rank	Province	Life Expectancy at Birth (male)	Life Expectancy at Birth (female)	Adult Literacy Rate (% age 15 and above)	Adult Literacy Rate (female) (% age 15 and above)	Combined Gross Enrolment Ratio (male) (%)	Combined Gross Enrolment Ratio (female) (%)	GDP per capita (male) (PPP US\$)	GDP per capita (female) (PPP US\$)	Population Share (female)	Equally Distributed Expectancy Life Index	Equally Distributed Education Index	Equally Distributed Income Index	GDI
		Whole Country	66.50	70.12	93.89	86.89	62.55	58.06	1,527.5	1,113.1	50.83	0.72	0.80	0.43	0.650
1	1	Ba Ria-Vung Tau	72.89	76.13	94.97	90.52	59.70	66.01	4,858.7	3,633.9	49.97	0.82	0.83	0.62	0.759
2	2	Ho Chi Minh City	76.77	79.44	96.38	92.66	53.78	47.66	3,934.6	2,654.9	51.84	0.88	0.80	0.58	0.753
3	3	Binh Duong	74.22	77.31	95.31	90.52	59.62	54.83	2,945.2	2,112.0	51.62	0.85	0.81	0.53	0.729
4	4	Da Nang	72.77	76.05	97.25	90.90	74.72	66.37	2,355.2	1,397.1	50.88	0.82	0.86	0.48	0.721
5	5	Hai Phong	72.07	75.41	98.09	92.20	65.13	64.97	1,557.2	1,374.8	50.66	0.81	0.85	0.45	0.703
6	6	Dong Nai	71.93	75.29	94.98	90.43	61.98	59.59	1,965.8	1,500.5	50.06	0.81	0.82	0.47	0.701
7	7	Hanoi (including Ha Tay)	71.07	74.23	98.24	92.51	62.92	58.61	2,304.4	2,072.8	50.71	0.79	0.84	0.47	0.700
8	8	Quang Ninh	68.25	71.68	95.53	89.11	61.03	65.19	2,117.6	1,315.6	48.97	0.75	0.83	0.47	0.681
9	9	Vinh Phuc	71.57	74.99	97.39	90.76	69.23	62.83	1,281.6	880.7	51.26	0.80	0.85	0.39	0.680
10	10	Tay Ninh	73.27	76.46	91.54	86.53	54.91	51.33	1,387.0	1,017.0	50.87	0.83	0.77	0.41	0.670
11	11	Hai Duong	70.01	73.57	98.09	91.03	67.42	61.17	925.6	886.7	51.42	0.78	0.84	0.37	0.663
12	13	Bac Ninh	68.28	71.89	97.73	90.39	66.89	60.23	1,332.6	885.1	51.60	0.75	0.84	0.39	0.660
13	12	Hung Yen	70.08	73.65	97.83	90.31	66.76	61.89	898.0	854.6	51.69	0.78	0.84	0.36	0.661
14	14	Lam Dong	70.90	74.38	93.56	86.12	65.90	66.24	911.7	757.9	49.53	0.79	0.82	0.35	0.655
15	15	Long An	70.58	74.11	94.79	88.32	51.99	51.80	1,174.5	882.4	50.97	0.79	0.78	0.39	0.652
16	17	Khanh Hoa	66.01	69.66	94.71	88.57	54.89	65.10	1,728.2	960.1	50.52	0.71	0.81	0.42	0.648
17	16	Ninh Binh	69.94	73.50	97.49	90.91	69.93	67.25	681.0	627.6	51.49	0.78	0.86	0.31	0.649
18	18	Binh Phuoc	70.94	74.42	91.01	83.13	62.43	58.25	1,035.8	795.7	48.40	0.79	0.78	0.37	0.648

HDI Rank	GDI Rank	Province	Life Expectancy at Birth (male)	Life Expectancy at Birth (female)	Adult Literacy Rate (male) (% age 15 and above)	Adult Literacy Rate (female) (% age 15 and above)	Combined Gross Enrolment Ratio (male) (%)	Combined Gross Enrolment Ratio (female) (%)	GDP per capita (male) (PPP US\$)	GDP per capita (female) (PPP US\$)	Population Share (female)	Equally Distributed Life Expectancy Index	Equally Distributed Education Index	Equally Distributed Income Index	GDI
19	20	Binh Thuan	70.83	74.30	91.34	85.72	59.78	56.43	1,053.3	723.5	50.08	0.79	0.78	0.36	0.645
20	19	Thai Binh	70.30	73.81	98.17	91.98	63.13	59.55	696.6	631.5	52.20	0.78	0.84	0.32	0.645
21	22	Vinh Long	69.97	73.53	93.47	87.81	60.81	52.52	1,037.2	734.3	51.46	0.78	0.79	0.36	0.643
22	23	Tien Giang	70.48	74.00	94.13	87.63	54.42	49.64	1,001.1	789.5	51.56	0.79	0.78	0.36	0.642
23	21	Ha Nam	70.05	73.61	97.70	90.73	63.05	64.00	671.6	619.1	51.38	0.78	0.84	0.31	0.643
24	25	Nghe An	68.39	71.99	96.05	90.03	72.79	66.58	753.6	613.8	50.74	0.75	0.85	0.32	0.641
25	24	Nam Dinh	70.01	73.57	98.20	91.50	61.89	61.71	663.7	601.2	51.32	0.78	0.84	0.31	0.641
26	27	Thai Nguyen	68.31	71.92	97.20	92.21	60.80	59.52	939.5	583.8	50.16	0.75	0.83	0.33	0.637
27	26	Ha Tinh	68.42	72.02	97.36	91.85	73.06	74.35	638.0	516.0	50.92	0.75	0.88	0.29	0.640
28	28	Ca Mau	65.18	68.85	94.18	90.96	60.61	49.35	1,413.7	909.0	50.65	0.70	0.80	0.40	0.633
29	29	Quang Nam	67.30	70.92	95.07	86.34	69.75	62.65	979.4	626.2	51.61	0.73	0.82	0.34	0.632
30	31	Kien Giang	66.27	69.92	90.80	84.74	57.89	50.02	1,397.1	1,036.6	50.78	0.72	0.76	0.41	0.631
31	30	Can Tho	65.72	69.40	92.00	86.70	52.84	46.82	1,481.6	1,125.7	50.89	0.71	0.76	0.43	0.632
32	32	Thua Thien Hue	68.51	72.12	92.44	79.74	69.02	65.21	894.6	669.2	50.66	0.75	0.79	0.34	0.629
33	33	Bac Lieu	65.93	69.60	91.02	86.63	57.64	49.17	1,359.5	983.5	51.02	0.71	0.77	0.41	0.629
34	34	Phu Tho	67.35	70.95	97.48	92.00	64.13	58.68	744.0	512.8	50.88	0.74	0.83	0.30	0.624
35	35	Tuyen Quang	68.11	71.72	93.01	84.73	72.66	66.65	744.6	468.7	50.54	0.75	0.82	0.29	0.621
36	36	Binh Dinh	65.58	69.24	96.26	88.78	62.26	60.95	916.6	599.5	51.44	0.71	0.82	0.33	0.619
37	37	Bac Giang	68.60	72.19	96.73	90.03	64.41	54.50	658.1	434.4	50.56	0.76	0.82	0.28	0.617
38	38	An Giang	67.90	71.52	88.12	81.47	50.51	42.92	1,260.4	825.6	50.79	0.74	0.72	0.38	0.616
39	40	Soc Trang	66.16	69.79	89.03	81.91	58.78	48.66	1,094.8	762.6	51.26	0.72	0.75	0.37	0.609
40	39	Quang Binh	63.85	67.52	95.57	88.48	70.43	63.94	766.5	587.9	50.54	0.68	0.84	0.32	0.610

HDI Rank	GDI Rank	Province	Life Expectancy at Birth (male)	Life Expectancy at Birth (female)	Adult Literacy Rate (% age 15 and above)	Adult Literacy Rate (male) (% age 15 and above)	Adult Literacy Rate (female) (% age 15 and above)	Combined Gross Enrolment Ratio (male) (%)	Combined Gross Enrolment Ratio (female) (%)	GDP per capita (male) (PPP US\$)	GDP per capita (female) (PPP US\$)	Population Share (female)	Equally Distributed Life Expectancy Index	Equally Distributed Education Index	Equally Distributed Income Index	GDI
41	43	Phu Yen	64.57	68.24	93.77	86.52	64.22	61.20	922.2	560.8	50.46	0.69	0.81	0.32	0.607	
42	41	Ben Tre	65.24	68.91	93.57	87.33	54.00	51.66	972.2	689.7	51.60	0.70	0.78	0.35	0.609	
43	42	Thanh Hoa	64.96	68.63	95.47	88.48	67.67	66.03	679.1	519.4	51.11	0.70	0.83	0.30	0.609	
44	44	Tra Vinh	66.39	70.02	87.93	77.94	60.83	47.79	878.7	748.6	50.13	0.72	0.73	0.35	0.599	
45	45	Quang Tri	62.36	66.07	93.27	81.20	47.53	96.31	808.8	619.5	50.77	0.65	0.82	0.32	0.599	
46	46	Ninh Thuan	68.36	71.96	86.49	77.12	62.07	59.65	681.2	507.5	50.67	0.75	0.75	0.29	0.597	
47	47	Bac Can	65.44	69.11	89.39	80.72	71.85	67.59	555.2	352.3	50.04	0.70	0.80	0.24	0.582	
48	51	Dak Lak	60.48	64.24	91.14	82.98	68.77	64.70	893.9	489.8	49.16	0.62	0.80	0.31	0.578	
49	48	Dong Thap	63.76	67.46	89.15	82.51	51.73	46.76	871.1	627.3	50.93	0.68	0.73	0.33	0.581	
50	49	Quang Ngai	61.62	65.34	92.49	82.89	68.98	61.07	740.8	500.4	51.24	0.64	0.80	0.30	0.579	
51	50	Lang Son	58.41	62.14	93.74	85.26	69.39	65.62	921.2	574.4	50.38	0.59	0.82	0.33	0.578	
52	53	Yen Bai	64.96	68.63	88.86	77.77	65.32	57.08	669.5	430.7	50.10	0.70	0.76	0.28	0.576	
53	52	Hoa Binh(2)	60.41	64.16	95.34	88.68	61.37	68.80	577.1	482.9	50.35	0.62	0.83	0.28	0.576	
54	54	Cao Bang	59.17	62.91	81.16	69.23	71.10	64.05	740.1	457.1	51.51	0.60	0.72	0.29	0.536	
55	55	Kon Tum	54.01	57.70	83.73	67.53	82.97	75.71	863.1	522.9	49.65	0.51	0.76	0.31	0.530	
56	57	Lao Cai	61.52	65.25	73.89	56.31	66.02	52.82	782.6	493.9	50.08	0.64	0.62	0.30	0.520	
57	56	Son La	61.59	65.31	81.71	56.73	64.28	51.35	603.4	504.9	49.64	0.64	0.64	0.28	0.521	
58	58	Gia Lai	56.25	59.98	80.78	64.34	70.33	49.34	855.0	515.3	49.49	0.55	0.67	0.31	0.512	
59	59	Ha Giang	58.21	61.94	72.35	50.03	70.70	51.10	519.2	317.2	50.49	0.58	0.59	0.23	0.467	
60	60	Lai Chau	58.55	62.31	66.13	40.65	58.81	39.09	629.9	531.4	49.44	0.59	0.49	0.29	0.459	
61	61	Dien Bien														
62	62	Dak Nong														
63	63	Hau Giang														

Region	Life Expectancy at Birth (male)	Life Expectancy at Birth (female)	Adult Literacy Rate (male) (% age 15 and above)	Adult Literacy Rate (female) (% age 15 and above)	Combined Gross Enrollment Ratio (male) (%)	Combined Gross Enrollment Ratio (female) (%)	GDP per capita (male) (PPP US\$)	GDP per capita (female) (PPP US\$)	Population Share (female)	Equally Distributed Life Expectancy Index	Equally Distributed Education Index	Equally Distributed Income Index	GDI
Northern Midlands and Mountainous Areas	64.01	67.68	88.89	77.41	65.40	57.74	710.9	482.5	50.35	0.68	0.75	0.29	0.574
Red River Delta	70.44	73.85	97.88	91.48	64.53	61.44	1,410.6	1,210.2	51.09	0.79	0.84	0.40	0.673
North Central Area and Central Coastal Area	66.60	70.22	94.75	87.25	67.00	65.54	910.0	633.9	50.91	0.72	0.83	0.33	0.626
Central Highlands	61.52	65.20	88.68	78.09	69.54	62.25	886.6	564.2	49.37	0.64	0.77	0.32	0.577
South East	74.63	77.61	95.11	90.71	56.93	52.98	3,123.8	2,192.6	51.01	0.85	0.80	0.53	0.727
Mekong River Delta	67.00	70.62	91.42	85.21	55.25	48.52	1,170.48	847.77	51.01	0.73	0.76	0.38	0.623

Source: Calculated for the NHDR by VASS and GSO 2011

GDI Change 1999-2008

2008 GDI Rank	Province	GDI 2008	GDI 2004	GDI 1999	Change 1999-2004 (%)	Change 2004-2008 (%)	Change 1999-2008 (%)
	Whole Country	0.728	0.701	0.650	7.87%	3.78%	11.95%
1	Ba Ria-Vung Tau	0.803	0.790	0.759	4.12%	1.63%	5.82%
2	Ho Chi Minh City	0.771	0.779	0.753	3.42%	-1.04%	2.35%
3	Hanoi (including Ha Tay)	0.770	0.730	0.700	4.26%	5.49%	9.98%
4	Da Nang	0.760	0.758	0.721	5.12%	0.32%	5.46%
5	Quang Ninh	0.755	0.721	0.681	5.93%	4.68%	10.88%
6	Can Tho	0.750	0.695	0.632	10.08%	7.87%	18.74%
7	Bac Ninh	0.745	0.697	0.660	5.56%	6.89%	12.83%
8	Dong Nai	0.744	0.722	0.701	2.94%	3.08%	6.11%
9	Hai Phong	0.744	0.730	0.703	3.76%	1.93%	5.76%
10	Vinh Phuc	0.742	0.694	0.680	1.99%	7.01%	9.14%
11	Khanh Hoa	0.735	0.710	0.648	9.57%	3.44%	13.34%
12	Long An	0.732	0.686	0.652	5.17%	6.79%	12.31%
13	Vinh Long	0.729	0.689	0.643	7.20%	5.84%	13.46%
14	Ben Tre	0.728	0.677	0.609	11.28%	7.42%	19.55%
15	Hai Duong	0.723	0.705	0.663	6.35%	2.55%	9.06%
16	Lam Dong	0.723	0.669	0.655	2.13%	8.05%	10.35%
17	Binh Duong	0.723	0.716	0.729	-1.89%	0.97%	-0.94%
18	Kien Giang	0.722	0.684	0.631	8.25%	5.70%	14.42%
19	Tay Ninh	0.720	0.675	0.670	0.64%	6.78%	7.45%
20	Ca Mau	0.720	0.682	0.633	7.60%	5.64%	13.66%
21	Thai Binh	0.719	0.683	0.645	5.84%	5.40%	11.55%
22	Tien Giang	0.719	0.681	0.642	5.99%	5.68%	12.01%
23	Binh Dinh	0.718	0.677	0.619	9.49%	6.03%	16.09%
24	Ninh Binh	0.718	0.672	0.649	3.51%	6.93%	10.68%
25	Hung Yen	0.718	0.691	0.661	4.59%	3.92%	8.69%
26	Ha Tinh	0.717	0.678	0.640	5.97%	5.80%	12.11%
27	Bac Lieu	0.714	0.676	0.629	7.43%	5.66%	13.51%

2008 GDI Rank	Province	GDI 2008	GDI 2004	GDI 1999	Change 1999-2004 (%)	Change 2004-2008 (%)	Change 1999-2008 (%)
28	Binh Thuan	0.712	0.672	0.645	4.22%	5.98%	10.46%
29	Quang Nam	0.710	0.686	0.632	8.64%	3.45%	12.39%
30	Thai Nguyen	0.709	0.669	0.637	4.88%	6.06%	11.23%
31	Ha Nam	0.709	0.685	0.643	6.44%	3.55%	10.22%
32	Nam Dinh	0.706	0.684	0.641	6.68%	3.20%	10.10%
33	An Giang	0.705	0.655	0.616	6.34%	7.66%	14.48%
34	Thanh Hoa	0.704	0.667	0.609	9.53%	5.62%	15.68%
35	Lang Son	0.702	0.650	0.578	12.42%	8.08%	21.51%
36	Quang Binh	0.702	0.665	0.610	9.10%	5.52%	15.12%
37	Binh Phuoc	0.702	0.652	0.648	0.64%	7.64%	8.33%
38	Nghe An	0.701	0.675	0.641	5.34%	3.87%	9.42%
39	Hau Giang	0.700	0.650			7.60%	
40	Dak Lak	0.694	0.628	0.578	8.76%	10.46%	20.13%
41	Thua Thien-Hue	0.694	0.670	0.629	6.47%	3.49%	10.18%
42	Phu Yen	0.693	0.648	0.607	6.71%	6.90%	14.08%
43	Dong Thap	0.690	0.654	0.581	12.65%	5.52%	18.87%
44	Quang Ngai	0.689	0.647	0.579	11.77%	6.50%	19.04%
45	Bac Giang	0.688	0.643	0.617	4.34%	6.89%	11.53%
46	Phu Tho	0.687	0.670	0.624	7.53%	2.42%	10.13%
47	Quang Tri	0.686	0.636	0.599	6.14%	7.91%	14.54%
48	Tuyen Quang	0.684	0.650	0.621	4.77%	5.17%	10.18%
49	Dak Nong	0.683	0.628			8.73%	
50	Hoa Binh	0.681	0.630	0.576	9.32%	8.16%	18.24%
51	Soc Trang	0.680	0.642	0.609	5.39%	5.99%	11.70%
52	Gia Lai	0.667	0.582	0.512	13.81%	14.59%	30.41%
53	Bac Can	0.666	0.622	0.582	6.93%	7.11%	14.54%
54	Tra Vinh	0.665	0.651	0.599	8.60%	2.15%	10.93%
55	Cao Bang	0.658	0.595	0.536	10.97%	10.56%	22.69%
56	Ninh Thuan	0.654	0.628	0.597	5.08%	4.24%	9.54%
57	Lao Cai	0.643	0.607	0.520	16.62%	5.98%	23.59%

2008 GDI Rank	Province	GDI 2008	GDI 2004	GDI 1999	Change 1999-2004 (%)	Change 2004-2008 (%)	Change 1999-2008 (%)
58	Kon Tum	0.641	0.574	0.530	8.30%	11.67%	20.94%
59	Son La	0.637	0.583	0.521	11.90%	9.27%	22.28%
60	Yen Bai	0.630	0.620	0.576	7.64%	1.68%	9.45%
61	Dien Bien	0.594	0.569			4.40%	
62	Ha Giang	0.566	0.520	0.467	11.40%	8.84%	21.25%
63	Lai Chau	0.531	0.489	0.459	6.47%	8.74%	15.78%
Region		GDI 2008	GDI 2004	GDI 1999	Change 1999-2004 (%)	Change 2004-2008 (%)	Change 1999-2008 (%)
Northern Midlands and Mountainous Areas		0.66	0.621	0.574	8.20%	6.23%	14.93%
Red River Delta		0.74	0.707	0.673	5.03%	4.77%	10.04%
North Central Area and Central Coastal Area		0.71	0.674	0.626	7.68%	4.93%	12.99%
Central Highlands		0.69	0.622	0.577	7.81%	10.73%	19.38%
South East		0.76	0.746	0.727	2.67%	1.15%	3.85%
Mekong River Delta		0.71	0.671	0.623	7.70%	6.17%	14.35%

Source: Calculated for the NHDR by VASS and GSO 2011

GDI Change and Contribution of Each Dimension to the GDI 1999-2008

	2008	2004	1999	Change 1999-2004 (%)	Change 2004-2008 (%)	Change 1999-2008 (%)	Contribution to Change 1999-2004 (% point)	Contribution to Change 2004-2008 (% point)	Contribution to Change 1999-2008 (% point)	Contribution (%) 1999-2004	Contribution (%) 2004-2008	Contribution (%) 1999-2008
Overall												
Life Expectancy Index	0.796	0.784	72.2	8.6	1.5	10.2	3.2	0.6	3.8	40.8	14.7	31.9
Education Index	0.830	0.826	80.3	2.8	0.5	34	1.2	0.2	1.4	15.0	5.7	11.8
Income Index	0.558	0.495	42.8	15.6	12.7	30.3	3.4	3.0	6.6	44.2	79.6	56.3
GDI	0.728	0.702	65.1	7.8	3.7	11.8	7.8	3.7	11.8	100.0	100.0	100.0
Northern Midland and Mountain Areas												
Life Expectancy Index	0.750	0.722	68.1	6.0	3.9	10.2	2.4	1.5	4.0	29.8	24.7	27.5
Education Index	0.794	0.788	75.9	3.9	0.8	46	1.7	0.3	2.0	21.3	5.2	13.9
Income Index	0.443	0.362	29.5	22.8	22.3	50.2	3.9	4.3	8.5	48.9	70.1	58.6
GDI	0.663	0.624	57.8	7.9	6.1	14.6	7.9	6.1	14.6	100.0	100.0	100.0
Red River Delta												
Life Expectancy Index	0.819	0.809	78.6	2.9	1.2	4.1	1.1	0.4	1.6	23.6	11.0	17.6
Education Index	0.852	0.854	84.1	1.6	-0.2	1.4	0.7	-0.1	0.6	14.1	-2.0	6.4
Income Index	0.568	0.488	42.9	13.9	16.2	32.4	2.9	3.7	6.8	62.2	91.0	75.9
GDI	0.746	0.717	68.5	4.7	4.0	8.9	4.7	4.0	8.9	100.0	100.0	100.0
North Central Area and Central Coastal Area												
Life Expectancy Index	0.778	0.770	72.4	6.3	1.1	7.5	2.4	0.4	2.9	32.3	8.9	22.8

	2008	2004	1999	Change 1999-2004 (%)	Change 2004-2008 (%)	Change 1999-2008 (%)	Contribution to Change 1999-2004 (% point)	Contribution to Change 2004-2008 (% point)	Contribution to Change 1999-2008 (% point)	Contribution (%) 1999-2004	Contribution (%) 2004-2008	Contribution (%) 1999-2008
Education Index	0.857	0.850	82.7	2.7	0.9	3.6	1.2	0.4	1.6	15.9	7.9	12.6
Income Index	0.491	0.411	33.8	21.6	19.6	45.4	3.9	4.0	8.1	51.8	83.2	64.5
GDI	0.709	0.677	63.0	7.5	4.8	12.6	7.5	4.8	12.6	100.0	100.0	100.0
Central Highlands												
Life Expectancy Index	0.757	0.702	63.9	9.8	7.8	18.4	3.6	2.9	6.7	49.0	27.6	36.0
Education Index	0.825	0.800	77.6	3.0	3.2	6.3	1.4	1.4	2.8	18.4	12.7	15.0
Income Index	0.487	0.369	32.7	12.7	32.2	49.0	2.4	6.3	9.2	32.5	59.7	49.1
HDI	0.690	0.623	58.1	7.3	10.6	18.7	7.3	10.6	18.7	100.0	100.0	100.0
South East												
Life Expectancy Index	0.836	0.825	85.3	-3.2	1.4	-1.9	-1.3	0.5	-0.7	-44.9	70.4	-20.8
Education Index	0.821	0.836	80.2	4.2	-1.8	2.3	1.5	-0.7	0.8	54.5	-93.0	23.7
Income Index	0.620	0.600	54.4	10.2	3.3	13.9	2.5	0.9	3.4	90.4	122.6	97.1
GDI	0.759	0.753	73.3	2.8	0.7	3.5	2.8	0.7	3.5	100.0	100.0	100.0
Mekong River Delta												
Life Expectancy Index	0.808	0.787	73.1	7.7	2.7	10.6	3.0	1.1	4.1	38.3	17.5	28.8
Education Index	0.800	0.786	76.1	3.2	1.8	5.1	1.3	0.7	2.1	16.8	11.5	14.4
Income Index	0.536	0.449	38.3	17.2	19.5	40.0	3.5	4.3	8.2	44.9	71.0	56.9
GDI	0.715	0.674	62.5	7.8	6.1	14.4	7.8	6.1	14.4	100.0	100.0	100.0

Source: Based on calculations for the NHDR by VASS and GSO 2011

Human Poverty Index 2008

HDI Rank	HPI Rank	Province	People Not Expected to Live to Age 40 (%)	Adult Illiteracy Rate (% of people 15 and older)	Proportion of People without Access to Clean Water (%)	Children under 5 Malnourished (%)	Overall Poverty Indicator (HPI)
		Whole Country	5.66	6.40	10.38	19.90	10.93
1	5	Ba Ria-Vung Tau	3.59	4.66	0.53	14.10	5.64
2	1	Ho Chi Minh City	3.24	2.77	0.18	4.60	2.84
3	2	Hanoi	3.89	2.87	0.27	8.20	3.75
4	3	Da Nang	3.98	3.00	2.62	11.20	5.19
5	25	Quang Ninh	5.68	4.17	7.64	20.00	9.88
6	43	Can Tho	3.46	5.41	19.10	17.70	12.89
7	8	Bac Ninh	4.73	3.86	0.46	18.90	7.09
8	4	Hai Phong	4.25	3.34	0.18	14.10	5.42
9	7	Dong Nai	3.54	3.95	3.97	14.90	6.81
10	18	Vinh Phuc	4.61	3.60	1.46	21.80	8.30
11	21	Khanh Hoa	5.84	4.47	7.12	17.50	8.95
12	15	Long An	3.98	5.92	3.63	16.90	7.67
13	61	Vinh Long	4.32	4.96	64.91	21.60	30.02
14	41	Ben Tre	4.65	5.77	17.25	18.80	12.70
15	10	Ca Mau	5.32	3.37	0.12	19.40	7.20
16	27	Kien Giang	5.32	9.91	5.87	19.60	10.21
17	6	Binh Duong	3.54	3.54	0.64	15.40	5.86
18	23	Lam Dong	5.19	7.09	6.44	18.90	9.45
19	16	Hai Duong	4.61	3.61	2.95	19.70	8.11
20	17	Tien Giang	4.32	7.22	3.19	18.20	8.24
21	20	Tay Ninh	5.00	7.57	1.68	19.90	8.46
22	9	Thai Binh	4.25	3.52	0.00	19.80	7.14
23	24	Binh Dinh	6.50	4.64	4.06	22.40	9.64
24	13	Hung Yen	4.73	4.16	0.19	19.70	7.29
25	19	Ninh Binh	5.62	3.40	1.00	22.30	8.43
26	12	Bac Lieu	5.00	5.04	0.04	19.20	7.25
27	32	Ha Tinh	6.41	2.57	5.88	23.90	10.61

HDI Rank	HPI Rank	Province	People Not Expected to Live to Age 40 (%)	Adult Illiteracy Rate (% of people 15 and older)	Proportion of People without Access to Clean Water (%)	Children under 5 Malnourished (%)	Overall Poverty Indicator (HPI)
28	28	Binh Thuan	5.32	7.13	6.15	21.70	10.23
29	30	Quang Nam	7.34	4.40	8.53	20.40	10.53
30	31	Thai Nguyen	5.24	3.66	9.40	20.60	10.60
31	14	Ha Nam	5.60	4.53	0.37	19.00	7.32
32	52	An Giang	5.99	9.39	38.90	18.20	20.09
33	11	Nam Dinh	4.83	4.25	0.16	19.40	7.21
34	38	Thanh Hoa	5.99	5.22	8.22	26.00	12.14
35	49	Lang Son	6.92	7.00	24.58	23.10	16.80
36	34	Hau Giang	4.32	8.22	11.77	18.30	11.04
37	44	Quang Binh	7.31	3.89	11.52	28.30	14.06
38	36	Binh Phuoc	6.67	6.76	10.32	22.30	11.81
39	33	Nghe An	6.50	5.74	6.28	23.50	10.79
40	35	Thua Thien-Hue	8.03	8.88	9.74	18.60	11.06
41	46	Dak Lak	7.69	9.22	11.35	29.10	14.69
42	29	Phu Yen	7.34	5.87	6.39	21.30	10.27
43	59	Dong Thap	5.64	10.58	59.42	20.30	27.83
44	40	Quang Ngai	7.01	10.47	10.11	22.60	12.51
45	26	Bac Giang	6.08	3.76	5.56	22.50	10.04
46	22	Phu Tho	6.60	4.40	3.73	21.60	9.29
47	39	Quang Tri	12.97	7.81	7.26	21.40	12.31
48	42	Soc Trang	5.99	16.37	3.03	20.60	12.77
49	48	Tuyen Quang	6.96	5.55	22.10	24.00	16.20
50	47	Dak Nong	9.30	10.67	13.13	30.50	16.05
51	45	Hoa Binh	6.96	6.33	16.00	25.00	14.53
52	37	Tra Vinh	5.99	13.58	4.43	21.90	11.86
53	54	Gia Lai	8.97	12.00	33.96	28.40	22.19
54	55	Bac Can	6.96	8.68	38.07	28.30	23.22
55	57	Cao Bang	9.92	16.19	47.27	23.90	25.59

HDI Rank	HPI Rank	Province	People Not Expected to Live to Age 40 (%)	Adult Illiteracy Rate (% of people 15 and older)	Proportion of People without Access to Clean Water (%)	Children under 5 Malnourished (%)	Overall Poverty Indicator (HPI)
56	50	Ninh Thuan	7.86	14.32	20.13	25.50	17.21
57	58	Lao Cai	12.23	19.40	41.28	28.40	25.78
58	56	Kon Tum	13.02	16.62	34.75	30.20	23.92
59	53	Son La	9.51	18.81	27.14	25.60	20.50
60	51	Yen Bai	9.92	16.56	27.85	24.70	19.90
61	62	Dien Bien	13.51	28.45	60.58	24.40	32.42
62	60	Ha Giang	12.82	26.90	47.89	27.50	29.26
63	63	Lai Chau	16.12	38.41	67.95	28.50	38.63
Region	People Not Expected to Live to Age 40 (%)	Adult Illiteracy Rate (% of people 15 and older)	Proportion of People without Access to Clean Water (%)	Children under 5 Malnourished (%)	Overall Poverty Indicator (HPI)		
Northern Midlands and Mountainous Areas	8.46	11.97	24.43	24.12	17.98		
Red River Delta	4.49	3.5	0.99	15.56	6.25		
North Central Area and Central Coastal Area	6.68	5.86	7.61	22.38	11.00		
Central Highlands	8.02	10.17	17.94	26.77	16.23		
South East	3.7	3.82	1.68	10.52	5.05		
Mekong River Delta	5.02	8.33	19.31	19.18	14.28		

Source: Calculated for the NHDR by VASS and GSO 2011

Human Poverty Index 2004

HDI Rank	HPI Rank	Province	People Not Expected to Live to Age 40 (%)	Adult Illiteracy Rate (% of People 15 and Older)	Proportion of People without Access to Clean Water (%)	Children under 5 Malnourished (%)	Overall Poverty Indicator (HPI)
		Whole Country	6.30	6.70	15.90	26.6	15.01
1	31	Ba Ria-Vung Tau	3.70	4.71	21.00	21.2	14.71
2	1	Ho Chi Minh City	2.90	3.16	2.30	10.9	4.86
3	4	Da Nang	3.00	3.20	0.70	21.4	7.77
4	3	Hai Phong	4.40	3.26	0.50	19.7	7.26
5	2	Hanoi (including Ha Tay)	4.89	3.00	0.66	18.3	6.96
6	5	Dong Nai	5.80	4.17	5.50	19.3	8.98
7	19	Quang Ninh	6.20	4.08	8.00	25.0	11.69
8	17	Binh Duong	5.60	3.62	9.40	22.2	11.16
9	23	Khanh Hoa	5.30	5.79	10.70	23.8	12.22
10	9	Hai Duong	4.20	3.31	0.70	26.2	9.46
11	51	Can Tho	6.00	6.18	45.10	24.1	24.08
12	11	Bac Ninh	5.90	3.82	0.30	27.0	9.78
13	18	Vinh Phuc	5.30	3.28	3.30	29.0	11.36
14	6	Ca Mau	6.20	4.05	0.80	24.0	9.03
15	57	Vinh Long	4.40	4.72	65.60	27.4	32.26
16	12	Hung Yen	5.50	4.42	0.80	26.9	9.90
17	34	Kien Giang	5.40	10.72	16.70	24.7	15.07
18	16	Long An	5.30	5.45	8.90	22.0	11.01
19	38	Quang Nam	6.20	6.55	17.40	27.9	15.94
20	8	Ha Nam	3.90	4.23	1.80	25.0	9.46
21	7	Nam Dinh	5.70	3.56	0.30	25.9	9.38
22	28	Tien Giang	5.10	6.58	15.40	23.4	13.70
23	10	Thai Binh	5.50	3.28	0.60	26.2	9.54
24	13	Bac Lieu	7.40	6.13	2.80	24.3	10.14
25	47	Ben Tre	7.10	5.27	33.10	25.1	20.31

HDI Rank	HPI Rank	Province	People Not Expected to Live to Age 40 (%)	Adult Illiteracy Rate (% of People 15 and Older)	Proportion of People without Access to Clean Water (%)	Children under 5 Malnourished (%)	Overall Poverty Indicator (HPI)
26	36	Binh Dinh	7.10	5.23	14.90	29.0	15.46
27	32	Ha Tinh	7.10	3.34	10.20	32.6	15.03
28	20	Tay Ninh	6.90	8.22	7.30	25.2	11.99
29	42	Nghe An	7.10	5.69	19.40	30.3	17.43
30	21	Binh Thuan	6.60	6.49	5.90	28.0	12.19
31	14	Ninh Binh	5.90	3.13	1.20	28.1	10.41
32	22	Thua Thien Hue	7.00	9.11	4.80	27.9	12.22
33	25	Lam Dong	6.40	7.89	9.00	25.3	12.46
34	15	Phu Tho	6.30	3.96	3.10	27.7	10.97
35	26	Thai Nguyen	7.40	3.93	8.50	28.3	13.07
36	37	Thanh Hoa	7.60	4.80	10.60	33.8	15.65
37	40	Quang Binh	8.90	4.94	11.80	35.7	16.80
38	61	Dong Thap	5.70	9.43	76.00	25.6	35.31
39	54	An Giang	7.30	11.65	58.90	26.7	29.92
40	46	Hau Giang	7.20	9.65	32.30	25.0	20.22
41	35	Tra Vinh	7.10	15.23	10.80	27.0	15.25
42	30	Binh Phuoc	7.40	6.17	12.60	28.5	14.59
43	39	Tuyen Quang	10.00	5.26	14.80	31.3	16.47
44	52	Lang Son	11.60	6.92	39.00	29.8	24.22
45	24	Phu Yen	10.60	5.18	3.50	29.2	12.39
46	33	Quang Ngai	7.30	10.49	10.10	31.0	15.05
47	29	Soc Trang	7.50	13.98	9.00	26.7	14.34
48	27	Bac Giang	9.40	3.63	6.90	29.8	13.30
49	41	Quang Tri	12.80	9.36	18.60	27.7	17.22
50	43	Ninh Thuan	7.80	14.32	18.90	30.8	18.42
51	48	Hoa Binh	9.50	6.15	28.10	32.2	21.18
52	44	Dak Nong	11.50	9.30	16.90	36.6	19.27
53	45	Dak Lak	11.00	11.63	19.50	36.4	20.20

HDI Rank	HPI Rank	Province	People Not Expected to Live to Age 40 (%)	Adult Illiteracy Rate (% of People 15 and Older)	Proportion of People without Access to Clean Water (%)	Children under 5 Malnourished (%)	Overall Poverty Indicator (HPI)
54	55	Bac Can	10.00	9.60	52.70	35.6	30.83
55	49	Yen Bai	9.60	15.06	27.00	31.9	21.51
56	56	Lao Cai	10.60	19.91	54.00	34.6	31.75
57	59	Cao Bang	14.40	19.47	61.60	30.2	32.92
58	58	Son La	10.50	21.35	58.90	31.6	32.56
59	50	Gia Lai	15.10	17.33	28.30	35.0	23.78
60	62	Dien Bien	12.10	28.28	86.40	29.1	41.67
61	53	Kon Tum	20.90	18.29	32.30	35.3	26.18
62	60	Ha Giang	18.80	30.33	58.50	33.4	35.26
63	63	Lai Chau	14.20	40.82	92.60	36.2	48.30
Region	People Not Expected to Live to Age 40 (%)	Adult Illiteracy Rate (% of People 15 and Older)	Proportion of People without Access to Clean Water (%)	Children under 5 Malnourished (%)	Overall Poverty Indicator (HPI)		
Northern Midlands and Mountainous Areas	10.30	12.29	32.65	30.83	22.93		
Red River Delta	5.12	3.40	1.25	23.38	8.83		
North Central Area and Central Coastal Area	7.26	6.17	11.97	29.95	14.94		
Central Highlands	11.76	12.48	19.98	33.36	19.65		
South East	4.37	4.13	6.04	16.59	8.16		
Mekong River Delta	6.23	8.56	31.15	25.07	20.02		

Source: Calculated for the NHDR by VASS and GSO 2011

Human Poverty Index 1999

HDI Rank	HPI Rank	Province	People Not Expected to Live to Age 40 (%)	Adult Illiteracy Rate (% of People 15 and Older)	Proportion of People without Access to Clean Water (%)	Children under 5 Malnourished (%)	Overall Poverty Indicator (HPI)
		Whole Country	9.70	9.75	22.90	36.70	21.13
1	5	Ba Ria-Vung Tau	8.60	7.30	6.09	34.00	14.47
2	1	Ho Chi Minh City	5.00	5.59	1.22	18.10	7.37
3	7	Binh Duong	6.29	7.22	6.81	34.50	14.65
4	2	Da Nang	5.49	6.05	4.81	27.60	11.57
5	6	Hai Phong	6.54	4.95	7.35	33.90	14.52
6	4	Dong Nai	7.24	7.34	6.04	32.20	13.73
7	3	Hanoi (including Ha Tay)	5.97	4.73	5.66	27.42	11.73
8	16	Quang Ninh	10.00	7.62	12.97	33.30	16.64
9	8	Vinh Phuc	7.57	6.10	3.62	37.70	14.67
10	13	Tay Ninh	5.69	11.07	8.50	34.90	15.77
11	11	Hai Duong	7.38	5.66	8.66	35.10	15.45
12	10	Bac Ninh	6.25	6.15	7.18	36.70	15.44
13	14	Hung Yen	6.75	6.18	6.43	39.80	16.26
14	20	Lam Dong	8.80	10.17	12.85	34.40	17.07
15	33	Long An	7.85	8.58	33.38	29.90	22.19
16	21	Khanh Hoa	10.48	8.46	11.10	36.40	17.16
17	23	Ninh Binh	10.71	5.95	11.84	36.50	17.31
18	28	Binh Phuoc	9.47	12.87	10.26	41.50	18.92
19	26	Binh Thuan	7.74	11.53	13.47	39.10	18.87
20	9	Thai Binh	6.35	5.16	9.97	32.20	14.82
21	57	Vinh Long	8.05	9.51	83.52	33.70	40.73
22	44	Tien Giang	9.30	9.31	48.18	31.50	27.86
23	19	Ha Nam	6.45	5.99	13.61	34.90	17.01
24	31	Nghe An	11.65	7.09	12.71	45.10	20.56
25	15	Nam Dinh	5.00	5.34	8.36	39.30	16.64
26	12	Thai Nguyen	9.00	5.33	5.78	37.80	15.52
27	27	Ha Tinh	8.65	5.53	9.49	44.20	18.87

HDI Rank	HPI Rank	Province	People Not Expected to Live to Age 40 (%)	Adult Illiteracy Rate (% of People 15 and Older)	Proportion of People without Access to Clean Water (%)	Children under 5 Malnourished (%)	Overall Poverty Indicator (HPI)
28	32	Ca Mau	13.50	7.49	23.87	33.50	20.67
29	25	Quang Nam	8.98	9.58	10.83	39.00	17.85
30	40	Kien Giang	10.21	12.35	37.91	30.60	24.32
31	50	Can Tho	11.01	10.76	66.89	32.50	34.70
32	18	Thua Thien Hue	9.05	14.17	9.61	34.70	16.89
33	30	Bac Lieu	13.03	11.29	23.98	31.90	20.40
34	17	Phu Tho	10.78	5.37	7.03	39.80	16.81
35	39	Tuyen Quang	8.55	11.22	26.77	40.90	23.86
36	22	Binh Dinh	9.66	7.72	8.14	39.90	17.18
37	24	Bac Giang	11.80	6.72	6.04	42.30	17.49
38	52	An Giang	8.42	15.35	73.00	32.80	37.02
39	36	Soc Trang	7.62	14.72	30.29	33.90	23.04
40	43	Quang Binh	13.07	8.09	27.00	51.50	27.62
41	37	Phu Yen	26.45	9.98	12.09	41.30	23.42
42	55	Ben Tre	10.22	9.72	79.95	33.70	39.54
43	29	Thanh Hoa	9.71	8.20	12.03	41.30	18.95
44	45	Tra Vinh	10.82	17.36	47.00	31.80	28.25
45	34	Quang Tri	12.20	13.04	22.75	39.20	22.41
46	46	Ninh Thuan	11.18	18.36	41.99	39.80	29.37
47	51	Bac Can	10.57	14.99	59.39	43.20	35.96
48	35	Dak Lak	19.19	12.90	8.23	51.10	22.75
49	58	Dong Thap	8.87	14.31	86.57	31.80	41.28
50	38	Quang Ngai	15.69	12.60	19.84	45.10	23.73
51	48	Lang Son	14.53	10.58	50.58	42.50	32.72
52	42	Yen Bai	12.95	16.78	31.30	40.60	26.10
53	41	Hoa Binh	9.28	8.08	28.33	43.30	25.07
54	54	Cao Bang	18.46	25.02	65.99	41.50	38.94
55	47	Kon Tum	28.60	24.44	30.80	44.20	31.16

HDI Rank	HPI Rank	Province	People Not Expected to Live to Age 40 (%)	Adult Illiteracy Rate (% of People 15 and Older)	Proportion of People without Access to Clean Water (%)	Children under 5 Malnourished (%)	Overall Poverty Indicator (HPI)
56	53	Lao Cai	13.89	34.99	54.23	45.50	38.37
57	56	Son La	16.94	30.86	68.66	39.40	40.00
58	49	Gia Lai	22.77	27.45	41.73	46.70	34.10
59	59	Ha Giang	20.59	38.99	63.46	43.00	41.78
60	60	Lai Chau	19.01	46.65	76.75	43.20	47.63
61	61	Dien Bien					
62	62	Dak Nong					
63	63	Hau Giang					
Region			People Not Expected to Live to Age 40 (%)	Adult Illiteracy Rate (% of People 15 and Older)	Proportion of People without Access to Clean Water (%)	Children under 5 Malnourished (%)	Overall Poverty Indicator (HPI)
Northern Midlands and Mountainous Areas			13.06	16.95	34.36	41.41	27.83
Red River Delta			6.73	5.47	7.89	33.45	14.60
North Central Area and Central Coastal Area			11.00	9.17	13.52	41.10	19.76
Central Highlands			18.22	16.61	19.13	45.41	24.72
South East			6.16	7.17	4.22	26.37	11.23
Mekong River Delta			9.73	11.83	55.61	32.26	30.88

Source: Calculated for the NHDR by VASS and GSO 2011

HPI Change 1999-2008

2008 HPI Rank	Province	HPI 2008	HPI 2004	HPI 1999	Change 1999-2004 (%)	Change 2004-2008 (%)	Change 1999-2008 (%)
	Whole Country	10.93	15.01	21.13	-28.96%	-27.21%	-48.29%
1	Ho Chi Minh City	2.84	4.86	7.37	-34.12%	-41.45%	-61.42%
2	Hanoi (including Ha Tay)	3.75	6.96	11.73	-40.70%	-46.06%	-68.01%
3	Da Nang	5.19	7.77	11.57	-32.80%	-33.20%	-55.11%
4	Hai Phong	5.42	7.26	14.52	-49.96%	-25.35%	-62.65%
5	Ba Ria-Vung Tau	5.64	14.71	14.47	1.69%	-61.64%	-60.99%
6	Binh Duong	5.86	11.16	14.65	-23.86%	-47.46%	-59.99%
7	Dong Nai	6.81	8.98	13.73	-34.58%	-24.23%	-50.43%
8	Bac Ninh	7.09	9.78	15.44	-36.66%	-27.47%	-54.06%
9	Thai Binh	7.14	9.54	14.82	-35.61%	-25.21%	-51.84%
10	Ca Mau	7.20	9.03	20.67	-56.29%	-20.33%	-65.18%
11	Nam Dinh	7.21	9.38	16.64	-43.60%	-23.14%	-56.65%
12	Bac Lieu	7.25	10.14	20.40	-50.31%	-28.48%	-64.46%
13	Hung Yen	7.29	9.90	16.26	-39.12%	-26.37%	-55.18%
14	Ha Nam	7.32	9.46	17.01	-44.36%	-22.63%	-56.95%
15	Long An	7.67	11.01	22.19	-50.41%	-30.33%	-65.45%
16	Hai Duong	8.11	9.46	15.45	-38.73%	-14.36%	-47.53%
17	Tien Giang	8.24	13.70	27.86	-50.81%	-39.84%	-70.41%
18	Vinh Phuc	8.30	11.36	14.67	-22.59%	-26.89%	-43.41%
19	Ninh Binh	8.43	10.41	17.31	-39.89%	-18.98%	-51.29%
20	Tay Ninh	8.46	11.99	15.77	-23.94%	-29.50%	-46.37%
21	Khanh Hoa	8.95	12.22	17.16	-28.76%	-26.74%	-47.81%
22	Phu Tho	9.29	10.97	16.81	-34.71%	-15.36%	-44.74%
23	Lam Dong	9.45	12.46	17.07	-27.02%	-24.14%	-44.64%
24	Binh Dinh	9.64	15.46	17.18	-10.05%	-37.61%	-43.88%
25	Quang Ninh	9.88	11.69	16.64	-29.72%	-15.50%	-40.61%
26	Bac Giang	10.04	13.30	17.49	-23.98%	-24.48%	-42.59%
27	Kien Giang	10.21	15.07	24.32	-38.04%	-32.25%	-58.02%

2008 HPI Rank	Province	HPI 2008	HPI 2004	HPI 1999	Change 1999-2004 (%)	Change 2004-2008 (%)	Change 1999-2008 (%)
28	Binh Thuan	10.23	12.19	18.87	-35.42%	-16.05%	-45.78%
29	Phu Yen	10.27	12.39	23.42	-47.11%	-17.07%	-56.14%
30	Quang Nam	10.53	15.94	17.85	-10.75%	-33.90%	-41.00%
31	Thai Nguyen	10.60	13.07	15.52	-15.82%	-18.92%	-31.75%
32	Ha Tinh	10.61	15.03	18.87	-20.33%	-29.44%	-43.78%
33	Nghe An	10.79	17.43	20.56	-15.24%	-38.12%	-47.55%
34	Hau Giang	11.04	20.22			-45.41%	
35	Thua Thien-Hue	11.06	12.22	16.89	-27.68%	-9.42%	-34.50%
36	Binh Phuoc	11.81	14.59	18.92	-22.87%	-19.04%	-37.56%
37	Tra Vinh	11.86	15.25	28.25	-46.03%	-22.25%	-58.04%
38	Thanh Hoa	12.14	15.65	18.95	-17.45%	-22.42%	-35.96%
39	Quang Tri	12.31	17.22	22.41	-23.14%	-28.51%	-45.05%
40	Quang Ngai	12.51	15.05	23.73	-36.59%	-16.90%	-47.31%
41	Ben Tre	12.70	20.31	39.54	-48.63%	-37.47%	-67.88%
42	Soc Trang	12.77	14.34	23.04	-37.78%	-10.90%	-44.56%
43	Can Tho	12.89	24.08	34.70	-30.60%	-46.45%	-62.84%
44	Quang Binh	14.06	16.80	27.62	-39.18%	-16.29%	-49.09%
45	Hoa Binh	14.53	21.18	25.07	-15.53%	-31.38%	-42.04%
46	Dak Lak	14.69	20.20	22.75	-11.19%	-27.29%	-35.42%
47	Dak Nong	16.05	19.27			-16.71%	
48	Tuyen Quang	16.20	16.47	23.86	-31.00%	-1.61%	-32.11%
49	Lang Son	16.80	24.22	32.72	-25.99%	-30.63%	-48.65%
50	Ninh Thuan	17.21	18.42	29.37	-37.27%	-6.57%	-41.39%
51	Yen Bai	19.90	21.51	26.10	-17.61%	-7.46%	-23.75%
52	An Giang	20.09	29.92	37.02	-19.18%	-32.87%	-45.75%
53	Son La	20.50	32.56	40.00	-18.60%	-37.03%	-48.74%
54	Gia Lai	22.19	23.78	34.10	-30.25%	-6.71%	-34.93%
55	Bac Can	23.22	30.83	35.96	-14.26%	-24.71%	-35.44%
56	Kon Tum	23.92	26.18	31.16	-15.95%	-8.66%	-23.23%
57	Cao Bang	25.59	32.92	38.94	-15.46%	-22.27%	-34.29%

2008 HPI Rank	Province	HPI 2008	HPI 2004	HPI 1999	Change 1999-2004 (%)	Change 2004-2008 (%)	Change 1999-2008 (%)
58	Lao Cai	25.78	31.75	38.37	-17.26%	-18.80%	-32.81%
59	Dong Thap	27.83	35.31	41.28	-14.44%	-21.18%	-32.56%
60	Ha Giang	29.26	35.26	41.78	-15.60%	-17.04%	-29.98%
61	Vinh Long	30.02	32.26	40.73	-20.80%	-6.96%	-26.31%
62	Dien Bien	32.42	41.67			-22.19%	
63	Lai Chau	38.63	48.30	47.63	1.41%	-20.01%	-18.88%

Region	HPI 2008	HPI 2004	HPI 1999	Change 1999-2004 (%)	Change 2004-2008 (%)	Change 1999-2008 (%)
Northern Midlands and Mountainous Areas	17.98	22.93	27.83	-17.62%	-21.58%	-35.40%
Red River Delta	6.25	8.83	14.60	-39.55%	-29.19%	-57.19%
North Central Area and Central Coastal Area	11	14.94	19.76	-24.38%	-26.39%	-44.33%
Central Highlands	16.23	19.65	24.72	-20.53%	-17.39%	-34.35%
South East	5.05	8.16	11.23	-27.29%	-38.14%	-55.02%
Mekong River Delta	14.28	20.02	30.88	-35.18%	-28.67%	-53.76%

Source: Calculated for the MHDR by VASS and GSO 2011

HPI change and contribution of each dimension to the HPI 1999-2008

	HPI 2008	HPI 2004	HPI 1999	Change 1999-2004 (%)	Change 2004-2008 (%)	Change 1999-2008 (%)	Contribution to Change 1999-2004 (% point)	Contribution to Change 2004-2008 (% point)	Contribution to Change 1999-2008 (% point)	Contribution (%) 1999-2004	Contribution (%) 2004-2008	Contribution (%) 1999-2008
Whole Country												
People not expected to live to age 40 (%)	5.66	6.30	9.70	-35.1	-10.2	-41.7	-6.4	-2.6	-8.8	22.1	9.6	18.3
Adult illiteracy rate (% of people 15 and older)	6.40	6.30	9.75	-35.4	1.5	-34.4	-6.5	0.4	-7.3	22.4	-1.5	15.2
Proportion of people without access to clean water (%)	15.14	21.25	29.80	-28.7	-28.8	-49.2	-16.1	-25.0	-32.1	55.5	91.8	66.5
HPI	10.93	15.01	21.13	-29.0	-27.2	-48.3	-29.0	-27.2	-48.3	100.0	100.0	100.0
Northern Midlands and Mountainous Areas												
People not expected to live to age 40 (%)	8.46	10.30	13.06	-21.1	-17.9	-35.2	-3.5	-4.2	-7.0	20.3	19.1	19.8
Adult illiteracy rate (% of people 15 and older)	11.97	12.29	16.95	-27.5	-2.6	-29.4	-5.9	-0.7	-7.6	34.3	3.3	21.5
Proportion of people without access to clean water (%)	24.28	31.74	37.88	-16.2	-23.5	-35.9	-7.8	-17.0	-20.7	45.3	77.5	58.7
HPI	17.70	22.66	27.36	-17.2	-21.9	-35.3	-17.2	-21.9	-35.3	100.0	100.0	100.0
Red River Delta												
People not expected to live to age 40 (%)	4.49	5.12	6.73	-24.0	-12.2	-33.3	-5.3	-4.1	-7.8	13.4	13.	13.5
Adult illiteracy rate (% of people 15 and older)	3.50	3.40	5.47	-37.9	3.1	-36.0	-6.8	0.7	-6.9	17.2	-2.3	11.9
Proportion of people without access to clean water (%)	8.28	12.32	20.67	-40.4	-32.8	-60.0	-27.5	-26.6	-43.1	69.4	88.5	74.6
HPI	6.16	8.79	14.58	-39.7	-30.0	-57.8	-39.7	-30.0	-57.8	100.0	100.0	100.0
North Central Area and Central Coastal Area												
People not expected to live to age 40 (%)	6.68	7.26	11.00	-34.0	-8.0	-39.3	-6.9	-2.3	-9.6	28.6	8.5	21.7
Adult illiteracy rate (% of people 15 and older)	5.86	6.17	9.17	-32.8	-5.0	-36.1	-5.5	-1.2	-7.4	23.0	4.5	16.6
Proportion of people without access to clean water (%)	15.00	20.96	27.31	-23.3	-28.5	-45.1	-11.7	-23.2	-27.4	48.5	87.1	61.7

	HPI 2008	HPI 2004	HPI 1999	Change 1999- 2004 (%)	Change 2004- 2008 (%)	Change 1999- 2008 (%)	Contribution to Change (% point) 1999-2004	Contribution to Change (% point) 2004-2008	Contribution to Change (% point) 1999-2008	Contribution (%) 1999-2004	Contribution (%) 2004-2008	Contribution (%) 1999-2008
HPI	10.89	14.85	19.57	-24.1	-26.7	-44.4	-24.1	-26.7	-44.4	100.0	100.0	100.0
Central Highlands												
People not expected to live to age 40 (%)	8.02	11.76	18.22	-35.5	-31.8	-56.0	-8.0	-6.2	-13.0	39.9	36.1	38.4
Adult illiteracy rate (% of people 15 and older)	10.17	12.48	16.61	-24.9	-18.5	-38.8	-5.1	-3.9	-8.2	25.5	22.3	24.2
Proportion of people without access to clean water (%)	22.36	26.67	32.27	-17.4	-16.2	-30.7	-7.0	-7.2	-12.7	34.6	41.6	37.3
HPI	16.19	19.58	24.52	-20.1	-17.3	-34.0	-20.1	-17.3	-34.0	100.0	100.0	100.0
South East												
People not expected to live to age 40 (%)	3.70	4.37	6.16	-29.2	-15.3	-40.0	-5.6	-4.4	-9.4	20.4	10.8	16.4
Adult illiteracy rate (% of people 15 and older)	3.82	4.13	7.17	-42.4	-7.6	-46.7	-9.4	-2.1	-12.7	34.5	5.1	22.3
Proportion of people without access to clean water (%)	6.10	11.31	15.29	-26.0	-46.1	-60.1	-12.4	-34.3	-34.9	45.1	84.2	61.3
HPI	4.81	8.11	11.17	-27.4	-40.7	-57.0	-27.4	-40.7	-57.0	100.0	100.0	100.0
Mekong River Delta												
People not expected to live to age 40 (%)	5.02	6.23	9.73	-36.0	-19.4	-48.4	-5.6	-3.6	-7.9	15.5	11.7	14.3
Adult illiteracy rate (% of people 15 and older)	8.33	8.56	11.83	-27.7	-2.6	-29.6	-5.2	-0.7	-5.9	14.5	2.2	10.6
Proportion of people without access to clean water (%)	19.25	28.11	43.93	-36.0	-31.5	-56.2	-25.1	-26.0	-41.5	70.0	86.1	75.0
HPI	13.77	19.74	30.77	-35.8	-30.2	-55.2	-35.8	-30.2	-55.2	100.0	100.0	100.0

Source: Based on calculations for the NHDR by VASS and GSO 2011

Multi-dimensional Poverty Indicator and Monetary Poverty 2008

HDI Rank	MPI Rank	Province	MPI		Population in Multi-dimensional Poverty		Population at Risk of Multidimensional Poverty*	Population with at Least One Severe Deprivation in: **			PPP\$2 a day		Monetary Poverty***	
			H*A	H% (A) (%)	Headcount (H) (%)	Intensity of Deprivation (A) (%)		Education (%)	Health (%)	Living Standards (%)	PPP\$1.25 a day (%)	National Poverty Line (%)		
		Whole Country	0.0936	40.2	23.3	40.2	20.2	1.6	20.0	17.5	32.9	13.2	14.6	
3	1	Hanoi	0.0053	34.9	1.5	34.9	7.5	0.4	8.7	0.6	4.9	0.8	1.7	
2	2	Ho Chi Minh City	0.0071	34.1	2.1	34.1	4.6	1.0	13.4	1.0	0.8	0.3	0.5	
19	3	Hai Duong	0.0087	35.0	2.5	35.0	11.4	1.6	10.7	0.9	25.4	8.0	8.9	
7	4	Bac Ninh	0.0091	34.0	2.7	34.0	10.9	1.7	14.1	0.4	24.8	4.7	5.9	
24	5	Hung Yen	0.0100	35.0	2.8	35.0	11.2	1.1	12.7	0.4	31.0	7.2	7.1	
8	6	Hai Phong	0.0108	35.8	3.0	35.8	10.8	1.7	10.2	0.8	19.9	4.1	4.9	
4	7	Da Nang	0.0110	36.3	3.0	36.3	5.0	0.9	12.2	1.9	11.0	2.0	3.0	
22	8	Thai Binh	0.0137	35.1	3.9	35.1	16.7	1.1	11.0	1.3	36.3	8.6	8.5	
1	9	Ba Ria-Vung Tau	0.0151	36.1	4.2	36.1	13.4	0.8	15.7	2.0	19.1	5.3	7.0	
33	10	Nam Dinh	0.0185	36.7	5.0	36.7	16.7	2.1	12.2	1.8	30.6	7.0	7.7	
31	11	Ha Nam	0.0197	36.1	5.5	36.1	22.6	1.2	12.9	1.5	41.5	8.2	8.4	
17	12	Binh Duong	0.0211	35.8	5.9	35.8	17.4	1.4	20.1	2.1	2.2	0.1	0.5	
10	13	Vinh Phuc	0.0244	34.8	7.0	34.8	28.7	2.0	13.9	2.0	31.3	10.1	11.3	
5	14	Quang Ninh	0.0299	43.9	6.8	43.9	10.3	0.5	11.1	4.9	16.8	6.6	7.2	
25	15	Ninh Binh	0.0324	35.3	9.2	35.3	31.8	4.0	13.9	1.8	42.5	11.7	12.9	
45	16	Bac Giang	0.0392	37.4	10.5	37.4	22.4	1.0	15.3	7.4	45.7	16.6	17.5	
27	17	Ha Tinh	0.0441	37.8	11.7	37.8	23.3	4.6	12.8	6.9	57.4	28.0	28.2	
39	18	Nghe An	0.0534	41.6	12.8	41.6	23.7	2.2	13.8	8.6	53.2	25.0	24.9	
46	19	Phu Tho	0.0549	37.1	14.8	37.1	24.2	2.1	11.2	11.3	43.4	16.3	17.4	
23	20	Binh Dinh	0.0552	35.8	15.4	35.8	36.3	1.0	20.6	4.3	34.1	13.3	13.3	
34	21	Thanh Hoa	0.0570	38.0	15.0	38.0	23.5	2.1	14.0	9.5	57.4	26.0	26.3	

		MPI	Population in Multi-dimensional Poverty		Population at Risk of Multidimensional Poverty*	Population with at Least One Severe Deprivation in: **			PPP\$2 a day	Monetary Poverty***	
			Headcount	Intensity of Deprivation		Education	Health	Living Standards		PPP\$1.25 a day	National Poverty Line
37	22	Quang Binh	16.1	37.2	26.6	1.4	12.3	12.9	51.8	22.8	23.6
18	23	Lam Dong	17.4	37.9	23.8	1.8	19.3	9.3	30.6	14.4	18.3
9	24	Dong Nai	16.8	39.5	18.4	1.5	17.3	13.8	11.2	2.3	4.3
11	25	Khanh Hoa	17.4	39.4	18.9	2.1	19.8	11.7	29.8	10.3	10.7
42	26	Phu Yen	19.2	36.0	33.1	1.2	24.1	7.4	39.1	16.7	17.6
30	27	Thai Nguyen	19.7	38.1	22.6	2.2	14.3	14.4	45.1	16.5	17.5
47	28	Quang Tri	20.4	38.5	30.6	2.2	17.9	13.8	47.8	26.9	27.6
28	29	Binh Thuan	20.2	38.8	21.1	0.7	31.0	11.1	31.6	4.9	9.3
40	30	Thua Thien Hue	20.3	40.0	23.2	1.6	26.0	14.4	37.5	13.7	15.7
29	31	Quang Nam	21.3	38.6	25.3	2.0	18.7	14.3	43.8	20.3	20.7
44	32	Quang Ngai	23.4	37.6	27.2	1.2	22.1	14.9	44.9	21.7	21.7
38	33	Binh Phuoc	23.2	40.1	25.9	1.5	21.2	15.7	19.2	7.3	10.1
50	34	Dak Nong	27.0	37.4	36.4	2.2	14.8	19.1	49.5	25.8	26.7
51	35	Hoa Binh	31.2	37.2	36.0	2.4	16.0	22.2	60.1	31.2	32.3
21	36	Tay Ninh	31.9	37.9	26.1	1.4	27.9	22.1	18.8	3.8	5.6
12	37	Long An	35.0	37.4	31.5	1.5	27.2	24.6	28.1	7.2	7.6
41	38	Dak Lak	36.0	37.3	28.7	2.5	20.4	27.0	44.3	19.9	24.6
56	39	Ninh Thuan	33.5	41.0	21.2	3.1	37.5	23.6	52.4	14.5	21.2
20	40	Tien Giang	38.3	37.8	32.3	1.7	31.5	25.6	30.9	9.7	10.7
49	41	Tuyen Quang	41.2	38.2	29.0	2.6	18.9	33.7	53.9	23.1	23.3
6	42	Can Tho	39.3	42.6	19.5	1.0	31.2	31.8	20.7	5.7	6.9
35	43	Lang Son	45.0	38.1	34.1	0.8	19.7	36.0	49.8	20.5	21.2
26	44	Bac Lieu	46.1	38.4	24.2	0.9	28.7	38.4	33.5	11.9	12.4
15	45	Ca Mau	46.2	39.1	26.2	2.0	30.0	35.6	27.0	13.3	13.7
54	46	Bac Can	45.2	40.2	28.4	0.7	18.0	40.1	64.2	38.9	39.9
32	47	An Giang	45.0	42.2	23.1	1.8	36.5	34.4	19.1	8.3	8.5

	MPI	Population in Multi-dimensional Poverty		Population at Risk of Multidimensional Poverty*	Population with at Least One Severe Deprivation in:**			PPP\$2 a day		Monetary Poverty***		
		Headcount	Intensity of Deprivation		Education	Health	Living Standards	PPP\$1.25 a day	National Poverty Line	Monetary Poverty***		
				(H) (%)						(A) (%)	(%)	(%)
53	48	Gia Lai	0.1916	46.3	41.4	24.9	1.5	32.6	34.8	48.9	26.6	29.1
16	49	Kien Giang	0.1987	49.2	40.4	23.8	2.1	32.6	38.4	33.5	8.7	9.5
60	50	Yen Bai	0.1997	45.4	44.0	22.4	2.2	21.4	40.6	53.0	24.6	24.6
14	51	Ben Tre	0.2006	51.0	39.3	29.2	1.4	29.4	39.4	31.6	14.9	15.5
58	52	Kon Tum	0.2074	50.1	41.4	23.2	2.1	26.9	42.1	51.6	25.1	32.0
52	53	Tra Vinh	0.2143	55.0	38.9	25.6	2.5	34.4	43.7	49.1	19.6	20.7
48	54	Soc Trang	0.2363	57.7	41.0	21.0	2.9	38.9	46.7	52.1	18.0	19.2
36	55	Hau Giang	0.2379	60.6	39.3	26.9	2.7	34.1	48.6	37.5	13.1	13.8
59	56	Son La	0.2513	60.1	41.8	25.3	1.2	35.0	46.0	66.9	41.8	42.4
57	57	Lao Cai	0.2591	57.0	45.4	19.4	0.7	32.6	50.0	64.6	37.1	37.7
43	58	Dong Thap	0.2800	65.6	42.7	19.4	1.5	35.3	58.8	38.7	11.1	10.3
55	59	Cao Bang	0.2819	60.9	46.3	22.0	1.4	27.0	57.2	62.4	41.9	42.0
13	60	Vinh Long	0.2898	71.3	40.7	14.8	1.4	25.5	67.2	28.2	9.4	10.0
62	61	Ha Giang	0.3325	73.0	45.6	11.4	0.6	35.7	68.6	74.4	41.4	43.0
61	62	Dien Bien	0.3622	75.0	48.3	11.3	1.5	37.5	71.0	73.6	48.5	49.0
63	63	Lai Chau	0.4119	82.3	50.0	7.8	1.9	43.0	77.7	80.8	60.1	61.3

Region	MPI	Population in Multi-dimensional Poverty		Population at risk of multidimensional poverty*	Population with at Least One Severe Deprivation in**			PPP\$2 a day		Monetary Poverty***	
		Headcount	Intensity of Deprivation		Education	Health	Living Standards	PPP\$1.25 a day	National Poverty Line	Monetary Poverty***	
				(H) (%)						(A) (%)	(%)
Northern Midlands and Mountainous Areas	0.1684	39.5	42.6	23.5	1.6	22.2	33.4	56.1	28.4	29.2	29.2
Red River Delta	0.0132	3.6	36.3	13.6	1.3	11.0	1.2	21.9	5.4	6.8	6.8
North Central Area and Central Coastal Area	0.0647	16.8	38.6	24.5	1.9	18.5	10.3	45.3	19.5	20.4	20.4
Central Highlands	0.1350	34.5	39.2	26.8	2.0	23.2	25.3	43.1	21.1	24.9	24.9
South East	0.0346	9.0	38.2	12.0	1.2	16.5	6.2	6.9	1.8	2.8	2.8

	MPI	Population in Multi-dimensional Poverty		Population at risk of multidimensional poverty*	Population with at Least One Severe Deprivation in **			PPP\$2 a day	Monetary Poverty***	
		Headcount	Intensity of Deprivation		Education	Health	Living Standards		PPP\$1.25 a day	National Poverty Line
Mekong River Delta	0.2004	49.7	40.3	24.7	1.8	32.3	39.8	32.0	11.1	11.7
Urban/Rural										
Urban	0.0232	5.9	39.1	7.3	1.1	12.6	4.0	11.3	3.8	6.7
Rural	0.1205	29.9	40.3	25.1	1.8	22.9	22.6	41.1	16.9	17.7
Ethnicity										
Ethnic minorities	0.2638	61.9	42.6	25.2	1.8	33.9	51.4	71.8	41.0	42.6
Kinh/Hoa	0.0676	17.4	38.8	19.5	1.6	17.9	12.3	26.9	9.0	10.2
By income quintile										
Poorest	0.2069	48.8	42.4	24.9	3.1	31.3	39.1	100.0	68.0	70.8
Second poorest	0.1224	30.9	39.6	25.8	2.1	24.3	23.0	70.6	0.0	1.8
Medium	0.0846	21.9	38.6	24.6	1.4	20.6	15.5	0.0	0.0	0.0
Second richest	0.0479	12.8	37.6	17.3	1.1	15.6	8.8	0.0	0.0	0.0
Richest	0.0206	5.7	36.5	10.1	0.4	9.7	3.7	0.0	0.0	0.0
Gender										
Men	0.0891	22.3	40.0	20.3	1.6	16.1	17.5	32.1	12.7	14.0
Women	0.0978	24.3	40.3	20.2	1.7	23.8	17.5	33.6	13.8	15.2

Source: GSO calculated for the NHDR 2011

(except for the case of combined education and health indicators).

** Percentage of the population suffering a deprivation in:

1. one or more of the two education indicators;
2. health indicator;
3. three or more of the six living standard indicators.

***The monetary poverty indicators are based on the following poverty lines:

1. \$PPP2 a day is equivalent to VND515,722.5 per person per month in 2008.
2. \$PPP1.25 a day is equivalent to VND322,312.8 per person per month in 2008.
3. National poverty line in 2008 is VND290,000 per person per month in rural areas.

HDI Rank			Proportion of People who are Both Poor and Deprived in*										Percentage Contribution of Deprivations in Each Indicator to MPI (%)																			
			Health Care					Education					Living Standards					Health Care					Education					Living Standards				
			MPI Rank	Province	Inaccessibility	Primary School	Child School Attendance	Electricity	Drinking Water	Sanitation	Toilet	House	Assets	Inaccessibility	Primary School	Child School Attendance	Electricity	Drinking Water	Sanitation	Toilet	House	Assets	Inaccessibility	Primary School	Child School Attendance	Electricity	Drinking Water	Sanitation	Toilet	House	Assets	
42	26	Phu Yen	4.4	65.2	75.5	2.9	22.6	99.8	94.6	11.4	10.4	1.37	17.59	6.58	0.89	6.96	30.75	29.15	3.51	3.20												
30	27	Thai Nguyen	7.2	38.2	49.0	6.7	30.0	100.0	92.0	52.6	9.6	2.11	9.01	4.13	1.95	8.74	29.14	26.79	15.33	2.81												
47	28	Quang Tri	7.5	57.3	32.7	1.2	25.4	100.0	97.3	53.2	10.9	2.16	12.01	2.67	0.35	7.34	28.87	28.08	15.37	3.16												
28	29	Binh Thuan	3.1	68.8	71.3	3.9	22.3	96.6	78.0	41.9	25.5	0.90	16.11	6.10	1.12	6.38	27.70	22.37	12.02	7.32												
40	30	Thua Thien-Hue	5.1	61.7	40.2	3.4	45.0	98.4	92.4	37.2	18.3	1.41	13.70	3.08	0.95	12.50	27.32	25.66	10.32	5.07												
29	31	Quang Nam	6.9	53.4	36.0	3.9	35.6	98.8	94.2	39.2	16.8	1.99	11.90	3.00	1.12	10.27	28.45	27.14	11.28	4.84												
44	32	Quang Ngai	3.4	66.2	40.7	4.9	33.4	99.9	90.6	23.7	19.7	1.01	15.69	2.94	1.45	9.85	29.50	26.77	6.99	5.81												
38	33	Binh Phuoc	4.6	58.4	56.4	6.5	34.9	99.8	92.6	49.2	10.9	1.29	12.59	4.69	1.80	9.66	27.67	25.66	13.63	3.01												
50	34	Dak Nong	5.6	42.9	35.5	11.9	37.8	99.9	91.8	40.9	5.8	1.65	9.33	3.37	3.54	11.25	29.70	27.28	12.17	1.72												
51	35	Hoa Binh	6.2	36.2	46.4	3.6	44.3	99.7	97.2	31.2	10.5	1.87	8.39	4.19	1.08	13.24	29.77	29.04	9.31	3.12												
21	36	Tay Ninh	4.2	59.3	54.1	4.6	4.7	99.9	94.4	69.0	1.6	1.23	14.20	4.21	1.34	1.38	29.28	27.68	20.23	0.46												
12	37	Long An	3.5	53.6	37.7	2.7	9.8	99.5	96.1	67.0	4.1	1.03	13.08	2.89	0.79	2.92	29.59	28.57	19.91	1.22												
41	38	Dak Lak	5.5	44.5	38.1	13.9	30.7	99.9	97.9	40.6	2.6	1.63	9.08	4.15	4.16	9.15	29.78	29.19	12.10	0.76												
56	39	Ninh Thuan	7.8	74.7	48.4	4.6	62.8	93.9	86.1	35.0	7.2	2.10	15.15	4.20	1.26	17.03	25.47	23.36	9.48	1.95												
20	40	Tien Giang	4.0	62.6	45.3	0.6	8.1	98.7	96.4	67.9	3.2	1.17	15.14	2.93	0.19	2.38	28.98	28.31	19.94	0.95												
49	41	Tuyen Quang	4.9	33.7	39.7	1.1	49.2	99.8	93.0	52.9	5.2	1.43	7.30	3.74	0.32	14.30	28.98	27.03	15.38	1.52												
6	42	Can Tho	2.1	62.5	50.7	4.5	41.1	99.2	97.1	68.1	9.1	0.55	13.42	2.84	1.18	10.72	25.85	25.31	17.76	2.37												
35	43	Lang Son	1.9	37.1	36.3	21.3	49.4	99.6	97.8	21.7	12.3	0.55	8.52	2.89	6.22	14.40	29.03	28.51	6.31	3.58												
26	44	Bac Lieu	1.9	48.4	44.9	2.2	0.1	99.8	94.9	83.0	16.7	0.55	10.88	2.86	0.63	0.03	28.84	27.43	23.98	4.81												
15	45	Ca Mau	3.8	52.1	59.3	14.3	0.3	100.0	98.5	72.6	7.2	1.08	11.69	4.13	4.05	0.07	28.39	27.95	20.60	2.04												
54	46	Bac Can	1.2	35.1	28.2	15.8	70.0	100.0	96.2	34.6	9.7	0.35	7.27	2.18	4.37	19.35	27.65	26.61	9.56	2.67												
32	47	An Giang	3.8	64.0	43.6	10.5	65.9	98.1	85.3	46.1	8.3	1.01	13.50	2.82	2.76	17.35	25.82	22.45	12.12	2.18												
53	48	Gia Lai	2.3	73.8	52.5	4.1	58.6	100.0	96.2	30.6	14.9	0.63	12.65	5.03	1.10	15.74	26.83	25.81	8.22	4.00												
16	49	Kien Giang	4.1	56.9	45.7	9.1	11.4	99.0	96.5	74.0	13.5	1.14	12.04	3.31	2.50	3.13	27.25	26.55	20.37	3.70												
60	50	Yen Bai	3.7	42.9	34.1	46.4	60.3	100.0	93.3	41.1	10.3	0.94	7.71	2.57	11.72	15.24	25.27	23.57	10.39	2.60												
14	51	Ben Tre	2.8	53.3	33.6	3.9	33.2	100.0	97.9	60.4	5.2	0.79	12.51	1.80	1.11	9.37	28.24	27.63	17.06	1.48												
58	52	Kon Tum	3.5	60.5	31.9	1.4	68.0	100.0	99.3	29.2	20.3	0.95	10.58	3.04	0.36	18.26	26.85	26.66	7.84	5.45												
52	53	Tra Vinh	4.4	58.0	41.7	3.1	8.1	100.0	97.2	76.5	5.0	1.27	13.28	2.72	0.88	2.30	28.54	27.75	21.83	1.43												

		Proportion of People who are Both Poor and Deprived in:*										Percentage Contribution of Deprivations in Each Indicator to MPI (%)										
HDI Rank	MPI Rank	Province	Health Care			Education			Living Standards				Health Care			Education			Living Standards			
			Inaccessibility	Primary School	Child School Attendance	Electricity	Drinking Water	Sanitation	Toilet	House	Assets	Inaccessibility	Primary School	Child School Attendance	Electricity	Drinking Water	Sanitation	Toilet	House	Assets		
48	54	Soc Trang	4.8	61.3	46.5	7.1	5.2	99.2	96.5	78.5	18.6	1.30	13.13	2.84	1.93	1.41	26.89	26.17	21.28	5.05		
36	55	Hau Giang	4.2	52.5	40.2	2.1	19.2	100.0	99.1	71.9	5.8	1.17	11.56	2.94	0.59	5.44	28.29	28.02	20.35	1.64		
59	56	Son La	1.8	60.8	46.8	39.7	45.0	100.0	99.0	19.8	12.7	0.48	11.67	3.89	10.54	11.95	26.54	26.30	5.26	3.38		
57	57	Lao Cai	1.1	61.0	33.6	42.2	68.6	99.8	93.2	14.4	36.3	0.28	10.45	2.53	10.33	16.78	24.42	22.81	3.52	8.89		
43	58	Dong Thap	2.3	48.7	39.8	2.6	79.1	99.7	93.9	53.4	4.3	0.60	10.26	2.48	0.67	20.60	25.94	24.44	13.89	1.12		
55	59	Cao Bang	2.2	48.0	28.4	47.6	74.6	99.8	99.6	15.6	33.7	0.54	8.48	1.89	11.44	17.92	23.96	23.93	3.75	8.09		
13	60	Vinh Long	1.6	36.6	18.2	2.0	85.3	99.5	97.6	44.2	2.6	0.44	8.03	1.05	0.55	23.31	27.18	26.66	12.06	0.71		
62	61	Ha Giang	0.7	58.0	30.6	21.2	64.2	100.0	98.5	49.1	27.4	0.18	9.85	2.10	5.18	15.66	24.38	24.02	11.97	6.67		
61	62	Dien Bien	2.0	63.7	32.1	49.3	78.1	99.6	99.7	35.3	18.9	0.45	9.41	2.55	11.34	17.96	22.90	22.92	8.12	4.35		
63	63	Lai Chau	2.3	69.5	31.3	57.0	80.0	99.0	97.2	24.5	35.5	0.50	9.88	2.30	12.66	17.76	21.99	21.59	5.43	7.89		

		Proportion of People who are Both Poor and Deprived in:*										Percentage Contribution of Deprivations in Each Indicator to MPI (%)									
Region	Health Care Inaccessibility	Education			Living Standards				Health Care Inaccessibility	Education			Living Standards								
		Primary School	Child School Attendance	Electricity	Drinking Water	Sanitation	Toilet	House		Assets	Primary School	Child School Attendance	Electricity	Drinking Water	Sanitation	Toilet	House	Assets			
Northern Midlands and Mountainous Areas	3.0	49.5	37.4	29.0	56.5	99.7	96.1	34.2	18.2	0.78	9.39	2.91	7.55	14.71	25.97	25.03	8.90	4.75			
Red River Delta	13.6	64.4	73.9	5.4	15.2	92.8	80.1	18.8	25.7	4.16	17.72	5.26	1.67	4.66	28.41	24.53	5.74	7.86			
North and South Central Coast	6.9	57.5	51.0	5.9	36.3	98.4	90.6	29.6	19.2	1.97	13.38	4.02	1.70	10.46	28.32	26.08	8.53	5.54			
Central Highlands	4.3	57.3	44.5	8.6	43.6	99.8	96.7	35.3	9.4	1.21	11.09	4.47	2.45	12.36	28.31	27.41	10.02	2.67			
South East	6.7	55.0	47.0	11.6	15.9	95.8	85.0	62.5	8.7	1.94	13.01	3.79	3.38	4.61	27.85	24.71	18.17	2.54			
Mekong River Delta	3.4	54.8	41.8	5.3	34.0	99.3	95.3	64.0	7.7	0.92	12.12	2.69	1.45	9.37	27.40	26.28	17.64	2.12			
Urban/Rural	7.6	59.3	53.9	2.9	28.4	93.4	88.3	58.3	11.5	2.17	13.71	3.73	0.82	8.06	26.54	25.10	16.58	3.28			

Region	Proportion of People who are Both Poor and Deprived in*									Percentage Contribution of Deprivations in Each Indicator to MPI (%)																		
	Health Care			Education			Living Standards			Assets			Health Inaccessibility			Education			Living Standards			Assets						
	Health Inaccessibility	Primary School	Child School Attendance	Electricity	Drinking Water	Sanitation	Toilet	House	Assets	Health Inaccessibility	Primary School	Child School Attendance	Electricity	Drinking Water	Sanitation	Toilet	House	Assets	Health Inaccessibility	Primary School	Child School Attendance	Electricity	Drinking Water	Sanitation	Toilet	House	Assets	
Rural	4.3	54.4	43.2	12.0	39.3	99.3	94.1	46.5	12.9	1.18	11.68	3.22	3.30	10.85	27.40	25.97	12.85	3.56										
Ethnicity																												
Others	2.8	56.4	40.0	23.3	52.6	99.9	97.5	35.5	19.1	0.72	10.56	3.20	6.08	13.71	26.05	25.43	9.26	4.99										
Kinh/Hoa	5.4	54.0	46.6	4.8	30.9	98.3	91.6	53.8	9.4	1.56	12.57	3.29	1.37	8.84	28.12	26.20	15.39	2.68										
By income quintile																												
Poorest	4.8	59.5	40.0	17.5	43.2	99.3	95.1	45.3	21.8	1.26	11.19	3.13	4.58	11.32	26.01	24.93	11.87	5.71										
Second poorest	4.8	54.5	43.8	7.6	37.2	98.9	94.3	49.7	8.9	1.34	12.05	3.28	2.13	10.45	27.79	26.49	13.95	2.51										
Medium	4.1	52.0	48.4	7.4	33.9	98.8	93.1	49.6	5.3	1.19	12.45	3.46	2.13	9.75	28.43	26.80	14.27	1.52										
Second richest	3.9	47.9	52.2	6.4	35.3	98.1	90.6	47.1	4.1	1.15	12.24	3.35	1.88	10.44	29.03	26.79	13.93	1.21										
Richest	2.7	47.4	51.2	4.9	33.2	97.8	88.3	45.9	3.8	0.81	12.85	3.03	1.50	10.10	29.75	26.85	13.96	1.15										
Gender																												
Men	4.3	46.2	44.7	11.8	40.1	99.0	94.9	49.7	11.9	1.19	9.75	3.69	3.28	11.12	27.49	26.37	13.79	3.31										
Women	4.7	62.0	43.0	10.9	37.2	98.8	92.6	45.3	13.6	1.29	13.62	2.87	3.00	10.25	27.22	25.51	12.50	3.74										

Source: GSO calculated for the NHDR 2011

* This counts the proportion of people who are MPI poor and experience deprivations in each of nine indicators. Those who are deprived in less than three indicators (no combination of health and education) are not considered in these headcounts.

MPI with those Experiencing Two or More Forms of Deprivation 2008

*This indicates vulnerability to multi-dimensional poverty (*excluding those with two deprivations in health and education indicators combined)

HDI Rank	MPI Rank	Province	MPI H*A	Population in Multi-dimensional Poverty		Proportion of People Who Are Both Poor and Deprived in:*												Percentage Contribution of Deprivations in Each Indicator to MPI (%)					
				Headcount (H) (%)	Living Standard	Health Care			Education			Living Standard			Health Care			Education			Living Standards		
						Inaccessibility	Electricity	Drinking Water	Sanitation	Toilet	House	Asset	Primary School	Child School Attendance	Electricity	Drinking Water	Sanitation	Toilet	House	Assets			
		Whole Country	0.0449	20.2	1.9	24.0	22.4	0.7	6.8	96.1	61.9	6.7	1.6	1.24	11.82	3.25	3.13	10.66	27.35	25.91	13.10	3.54	
3	1	Hanoi	0.0167	7.5	0.9	37.4	39.4	0.0	3.6	87.3	56.1	7.2	4.2	0.46	15.19	5.12	0.00	1.81	43.65	28.05	3.61	2.10	
2	2	Ho Chi Minh City	0.0103	4.6	6.2	62.8	45.4	0.0	3.2	76.1	22.4	28.5	2.0	3.10	26.71	4.13	0.00	1.58	38.05	11.19	14.24	1.00	
19	3	Hai Duong	0.0253	11.4	6.4	42.5	61.6	0.3	12.3	93.9	17.7	7.2	7.2	3.18	19.08	8.50	0.13	6.14	46.95	8.85	3.58	3.58	
7	4	Bac Ninh	0.0241	10.9	5.8	36.1	41.8	0.6	3.5	84.4	59.0	1.6	2.8	2.88	14.58	6.57	0.30	1.77	42.21	29.52	0.78	1.41	
24	5	Hung Yen	0.0249	11.2	4.2	32.9	50.9	0.0	0.3	86.5	51.7	4.7	9.1	2.10	14.16	7.56	0.00	0.17	43.26	25.86	2.34	4.55	
8	6	Hai Phong	0.0239	10.8	7.0	30.4	47.0	0.0	1.7	95.9	52.9	1.7	3.5	3.49	12.79	5.84	0.00	0.85	47.95	26.47	0.87	1.75	
4	7	Da Nang	0.0112	5.0	1.6	39.2	30.7	0.0	16.5	92.9	33.3	10.5	4.7	0.82	16.07	4.24	0.00	8.25	46.44	16.63	5.23	2.34	
22	8	Thai Binh	0.0371	16.7	3.7	30.6	39.9	0.0	0.0	91.8	65.6	1.8	1.9	1.84	12.64	4.97	0.00	0.00	45.89	32.81	0.91	0.94	
1	9	Ba Ria-Vung Tau	0.0298	13.4	2.5	50.7	39.7	0.0	1.5	95.1	31.7	15.6	2.1	1.26	19.95	5.83	0.00	0.77	47.55	15.84	7.78	1.03	
33	10	Nam Dinh	0.0371	16.7	4.7	29.3	38.6	0.5	0.8	91.8	62.1	1.5	4.4	2.35	12.22	4.83	0.25	0.38	45.91	31.07	0.77	2.21	
31	11	Ha Nam	0.0502	22.6	1.5	23.4	31.5	0.0	0.2	96.6	68.2	2.9	3.9	0.77	9.39	3.96	0.00	0.09	48.31	34.08	1.46	1.94	
17	12	Binh Duong	0.0386	17.4	2.4	54.4	49.6	0.0	1.7	95.5	36.4	3.1	3.9	1.19	23.62	4.92	0.00	0.83	47.73	18.20	1.57	1.95	
10	13	Vinh Phuc	0.0638	28.7	2.3	19.5	21.8	0.0	1.8	96.2	77.5	0.8	0.5	1.16	7.39	2.99	0.00	0.91	48.12	38.76	0.42	0.25	
5	14	Quang Ninh	0.0228	10.3	2.4	32.9	40.2	1.1	24.0	95.5	24.3	5.1	10.0	1.22	13.37	5.44	0.53	12.00	47.76	12.13	2.55	5.01	
25	15	Ninh Binh	0.0707	31.8	3.7	14.1	23.3	0.9	0.8	94.7	78.4	2.9	0.7	1.84	5.45	3.44	0.46	0.40	47.37	39.22	1.46	0.36	
45	16	Bac Giang	0.0498	22.4	2.4	32.2	45.9	1.2	8.1	97.3	42.7	7.9	1.5	1.19	12.92	6.51	0.60	4.04	48.67	21.35	3.97	0.75	
27	17	Ha Tinh	0.0517	23.3	9.5	18.8	31.0	0.4	11.0	97.9	44.4	12.0	1.1	4.73	7.29	4.56	0.20	5.52	48.95	22.19	6.02	0.54	

			MPI		Population in Multi-dimensional Poverty		Proportion of People Who Are Both Poor and Deprived in.*												Percentage Contribution of Deprivations in Each Indicator to MPI (%)				
HDI Rank	MPI Rank	Province	H*A	Headcount (H) (%)	Health Care			Education				Living Standard					Living Standards						
					Inaccessibility	Primary School	Child School Attendance	Electricity	Drinking Water	Sanitation	Toilet	House	Asset	Inaccessibility	Primary School	Child School Attendance	Electricity	Drinking Water	Sanitation	Toilet	House	Assets	
39	18	Nghe An	0.0526	23.7	3.8	20.9	28.0	0.1	6.2	95.5	64.7	2.0	2.7	1.92	7.88	4.60	0.04	3.10	47.76	32.34	1.00	1.36	
46	19	Phu Tho	0.0537	24.2	2.4	18.1	33.5	0.0	3.1	97.5	59.9	11.6	2.3	1.21	7.26	4.35	0.00	1.56	48.73	29.94	5.79	1.15	
23	20	Binh Dinh	0.0806	36.3	0.7	18.3	8.6	0.0	4.4	99.2	77.9	1.6	0.7	0.37	6.38	1.27	0.00	2.20	49.62	38.96	0.82	0.37	
34	21	Thanh Hoa	0.0522	23.5	2.9	18.0	28.0	0.0	4.9	98.3	68.8	1.8	1.0	1.44	7.08	4.12	0.00	2.43	49.14	34.39	0.88	0.52	
37	22	Quang Binh	0.0592	26.6	1.6	14.5	18.8	0.5	8.9	96.5	69.7	2.1	3.3	0.81	5.27	3.39	0.27	4.44	48.24	34.87	1.05	1.67	
18	23	Lam Dong	0.0528	23.8	2.5	25.2	21.7	0.4	5.9	98.9	63.3	2.4	0.9	1.27	8.90	3.85	0.22	2.97	49.46	31.66	1.21	0.46	
9	24	Dong Nai	0.0409	18.4	2.1	32.9	42.5	5.1	8.6	97.6	18.4	21.1	8.4	1.03	13.21	6.17	2.55	4.30	48.82	9.21	10.54	4.18	
11	25	Khanh Hoa	0.0421	18.9	3.4	38.3	28.6	0.0	8.7	95.6	49.3	5.1	0.4	1.70	14.83	3.96	0.00	4.34	47.78	24.65	2.53	0.21	
42	26	Phu Yen	0.0736	33.1	1.0	22.1	15.6	0.0	6.2	98.2	69.8	1.9	1.8	0.51	8.21	2.40	0.00	3.08	49.08	34.91	0.93	0.88	
30	27	Thai Nguyen	0.0501	22.6	2.8	18.0	29.5	0.8	15.0	99.8	54.6	5.5	0.4	1.39	7.26	3.26	0.41	7.51	49.91	27.28	2.77	0.22	
47	28	Quang Tri	0.0679	30.6	1.7	23.1	14.4	0.1	4.0	97.6	70.6	5.0	0.5	0.83	7.95	2.29	0.07	2.00	48.80	35.30	2.52	0.24	
28	29	Binh Thuan	0.0468	21.1	0.3	47.1	35.1	0.0	7.8	88.1	48.3	5.5	4.4	0.13	17.27	5.52	0.00	3.92	44.05	24.15	2.76	2.20	
40	30	Thien Hue	0.0514	23.2	2.2	50.7	27.9	0.1	2.3	95.0	48.5	2.6	2.6	1.12	19.40	3.99	0.07	1.13	47.49	24.23	1.29	1.28	
29	31	Quang Nam	0.0561	25.3	2.2	27.0	18.9	0.0	7.6	98.3	61.0	4.5	1.0	1.10	10.10	2.64	0.00	3.81	49.13	30.48	2.26	0.49	
44	32	Quang Ngai	0.0605	27.2	1.3	27.0	15.1	6.3	6.6	99.5	55.3	5.0	1.1	0.66	10.24	2.19	3.17	3.31	49.77	27.65	2.49	0.53	
38	33	Binh Phuoc	0.0574	25.9	1.4	21.9	28.9	0.3	6.1	99.3	58.0	8.5	0.2	0.69	7.99	5.05	0.16	3.07	49.66	29.01	4.27	0.09	
50	34	Dak Nong	0.0809	36.4	1.6	9.1	8.2	0.3	8.0	99.1	71.6	10.5	0.4	0.79	2.83	1.46	0.13	4.00	49.55	35.81	5.23	0.20	
51	35	Hoa Binh	0.0800	36.0	0.9	6.7	10.2	0.0	5.1	99.5	85.1	1.9	0.0	0.45	2.57	1.20	0.00	2.53	49.74	42.57	0.93	0.00	

HDI Rank	MPI Rank	Province	MPI H*A	Proportion of People Who Are Both Poor and Deprived in.*										Percentage Contribution of Deprivations in Each Indicator to MPI (%)									
				Population in Multi-dimensional Poverty		Health Care		Education		Living Standard		Asset		Health Care		Education		Living Standards		Assets			
				Headcount (H) (%)	H (%)	Inaccessibility	Primary School	Child School Attendance	Electricity	Drinking Water	Sanitation	Toilet	House	Asset	Inaccessibility	Primary School	Child School Attendance	Electricity	Drinking Water	Sanitation	Toilet	House	Assets
43	58	Dong Thap	0.0432	19.4	0.0	0.0	13.9	13.0	0.0	38.2	94.6	45.1	7.1	1.3	0.00	5.23	1.63	0.00	19.08	47.32	22.53	3.56	0.65
55	59	Cao Bang	0.0490	22.0	0.0	0.0	3.3	3.5	0.0	3.2	97.5	94.0	1.1	0.9	0.00	1.25	0.46	0.00	1.58	48.74	46.98	0.56	0.43
13	60	Vinh Long	0.0330	14.8	0.7	0.0	9.5	11.2	0.0	27.7	97.4	60.3	4.0	0.2	0.36	3.62	1.19	0.00	13.83	48.71	30.17	2.00	0.10
62	61	Ha Giang	0.0253	11.4	0.0	0.0	7.0	7.5	0.0	9.0	100.0	81.3	1.4	1.1	0.00	2.36	1.24	0.00	4.50	50.00	40.63	0.70	0.57
61	62	Dien Bien	0.0251	11.3	0.5	0.0	6.1	4.0	0.0	11.0	91.7	85.0	5.9	0.0	0.26	2.23	0.63	0.00	5.52	45.87	42.52	2.96	0.00
63	63	Lai Chau	0.0172	7.8	0.3	0.0	7.3	4.3	24.9	17.0	85.3	62.9	3.8	0.0	0.16	2.13	0.72	12.43	8.50	42.67	31.47	1.91	0.00

Region	MPI H*A	Proportion of People Who Are Both Poor and Deprived in.*										"Percentage Contribution of Deprivations in Each Indicator to MPI (%)"									
		Population in Multi-dimensional Poverty		Health Care		Education		Living Standard		Asset		Health Care		Education		Living Standards		Assets			
		Headcount (H) (%)	H (%)	Inaccessibility	Primary School	Child School Attendance	Electricity	Drinking Water	Sanitation	Toilet	House	Asset	Inaccessibility	Primary School	Child School Attendance	Electricity	Drinking Water	Sanitation	Toilet	House	Assets
Northern Midlands and Mountainous Areas	0.0523	23.5	1.3	1.3	13.8	18.3	0.9	7.5	98.4	69.5	6.4	0.7	0.78	9.39	2.91	7.55	14.71	25.97	25.03	8.90	4.75
Red River Delta	0.0303	13.6	3.5	29.3	37.4	37.4	0.3	3.3	92.3	59.7	3.4	3.6	4.16	17.72	5.26	1.67	4.66	28.41	24.53	5.74	7.86
North Central Area and Central Coastal Area	0.0544	24.5	2.6	25.5	22.9	22.9	0.6	6.9	96.7	61.9	3.7	1.7	1.97	13.38	4.02	1.70	10.46	28.32	26.08	8.53	5.54
Central Highlands	0.0595	26.8	1.5	15.3	12.7	12.7	0.9	5.8	98.6	74.7	3.9	0.2	1.21	11.09	4.47	2.45	12.36	28.31	27.41	10.02	2.67
South East	0.0266	12.0	2.5	41.6	37.3	37.3	1.6	4.4	93.4	34.1	17.4	3.4	1.94	13.01	3.79	3.38	4.61	27.85	24.71	18.17	2.54

Region	MPI	Population in Multi-dimensional Poverty		Proportion of People Who Are Both Poor and Deprived in:**												"Percentage Contribution of Deprivations in Each Indicator to MPI (%)"								
		Headcount (H) (%)	H*A	Health Care			Education			Living Standard						Health Care			Education			Living Standards		
				Inaccessibility	Primary School	Child School Attendance	Electricity	Drinking Water	Sanitation	Toilet	House	Asset	Inaccessibility	Primary School	Child School Attendance	Electricity	Drinking Water	Sanitation	Toilet	House	Assets			
Mekong River Delta	0.0549	24.7	0.4	20.8	13.0	0.5	9.9	96.7	64.0	9.4	0.4	0.92	12.12	2.69	1.45	9.37	27.40	26.28	17.64	2.12				
Urban/Rural																								
Urban	0.0163	7.3	2.7	35.2	29.7	0.7	8.4	84.8	50.0	15.2	2.9	2.17	13.71	3.73	0.82	8.06	26.54	25.10	16.58	3.28				
Rural	0.0558	25.1	1.8	22.7	21.7	0.7	6.7	97.4	63.2	5.7	1.4	1.18	11.68	3.22	3.30	10.85	27.40	25.97	12.85	3.56				
Ethnicity																								
Others	0.0559	25.2	0.5	10.6	7.6	0.5	4.9	99.5	81.7	3.2	0.3	0.72	10.56	3.20	6.08	13.71	26.05	25.43	9.26	4.99				
Kinh/Hoa	0.0432	19.5	2.2	26.3	25.9	0.7	7.2	95.5	57.9	7.4	1.8	1.56	12.57	3.29	1.37	8.84	28.12	26.20	15.39	2.68				
By income quintile																								
Poorest	0.0552	24.9	2.7	20.9	12.8	0.4	4.1	96.7	71.0	5.5	1.7	1.26	11.19	3.13	4.58	11.32	26.01	24.93	11.87	5.71				
Second poorest	0.0573	25.8	1.9	22.2	20.9	0.6	5.6	96.1	65.6	6.0	1.7	1.34	12.05	3.28	2.13	10.45	27.79	26.49	13.95	2.51				
Medium	0.0547	24.6	1.5	24.1	24.6	0.5	7.2	95.8	61.3	6.9	1.6	1.19	12.45	3.46	2.13	9.75	28.43	26.80	14.27	1.52				
Second richest	0.0385	17.3	1.9	26.1	32.9	0.9	8.5	96.0	54.1	8.2	1.2	1.15	12.24	3.35	1.88	10.44	29.03	26.79	13.93	1.21				
Richest	0.0223	10.1	1.1	26.6	31.1	1.8	14.0	97.2	48.0	7.5	1.3	0.81	12.85	3.03	1.50	10.10	29.75	26.85	13.96	1.15				
Gender																								
Men	0.0450	20.3	2.1	15.7	23.6	0.8	7.2	96.6	66.4	6.9	1.4	1.19	9.75	3.69	3.28	11.12	27.49	26.37	13.79	3.31				
Women	0.0448	20.2	1.7	31.7	21.1	0.6	6.5	95.7	57.5	6.4	1.7	1.29	13.62	2.87	3.00	10.25	27.22	25.51	12.50	3.74				
Whole Country	0.0449	20.2	1.9	24.0	22.4	0.7	6.8	96.1	61.9	6.7	1.6	1.24	11.82	3.25	3.13	10.66	27.35	25.91	13.10	3.54				

Source: GSO calculated for the NHDR 2011

Note:

* This counts the proportion of people who are MPI poor and experience deprivations in each of nine indicators. Those who are deprived in less than two indicators (no combination of health and education) are not considered in these headcounts.

Percentage of Population Deprived in Each Indicator (Health Care, Education and Living Conditions)

HDI Rank	MPI Rank	Province	Health		Education			Living Standards				
			People at Risk or Vulnerable Due to Their Access to Health Services	People aged 15 and Above who have Not Completed Primary Education School	Children from 6 to 18 Currently Not Enrolled in School	No Electricity	Unsafe Drinking Water Sources	Inadequate Sanitation	Under-standard Toilet	Temporary House	Inadequate Assets	
3	1	Whole Country	1.61	20.42	18.95	2.80	10.61	67.89	35.67	12.71	3.40	
2	2	Hanoi	0.44	8.46	10.62	0.12	0.57	24.14	6.87	1.33	0.98	
2	2	Ho Chi Minh City	1.03	14.64	11.16	0.04	0.48	15.50	2.68	3.78	0.29	
19	3	Hai Duong	1.62	9.17	14.41	0.18	3.38	63.84	4.39	1.69	1.55	
7	4	Bac Ninh	1.67	13.51	15.24	0.13	0.45	30.03	16.07	0.65	0.88	
24	5	Hung Yen	1.06	11.00	17.50	0.08	0.19	44.67	11.86	1.41	2.97	
8	6	Hai Phong	1.73	8.72	16.00	0.00	0.42	40.85	8.97	1.03	1.54	
4	7	Da Nang	0.86	12.34	11.33	0.00	2.62	17.28	4.14	2.12	1.15	
22	8	Thai Binh	1.09	10.28	12.42	0.14	0.00	59.81	23.91	1.53	1.35	
1	9	Ba Ria-Vung Tau	0.77	16.00	14.33	0.22	0.53	45.94	8.29	4.57	0.73	
33	10	Nam Dinh	2.13	11.48	13.21	0.33	0.20	61.35	19.68	1.47	2.83	
31	11	Ha Nam	1.23	11.79	15.06	0.16	0.36	70.06	22.49	1.23	3.17	
17	12	Binh Duong	1.36	20.52	20.58	0.24	0.65	56.85	11.58	2.49	1.72	
10	13	Vinh Phuc	1.98	13.26	14.53	0.00	1.46	73.54	32.67	1.09	1.02	
5	14	Quang Ninh	0.51	10.19	14.03	2.85	7.64	47.40	9.45	1.55	3.70	
25	15	Ninh Binh	4.05	11.77	17.22	0.49	1.00	69.20	39.78	2.11	0.79	
45	16	Bac Giang	1.04	14.12	17.91	0.51	5.56	86.48	19.90	6.63	1.20	
27	17	Ha Tinh	4.62	11.83	13.21	0.28	5.87	84.95	21.03	6.81	3.22	
39	18	Nghe An	2.19	12.53	16.30	2.85	6.28	78.07	29.43	4.80	4.89	
46	19	Phu Tho	2.15	9.44	16.25	0.27	3.73	84.57	30.00	13.66	2.09	
23	20	Binh Dinh	1.01	22.53	13.81	0.38	4.23	77.60	42.92	2.09	2.41	
34	21	Thanh Hoa	2.10	12.23	17.21	1.02	8.48	80.01	31.30	3.56	3.00	

HDI Rank	MPI Rank	Province	Health	Education		Living Standards					
			People at Risk or Vulnerable Due to Their Access to Health Services	People aged 15 and Above who have Not Completed Primary Education School	Children from 6 to 18 Currently Not Enrolled in School	No Electricity	Unsafe Drinking Water Sources	Inadequate Sanitation	Under-standard Toilet	Temporary House	Inadequate Assets
37	22	Quang Binh	1.39	10.58	15.31	0.18	11.52	75.26	35.68	4.37	5.18
18	23	Lam Dong	1.80	19.22	18.54	1.83	6.44	69.54	31.73	7.08	1.49
9	24	Dong Nai	1.46	16.53	17.77	5.10	5.53	66.51	17.27	15.06	3.91
11	25	Khanh Hoa	2.15	20.50	17.00	0.29	7.87	59.51	26.44	8.91	3.53
42	26	Phu Yen	1.19	23.17	22.12	0.55	6.39	81.22	42.31	2.81	2.58
30	27	Thai Nguyen	2.21	12.28	21.48	1.51	9.42	79.27	30.82	11.80	2.00
47	28	Quang Tri	2.23	19.46	13.60	0.29	7.26	80.73	42.32	12.37	2.46
28	29	Binh Thuan	0.74	31.32	27.66	0.79	6.16	64.04	27.98	10.41	6.29
40	30	Thua Thien-Hue	1.64	29.06	16.22	0.72	9.89	70.12	30.90	8.27	5.00
29	31	Quang Nam	2.03	19.84	14.54	0.83	9.65	84.64	35.90	9.49	3.83
44	32	Quang Ngai	1.16	24.12	13.65	2.87	10.11	88.22	36.69	7.01	4.90
38	33	Binh Phuoc	1.52	20.42	23.05	1.59	10.32	89.80	36.64	14.06	2.57
50	34	Dak Nong	2.23	15.98	13.30	3.31	13.13	92.46	52.12	14.86	1.70
51	35	Hoa Binh	2.36	14.04	21.62	1.13	16.27	88.18	61.24	10.39	3.46
21	36	Tay Ninh	1.38	28.80	25.29	1.63	1.68	89.31	44.37	27.11	0.50
12	37	Long An	1.52	28.83	22.08	0.93	3.75	90.78	55.45	26.24	1.43
41	38	Dak Lak	2.50	20.83	19.85	5.51	11.35	83.21	59.14	15.92	0.94
56	39	Ninh Thuan	3.14	42.82	26.70	1.55	28.93	66.27	36.04	13.54	2.87
20	40	Tien Giang	1.67	33.75	24.79	0.25	3.19	86.85	59.29	31.86	1.35
49	41	Tuyen Quang	2.58	16.08	24.65	0.45	22.09	88.56	58.41	26.53	2.16
6	42	Can Tho	1.04	32.00	30.22	1.78	19.11	70.94	51.42	27.64	3.63
35	43	Lang Son	0.84	18.95	19.86	9.83	24.58	90.02	73.92	10.01	5.52
26	44	Bac Lieu	0.87	29.94	28.23	1.14	0.05	88.11	58.55	42.84	7.94
15	45	Ca Mau	2.00	29.49	35.06	6.85	0.12	88.63	65.17	36.26	3.34

HDI Rank	MPI Rank	Province	Health		Education			Living Standards				
			People at Risk or Vulnerable Due to Their Access to Health Services	People aged 15 and Above who have Not Completed Primary Education School	Children from 6 to 18 Currently Not Enrolled in School	No Electricity	Unsafe Drinking Water Sources	Inadequate Sanitation	Under-standard Toilet	Temporary House	Inadequate Assets	
54	46	Bac Can	0.66	17.97	18.78	7.14	38.06	94.17	61.27	17.66	4.68	
32	47	An Giang	1.84	40.20	27.79	4.71	38.90	80.57	46.78	22.66	4.01	
53	48	Gia Lai	1.54	37.43	30.69	2.03	34.05	83.20	62.74	14.89	6.89	
16	49	Kien Giang	2.15	34.55	28.02	5.42	6.03	85.12	63.70	40.52	6.87	
60	50	Yen Bai	2.18	21.59	21.30	21.41	27.85	87.05	57.86	23.44	4.67	
14	51	Ben Tre	1.44	32.55	18.53	2.13	17.78	94.21	73.83	32.42	2.70	
58	52	Kon Tum	2.05	32.39	18.39	0.68	34.75	80.91	74.62	15.60	10.17	
52	53	Tra Vinh	2.52	37.20	24.48	1.89	4.44	91.18	74.00	44.56	2.75	
48	54	Soc Trang	2.92	42.77	31.13	4.27	3.03	88.60	69.49	49.40	10.74	
36	55	Hau Giang	2.66	36.13	27.40	1.26	11.76	98.85	81.89	45.12	3.52	
59	56	Son La	1.22	39.72	29.95	23.93	28.44	91.56	81.96	12.43	7.64	
57	57	Lao Cai	0.74	36.99	23.87	25.00	41.29	87.19	66.55	8.69	21.38	
43	58	Dong Thap	1.51	36.19	30.87	1.70	59.43	91.53	70.37	37.13	3.08	
55	59	Cao Bang	1.37	29.83	19.88	29.02	47.26	87.96	82.12	10.04	20.71	
13	60	Vinh Long	1.41	28.27	15.99	1.44	64.91	90.49	78.61	32.23	1.89	
62	61	Ha Giang	0.56	42.70	24.65	15.49	47.90	88.86	81.12	36.37	20.09	
61	62	Dien Bien	1.54	46.79	26.77	36.97	60.57	90.00	84.48	27.50	14.17	
63	63	Lai Chau	1.89	57.60	27.07	49.98	67.95	92.12	85.10	20.76	29.23	

Region	Health	Education		Living Standards					
	People at Risk or Vulnerable Due to Their Access to Health Services	People aged 15 and Above who have Not Completed Primary Education School	Children from 6 to 18 Currently Not Enrolled in School	No Electricity	Unsafe Drinking Water Sources	Inadequate Sanitation	Under-standard Toilet	Temporary House	Inadequate Assets
Northern Midlands and Mountainous Areas	1.58	22.61	22.15	11.70	24.23	87.31	54.99	15.20	7.42
Red River Delta	1.30	10.11	13.57	0.31	1.16	46.22	14.56	1.37	1.65
North Central Area and Central Coastal Area	1.94	18.57	16.83	1.13	8.11	74.97	31.55	6.05	3.77
Central Highlands	2.04	24.76	21.55	3.22	17.72	80.47	54.16	13.45	3.33
South East	1.17	17.06	15.94	1.25	2.18	41.41	12.09	8.38	1.28
Mekong River Delta	1.80	34.40	26.72	2.77	19.42	87.49	63.50	34.63	3.94
Urban/Rural									
Urban	1.06	12.61	13.66	0.30	2.78	22.80	9.88	5.35	1.18
Rural	1.82	23.54	20.50	3.75	13.60	85.12	45.52	15.52	4.25
Ethnicity									
Others	1.85	38.09	27.65	14.56	33.87	96.46	81.12	22.91	11.91
Kinh/Hoa	1.58	17.97	17.28	1.00	7.06	63.53	28.72	11.15	2.10
By income quintile									
Poorest	3.14	36.41	22.62	8.64	22.20	91.36	65.54	23.68	11.11
Second poorest	2.13	25.60	20.34	2.53	13.21	81.77	47.75	17.18	3.30
Medium	1.42	20.54	19.68	1.74	9.44	76.51	37.23	12.79	1.68

Region	Health	Education		Living Standards					
	People at Risk or Vulnerable Due to Their Access to Health Services	People aged 15 and Above who have Not Completed Primary Education School	Children from 6 to 18 Currently Not Enrolled in School	No Electricity	Unsafe Drinking Water Sources	Inadequate Sanitation	Under-standard Toilet	Temporary House	Inadequate Assets
Second richest	1.12	14.89	17.80	0.98	6.34	57.56	22.08	8.02	0.79
Richest	0.44	9.15	11.89	0.54	3.60	36.23	10.36	3.65	0.50
Gender									
Men	1.55	15.07	19.82	2.81	10.66	68.26	35.98	12.81	3.04
Women	1.67	25.42	18.04	2.78	10.57	67.54	35.37	12.61	3.75

Source: GSO calculated for the NHDR 2011



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