Impacts of Basic Public Services Liberalization on the Poor and Marginalized People: The Case of Health, Education and Electricity in Viet Nam

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Acronyms and Abbreviations

GATS	General Agreement on Trade in Services
MDGs	Millennium Development Goals
ADB	Asian Development Bank
AFAS	ASEAN Framework Agreement on Services
ASEAN	Association of Southeast Asian Nations
BEA	Branch Electricity Authorities
BTA	Bilateral Trade Agreement
CHC	Commune Health Centers
EDSP	Education Development Strategic Plan
EVN	Electricity of Viet Nam
FGD	**F**ocused group discussion
FTAs	Free Trade Agreements
GMS	Greater Mekong Sub-region
HEPR	Hunger Elimination and Poverty Reduction Programme
HMOs	Health Maintenance Organizations
JBIC	Japan Bank for International Cooperation
kV	Kilo Voltage
MCOs	Managed Care Organizations
MFN	Most Favoured Nations
MOET	Ministry of Education and Training
MoH	Ministry of Health
MOI	Ministry of Industry
MoLISA	Ministry of Labour, Invalids and Social Affairs
MW	Mega Watts
ODA	Overseas Development Assistance
PC	Power Companies
PEA	Provincial Electricity Authorities
PPA	Power Purchase Agreements
PRA/RRA	Participatory/Rapid Rural Appraisal (PRA/RRA)
REP	Rural Electrification Programme
SIDA	Swedish International Development Agency
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TPA	Third Party Access
TRIPS	Agreement on Trade-Related Aspects of Intellectual Property Rights
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
VHW	Village Health Workers
WB	World Bank
WHS	Wind Home System
WTO	World Trade Organization

Executive Summary

Viet Nam's overall progress towards the Millennium Development Goals (MDGs) has been impressive, with the country having reached or exceeded them. In particular, Viet Nam's performance in providing access to basic services of health, education and energy has surpassed that of countries with much higher levels of per capita income. Obviously, Viet Nam has been doing something right.

Fundamentally, Viet Nam is still an agricultural country with over 78 percent of the population living in rural areas and often in isolated mountainous regions, many of whom belong to ethnic minority groups. People living in poverty in Viet Nam are essentially the rural poor, and the challenge facing the Government of Viet Nam is first, that these basic services should reach the poor at an adequate level of quality and second, that the poor should be able to afford them, In this respect it has achieved notable success through programmes such as the National Hunger Elimination and Poverty Reduction Programme (HEPR)a nd the Rural Electrification Programme (REP), and although many poor people still do not enjoy such access, the government has set up programmes to address remaining obstacles. The strong community involvement in programmes to provide health, education and energy services in rural areas has been a major factor in the achievements to date and will be essential for their success in the future. Grassroots involvement has permitted Viet Nam to avoid errors made by countries which have followed a more "top down" approach.

Since the launch of the *Doi Moi* economic liberalization programme in 1986, the structure of markets that provide these services has undergone significant changes. There is now a greater diversity in private service providers and an increase in the volume of resources committed by both the public and the private sectors.The involvement of the private sector has effectively supplemented public sector initiatives to improve the quality and range of services provided to the population at large, particularly in the health and energy sectors. However, their outreach to poor and marginalized people is not completely satisfactory. In fact, UNDP's most recent report on Viet Nam's efforts to achieve the MDGs indicates that socio-economic gaps are widening, as are regional disparities.[1] These growing disparities increase the urgency of efforts to extend these services to the poor. The contribution of the private sector has essentially been made by the domestic private sector; foreign participation to date has been very limited. However, the privatization of these sectors created interest in the Vietnamese market for these services on the part of foreign enterprises. Viet Nam has been obliged to make market opening commitments on these services in its bilateral trade agreement with the United States and its GATS commitments, to be included in Viet Nam's terms of accession to the WTO will likely bind Viet Nam to even greater liberalization. Viet Nam is also liberalizing trade in services with its Association of Southeast Asian Nations (ASEAN) partners in the ASEAN Framework Agreement on Services (AFAS) negotiations, and it will likely extend many of these concessions to China and other countries within the Free Trade Agreements (FTAs) framework between ASEAN and third-party countries.

The Government of Viet Nam has thus accepted bound commitments to liberalize trade in services, including basic services, and it is under pressure to engage in further liberalization. Foreign participation is seen vital to obtain capital and technology. However, the opening of public services, which all citizens have a right to access, to foreign participation must be carried out within a strong, detailed regulatory framework. In addition, the different characteristics of the health, education and energy sectors that are examined in this report seem to call for tailored approaches. In the case of health services, the penetration of foreign suppliers of health services, including health insurance could pose a direct threat to the basis health system in Viet Nam and divert resources from the poor. In the education sector, foreign suppliers could make a positive contribution if directed to in specific targeted areas, in energy services foreign investors could make a major contribution, particularly if they can be attracted to providing services in the rural and isolated areas. The challenge facing the Government is to modulate international commitments and devise an appropriate regulatory framework consistent with such commitments to ensure that foreign participation complements, rather than undermines the major efforts of the Vietnamese government to improve access to these services for the poor.

[1] 'Viet Nam: Closing the Millennium Gaps', 2003, United Nations Country Team Viet Nam, Ha Noi.

The basic health system has been extended widely to communes and villages. However, the cost of health services has been a burden to people living in poverty and many people have fallen into the "medical poverty trap." The mechanism of user fees exemptions has not worked well, and a system of universal health insurance, with special exemptions, such as health cards for the poor, is being established. Currently, the government is creating a massive programme to ensure access to all. In the case of the health sector, the pressures for foreign participation have arisen at a moment when the impact of the WTO and other trade agreements on health is a subject of major concern to the international community. The 2001 WTO Ministerial Declaration on the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement and Public Health was deemed necessary to protect developing countries against bilateral pressures from powerful trading partners that would have undermined their rights to ensure access to medicines for people, including the most impoverished. International health experts have strongly and continually cautioned prudence to developing countries in committing themselves to allowing foreign providers of health services, including health insurance, to enter their markets.

Viet Nam has already committed to permit the establishment of foreign medical facilities in Viet Nam, subject to minimum investment conditions. Such facilities would provide a useful service to the large expatriate community as well as supplement incentives to attract foreign investment. They also may provide specialized services to wealthy Vietnamese who would have otherwise sought medical treatment abroad.

However, it is essential that the opening of services to foreign health providers does not reach the point where they attract a sufficient number of medical staff, which could seriously divert human resources from the public and domestic private sectors. Foreign health insurance should not operate in such a way that undermines the government's plan to establish universal compulsory health insurance system. Based on the experience of neighbouring countries, Health Maintenance Organizations (HMOs), which create a captive supply of medical staff, are to be particularly discouraged. Such challenges can be managed through the stringent regulation of the health sector, in such a fashion that commitments made with respect to national treatment are not violated.

In the education sector somewhat similar considerations apply. International educators, including from the countries most active in seeking commitments in this sector, have cautioned developing countries against the liberalization of education services. In this sector, the contribution of the private sector is somewhat different than in the health sector. In the health sector the domestic private sector supplements the activities of the public sector, while in the education sector, the private sector largely has focused on sub-sectors, such as pre-school and upper secondary education, where education is not provided free of charge. As free education is progressively extended to lower and higher levels of secondary education the role of the private sector could diminish. At the primary and secondary levels, foreign participation should be limited to international schools primarily serving the expatriate community, as a further means of creating an environment favourable to foreign investment. However, the extension of foreign private schools targeted to wealthy Vietnamese should not be permitted because it would not only divert human resources from the public sector, but it risks creating elitist attitudes and divisions in Vietnamese society. At the post secondary level and in the area of vocational training there seems to be a role for foreign private education providers in the areas of technical and linguistic training, to assist with absorbing students seeking higher education. On the other hand, there is room for government to-government collaboration at all levels, particularly for curriculum reform, in order to ensure that the education provided is relevant to the exigencies of a globalized world. As well, governments could collaborate to obtain financing for the production of educational materials and the building of schools in isolated areas.In the electricity sector, the challenges are quite different. The challenge is that electricity does not reach the poor people, and when it does it is of poor quality. The setting of a maximum price for rural consumers had greatly improved the affordability of electricity for the poor. Massive investment is required to meet rapidly expanding demands in Viet Nam, and if this is not obtained efforts to provide electricity to people who do not currently have access will not be effective. On the other hand, there is a need to attract foreign investment in rural and isolated areas, particularly to provide off-grid renewable energy generation. This service will require efforts to improve the regulatory system to provide an independent

regulatory body, fair and transparent dispute settlement procedures, transparent rules governing third party access to networks, and "smart" subsidies to ensure the profitability of investments in disadvantaged areas. Meanwhile maintaining the ceiling price to rural consumers is to be maintained. Commitments in this sector would be a useful complement to efforts to attract investment, provided that operational social obligations are inscribed.

The recommendations of the General Framework for a National Strategy for the Services Sector in Viet Nam up to 2020[2] that a strong regulatory environment is needed for the services sector is particularly valid in these sectors. While the main impact of liberalization arises from the commercial presence of foreign service providers, a strong regulatory environment needs to be applied to trade through Mode 1 (cross-border supply). For example, telemedicine and distance learning would need regulation to ensure the widest possible diffusion of benefits, as well as to establish responsibility, liability and quality control. The same considerations of quality control would apply to trade under Mode 4 (movement of persons). In both cases imports could be seen as beneficial to the strengthening of the service sector in Viet Nam, for upgrading medical technology, for acquiring specialized education, and for the design and maintenance of electrical facilities. However, the positive impacts would be determined by the regulatory framework in which the trade took place.

[2] Submitted by Dorothy Riddle, Nguyen Hong Son, and Cristina Hernandez on 15 June, 2006.

1. General Introduction

Many services in developing countries have been, and often remain under public ownership. A development priority has been to ensure universal access to key social services, notably water and sanitation, health, energy, and education. In many cases, the pressing need for capital and technology has led to the privatization of all or parts of these sectors. However, while privatization may increase the capacity of the sector, it may not lead to the provision of universal service, as the private sector will normally focus on those segments of the population with the greatest capacity to pay. The opening of service sectors to private sector participation calls for "re-regulation," because often more complex regulations are necessary to provide an adequate framework to govern private activities. This opening and re-regulation has been an inherent component of the Doi Moi economic liberalization programme. In the context of Viet Nam's accession to the WTO or in bilateral an sub-regional trade agreements, opening services sectors that were previously exclusively provided by the public sector, to private participation, brings these sectors within the scope of trade negotiations and has led to requests by trade partners for access to the Vietnamese markets for these services..

The provision of health, education, and energy sectors to all segments of the population is a key human development objective. Access to these services empowers poorer people, and provides them with the means of increasing their productivity, which enables them to compete in a market economy and a globalized world. Lack of access to these services results in their increased marginalization as the rest of the country moves forward and integrates into the global economy, leaving the poor within a poverty trap, exacerbated by ill health, inadequate education and no access to up-to-date energy sources. For a poor country, Viet Nam has achieved remarkable gains in the areas of health and education, and indicators place Viet Nam at levels comparable to countries with much higher per capita incomes.

In the three sectors under consideration the government of Viet Nam has greatly increased public spending, and implemented ambitious and imaginative programmes in an attempt to improve the quality of these services and extend access to the whole population. Despite recent rapid urbanization, Viet Nam is still a predominately rural country with three quarters of the people living in rural areas, which presents a challenge to the achievement of universal service; the rapid growth in recent years has benefited the urban population to a much greater extent as 90 percent of the poor continue to live in rural, isolated, mountainous areas. A further challenge arises from the fact that 14 percent of Viet Nam's population belong to ethnic minority groups. The overall objectives of this Report are outlined in Annex 1. This Report assesses the advancement that Viet Nam has made toward universal access in health, education and electricity services, and the actions by the Government that have contributed to this objective. Then it examines the roles played by the private sector, in achieving these objectives and how these roles could be improved in the future. It also assesses the contributions made to date by the foreign private sector, and the impact of provisions of services-related international commitments on the poor. As well, the Report examines whether international commitments give access to foreign providers, bearing in mind, that few countries have made liberalization commitments in any of these sectors, and that Viet Nam is under no obligation to do so.

Recommendations address measures to be taken in order to continue to improve access to the poor, including how to enhance the contribution of the domestic private sector toward this objective. Recommendations also address policy measures with respect to the foreign private sector, and the suitability, from the point of view of impacts on the poor, of making international commitments, such as under GATS,, aimed to grant access and national treatment to foreign providers in the three service sectors concerned. The Report is heavily referenced using international sources, which relate to the experiences of other countries, relating to trade in these sectors. This Report is intended to assist the reader in understanding the international context in which these national policy decisions are made, and to make recommendations for further research.

This Report summarizes and highlights the salient points from the three Sectoral Reports prepared under VIE/02/009, on the Impacts of Market Liberalization on Access to Basic Health, Education and Electricity Services by The Poor and Marginalized in Viet Nam, submitted on 12 December 2005, and their accompanying tables and annexes. The Reports in turn were derived from a survey carried out in four provinces of Viet Nam at the level of selected towns, districts, communes and villages. The primary data generated by the survey was supplemented by desk research that concentrated on reports and publications from the Government and key international agencies working on health, education, electricity, poverty and trade. Annex 2 contains an explanation of the methodology. It also draws upon the relevant sections of The General Framework for a National Strategy for the Services Sector in Viet Nam up to 2020.[3] It incorporates findings from the current international debate on these issues, academic works, and the experiences of other countries.

[3] Submitted by Dorothy Riddle, Nguyen Hong Son and Cristina Hernandez , 5 June, 2006.

2. Trade Negotiations and Commitments on Trade in Services

The general considerations facing Viet Nam in negotiating commitments on trade in services have been set out in The General Framework for a National Strategy for the Services Sector in Viet Nam up to 2020,[4] prepared under project VIE/02/09. The sectors dealt with in this study posses the particular characteristics of "core public services" where the main concerns of governments are to ensure universal services, continuity, quality, affordability and user and consumer protection.[5] A limited number of countries have included these sectors in their GATS schedules of commitments, and where they have done so such commitments have usually been subject to strict qualifying conditions, usually involving economic needs tests. In addition, providers of these services are usually subject to strict domestic regulation to ensure standards of quality, security and universal access which presents an additional restraint on access to markets.

Under GATS countries negotiate commitments with respect to access to their markets for trade in services. Such "trade" is classified into four "'Mode of Supply." Governments make commitments under each Mode, either "horizontally" (i.e.applcable to all sectors, or with respect to specific sectors and sub-sectors of services. These commitments pertain to measures which are seen as "barriers" to domestic markets. They include limitations on the number of suppliers or service operations, or the numbers of persons employed in the supply of services, or on the value of service assets or transactions, which usually are enforced by economic need tests, as well as measures that require specific types of legal entities or that limit the participation of foreign capital. Commitments also can include granting national treatment to foreign service providers in the sector or sub-sector concerned. In particular, there is no obligation under the GATS Agreement to grant national treatment to foreign suppliers; national treatment of foreign firms is a subject for negotiations on a sectoral basis and it does not constitute a "right" for foreign firms. All commitments can be made subject to conditions and qualifications, e.g. joint venture requirements, economic needs tests, but where commitments have been made such qualifications have to be inscribed in the schedules. Performance requirements aimed at strengthening service sectors in developing countries by acquiring access to technology or to distribution channels and information networks are specifically permitted by GATS. Governments are free to regulate services so long as these regulations do not constitute "unnecessary barriers to trade" in services. Regulations that apply equally to domestic and foreign suppliers would be in conformity with national treatment commitments. As noted in the "National Strategy"[6] liberalization of trade in services can only have a positive impact on the development of the national services sector if there is a strong regulatory framework that supports national policy objectives.

The four Modes of Supply of GATS and examples of what commitments by Viet Nam could entail:

Mode 1 -	***Cross-border supply*****:** *The supply of a service "from the territory of one Member into the territory of any other Member." The service travels, but both the provider and the consumer stay home.* This provision applies to diagnosis or treatment between countries. Vietnamese people can have access to telemedicine or to distance-learning education facilities. It also applies to the service of transmission and distribution of electricity across national borders.
Mode 2 -	***Consumption abroad*****.** *The supply of a service is provided "in the territory of one Member to the service consumer of any other Member." The consumer travels, but the provider stays home.* Movement of persons abroad is permitted under this Mode. For example, patients from Viet Nam are permitted to seek health care services or purchase health insurance policies in other countries. As well, students are permitted to study abroad.

[4] Ibid.

[5] For example, Canada has stated that it will not seek nor make commitments in the health and education sectors inthe GATS negotiations.

[6] Ibid.

Mode 3 -	***Commercial presence*****:** *The supply of a service "by a service supplier of one Member, through commercial presence in the territory of any other Member." The provider "travels" through investment*. Commitments under this Mode permit the establishment of, or investment in, hospitals and health facilities, including health insurance firms. They also allow the establishment of foreign private schools, or they enable foreign investment, including joint ventures, in power generation facilities in Viet Nam.
Mode 4 -	***Presence of natural persons*****:** *The supply of a service "by a service supplier of one Member, through presence of natural persons of a Member in the territory of any other Member." The provider travels through temporary emigration or business travel.* Professionals or workers from other countries, such as medical staff, teachers or electricity technicians can come to work (but not seek work) in Viet Nam.
National Treatment	If a sector is included in a schedule any commitment on national treatment will apply to those suppliers that meet the market access conditions specified for that sector,: if a particular sector is not included in the schedule there is no obligation to apply national treatment.[7]

Prominent experts in the areas of health and education have been firmly opposed to liberalization commitments in the health and education sectors, and have requested their governments not to seek such commitments from developing countries. Even WTO staff experts have cautioned governments that they should take care in making commitments in these sectors, and they advised them to analyse the relevant provisions of GATS carefully "to avoid unpleasant surprises". Such surprises would arise, in many cases, in carelessly granting national treatment, without examining closely the implications. This treatment is important with respect to subsidies, where it is necessary to indicate that subsidies would be available only to domestic providers, to avoid challenges under national treatment provisions.[8]

It is frequently emphasized that GATS negotiations provide flexibility to developing countries as they are, in principle, able to confine their commitments to those sectors and to those measures which they find compatible with their development strategies. However, in practice, Viet Nam has found itself confronted, in the bilateral negotiations with the United States and in the WTO accession process, with a dramatically asymmetrical power relation with its trading partners. Viet Nam was particularly vulnerable due to its non-WTO status. The consequence has been that Viet Nam has been obliged to accept commitments that may prove to be incompatible with the success of the programmes in place to improve access to these vital services to the poor. Thus, extreme care should be taken to ensure that such commitments take place against a framework of strong domestic regulations, drawn up in conformity with international commitments that would ensure the development compatibility of trade liberalization in services. If the impact of these commitments proves to be too negative, Viet Nam should seek to modify these commitments through recourse in regards to Article XXI of GATS.

GATS requires all commitments to be extended to all WTO members under the unconditional Most Favoured Nations (MFN) clause. This requirementmeans that all commitments on services imposed on Viet Nam under its Bilateral Free Trade Agreement (BTA) with the United States will have to be carried over into its WTO GATS commitments. In fact, other WTO members have viewed the BTA commitments as a starting point to make additional, even more onerous requests.

The BTA is a hybrid agreement in that the commitments on trade in services are formulated in the GATS *positive list* style, (i.e. what is not specifically covered is *excluded*), presumably as the BTA was presented as a step towards Viet Nam's accession to the WTO. However, the commitments accepted by Viet Nam on investment which overlap with Mode 3 are set out in a *negative list* format, (i.e. whatever is not specifically excluded is *covered*). There is an exchange of letters to the effect that in case of conflict the commitments on trade in services will prevail. Furthermore, the national treatment obligation in the BTA is of greater scope that that in Article XVII of GATS, including establishment, which is actually defined as market access not national treatment in GATS. However, once Viet Nam becomes a member of the WTO its commitments on services will be subject to the dispute settlement mechanism while those on investment under the BTA will not, how the differing definitions of national treatment will be addressed in

[7] For example, China's current GATS offer on education services would provide full market access on Mode 3 , buy deny national treatment.

[8] See Rolf Adlung , *Public Services and the GATS,* WTO Working Paper ERSD-2005-03 Geneva, July 2005.

any future dispute with the United States in the WTO remains rather unclear. It is hoped that the Viet Nam authorities have received legal advice, particularly from the WTO secretariat on this matter, and that they have obtained specific undertakings from the United States government that it will not unpleasantly surprise Viet Nam by invoking Article XIII of the WTO (the non-application clause) at the last minute.

The United States BTA contains horizontal commitments by Viet Nam on Mode 1 permitting the entry for at least three years of intracorporate transferees, who cannot be substituted by Vietnamese (economic need test) in the category of mangers, executives and specialists, and well as service salespersons, for 90 days. These commitments, which are quite usual and will be extended to all WTO members under GATS, and will apply to the health, education and energy sectors.

The ASEAN Framework Agreement on Services (AFAS), signed on 15 December 1995, builds on GATS and aim to achieve higher commitments in both terms of scale and level. The third round of AFAS negotiations, currently underway, aims at removing limitations on trade in services among ASEAN countries through two negotiation approaches based on a preferential expansion of the positive lists agreed in GATS. The modified common sub-sector approach applies to sectors where three or more ASEAN countries have made commitments under GATS, the identified sub-sector would be subjected to the removal of all limitations for Mode 1 and 2, and progressive liberalization would occur for Modes 3 and 4. Under the ASEAN X formula two or more member countries may conduct negotiations and agree to liberalize trade in services for specific sectors or sub-sectors, while other member countries may join at a later stage.

Trade in Services also will be included in the Free Trade Agreements within the "FTA framework agreements" between ASEAN and China, Australia, New Zealand, the Republic of Korea, India and Japan. Agreements negotiated outside the framework of trade agreements can impact the service sector. For example, the bilateral investment agreement with Japan commits Viet Nam to provide national treatment in a number of service sectors, however, electricity is excluded.[9] Viet Nam has relinquished the right to impose or enforce performance requirements on Japanese investors, despite having the rights to do so under GATS. If this situation is not corrected, and these commitments are carried over into Viet Nam's terms of accession to the WTO, Viet Nam will find its hands tied, compared to other countries in the region in its negotiations with foreign investors.

[9] See Dorothy Riddle, Nguyen Hong Son and Cristina Hernandez, *General Framework for a National Strategy for the Services Sector in Viet Nam up to 2020*, p. 107.

3. Health Sector

3.1. Introduction

Viet Nam's overall health status indicators are much better than would be expected for a country at its level of income per capita. In terms of the basic health indicators, life expectancy at birth is 71 years, under-five child mortality is 38 per 1,000 live-births, and maternal mortality is 90 per 100,000 are comparable to those of middle-income countries.

All this has been achieved at very low cost, health expenditures, at around US$6 per capita.

Some contributing factors are general in nature and derive from Viet Nam's relatively high position on the HDI index, including political stability, sustained economic growth (about 7.5% a year, during last ten years), a high rate of adult literacy and an egalitarian distribution of income. However, the positive results can be mainly attributed to specific policy measures taken by the government of Viet Nam to ensure good quality and accessible basic health care services through an extensive network, and the implementation of targeted programmes to deal with priority health problems, which have had remarkable success against diseases such as malaria, tuberculosis, leprosy etc. Policy measures have directed resources to the health problems of the poor, extension of the basic health care network to the entire population, reduction of health-related financial burdens on the poor via fee-exemption, expansion of pre-payment schemes, health care fund for the poor, so forth.

The Doi Moi programme resulted in major changes in the health care, system, including (i) the introduction of user fees for health services at higher-level public health facilities (viz., hospitals); (ii) legalization of private medical practice, liberalization of the pharmaceutical industry, and deregulation of the retail trade in drugs and medicines; (iii) and the introduction and expansion of health insurance.[10] The private sector has assumed a useful complementary role contributing to the access to out-patient health care. Access to poor people has been greatly improved through the establishment of Community Health Centres in every commune of over 7000 inhabitants, and the presence of a health worker in 80 percent of villages.

Despite these achievements many poor people still lack access to affordable and quality health services, particularly those living in isolated regions. The government is making a major effort to establish a universal health insurance, improve quality of services, increase the number of qualified medical staff, and address disparities in access to health services between rich and poor, urban and rural dwellers.

To date the foreign private sector has focused on the expatriate community and wealthy Vietnamese, making no contribution in providing access to the poor. Viet Nam was obliged to make some commitments to open its health sector to foreign medical providers in the BTA with the United States, commitments which will be extended to all WTO members upon Viet Nam's accession to the WTO. This pressure to provide access to foreign health service providers comes at a time when the whole question of the impact of the WTO and other trade agreements on health is the subject of intense international debate. It is generally perceived that the presence of foreign health providers can undermine efforts to provide universal quality health services and frustrate efforts to improve access for the poor[11].

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[10] The Law on Health Care and Protection for the People (1989) and the Resolution of the Central Executive Committee of the Party (1993) were important milestones of the health policy renovation. In October 1993, the National Assembly Steering Committee of Viet Nam enacted the Ordinance on Private Medical and Pharmaceutical Practices, creating the highest legal basis for private medical and pharmaceutical practices. Following the Government, Ministry of Health issued specific legal regulations/guiding documents to implement the above Ordinance. Once authorized to practice, private health sector strongly developed (and became an integral part of the Viet Nam health system to respond to the increasing needs of health care of the people).

[11] See for example, Richard D. Smith *Foreign Direct Investment in Health Services, a review of theliterature*, Elsevier 2004, www.elsevier.com/.locate/socscimed.

3.2. Economic Reforms, Trade Liberalization and Poverty Reduction Policies

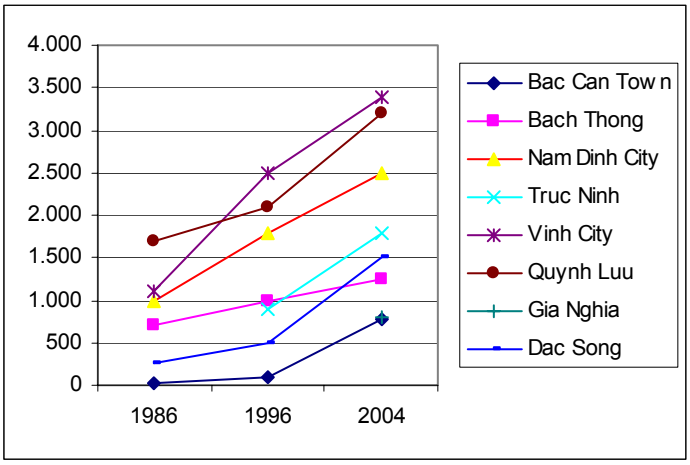
Health services in Viet Nam are organized on three levels. At the first level is the Ministry of Health (MoH), which is the main national authority in the health sector and together with the Provincial, District and Commune People's Committees, it formulates and executes the health policy and programs in the country. The Ministry manufactures and distributes pharmaceuticals, trains physicians, coordinates medical research, sets prices in private health facilities, and is ultimately responsible for the provision of all preventive and a large part of curative health services in the country.

At the second level are the 61 Provincial Health Bureaus, which follow Ministry of Health policies, but are in fact organic units of the provincial local governments under the Provincial People's Committees (PPC). Planning of health services and programs is mainly the task of the provincial health bureau, including human resource management planning. The provinces prepare annual and multi-year plans on the basis of reports from the districts, including supervision reports from both provinces and districts. Each province has at least one general hospital with 200-1,000 beds that typically has all seven departments: internal medicine, obstetrics and gynecology, surgery, pediatrics, infectious diseases, traditional medicine, and an emergency ward. The provincial hospitals are intended to be referral centers only, but relatively few of the patients that are cared for at these hospitals are referred from outer communities; most reside in the general vicinity of the hospitals. In addition to the general hospital, each province may also have one or more specialized centers or hospitals (e.g., ontological hospitals, cardiology centers, psychiatric hospitals, traditional medicine hospitals or tuberculosis hospitals).

The third level - or Basic Health Network - includes district health centres, commune health stations and village health workers. District health centres serve the population of their respective districts. The district health centres are in charge of health management in the district. Each district health centre has anywhere from 2-9 different departments. In each district, there is a district general hospital, including a laboratory and a post for hygiene, epidemiology and malariology. District hospitals are supposed to serve as referral institutions for all inter-communal polyclinics in the district. Commune health centers (CHCs) are responsible for providing primary health care, including preventive, ambulatory and inpatient services, to between 5,000 and 10,000 persons, and for referring complicated cases to upper levels of care. They are expected to implement national health programs, such as maternal and child's health and family planning, and are generally responsible for the management of all health services at the commune level. A commune health center is supposed to have 3-5 health staff, under the leadership of the head of the commune health centre, 65 percent have a medical doctor. Each commune has 10-15 villages, and in each of the villages (actually 80 percent to date) should have a village health worker (VHW).

Thus, the bulk of health services are provided by the public sector which has greatly increased spending on health. The public health system includes 1,032 hospitals (30 central hospitals, 255 provincial hospitals, 519 district hospitals and 58 hospitals of other sectors), 1,216 clinics, 47 maternal homes, and more than 10,000 CHCs, and more than 250,000 health staff working for public health facilities.

Figure1. Government funding for health in the study districts by year (million VND)



The public sector also finances the commune health centers. During the last decade, considerable public investment has taken place to improve commune health facilities through new construction, upgrading health facilities, providing medical equipment and essential drugs, retraining of commune health workers, and sending medical doctors to work at CHCs. The Government budget remains the most important financial source to ensure quality of and access to health care. By 2010 tenpercent of government expenditures should be dedicated to health care. Recently, the Ministry of Health issued the "National Standards for Commune Health Care," wich should be fully enforced to ensure continuous improvement of health care activities at the commune level.

Social Health Insurance was first attempted by several provinces during the 1980s. In 1989, three provinces (Hai Phong, Quang Tri, Vinh Phu) started pilot health insurance schemes. Then four provinces created their provincial Health Insurance Agency (Hai Phong, Quang Tri, Phu Yen, Ben Tre). A total of 24 districts in 14 provinces throughout the country piloted health insurance schemes. After a pilot period, an Ordinance on Health Insurance (Decree 299/HDBT) promulgated the Statute of Health Insurance. Decree 299/HDBT placed Viet Nam Health Insurance directly under the Ministry of Health, while at the provincial level, Health Insurance was directly under the Provincial Health Bureaus each with its own independent accounts and legal identity. Since 1998, under Decree 58/1998/ND-CP Viet Nam Health Insurance has been organized and managed in a uniform Social Insurance system from central to local levels, with one central agency, 61 provincial and municipal agencies and 4 sectoral agencies (transportation, coal, oil and gas and rubber industry). The Health Insurance fund is independent from the State budget and protected by the Government. Between 1992 and 1998, Health Insurance Agencies signed a contract of curative care provisions with public health facilities. Since 1999, Health Insurance Agencies also signed such contracts with private health facilities as stipulated by new the Regulation on Health Insurance.

The private health sector has assumed an active complementary role. Following Doi Moi, the Government of Viet Nam began allowing private provision of health services aimed at meeting demand that the public sector was unable to fulfill. Since 1989, the government has implemented numerous laws, ordinances, and decrees which govern the private health sector. Enacted in 1993, and then newly re-enacted in 2003, the Ordinance on Private Practices of Medicine and Pharmacy and its subsidiary regulations delineate specific rules and conditions regarding private health services. They define five types of practices: (a) Medical practices (hospitals, clinics, delivery homes, other health services, e.g, injection, intra-venous); (b) Pharmaceutical practices (Pharmaceutical Trade Companies, pharmacies, drug outlets, Drug Quality Control, drug storage); (c) Traditional medical practices; (d) Vaccines and medical products; (e) Medical equipment.

The development of the private health sector throughout the country has significantly improved access to health care services for a large percentage of the population, including in isolated rural areas. About 20-30% of sick people received health services from private health providers. Private health providers are mostly small clinics, providing out-patient care services for patients with common health problems. About 60% of out-patient care services were provided by private health providers. However, private health providers provided only 4% of in-patient care services. The extension of health facilities, for example through the proliferation of small private clinics provides people with better access for early detection and treatment of their illnesses, thus, reducing the workload of the higher level public facilities. However, about one-half of private providers are actually government staff who works in the private sector during evening and weekend hours. Many poor patients in rural areas no longer have to travel long distance for treatment. Therefore they avoid unnecessary travel costs. In addition private practitioners are reputed to show more flexibility in their payment conditions; for example, by deferring payment until after the harvest, or accepting in-kind payments. They also are credited with good staff attitudes, shorter waiting times, less administrative papers and formalities, and less "under the table" payments. Private health practitioners also participate in campaigns for hygiene and epidemic prevention and in the implementation of national health programs at the grassroots level.

Thus, private health providers in Viet Nam are an effective supplement to the public health scheme. Private practitioners help in the initial treatment of emergencies and common diseases for many people and the lightening of the heavy clinical load of the public system. This permits the public system to devote more resources to the development and application of high technologies, construction of specialized medical centers to bring into full play the leading role of state health care services. By 30 June, 2004 there were 30,020 private clinics, 8,378 private pharmacies and drug outlets, 2,974 pharmacies of joint-stock companies, and 10,317 drug dispensers' pharmacies. There were 36 private hospitals in 9 major cities and provinces with a total of 2,538 in-patient beds (about 2% of total in-patient beds in the country). Among private hospitals, there are 5 hospitals (158 beds in total) in Ha Noi – about 4.9% of total beds in Ha Noi – both public and private; 18 hospitals (1,631 beds, 12,6%) in Ho Chi Minh City; four hospitals (242 beds, 11,8%) in Da Nang; three private hospitals in An Giang and two private hospitals in Binh Duong.

Table 1: **Public vs. private service providers for the rural poor**

Characteristics	Public	Private
Service providers	District hospitals (50-150 in-patient beds), commune health centers – CHCs (3-5 health workers), village health workers – VHWs (one in each village)	Retired nurses, assistance doctors, some doctors, sometimes unlicensed
Out-reach	CHCs provide outreach services through health exam campaigns; VHWs provide outreach (PHC) services through home visits. Outreach services are actively provided by health providers	Private providers live in the community, among the population. They may provide services for the population 24hrs when required. However, service provision is more passive (when required or called by the patients)
Service quality	In general, service technical quality provided by public sector is much better (with more and experienced health staff; more equipment and drugs etc). Management quality (patient satisfaction) is lower mainly due to longer waiting time and poor staff attitude.	Service technical quality is low due to low professional capacity, poor equipment and limited medicines. Patient satisfaction is sometimes higher due to short waiting time, no administrative paper needed, warm provider attitude.
Cost	Cost for services is sometime higher because of higher service quality (examination, lab tests, drugs etc), and indirect costs attached (longer distance and higher travel costs)	Cost is normally low because of low service quality (only for simple examination without lab tests, and some simple tablets)
Affordability	Cost for district hospital service sometime high, but still be affordable by most of rural population. Cost for services provided by	Service cost is widely affordable due to low cost and flexible payment (can pay latter, and in goods).

	CHCs and VHWs are widely affordable.	Examination cost can be free because they are relatives or close neighbours.

However, more stringent regulation of private health providers is required. Some private health facilities have violated technical procedures, created complications, whichbadly affect the health and lives of patients. In 1999, out of the total 19,836 private facilities, 1,805 (9.1%) were punished administratively and a number were brought to court. Many facilities with operational certificates did not follow regulations on operational conditions, such as space requirements, lighting, facility hygiene, appropriate medical equipment and tools, sterilization standards, and dress code. Furthermore, more than 6% of the operating private facilities do not have operational certificates, in 1999 it was discovered that approximately, 12.6% of private health facilities were unlicensed. Common forms of abuse by private providers include:

- Over-use of medical technologies/tests
- Over-prescription/treatment (e.g., new and expensive drugs and injections), excessive drug-dispensing and prescribing according to ability to pay, or selling drugs without prescriptions
- Taking "easy" cases for benefit; transferring difficult cases to public hospitals
- Unlicensed and lowly qualification of many private providers, (e.g., nurses, assistant doctors), poorly controlled and low quality of services (poor sterilization facilities, lack of essential drugs, insufficient professional knowledge etc).
- Poor collaboration of private providers: only 26% of private providers participated in PHC activities when requested, with poor recording and reporting.
- Unregulated fees

It is clear that there is a need for stronger regulation of private health provides to prevent such abuses.

3.4. Challenges and Initiatives to Improve Poor's Access to Health Services

Access to Health Services still remains a challenge. The dramatic improvement of health services in Viet Nam unfortunately has not been equally shared by all segments of the population. Poor people in rural populations and ethnic minorities have not benefited as much as the rest of the population. Their access to health services is hindered by their inability to pay the user fees, as well as by the fact that a high proportion of the poor live in remote areas where physical access to health facilities is more difficult. Cultural elements impede access to health care for women and for ethnic minorities. Evidence shows that poor people also have greater needs for health care. When examined against standard health indicators, poor people in Viet Nam show considerably higher rates of malnutrition, infant mortality, the frequency of episodes of illness, and physical disabilities than richer segments of the population.

Table 2. Illness status by living standard[12]

Living standard quintile	Episodes of illness affecting normal activities per year	% with illness affecting normal activities in 4 weeks before survey	% of ill people bedridden in the 4 weeks before survey	% ill people requiring assistance for daily living in 4 weeks	Annual ill days unable to do normal activities in the past 12 months
Poor	1.8	13.1	6.4	2.3	7.4
Near poor	1.8	13.2	5.9	1.5	7.2
Average	1.7	11.9	5.6	1.3	6.8
Better-off	1.4	10.0	4.5	1.3	6.0
Rich	0.9	6.5	3.3	1.1	3.9

[12] Source: National Health Survey 2001-2002.

There is a vicious cycle between ill health and poverty. The patient's household has to increase expenses to meet the health care costs. As most diseases develop suddenly without advance warning, especially acute disease and accidents, the patients have no time to prepare the financing of their health care, and very often, at least fifty percent of the time, obtain the necessary funds by borrowing. An average hospital visit will take up 45% of annual non-food expenditures for people in the lowest expenditure quintile. For the richest quintile it only accounts for 5%.[13] As noted in Table 4 below, poor people rely heavily on loans to meet medical expenses. These loans have to be repaid though extra work and force the household to reduce spending on food, education and other basic provisions. At the same time, the production capacity of the household is reduced by the illness of one of its members. This situation exacerbates the poverty of the household, exacerbating ill health because the poor normally have poorer nutrition, work in more harmful conditions, and have poor access to health care services. The World Bank estimated in 1998 that around 2.6 million people in Viet Nam had fallen into this "medical poverty trap".

Figure 2. The Medical Poverty Trap

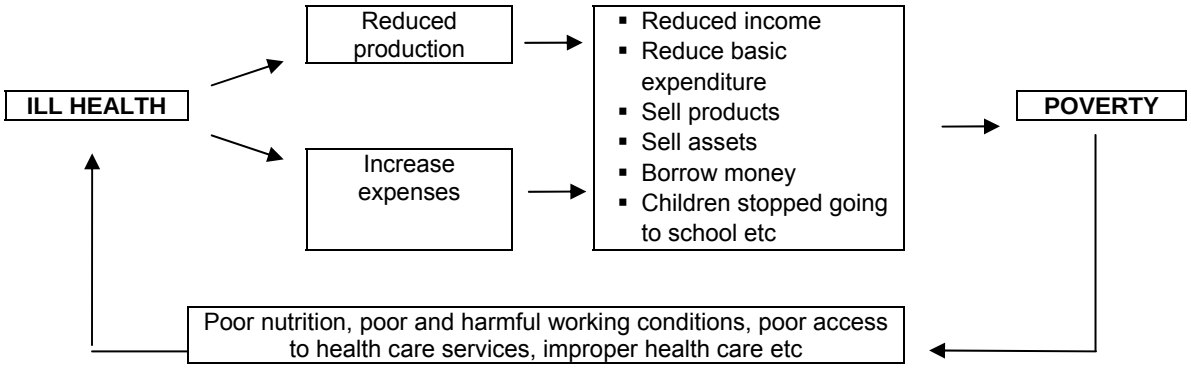


Table 3. Average spending for out and in-patient services by quintile(Unit: x 1,000 VND)

Quintile	Out-patient (4 wks)	In-patient (12 mths)	One in-patient treatment period
Q1 (lowest)	44.2	443.7	565.1
Q2	60.5	656.2	786.5
Q3	67.6	686.7	866.2
Q4	82.7	1007.4	1232.4
Q5 (highest)	126.9	1497.2	1887.3
Total	**79.5**	**851.1**	**1057.2**

Table 4. How to pay for the in-patient service (during 12 months prior to the interview), (%)

Quintile	HI	Exempt	Saving	Borrow	Extra work	Reduce exp	Ralative/friend	Others
Q1 (lowest)	8.8	32.9	56.0	52.1	14.5	1.5	7.7	15.9
Q2	13.1	17.5	66.2	46.0	10.7	1.6	9.6	11.4
Q3	18.9	17.2	76.8	35.6	9.8	1.1	11.5	10.4
Q4	27.0	11.0	82.6	25.0	6.3	1.0	14.4	6.7
Q5 (highest)	30.5	6.9	92.7	13.8	2.3	0.4	11.3	2.5
Total	**19.6**	**17.0**	**74.9**	**34.6**	**8.7**	**1.1**	**11.0**	**9.4**

[13] Report on Viet Nam's development situation. Attacking Poverty. Presented at the CG meeting in 12/1999.

Hospital User-fees

Due to serious lack of financial resources for health care, a hospital fee policy was introduced in April 1989 in pursuance of the Decision No. 45/HDBT dated 24/4/1989 by the Ministers' Council.[14] This Decision allowed public health facilities to collect hospital fees, which are a part of the costs. Hospital fees included charges for hospital bed use, medications, tests, X-ray films, and other consumables. After 5 years' implementation the Decision 45/HDBT, the hospital fee policy was reviewed. The Government issued Decree No. 95/CP on August 27th 1994 regulating the partial hospital fee policy. According to this Decree, a number of people who have been exempted from user-fees, including:

- Children aged under 6 years old;
- Disabled people, orphans and the elderly;
- Patients with schizophrenia/hebephrenic, epilepsy, leprosy, smear-positive pulmonary tuberculosis;
- People in communes in mountainous areas by the Committee of Ethnicity and Mountainous Affairs;
- People reclaiming virgin soil and developing new economic zones during the first three years since arrival;
- Sick persons in poverty-stricken status.

According to Decree No. 33/CP, the revenue from hospital user fees, considered as the revenue for the Government budget, should be utilized as follows:

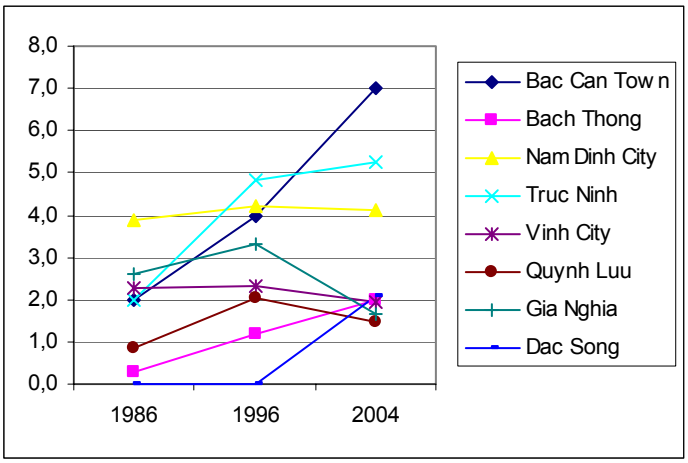
70 percent from this revenue should remain at the health facility that makes this charge as a supplementary share for buying drugs, blood, solutions, chemicals, X-ray films, and other medical material, as well as equipment and tools for the prompt provision of services.

30 percent from this revenue should be used for giving bonuses to health workers who have good responsiveness towards patients, a responsibility to their work, and professionally do well. Approximately 2%-2.5% of this share should be set aside for submitting to the host agency (MoH, provincial Health Bureau, or the host Ministry/sector) for establishing a fund for giving incentives to institutions and individuals who make excellent achievements in their professional work and for supporting hospitals where the possibility of charging user fees is limited.

There is a shortage of health staff. In 2002 Viet Nam had 45,073 doctors (about 5.6 doctors per 10,000 population[15]) which is low in comparison to other countries in the region, (e.g. Malaysia: 6.8; Brunei: 9.9; Philippines: 11.5; Singapore: 14.0; China: 16.4). There is a shortage of nurses; the doctor/nurse ratio is only 1: 1.3. This figure is much below the 1: 3-4 ratio required to provide comprehensive care for the patient. The number of pharmacists with a university degree is also very low: in 2002, there were only 6,025 university pharmacists (0.75 per 10,000 inhabitants), which is very low compared with other countries, (e.g. Pakistan: 3.4; Switzerland: 6.2; Ireland: 7.8; France: 10.0). These shortages are much more severe in poor, remote and mountainous areas. Good doctors and pharmacists normally prefer work in urban and more developed areas. Many poor provinces have launched different incentive programmes to attract doctors, e.g., financial bonuses, free land or accommodation, monthly allowances, but these have not provided adequate incentives to attract staff to disadvantaged areas. ***The programme to train health workers for mountainous and remote areas, including preparatory training and appointment of ethnic minority students should be intensified, financial incentives and accommodation should be provided to retain medical staff in remote areas.***

[14] Partial hospital fee is some expense in consultation & treatment for out-patients and in bed-occupation for in-patient.
[15] Data from Ministry of Health.

Figure 3. Number of medical doctors per 10,000 population by year in survey areas



The government has implemented a series of policies and initiatives designed to provide access to health services to all segments of the population. The Government is giving priority to those health problems which mainly affect the poor in Viet Nam, primarily communicable and transmittable diseases (tuberculosis, leprosy, malaria, HIV/AIDS, etc.). During the last three decades, public health programmes have been effectively implemented on a nation-wide scale, e.g., control of tuberculosis, leprosy, malaria, HIV/AIDS, safe water.. For example, in the beginning of the 1990s, there were thousands of malaria-related deaths, but by 1999 there were only 190 and by 2003 only 50 people.[16]. However, many patients with chronic and severe diseases do not seek health care due to many poor-related reasons. ***At district and commune levels, out-reach campaigns should be organized to give medical exams to remote population, in order to detect and provide treatment for common public health problems (e.g., tuberculosis, malaria, sexually transmitted infections (STIs), dermatological problems).***

Efforts are being made to overcome geographic impediments by the decentralization of health care service delivery systems. The basic health network in Viet Nam, including district health facilities, commune health centers (CHCs) and village health workers (VHWs), has been developed in Viet Nam since early 1950s. This network was funded by agricultural cooperatives under the direct management of the commune People's Committee. However, when the agricultural cooperatives were dissolved the communal budget became very limited, and it was insufficient to pay the subsidy allowance to communal health staff. Many commune health workers abandoned their work and communal health stations had to close. Health care at the grassroots level declined substantially. Corrective action was taken 1994-95 by PM Decisions No 58/QD-TTG and No 131 dated 4/3/1995 on using the State budget to pay allowances and salary for 3-5 health workers in each commune and a stipend for village health workers. These salaries and benefits were the same as State employees under permanent employment contracts. These Decisions, which led almost all the 20,000 commune health workers who had left their jobs to return to work at the commune health stations, are considered as the most important policy decisions for the recovery of the grassroots health care during the socio-economic renovation in rural areas in the mid-1990s.

In 2002, Central Party Secretariat Decree No. 06 further strengthened and consolidating the basic health care network, guaranteeing coverage of basic health care with low cost to contribute to social equity, hunger eradication and poverty reduction and defining the roles of local Party officials, local authorities and the participation of the people. A campaign was initiated of "sending doctors to the communes" and ensuring that all communes have midwives. Many medical and health services and techniques also have been transferred from higher to lower levels, and CHC staff has been retrained to upgrade their knowledge, for example, by improving the training of midwives from elementary to secondary-level. Each

[16] Health Statistics Yearbook 2003.

central hospital is responsible for assisting a number of provinces to raise their professional standards. Many localities organize mobile health teams to diagnose, treat and care for the health of the population in mountainous, remote, isolated and disadvantaged areas. ***Medical skills and technologies systematically should be transferred to lower levels, for example, the practice of temporarily transferring experienced doctors from high level hospitals to provide practical on-the-job training for local staff should be continued and intensified.***

The strategy and policies for strengthening the public health system, especially the grassroots health network yielded major achievements in improvement to people's health, especially the poor, provided low cost access to those basic health care services, that can cure most of their common health problems. The grassroots health network supplied about 80% of health services, served the poor and people in remote, isolated and disadvantaged areas, and it was responsible for the success of public health programs, such as in the prevention and control of tuberculosis, malaria, leprosy, dengue fever, goiter, mental illness, epilepsy, malnutrition and other immunization cases. ***There is still a need to strengthen the basic health care network, by 2010; 100 per cent of communes should have adequate facilities; 80 percent should have doctors (100% of this percentage should be in lowland and 60 percent in highland areas; and 75 percent of communes should fully meet standards for commune health care.***

There is an overall need to increase the Government budget for health in order to ensure access to health care services of the poor and in rural regions. In order to accelerate access to basic health care services, public health providers and the Government should accelerate increases in the Government budget for health. ***The goal for 2010 is that about 10% of total government expenditures will be for health care, this should include a pro-poor budget allocation, including higher budget allocation index per capita 2.5 to three times for mountainous areas, with a higher allocation for preventive health care.***

Poor provinces require budgetary support. Although the Government budget for health in mountainous and remote provinces is 1.7 times higher per capita than for Delta provinces, the latter still have a higher health budget per capita due to much higher revenues from user-fees and health insurance. The Government should further increase the per capita public health budget allocation index for provinces facing particular difficulties up to 2.5 to 3 times higher than that of urban and Delta areas. User fee exemptions by public hospitals were the main support to the poor in health care up to 1999. Fee exemptions are granted upon presentation of a "poor household" certificate issued by the local government, or based on assessment of the physicians directly treating patients. Major difficulties have arisen in identifying eligible beneficiaries, and there is a lack of adequate financial resources due to fee exemptions that are provided from the hospitals' own revenues. As a result, the amount of fee exemptions have varied between hospitals, depending on hospital resources, and relatively few patients (about 5-10%) have benefited from fee exemptions.[17]

Universal, compulsory health insurance should be the main objective. As noted above, direct out-of-pocket payment for health services (e.g., via user-fees) can initiate the downward spiral into the "medical poverty trap." To assist poor people with avoiding this situation the Government has introduced and expanded pre-payment schemes since the early 1990s. At present, the coverage of health insurance schemes is about 27%, which is mainly compulsory health insurance. The targeted universal coverage is 80% of the population covered or more by the year 2010. The Government is currently considering adjustments in its health insurance policy, such as expansion of subject groups for compulsory insurance and elimination of co-payment (20%) until total spending for health is up to a certain level. ***The establishment of an universal compulsory health insurance would be a major achievement for Viet Nam, it would mean that the health system would be financed by the healthy rather than the sick.***

[17] In virtually all cases where user fees were increased or introduced there has been a concurrent decrease in service utilisation, especially by the poor. general exemptions from fees for the poor are often badly implemented (see Bennett, Sara and Gilson, Lucy. 2001. *Health Financing: Designing and Implementing Pro-poor policies.* DFID Health Systems Resource Centre). Based on some of this evidence, the World Bank now discourages user fees for basic health services (i.e., immunization, maternal and child care) to poor people see World Bank Policy Brief on User fees updated August 2003.

It would also mean that all segments of the population would contribute, including those who could afford private treatment in foreign hospitals. It is essential that the wealthier segments of the population are not permitted to opt out of the universal health insurance system.[18]The target of universal coverage should be vigourously pursued.

Healthcare Cards exempt the poor from health insurance payments. In 1999, Ministry of Health, Ministry of Finance and MOLISA issued an inter-ministerial Circular (05), allowing provinces to use their social security budgets to buy health insurance cards for hungry people and the 30% of the poorest among the poor households. However, only about 1.5 to 2.0 million people were actually issued with cards. Problems in implementing this policy included (a) difficulties in the identification of beneficiaries with criteria varying among provinces, (b) many other expenses had to be met from the limited provincial budgets for social security, and (c) the premium of 30.000 VND was not enough to provide health services with adequate quality to the poor. This policy was corrected in 2002 by PM Decision 139/2002/QD-TTg, which provided that Health Care Funds for the Poor (HCFP) should be established in all provinces. A premium of 70,000 VND/person/year is financed 75% from the Government budget (central and local) and 25% from local or international individuals or organizations. ***These funds are used to buy health insurance card for the poor and/or reimburse treatment costs provided to the beneficiaries at health facilities from commune up to central levels, for which the porest provinces are totally subsidized by the nationalbudget.. About 13 million people are beneficiaries from this policy, which should be maintained an extended to ensure that all poor people are covered by health insurance.***

Table 5. Number of HCFP beneficiaries by region, 2004

Region	Population	Beneficiaries	% among pop	% among total beneficiaries
Northern uplands	13.996.689	4.599.431	32,9	34,9
Red River Delta	15.711.693	799.190	5,1	6,1
North Central	10.409.411	1.971.557	18,9	15,0
South Central	7.296.942	938.709	12,9	7,1
Central Highlands	4.712.086	1.777.389	37,7	13,5
North-east	13.353.241	1.101.581	8,2	8,4
Mekong	17.087.224	1.976.376	11,6	15,0
Total	**82.567.286**	**13.164.233**	**15,9**	**100,0**

Table 6: 2004 Budget and disbursement of HCFP by region, *(Unit: Billion VND)*

Region	Total budget	HI	DR	Near poor	Management	Total	Disburse-ment rate
Northern uplands	195,2	33,5	89,1	2,0	2,5	127,1	65,1
Red River Delta	48,7	21,3	13,3	0,7	0,8	36,2	74,3
North Central	115,2	23,2	49,1	1,0	1,8	75,0	65,1

[18] See Debra Lipson, *GATS and Health Insurance Services,* Background Note for WHO Commission on Macroeconomics and Health, CMH Working Paper Series, www.whoindia.org.

South Central	53,1	17,3	12,8	0,9	0,3	31,3	58,9
Central Highlands	97,6	1,5	68,0	0,6	0,9	70,9	72,6
North-east	58,3	47,6	1,8	0,2	1,0	50,6	86,8
Mekong	149,5	27,4	50,8	3,3	1,5	82,9	55,4
Whole country	**717,7**	**171,7**	**284,9**	**8,7**	**8,7**	**474,0**	**66,0**
%		36,2	60,1	1,8	1,8	100,0	

Each year, the Government has allocated about 700 billion VND (about 55 million USD) to the funds in all provinces. The poorer provinces are totally subsidised by the central budget. During 2004, the Funds have provided free health insurance cards to 3.7 million beneficiaries and about 7.4 million people are under direct reimbursement scheme. ***The HCFP should be continued and expanded, all the poor should be provided with free health insurance cards with a premium of 60,000 VND/person/year. The "near poor", the population living up to 50 percent above poverty line also should receive financial support to ensure their participation in the health insurance schemes.***

Other measures to support to the poor applied to the provinces include free meals, free accommodation, free travel provided to the poor patients. ***In particular, the system of free transportation, (originally supported by Swedish International Development Agency (SIDA)) should be expanded to all remote and mountainous areas. The system of providing patients in mountainous provinces with daily food allowances also should be expanded.***

Targeted public health programmes providing health care for women also are highly prioritized in Vietnam, especially regarding family planning, STIs/STDs, malnutrition, and maternal care. The decentralization of health care services benefits both men and women, but women normally receive less benefits because women have relatively poorer access to higher levels of care, a situation often aggravated by cultural factors for women from ethnic minorities, such as the restrictions on the mobility of women and their seclusion in the household. ***Health policy should be gender-sensitive, giving attention to women's additional limited access to health care services, e.g., regarding the control of STIs, tuberculosis, malaria, and programmes on family planning.***

According to Decree number 63 of the Government, private health care providers who fully meet technical requirements set by the Ministry of Health and who have a contract signed with a Social Insurance Agency can provide health care services for insured people. ***The private health sector should be further and more quickly developed, especially in the form of better organized and regulated facilities (e.g., general poli-clinics and hospitals). Roles and potentials of private health providers should be carefully studied in order to better mobilize private health care providers to provide health care for the poor people, especially in rural and mountainous areas.***

Foreign private providers have been given access to the Vietnamese market. The 1993 Ordinance enabled foreign organizations, individual foreigners, and Vietnamese people living abroad to provide private health care services. Ordinance No. 07 on private health practices, issued by the National Assembly Steering Committee on 25 February, 2003, clarified that both domestic and international organizations and individuals who meet the requirements specified in the Ordinance are allowed to provide private health services. These regulations apply equally to domestic and international providers. Although foreign private health providers have been permitted to practice in Vietnam, for 12 years their contribution is still very limited and largely confined to 14 foreign clinics/hospitals, including five small-size hospitals with only about 20-50 beds each. Most were established during the last five years (except Viet Nam – France hospital in Ha Noi, estabkished in 1997).

Table 7. List of foreign private health providers

No	Hospital/clinic name	Beds	Address
1.	Viet Nam – France Hospital (1997)	56	1 Phuong Mai, Dong D, Ha Noi
2.	International Hospital of kidneys and dialysis (2000)	22	253 Dien Bien Phu, Q3, HCMC
3.	Viet Nam – France Hospital (2002)	65	MD5 - 1, South Sai Gon zone, Tan Phu, Q7, HCMC.
4.	International Hospital Columbia Asia - Gia Dinh (2003)	21	01 No Trang Long, Binh Thanh, HCMC
5.	Vietnam – Korea hospital of Opthology	21	No 355 - 365 Ngo Gia Tu, P3, Q10, HCMC
6.	Dentistry Clinic Koseikai		29 Le Duan, Ben Nghe, Q.1, HCMC
7.	Diagnostic and Laboratory Australia		38 M¹c §Ünh Chi,P. Da Kao, Q.1, HCMC
8.	Family Clinic HCM		Diamond Plaza Building, 34 Le Duan, HCMC
9.	Family Clinic Ha Noi		A1 building, R 109 – 112, Van Phuc, Ha Noi
10.	Medical Lab – Lab Group		146 An Binh, Q.5, HCMC
11.	Internal medicine clinic Columbia Asia Sai Gon		08 Alexandre de Rhodes, Q.1, HCMC
12.	Clinic AEA/SOS Ha Noi		Ha Noi
13.	Clinic AEA/SOS Ho Chi Minh		Tp. Ho Chi Minh
14.	Clinic AEA/SOS Vòng Tµu		Vòng Tµu
15.	Bac Viet General Clinic		

Foreign private health providers in Viet Nam primarily service the expatriate community and a growing number of rich Vietnamese people (e.g. those employed by foreign companies), indicating a portion of the population with greater expectations in terms of quality and higher capacity to pay. The availability of such services to the foreign resident community is an important consideration for foreign investors. Thus, indirectly foreign private health providers may have contributed to increased foreign investment in Viet Nam, and, to some extent, may have stimulated the public sector and domestic heath care providers to increase the quality of care. However, as foreign private health care providers serve the richest population of the country, with high quality services and high prices, they can attract many of the country's experienced doctors and health workers, from the domestic private and public health sector, (termed as the "brain drain"). Thus, while the domestic private sector has had an important supportive role in this extension of health services, the foreign private sector does not appear to have made any positive contribution, and the increased presence of foreign health service providers could exacerbate disparities and reduce impoverished peoples' access to health services.

Commitments already imposed on Viet Nam (see below) can be expected to lead to an expansion of the foreign private health sector in Viet Nam. While, in theory, the entry of foreign capital can provide additional resources to invest in the health care infrastructure, the most direct beneficiaries are likely to be households who can afford the higher priced services. While infusion of foreign capital could free up public resources and facilitate state reallocation in favor of poor patients, the prospect of foreign

investment providing health services to poor people is negligible.[19] ***These commitments should be counterbalanced by regulations aimed at minimizing the negative impact of foreign health providers on access to the poor, and maximizing their positive contribution to the health sector.***

Foreign participation in the health sector also can take place through the provision of health insurance. Some developed countries are pressing for commercial presence in the health insurance sector. International health experts consider that while, in theory, greater access for health insurance companies could stimulate competition and reduce costs, in actual practice, evidence shows that greater competition among health insurers segments and destabilizes the market as well as undermines the ability to build larger, more equitable risk pools that spread costs between rich and poor, healthy and sick. In particular, it is crucial to prevent the opting out of the wealthier population groups which would undermine the possibilities of creating equitable risk-pools that spread costs between rich and poor, healthy and sick. International health experts consider that the entry of foreign suppliers makes it more urgent for countries to create an effective regulatory framework for the health insurance sector, and that until such a system is in place it could be harmful for developing countries to make full commitments in the health insurance sub-sector under GATS financial service schedules.[20] ***Viet Nam should examine the implications of the presence of foreign suppliers of health insurance carefully and draw up regulations in consequence.***

3.5. Issues for Consideration in Liberalization of Trade in Health Services

Commitments on health in GATS and other trade agreements can impact the provision of basic health services to the poor. The impact of the WTO and bilateral trade agreements on health has been a serious concern to the international community[21]. Most attention has focused on the intellectual property aspect and the impact of the TRIPS Agreement on access to medicines. However, the ensuing WTO Ministerial Declaration on the TRIPS Agreement and Public Health addressed not so much the obligations of the TRIPs Agreement itself, but the practices of certain countries which exercise bilateral pressures to force countries to give up their rights to public health care, under the TRIPS Agreement. The GATS Agreement's impact on universal access to health care also has created serious concern by health experts. As countries are free to exempt the health sector from commitments, the problem would seem somewhat less significant. However, the similar phenomenon of commitments extracted through bilateral pressures from stronger trading partners has occurred in the services negotiations, in particularly where the stronger countries have the upper hand, notably in WTO Accession negotiations and FTAs. While countries are free to experiment with the provision of health services by foreigners, GATS commitments "lock in" this liberalization and make it extremely difficult to reverse the course of the liberalization measures, which produces negative effects. More than half of the WTO Members have refused to make commitments in this sector.[22]

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[19] Even in China, currently Asia's favorite destination for FDI, the Ministry of Health found that only six of the 46 Sino-foreign health facilities received investments above a (modest) sum of US$ 12 million. The survey also revealed that every four in five of these health facilities were located in large coastal cities, not the poorer hinterlands of its Western provinces.

[20] See Debra Lipson, *GATS and Health Insurance Services,* Background Note for WHO Commission on Macroeconomics and Health, CMH Working Paper Series, www.whoindia.org

[21] For links to the international debate on trade in health services see Choike Health and Health Services, Goods for Sale at www.choike.org

[22] The following countries have made no commitments in this sector: Argentina, Aruba, Bahrain, Brazil, Canada, Chile, Colombia, Cuba, Cyprus, Egypt, Gabon, Ghana, Guinea, Haiti, Honduras, Hong Kong (China), Iceland, Indonesia, Israel, Kenya, Liechtenstein, Macao (China), Mauritius, Morocco, New Zealand, Nicaragua, Nigeria, Paraguay, Peru, Philippines, Republic of Korea, Romania, Solomon Islands, Sri Lanka, Thailand, Tunisia, United Arab Emirates, and Venezuela.

Figure 4. WTO Members' commitments on market access for medical, hospital and other health services, and on health insurance, (number of Members), 3rd Quarter 2000
(Source: WHO and WTO)

		Medical and Dental Services	Midwife and Nursing Services	Hospital services	Other Human Health Service	Health Insurance (in Financial Services)*	
TOTAL		52	28	42	15	78	
MARKET ACCESS							
Mode 1	Full	16 (-2)	7 (-1)	13	7	10	
	Partial	10	4	0	1	59	
	Unbound	26	17	29	7	31	
Mode 2	Full	28 (-3)	9 (-1)	36	9	22	
	Partial	22	19	4	5	52	
	Unbound	2	0	2	1	26	
Mode 3	Full	15 (-7)	5 (-2)	15 (-7)	9 (-4)	9	
	Partial	31	22	25	6	88	
	Unbound	6	1	2	0	3	
Mode 4	Full	0	0	0	0	0	
	Partial	47	27	39	15	92	
	Unbound	5	1	3	0	8	

Commitments made with respect to health insurance, which is included as part of the Financial Service sector, also can impact the provision of health services in Viet Nam. As noted above, international health experts are cautious against making commitments on health insurance until appropriate regulations have been drawn up to ensure that foreign competition in the health insurance system does not undermine the national health insurance system, and that richer segments of the population are not able to opt out.

Mode 1 - Cross-border supply

This mode provides possibilities for health providers in Viet Nam to access medical technologies and capacity from all over the world. Promising results have been gained in high medical technology centers in Hanoi and Ho Chi Minh City. Commitments on Mode 1 would seem consistent with the strategy to establish high-tech centers for health in Viet Nam. ***The provision of telemedicine should be subject to regulations to ensure that telemedicine facilities would be available to all patients, including the poor, for example, establishing such facilities in provincial and communal hospitals, as has been done in Thailand,[23] can ensure that telemedicine is not just a luxury provided by foreign hospitals to rich people.[24] Regulations also would have to deal with issues of responsibility and liability. Such conditions should be inscribed in the GATS schedules if commitments are made under this mode.***

Mode 2 - Consumption abroad

This Mode is very important in the health service sector as it covers the ability of patients to travel to other countries to obtain medical treatment. Traditionally, advanced countries have attracted rich patients based on their reputations for high quality medical treatment; however, recently some developing countries have adopted health export strategies with some success. Recently, wealthy Vietnamese patients have obtained medical treatment in neighboring countries, e.g., kidney transplants in China, heart and cancer treatment in Singapore, dental care in Thailand.

[23] See Wattana S. Janjaroen and Siripen Supakankunti, *International Trade in Health Services in the Millennium, The case of Thailand* http:// publications.paho.org.

[24] See Rupa Chanda *Trade in Health Services* in *Trade in Health Services: Global, Regional and Country Perspectives* Pan American Health Organization, Washington 2002, www.who.int/trade.

Patients come to developing countries for medical treatment not only because of lower costs, but also to obtain traditional medical treatment, and often to enjoy more labor intensive and compassionate treatment from medical staff. During recent years, Viet Nam has attracted a limited number of patients from other countries, (notably Vietnamese living in USA, Canada, Australia, and other countries), who are attracted by low user fees and seek traditional medicines, including acupunctures. However, health export policies can impact, both positively and negatively, domestic heath care, in particular, access to health services by the poor. This access by people living in poverty can depend on the number of medical staff and facilities in the exporting country and the regulatory structure that is established.[25]

Developing countries that expend resources on the treatment of foreign patients may divert resources from domestic needs. In addition, by offering more attractive employment conditions, they exacerbate shortages of skilled staff in public facilities, on which the poor rely. The export of health services through Mode 2 ("health tourism") requires a comprehensive strategy based on an analysis of the potential gains and the impacts on the national health system and access for the poor. These impacts will differ among countries, as a function of specific characteristics of the health system of each potential exporting country.

More than half of all Mode 2 commitments on medical and dental services, hospital services, and other human health services are without limitations. This issue may reflect an assessment by WTO members that consumption abroad is a possible response to a shortage in domestic health service capacity, or that their ability to prevent nationals from leaving the country and consuming services abroad is limited in any event. It is clear that without the portability of insurance coverage for services received abroad, consumption abroad remains an option only for well-to-do patients.[26] The establishment of high-tech medical services should discourage this outflow.

Mode 3 - Commercial presence

As noted above, the domestic private sector has made an important contribution to improve access to health services in Viet Nam, particularly for out-patient treatment. However, the foreign private sector has made no contribution to this objective, and any extension of its presence in Viet Nam could seriously impact the poor's access to health services. Foreign private health facilities will provide high quality health services but exclusively to better-off people with a higher capacity to pay, thus leaving the public health system with poorer patients, who often have more severe and complicated health problems. This trend will lead to increased inequalities between the better-off and the poor in accessing and using health care services, especially high quality services. Private foreign invested health facilities are, and will be, located mostly in urban areas, thus widening the existing rural-urban disparity in availability and accessibility of high quality health care services. Even more, it may lead to a "two-tiered health system," one for the rich and one for the poor, as experienced by many countries.

The current hospital user fee in Viet Nam is estimated at about one-third the full costs for provided services, meaning that health services in public health facilities are highly subsidized by the government. With commercial presence, foreign private hospitals will probably charge the full-cost prices, even with additional benefits. Therefore, consideration should be given to a service fee mechanism that would work well with the presence of both public and private health providers. Foreign service providers could be obliged to provide services to Vietnamese patients under the universal health insurance programme at low costs, in cases where the treatment required was not available in the public sector. ***It would be necessary to draw up regulations to govern the operation of foreign health service providers with respect to quality and fees, and to devise mechanisms to ensure that their contributions to the health system in Viet Nam is positive, such as by providing high-tech training to produce highly qualified doctors who would subsequently provide services to the majority of the population.***

The presence of foreign health insurance providers would also be a cause for concern, as noted above, regulations should be drawn up to ensued that these do not undermine the universal

[25] See WHO/UNCTAD study *International Trade in Health Services: a Development Perspective* UNCTAD/ITCD/TS B/5, WHO/TFHE/98.1 Geneva 1998,http://www.unctad.org.

[26] WHO and WTO. *WTO Agreements and Public Health,* A joint study by the WHO and WTO Secretariat, www.wto.org

health insurance system that is being established. In particular, no one should be permitted to opt out of the national system. The experience of other countries indicated that penetration of the Viet Nam market by Health Management Organizations (HMOs) or Managed Care Organizations (MCOs) should be avoided s these create a captive supply of doctors and will exacerbate existing shortages of medical staff for the treatment of poor people.[27]

It is recommended that Viet Nam does not make any further commitments on commercial presence in the health services sector. If it is unavoidable due to pressure from powerful countries, any further commitments on commercial presence should be subject to economic needs tests. Unfortunately, Viet Nam was obliged to make commitments on commercial presence in health services in the Viet Nam-US BTA, under which 100% of US equity investment is allowed for hospitals, (minimum investment $20 million), clinics ($2 million), and specialty units ($1 million). Other WTO Member countries will consider this commitment as a starting point to seek even more commitments from Viet Nam in the accession negotiations. ***The impact of these commitments on the access of the poor to health services in Viet Nam, should be carefully scrutinized. If they are shown over time to seriously undermine programmes to improve access to the poor, Viet Nam should renegotiate these commitments under Article XXI of GATS.***[28] GATS Article XIV(b) stipulates that nothing in the Agreement shall be construed to prevent the adoption or enforcement by any Member of measures necessary to protect human, animal or plant life or health.

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[27] See, for example, Consensus Paper on Managed Care Organizations by Association of Private Hospitals of Malaysia 10 April 2001, www.hospitals-malaysia.org.

[28] The USTR is coming under sharp criticism from prominent health experts in the United States who claim that the commitments on health services and intellectual property obtained by the United States in bilateral trade agreements "significantly shape public health related policies in the United States and other countries by requiring changes in laws and regulations and especially by foreclosing policy options that countries may wish to pursue in the future", see Center for Policy Analysis on *Trade and Health, Advice and No Dissent Public Health and the Rigged US Trade Advisory System,* www.multinationalmonitor.org/mm/2004/112004/brenner.hml.

Figure 5. WTO Members' commitments national treatment for medical, hospital and other health services, and on health insurance (number of Members), 3rd Quarter 2000, *(Source: WHO and WTO)*

		Medical and Dental Services	Midwife and Nursing Services	Hospital services	Other Human Health Service	Health Insurance (in Financial Services)*
NATIONAL TREATMENT						
Mode 1	Full	19	7	16	8	29
	Partial	8	4	0	1	32
	Unbound	25	17	26	6	39
Mode 2	Full	27 (-1)	9	36 (-1)	9 (-1)	42
	Partial	21	19	4	5	26
	Unbound	4	0	2	1	32
Mode 3	Full	17	8	29 (-23)	7 (-4)	29
	Partial	30	19	10	7	62
	Unbound	5	1	3	1	9
Mode 4	Full	1	0	2 (-1)	0	6
	Partial	47	27	37	15	82
	Unbound	4	1	3	0	12

* *In a few cases, Members may have specifically excluded health insurance from coverage under their insurance-related commitments, but this has not yet been tabulated.*

Source: WTO, 2000.

Note: EC Member States are counted individually.

( ) Reduced number of full commitments if horizontal limitations are taken into account.

Mode 4 – Movement of natural persons

Movement of natural persons also is important in the health service sector as the international movement of health professionals is very large. Commitments on Mode 4 would involve permitting foreign health workers to come to Viet Nam, in addition to intracorporate transferees covered by the horizontal commitments. Policies to attract good health experts from other countries to come and work in Viet Nam, cold be reflected in commitments specific to the health sector as has been done by other countries. The goal should be high-tech and high quality health care services, and the quality of the medical staff coming to Viet Nam should be carefully scrutinized. The BTA with the United States requires that foreign medical staff possess five years experience.

However, it is unlikely that Mode 4 commitments would result in an influx of medical personnel to Viet Nam. On the other hand, shortage of health personnel, especially high quality personnel, in low-income countries has been exacerbated by the increase in the "brain-drain" of health professionals to higher income countries, leading to problems in access to and quality of health services. It also results in losses to governments with respect to the investment made on training health professionals.[29] On the other hand, some developing countries, such as the Philippines, actually encourage the export of medical staff. For example, the access of Filipino nurses to the Japanese market has been a major issue in the current FTA negotiations between the two counties.

[29] Bundred, P.E., Levitt, C. Medical migration: who are the real losers? The Lancet, 365: pp.245-246.

The public health sector provides doctors with job sustainability, income stability, and good opportunities for further training, education, and career development. However, many doctors move to the private sector and especially to urban areas after having received training and experience in the public sector. Thus, resources invested by the Government to train a qualified health staff, are not available to the people particularly not to the poor. Any expansion of foreign private health care in Viet Nam can be expected to exacerbate this internal brain drain. ***A strategy should be developed for keeping good health professionals working in the public sector, in the rural private sector, or at least in Vietnam. Some provinces and facilities required health staff to sign an agreement before sending health staff for training, in addition to providing financial incentives, free lodging, ad other benefits.[30] Another approach has been to train students from ethnic minorities and remote areas to work in the remote areas with the promise of being transferred to urban areas after several years service.***

Health services are presently under negotiation in AFAS. Three ASEAN countries, Brunei, Malaysia and Singapore have made commitments in GATS. Both Malaysia and Singapore have subjected these commitments to limitations, particularly by Malaysia, in the form of economic needs tests. Singapore also has included some reservations on health services in its FTA with the United States. Thailand has liberalized the domestic health sector, permitting telemedicine, an active private sector, and foreign participation through joint ventures, and it has entered into the export of health services,[31] However, Thailand has not made any commitments in this sector in GATS.[32]

Trade liberalization calls for the need for effective regulatory frameworks to ensure that the private health sector should contribute to overall health goals of the Government, especially for poor and disadvantaged people. The government should monitor the impacts of trade liberalization in health in the coming years and identify indicators and create systematic data collection for this purpose.

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30 According to Adlung, op.cit. Indonesia and other ASEAN countries maintain certain public service obligations on young medical professionals, thereby enabling hospitals in remote regions to recruit staff.

31 See International service trade and its implications for human resources for health: a case study of Thailand at www.human-resources-health.com/content/2/1/10.

32 See presentation of Jutamas Arunanondchai at the 4th AEF meting 22-23 June 2004, this presentation also points out how the private sector in Thailand has attracted the most competent medical staff from the public sector. http://ei.cambodia.org.events/upfile/jutamas_dang_nguyen.pdf.

4. Education Sector

4.1. Introduction

Viet Nam has made remarkable achievements in the education sector, outperforming many countries with much higher average per capita income. These have included very high levels of primary and secondary education enrolment and full literacy of the population between 15-40 years of age. Tertiary and post-graduate training has developed markedly. Students from rural and mountainous areas make up around 70 percent of all the students admitted to colleges and universities annually. In the 2002-2003 academic year, about 22.7 million people were trained at educational establishments. Of them 2.6 million were pre-school children. The rate of trained workers increased to 23 percent in 2003 from 13 percent in 1998. In the 2002-03 school year, university students numbered more than 1.032 million and 33,000 postgraduates. The achievements in illiteracy eradication and primary education universalization have been maintained and strengthened. Twenty of the 64 provinces and cities have achieved universal lower secondary education, and a number have begun to universalize upper secondary education.

However, increasing rural-urban disparities present a challenge to attaining equality of opportunities. As 78 percent of the population, including 90 percent of the poor in Viet Nam lives in rural areas, ensuring access to affordable and quality education in rural areas is a matter of concern to the Government. The disparities are both of a regional and ethnic nature. This issue poses a particular challenge for achieving the educational goals for the next decade, in terms of affordability and quality for poorer people, particularly at the secondary level. The Government aims to totally eliminate illiteracy, make lower secondary education universal and greatly expand enrolment in upper secondary education. This will call for a major investment in human and physical resources. There is also a perceived need to revise traditional forms of public sector management, improve quality and ensure that education provides the skills and knowledge required to equip students to be productive and employable in the context of Viet Nam's increasing integration into the world economy.

The private sector has made a contribution to the success of Viet Nam in the education sector, however, private education has grown most rapidly at the pre-school and upper secondary levels where public education is not yet provided free of charge. Foreign private schools exist at these levels but mainly to service the expatriate population.

Viet Nam accepted certain commitments to permit the entry of foreign service providers in the BTA with the United States and these are likely to be further expanded in Viet Nam's terms of accession to the WTO. It is hoped that the presence of foreign education suppliers, and the provision of distance learning facilities could make a positive contribution to upgrading skills and assisting Viet Nam to compete in a globalized world. On the other hand, internationally prominent educators, continually caution prudence to developing countries in permitting the penetration of their education system by foreign private education service suppliers. They consider that these could undermine the public system by attracting the best teachers and lead to the creation of a two-tiered system, propagating elitist attitudes. They also stress the difficulties in exercising quality control over foreign private education service suppliers, particularly distance learning providers. These would seem to be among the reasons that few countries have made commitments in the education service sector in GATS. Thus Viet Nam is faced with the challenge of upgrading and modernizing its education system while ensuring that its goal of access by the poor at all levels is not compromised.

4.2. Economic Reforms, Trade Liberalization and Poverty Reduction Policies

The education system in Viet Nam consists of five-year primary, four-year lower secondary, three-year upper secondary, two to three-year technical and four-year higher education. “Compulsory” education starts for children at 6 years old and continues through five years of primary schooling. (Figure 1).

Progress in the provision of education has covered all levels of the system. The Government and people of Viet Nam have traditionally accorded high priority to education. The rights of all children and adults to education constitute a central goal of Viet Nam’s education law, and Viet Nam has devoted considerable efforts and resources to the realization of these rights. Major achievements of the last decades include a spectacular expansion of the education system and an impressive increase in access to basic schooling. These gains have given Viet Nam international recognition for achieving among the highest levels of literacy and access to basic education of low-income countries at similar levels of economic development.

Figure 1. The National Education System in Viet Nam

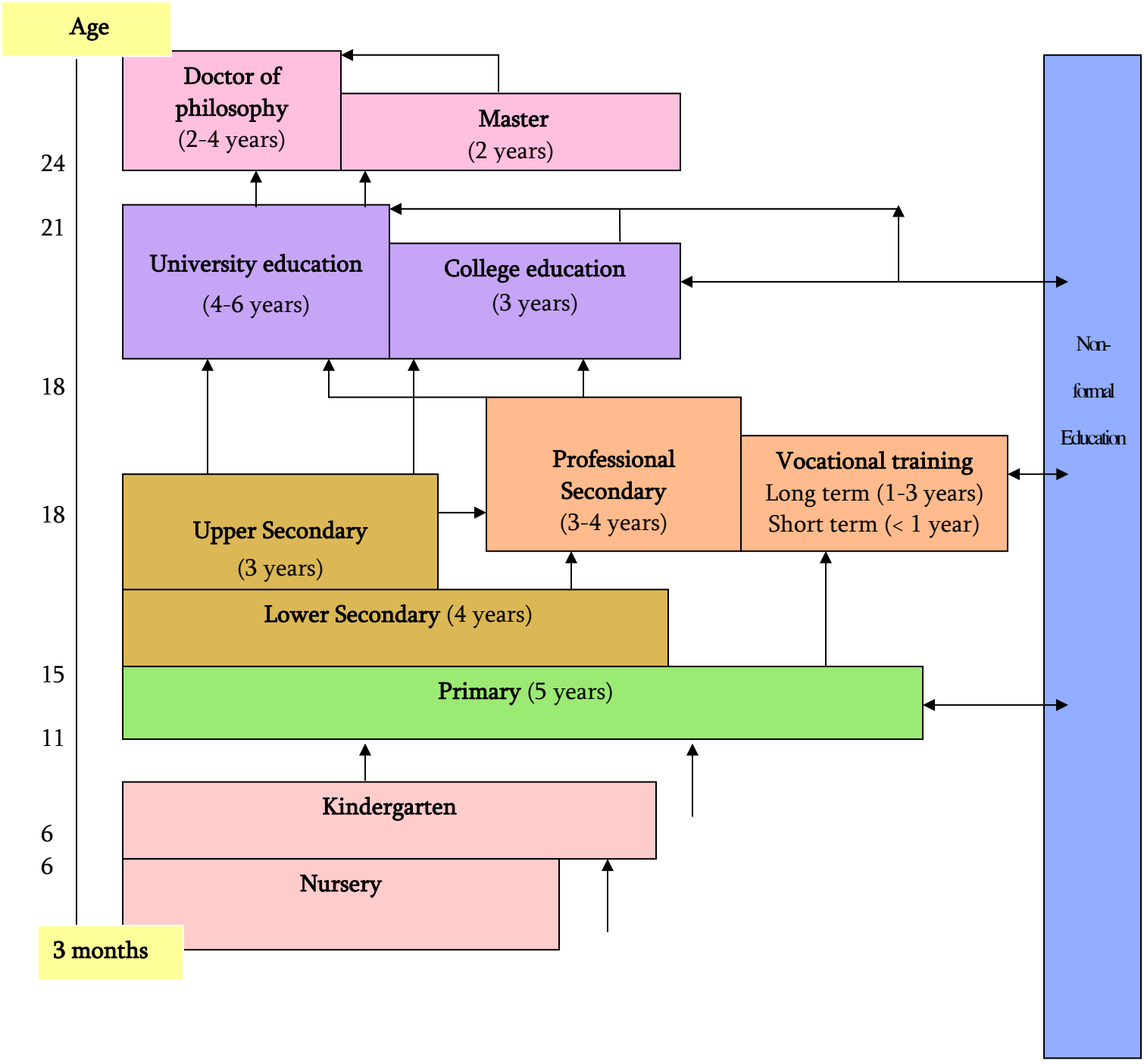

Table 1. Illiteracy Rate, Adult Total (% of population at the age of 15 and above)[33]

Countries	1998	1999	2000	2001	2002
Viet Nam	7.89	7.69	7.49	7.32	7.15
Brunei	9.55	9.08	8.50	4.44	8.55
Cambodia	33.47	32.73	31.99	31.29	30.58
Indonesia	14.50	13.85	13.19	12.66	12.13
Lao PDR	36.88	36.06	35.21	34.40	33.56
Malaysia	13.84	13.22	12.61	12.12	11.64
Myanmar	16.04	15.68	15.33	15.02	14.72
Philippines	5.64	5.35	5.07	4.85	4.64
Singapore	8.43	8.09	7.73	7.45	7.16
Thailand	5.09	4.81	4.52	4.35	4.17

Impressive progress has been made at all levels of education, enrolment has increased, while teacher/pupil ratios have been maintained or improved, and drop out rates have declined significantly.

At the pre-school level day nurseries exist for infants from 6 months to 3 years old, and kindergarten, for children from 3 to 5 years old. In 2002-2003, there were 9,500 day nurseries and kindergartens in the whole country and only 6 communes do not have pre-school establishments, 2,100,000 children were in kindergarten during this period. Free and compulsory primary education is provided for children from 6 years (for 5 years). The net enrolment rate for primary school in the 2002-03 school year was 95%.[34] While the number of primary school pupils increased only slightly from 1990-91 to 2002-03, the number of primary school teachers increased dramatically, due to the expansion of the teacher training institutions in the country serving to reduce the pupil/teacher ratio from 35:1 in 1990-91 to 24:3 in 2002-03 and pupil/class ratio from 33:8 in 1990-91 to 28:5 in 2002-03 (Table 4).

Table 2. Basic Indicators for Primary Education (1991-2003)[35]

[33] Source: World Bank, World Development Indicator (2003).
[34] UNESCO statistics.
[35] Table 3 from sectoral report. Sources: GSO (data for 2002 – 2003), MOET (data for 1990, 1995), GSO. Statistical Book 2003.

	1990/91	1995/96	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03
Primary schools	5,673	11,685	12,764	13,259	13,517	13,859	13,903	14,163
Classes	262,509	309,942	323,400	327,300	322,400	320,100	314,500	308,800
Pupils	8,862,295	10,218,169	10,383,600	10,223,900	10,033,500	9,741,100	9,315,300	8,815,700
Teachers	252,413	298,407	333,100	346,000	351,300	355,900	359,900	363,100

Table 3. Pupil-teacher-class ratios in Primary Education[36]

	1990/91	1995/96	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03
Pupil/Teacher ratio	35.1	34.2	31.2	29.5	28.6	27.4	25.9	24.3
Teacher/Class ratio	1.0	1.0	1.0	1.1	1.1	1.1	1.1	1.2
Pupil/Class ratio	33.8	33.0	32.1	31.2	31.1	30.4	29.6	28.5

Secondary education also has expanded remarkably during the past decade, at both the lower secondary (children from 11 years old for 4 years' education) and upper secondary levels (children from 15 years old for 3 years' education). Secondary education is not compulsory and tuition fees are charged. Gross enrolment rate for secondary school, both lower and upper, is 67% and net enrolment rate is 62% (2002-2003).[37] There are 9,969 lower secondary and 2,069 upper secondary schools in the whole country in the 2002-03 school year. Despite the rapid growth in the number of secondary students, (due to the population growth and better promotion from the primary level) the teacher/student ratio has been maintained.

Table 4.Basic Indicators for Secondary Education[38]

	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03
Lower secondary schools	6,258	7,161	7,417	7,741	8,096	8,396
Classes	124,900	133,400	139,500	144,400	153,700	161,300
Pupils	5,204,600	5,414,300	5,694,800	5,863,600	6,259,100	6,429,700
Teachers	184,200	202,700	216,200	233,800	254,100	271,800
Upper secondary schools	894	962	1,101	1,258	1,396	1,532

[36] Sources: GSO (data for 2002 – 2003), MOET (data for 1990, 1995), GSO. Statistical Book 2003.
[37] UNESCO
[38] *Sources: GSO, Statistical Yearbooks*

Classes	28,600	33,900	39,300	45,100	50,200	52,100
Pupils	1,382,000	1652,900	1,957,000	2,171,400	2,301,200	2,454,200
Teachers	48,300	55,800	64,200	72,000	80,100	88,600

Table 5. Pupil-teacher-class ratios in secondary schools[39]

	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03
Lower secondary						
Pupil/Teacher ratio	28.3	27.2	26.3	25.1	24.6	23.7
Teacher/Class ratio	1.5	1.5	1.5	1.6	1.7	1.7
Pupil/Class ratio	41.7	41.3	40.8	40.6	40.7	39.9
Upper secondary						
Pupil/Teacher ratio	28.6	29.6	30.5	30.2	28.7	27.7
Teacher/Class ratio	1.7	1.6	1.6	1.6	1.6	1.7
Pupil/Class ratio	48.3	48.8	49.8	48.1	45.8	47.1

With primary education close to being universal, the Government has shifted its attention to lower secondary education, by focusing on physical expansion and quality improvements with external support from funding agencies. Provinces have been supported by increased subventions to expand their physical facilities for lower secondary education, alongside those for primary education. The Government's education sector targets include universal lower secondary education in urban areas by 2010, and gradual expansion of upper secondary education to promote industrialization and economic modernization. The target of providing free universal secondary education must be pursued as matter of priority to counter the impact of increasing income and urban/rural disparities on access to education at this at this level.

Vocational and technical training is provided by several types of institutions. The vocational training schools and training centers administered by Ministry of Labour, Invalids and Social Affairs (MOLISA) correspond to the level of secondary school and their admission requires certification of graduation of primary school or lower secondary school. Non-public training centers and vocational secondary schools are equivalent to the upper secondary and require certification of graduation of lower or upper secondary school. These are also semi-public training programmes of less than one year and no certification of completion is issued. Skilled training is a program of 1 to 3 year duration, for the fields of engineering, agriculture, commerce and business, teacher training, health and nursery and arts and sports. Teachers require a university degree or pedagogic junior college degree. Provincial authorities are responsible for the quality of teachers and curriculum. Monthly tuition fees range from 20 to 100 thousand VND. Vocational and technical institutions tend to attract students from relatively poorer families. Scholarships and other education stipends should available to talented children from poor households for vocational training..

[39] *Source: GSO, Statistical Yearbook.*

Higher education also has expanded rapidly, the number of higher education institutions including national universities, regional universities, other universities, institutions, colleges, community colleges, open universities and foreign universities has almost doubled since 1990 (102 in 1990 to 191 in 2003). At present, there are two national universities, three regional universities, 71 universities, 114 colleges and one foreign university.[40] In term of ownership form, there are 166 public institutions, five semi-public, 17 private, two open and only one using 100% foreign capital. There are 52 universities offering master and PhD programs, 78 universities offering only Master's programmes. Enrolment in higher education institutions has more than doubled since 1995. This figure however, falls short of demand. The national educational institutions can accommodate only 100,000 of the estimated one million students seeking higher education in Viet Nam.

Table 6. Enrolment at university/college level[41]

Year	Number of New Students		
	Total	University	College
1986-1987	37,404	N.A.	N.A.
1990-1991	48,433	41,329	7,104
1995-1996	138,572	115,930	22,642
1999-2000	195,160	134,136	61,024
2000-2001	215,281	155,389	59,892
2001-2002	239,584	170,941	68,643
2002-2003	256,935	186,557	70,378

4.3. Challenges and Initiatives to Improve the Poor's Access to Education Services

The poor have been major beneficiaries in the remarkable increase in the country's net enrollment in all the three levels of general education. There has been a sharp growth of net enrolment rates of the first quintile (the poorest) in all three levels of general education, especially the primary education, meaning that more children from poor households attend schools. They have been enrolled at the primary schools. Improvement in net enrollment rates at higher levels was even more impressive, more than four-fold at the lower secondary level, and ten-fold at the upper secondary level (see Table 8 below).

Table 7.Net Enrolment Rates over 10-year period (1993-2002) [42]

	Primary			Lower secondary			Upper secondary		
In percent	1993	1998	2002	1993	1998	2002	1993	1998	2002
Viet Nam	86.7	91.4	90.1	30.1	61.7	72.1	7.2	28.6	41.8
Poorest	72.0	81.9	84.5	12.0	33.6	53.8	1.1	4.5	17.1

[40] College level offers three-year programs for those who have graduation certificates from upper secondary school or vocational secondary school. It provides students with necessary knowledge of basic science and specific fields of training, with a focus on the training of basic skills and the ability of implementing professional knowledge. Undergraduate level offers 4 – 6 year training programs (depending on the field of study) for those who have a graduation certificate granted by upper secondary school. For students who have a diploma from colleges of the same field, they can earn a Bachelor's degree after the completion of one or two years of training. Graduates at this level relatively have complete knowledge of basic sciences and specific fields of study that enable them to apply scientific methods to work situations and theoretical knowledge to their professions.

[41] Centre for Educational Management Information, MOET

[42] Table 17 from Sectoral report *Source: Ministry of Education & Training (1993-2002)*.

Near poorest	87.0	93.2	90.3	16.6	53.0	71.3	1.6	13.3	34.1
Middle	90.8	94.6	91.9	28.8	65.5	77.6	2.6	20.7	42.6
Near richest	93.5	96.0	93.7	38.4	71.8	78.8	7.7	36.4	53.0
Richest	95.9	96.4	95.3	55.0	91.0	85.8	20.9	64.3	67.2

However, not all children have access to and complete the full cycle of formal basic education. Despite the overall high enrolment level, 20% of primary school-aged children from the poorest families are not in school or do not complete the basic primary cycle. Most of these children live in regions or belong to population groups that experience different types of disadvantage in their economic, social, and health conditions. Students in ethnic minority areas suffer particular disadvantages due to poverty, remoteness, language, and opportunity costs. For example, only 8 percent of ethnic minorities were enrolled in upper secondary schools. Thus, reaching these children will require a special set of targeted and probably more costly measures, with emphasis on inclusive approaches to learning and on bridging programs to reintegrate school drop-outs into the mainstream primary and lower secondary systems. The Education Development Strategic Plan (EDSP) from 2001–2010 set the target for primary school net enrolment rate at 97% in 2005 and 99% in 2010.

Access to primary education of children in disadvantaged areas is negatively affected by; quality of education, repetition and drop-out rate, qualification of teachers, instruction hours, facilities, and especially financial burdens. Parents have to buy books, uniforms for their children and to pay other fees (including for school building, parents' associations, and extra classes). The state budget is mainly used for personnel expenditures, with a decentralization of educational policy; communes are left to defray the costs of maintaining school facilities and capital investment. Nearly 80% of financial resources for capital investment are provided by communes.[43]

However, in reality, poorer regions cannot afford the expenses and pupils' parents have to take a significant burden of sharing the costs. It is such a burden to poorer families that some of them give up continuing education. It should be noted from the following Table 8 that the richest group has spent almost three times (in absolute figure) more than the national average and five times as compared to the poorest. Poorer people simply cannot afford secondary education; the costs are equivalent to the per capita non-food expenditure of poor families.[44] For these reasons, the gap between the rich and the poor at the secondary school level has widened. The results of the survey in the selected districts demonstrate how the financial burden has been shifted to the households over the years. ***This cost burden does not seem sustainable for poorer families; free secondary education and direct subsidies to poor households are required.***

Table 8. Financing educational services in surveyed districts (in 1,000,000 VND) [45]

	TOTAL			**AVERAGE**		
Sources of funds	**1986**	**1996**	**2004**	**1986**	**1996**	**2004**
Governmentexpenditure on education (year)	9,238	37,221.71	137,3873	1,154.75	4,652.7	17,173.4
Fees and costs incurred by students (year)	944	73,139.11	193,421	118l	9,142.4	24,177.6

[43] JBIC 2002.

[44] See Asian Development Bank Education Sector in Viet Nam, ADB's Road Map: Toward Secondary Education for All, February 2003

[45] Source: 2005 survey

Share of government expenditure on education in total district expenditure	331.00	169.00	162.60	47.63%	21.20%	20.33%
Allocation of funds	**1986**	**1996**	**2004**	**1986**	**1996**	**2004**
Capital expenditure (year)	2,100	3,310	17,700	525	413.75	2,212.5
Subsidies/grants for the poor included in above (year)	531	1,116	2,074	66.375	139.5	229.25
Recurring expenditure (year)	4,500	10,922	57,00	562.5	1,365.22	712.5

Gender disparities are provoked by financial concerns. For many rural households the labour of children, even young children, is important to the family economy, and their attendance in school represents an opportunity cost, which increases as the children mature, making attendance at school a more expensive undertaking, especially for a poor family. On average the rates of school enrolment for girls and boys at primary and lower secondary school are almost equal. However, among the poor and ethnic minority communities, girls have fewer opportunities for education, reflecting a long-standing tradition, which places higher value on the education of boys. ***The gender aspect should be taken into account in programmes to assist poor households obtain secondary education for their children.***

Table 9. Household Expenditures in Education in 2002[46]

Primary education	In thousand VND per year							
	Tuition fee	Contri-bution	Uniform	Text-books	School tools	Extra classes	Others	Total
Q1 (poorest)	4.7	41.9	17.0	27.6	26.5	7.4	4.8	130.7
Q2	7.5	47.2	24.9	36.4	34.6	14.1	8.8	174.3
Q3 (Middle)	11.5	50.3	33.0	41.3	38.6	22.6	15.4	215.0
Q4	26.4	59.8	44.9	44.9	43.8	44.7	22.0	290.8
Q5 (Richest)	131.1	102.5	73.9	58.8	62.6	218.2	89.3	756.7
Viet Nam	27.8	56.0	34.4	39.5	38.6	47.2	22.3	270.3
Lower secondary education	In thousand VND per year							
	Tuition fee	Contri-bution	Uniform	Text-books	School tools	Extra classes	Others	Total
Q1 (poorest)	30.7	51.3	28.3	49.0	40.4	15.5	9.1	225.7
Q2	45.9	56.4	39.1	56.3	49.3	28.9	16.0	293.2
Q3 (Middle)	55.0	60.5	44.5	62.7	54.7	45.6	18.0	343.1
Q4	70.0	68.8	60.7	70.1	63.3	89.9	31.0	457.5
Q5 (Richest)	180.1	103.4	100.8	90.6	79.3	425.7	89.4	1076.0
Viet Nam	72.2	66.7	53.1	65.0	56.8	107.5	30.3	454.8

[46] Table 20 in Sectoral Report.

The quality of schooling varies considerably according to parental ability to pay. Technical and material facilities are poor in quality and short in quantity. Teaching aid supplies are only 20% of the requirement facilities. However, schools in more affluent areas have better quality facilities and learning materials than schools in remote and poor areas. As a result, the in-school performance and examinations required for entrance into higher levels of education constitute a relatively greater barrier for poor children. Current levels of basic education provisions depend, to a large extent, on parental and community contributions. which provide essential resources to fill public funding gaps in construction, maintenance and provision of learning materials. During the 1990s, cost sharing became an important feature of education provision. While cost sharing can foster a joint feeling of responsibility between parents and state for schooling and the provision of vital funds to top up already-stretched public budgets, it can also be a deterrent if the financial burden is too heavy, particularly for poorer families. ***The challenge is how to define a reasonable user charge, with exemptions for the poor, consistent with the need to generate local resources to finance rising education costs with the goal of providing quality and affordable education for all.***

There is also a shortage of teachers, and their skills may be outdated. Over 100,000 teachers are needed for primary and secondary schools, especially those in remote and mountainous areas. In the whole country, there are still over 2,000 three-shift classrooms including Hanoi and Ho Chi Minh City. Qualification of primary school teachers is the completion of upper secondary education and two years of pedagogic secondary school. While in 2002-2003, 91% of the 360,000 teachers possessed more than minimum requirements for teachers, the majority were trained in the old teacher training programs. It is perceived that there is a need to improve their skills to encourage creativity, participation and extra activities of pupils. The public schools do not prepare students adequately for the challenges of the modern world and the exigencies of the marketplace. As noted in the "National Strategy" the lack of skilled workers in Viet Nam has been identified as one of the main constraints to the development of the private sector.[47] Quality improvement will involve effective implementation of curricular reform. Progress towards full-day schooling, and the establishment of a minimum level of learning quality, is necessary in order to reverse the widening learning gap between urban and rural areas, in particular, remote and mountainous areas. Pupils who have fallen behind or dropped out will require special attention involving extra costs.

The renovation of curriculum, textbook and teaching methodology is being introduced progressively up to 2007 with bilateral and multilateral assistance. A Teacher Training Upgrading and Strengthening Programme has been underway since 1994, the objective is to equip teachers so as to make them agents for change. There is need for trainers to teach these programs; availability of an adequate supply of appropriate learning materials in the classroom; new student and teacher assessment systems; timely management as well as pedagogical support and advice; continuous monitoring to adjust and strengthen activities are part of the overall objective. ***The challenge is how to define a reasonable user charge, with exemptions for the poor, consistent with the need to generate local resources to finance rising education costs with the goal of providing quality and affordable education for all.***

Private Education Providers have entered the market. Until 1993 when the Government introduced the Strategy for Education Development, all schools were state-owned (or public). The demand for new forms of school ownership was a response to demographical change and the financial constraints on the part of the central and local governments. People-founded schools (educational institutions established by social, social-professional, or economic organizations) and semi-public schools have been playing an important role in the country's development of education. At those levels where school attendance is not free of charge they are helpful in providing supplementary extra education.

[47] Submitted by Dorothy Riddle, Nguyen Hong Son and Cristina Hernandez, 5 June, 2006, pp.65-66.

Table 10. Non-public school enrolment (1986-2003) [48]

	1985-1986		1994-1995		1999-2000		2002-2003	
	Total	%	Total	%	Total	%	Total	%
Pre-school	2739964	0	2088995	26.25%	4177990	31.82%	2547430	62.15%
Primary	8166372	0	10047564	0.23%	100630.25	0.30%	8841004	0.47%
Lower-secondary	11252786	0	3678734	4.15%	57672.98	3.51%	6497588	2.48%
Upper-secondary	791989	0	863270	20.01%	19758.35	34.04%	2458446	32.60%

The increase in non-public enrolment was largely concentrated at levels where education is not provided free of charge. For example, at the pre-school level enrolment in non-public schools increased dramatically. The shift to non-public education was negligible for primary education which is provided free of charge, and minor for lower secondary education, but substantial for in the upper secondary training (see Table 10). Early childhood care education and continuing education programs tend to be concentrated in more affluent areas rather than in remote areas where needs are greatest. By 2002-2003, there were 35,800 schools in the whole country, among which more than 9,500 were nurseries and kindergartens, 14,100 primary schools, 2,069 secondary (both lower and upper) schools, 252 technical and professional training schools, 114 colleges and 77 universities.[49] The total non-public schools in pre-education in 2002-2003 were 5,890, of which 4,883 were semi-public schools (or 83%). Results of the 2005 survey in 8 districts of the 4 provinces show the same trend with an increasing number of the non-public schools and pupils.

Table 11.Percentage of non-public school enrolment in survey areas (%)[50]

Bach Thong	12.5
Bac Kan Town	16.7
Truc Ninh	2.4
Nam Dinh city	10.0
Quynh Luu	29.7
Vinh city	15,8
Dac Song	0.6
Gia Nghia	1.8

[48] Table 12 in Sectoral report. Source: Viet Nam Education 1945-2005.
[49] Source: MOET
[50] Table 13 in Sectoral Report, Source: 2005 survey.

As noted in the "National Strategy Report" there is an urgent need for ongoing training after formal tertiary or vocational training has been completed.[51] The establishment of private training enterprises should be encouraged.

Foreign education service providers in Viet Nam are limited in number. They offer mainly technical and vocational training, as well as tertiary education and foreign languages. However, in Ha Noi and Ho Chi Minh City, foreign education service providers have penetrated in all levels of education: pre-school, primary, secondary, vocational and technical training, and tertiary education (see Table 14 below). These foreign schools charge fees much higher than those in local schools, and are mainly attended by children of foreign expatriates and local rich people.[52] They make no positive contribution to the access of education service to the poor, however, due to their limited number, negative impacts, e.g. by draining skilled teachers from the domestic public and private sectors, are so far minimal.

Table12. International education service providers in Viet Nam[53]

Schools	Level	Country	Year of establishment	Location
Bambou Bulles	Pre-school	Korea	2000	HCMC
Kinderworld International	Pre-school	Singapore	2003	HCMC
Kinder World	Pre-school			Ha Noi
Little House	Pre-school			Ha Noi
Morning star	Primary			Ha Noi
Viet Nam - Australia international school	Primary	Australia	2004	District 3 and 5, HCMC
Thai Van Lung international school	Primary	Joint venture	2003	District 1, HCMC
Australia international school	Primary		2004	District 3, HCMC
International grammar school	Primary	UK	1999	District 1, HCMC
The British International school	Primary	UK		District 2, HCMC
APU	Lower secondary	USA	2004	HCMC
Asia school	Lower & upper secondary	USA		Tan Binh, HCMC
International high school	Upper secondary	UK		HCMC
Horizon international school	Upper secondary			HCMC
Viet Nam-Australia school	Upper secondary	Australia	2001	HCMC
Saigon Tech	Technical	joint venture	2002	Phu Nhuan, HCMC
Ha Noi International School (UNIS Hanoi)	elementary & secondary		1997	Ha Noi
AITCV	Post-grad		1999	Hanoi and HCMC
RMIT – Viet Nam	Under-graduate	Australia	2001	HCMC
HSB – Hawaii	Post-grad	USA	2002	Ha Noi

[51] Dorothy Riddle, Nguyen Hong Son and Cristina Hernandez, General Framework for a National Strategy for the Services Sector in Viet Nam up to 2020, VIE/02/009.

[52] In many developed countries, private education at the primary and secondary levels basically serves to provide special linguistic training, or religious or ideological indoctrination, Private education at the post-secondary level is essentially an "escape valve" enabling students who do not meet the standards set by the public system to obtain university degrees.

[53] Table14 from Sectoral Report.

CFVG	Post-grad	France	1992	Ha Noi
HUT in Ha Noi-NCU				Ha Noi
NEU – Swinburne	Post-grad	Australia	2002	Ha Noi
La Trobe – HUFS	Under-graduate	Australia	2003	Ha Noi
Victoria University	Under-graduate	Australia	2003	Ha Noi and HCMC
Thames Business School	Diploma and language certificate	Singapore	2002	Ha Noi

Foreign education providers are expected to make a contribution to tertiary, technical education and language training in the future. However, the Government should be vigilant to ensure that their presence does not exacerbate the growing disparities in access to quality education services, nor should they be permitted to undermine Vietnamese society by fostering elitist attitudes. Regulations should be drawn up to ensure that foreign schools maintain acceptable standards of quality.

At the general education level, (pre-school, primary and secondary) foreign education service providers should be permitted to open schools of general education only to the scope necessary to provide education to the expatriate community, and not to the extent that could effectively compete with domestic public or private institutions for teachers or students. Foreign participation in professional secondary education should be limited to foreign language teaching and vocational training for foreign and Vietnamese nationals;

At the tertiary (college, university) and post-graduate education level foreign providers should be directed to the fields of technological sciences, technology, natural sciences, economic management science and languages. They should contribute to absorbing some of the 900,000 students seeking higher education. Foreign institutions opening technical/vocational and higher education schools or entering into collaborative arrangements with local training institutions should be subject to strict quality control. ***Foreign education service providers should be encouraged to concentrate on those areas where they have a "comparative advantage, such as providing ongoing training to staff of enterprises in technical skills and customer service, quality control and innovation.***

The education sector has received significant external assistance. **O**fficial Development Assistance was estimated to cover around 10% of the total public education budget in 2004. External assistance to the education sector from multilateral and bilateral funding agencies has targeted primary education. Assistance at this level provided by United Nations Children's Fund, the World Bank, the Asian Development Bank, Australia, Belgium, Canada, the European Union, Japan, the United Kingdom has focused on curriculum development, textbook writing, provision of teaching aids, and rehabilitation of primary schools in selected provinces, teacher training for primary education, focusing on improving primary school teachers' quality, utilization, and remuneration system. A project on primary education for disadvantaged pupils was commenced in October 2004, funded by WB, Australia, Canada, and Norway.

The ADB, World Bank and Belgium have assisted lower secondary education focusing on new curriculum, textbooks, and teacher manuals for lower secondary schools as well as for lower secondary in-service teacher training; provision of teaching aids; and rehabilitation and even construction of lower secondary schools in selected provinces. The ADB has also been focusing on ethnic minorities. The ADB, World Bank, France, the Nordic Development Fund, Japan, Germany and the Republic of Korea are supporting technical and vocational education and training. The World Bank also has provided assistance to higher education along with Canada, Japan and the Netherlands. ***The Government should intensify its efforts to mobilize ODA towards its goal of providing universal secondary education.***

4.4. Issues for Consideration in Liberalization of Trade in Education Services

Education is a politically sensitive sector for trade negotiations. Almost all countries view education, at least up to a certain age, as an essential social service and provide public-funded education on a

compulsory and universal basis. However, there are significant variations between countries' education systems concerning the level of public funding and public delivery of education and the degree to which private education is available; mixed systems, allowing the choice between public and private schooling, are common. However, despite these differences among national education systems, WTO members have been very reluctant to make GATS commitments in the educational services sector[54], and many have excluded this sector from coverage in FTAs.[55] They seem to have taken into account the strong concern expressed by prominent education experts over what they consider to be a growing threat to education arising from global, regional and bilateral agreements aimed at the creation of a profit-led education marketplace[56]. These experts believe that this will undermine the quality of education and research, and subvert the role and purpose in a way which has implications for civil society globally.[57] Another reason for the low level of commitments in this sector may be that in many countries with a federal system, education is entirely under the responsibility of the provinces or states, some countries have no Ministry of Education at the central level.

Mode 1: Cross border Movement. Commitments under Mode 1 would apply primarily to access for distance-learning providers, and educational software.[58] With the advancement of telecommunication technology, this mode of trade of education services can be a useful supplement to the public education system. Flexible and effective forms of learning can be made available to teachers and students through the internet and telecommunication. As noted in the "National Strategy" the Ha Noi and Ho Chi Minh City distance-learning programmes have been particularly effective and have networked with 18 provincial Continuing Education Centres. ***Such facilities should be made available to learners and the general public.[59] However, as has been stressed by internationally prominent educators the problem of quality control will have to be addressed; students should be protected against low quality and "rogue" providers.[60]*** In the BTA with the United States Viet Nam did not agree to provide either market access or national treatment for cross-border supply of educational services.

Mode 2: Consumption Abroad
There would not seem to be any valid reason for not accepting commitments in this Mode. Foreign exchange limits on students studying abroad and exit visa restriction can be considered barriers in this Mode. ***The Government should continue the financial support to students studying abroad, as in Program 322, and encourage the self-support students to study overseas.***

Mode 3: Commercial presence Viet Nam has already made commitments on commercial presence for education services, under the framework of the Viet Nam-US BTA, where Viet Nam agreed to permit United States educational service providers to set up joint-venture with Vietnamese partners to supply education in technical, natural science and technology fields. Seven years after the date the BTA enters into force, schools with 100% US invested capital can be established.[61] It appears that in the negotiations of its terms of accession to the WTO, Viet Nam has offered further commitments in the sub-sectors of higher education, adult education and English language training.[62] ***However, it is recommended that Viet Nam does not make any additional commitments under this Mode on educational services in***

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54 Only 21 WTO members have made commitments in this sector, among ASEAN countries, only Thailand.

55 For example, Singapore has "carved out" most of the education sector from its FTA with the United States.

56 For links to the international debate on trade in educational services see Choike, *Education on the Market* at www.choike.org

57 In a *Joint Declaration on Higher Education and the GATS*, the Associations of Universities and Colleges of Canada, the American Council for Higher Education, the European University Association and the United States Council for Higher Education Accreditation have urged their countries not to make commitments in higher education services in the context of GATS, and where such commitments have already been made, no further ones should be forthcoming, http://www.aic.lv/ace/ace_disk/GATS/jointdec.

58 Saner, Raymond and Fasel, Sylvie, Negotiating Trade in Educational Services within the WTO/GATS Context Centre for Socio-economic Development (CNSED) and Basle University Zurich 2003

59 See Riddle, Son, Hernandez, p. General Strategy op. cit

60 See Statement by Education International, www.ei-ie.org/hiednet.

61 It is ironic that the United States would oblige Viet Nam to accept commitments on educational services when the leading educators in the United States are opposed to GATS and warn of its potential detrimental impact on access to education and on national culture in developing countries. See Remarks by ACE President David Ward at the OECD/US Forum on Trade in Educational Services, http://www.acenet.edu,

62 See Riddle, Son, Hernandez, p. General Strategy op. cit. p. 106.

its accession negotiations. Viet Nam should retain the right to impose economic (or social) needs tests on the commercial presence of any education service.

Regulations should be drawn up to ensure that the presence of foreign suppliers does not have an excessively negative impact on the education sector, and in particular, on programmes to ensure access of quality education to the poor; ways of deriving widespread benefits from any foreign participation should be defined. In this context, the advice of prominent educators, both Vietnamese and foreign should be sought. Viet Nam should not rule out the possibility of resort to GATS Article XXI to modify these commitments should this prove necessary.

Mode 4: Movement of Natural Persons

Sector specific commitments going beyond those in the horizontal section could specify the conditions under which educational staff could enter and work in Viet Nam and the qualifications required. Under the BTA with the United States Viet Nam specified that the foreign teachers employed by the United States education service suppliers mentioned above must have five years of teaching experience and be recognized by the Ministry of Education, this commitment will have to be extended to all upon accession to the WTO. The exchange of scholars and professionals with other countries for better attainment of academic and professional development should be encouraged. However, the quality of foreign teachers should be ensured, while foreign countries should recognize the qualifications of Vietnamese teachers. Viet Nam should actively pursue international recognition of degrees granted by Vietnamese educational institutions, particularly in the context of UNESCO.

5. Electricity Sector

5.1. Introduction

Access to electricity is a prerequisite to the improvement of the basic services of health and education. The provision of affordable and reliable electricity to the poor empowers them to assume a productive role in the economy and society. The Government of Viet Nam has paid special attention to electricity system development, with the result that Viet Nam's overall electricity status indicators is much better than would be expected for a country at its low per capita income. The national electricity network system has reached to all 64 provinces as a result, 98 percent of districts, 95% of communes and 91% of households (88% of rural households) have access to electricity. Average electricity consumption per capita is about 500 kWh.

The national grid has been continuously expanded to reach more remote areas and greatly contributed to socio-economic development in Viet Nam, where 78% of the population live in rural areas. As 90% of the poor are concentrated in remote, isolated and mountainous areas and only 10% of poor concentrated in urban areas, providing access to the poor is a matter of extending rural electricity supply. Rural electrification is central to the policies of the Party and State for the industrialization and modernization of rural areas, and the strong local community involvement had enhanced the rural electrification process. The domestic private sector has an ever increasing role to play in contributing to rural electrification and the development of renewable energy sources.

The significance of Viet Nam's achievement in providing 88% of rural households with access to electricity, is even more impressive when viewed against the fact an estimated 1.6 billion people, one quarter of the population of the planet, do not have access to electricity, and that in many countries this figure is actually increasing. Electrification has had a strong positive impact on rural life. It supports more efficient agricultural production, facilitates the diversification of economic activity including the development of local crafts and industry, and contributes to an increase in knowledge and skills. It also serves to mitigate disparities between urban and rural populations, and thus reduced the motivation for rural dwellers to migrate to the cities. Electrification has had a major beneficial impact on women, pre-empting the use of unclean fuels for cooking and the accompanying risk of disease and death.

However, despite these achievements, Viet Nam finds itself faced with the dilemma shared by most other countries as to how to obtain the necessary capital and technology to supply enough electricity to meet rapidly growing demand for electricity in Viet Nam. Meanwhile it must continue to ensure affordable access to poor people and extend access to those who are still excluded. Like many other countries, Viet Nam is implementing structural and ownership changes in its electricity sector.[63] Care must be taken to avoid the experience of a number of other developing countries where reform of the power sector has resulted in increased costs and declining access for the poor.[64] In negotiating international commitments on electricity services, in WTO or elsewhere, it will be essential to ensure that the foreign suppliers directly support the rural electrification programme and do not concentrate on the higher income segments of the market.[65]

5.2. Economic Reforms, Trade Liberalization and Poverty Reduction Policies

Many of the *doi moi* reforms touched the electricity sector. Among the most important electricity - sector reforms included: (i) a major change on power sector organization related to rural electrification; (ii) the development of power generation in national grid and decentralized source in rural areas; (iii) the

[63] See UNDP Asia Pacific Trade and Investment Initiative International trade in Environmental and Energy services and Human Development, Colombo 2005 www.colomboregionalcentre.lk.undp.org.

[64] See GNESD, Regional Workshops on Electricity and Development in Africa, Asia and Latin America, Consolidated Report January 2006, www.gnesd.org.

[65] See Simonetta Zarrilli Multilateral Rules and Trade in Energy Services in Electricity Trade in Europe: Review of Economic and Regulatory Challenges, J. Bielecki and M.G..Desta eds. Kluwer Law International www.dundee.ac.uk/ccpmlp

development transmission and distribution network and rural electricity supply for the poor. (iv) the improvement of rural electricity business (electricity price, management model in rural areas).

The public sector has been responsible for the electrification of Viet Nam. Electricity of Viet Nam (EVN) the stated owned enterprise, is the ultimate utility responsible for generation, transmission, and distribution. The participation of other sectors such as private or foreign investors is limited to generation and distribution. EVN operates in the areas of generation, transmission, distribution and sales of electric power, and takes decisions on electricity investment in development, production and business of electricity, and related areas of business. EVN has also been delegated authority to deal with a wide range of matters such as allocation of after-tax profits, arrange loans, debt payment and approval of power purchase agreements, internal electricity prices; to make decisions on organization structure, management system of member units within EVN; as well as on indicators, economic technical criteria in operation and customer service standards.

The administration system for rural electrification service in Viet Nam is organized along a five-level system.

1. EVN, (under MOI), has responsibility at the national level, as described above.
2. Power companies (PC)have responsibility at the regional level (northern, central and southern regions), and presently there are 8 PC (PC1, PC2 and PC3 Ha Noi, HCM, Hai Phong, Dong Nai and Ninh Binh). The PC follows the EVN and has focused on distribution and supply in regions.
3. The 64 Provincial Electricity Authorities (PEA)follow the PC,It has main activities on distribution and supply in each of provincial branches. In the future reform plan of EVN, some of PEA will be converted to joint venture companies.
4. The 115 Branch Electricity Authorities (BEA) cover all 536 ward & districts administration unit. The BEA follow the PEA on electricity distribution and supply in ward & distribution branches, collect bills, and maintain the medium voltage (35, 22, 10, 6 kV).
5. The 6397 commune electricity management boards, which have the responsibility for distribution and supply at a low voltage level (0.4 kV) for 8524 communes accessed to electricity out of 9008 total communes in the whole country.

In 2004, total capacity of EVN's power plant was about 8400 MW accounting for 85% total installed capacity of power system generating 39,000 MW, presenting 96% of total electricity generated. To meet rapidly growing power demands, Viet Nam needs to create annually an additional capacity of 1000-1500 MW over the coming years. A large part of the new capacity will be provided by EVN and the remaining capacity is expected from non-utility developers, including foreign and private investors.
EVN is the sole organization in charge of operating the power transmission system. The national dispatch center and 4 transmission companies in each region manage the daily operation of the transmission system.

5.3. Challenges and Initiatives to Improve Poor's Access to Electricity

Access to electricity by the poor faces essentially three impediments: (a) lack of access to the grid due to geographical factors -- most of the poor in Viet Nam live in rural areas, and many in isolated, mountain areas, (b) low quality of electricity service, and (c) capacity to pay. The Government is taking measures to deal with these three problems. The private sector also is making its contribution.

Viet Nam has made remarkable progress in the electrification of the country, including the rural areas through extension of the national grid. Before 1986, the rural power network basically serviced agricultural pumping combined with household lighting, and was completely financed from Government budget and agricultural cooperation. Insufficient power supply and an inadequate power transmission network severely limited rural access to electricity. At that time, only 70% of districts, 45% of total communes and 25-30% of total rural household access had access to electricity, in which the poor household only accounted for about 1-3%. After almost two decades of Doi Moi by 2005, 100% of districts had access to electricity in which 522 districts (98% of total national districts) supplied from national grid and the

remaining 10 districts (2%) by decentralized power generation resources; 8.498 communes had access to electricity (94% of total national communes), in which there are 27 communes to be electrified by decentralized power generation. In 39 of the 64 provinces, all communes have access to electricity.

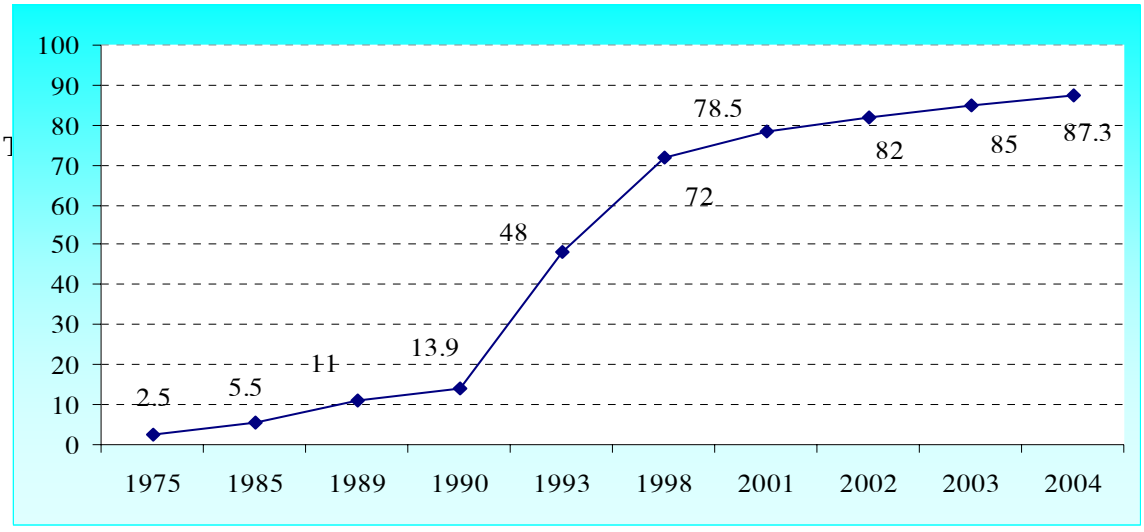
Therefore, only 484 communes do not have access to electricity, thus there are about 8 million people (over 1.5 million households), which still have no access to electricity. The distribution of rural electrification by power companies (PC) in the whole of Vietnam in 2004 is presented as follows:

Table 1. Distribution of rural electrification by power companies in Viet Nam, 2004

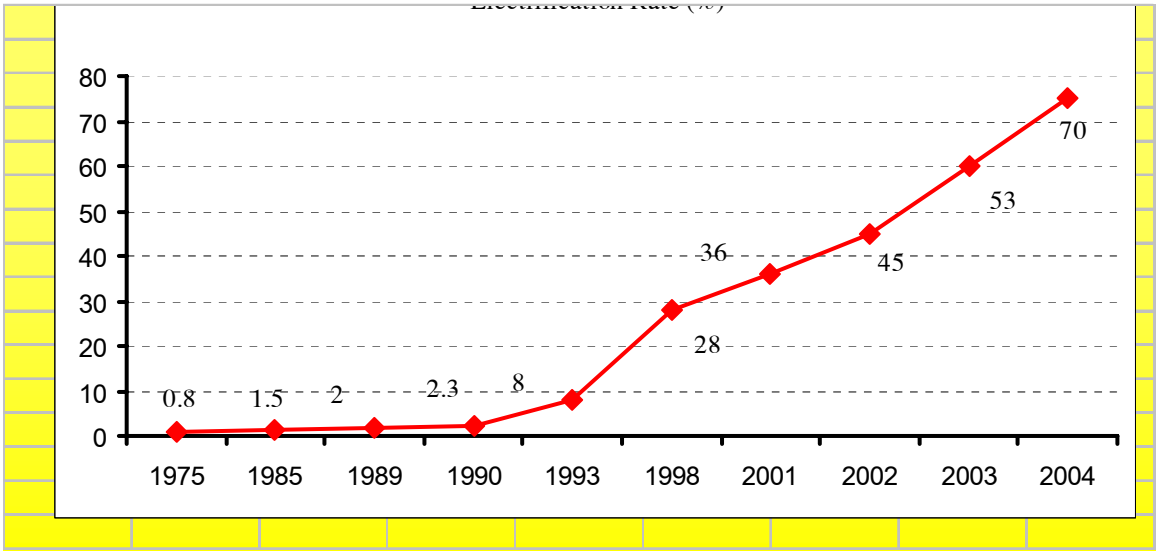
PC	Provinces	Districts	Communes	Rural Household
Ha Noi	1	5/5 (100%)	99/99 (100%)	224370/224370 (100%)
H.Chi Minh	1	5/5 (100%)	61/61 (100%)	201165/185052 (91,99)
Hai Phong	1	9/8 (88,89)	152/151 (99,34)	264596/264340 (99,99)
Dong Nai	1	9/9	136/136 (100%)	330074/274555 (83,18)
Ninh Binh	1	6/6	127/127 (100%)	189853/189546 (99,84)
PC1	26	242/240	5143/4713 (91,64)	6099039/5506244 (90,28)
PC2	20	14743 (97,28)	2182/2160 (98,99)	3737656/3053727 (81,7)
PC3	13	111/108	1496/1435 (95,92)	1998633/1702778 (85,2)
Total	**64**	**534/524 (98,13)**	**9009/8498 (94,33)**	**13045386/11400612(87,39)**

The historical development of electricity connection rate in percentage (%) of rural households in the period of 1975-2004 is presented in the following Figure 1.

Figure 1: Electricity connection rate of rural HH



Electricity connection rate of poor



Outside the national grid, energy is provided by modern small-scale renewable energy sources. Decision No 22/1999/QD-TTg provided a policy framework for development of renewable electricity related to rural electrification. This Decision instructed local authorities in mountainous and island communes not yet connected to the national power grid, to submit plans for construction of local power plants such as small hydropower, wind power or solar power projects. The Government encourages both domestic and foreign investment in Independent Power Producers (IPPs) with capacity less than 5000 kW, to be approved by the provincial people committees or lower authority levels, depending on the size of the proposed investment. Over the period of 1997-2003, a total of 88 communes were electrified by site and renewable energy sources with total installed capacity of 1.857kW, in which 574kW from diesel (31%), 1.089kW from micro hydro (59%) and 194kW from solar energy (10%).[66]

Access to electricity also was enhanced by pricing policies, to make electricity affordable. Before the Doi Moi period, the average rural electricity price was high, often exceeding 1200 VND/kWh, and connection charges were costly negatively impacting the poor, and leading to low electricity consumption in rural areas in general, particularly for poor areas. A major step toward improving access for the poor, was taken in Inter-Ministerial Circular No.01/1999/TTLT/BVGCP-BCN, which set an electricity ceiling sale price of 700 VND/kWh for rural areas, positively affecting rural economic activity. The government stipulated that rural electricity management units need not operate on the basis of profit.[67]

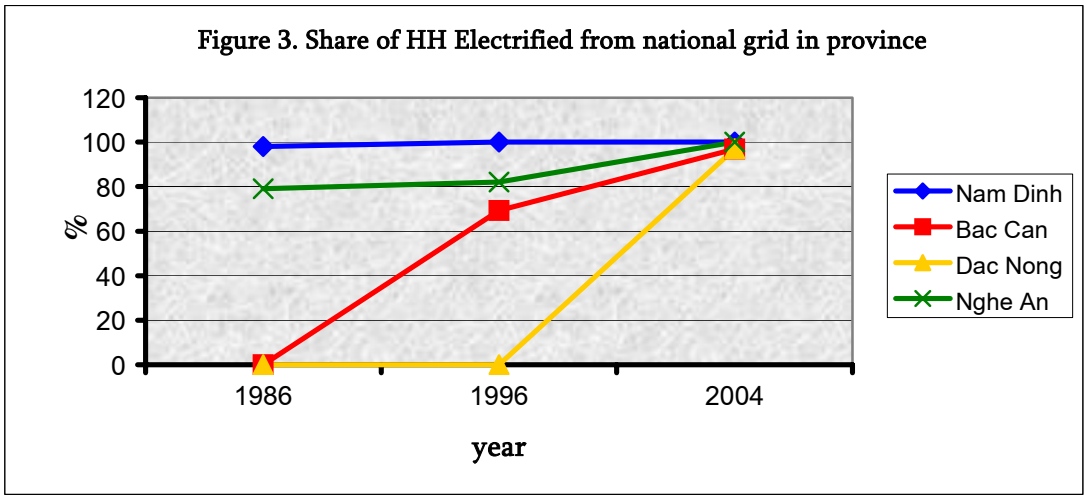
Rural electricity tariffs are subsidized within the range of 55 to 75% of the total generation cost. The wholesale selling price for rural residential use is fixed at VND 390/kWh whereas the production cost is 1560 VND/kWh in 1999. The average retail tariff for rural households directly connected to the low voltage line is 700 VND/kWh. Urban residential customers pay 550 VND per kWh for the first 100k, and above that 1,340 VND. According to EVN, 86 per cent of communes pay less than the average tariff (VND700/kWh). There is no minimum monthly charge. The national uniform tariff requires EVN to cross subsidize among regions through the internal bulk power transfer pricing. The cross subsidies in the tariff structures are not transparent. The fixed rate provides an incentive for higher electricity consumption. The wholesale tariff includes five categories with five different prices, however, it is very difficult to separate residential from commercial uses because they often use the same meter. For the most remote areas, the central government constructs the low voltage line, and, in some cases, shares the cost of the connection up to the meter. However, capacity to pay remains a problem for some people. ***The***

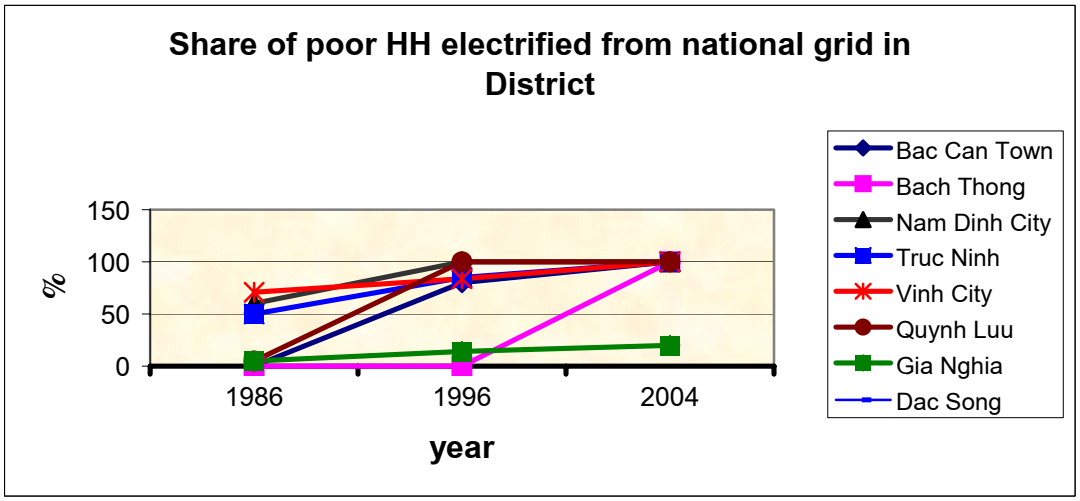
[66] EVN data

[67] (Decision of PM no 22/1999 concerning the organization of rural electricity) and a Government letter No 1928/VPCP-KTTH dated 07 May 1999 to the Ministry of Finance, Ministry of Planning and Investment, Ministry of Industry and the Government Pricing Board on tax policy and management of rural electricity.

Government-regulated ceiling price for rural electricity supply of 700 VND/ kWh still burdens the poorest people, who often have to take a loan from the Electricity Board Management to pay their consumption and repay after crops harvest. These payments in kind should be continued.

The results the four provinces that were surveyed illustrate the progress in electrification.





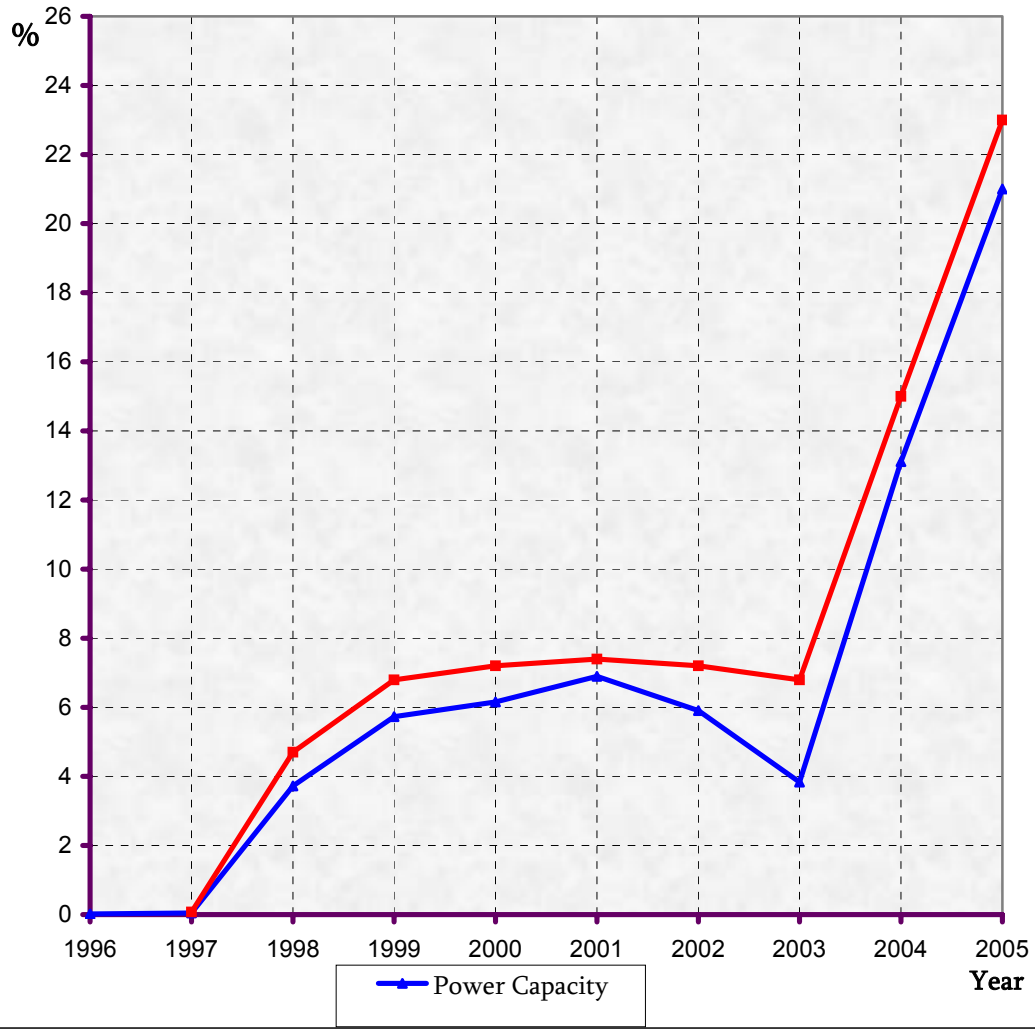
Quality of access is also a problem for the poor. It is not sufficient to have access to electricity, but also to be able to use it**.** The rural power grid is generally of bad quality, does not meet technical standards, and is unsafe. Electricity losses of 25-30% are common and can reach 50-60%. As a result, the real voltage is much lower than standard, in some areas, the poor require supplementary equipment to increase the voltage for household use. The households' connections and internal electricity network are often unsafe. Low quality meters can result in over billing to poor consumers. The MV and LV networks are not regularly maintained, but only repaired in case of a failure, usually by local electricians who do not have proper tools, materials and sufficient skills. It is difficult to maintain technical standards and training for the part-time staff who manage the network.

Private electricity suppliers are rapidly assuming an important role in rural electrification. Private investment in the form of IPP and BOT has been permitted since 1996. However, PM Decision no 22/1999 encouraged the private sector to participate in rural electricity distribution by investing in development of grid-connected renewable electricity projects, including small hydropower plants, biomass power plants, wind farms or geothermal power plants. The initial involvement of private providers was

through investment in the rural distribution network (LV), buying electricity at bundle tariffs and selling electricity to household at tariffs often higher than the ceiling tariff of 700 VND/kWh. The higher tariffs charged by private providers to rural households result from the fact that most of privately developed distribution networks do not meet technical requirements and thus require regularly rehabilitation resulting in very high losses and operation costs, as well as poor management, lack of qualified staff, and absence of monitoring schemes.

Decree No. 45 /2001/ND-CP permits both Vietnamese and foreign investors to develop independent power plants or power systems which may be connected to the national power grid provided that they have PPAs with EVN. The share of Independent Power Producers (IPPs) in electricity generation has increased rapidly from 7% in 2002 to 23% in 2004. The first step by private investors was by developing IPPs, mainly in grid-connected, small hydropower to feed electricity into the grid through a power purchase agreement (PPA) with EVN at negotiated tariff rates. By mid-2005, non-utility investors have registered 200IPPs accounting for over 21% of total installed capacity. The number of IPPs is expected to increase as the remaining barriers for private investment in the sector are removed. The sale of shares to private investors in the framework of the "equitization" of EVNs power plants provides an additional investment channel for private investors.

Figure 4. Share of IPP in Total Electricity & Power



The national uniform electricity tariff conflicts with market-based reform. Due to different customer density and mix and geographical circumstances, the cost of providing electricity is inherently different in different regions. EVN's attempts to form limited liability power companies at the provincial and district level failed because such companies would have only been able to bill at the national uniform tariff, regardless of the cost of providing services. The national uniform tariff requires EVN to provide cross subsidies among regions (by the power companies) through the internal bulk power transfer pricing.[68] The cross subsidy practice does not encourage the power companies to cut costs and improve efficiency. The national uniform retail electricity tariff is in conflict with the Government's economic reform and the cost-based pricing principle[69]. ***The Government, thus, must devise a regime that, on the one hand, will permit fee levels high enough to ensure the profitability of investments in new capacity in rural areas, while at the same time maintaining fees that are affordable for poor people, this can be achieved by maintaining a low fixed price for rural consumers and to provide direct subsidies to the energy producers.***

Thus, a mechanism is required to determine the optimum level of subsidy for rural communities. Such subsidy should not be so high so as to act as a disincentive to investment in renewable energy. The policy and regulatory framework should encourage either national grid or renewable electricity, whichever is least costly. Government policies, regulations, and procedures should be neutral, so as to create a level playing field for renewable electricity projects with conventional generation. The setting up of an independent regulatory system separate from, and not accountable to, any supplier of energy services and/or other government agencies with energy interests; and the establishment of non-discriminatory, objective and timely regulatory procedures governing transportation and transmission of energy would provide a clear encouragement for investors.

Long-term financing is needed for community mini-grids and developers of grid-connected projects. Potential electricity suppliers among small and medium size enterprises require a transparent regulatory framework that will ensure that publicly and privately owned businesses receive equal treatment in project approval and access to financing. As the cost of renewable energy devices is high relative to the low income of off-grid rural households, banks will remain reluctant to provide credit for renewable electricity projects. Special credit mechanisms need to be set up.

Local standards and technologies are not sufficient to ensure equipment is of adequate quality, particularly of auxiliary devices and control units, and renewable energy equipment. There is a risk that private suppliers will use older, dirtier generation technologies unless properly supervised.[70] Imports of equipment incorporating advanced technologies or joint venture investment are needed to improve domestic equipment quality in support of rural electrification programmes, especially renewable electricity projects. Furthermore, there is a need to encourage the presence of consulting and technical services for renewable energy technology. These enterprises would lend support to projects in communes where the managing and operating skills for stand-alone off-grid power projects are very weak, particularly where there was a need for maintenance and repair of imported equipment.

While the electricity supply will remain a public service, it should be supplied to rural consumers on a commercial basis; except for those areas where subsidies are deemed to be socially necessary and consistent with the objectives of equitable development. The costs of operation, maintenance and the economic depreciation of rural electrification infrastructure and supply should be financially recovered

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[68] For example, in Malaysia there is a fixed rate for all consumers throughout the country, regardless of the cost of provision. This implied a cross subsidy from high volume consumers. See K.V.Ramani, *Trade in Energy Services and Human Development*, UNDP Asia Trade Initiative www.colomboregionalcentre.lk.undp.org,

[69] A reiview of how other countries in Asia have confronted these issues is contained in Steve Thomas, *Electricity Reform Experiences in Asia Pacific Region, GATS and Privatisation of the Industry*, University of Greenwich, Public Services International Research Unit. www.psiru.org

[70] See Romeo Pacudan. *Trade in Energy Services, Philippines country case study,* Asia Trade Initiative www.colomboregionalcentre.lk.undp.org.

from the revenues earned by EVN, PCs, and other operating entities in Viet Nam's power sector. Adequate financial incentives should be provided to all entities responsible for the final delivery of electricity service to rural consumers, including renewable energy projects in remote areas. The Government has recently begun putting in place a policy framework for grid and renewable electricity supply development, including a subsidy mechanism for grid and off-grid renewable energy projects. ***The Government should provide a transparent ("smart") subsidy to investment in rural electrification networks and supply infrastructure, including renewable energy-based grid and off-grid services, when these are deemed commercially unviable. Transparent subsidies encourage investment as they enable potential investors to see the cost structure of the electricity system. Priority should be given to providing electricity for productive activities, particularly enhancing the pace of agricultural productivity, modernization, and economic restructuring of strategic areas.*** Where productive uses are likely to be limited, off-grid options may be a lower cost solution to enhance quality of life.

A strong community commitment is a precondition for sustainability of projects for individual grid systems. Local agencies, such as Provincial and District Power Utilities, People's Committees, and local business organizations will be responsible for the management of off-grid renewable energy systems. Participation of community members in the early stages of project design usually ensures a greater financial involvement, the use of the most appropriate technologies, and better maintenance. However, most require improved market data to plan a major program and to develop projects. For stand-alone power projects, communities should have a commitment to contribute to the majority of capital investment to ensure their ownership, for example, by providing a percentage of the investment cost or labour and materials. The strong community involvement in rural electrification has enabled Viet Nam to avoid the pitfalls of the "top down" approaches that have been followed by many other developing countries.[71] Community awareness of renewable energy technologies and services, social and environmental benefits from renewable energy power projects are still limited, investment in renewable energy is seen as too risky for many. Most communities still expect to be connected to the national grid by EVN.

The main sources of renewable energy for isolated areas are solar energy, wind energy and mini-hydro plants. There are about 1,000 solar power systems used in the country. Most of the systems are in operation and of good quality. There is a plan to install 12,000 solar home systems over a two year period. The national experience with small wind generators began in 1980s with household energy systems, with power ranging from 100-150 to 500 Wp To date over 800 wind home system (WHS) have been installed, over 60% of them still operating. These systems have been disseminated among rural families mostly via government grants (90%). The mini-hydro power resources are mainly located in the northern mountainous areas and central region. About 20% are used in irrigation purposes. Over 300 commune-based small hydro systems with a total capacity of 61 MW have been installed and a further 300–600 MW of small hydropower could be feasibly developed for community use in agricultural production, handicrafts and residential lighting in households. About 150,000 pico-hydro systems (with capacity of 0.1 – 1 kW each) have been sold in the market.

Legally independent electricity cooperatives, to be responsible for the continued operation of stations, should be established that possess a transparent organizational structure, a sound accounting and bookkeeping system, training programmes, and an appropriate reward system for employees. Communes and/or cooperatives should set a minimum tariff, formalized in a legal document, to cover the operational costs, including funds for spare parts and repairs. Such tariffs must be affordable for at least 60 percent of the end users. Technical assistance should be provided for renewable energy projects to ensure the use of the most efficient technology. State or private enterprises which bear the risk of developing products, services, and distribution networks to sell power systems (such as solar and pico-hydropower systems), battery charging stations and repair, and maintenance services for household-level projects will receive assistance in the form of price subsidies, loans, and loan guarantees.

[71] GNESD op.cit.

The subsidy mechanism for rural electrification should be targeted at investors, (both domestic and foreign) to encourage them to invest in local power systems, especially in areas that cannot be economically connected to the national power grid. In order to reduce risks for investors in decentralized power plants, power companies will pay for capacity or energy equal to investment and operation costs. Domestic, multilateral or bilateral loans should be mobilized to establish a special budget fund for investment in rural electrification.[72] Long-term finance is required to support risky renewable energy investment. Rural power companies must obtain adequate financial encouragement to continue and maintain business at an acceptable service level.

Rural Electrification Master Plan for Viet N

REP II is the next phase of the Government's rural electrification strategy. The overall sector related goals of the REP II project are to: (a) enhance equitable, inclusive and sustainable development by rehabilitation of existing rural networks and improving access to services among poor communes in rural areas; (b) help transition to a market economy by mobilization of additional investments for rural development and improving management and maintenance of investments; and (c) promote good governance by conversion of existing ad-hoc local management entities to legal entities with strong corporate governance. The development objective of the proposed project is to improve access to good quality, affordable electricity services to rural communities, in an efficient and sustainable manner. This would be achieved through: (a) repair and maintenance of the existing rural power network in about 1000 communes and connection of about 200 new communes to the national grid; (b) conversion of ad-hoc local management systems in about 1000 communes to local distribution utilities (LDUs) in legal forms like companies/cooperatives, to improve management of power distribution in rural areas and enable mobilization of private funds; (c) expansion of community based renewable energy grids in about 100 communes in the remote and isolated areas; and (d) institution building for implementation of the national strategy for rural electrification with special focus on (i) planning rural electrification at national and provincial level, especially for least cost provision of energy to the remote mountainous areas and islands; (ii) contributing to development of a regulatory and institutional framework for rural electrification at national and provincial levels; and (iii) capacity building and training of the institutions involved, the provincial authorities, Electricity of Viet Nam(EVN) and Ministry of Industry (MOI). The proposed project is expected to provide improved access to energy to about 1 million households in Vietnam, including many living in some of the poorest communes identified in the government's special commune program.

Massive investment is needed to meet the growing demand of 15 to 18% per year. Sources of capital for electricity development include both local capital, accumulated from the production process, local loans, bond and share distribution, and foreign capital borrowed from international lending institutions, such as, Asian Development Bank (ADB), Japan Bank for International Cooperation (JBIC), and World Bank (WB). Total investment required over the period 2005–2015 is 34.664 billion VND, to be obtained from the following sources: (a) national budget (budget and ODA funds) of 974 billion VND (only calculated for a new renewable programme); (b) EVN: 8750 billion VND; (c) local authorities: 21,406 billion VND, in which the loan from WB was 2635 billion for rural energy project II and the remaining part will be taken from local budget, loan concession credit, and other Overseas Development Assistance (ODA) funds; (d) households: 1718,75 billion VND (average value for electricity for new connection of household is 600.000 VND). The Government continues to negotiate a loan for rural energy project III and IV with the World Bank. Private investment is sought for new renewable energy production resources for remote areas which cannot reach national grid IPPs are encouraged to invest in renewable energy resources..

There is stiff international competition to attract investment to the electricity sector. World energy demand is projected to grow between 60 and 65 per cent by 2020, with two-thirds of this increase taking place in China and other developing countries. Growth of energy demand in developing countries is driven both by economic activities and by the legitimate aspiration of the population to achieve minimum comfort levels.

[72] In the Philippines power utilities are mandated to remit one centavo per kWh sold to a trust fund of this nature. See Romeo Pacudan *Trade in Energy Services, Philippines country case study,* Asia Trade Initiative www.colomboregionalcentre.lk.undp.org.

Energy investment requirements will amount to 3-4 per cent of world GDP over the next two decades.[73] Many governments in developing countries may no longer wish, or be able to, provide the needed capital investment. On the other hand, multilateral and other official lending institutions are unlikely to provide more than 15 per cent of the funding required for energy investments over the next few decades.[74]

However, transnational energy enterprises have benefited enormously from their involvement in liberalizing and expanding energy markets, especially the electricity market. The reform programmes implemented in the 1990s resulted in massive flows of direct investment stimulated by the rapid increase in sales of energy services through foreign affiliates. Given the rapid expansion of domestic demand Viet Nam should have little trouble in attracting foreign investors in the electricity sector, provided that the necessary regulatory reform is instituted. What is required is the establishment of an independent regulator authority to guarantee non-discriminatory competition and a fair mechanism for resolving disputes between foreign and domestic suppliers.[75]

Fair and transparent regulations governing the conditions for third-party access (TPA) to the transmission and distribution network are an essential consideration for investors.[76] TPA regulations should oblige that the network operator has to make its network available to other enterprises under conditions no less favorable than those which the operator offers in similar cases within its own enterprise or to associated enterprises. TPA to electricity infrastructures can be regulated or negotiated. Under a negotiated TPA regime, the third party has to agree with the grid owner on the terms and conditions of access. *Ex post* control by either a sector-specific regulatory authority or by a cartel/anti-trust authority ensures that the grid-owner may not abuse the power arising from its control of the monopoly. Under a regulated TPA, third parties are enabled to use the grid according to regulated terms and conditions of access. This entails e*x ante* review of the terms and conditions by a competent regulatory authority. ***Differences in TPA tariffs could be a means of encouraging investment in more remote rural areas, or of giving preferential treatment to renewable energy suppliers.***[77]

Internationally interconnecting grids can serve to reduce overall generating cost and facilitate the charging of lower fees. The power interconnection with the region, particularly with the countries in the Mekong river system will reduce capital requirements for building new sources of energy. As the seasonal flow of the Mekong River is relatively even, Viet Nam will be able to import power from hydropower projects locating in other upstream countries during dry season. Viet Nam is taking part in several feasibility studies of regional grid interconnection, including a study of a power grid interconnection in the Greater Mekong Sub-region (GMS) to set up a unified network in the region. Viet Nam has signed Agreements on Co-operation in Power with Laos, Cambodia and China. On a larger regional scale, the Trans-ASEAN Power Grid Project and Trans-ASEAN Gas Pipeline Project are being considered by the ASEAN member countries. EVN keeps placing emphasis on the expansion of cooperation relations with power utilities of the region, especially of ASEAN countries, and the inter-connection amongst Asian countries and neighbouring countries to satisfy both the regional and the national power demand.[78]

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[73] Thompson R., *Integrating Energy Services into the World Trading System*, The Energy Services Coalition, April 2000, p. 3.

[74] United Nations Development Programme, United Nations Department of Economic and Social Affairs, World Energy Council, *World Energy Assessment: Energy and the Challenge of Sustainability*, New York, 2000, p. 431.

[75] See discussion on "Mode 3" below.

[76] On TPA in the gas industry: Achmin, R.B. "Negotiated Third Party Access in Germany: Electricity and Gas", in *Journal of Energy & Natural resources Law* 20(1) 2002: 27-39.

[77] Zarrilli op.cit.

[78] For example, Viet Nam plans to build a 210 MW hydroelectric plant in Laos' Sekong Province based on a memorandum of understanding signed by the Lao Government and the Viet Nam Laos Investment and Development Joint Stock Company, funded by the Viet Nam Laos Investment and Development Joint Stock Company, with investment capital of US$232 million. The Sekaman 3 Plant, built under the Build Operate and Transfer (BOT) method, is expected to start generating electricity by 2008.

5.3. Issues for Consideration in Liberalization of Trade in Electricity Services

Under GATS very few countries have made commitments on energy services, including on the sub-sector most relevant to this paper, "services incidental to energy distribution," which covers transmission and distribution services on a fee or contract basis of electricity, gaseous fuels and steam and hot water to household , industrial, commercial and other users.[79] This was mainly because at the time of the Uruguay Round such services were normally provided by government monopolies and therefore the market was not interesting. However, over the last decade, most countries have been engaged in structural reforms of the energy sector meant to cut costs and improve the economic performance and efficiency of the energy sector by imposing free market disciplines and commercial criteria.[80] These can include deregulation (covering both the removal of regulations and the reassessment of regulatory methods), corporatization (placing public energy utilities under commercial discipline), unbundling (i.e. breaking up vertically integrated state monopolies), increased private sector participation and outright privatization. These measures have been accompanied by action to ensure competition require provisions to ensure access (third party access-TPA) to networks (grids, pipelines).

The dismantling of state monopolies has provided lucrative possibilities for the private sector and led to considerable interest in obtaining bound commitments on trade in energy services, which are the subject of requests in GATS and covered in FTAs. Such requests are aimed at gaining a share of dynamic "downstream" energy, particularly electricity trading markets, while seeking to gain control of "upstream" services to improve security of supply.

Governments of developing countries are seeking private sector participation to obtain the necessary capital and technology. Many governments face the same dilemma as Viet Nam, i.e. how to obtain foreign investment to increase capacity and efficiency, while at the same time keeping the price of electricity, in particular, at level accessible for the poor. In the energy sector, conditions for entry and performance requirements are essential tools for ensuring that liberalization attains the ultimate objective of universal service. One technique has been to oblige foreign investors to meet certain performance requirements as a condition for entry into the market. ***These conditions which must be stipulated in GATS commitments or in FTA "reservations" could include price undertakings (as liberalization tends to result in increased prices if not controlled), universal service obligations and transfer of technology requirements.***

Mode 1 - Cross-border supply

This Mode covers online trading and energy brokering and professional services that can be delivered by mail or electronically, such as consulting or legal services. It also covers services related to the cross-border transmission of electricity and gas through pipelines and interconnected grids. Thus Mode 1 commitments cover the service of transmitting electricity, but not the trade in electricity itself. Electricity is considered a "good," not a service by most countries, and it is included in the Harmonized Commodity Description and Coding System of the World Customs Organization, and by the members of the Energy Charter Treaty.[81] Commitments under this Mode would imply that foreign providers could provide electricity to Vit Nam from other countries.

In principle cross border movement of energy services should be facilitated, but could be conditioned on the establishment of a commercial presence in Viet Nam. The implications of accepting commitments under this Mode should be viewed in the perspective of Viet Nam's long term plans to create a power market.

Mode 2 - Movement of Consumers

This Mode is not very relevant to the electricity sector, it could involve facilitating the movement of Vietnamese abroad to engage in training activities, for example.

Mode 3- Commercial presence

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[79] See various papers in Sieh Mei Ling ed. *Investment, Energy and Environmental Services: Promoting Human Development in Trade Negotiations,* UNDP, University of Malaya, Malaysian Institute of Economic Research, Kuala Lumpur, March 2004 www.um.edu.my

[80] UNCTAD (2003), *Managing "Request-Offer" Negotiations under the GATS: The Case of Energy Services*, UNCTAD/DITC/TNCD/2003/5, 23 May, p. 2.

[81] See discussion in Zarrilli op.cit p7

Mode 3 is crucial in the electricity sector since it covers all different forms of foreign commercial presence, in Viet Nam from direct investment and joint ventures to mechanisms such as BOT[82] contractors and IPPs. Within the framework of Viet Nam's policy to encourage participation of the domestic and foreign power suppliers, the private sector's share of power generation has been increasing rapidly from 6-7% in 2000 to about 21% in 2005. This shows that Viet Nam is potentially an attractive market for foreign investors in the electricity sector.

The granting of commitments for commercial presence in the electricity sector by Viet Nam should be subject to conditions that would ensure that the foreign participants make a direct contribution to the policy of rural electrification and access for the poor. ***Foreign investors would be much more amenable to accept such conditions if parallel measures were taken to provide a favourable environment of investment as described above. Investors would be encouraged by the establishment of an independent regulatory body, removal of limitations foreign ownership; fair court system for cases involving foreigners in the event of disputes with a local partner; removal of preference for local firms in public procurement rules discourage investors; and lack of clear rules on TPA, i.e. difficulties in gaining uncontrolled access at a competitive price to transmission and distribution networks due to pre-existing exclusive rights and monopolies.***

Such conditions might include:

(a) Joint venture requirement. Forging joint-venture structures between domestic suppliers and foreign firms has proven crucial in enhancing domestic management skills and technological upgrading of the labour force, joint-venture requirements could be variously specified as restrictions on market access commitments. Measures aimed at promoting business alliances with foreign suppliers would amount to "measures that restrict or require specific types of legal entity or joint venture through which a service supplier may supply a service" (GATS article XVI: 2(e)). Accordingly, partnership requirements may not be adopted or maintained unless clearly specified in the Schedules in either the sector specific section (if the requirements pertain only to the inscribed energy functions), or the horizontal part (if the limitations apply across-sectors).

(b) Capacity building requirement. ***Foreign investors could accept to provide training for domestic nationals, and to subcontract to domestic enterprises***

(c) Best available technology requirement. ***Commitments could also be qualified with regard to the technology used to provide energy services so as to ensure that the best available technology is used, especially in terms of its efficiency and its impact on health and the environment.*** The countries may attach technological qualifications to the services transactions that are being liberalized. Technology specifications might fit in the additional commitment column of the Schedule, where positive qualifications and standards are typically entered. Under the BTA with the United States Viet Nam has accepted not to apply transfer of technology requirements to foreign investors, which places it at a disadvantage compared to its ASEAN partners in obtaining technology.

(d) Universal service requirement. ***Foreign providers could agree to provide electricity at prices acceptable to poor people in rural areas, (e.g. affordable to 60 percent of the customers as it is the current practice) and/or to extend their grids or set up off-grid, renewable energy facilities.*** In return they could benefit from subsidies, under certain conditions. ***Regulations should ensure that foreign investment contributes to rural electrification and does not result in "cherry picking," i.e. concentrating on serving the high income, urban segments of the electricity market.***

Viet Nam did not include the energy services sector within the list of exemptions for national treatment under the USA BTA, thus this broad commitment will be carried over into Viet Nam's GATS commitments in the WTO. However, these conditions may be applied if they are equally applicable to domestic

[82] Build, operate and transfer.

investors, as this would not be in breach of the national treatment commitment. For example, the EU requires member states to guarantee a secure supply for all consumers, to take steps to protect vulnerable persons and to take steps to protect the rights of energy consumers by developing strict rules to govern energy supply contracts, providing transparent information on prices, and enforcing low-cost and transparent procedures for dealing with consumer complaints.[83] ***Thus, if these conditions are to be imposed within the context of Viet Nam's national treatment commitments, regulations would have to be drawn up in such a way as they would apply equally to domestic suppliers.***

Against the background of the liberalization of domestic energy markets, the economic value of commercial presence commitments to the exporting countries is enormous. For example, as shown in figure 1, sales of services by foreign affiliates of U.S. firms in the utilities business increased from just $357 million in 1993 to more than $25 billion in 1998, an annual growth rate of over 100 per cent.[84] This rapid growth in investment and services trade coincided directly with major regulatory reforms undertaken in the United Kingdom, Australia and Latin America that permitted U.S. firms to enter the market.[85] Therefore, firms would be quite willing to accept reasonable conditions to gain access to electricity markets.

Mode 4 - Movement of natural persons

This Mode includes the movement of skilled personnel who deliver technical and managerial services, as well as the movement of semi-skilled and unskilled personnel needed, for example, for the construction and upgrading of grids. ***If it is wished to prioritize this movement, sector specific commitments could be made, for example, to permit the entry of project staff from foreign countries.***

According to the WTO Agreement on Subsidies and Countervailing Measures, the provision of low cost energy by the government, i.e. at subsidized rates, is not considered an "actionable" subsidy if the subsidy is generally available, i.e. not limited to specific enterprises. However, despite this provision, in WTO accession negotiations, some countries have insisted on the acceding country accepting terms that would prevent the country from providing energy derived from petroleum or gas, for example to domestic consumers, both commercial and residential, at rates lower than the country exports the same energy product (i.e. the "world price"). Obviously, countries obliged to accept this type of additional "WTO-plus" commitment will find themselves at a competitive disadvantage with respect to the original WTO members which have not made this commitment. ***Viet Nam should avoid any international commitment with respect to domestic energy prices.***

The Future Orientation of the Electricity Sector in Viet Nam

Orientation of power sector development

There will be a comprehensive development and modernization of power generation and the power network. Development of hydropower, coal-fired thermal power, gas-fired thermal power and nuclear power. Interconnecting power network with other countries in the region. EVN will create space for other enterprises to invest into power projects by limiting its investment to projects exceeding 100MW. The transmission and distribution network will be upgraded to improve reliability and reduce power loss.

Power generation priorities

In terms of hydropower generation development, Vietnam will build hydropower plants in almost all potential sites over the next 20 years. Pump storage power plants will be put into operation in support of the development of power system.

Thermal power generation development.

Rational development of gas-fired, coal-fired thermal power and nuclear power projects in accordance with fuel supply and allocation.

New and renewable power development.

[83] Zarrilli op.cit.

[84] U.S. Dept. of Commerce, Bureau of Economic Affairs, U.S. Direct Investment Abroad: Operations of U.S. Parent Companies and their Foreign Affiliates, and U.S. Direct Investment Abroad, Detail for Historical-Cost Position and Related Capital and Income Flows, found at Internet website: http://www.bea.doc.gov.

[85] C. Melly, "Electric power and gas market reform and international trade in services", in *Energy and Environmental Services: Negotiating Objectives and Development Priorities*, UNCTAD, DITC/TNCD/2003/3,p. 173.

This kind of power generation capacity from small hydropower projects, geothermal, wind-power and solar-power projects should supply about 8-9 billion kWh by 2020 and 60-80 billion kWh by 2050.

Electricity imports should be promoted from countries with large of hydropower potential Total imports from Laos, Van Nam, provinces in China and Cambodia should reach about 400 MW, 4000 MW and 10,000 MW by 2010, 2020 and 2050, respectively. Arrangements to import power should ensure mutual benefit of involved parties and the safety of the system.

Power generation configuration should be modified to incorporate increased thermal power generation (e.g. coal, gas), as well as power generation from new and renewable energy, and nuclear power projects.

Rural electrification

The rural electrification programme should target industrialization and the modernization of agriculture production. By 2010, 90% of rural households should have access to electricity, and all by 2020.

New and renewable energy sources should be utilized for electricity generation in isolated, remote, bordering areas and islands. Management mechanisms should be established to maintain and develop power generation in such areas.

Establishment of a power market in Viet Nam

a) *Power generation:* EVN's power plants will be gradually unbundled, creating independent plants to compete with IPPs. Electricity will be provided wholesale through power transmission companies or power markets at competitive prices as set in Power Purchase Agreements (PPA). These power plants will operate under the supervision of the National Load Dispatch Center.

b) *Power transmission:* Power transmission will remain a state-owned monopoly overpower transmission units, which will merge into a sole independent Power Transmission Company.

c) *Power distribution:* Electric power utilities shall take responsibility to supply their electricity to customers within their areas, and to invest in their power distribution network. Non- EVN-power companies are encouraged to engage in modes of equitization, privatization or joint ventures, in which EVN could purchase shares.

Stages in the establishment of a power market in Viet Nam

Current situation 2005): EVN controls all power generation, transmission and distribution. Power generation efforts expect to pilot some power plants to do their independent accounting. EVN still keeps control of accounting in power generation and power transmission. Power distribution measures get companies to purchase electricity from EVN, and then sell to households, and are responsible for investing into their power distribution networks.

Period of 2006- 2014: Establish and develop competitive power generation market

EVN power plants shall be subject to independent accounting, and compete with IPPs in the power generation market. Power transmission units will be merged into a sole Power Transmission Company which will be a non-profit organization charging power transmission fees; EVN will be the sole purchaser of electricity from power plants, and will sell to distribution companies.

Period of 2015-2020: Establish and develop competitive wholesale power market

Wholesale power companies will be established to purchase electricity from power generation companies to sell to power distribution ones. Power distribution companies will become independent from EVN and compete in purchasing power from generation companies as well as from wholesale power companies.

Period after 2020: Establishment of retail power market.

In this period, IPPs and BOT projects will participate in a competitive power market; electricity-selling price will be offered on an hourly basis. Power distribution will be commercialized, while the State shall maintain direct control over transmission companies.

Policies and strategies for power sector development Ensure sufficient supply of electricity for national socio-economic development will occur, through the rational development of hydropower projects, together with development of coal-fired and gas-fired thermal power projects and new and renewable power generation projects. The development of the power network should keep up with power generation:

To diversify investment modes in power generation and distribution network development.

To continue implementing pilot "equitization" and enable private participation in the development of power plants and power distribution units.

To separate public benefit and business activities. Electricity in isolated and remote areas will continue to receive a subsidy.

To promote international cooperation and integration.

To gradually establish and develop power markets in Viet Nam.

To study the feasibility of nuclear power projects. To ensure sustainable development and minimize negative impact on the environment.

6. Conclusions and Recommendations

Detailed conclusions and recommendations have been set out in the body of Report in the context of the discussion of specific topics. The following summarize the main findings.

General

The general background to these recommendations is the Viet Nam has made impressive achievements in providing the poor with the essential services of health, education and energy. Thus, future policies with respect to the participation of foreign suppliers of the services concerned should start from the premise that there is no need for a dramatic change in the basic approach. Foreign service providers can make a contribution to these objectives if there is a regulatory framework that ensures that their role will be positive. Commitments to liberalize trade in the health and education should be confined to those "niches" where the foreign suppliers can effectively contribute a "value added" component to the existing system. In the electricity sector foreign participation should be directed to contribute to Vietnam's rural electrification programme. Vietnamese citizens have a right to health, to education and to energy, which cannot be confiscated by international negotiations. Geneder issues should receive particular attention.

Health

Viet Nam has been extremely successful, in extending health services to the poor in rural areas, the programme to continue to extend these services geographically, through placing CHC in each commune and VHW in each village should be extended. By 2010; 100 per cent of communes should have adequate facilities; 80 percent should have doctors (100% of this percentage should be in lowland and 60 percent in highland areas; and 75 percent of communes should fully meet standards for commune health care.

More government expenditure should be devoted to including a pro-poor budget allocation, including higher budget allocation index per capita 2.5 to three times for mountainous areas, with a higher allocation for preventive health care.

The domestic private sector has made an important contribution to this success, especially for the extension of out-patient services should be further and more quickly developed, especially in the form of better organized and regulated facilities (e.g., general policlinics and hospitals). However, more stringent regulation is required to prevent abuses.

Measures to provide greater access to the poor should be gender-sensitive, giving attention to addressing those additional factors which limit women's access to health care services, and give more focus to the health needs of women e.g. the control of STIs, tuberculosis, malaria, and programmes on family planning.

The quality of health services should be improved through enhanced training of more staff and the use of higher technologies, such a telemedicine, to be provided at the provincial level. Medical skills and technologies systematically should be transferred to lower levels, for example, the practice of temporarily transferring experienced doctors from high level hospitals to provide practical on-the-job training for local staff should be continued and intensified. Greater efforts should be made to provide incentives for medical staff to work in isolated regions including guarantees that upon graduation medical staff will spend time in disadvantaged areas.. Telemedicine facilities should be extended to the provinces.

The cost of medical treatment is a serious problem for the poor, the system of user fee exemptions did not work well. The health system should be financed by the healthy rather than the sick. **.**Efforts toward the establishment of a universal compulsory health insurance scheme should be pursued as a matter of priority. Premium exemptions (such as health cards) for poorer people would ensure that the poor would be effectively covered.

Foreign private health providers should be limited to service the expatriate community, their presence should not be allowed to reach the point where they create a drain on resources from the private sector. Regulation should be drawn up to ensure that the foreign providers effectively contribute to the basic health system. Foreign health insurance providers should not be allowed to disrupt the establishment of a universal health insurance system at the national level. Rich people should not be permitted to opt out of the universal health insurance scheme. HMOs and MCOs, which create a captive supply of doctors, should not be permitted.

Viet Nam did not follow the example of other countries and has entered into international commitments in the USA BTA and GATS. Regulations should be drawn up, with the advice from national and international health experts, to ensure that the access of foreign suppliers does not undermine the health system, while simultaneously respecting international commitments. If this does not prove effective Viet Nam should consider modifying its commitments under the appropriate provisions of GATS.

Education

The target of providing free universal secondary education must be pursued as matter of priority to counter the impact of increasing income and urban/rural disparities on access to education at this at this level. The target of 2010 for achieving free lower secondary education should be met and a similar fixed target should be set for higher secondary level education. Poor households should be exempted from any fees and provided with stipends where necessary.

Quality improvements should be made in terms of curriculum reform to make education more relevant to exigencies of a modern economy, supported by improved physical facilities and increased duration of school time, with a focus on reducing regional disparities. Incentives to induce teachers to work in disadvantaged regions should be increased.

The private sector, including the foreign private service providers, should be oriented to those sub-sectors where they can make a unique contribution and not merely duplicate the public sector, notably in the areas of technical, vocational and linguistic training, including at the adult level. Foreign education service providers should concentrate on those areas where they have a “comparative advantage”, such as providing ongoing training to staff of enterprises in technical skills and customer service, quality control and innovation. Firms providing specialized training targeted to the needs of enterprises should be encouraged.

Viet Nam should avoid international commitments in the areas of primary and secondary education, where the role of foreign providers is unlikely to be beneficial. The advice of prominent national and international educators should be sought in drawing up regulations to effectively regulate the private sector, both domestic and foreign.

Regulations should be drawn up to ensure the quality of foreign suppliers, to increase their positive impacts throughout the country and reduce their negative impacts on the national education system. Distance learning facilities should be expanded throughout Viet Nam but the quality and applicability of foreign providers should be strictly controlled.

The Government should continue the financial support to students traveling abroad to study as in Program 322 and encourage the self-support students to study overseas.

Electricity

Viet Nam has greatly outperformed countries at similar levels of development in providing electricity to the rural poor, and the resources devoted to further extension should be increased. The programme aimed

at establishing a power market in Viet Nam should recognize that access to electricity is a right and the electricity is essentially a public service.

The EVN should accelerate investment to ensure the quality of electricity received in rural areas. Special incentives should be provided to investors in non-renewable energy projects in isolated areas and islands, communes should receive more information and training regarding technology and management skills.

A maximum ceiling price for rural suppliers should be maintained although this could be indexed to increases in income. Subsidies and cross subsidies should be transparent and targeted at investors, to ensure an adequate return on their investment despite the price ceiling. The subsidy mechanism for rural electrification should be targeted at investors, (both domestic and foreign) to encourage them to invest in local power systems, especially in areas that cannot be economically connected to the national power grid.

International commitments on commercial presence could encourage foreign investment in electricity services, subject to conditions and regulations to ensure quality and "social obligations" for investors. However, private investment should be encouraged primarily through the reform of the administrative system governing the power sector. Such reform would include such measures as the establishment of an independent regulatory body to ensure transparency and the fair resolution of disputes. Conditions for third party access to the transmission network should be clear and transparent, but could favour suppliers to disadvantaged regions.

Domestic, multilateral or bilateral loans should be mobilized to establish a special budget fund for investment in rural electrification.[86] Long-term finance is required to support risky renewable energy investment. Rural power companies must obtain adequate financial encouragement to continue and maintain business at an acceptable service level.

Viet Nam should avoid any international commitment with respect to domestic energy prices.

Cooperation with neighboring countries regarding trade in electricity should be intensified, and efforts should be made to harmonize regulations within ASEAN and China.

[86] In the Philippines power utilities are mandated to remit one centavo per kWh sold to a trust fund of this nature. See Romeo Pacudan *Trade in Energy Services, Philippines country case study,* Asia Trade Initiative www.colomboregionalcentre.lk.undp.org.

Annex 1
Study Objectives

The overall development objectives of the study are to:

Ensure that liberalization of the services sectors under analysis will benefit the poor and marginalized people by not jeopardizing but rather improving the affordability and universal access to these services.

Reduce the negative impacts of liberalization on the poor and eliminate the inequalities so far registered.

The immediate objectives of the study are to:

assess the impacts of Vietnam's market reforms and potential trade liberalization commitments in the three services sectors in terms of benefits and costs that such reform/liberalization process has entailed so far or will entail in the future on poor and marginalized groups; assist Vietnam's policy makers and trade negotiators in formulating appropriate domestic policies and coherent negotiating positions in these services sectors in accordance with the country's socio-economic development goals; inform the business community and the general public of the opportunities and challenges arising from the liberalization of these services sectors, and to raise awareness of the potential impacts — positive and negative — that such liberalization may have on the poor and marginalized people; and strengthen the research and policy analysis capacities of the country in the three services sectors.

Annex 2
Note on Approach and Methodology

Approach

The poverty impacts of market/trade liberalization have been the guiding focus for the study. Substantial information exists in Vietnam on poverty conditions, and the status of health, education and electricity access. The study has made use of this information and concentrated on populations below the national poverty line. Its data collection and analytical steps have sought to capture the impacts of past and potential future market transformations in the three services sectors, assuming continued transformations in future market conditions allowing increasing degrees of competition. The intent has been to assess how domestic market liberalization, as well as foreign trade liberalization, have affected the availability, diversity, quality and cost of these services to the poor; and how the impacts on the poor compare against impacts on the national population at large.

> The central hypotheses of the study have been the following: for the purpose of the study, the poor in Viet Nam are those whose incomes are below the national poverty standard;
> their 'basic' levels of access to health, education and electricity services are defined by national standards where these are available, or by international norms where these are not available; in identifying differences in access levels between the urban poor and the rural poor, 'effective access' --as determined by affordability rather than the mere presence of service providers --is the main criterion; since 'cost' is relative to the 'quality' of services, comparisons between the public provided services and privately provided services considers the two elements together; and the impacts of private sector service providers, both domestic and foreign, is used as a proxy measure of the impacts of market/trade liberalization.

Methodology

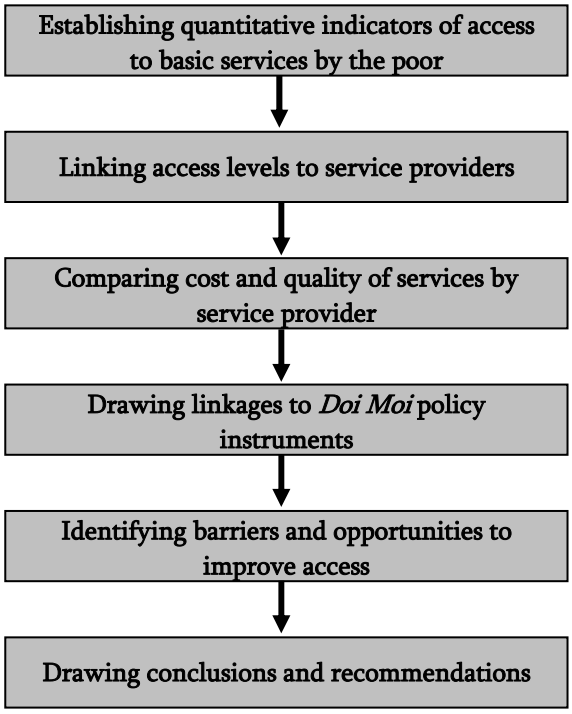
The study methodology was centered on a survey carried out in four provinces of Viet Nam. In each province, one city/town and two districts were covered. In each district two communes and two villages per commune were covered. Quantitative and qualitative data was collected at the levels of 32 villages, 16 communes, eight districts and four cities/towns in all. Primary data generated by the survey was supplemented by desk research that concentrated on reports and publications of the Government and key international agencies on health, education, electricity, poverty and trade.

Time and resource constraints did not permit a statistically valid survey of the poor and marginalized population in Viet Nam. Therefore, the study relied on a purposive sample in a limited number of locations chosen on the basis of poverty incidence and regional diversity considerations. The statistical limitations of the study were sought to be compensated by employing participatory/rapid rural appraisal (PRA/RRA) techniques, such as ocular inspections, key informant interviews and focus groups at various levels. An attempt was also made to gather gender-disaggregated information and feedback at the level of poor communities.

The analytical tasks of the study followed a six-step process leading to conclusions and recommendations (Figure 1):

i. *Establishing quantitative indicators of 'access' in each sector:* For each sector, a set of quantitative progress indicators was identified -- for example, number of medical personnel, nature of medical facilities (health services); number of primary/secondary schools, school enrolment rates (education services); and number of households with electricity, number of community facilities with electricity (electricity services). Quantitative data against the indicators was collected at the province, district and commune levels in selected sites for three snapshot years: 1986 (start of *Doi Moi*), 1996 and 2004.

Figure 1: Main Analytical Steps



ii. *Linking access levels to service providers in each sector:* In each sector, the presence of private sector service providers and the extent to which the poor have access to them ('effective access') was identified together with access to public service sector providers. A combination of quantitative and qualitative was collected from poor communities, and key government agencies and public/private service providers at the province, district and commune levels.

Comparing cost and quality of services offered: This was carried out in each sector across the three snapshot years by type of service provider (public, domestic private, foreign private). Data for this purpose was collected through consultations with different stakeholders at the province, district and commune levels and feedback from poor communities based on a combination of focus groups and objectives-oriented workshops. iv. *Drawing linkages to main policy instruments employed under Doi Moi:* Various policy instruments facilitating or inhibiting the role of private service providers and market competition in services provision were identified and linked, to the extent possible, to data from the preceding steps to establish causality. *v. Identifying barriers and opportunities:* The outcomes of the preceding steps were combined with qualitative perceptions, views and ideas gathered at the provincial, district, city/town commune/village levels to identify key barriers and opportunities to improve future access to basic services for the poor.

vi. Drawing conclusions and making recommendations: The conclusions drawn at the end of this process essentially reflect the findings of the study as assessed from primary and secondary national data. The study recommendations also draw upon secondary data from other sources, such as international institutions and other regional countries, so as to widen the options presented to Viet Nam's policy makers.

Data sources The primary data collected by the study is drawn from a diversity of stakeholders, including government authorities, public service providers, private service providers, service professionals and poor communities (including both men and women at the poor community levels). The following survey instruments were used for the purpose:

a) a quantitative questionnaire addressed to province and district authorities;

b) a quantitative questionnaire addressed to commune authorities.
c) a quantitative questionnaire addressed to poor households at the village and city/town levels; and
d) focus group guidelines for each sector addressed to diverse stakeholders at the province, district, commune and household levels.

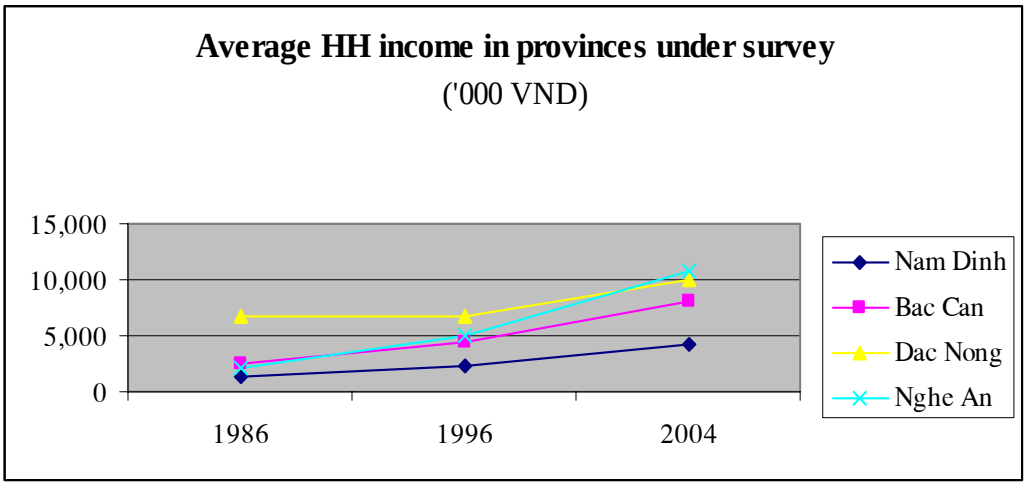
The study's hypotheses and the adequacy of data collection instruments were validated by a Pilot Survey in Haiphong Province. The outcomes of the Pilot Survey were presented to a workshop attended by representatives of key national and international agencies for comments/suggestions. The data collection instruments were amended on the basis of these activities before being employed in the main survey carried out in four provinces.

Secondary data for the study was collected from both national and international sources. The national data sources consisted mainly of the ministries/agencies in charge of health, education, electricity, poverty reduction, trade, and planning and investment.

1.1. Socio-economic background of survey locations

The main survey was conducted in five cities, in the provinces of Hanoi, Bak Kan, Nam Dinh, Nghe An and Dak Nong. In Hanoi, Focus Group Discussions with only the three citybranches of Health, Education and Electricity were conducted. So, this Final Report concentrated on assessing the implementation of the survey activities in Bak Kan, Nam Dinh, Nghe An and Dak Nong. One rural district and one urban district were surveyed in each province; two communes were surveyed in each rural district; one ward was surveyed in each city/town; 20 poor households were surveyed in each commune/ward.

Figure 2



Profiles of the four sites, which related to the objective of the survey are as follows:

Bak Kan

- A Northen mountainous province, re-established in 1997 with 300,000 persons. Ethnic minorities account for 80% of the total population. There are 59,958 households, of which, the rate of poor households is 17.9% of the total population (10,740 households) a high rate in comparison to the rate of nationwide, (from applied old criteria by the Ministry of Labour, Invalid and Social Affairs). Poor households were mainly located in rural and mountainous areas.
- Bac Kan consisted of seven districts and one city; 122 communes or wards. Of which, there are 103 highland communes with extreme difficulties. The province topography is complex with sharp slopes and various streams and rivers.

- Main economy structure of Bak Kan is Agriculture-Forestry. Agricultural land accounts for 10%, and 87% is Forestry land.
- Education and Training, Being a mountainous province with difficulties in economic development, Bac Kan has paid attention to education and training by the Government. Pupils from ethnic minorities and poor households are exempted from school fees and supported with textbooks. The supply of books in communes benefited from 135 programmes; (the Government-supported programmes were geared to support extremely difficult to access communes). The rate of poor pupils attending school sharply increased compared to that before the *Doi Moi* period. About 95% of the communes or wards have currently fullfiled compulsory lower high school in the province. However, Bac Kan's education and training has met many difficulties in the development of education and training. Non-public education services has not developed. There is only one non-public high school (located in Bac Kan city) in the whole province.
- Heath care: Health care activities have been covered in the community, which partly meets people's needs, especially the poor and ethnic minorities. The poor have benefited from health care policies such as free health checks and treatment from health care insurance. Social diseases have been strongly reduced. Village health care infra-structure has been upgraded. Non-public health care services have recently blossomed, which mainly are located in urban and rich areas. However, there are many difficulties that have occured in rural and mountainous areas. These areas have private small health care services that only provide health care checks for common diseases and popular medicines, but they facilitate people's access to these services, including the poor.
- Electricity: To date, 100% of communes and 86.2% of households have been covered by the national power grid. Bac Kan electricity management modes area includes the Province Electricity and Electricity Collective. There are only three private electricity companies. They are mainly specialized in electricity installation in Cho Don and Na Ri districts. In addition, Bac Kan also has other electricity sources from micro-hydro power and mini-hydro power with capactity under 5KW for households. There were 10,629 units according to statistics from 1997. The National electricity grid has currently covered 100% of the communes. However, there is still a large number of families who have not been connected to the grid. These families use mini-hydro power instead. This energy form has not been controlled by the Ministry of Industry from 1997 so far. Therefore, there was no information available. The poor have not received any support in using this kind of electricity.

Nam Dinh

- A coastal province in the southern Hong River Delta, Nam Dinh has 1,950,000 people, consisting of 448,804 households, of which there are 46,137 poor households, equalling10.28% (from applied old criteria by the Ministry of Labour, Invalid and Social Affairs). Living conditions for poor households are particulalry miserable in urban areas; most of them are homeless.
- Nam Dinh consisted of nine districts and one city. There is no poor district; there are 229 communes or wards.
- Nam Dinh economic structure is Agriculture-Indutry-Pisciculture-Service enjoying an annual growth rate of up to 8.2%. Average income per capita is 5 million VNDs.
- Education and Training: Nam Dinh has been one of the leading provinces in education and training nationwide in the recent years; the infra-structure has been continually strengthened year by year. To date, 100% of communes/wards have completed compulsory lower high school. During the previous ten years, several kinds of non-public education services have been developed, particularly in Nam Dinh city and in rich areas. Policies for poor pupils have been considered and implemented. Poor pupils benefited from exemptions and reduction of school expenses in line with common regulation of the Government.
- Health Care: Nam Dinh has made impressive achivements. The health care infra-struture and equipment have been upgraded; quality of health care workers has been improved. People's living standard and health, including the poor's is has greatly improved, together with the development of the economy. Private health care services started their business since the launch of *Doi Moi* process, which took part in easing the poor's access to health care services.
- Electricity: 100% of communes and wards and 100% of households have been connected to the national power grid. There is no energy model except the national power grid. Electricity management modes of Nam Dinh included: Province Electricity, Electricity Collective, and Commune Electricity

Management Board. There are several private companies that provide manufacturing and design electricity works. These companies have not yet taken part in generating, contributing and selling electricity, they are located mainly in Nam Dinh city.

Nghe An

- Nghe An is one of the largest provinces, lying in the Northen Center of Vietnam. Nghe An has 3 million people, 644,106 households (of which there are 59,453 poor households (9.23%) in 2004, based on the older criteria used by the Ministry of Labour, Invalid and Social Affairs). Most poor houseoholds are located in rural and mountainous areas.
- Nghe An covered 18 districts, one city (including two poor districts in mountainous areas), 473 communes/wards (of which there are 244 mountainous areas).
- Nghe An's economic structure consisted of Agriculture-Forestry-Pisciculture-Industry-Construction-Services with a recent annual growth rate of 8.5%. Average income per capita is 5,590,000VNDs. Total amount invested into health care and education reached up to 60% of the total investment budget.
- Education and Training: Nghe An has had significant achivements in education and training. There are currently 14/19 districts, cities; 70% of communes or wards have completed compulsory lower high school education. Non-public education services have developed within the last 10 years, particularly in rich and urban areas. Policies for poor pupils have been initiated and implemented. Poor pupils benefited from exemptions from and reduction of school expenses in line with common regulations of the Government. Other support for poor pupils from the province is discontinuous, which is completely dependant on the Study Fund raised by different locations in the province.
- Health care: Epidemic diseases are controlled and timely treated. Social diseases are also significantly reduced. People's health has improved including that of the poor. Generally, facilities, equipment and health care workers are given extra attention. However, there are still difficulties in the rural and mountainous areas. Nghe An's types of health care services have been developing very fast and become more diversified, particularly the ones in urban areas. The development of private health care services are joining effectively in providing health care activities for people, incuding the poor.
- Electricity: In 2004, 97% of communes and 93,24% of households were covered by the national electricity grid.. In addition to the national power, Nghe An has pico energy, from 100-200W (not much developed) and solar energy (in the form of its application, managed by Nghe An Department of Science and Technology). Nghe An's electricity management modes included Province Electricity, Electricity Collective, and Commune Electricity Management Board. There are three enterprises distributing and selling electricity in the province, which are located in the Quynh Luu district. In addition, there are 215 private enterprises to install electricity works in the province.

Dak Nong

- A seperate province from Dak Lak since January, 2004, Dak Nong is located in South Highland Tay Nguyen with 400,000 persons, 80,000 households, 34.5% of ethnic minorities.
- Dak Nong has seven districts and cities; 61 communes and wards
- The main economic structure of Dak Nong is Agriculture-Forestry. Average income per capita is VNDs 4,500,000 with annual growth rate of 6%. Social investment reached 42%. There are 61 communes with 60% of households that have been covered by electricity. The rate of poor households is 11% (old criteria) and 33.7% (new one).
- Education and Training in Dak Nong has been strengthend over recent years. About 16.9% of the total communes or wards have accomplished compulsory lower high school education. Dak Nong's education is majority public , with policies targeted at poor pupils such as school fee support, school contruction fee exemption, textbooks and schooling tools support.
- Health care: Dak Nong has made imprsessive progress.. Epidemic diseases are controlled and timely treated. Malaria was reduced to 33% compared to the previous period. However, health care services still lack adequate facilities and equipment. Servicies are not diversified. Qualified health care facilities are mainly controlled by the Government. Private health care clinics, which develop mainly in the provinces and districts, provide common medicines and treatment. Health care for the poor followed the Government’s policies., there is no specic local polcy due to economic difficulties.

- Electricity: 100% of the communes or wards have been covered with electricity by 2004. However, the rate of households to be connected is 60% only. The unelectrified households, located mainly in rural and mountainous areas, use either kerosense for lighting or electricity from generators from rich households or mini-hydro power. There is no policy for households that use non-electricity national grid sources. Dak Nong Electricity is a State company which sells electricity directly to households. There is no non-public electricity service in the province.

Given the above charateristics of the four provinces, it should be noted that there were difficulties during the data collection due to the re-allocation of provinces which affected the data separation. The survey team assured the researchersthat Bac Kan, Nam Dinh, Nghe An and Dak Nong were the most suitable sites for the survey. Thus, the following samples were surveyed:

Province	District	Commune/ward/town
Bak Kan	Bak Kan town	S«ng Cau ward
	Bach Thong district	Don Phong commune My Thanh commune
am Dinh	Nam Dinh city	Ba Trieu ward
	HuyÖn Trùc Ninh	Cat Thanh commune Truc Chinh commune
Nghe An	Vinh city	Ha Huy Tap ward
	Quynh Luu district	Quynh Hoa commune X· Ngäc S¬n
Dak N«ng	Dak Nong town	Gia Nghia town
	Dak Song ditrict	Dak ND'Rung commune Thuan Hanh commune

The subjects of the survey in the four provinces included:

i. 182 representatives from the People's Committee, related branches and Public Health Care Services of three levels;
ii. 159 representatives from the People's Committee, related branches and Public Education Services of three levels;
iii. 165 representatives from the People's Committee, related branches and Electricity Services of three levels;
iv. 86 representatives from non-public services of Health Care, Education and Electricity of three levels;
v. There were 240 households from 12 communes or wards of the four provinces.

Participants, such as leaders of People's Committee; Ministry of Labor, Invalid and Social Affairs, of Trade, of Health Care, of Education, fully attended the discussion. Participants who were difficult to attract to the meetings:

- Electricity staff (e.g., Staff of Electricity from Vinh city, NghÖ An province; Bac Kan province and Dak Song district did not attend the discussion as planned by the letter of invitation, so the discussion had to be delayed and re-held in the office of the local electricity branch).
- Non-public participants accounted for a maximum of 30 per cent of the total participants (mainly in health and education branches). The rate participation of private and non-public electricity services was very low, primarily from those involved in consultancy and manufacturing in Nghe An province, and were largely absent in the other provinces. The low participation from the private sector was attributed to the fact that non-public electricity has not yet been developed; staff have no time to attend these discussions due to the exigencies of their business; or electricity incidents occurred during the meeting day obliging the staff to absent themselves to solve these problems.

1.2. Data limitations

Significant data collection difficulties were faced in the electricity sector due to unstable recruitment and changes of local personnel. The Business Department of Electricity only provided sales data. Social data of the poor had to be grasped through the unit of rural electricity development, so it took time (the most time-consuming branch), and surveyors relied on contact through several people to get the information.

The most convenient branch was health care due to health care records (e.g., Quynh Hoa commune health care and Nghe An province had an adequate record of people's health care by years). Education branches were the next, Nghe An education branch considered the survey as the local's responsibility, and it was concentrated on providing information relating to the survey. These data had been filed and respondents formulated documents into files to send to the survey team. Data of finance for every sector also was difficult to gather due to personnel changes in local areas.

The most serious difficulties were to collect province's data through snapshot years of 1986, 1996, 2004, particularly those in 1986 and 1996. Reasons include:

- Data filing had not been paid due attention by local residents.
- Newly-separated provinces such as Bac Kan and Dak Nong found it difficult to separate their provincial data from that of the former province.
- Several local areas had not received briefing from the local People's Committee. It was thought that that the survey was responsibility of the Women's Unions, so they were not enthusiastic to provide information.

However, several steps were taken to gather data and information by the survey team:

- Questionnaires were dispatched to local authorities 10 days prior to the date of survey conduction. The survey team spent considerable time rechecking data, identifying missing data and worked overtime to complete the data.
- Data of the snap shot years 1986, 1996 were estimated based on the growth rate of the local area's socio-economic and experience of the interviewees. In addition, interviews through phone calls and other efforts were constantly made to gather information from staff, statistic offices, and from report systems of the locals.
- For the newly-separated provinces such as Bac Kan and Dak Nong, 1986, 1996 data were gathered as followed. The data of the new province was extracted from data of the district which had belonged to the former province, e.g., the former Dak Lak province had 20 districts. It was separated in 2004 into Dak Lak and Dak Nong provinces. Dak Nong currently has seven districts. Thus, the data of these seven districts in the snap shot years of 1986 and 1996 were added to the data of the former seven districts of the previous Dak Lak province, therefore, the data of the current scope of the Dak Nong province had been fulfilled.

Overall,

- There were too many requirements in the questionnaires. It was difficult to gather certain data because either they were un-available or loosely stored, (e.g., it was hard to extract data of the poor in certain contents of health care and electricity services, so forth).

- Time for survey was too short, specially surveys for FGD (90 minutes each session given to include all contents). Therefore, there were not many interesting ideas as participants had not enough time to figure out everything. One day-training for province Women's Union staff was also not enough for them to conduct good FGDs, due to new content and methods. As well, a multi-branches survey required profound summarizing skills of the moderators. Thus, in order to ensure the quality of the survey, most of the FGDs were conducted by the central Women's Union staff. Continuous and hard work had been done to accomplish all the survey activities. Time for data treatment as assigned in the contract was too short as there were too many outputs to be completed, while missing data was a common occurrence.

Annex 3
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