

Unequal Benefits of Growth in Viet Nam

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The economy of Viet Nam, stimulated by a set of reforms popularly called *doi moi* (renewal), grew at the impressive annual rate of 7.3 percent from 1990 to 1999. Contemporaneously, poverty incidence fell dramatically from 75 percent in the mid-1980s to 58 percent in 1993 and 37 percent in 1998.¹ Access to primary health care and basic education became almost universal by 1998. Infant mortality rate fell from 36 per 1,000 live births in 1993 to 27 in 1998. Enrollment rates in lower secondary schools also increased from 42 percent in 1992-1993 to 61 percent in 1997-1998. These advances in social indicators are impressive by international standards.

The Lowest Quintile

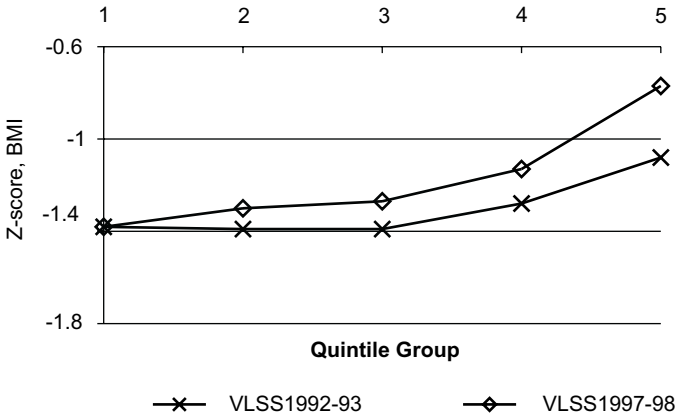
Nevertheless, poverty reduction efforts have a long way to go. The poor still represent a sizable number in both absolute and relative terms. In particular, the hard core poor have not sufficiently benefited from the overall economic growth and social development. For example, while per capita consumption of the richest quintile increased by 64 percent between 1993 and 1998, it rose by only 34 percent for the poorest quintile.

The benefits in the areas of health and education also became less evenly distributed in the past decade. Table 1 presents summary social indicators for Viet Nam. Inequality in terms of morbidity and mortality noticeably increased between 1993 and 1998. For example, 27 percent in the lowest quintile are reported to have lost one or more working days in the previous month due to illness in 1998, compared to 23 percent in 1993. The corresponding indicator for the wealthiest quintile fell from 22 to 16 percent. Likewise, infant mortality fell from 34 to 24 for the richest, but it declined from 39 to only 34 for the poorest. Moreover, while the poorest adults have seen little increase in their nutritional status, measured by body mass index (BMI)², the richest adults have experienced marked increases in their BMI [See Figure 1 which is based on the Viet Nam Living Standards Survey (VLSS).]

1 The estimate for the mid-1980s is taken from Glewwe, Gragnolati, and Zaman (2000). Figures for 1993 and 1998 are based on the GSO-World Bank poverty line.

2 Body mass index is a measure of weight for height commonly used for adults. Both high and low measures are associated with decreased work capacity and early mortality.

Figure 1: Trends in Body Mass Index of Adults



Although primary school enrollment is close to universal, secondary school enrollment shows a widening disparity between the poor and nonpoor. In 1997-1998, enrollment in lower secondary schools was nearly universal for children from the richest quintile (who are largely urban and have educated parents), but it was only 36 percent for those from the poorest. The corresponding figures in 1992-1993 were 64 percent for the top quintile and 24 percent for the bottom one.

The factors behind this increased inequality in human capital access and persistent poverty among people with low human capital endowment can be discussed under two separate headings: (i) unequal ability to access education and health, and (ii) unequal availability of education and health services.

Unequal Ability to Access Education and Health Services

Doi moi has provided people with greater economic opportunities. However, these opportunities vary significantly with geographical locations and individual characteristics. Not surprisingly, individuals who have high levels of human capital to start with—the

educated, healthy, city dwellers, and those with access to capital and credit—were better placed to benefit from the opportunities that came with the opening of the economy. They experienced greater rise in income and were, in turn, able to invest more in their health and education. At the other extreme, many of the poor people (especially ethnic minorities, those with low education, and households in remote areas) did not have the necessary human capital to benefit from the new economic opportunities. They were thus unable to generate enough additional income to pay for health and education services. Yet, human capital improvement is critical to getting out of poverty.

Unequal Availability of Education and Health Services

Doi moi has also affected the financing, quality, and private sector availability of services and, hence, has significantly influenced the affordability of health and education services for the poor. Previously, communes relied heavily on implicit taxes on collective farms and enterprises. The introduction of individual initiative saw a reduction in funds at the local level. At the same time, government subsidies for social services also declined leading to reliance on other financing mechanisms such as user charges and insurance. The increased cost of health and education services was probably more than offset for some groups through higher incomes. However, for those who did not benefit from the greater economic opportunities, the higher cost of services was an additional constraint. And more than the increased cost perhaps, the poor have been hit by the lower quality of services. Education and health costs represent a significantly larger proportion of household budgets for the poor than for the nonpoor. For example, in 1998 the hardcore poor were less likely to use modern facilities for delivering babies than in 1993.

Driven by the incentive of private practice ushered in by doi moi, health and education service providers have tended to gravitate toward the richer and urban areas. Providers in poor areas do not have the motivation to offer quality services, and there is evidence that the quality of services available to the poor has been declining in absolute terms. This has led to a decreased demand for these services.

Policy Implications

The increasing inequality in human capital has the following two important implications for policy:

- (i) The nonpoor disproportionately capture government subsidies for health and education sectors.
- (ii) There are rigidities in the upward mobility of the remaining poor, so that the growth process needs to be complemented by targeted assistance.

The government must find ways to improve the human capital of the poor and reduce poverty through:

- (i) Rationalization of resource allocation to improve the equity and efficiency of investments in health and education. This should include greater incentives for providers to remain in poorer communities.
- (ii) Removal of barriers to the use of services by the poor so that they can obtain the maximum benefits from the rationalized resource allocation and available services. For example, targeted subsidies for primary health care and basic education are called for.
- (iii) Provision of safety nets for catastrophic illnesses, natural calamities, and macro-level economic crises. The provision of health insurance for the poor and insurance against natural disasters are examples of policies that would encourage the poor to invest in their human capital.
- (iv) Continued robust growth to ensure that all segments of society continue to experience rising living standards, as described in the first paragraph of this brief.

Table 1: **Basic Human Capital Indicators of the Poorest and Wealthiest Groups**

| Indicator | 1992-1993 | | 1997-1998 | |
|---------------------------------------------------------------------------------------------|-----------|------------|-----------|------------|
| | Poorest | Wealthiest | Poorest | Wealthiest |
| Education Outcomes | | | | |
| Literacy rate of population above 18 years (%) | 78.1 | 93.3 | 75.2 | 94.1 |
| Years of education, adults from 25 to 65 | 5.1 | 7.5 | 5.5 | 9 |
| Net enrollment rate, primary level (%) | 72 | 91 | 85 | 96 |
| Gross enrollment rate, children from 11-14 | 24.3 | 83.7 | 47.3 | 107.3 |
| Gross enrollment rate, children from 15-17 | 2 | 35.3 | 9.5 | 75.4 |
| Education Inputs | | | | |
| Proportion of children with required textbooks (%) | 84 | 97 | 70 | 97 |
| Students in nonpublic primary schools in 1997-1998 (%) | | | 0.2 | 2.2 |
| Students in nonpublic lower secondary schools in 1997-1998 (%) | | | 0.8 | 5.5 |
| Students in nonpublic upper secondary schools in 1997-1998 (%) | | | 4 | 25.4 |
| Number of working hours per week, children 11-14 years | 13.5 | 4.2 | 10 | 1.1 |
| Number of working hours per week, children 15-17 years | 27.5 | 14.5 | 24.5 | 5.1 |
| Health and Nutrition Outcomes | | | | |
| Infant mortality rate (per thousand) | 39.4 | 34.4 | 33.6 | 24.5 |
| Average sick days in the last 4 weeks, children 6-11 years | 0.9 | 0.6 | 0.9 | 0.5 |
| Average sick days in the last 4 weeks, children 12-17 years | 0.8 | 0.6 | 0.6 | 0. |
| Average number of sick days in the last 4 weeks, adults 18 years and above | 1.8 | 1.6 | 1.7 | 1.1 |
| Malnourished children 1-5 years, using arm circumference (%) | 32.7 | 15.9 | 23.4 | 8.5 |
| Seriously malnourished children 1-5 years, using arm circumference (%) | 6.4 | 1.3 | 3.8 | 0.8 |
| Rate of stunted children (%) | 35.9 | 27.5 | 37.9 | 21.1 |
| Rate of severely stunted children (%) | 36.6 | 12.5 | 22.6 | 3.1 |
| Health and Nutrition Inputs | | | | |
| "Do nothing" when ill (%) | 14.5 | 3.3 | 26.7 | 12.5 |
| Women attended by doctors at birth (%) | 5.9 | 45.7 | 6.9 | 53.3 |
| Children immunized with at least one kind of vaccine (%) | 62.1 | 81.0 | 88.0 | 97.9 |
| Children sufficiently immunized (%) | 48.6 | 69.0 | 60.7 | 68.2 |
| Commune health clinics with a shortage of medicines (%) | 37.7 | 24.6 | 60.6 | 38.6 |
| Average cost of a hospital visit as a percentage of total nonfood expenditure | 73 | 7 | 44.4 | 4.7 |
| Average cost of a commune health clinics visit as a percentage of total nonfood expenditure | 21.2 | 2.1 | 4.7 | 0.5 |

Source: Bhushan, Bloom, Nguyen, and Nguyen (2000).

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