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**Universal Health Coverage for Inclusive and  
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**Country Summary Report for Vietnam**

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## Acronyms

CHS	Commune health station
COPD	Chronic Obstructive Pulmonary Disease
DRG	Diagnostic-Related Group
EPI	Expanded Program on Immunization
GDP	Gross Domestic Product
GNI	Gross National Income
HCFP	Health Care Fund for the Poor
HRH	Human Resources for Health
MDG	Millennium Development Goals
NGO	Non-governmental organization
OOP	Out of pocket health spending
PPP	Purchasing power parity
SHI	Social Health Insurance
THE	Total Health Expenditure
UHC	Universal Health Coverage
VSS	Vietnam Social Security

## Preface

In 2011, Japan celebrated the 50<sup>th</sup> anniversary of achieving universal health coverage (UHC). To mark the occasion, the government of Japan and the World Bank conceived the idea of undertaking a multicountry study to respond to this growing demand by sharing rich and varied country experiences from countries at different stages of adopting and implementing strategies for UHC, including Japan itself. This led to the formation of a joint Japan–World Bank research team under The Japan–World Bank Partnership Program for Universal Health Coverage. The Program was set up as a two-year multicountry study to help fill the gap in knowledge about the policy decisions and implementation processes that countries undertake when they adopt the UHC goals. The Program was funded through the generous support of the Government of Japan.

This Country Summary Report on Vietnam is one of the 11 country studies on UHC that was commissioned under the Japan–World Bank Partnership Program. The other participating countries are Bangladesh, Brazil, Ethiopia, France, Ghana, Indonesia, Japan, Peru, Thailand, and Turkey. A synthesis of these country reports is in the publication “Universal Health Coverage for Inclusive and Sustainable Development: A Synthesis of 11 Country Case Studies,” available at:

<http://www.worldbank.org/en/topic/health/brief/uhc-japan>.

These reports are intended to provide an overview of the country experiences and some key lessons that may be shared with other countries aspiring to adopt, achieve, and sustain UHC. The goals of UHC are to ensure that all people can access quality health services, to safeguard all people from public health risks, and to protect all people from impoverishment due to illness, whether from out-of-pocket payments or loss of income when a household member falls sick. Although the path to UHC is specific to each country, it is hoped that countries can benefit from the experiences of others in learning about different approaches and avoiding potential risks.

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# Country Summary Report for Vietnam

## Overview

Vietnam is regarded as a development success story. Political and economic reforms (“Doi Moi”) launched at the end of the 1980s have transformed the country from one of the poorest in the world to a lower middle-income country in a quarter century, with per capita income of \$1,130 (World Bank, 2013).

Over the past 10 years, Vietnam has seen average annual economic growth of nearly 8 percent. Poverty tumbled from 58 percent in 1993 to 12 percent in 2009. Economic development and innovative policy interventions led to steep gains in health outcomes and access to health care, although large disparities persist between the rich and poor, and between poorer and better-off regions (Vietnam General Statistics Office 2011b). Infant mortality declined from 30 to 16 per 100,000 live births, and under-five mortality rates from 42 to 25 per 100,000 live births, between 2001 and 2009 (Vietnam General Statistics Office 2011a, 2011c). Vietnam has shown strong political commitment toward universal health coverage (UHC), making it a national goal for 2014. A major challenge lies now in expanding coverage to the non-covered population (64 percent had coverage in 2012) while addressing the model’s financial sustainability.

**Table 1: Data overview**

Population	87.84 million (2011)
GDP	\$123.6 billion (2011)
Gross national income per capita in purchasing power parity (PPP)	\$3,250 (2011)
Total health expenditure (THE) as % of GDP	6.8% (2010)
THE per capita (in current exchange rate dollars)	\$82.9 (2010)
Public expenditure ratio of THE	37.8% (2010)
Life expectancy at birth	74.8 years for total population (2010)
Hospital beds per capita	3.1 hospital beds per 1,000 population (2009)

Source: World Development Indicators.

## **PART I. Universal coverage—status and sequencing**

### **A. Overview of current status**

#### **1. Legal and statutory basis**

The legal right of citizens to health protection and the priority of ensuring health care for vulnerable groups are enshrined in the Vietnamese Constitution of 1992.

The country officially launched a national health insurance in 1993 for formal public and nonpublic sectors. Ten years later, a Health Care Fund for the Poor (HCFP) was created to provide coverage for the poor, ethnic minorities, and the disadvantaged. Initially implemented as a separate social program, HCFP was merged and rolled into the national insurance program in 2009. Currently, the system includes a contributory program for the formally employed, pensioners, and civil servants, and a noncontributory one for the poor and disadvantaged.<sup>1</sup>

A voluntary insurance program targets dependents of those in compulsory programs and the informal sector. Students and priority groups under social security allowances are, respectively, partially or fully subsidized by the government.

#### **2. Population and services covered**

Vietnam expanded coverage to 64 percent of the population in 2012 and intends to cover 80 percent by 2020. Thus 32 million people are uncovered, predominantly those working in the informal sector. Though the insurance program was opened up to informal workers, enrollment remains low at 10 percent of the population group (Vietnam Ministry of Health 2011b).

The curative care service package covered under health insurance is generous, covering many drugs and medical services in ambulatory and hospital care. Services are defined in lists for different levels of health facilities. Recent reforms have deepened the depth of coverage and all members, including the poor, are now eligible for the same package.

The preventive and public health service package provided through direct state budget funding, with little or no copayment from patients, includes the expanded program on immunization (EPI), control and prevention of infectious diseases (malaria, tuberculosis, leprosy, HIV/AIDS, dengue fever) (Government of Vietnam 2012), and noncommunicable diseases (mental illness, hypertension, diabetes, cancer, COPD/asthma). Reproductive health and maternal and child health services, too, are widely available at the commune level. General public health measures have gradually been put in place for food safety, clean water and sanitation, health promotion, and risk reduction (smoking, alcohol, drugs, and promotion of safe sex).

Coverage for infectious disease programs and EPI is high, but services and programs covering noncommunicable diseases have yet to become nationwide.

#### **3. Financial protection**

Financial protection has improved since 2005 as social health insurance coverage has expanded rapidly from 6 percent during 1998–2002 to 17 percent in 2010. Out-of-pocket spending has consequently fallen, from 63 percent in the earlier period to below 50 percent in 2010. However, financial protection remains a challenge. The rate of households experiencing catastrophic expenditure in 2008 was 5.5 percent, while the poorest quintile experiences higher

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<sup>1</sup> Under the leadership of the Ministry of Labor, Invalids and Social Affairs (MOLISA), the provinces are responsible for identifying the poor and ethnic minorities.

rates of catastrophic payments (7.8 percent) and of impoverishment (7.5 percent) than other income groups. Of out-of-pocket spending in 2009, 44 percent is spent on user fees at public facilities (up from 12 percent in 1998), 22 percent on private facilities, and 35 percent on self-medication, down from 68 percent in 1998 (Bales, S. and Tuong, D. T. 2012).

Official copayments vary from zero percent for people with meritorious service to the nation and children under age six; to 5 percent for the poor, ethnic minorities, and social assistance beneficiaries; and 20 percent for other groups. Higher copayments are required if the patient bypasses their primary health care facility. The absolute value of copayments rose in 2012 when 477 basic medical services prices were officially raised. The financial benefits are capped at 40 times the monthly minimum wage for most groups (Somanathan et al. 2013).

Informal payments and overprovision of services are widespread, contributing to high financial burdens on households and the health insurance fund. Efforts to reduce informal payments and overprovision of services have recently begun with ethics and codes of conducts to clarify what constitutes unethical behavior (Ha Tran Thi Thu et al. 2011). More recently financial penalties have been introduced, and inspection and health insurance claims procedures tightened up to try and catch abuses.

#### **4. Governance and service delivery systems**

The Ministry of Health (MOH) is responsible for leading the process of setting rules and regulations. Vietnam Social Security is in charge of managing funds and paying providers, but does not act as a strategic purchaser due to limited competition among providers.

The public sector remains the predominant health care provider, though the private sector has expanded in the last decade. In 2010, 40 percent of outpatient visits were at private modern or traditional-medicine facilities, 37 percent at state hospitals, and the rest at commune health stations or regional polyclinics. For inpatient care only 5.4 percent of admissions were in private facilities compared with 83 percent in state hospitals and 11 percent in commune health stations and polyclinics. The country has 980 hospitals in operation (610 of them district entities). The number of private hospital beds accounts for only 4 percent of total beds at the 85 private hospitals (Somanathan et al 2013).

In recent years, the government has made substantial investments in improving the public health infrastructure, with some emphasis on primary care. By the end of December 2011, 91.3 percent of district hospitals had received investment capital from government bonds to build their infrastructure. Construction has been completed at 147 district hospitals and 46 regional polyclinics; a further 275 hospitals and 60 regional polyclinics are to be completed soon. In addition, 51 provincial general hospitals, 48 specialized tuberculosis hospitals, 35 mental health hospitals, 23 pediatrics/obstetrics-pediatrics hospitals, and 5 oncology hospitals/centers have received investment funds, 86 of which are completed (Ministry of Health and Health Partnership Group 2012).

### **B. Current status of health financing and HRH policies**

#### **1. Health Financing**

Vietnam's health financing system has evolved from an exclusively government revenue-based system to a multi-source financing system, with the launching of its national health insurance program in 1993. In 2003, a Health Care Fund for the Poor (HCFP) was created to provide coverage for the poor, ethnic minorities and the disadvantaged. Initially implemented as a

separate social program, the HCFP was eventually merged with the national contributory scheme in 2009. The national program now includes a contributory program for the formally employed, pensioners and civil servants, and a non-contributory program for the poor and disadvantaged. Social health insurance (SHI) premiums (contributory system) account for 14 percent of the THE. Government revenues which subsidize the cost of non-contributory programs mainly originate from VAT and other local taxes (IMF 2012). Private spending still represents more than one-half of THE (Vietnam General Statistics Office 2012).

Vietnam has benefited from growing economy, which has provided a growing fiscal space for increasing the share of state budget allocated to health. Under HCFP, state spending has increased to cover the poor, ethnic minorities, residents of disadvantaged areas, and children under age 6 (Vietnam Ministry of Health and World Health Organization 2011). In 2010, some 9.1 percent of the state budget was spent on health, and total spending on health reached almost 7 percent of GDP. In addition, major investments in infrastructure have been funded from the state budget mobilized through treasury bonds. Economic projections forecast further rapid growth in the near future, which would potentially increase the fiscal space for health (IMF 2013). Economic growth has also supported the expansion of formal workforce, with potential increased expansion of revenue base for compulsory health insurance programs. Tobacco taxes in Vietnam are still somewhat low and there is potential scope for raising revenues from this source while creating incentives to reduce smoking, with consequent health benefits.

Risk pooling in the SHI system remains highly fragmented. Vietnam has 63 provincial funds, and only marginal redistributions are made across these funds through central reserves, and redistribution is often regressive, i.e., from poorer to richer regions or groups. Central and provincial budgets cover, respectively, 4 percent and 19 percent of current THE. A large part of government health spending is in the form of subsidies, either as premium subsidies to health insurance programs, and direct transfers to health providers.

Budget allocations in the health system are made as part of the annual planning process, guided by annual resolutions of the government that remind localities and ministries of their legal obligations for spending on priority areas. The Health Insurance Law passed in 2009 provides a legal basis for earmarking state budget to subsidize health insurance for several large target groups. However, budget allocations for fulfilling national target programs, such as ensuring the quality of the grassroots primary care network, are discretionary and have resulted in delays and inadequate budget allocations and executions relative to annual plans.

## **2. Cost Management**

With the expansion of health coverage in recent years, Vietnam has been facing cost escalation and has been introducing a number of initiatives to strengthen its cost management systems. The existing payment systems for health care providers are fragmented, and often create contradictory incentives for the health care providers. Vietnam has three types of provider-payment mechanisms: fee-for-service, capitation, and case-based payment. Fee-for-service has been the dominant system since 1995, and the rates are set in the form of the national fee schedule, which was only updated in 2012, after 17 years of no change.

Vietnam Social Security (VSS), the national health insurance fund, pays most hospitals by fee-for-service. VSS placed a global budget cap on hospital payments to contain costs, but there are strong incentives for hospitals to spend beyond the cap; overspending in one year leads to a higher cap the next year. Consequently, these measures often increase informal payments and erode financial protection. Case-based payments are currently being piloted in two Hanoi hospitals, but no evaluation is yet available (Phuong Nguyen Khanh 2013).

Capitation payment was introduced for primary health care in some provinces in 2004, with the intention of enhancing primary health care. Capitation was also introduced in 2011 at the district hospital level in response to cost escalation, but it is unevenly applied in some districts. District-level capitation rates were intended to cover costs associated with hospital stays as well as referrals. The approach is currently under review since it has led to unintended consequences, notably, by placing financial risk on the district hospitals as fund-holders, it resulted in reduced funding for primary health care. Capitation rates are also determined by SHI membership groups rather than health risks or actual cost of care, and consequently hospitals receive less subsidization for the poorer groups.

It is evident that Vietnam will need to make substantial efforts to ensure the sustainability and affordability of health coverage. There is evidence of considerable inefficiencies in the existing health care system that will require a multi-pronged approach to improve performance. For example, many prefer to bypass primary health care due to poor quality of services and prefer to opt for more costly hospital-level services. Pharmaceutical expenditures will require well-designed measures to place such as more centralized pharmaceutical procurement to push down prices, and application of case mix and capitation payments to reduce incentives for provision of unnecessary services. Introduction of information technologies in processing insurance claims would also help detect fraud and waste.

### 3. Human resources for health

Recognizing the importance of health workforce as the backbone of a quality service-delivery system, Vietnam has made substantial investments in and given high priority to reform the health education system to increase the availability of health workers.<sup>2</sup> Currently, 70 percent of commune health stations have medical doctors, and the country has 24 medical universities 30 junior colleges and 35 secondary medical schools. While the number and availability of practicing health professionals have increased significantly, quality of health workers remain a significant challenge. There is weakness in both accreditation system and continuing education program for professionals to maintain their knowledge and quality of services. Medical education institutions are oriented toward hospital services, and do not prepare the health workers to serve in primary health care settings (Van Tien 2013). The Government is turning its attention to these issues by expanding investments in regulation and accreditation systems for health professional education and training.

The existing health workforce structure also reveals imbalances in skill mix with acute shortages of nurses and midwives,<sup>3</sup> in preventive and family medicine practitioners, and in some specialties, including pediatrics (Ministry of Health and Health Partnership Group 2012). Shortage of health workers remains a concern in the disadvantaged remote and mountainous areas: 59 percent of medical doctors practice in towns, but only 27 percent of the general population is urban; and physician ratio in the Southeast region is 4.7 per 10,000 population, significantly below the national average of 6.6 per 10,000. Imbalances within provinces are also high, and only one-third of communes have medical doctors.

Government has launched several initiatives to reduce the geographic imbalance. They include: financial incentives up to 70 percent of basic salary, for both recruitment and retention of health workers in rural areas; introduction of “rural pipeline” strategy to expand training of assistant doctors from rural areas who wish to become medical doctors in the rural areas; and short-term rotation system from higher to lower level facilities to boost quality of services at

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<sup>2</sup> In 2001, Vietnam had 229,887 health workers; in 2008, 299,100. Source: MOH, Book of National Statistics.

<sup>3</sup> Nurse–doctor ratio: 1.3 (Source: MOH).

commune level as well as foster greater interaction between urban and rural health workers (Van Tien 2013).

There has been a substantial increase in the number of medical and nursing education institutions. But the quality of education delivered in the medical and nursing schools is reportedly uneven, and continuing education for professionals is lacking (World Bank, Forthcoming b).

A draft master plan for Human Resources Development was approved for 2011–2020, notably to strengthen health professional education and to improve recruitment and retention of health workers at the grass-roots level (commune health stations).

### **C. Sequencing of reforms**

In the late 1980s, Doi Moi included structural reforms for the health sector, encompassing growth of the private sector, introduction of fees, and quality enhancement. This led to the 1993 health insurance law that helped to diversify the source of revenues and raise contributions from the health workers. Since then, the government has taken incremental steps to expand health coverage for different population groups. The introduction of the Health Care Fund for the Poor (HCFP) in 2003 was an important recognition of and reestablishment of equity coverage for the poor, ethnic minorities and the disadvantaged.

Initially implemented as a separate social program, the HCFP was eventually merged with the national contributory scheme in 2009. This merging of HCFP (non-contributory system for the poor) with the national contributory scheme in 2009 had helped to reduce fragmentation in the Vietnamese system. Thus, the Health Insurance Law of 2009 was a milestone for the health sector by creating the foundation for a national system and eventual merging of the programs. It also provided a roadmap for universal coverage, which aims to reach 80 percent coverage by 2020 (Bui Thi Thu Ha et al. 2013).

Over the course of the reform process, however, multiple programs have been created and disparities among them still persist, and it has also contributed to proliferation of different forms of payment systems have proven to be problematic. Recent reforms have helped to reduce disparities among groups in terms of access to services, but redistribution of resources across the different SHI risk pools remains limited, and often takes a regressive form.

Vietnam is considering further steps to consolidate the risk pool into a national insurance program and strengthen cross-subsidization mechanisms to ensure that the risks faced by vulnerable populations/regions are adequately protected and subsidies are targeted to those most in need. The Ministry of Health and Vietnam Social Security have initiated a comprehensive assessment of the national health insurance system to propose adjustments in order to ensure universal coverage and address the fragmented payment system in an upcoming revision of the Health Insurance Law. Vietnam is also taking steps toward pro-active regulation and reform of provider payment systems.

Strong national ownership, sustained political commitment and leadership, and active legislative regulation have supported the passage of bold UHC reforms over the past two decades. Having healthcare access embedded in the Constitution as a right has served as important institutional underpinning to UHC initiatives in Vietnam by providing reformers with a legal basis for UHC advocacy. Vietnam has set 2020 as an explicit target date for UHC as a way to mobilize political support and keep the nation focused on the goal.

## **PART II. Lessons to be Shared**

Vietnam has established the foundational policies and systems in place for UHC, and this has enabled the country to achieve significant expansion of health coverage to approximately 90 percent of the poor and 60 percent of the near-poor through state subsidies and financial protection has substantially improved over time. National ownership, sustained political commitment, and legislative regulation are among the key enabling factors that have allowed UHC policy reforms to be implemented continuously over the last two decades.

The country has invested heavily in curative and preventive care services, which are now delivered under social health insurance, as part of the benefit package, or through public health programs. These investments have been made possible during this period of continued high economic growth, which helped the government to generate revenues and create fiscal space for health. Prioritization of health within government spending, without earmarking, has provided the core resources for health coverage expansion.

While much has been achieved to finance coverage expansion in the last decades, further steps are needed to expand coverage to the remaining 40 percent of the population, most of whom work in the informal sector, and to improve overall financial protection through contained out-of-pocket spending.

Multiple funds and programs were created over the course of the reforms, and this has led to fragmentation and inconsistencies in the management of resources, making it difficult to monitor and ensure equitable and efficient allocation and use of resources. Vietnam is taking steps to consolidate these into a national insurance program to enhance harmonization and redistribution.

Despite sizable investments to strengthen service delivery, availability and distribution of human resources for health remains a significant concern. Recent policy initiatives have helped increase the availability of practicing health professionals, particularly in poorer regions, but the quality and performance of health workers remain problematic. The Government is increasing investments in regulating and improving the quality of health professional education system.

With economic growth and changing demographic and epidemiological profile, the demand for more complex and high cost health services is expected to rise. Managing costs more effectively and improving health system efficiency, e.g., through robust expenditure management and introduction of appropriate incentives to shift the system toward cost-effective interventions, will be essential for long-term sustainability.

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