

## Mobilizing Resources for Universal Coverage: The Macro-Fiscal Context

*This chapter examines how the achievement of universal coverage (UC) goals can be financed, based on the indicative cost projections provided in chapter 4. The recommendations provided in earlier chapters all require an increase in budgetary spending to meet the two major goals of the Master Plan. This chapter therefore focuses on public expenditures for health from a fiscal space perspective, and the extent to which additional resources can be mobilized to finance the expansion in coverage. The prospects of expanding fiscal space for health are assessed with respect to the five major pillars: (a) conducive macroeconomic conditions; (b) reprioritization of health in the budget; (c) health sector-specific resources; (d) grants and foreign aid; and (e) efficiency gains. Vietnam can expect additional fiscal resources for health of about 0.4 percent of GDP by 2015, given projections of macroeconomic growth rates and assuming that the relatively high income elasticity of government expenditures on health is sustained and the health share of budget is protected and sustained. Clearly, only a portion of the total projected costs of expanding coverage can be met through additional fiscal outlays. Reducing inefficiency will be critical for making further sustained progress toward achieving UC.*

Assessing fiscal space for health basically entails an evaluation of the different sources of financing that might potentially be available to increase government health spending. This assumes a clear case has been made that such an increase is merited and that the net societal benefits of increasing government health spending are positive. Clearly, from a financial sustainability perspective, controlling costs and improving efficiency is an important aspect of the overall framework within which such an assessment for the health sector needs to be made. However, macro-fiscal constraints and cross-sectoral considerations can severely limit the amount of flexibility countries have in terms of their ability to increase government health spending, regardless of how meritorious the purpose might be.

Fiscal space for health entails examining five broad sources of public financing in detail:

1. a conducive macro-fiscal environment such as high levels of economic growth and increases in government revenues that, in turn, could facilitate increases in public spending for health;
2. a reprioritization of health within the government budget;
3. an increase in health sector-specific resources, for example through earmarked taxation;
4. health sector-specific grants and foreign aid; and
5. an increase in the efficiency of existing government health outlays, either via cost-containment policies and/or through improvements in technical and allocative efficiency of health outlays.

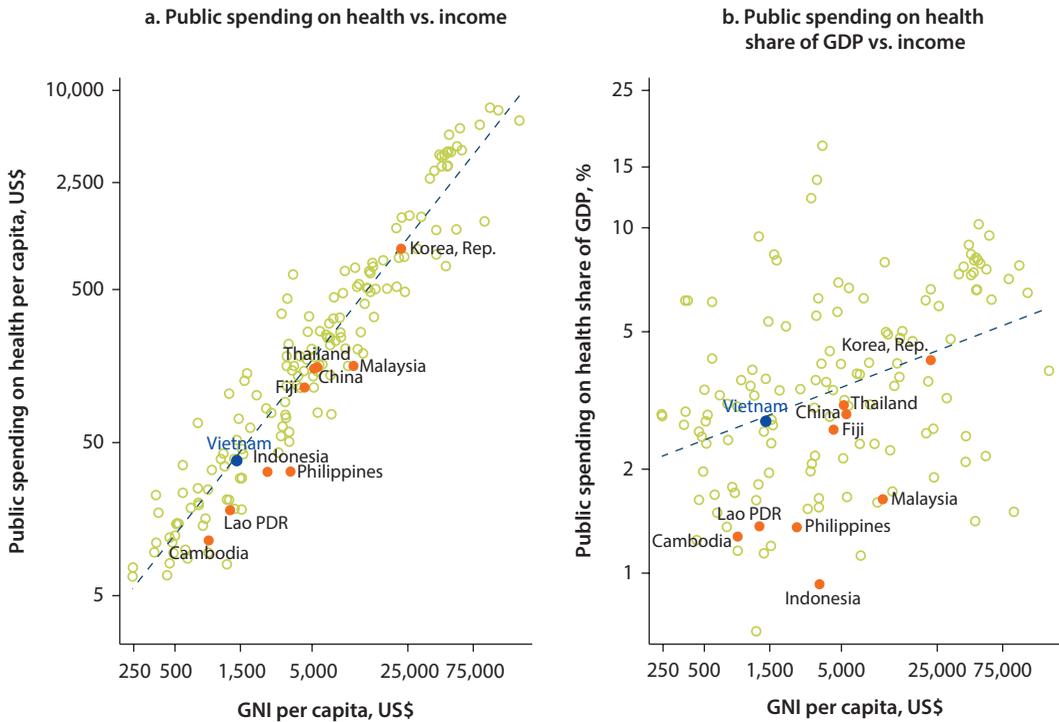
This chapter of the report examines the first four of these possible sources for public financing. The importance of efficiency savings and cost control in achieving UC in a financially sustainable manner are discussed in the next chapter, and recommendations provided on how to achieve this.

### **Macro-Fiscal Environment**

Conducive macro-fiscal conditions are important for fiscal space considerations for any sector. These conditions include sustained economic growth, improvements in revenue generation, and sustainable levels of deficits and debt. There are several reasons why economic growth is an important factor driving fiscal space more generally, and specifically for health. First, even if public spending on health as a proportion of gross domestic product (GDP) remains unchanged, an increase in GDP by a certain percentage per year in real terms implies that public spending on health would also increase by the same percentage per year in real terms (assuming changes in prices of health are not significantly different from changes in overall prices over time). Second, as noted in a seminal article by Newhouse (1977), national income tends to be the biggest determinant of public (and private) health spending across countries. Hence, it is critical to assess public spending on health within a broader macroeconomic context.

Sustained periods of economic growth and macro-fiscal stability usually result in increases in public spending on health. Periods of robust economic growth and macro-fiscal stability often result in increases not only in the level but also in the share of the public sector in the economy, including for health (ADB 2006). In health, this is evident in cross-sectional data (figure 5.1). Across a range of countries, public expenditure on health increases both in levels and as a share of GDP as national income rises.

The reasons for this are grounded, in part, on the macro-fiscal environment within which a government operates, as well as the relaxation of budgetary constraints with rising income. As economies grow and the population becomes richer, the nature of the disease burden, demographics, and the preference

**Figure 5.1 Public Spending on Health versus Income (2011)**

Source: WHO 2013b; World Bank 2013.

Note: x and y axes on each figure in log scale.

structure for the demand for public financing for health also tend to evolve (Shelton 2007). The provision of health services—a relatively labor-intensive process—tends to also be more expensive in richer countries, driving up public (and private) spending on health. Health care costs tend to be higher in richer countries, driven by relative price differences as well as availability of higher-technology care, among other factors. Richer countries also tend to have more educated and older, aging populations with a preference structure that generally emphasizes greater levels of social protection. Higher costs and more demand for publicly financed health care, as well as private health insurance market failures—combined with a greater fiscal and institutional ability to address these issues—help explain why governments spend more as a share of their budget on health, on average, as countries become richer (Shelton 2007).<sup>1</sup>

With a gross national income (GNI) per capita in 2011 of US\$1,270, Vietnam is classified as a lower-middle-income country. About 17 percent of the country's population continues to live on less than US\$1 per day, and about one-half lives on less than US\$2 per day.<sup>2</sup> Vietnam has been an economic powerhouse in recent years, with economic growth rates averaging 7 percent per year since the onset of liberalization under Doi Moi in 1986 (7.2 percent per year in the past decade). Taxes comprise the main source of revenue for Vietnam's government.

**Table 5.1 Revenue Sources in Vietnam (2008–11)**

Revenue item	2008		2009		2010		2011	
	Trillions of VND	%						
Tax revenue	363	85	373	82	477	86	615	87
Oil revenue	90	25	61	16	69	14	111	18
Nonoil revenue	274	75	312	84	408	86	504	82
Grants	9	2	8	2	5	1	7	1
Other revenue	57	13	72	16	69	13	82	12
Total revenue	429	100	453	100	551	100	704	100

Source: IMF 2012.

Note: Numbers for 2010 and 2011 are estimates.

In 2011, taxes accounted for about 87 percent of total revenues in the country, with other sources comprising about 12 percent and grants filling in the remaining 1 percent (table 5.1).

The first five-year plan following national reunification, passed in 1978, established the basis for fiscal decentralization in Vietnam by assigning expenditure responsibilities to subnational governments (Vo 2005). In the 30 years of reforms since then, fiscal decentralization has increased. By 2010, local governments executed 51 percent of investment from the state budget (World Bank 2011). The Budget Law, passed in 2002, currently governs revenue assignment between the central and local levels. This law stipulates that all taxes are defined as national.

Subnational governments (at the provincial, district, and commune levels) have limited ability to establish their own funding resources: revenue sharing and intergovernmental transfers are important for financing local budgets. About 60 percent of all revenues are assigned to the central government (for example, export and oil taxes and revenues). The remaining 40 percent are shared between the central and provincial levels (for example, corporate income tax, excise tax on domestic goods and services) or are assigned only to the provincial level (for example, land taxes, including land use tax and taxes on land use transfers, and natural resource taxes, excluding oil) (Hanai and Huyen Thi Bach 2006). However, approximately one-half of the revenues assigned to the central government are transferred to the province level. After transfers, the share of total revenues held by the central government is about 30 percent, with 70 percent held at the province level (World Bank 2011).

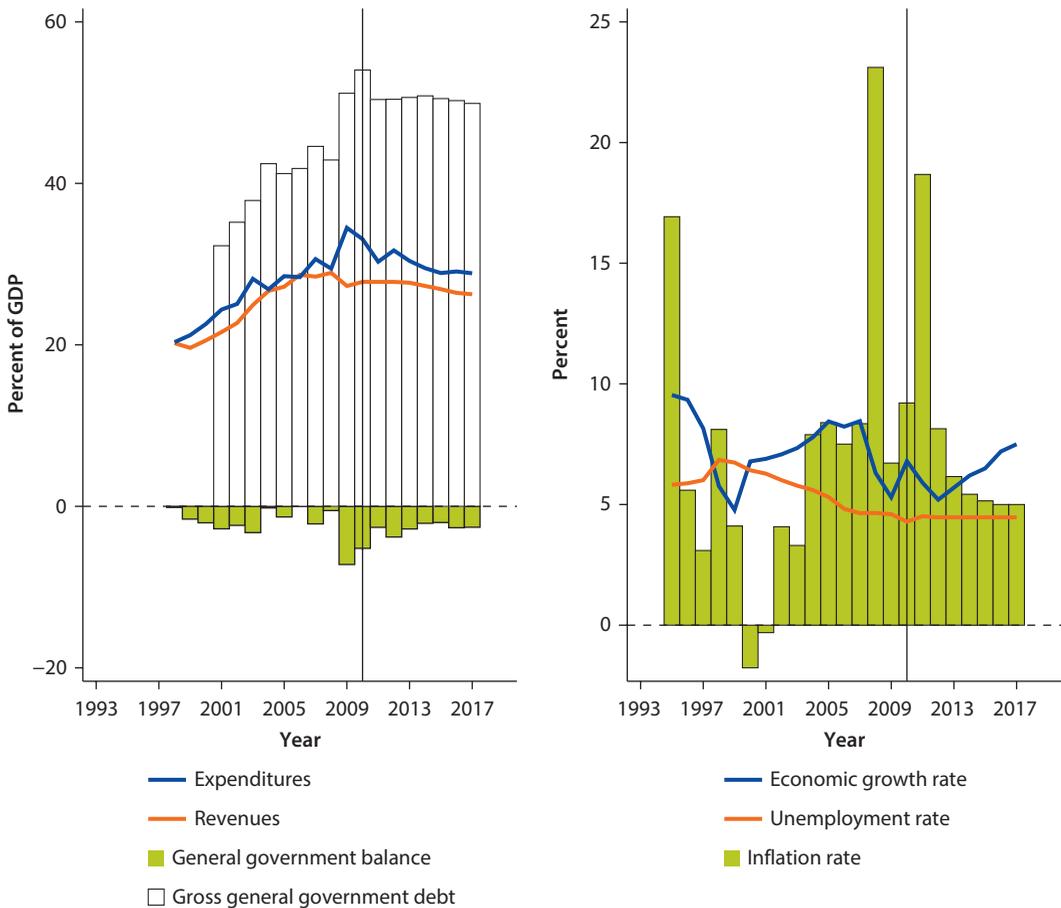
Growth in Vietnam has slowed in the past couple of years as a result of the global economic slowdown, but projections indicate that Vietnam will rebound in the medium term. Vietnam's GDP growth was about 8.5 percent in 2007. Following the onset of the global economic crisis, growth declined to 6.3 percent in 2008, and to only about 5.3 percent in 2009. Growth rates recovered to 6.8 percent in 2010 before declining to 6.2 percent in 2011 and then falling sharply to 5.2 percent in 2012. Growth is expected to remain relatively flat in the 5.3–5.5 percent range through 2017.<sup>3</sup> This second-round macroeconomic slowdown has been the result of a slow reversal of fiscal and monetary stimulus

measures put in place to deal with the original 2008 global crisis. Inflation, which has been a problem in recent years, is projected to stabilize at around 5 percent per annum (figure 5.2). Debt levels have been relatively low in Vietnam, and are projected to decline over the coming three to five years. The government revenue share of GDP is expected to remain in the range of 21–22 percent of GDP.<sup>4</sup>

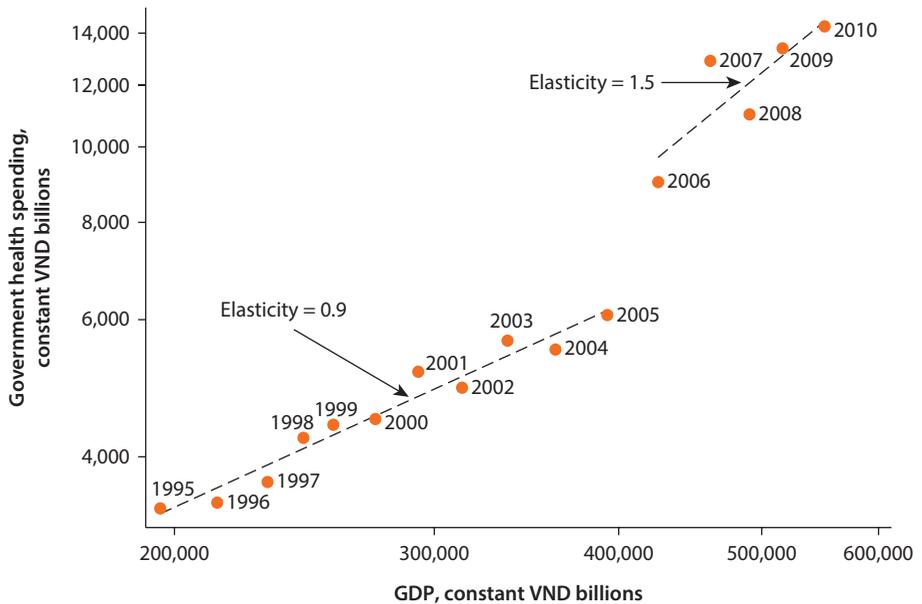
Vietnam is not an outlier relative to comparator countries when it comes to government spending on health. At roughly US\$38 per capita in 2011, general government spending on health in Vietnam was exactly as expected for its income level and higher than that of regional neighbors such as Cambodia, Lao PDR, and the Philippines.<sup>5</sup> Public spending on health as a share of GDP in Vietnam was also about as expected for its income level (figure 5.1).

The income elasticity of government health spending in Vietnam has varied significantly over the past decade or so.<sup>6</sup> Two regimes are apparent, with a break occurring around 2006. Prior to 2006, government health spending grew at a rate

**Figure 5.2 Key Fiscal/Economic Indicators for Vietnam (1995–2017)**



Source: World Bank 2013; IMF 2013.

**Figure 5.3 Income Elasticity of Government Health Spending in Vietnam (1995–2010)**

Source: Estimates based on data from WHO 2013a.

Note: x and y axis are in log scale.

**Table 5.2 Projections of Government Health Spending Based on Economic Growth (2010–17)**

Year	2010	2011	2012	2013	2014	2015	2016	2017
Real GDP growth (%)	6.8	6.2	5.2	5.3	5.4	5.4	5.5	5.5
Government health spending share of GDP (%)	1.9	1.9	2.0	2.0	2.1	2.2	2.2	2.3

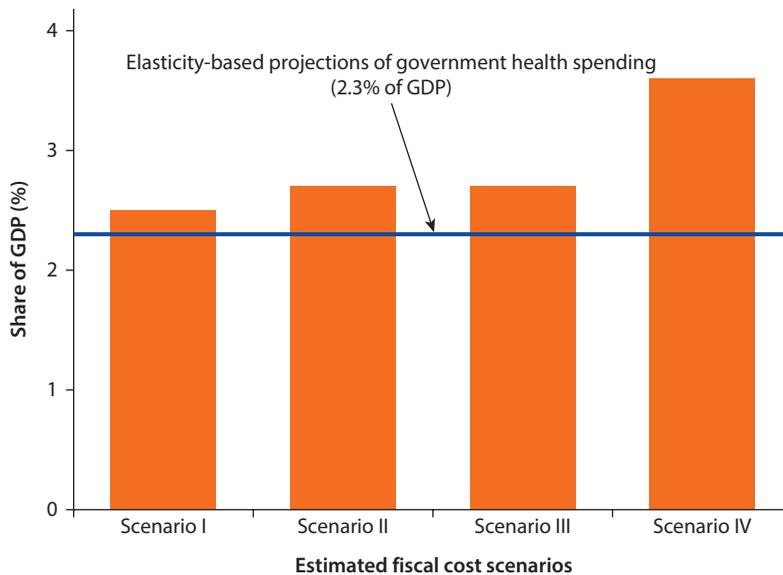
Note: Elasticity-based projections 2011–17.

lower than that of economic growth: the income elasticity was only about 0.9 (figure 5.3). Following 2006, the income elasticity increased significantly to 1.5.

At current growth projections—and if income elasticity stays at post-2006 levels—Vietnam could expect additional fiscal resources for health of about 0.3 percent of GDP from 2010 to 2015. At current growth projections, and assuming that government health expenditures on health follow the same rising trend as they have in the period post-2006, Vietnam could expect government spending on health to be about 2.2 percent of GDP by 2015, an increase of about 0.3 percent of GDP from 2010 numbers (table 5.2). This would not be within the range required under all of the scenarios for financing 70 percent of UC discussed in chapter 4. Additional fiscal resources—over and above what may be expected to be realized based on macro-fiscal trends alone—will be needed (figure 5.4).

To summarize, from a macro-fiscal perspective, the prospect of additional public resources for health becoming available is likely to be limited, even if the

**Figure 5.4 Projected Government Health Spending Scenarios: Needs vs. Predicted (2015)**



income elasticity of government health spending remains as high as it has been in the post-2006 period. Until recently, Vietnam's rapid economic growth over an extended period and healthy revenue flows were instrumental in providing substantial additional revenues for all sectors, including health. The economy has now slowed. However, if trends continue, then, at least in the short to medium term, the availability of additional fiscal resources for health is likely to increase government health spending as a share of GDP to about 2.3 percent by 2015. Additional reprioritization efforts will be required for health's spending share to increase beyond this as required under the scenarios described in chapter 4, and this is the focus of the next subsection.

## Reprioritizing Health

A second source of fiscal space can arise from reprioritizing health to increase its share in the government's budget. There may be scope for raising health's share of overall government spending in some countries, particularly if the share of health in the government budget is lower than comparator countries in the same region or those with similar income levels and if certain expenditure categories can be identified that are deemed unproductive or unnecessary and can be reduced to allow room for additional health spending.

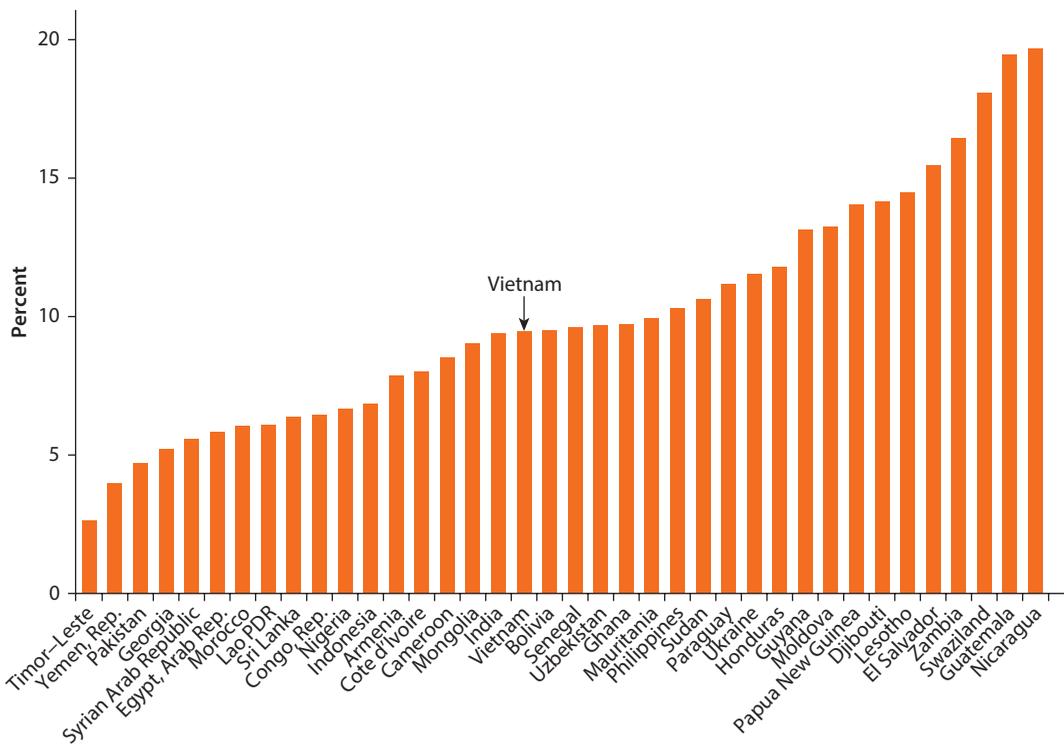
Even though a country's macroeconomic fundamentals may suggest that an increase in overall spending may be feasible if warranted, there is no guarantee that a conducive macro-fiscal environment will lead to an increase in government

spending specifically for health, even if overall government expenditures rise. On average, as countries become richer, the share of health in the government's budget (and as a share of GDP) does tend to increase. However, there are huge variations around this trend, reflecting in large part the intervening influence of other factors such as the extent to which health is prioritized over other sectors as well as the ways in which the health system is organized and financed.

Among lower-middle-income countries, health's budget share ranged from less than 5 percent for countries such as Pakistan to more than 15 percent for countries such as Zambia (figure 5.5).<sup>7</sup> Averaging in the 6–7 percent range over the past couple of years, Vietnam share of health in aggregate government expenditures is somewhat below average relative to its income and regional comparators (the average among East Asia and Pacific [EAP] and lower-middle-income countries tends to be in the 10–11 percent range).<sup>8</sup>

Health appears to be increasingly accorded a higher priority in Vietnam. In fact, health spending is protected by law in Vietnam: the National Assembly passed Resolution No. 18/2008/NQ-QH12 in 2008 to protect and promote government spending on health. According to Article 2 of the resolution, the government would commit "...to increase the share of annual state budget allocations for health, and to ensure that the growth rate of spending on health is

**Figure 5.5 Health Share of the Government Budget in Lower-Middle-Income Countries (2012)**



Source: WHO 2013b.

greater than the growth rate of overall spending through the state budget” (Grover 2011). Due to the resolution the government is obligated to reserve at least 30 percent of the health budget of the state for preventive medicine. Following implementation of the resolution, the annual growth in government health budgetary allocations since 2009 has generally exceeded the average growth of the total government budget (see also discussion in previous subsection)(Van Tien et al. 2011).

Given the costs of UC and projections of government expenditures and revenues to 2015, non-SHI (social health insurance) spending on health as a share of the overall budget will need to increase under the different scenarios summarized in chapter 4. This is going to require health’s share of aggregate government expenditure to increase by several percentage points. Some reprioritization within the budget could be considered if potentially unproductive spending in other sectors can be identified (or to identify cost efficiencies within existing health sector allocations, as discussed in the next chapter).

### **Health Sector-Specific Resources**

New health-specific resources can be an additional source of fiscal space for the sector. These policy options might entail the introduction of earmarked taxes and/or expansion of the SHI pool to include larger numbers of contributing members or increasing their premium rates. Earmarking can involve dedicating an entire tax to fund a particular program (for example, a dedicated payroll tax earmarked for SHI) or setting aside a fixed portion of a particular tax to fund a program (for example, a fixed proportion of general tax revenues allocated to the health budget).

If health spending is low or unstable, an earmarked tax may be seen as a way to insulate health spending from other competing publicly funded activities. From an economic perspective, earmarking is often viewed as an imposition of an unnecessary constraint on fiscal policy making, one that reduces flexibility and allocative efficiency (Savedoff 2004). In addition, there are numerous examples of situations where earmarked funds have been diverted to other activities, especially in poor governance settings (Prakongsai, Patcharanarumol, and Tangcharoensathien 2008). In addition, earmarking may not necessarily guarantee that additional resources will be available to the health sector.

Taxes on the consumption of goods that adversely affect health are often earmarked for the health sector. Taxes on the consumption of tobacco and alcohol, for instance, are often considered to be beneficial not only from a public health perspective but also from an economic perspective.<sup>9</sup> Even if not earmarked for health, higher taxes can discourage consumption, reduce illness and accidents (in the case of alcohol), and reduce future demand for health services, which can reduce the pressure for more resources. Tobacco use, of any kind, is the leading cause of preventable death in the world and killed nearly 6 million people in 2011. Almost 80 percent of these deaths occurred in low- and middle-income countries. On current trends, the number will rise to 8 million deaths annually by 2030.

These deaths and health problems associated with smoking, including chronic diseases such as cancer, lung diseases, and cardiovascular diseases, cause hundreds of billions of dollars of economic damage worldwide each year (WHO 2011). Many deaths occur during prime working years (30–69), which both reduces overall productivity and deprives families of wage earners (Anh et al. 2011).

It has been shown in a number of countries that the most effective method for reducing tobacco consumption and improving health is to increase the price of tobacco products through tax increases (WHO 2011). Higher tobacco prices are effective because they encourage existing tobacco users to quit, prevent young people from starting, and reduce the amount of tobacco consumed among continuing users. Despite reducing demand, tobacco tax revenues also increase. Although all consumption taxes are regressive—since poorer households spend a larger proportion of their income on consumption—there are other issues with tobacco taxation that should be considered.

Thailand is an example of a country that has successfully implemented an earmarked tax that directly funds health promotion activities. In 2001, Thailand instituted the Thai Health Promotion Foundation (ThaiHealth), funding for which comes directly from a 2 percent earmarked tax on tobacco and alcohol consumption that provides an estimated annual revenue stream of US\$100 million. Thailand has also steadily increased cigarette taxation over the years, leading to declining consumption rates but increased government revenue from tobacco taxes. Other countries that have earmarked sin taxes include Australia, the Republic of Korea, and the United States (WHO 2010).

Almost one-half of Vietnamese men (but less than 2 percent of women) are smokers, and two-thirds of all households in Vietnam have at least one smoker. Water pipes and cigarettes are the primary forms of tobacco consumption in the country, with water pipes more common among lower-income groups and cigarettes more common among higher-income groups (Guindon et al. 2010). Cigarettes are taxed at a rate of 42 percent in the country (excise taxes are about 33 percent of the retail sales price, and value-added tax is about 9 percent), whereas water pipe tobacco is not taxed.

The cigarette tax rate is well below the 65–80 percent of the retail sales price recommended by the World Bank. World Health Organization (WHO) has recommended that excise taxes alone should account for 70 percent of the sales price based on studies of countries that have seen health improvements from decreased smoking). Tobacco use is higher among the poor worldwide and this holds true in Vietnam as well (Anh et al. 2011). On average, poorer households spend more on cigarettes than on education or health care (Lam, Simon, and Taylor 2006). Poorer households also carry a higher health burden from smoking. The government pays more than half of these costs in Vietnam (Ross, Trung, and Phu 2007). The latter study (2007) estimated that VND 4.5 trillion could be raised as additional revenues should tobacco taxes be increased by one-third on cigarettes in the country (this would also reduce the number of smokers by about 1 million).

There is some potential for mobilizing additional resources for UC through increasing the number of contributing SHI members in Vietnam. In fact, the

Master Plan assumes that SHI coverage of contributory members (civil servants and private formal sector workers) would increase from roughly 60 percent currently to 75 percent by 2015, and that some of the additional resources needed to cover the fully- and partially-subsidized groups would come from the contributory group. Although a large proportion of those who are not currently covered are nonpoor, informality remains a barrier to collecting contributions, as was discussed in chapter 2.

Increasing the premium provides an alternative way to mobilize additional resources for UC. Lieberman and Wagstaff (2009) argue that there is room to increase the premium for contributory members, given the relatively large incidence of out-of-pocket (OOP) payments in the country. In their model, a doubling of premium contributions from the formal sector could also make additional resources available to increase the depth of the SHI program for all members. The law in Vietnam does allow for premium rates to be increased, however, given the current slowdown in economic growth, this may be a difficult option to implement.

Rising premiums could adversely impact employment, as employers may react negatively to higher insurance costs. Raising the premium may also encourage informality, given that premium rates for informal workers are subsidized. One option might be for the government to introduce increases in contributions in a phased manner—rather than a “big bang” increase—over the next three to five years, taking account of efficiency gains in the health sector and the potential burden on households and employers as well as managing perceptions that certain groups are not “overpaying” in terms of their contributions to SHI (even if such an increase in contributions may be merited from the perspective of progressivity and social solidarity). In managing the latter, if additional complementary increases in the subsidized premium are also implemented over the same time period, then this might end up increasing, rather than reducing, fiscal costs.

## External Resources

Another way to generate fiscal space for health—especially in low-income countries—is for governments to seek additional health-specific foreign aid and grants from international donors. Official development assistance (ODA) commitments for health in Vietnam over the period 2008–10 totaled US\$479 million from bilateral sources and US\$507 million from multilateral sources. The United States and Korea were the largest bilateral donors and the World Bank and the Asian Development Bank (ADB; special funds) were the largest multilateral donors (table 5.3). Over the period 2008–10, about 9 percent of all donor commitments were for sexually transmitted infection (STI) control including human immunodeficiency virus (HIV), 5 percent were for basic health care, and 1 percent was for tuberculosis (TB) control. Between 2006 and 2008, 1.3 percent and 0.05 percent of all donor commitments were for malaria and family planning, respectively.<sup>10</sup>

WHO estimates that about 3.4 percent of total health expenditure in Vietnam in 2010 was financed by external sources. This proportion has generally been constant since 1998 (figure 5.6). The current proportion of external resources as a share of health spending for Vietnam is substantially lower than the average for lower-middle-income countries (12.4 percent) and for the EAP region as a whole (18.1 percent), although the latter average, in particular, is biased upwards because of the inclusion of small Pacific countries.

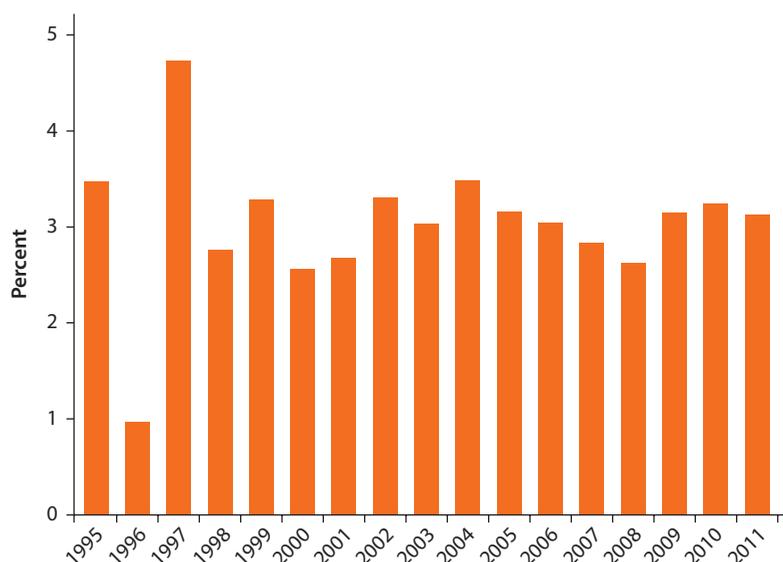
Given recent declining trends and Vietnam's lower-middle-income status, it does not appear as though foreign aid is a viable option for generating fiscal space for health in Vietnam, particularly since the current crisis is having an impact on

**Table 5.3 Annual ODA for Health in Vietnam (2008–10) (Average)**

<i>Source</i>	<i>Commitment amount (US\$ millions)</i>
<b>Total bilateral</b>	<b>160</b>
United States	70
Republic of Korea	22
Germany	15
<b>Total multilateral</b>	<b>169</b>
International Development Association	52
ADB Special Funds	44
European Union (EU) institutions	24

Source: OECD 2013.

**Figure 5.6 External Resources Share of Total Health Spending in Vietnam (1995–2011)**



Source: WHO 2013a.

**Table 5.4 Fiscal Space for Health at a Glance for Vietnam**

<i>Fiscal space source</i>	<i>Key information</i>	<i>Prospects for fiscal space</i>
Macroeconomic conditions	Growth rates expected to rebound to precrisis levels; high income elasticity of government expenditures on health.	Medium
Reprioritization of health in the government budget	Health spending as share of budget is protected by law but unclear how this will be enforced and whether this will be sustained.	Medium
Health sector-specific resources	“Sin” taxes, especially on cigarettes, and increasing the number of contributing SHI members may be utilized to generate fiscal space earmarked for health, but this may not be enough.	Medium
Health sector-specific grants and foreign aid	Dependence on external assistance is low, but declining aid trends limit potential to receive increases in aid for health.	Poor
Efficiency gains	Next chapter	Very good

most of the donor countries. Until 2011, aid had risen steadily for more than 10 years, however, aid for core bilateral projects, which fund many health programs in Vietnam, fell by 4.5 percent in real terms in 2011 (OECD 2012).

## Recommendation

**The costs of attaining the UC targets in the Master Plan cannot be met through additional fiscal outlays alone. Cost containment and mobilizing resources through efficiency savings will therefore be critical for achieving UC.**

The future challenge for Vietnam will be to find ways to expand the fiscal space for health to accommodate emerging pressures for increases in expenditures, particularly given the policy goals of reaching 70 percent coverage by 2015 and 80 percent by 2020. This chapter assessed public expenditures on health in Vietnam from a fiscal space perspective. Table 5.4 summarizes the prospects of fiscal space for health from the five major pillars described in this chapter. The best options for fiscal space for health for Vietnam are likely to be from an improvement in the efficiency of existing resources in the health sector. This is the subject of the next chapter.

## Notes

1. Empirical evidence suggests the importance of other factors such as the prevalence of corruption, ethno-linguistic fractionalization, and average education levels in the population as determinants of the extent to which health is, or is not, prioritized by governments.
2. These are based on the World Bank’s analysis of 2008 data from Vietnam.
3. World Bank staff estimates.

4. Vietnam's revenue share of GDP is about average for lower-middle-income countries; it is notably higher than that of neighboring countries such as Indonesia and the Philippines, which have revenue-to-GDP shares that are closer to 20 percent.
5. Public (or general) government spending on health includes all SHI expenditures.
6. Income elasticity is defined as the percent change in government health spending for a percent change in GDP.
7. This refers to health's share of aggregate government spending and is a proxy for prioritization; higher shares may not necessarily translate into higher per capita government health spending rates if, for instance, aggregate government spending is low in a given country.
8. National Health Accounts (NHA) estimates from WHO differ somewhat from country-specific estimates of government health spending and aggregate government expenditures reported in earlier sections of the policy note; for cross-country comparisons, the note reports WHO NHA data and for Vietnam-specific analyses the note reports country-specific data, the latter obtained from Vietnam Social Security (VSS), International Monetary Fund (IMF), and World Bank estimates.
9. Australia, the Republic of Korea, Thailand, and the United States are examples of countries that have successfully implemented earmarked taxes on tobacco and used the revenues for public health purposes. The Philippines has recently passed legislation that earmarks sin taxes for financing premiums of poor and vulnerable groups under their social insurance program.
10. Although there were no commitments for malaria or family planning in 2009 or 2010, there were disbursements for malaria in both years and for family planning in 2009. Between 2008 and 2010, about 13 percent of all disbursements were for STI control including HIV, 3.2 percent were for basic health care, 0.9 percent were for TB control, 1.1 percent for malaria, and 0.3 percent for family planning.

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