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SUMMARY OF DOCTORAL DISSERTATION

MAJOR: FINANCE AND BANKING
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DISSERTATION TITLE:
HEALTH FINANCING POLICY IN VIETNAM

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INTRODUCTION

1. Rationale

Health financing is an important pillar of the social security system, playing a key role in mobilizing, allocating, and utilizing resources for healthcare services. According to the World Health Organization (WHO), health financing is a prerequisite for achieving the goal of Universal Health Coverage (UHC). In the context of countries transitioning from budget-dependent healthcare models to multi-source financing models, health financing policies have increasingly become a central instrument for ensuring efficiency and equity within healthcare systems. Therefore, studying health financing policies is of great significance both theoretically and practically.

In Vietnam, state budget expenditure on healthcare has shown an upward trend in recent years, contributing to improved access to healthcare services and enhancing several public health indicators. However, the scale and structure of healthcare expenditure still reveal many limitations. Total health expenditure accounts for only around 5.5–6% of GDP, of which public expenditure represents approximately 45–50%, lower than in many developed countries. Notably, out-of-pocket payments by citizens remain high (around 38–42%), far exceeding the threshold recommended by the World Health Organization. This indicates that the financial burden of healthcare remains substantial, posing risks of catastrophic health expenditure and inequality in access to healthcare services.

In addition, the structure of the healthcare budget remains imbalanced, as recurrent expenditures account for a large proportion, while spending on development investment and preventive healthcare has not been commensurate with actual needs. Resource allocation among different healthcare levels is still unreasonable, and primary healthcare has not received adequate investment. At the same time, the budget allocation mechanism remains heavily input-based and has not been sufficiently linked to output efficiency, thereby limiting the effective use of resources.

For public healthcare institutions, the financial autonomy mechanism has created incentives to increase revenue and improve flexibility in management. However, in practice, there are significant disparities in financial capacity among different healthcare levels, while service pricing mechanisms and health insurance payment systems still contain many shortcomings. Financial pressure

may lead to the commercialization of healthcare services, thereby affecting the objective of equity. In particular, following the COVID-19 pandemic, many healthcare institutions encountered difficulties in maintaining financial balance, highlighting the vulnerability of the healthcare system.

From a theoretical perspective, current studies still lack an integrated approach that combines state budget expenditure policies with financial mechanisms at healthcare institutions. From a practical perspective, Vietnam's healthcare system is facing numerous challenges, including population aging, the increasing prevalence of non-communicable diseases, and growing cost pressures.

Based on the issues mentioned above, conducting research on the topic "Health Financing Policy in Vietnam" is necessary in order to improve the scientific foundation for policymaking, contribute to enhancing the efficiency of resource allocation, ensure equity in access to healthcare services, and strengthen the financial sustainability of the healthcare system.

2. Research Objectives and Research Tasks

2.1. Research Objectives

The dissertation aims to comprehensively analyze and evaluate health financing policies in Vietnam, focusing on two major components: state budget expenditure on healthcare and financial mechanisms at public healthcare institutions. On that basis, the study examines the extent to which these policies contribute to the objectives of efficiency, equity, and sustainability within the healthcare system. At the same time, the dissertation proposes orientations and solutions for improving health financing policies in line with the socio-economic development context, with the goal of enhancing the efficiency of resource allocation and ensuring financial sustainability through 2030.

2.2. Research Tasks

The dissertation undertakes several key tasks: reviewing related studies in order to identify research gaps; systematizing the theoretical foundations of health financing policies; analyzing international experiences; evaluating the current situation of health financing policies in Vietnam from both quantitative and qualitative perspectives; and proposing solutions for policy improvement. These tasks are implemented in an integrated manner to clarify the relationship between state budget expenditure and financial mechanisms at public healthcare

institutions, thereby enhancing the efficiency and sustainability of the healthcare system.

3. Research Subjects and Research Scope

3.1. Research Subjects

The research subjects of the dissertation are the theoretical and practical issues related to health financing policies in Vietnam, focusing on two main components: (i) state budget expenditure policies for healthcare, and (ii) financial policies at public healthcare institutions.

3.2. Research Scope

3.2.1. Scope of Content

The study focuses on health financing policies in Vietnam, limited to two core areas: state budget expenditure and financial mechanisms at public healthcare institutions. Regarding state budget expenditure, the study examines the scale, structure, and efficiency of resource utilization. Regarding public healthcare institutions, the study analyzes financial autonomy mechanisms, revenue–expenditure structures, and financial balancing capacity. Through this, the study clarifies the operational mechanism of the health financing system and its level of responsiveness to policy objectives.

3.2.2. Spatial Scope

The scope of the study is defined within the territory of Vietnam, focusing on the public healthcare system. The research examines the allocation and utilization of healthcare budgets nationwide, including both central and local government budgets. At the same time, it analyzes public healthcare institutions at different levels from the perspective of the overall system, without going into detailed analysis of individual localities. In addition, the study refers to international experiences in order to draw relevant lessons, but it does not extend empirical analysis beyond Vietnam.

3.2.3. Time Scope

The study focuses on the period from 2016 to 2025, with the primary data covering 2016–2023 and trend updates extended to 2025. This period marks a stage in which Vietnam accelerated health financing reforms and expanded the financial autonomy of public service units. The research process is implemented through stages including proposal development, data collection, situation analysis, and the formulation of policy recommendations during the 2023–2026

period. Defining this time scope ensures the relevance, continuity, and appropriateness of the study in relation to the ongoing policy reform process.

4. Research Methods

4.1. Desk Research Method

The dissertation employs the desk research method to systematize the theoretical foundation and review studies related to health financing policies. The sources of information are collected from textbooks, scientific journal articles, policy reports, and legal documents from both domestic and international sources through reputable academic databases. Methods such as analysis–synthesis, comparison, and systematization are applied to develop the theoretical framework and identify research gaps, thereby providing the foundation for subsequent analytical stages.

4.2. Interview method

The interview method involves in-depth interviews with experts, managers, and experienced officials in the fields of public finance, healthcare finance, and public health facility management. Expert selection utilized purposive sampling to ensure participants possessed the professional knowledge and practical experience relevant to the research objectives. Interviews focused on evaluating the current state of healthcare financial policy, elucidating limitations in policy design and implementation, and gathering perspectives on factors affecting policy outcomes and future refinement orientations. Qualitative data were synthesized, coded, and thematically analyzed to identify converging and diverging viewpoints among experts.

4.3. Survey method

The formal survey was conducted from April to July 2025, combining face-to-face and online formats. Prior to the formal survey, the questionnaire was reviewed and adjusted regarding content, phrasing, and presentation format to ensure clarity and suitability for the target respondents. Following collection, data checking, and screening, 243 valid questionnaires were utilized for quantitative analysis. Research variables were measured using a 5-point Likert scale, with the measurement system adapted from previous studies and customized for the research context.

4.4. Descriptive statistical analysis method

Collected data were cleaned, coded, and analyzed using SmartPLS 3 software, applying the Partial Least Squares Structural Equation Modeling (PLS-SEM) method. The analytical process was conducted in two steps. First, the measurement model was evaluated for reliability, convergent validity, discriminant validity, and multicollinearity. Next, the structural model was assessed to test hypotheses, determine the magnitude of impacts between variables, and verify the mediating role of policy implementation capacity. The quantitative analysis provides empirical evidence on the impact mechanism of policy quality, policy governance, and implementation capacity on healthcare financial policy outcomes, serving as a basis for proposing policy refinement solutions.

CHAPTER 1: LITERATURE REVIEW

1.1. Review of Empirical Studies

1.1.1. Empirical Studies on State Budget Expenditure Policies for Healthcare

Empirical studies indicate that state budget expenditure is a core instrument for ensuring equity and maintaining the stability of the healthcare system. In Vietnam, Axelson et al. (2009), using VHLSS data and the propensity score matching method, found that budget support policies improved access to healthcare services and reduced out-of-pocket payments among poor households. However, the effectiveness of these policies was not sustainable due to limitations in resources and monitoring mechanisms. Lê et al. (2011) emphasized the imbalance in budget allocation among healthcare levels, where resources were concentrated at central-level hospitals while primary healthcare facilities did not receive proportionate investment. Oh et al. (2015) showed that although healthcare expenditure and health insurance coverage had increased, private healthcare spending remained high, reflecting the limited regulatory role of the state budget.

At the international level, Colombier (2018) argued that healthcare expenditure has increased faster than GDP mainly due to technological advancement and changing consumption behavior, thereby creating fiscal pressure if not effectively controlled. Rabiej (2020) further noted that even insurance-based healthcare systems could impose substantial fiscal burdens in the absence of strong fiscal discipline. Costa (2021) confirmed that increasing healthcare expenditure does not necessarily undermine fiscal sustainability if accompanied by improvements in spending efficiency. More recently, Dwivedi and Gurpur (2023), as well as Chipunza and Nhamo (2023), emphasized the importance of fiscal capacity and decentralization mechanisms in maintaining stable healthcare expenditure.

1.1.2. Empirical Studies on Financial Autonomy Policies and Financial Policies at Public Healthcare Institutions

Studies on hospital financial autonomy mainly focus on institutional conditions and multidimensional impacts. Chawla et al. (1996) argued that financial autonomy enhances the ability of hospitals to mobilize non-budgetary revenues, although its effectiveness depends heavily on managerial capacity and accounting systems. Preker and Harding (2000) highlighted three core conditions for effective autonomy: hard budget constraints, genuine decision-

making authority, and transparent accountability mechanisms. Sharma and Hotchkiss (2001) found that hospital revenues increased by 20–30% following reforms, but the reforms also widened disparities in access to healthcare services.

Harding and Preker (2003) suggested that autonomy improves technical efficiency, whereas Shen (2003) warned that financial pressure could negatively affect treatment quality. Hollingsworth (2008) concluded that autonomous hospitals tend to achieve efficiency gains of approximately 5–15%, although evidence regarding improvements in equity remains inconclusive.

In Vietnam, London (2013) argued that financial autonomy was largely implemented as an "administrative imposition," while Lê et al. (2015) noted that hospitals often had to engage in "negotiated compliance" between financial pressures and regulatory requirements. Võ and Löfgren (2018) highlighted the "hybrid" nature of the autonomy model in Vietnam. More recent studies, including Handayani et al. (2019), Thi et al. (2023), and Nguyễn et al. (2024), consistently found that financial autonomy improves financial efficiency, although its impacts on service quality and equity remain unclear.

1.2. Research Gaps

A synthesis of previous studies reveals several important research gaps. In terms of content, studies on state budget expenditure have mainly focused on expenditure scale and output impacts, while lacking evaluations of policy quality in aspects such as appropriateness, transparency, accountability, and sustainability. At the same time, the relationship between policy design and implementation outcomes has not been sufficiently clarified, particularly in the context of Vietnam's public finance reforms.

Regarding financial policies at healthcare institutions, existing studies remain fragmented, focusing separately on factors such as financial autonomy, service pricing, or health insurance, rather than providing a comprehensive assessment across multiple objectives including efficiency, equity, and sustainability. In particular, there is still a lack of integrated studies examining both state budget expenditure and institutional financial mechanisms within a unified analytical framework, despite the close interrelationship between these two components.

From a methodological perspective, most studies rely heavily on quantitative approaches using secondary data, while qualitative approaches

remain limited and rarely incorporate quantification tools such as Likert scales. This reduces the ability to comprehensively evaluate health financing policies, especially regarding policy implementation aspects. Therefore, there is a need for an integrated approach that combines quantitative and qualitative methods in order to provide a comprehensive evaluation of health financing policies in Vietnam.

CHAPTER 2: THEORETICAL FOUNDATION AND EXPERIENCE ON HEALTHCARE FINANCIAL POLICY

2.1. Health Financing Policy

2.1.1. Concept of Health Financing Policy

Health financing policy is a component of public policy that reflects government decisions regarding the mobilization, allocation, and utilization of financial resources to achieve the objectives of the healthcare system. Based on public policy theory, health financing policy is not merely technical in nature but also serves as an instrument for socio-economic regulation. Due to the distinctive characteristics of the healthcare sector, which is characterized by various forms of market failure such as information asymmetry and social externalities, government intervention through financial instruments is necessary. Accordingly, health financing policy acts as an intermediary between policy objectives and practical outcomes, aiming to ensure efficiency, equity, and sustainability within the healthcare system.

2.1.2. Characteristics of Health Financing Policy

Health financing policy possesses several notable characteristics. First, it involves multiple stakeholders, including the government, healthcare institutions, intermediary organizations, and citizens, with the government playing the central role. Second, its regulatory object consists of financial relations within the healthcare system, which indirectly but decisively influence operational outcomes. Third, the policy pursues multidimensional objectives, including efficiency, equity, and financial protection, while simultaneously requiring a balance among these objectives. Finally, the policy is governed by principles such as equity, efficiency, and sustainability, and is highly dependent on institutional design and implementation capacity, making the implementation process both complex and flexible.

2.1.3. Stakeholders in healthcare financial policy

First, the formulators and decision-makers are competent state agencies that define objectives, select instruments, enact legal frameworks, and decide public resource allocations for healthcare.

Second, the managers and implementers include health authorities, financial authorities, and organizations performing pooling, purchasing, and payment functions for medical services.

Third, the direct implementers are healthcare service providers,

particularly public health facilities concerning public financial policy.

Fourth, relevant stakeholders encompass service users, insurance scheme participants, the healthcare workforce, civil society organizations, the private sector, and groups holding interests in or affected by healthcare financial decisions.

2.1.4. Classification of Health Financing Policy

Health financing policy may be classified according to different criteria. Based on functional classification, it includes policies for resource mobilization, resource allocation and utilization, and service payment. However, in the context of Vietnam, classification according to the structure of the healthcare system is considered more appropriate, consisting of: (i) state budget expenditure policies for healthcare, and (ii) financial policies at public healthcare institutions. These two groups are organically connected, respectively reflecting input resources and the mechanisms for utilizing those resources. In addition, health financing policies may also be classified according to funding sources (public, insurance-based, and private) or levels of governance (macro and micro). Such classification helps clarify the policy structure and supports more effective policy analysis.

2.1.5. The Role of Health Financing Policy

Health financing policy plays a central role within the healthcare system. First, it ensures financial resources for healthcare activities, in which state budget expenditure serves as the foundation. Second, it guides the allocation and utilization of resources through financial mechanisms, thereby influencing the behavior of stakeholders. Third, it promotes equity in access to healthcare services by prioritizing resource allocation for vulnerable groups. Fourth, it enhances the operational efficiency of the healthcare system through appropriate financial instruments. In addition, health financing policy contributes to providing financial protection for citizens and ensuring the sustainability and adaptability of the healthcare system in response to various changes and shocks.

2.1.6. Contents of Health Financing Policy

2.1.6.1. Contents of State Budget Expenditure Policy for Healthcare

This involves determining expenditure scope and targets, scale and proportion, allocation structure, and funding methods. The scope focuses on essential services like preventive and primary care. The scale reflects State prioritization, while the structure shows allocation orientation across sectors and

levels. Allocation methods are shifting from input-based to output-based to enhance efficiency.

2.1.6.2. Contents of Financial Policy at Public Healthcare Institutions

Financial policy at public healthcare institutions focuses on financial autonomy mechanisms and resource management at the institutional level. Its contents include the classification of autonomy levels, determination of revenue structures (state budget, insurance, and service revenues), mechanisms for mobilizing non-budgetary resources, and the distribution of financial results. Financial autonomy helps increase institutional proactiveness and operational efficiency, but it also creates requirements for supervision and regulation in order to ensure equity objectives. At the same time, this policy directly affects staff motivation and service quality, thereby playing an important role in the operation of the healthcare system.

2.2. Novel theories

2.2.1. *Public Economics Theory*

Provides the rationale for State intervention in resource allocation to rectify market failures and achieve social goals, focusing on resource allocation, income redistribution, and economic stabilization. Stakeholder Theory: Developed by Freeman (1984), it posits that organizational efficiency depends on identifying and managing the interests and impacts of diverse groups interacting with the organization's objectives.

2.2.2. Stakeholder Theory

Developed by Freeman (1984), it posits that organizational efficiency depends on identifying and managing the interests and impacts of diverse groups interacting with the organization's objectives.

2.2.3. *New Public Management*

Systematized by Hood (1991), NPM advocates public sector reform through enhanced managerial accountability, explicit output controls, decentralization, competition, and the selective adoption of private-sector management practices.

2.2.4. Policy Implementation Theory

Formulated by Pressman and Wildavsky (1973) to explain the gap between enacted policies and actual outcomes, emphasizing that implementation involves complex interactions to translate goals into reality.

2.2.5. *Value-Based Health Care*

Developed by Porter and Teisberg (2006), VBHC shifts the focus from inputs and service volume to the value generated—defined as patient outcomes achieved relative to the costs incurred.

2.3. Factors Affecting Health Financing Policy

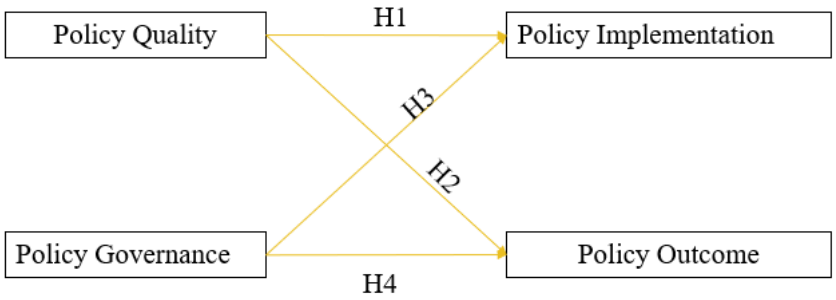
2.3.1. Subjective Factors

Health financing policy is directly influenced by the way the government perceives, designs, and organizes policy implementation. First, the identification of policy problems and priorities plays a decisive role because it shapes objectives such as equity, cost control, or service quality improvement. Second, the selection of policy instruments - such as budget allocation methods, payment mechanisms, and levels of financial autonomy - reflects the government's perspective on the role of the public sector in healthcare. In addition, the organization of implementation and coordination among agencies such as the health sector, financial authorities, and social insurance agencies significantly affect policy effectiveness. Without effective coordination, even well-designed policies may fail to achieve desired outcomes. Furthermore, resource allocation decisions reflect the government's priorities among healthcare levels, sectors, and target groups. Finally, mechanisms for supervision, transparency, and policy feedback play important roles in adjusting and improving policy implementation. Thus, subjective factors influence the entire policy cycle.

2.3.2. Objective Factors

Health financing policy is also affected by objective factors, namely socio-economic and institutional conditions to which the government must adapt. First, the level of economic development determines the ability to mobilize resources and sets limits on public healthcare expenditure. Countries with higher income levels generally have greater public healthcare spending and broader coverage. Second, demographic characteristics and disease patterns directly affect healthcare expenditure needs. Population aging and the increasing prevalence of non-communicable diseases raise healthcare costs and require sustainable financing mechanisms. Third, advances in medical science and technology improve service quality but also increase costs, thereby placing additional pressure on public budgets. In addition, public management theories, international trends, and integration processes also shape policy approaches. Finally, shocks such as epidemics or economic crises may force governments to adjust policies in the short term.

2.4. Proposed research model and hypotheses



2.5. International Experiences in Health Financing Policy and Lessons for Vietnam

2.5.1. International Experiences

2.5.1.1. The Experience of China

China has reformed its health financing system by shifting from input-based allocation toward performance- and service quality-based allocation under the "Healthy China 2030" strategy. Healthcare expenditure has been maintained at a large scale (approximately 398 billion yuan in 2025), combined with a health insurance system covering more than 95% of the population. Payment methods such as Diagnosis-Related Groups (DRG) and Diagnosis-Intervention Packet (DIP) systems have helped control costs and regulate provider behavior. At the same time, the "zero-markup drug" policy has reduced hospitals' dependence on pharmaceutical revenues, while centralized procurement mechanisms have reduced medicine prices by 50–90%. However, the reforms have also created financial pressure, as approximately 41% of hospitals experienced declines in profitability.

2.5.1.2. The Experience of Thailand

Thailand has achieved healthcare coverage for more than 98% of its population while maintaining healthcare expenditure at only around 4% of GDP, mainly through a financing model based on state budget funding and the Universal Coverage Scheme (UCS). The state budget accounts for approximately 65–70% of total healthcare expenditure and is allocated through a "purchasing of services" mechanism rather than direct budget allocation. The separation between purchasers and providers has enabled effective cost control. Payment systems based on capitation for outpatient services and DRG for inpatient services have limited cost escalation. In addition, centralized

procurement and priority investment in primary healthcare have contributed to reducing costs and improving equity in access to healthcare services.

2.5.1.3. The Experience of Indonesia

Indonesia has implemented the National Health Insurance System (JKN), which covers approximately 83% of the population (around 230 million people) and plays a central role in the country's health financing system. However, healthcare expenditure remains heavily concentrated on inpatient treatment (approximately 80%), creating imbalances and resulting in a deficit of about USD 2.17 billion in 2023. To control costs, Indonesia applies capitation payments for primary healthcare and case-based group payments for inpatient services. At the same time, the autonomy mechanism known as Badan Layanan Umum Daerah (BLUD) allows hospitals to retain their revenues. Tools such as the e-Katalog system have also helped control input prices and improve financial efficiency.

2.5.1.4. The Experience of the Philippines

The Philippines combines state budget financing with the national health insurance system, PhilHealth, in which revenues from excise taxes on products such as tobacco and alcohol increased from 34 billion pesos to more than 100 billion pesos during the 2013–2025 period, thereby supporting the expansion of healthcare coverage. State healthcare expenditure is expected to reach approximately 448 billion pesos in 2026. PhilHealth applies package-based and case-based payment methods to control costs while simultaneously expanding benefit coverage, contributing to a reduction in out-of-pocket expenditure to around 44%. The financial system is closely linked to healthcare providers and local decentralization mechanisms, thereby improving efficiency and access to healthcare services.

2.5.2. Lessons for Vietnam

Based on international experiences, Vietnam should strongly shift from input-based budget allocation toward performance-based allocation, combined with "strategic purchasing" mechanisms in order to improve the efficiency of resource utilization. At the same time, it is necessary to expand fiscal space through instruments such as health taxes while ensuring a reasonable expenditure structure that prioritizes primary healthcare and preventive healthcare. Controlling input costs through procurement mechanisms and price negotiations is also an important factor.

At the institutional level, Vietnam should improve financial autonomy mechanisms in association with stronger accountability, better control of financial incentives, and diversification of revenue sources while still ensuring equity. In addition, it is necessary to strengthen financial protection for citizens and promote the application of technology in healthcare financial management in order to improve the efficiency and transparency of the healthcare system.

CHAPTER 3: RESEARCH METHODOLOGY

3.1. Research process

The dissertation employs a mixed-methods approach, integrating document research, quantitative research, and qualitative research. These methods are sequenced to ensure logical linkage between theoretical foundation building, situational assessment, model testing, and solution proposition.

3.2. Desk research method

Used to synthesize domestic and international literature to identify research gaps, and construct the theoretical framework, models, hypotheses, and measurement scales.

3.3. Quantitative research method

Employed to test models and hypotheses regarding the relationships between policy quality, policy governance, implementation capacity, and healthcare financial policy outcomes. The focus is on determining direct impacts and verifying the mediating role of implementation capacity.

3.4. Qualitative research method

Conducted to supplement, explain, and cross-reference quantitative findings with Vietnam's practical policy context, particularly elucidating the underlying mechanisms of how policy quality, governance, and implementation affect outcomes.

CHAPTER 4: RESEARCH RESULTS

4.1. Overview of healthcare in Vietnam 2016–2025

4.1.1. Development of the Healthcare Network during the 2016–2025 Period

During the 2016–2025 period, Vietnam's healthcare network developed in the direction of maintaining stability in quantity while improving quality. The total number of healthcare facilities increased slightly from 13,333 to 13,750, indicating that the system had achieved a basic level of coverage. The number of hospitals increased significantly from 1,050 to 1,320, especially after the COVID-19 pandemic, reflecting the growing demand for treatment capacity. Meanwhile, the number of commune health stations remained relatively stable at approximately 11,200, but the proportion of communes meeting national healthcare standards increased from 68% to more than 99%. This demonstrates a shift from expansion toward standardization and quality improvement in primary healthcare.

4.1.2. Requirements posed for healthcare financial policy in the context of health system development

The development of Vietnam's health system during the 2016–2025 period facilitated improved access to healthcare services for citizens and significantly expanded the operational scale of the entire sector. However, this developmental process also altered the nature of healthcare financial needs. While financial policies previously focused primarily on securing funding to maintain the operations of public health facilities, in the current context, policies must simultaneously address multiple objectives: mobilizing sufficient resources, reasonably allocating funds across priority areas, enhancing budget utilization efficiency, ensuring equity in service access, and maintaining system sustainability. This necessitates further perfection of healthcare financial policy in terms of content, governance mechanisms, and implementation organization.

4.2. Health Financing Policies in Vietnam during the 2016–2025 Period

4.2.1. Legal Framework of Health Financing Policies in Vietnam during the 2016–2025 Period

4.2.1.1. Legal Framework for State Budget Expenditure Policies for Healthcare in Vietnam during the 2016–2025 Period

The legal framework governing state budget expenditure for healthcare during the 2016–2025 period was primarily established by the 2015 State Budget Law, which identified healthcare as a priority sector and required public

expenditure to ensure transparency, accountability, and efficiency. Resolution No. 20-NQ/TW (2017) emphasized that healthcare expenditure should increase at a rate higher than overall state budget expenditure, while prioritizing primary healthcare and preventive healthcare with an allocation of at least 30%. Subsequent regulations, such as Decree No. 120/2020 and Decision No. 16/2022/QĐ-TTg, further demonstrated the government's regulatory role, particularly during the COVID-19 pandemic. In addition, Strategy No. 89/QĐ-TTg (2024) continued to orient healthcare budget allocation toward greater equity and improved efficiency in the use of public financial resources.

4.2.1.2. Legal Framework for Financial Policies at Public Healthcare Institutions in Vietnam during the 2016–2025 Period

The financial autonomy mechanism for public healthcare institutions was initially established through Decree No. 16/2015 and further refined through Decree No. 60/2021, reflecting a transition from subsidy-based management toward performance-oriented governance. Resolutions No. 19-NQ/TW and No. 20-NQ/TW (2017) provided the political foundation for autonomy associated with the principle of fully calculating healthcare service costs. The 2023 Law on Medical Examination and Treatment institutionalized financial autonomy rights for the first time, allowing healthcare institutions to make decisions regarding revenues, expenditures, and resource utilization. Decree No. 111/2025 further expanded the authority of institutions in determining service prices, while the Health Insurance Law continued to ensure financial support for citizens and maintain equity in access to healthcare services.

4.2.2. Current Situation of State Budget Expenditure on Healthcare in Vietnam during the 2016–2025 Period

4.2.2.1. Trends in State Budget Expenditure on Healthcare in Vietnam

During the 2016–2025 period, state budget expenditure on healthcare increased significantly in both scale and importance. Total state budget expenditure increased from VND 1,462,015 billion to VND 3,071,078 billion, representing an increase of more than 2.1 times, while healthcare expenditure increased from VND 70,695 billion to VND 130,721 billion, equivalent to approximately 85%. This demonstrates that the government consistently maintained healthcare as a priority sector, particularly in the context of ensuring social welfare.

However, the proportion of healthcare expenditure within total state

budget expenditure fluctuated and declined toward the end of the period. During 2016–2019, the ratio ranged from 4.8% to 6%, reaching a peak of 7.23% in 2021 due to the COVID-19 pandemic before declining to approximately 4.26% by 2025. This trend reflects three important points: healthcare expenditure is highly flexible during crises; long-term prioritization remains unstable; and healthcare expenditure is strongly influenced by broader economic and fiscal conditions.

Thus, although the scale of healthcare expenditure has increased, there remains a need to improve the stability and sustainability of budget prioritization for the healthcare sector.

4.2.2.2. Structure of State Budget Expenditure on Healthcare in Vietnam

The structure of state budget expenditure on healthcare during the 2016–2025 period reveals significant changes in three main aspects. First, by expenditure type, recurrent expenditure accounted for the dominant share (72–80%), increasing sharply to 86% in 2021 due to COVID-19 before gradually declining as development investment expenditure increased substantially, reaching VND 32,531 billion in 2025.

Second, by budget decentralization level, local government budgets accounted for approximately 75–85% of healthcare expenditure, reflecting the decentralization of healthcare management. Meanwhile, central government expenditure increased significantly in 2021 to coordinate pandemic prevention and control activities, thereby demonstrating the macro-regulatory role of the central government.

Third, by expenditure content, the expenditure structure shifted from a primarily "treatment-oriented" model toward a combined approach emphasizing both "prevention and financial protection." Expenditure supporting health insurance increased from VND 30,338 billion to VND 47,643 billion, while preventive healthcare expenditure rose sharply in 2021, reaching VND 42,903 billion.

Overall, the expenditure structure has shifted toward a more modern orientation, although further adjustments are still needed to improve long-term efficiency across different healthcare sectors.

4.2.3. Current Situation of Financial Policies at Public Healthcare Institutions in Vietnam during the 2016–2025 Period

4.2.3.1. Trends in Financial Autonomy in Vietnam's Healthcare Sector

During the 2016–2025 period, financial autonomy in the public healthcare

sector expanded considerably. In 2016, most institutions belonged to Groups 3 and 4, meaning they remained heavily dependent on state budget support, while Group 2 institutions accounted for only a small proportion. By 2020, the number of Group 2 institutions increased significantly from 147 to 281, while the number of Group 4 institutions declined substantially, indicating improvements in the ability of institutions to cover recurrent expenditures independently.

During the 2021–2023 period, this trend continued despite the impacts of COVID-19, with the number of Group 2 institutions reaching 352 by 2023. However, during 2024–2025, adjustments emerged as some institutions returned to greater dependence on state budget support due to stricter autonomy criteria and declining revenue sources.

At the central government level, financial autonomy remained more stable, with most institutions classified within Group 2. Overall, the healthcare system has gradually shifted from a subsidy-based model toward a more autonomous model, although the process remains highly differentiated, reflecting differences in institutional capacity and operating conditions.

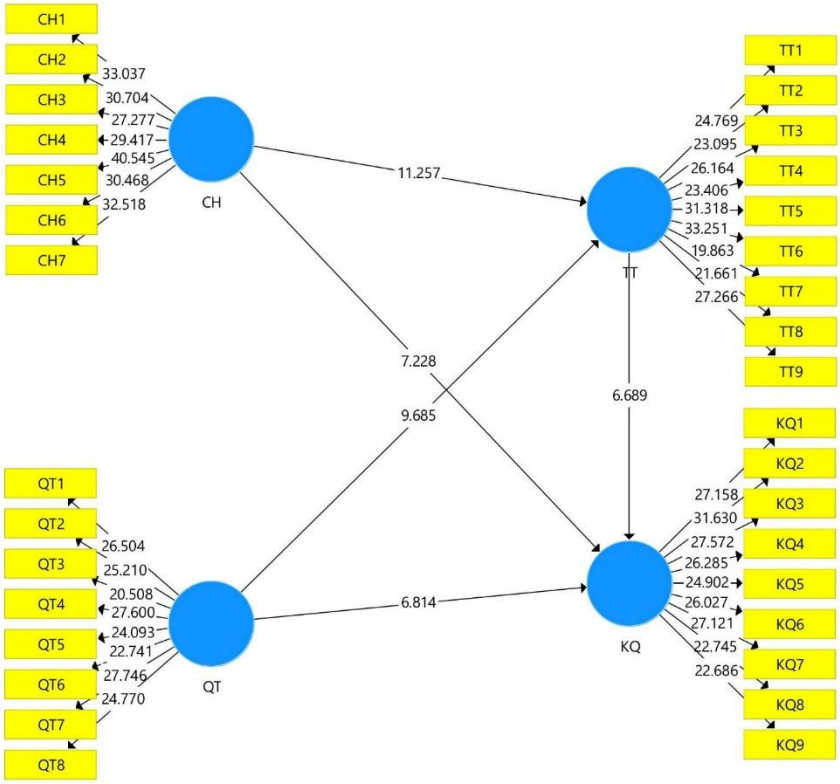
4.2.3.2. Typical Cases of Financial Autonomy in Vietnam's Healthcare Sector

The financial autonomy models reflect four distinct conditions within the healthcare system. Group 1 institutions, which operate under comprehensive financial autonomy, have improved operational efficiency but face sustainability challenges due to financial risks, particularly after the COVID-19 pandemic. Group 2 institutions, which are autonomous in covering recurrent expenditures, represent the most effective model because they create incentives for improving service quality while reducing pressure on the state budget, although they still depend significantly on health insurance payments.

Group 3 institutions, characterized by partial autonomy, account for a large proportion of healthcare institutions but remain vulnerable due to unstable revenue sources and limitations in healthcare service pricing mechanisms. Group 4 institutions, which remain dependent on state budget support, continue to play an important social welfare role, particularly at the primary healthcare level and in disadvantaged areas, although they lack flexibility and development incentives.

Overall, the healthcare system exhibits a clearly stratified structure, requiring the design of financial autonomy policies that are more flexible, differentiated, and supported by appropriate regulatory mechanisms.

4.3. Qualtitative results



The total impact results indicate that policy quality is the factor with the greatest influence on health financing policy outcomes, with a coefficient of 0.537 - comprising both direct and indirect effects (the latter mediated by the variable TT). This is followed by policy governance (coefficient of 0.455), while policy implementation has a direct impact of 0.358.

4.4. Evaluation of the Current Situation of Health Financing Policy in Vietnam during the 2016–2025 Period

4.4.1. Achievements

4.4.1.1. Results of the Analysis of State Budget Expenditure Policy

During the 2016–2025 period, state budget expenditure on healthcare increased from VND 70,695 billion to VND 130,721 billion, representing an increase of approximately 85%, with an average annual growth rate of around 7–7.5%. This demonstrates the leading role of the state budget in maintaining the healthcare system. In particular, expenditure increased by nearly 30% during the 2020–2021 period due to the COVID-19 pandemic, reflecting the flexibility of the state budget in responding to crises. However, the proportion of healthcare expenditure within total state budget expenditure declined from 4.83% to 4.26%, indicating that the level of prioritization has not remained stable over time. The Likert-scale survey results reached approximately 3.9–4.0

points, with the highest score recorded for the equity criterion (4.03 points), thereby confirming the important role of the state budget in maintaining the healthcare system and ensuring social welfare.

4.4.1.2. Results of the Analysis of Financial Policy at Public Healthcare Institutions

Financial autonomy in public healthcare institutions improved significantly during the period, as the number of institutions capable of fully covering recurrent expenditures increased to 381 by 2025, while the number of institutions dependent on state budget support declined. The financial scale of the system increased by approximately 2.52 times, from VND 95,000,000 million to VND 239,054,801 million, corresponding to an average annual growth rate of approximately 10.8%. In addition, the healthcare system demonstrated a rapid recovery following the COVID-19 pandemic. Additional income payments increased by approximately 91.5%, thereby improving staff motivation and work incentives. Survey results showed efficiency scores ranging from 3.7 to 3.88 points, reflecting the positive impacts of financial autonomy on service quality and institutional governance, although disparities among institutions still remain.

4.4.2. Limitations and Causes

4.4.2.1. Limitations of Health Financing Policy

Health financing policy in Vietnam still faces several limitations. The proportion of state budget expenditure on healthcare declined from 4.83% to 4.26% and fluctuated considerably across years, indicating a lack of stability in budget prioritization. The expenditure structure remains heavily treatment-oriented and has not sufficiently prioritized preventive healthcare. Financial autonomy has also been implemented unevenly, with 349 institutions still dependent on state budget support. Revenue sources remain highly dependent on health insurance payments, which account for approximately 60–70% of total revenue, while socialization and diversification of funding sources remain limited. Survey results further indicate that transparency and sustainability achieved only moderate scores of approximately 3.6–3.75 points, reflecting broader systemic limitations.

4.4.2.2. Causes of the Limitations

The limitations of health financing policy originate from both subjective and objective factors. From a subjective perspective, fiscal prioritization for

healthcare has not been institutionalized into long-term commitments, resulting in fluctuations in the proportion of healthcare expenditure. In addition, the budget allocation mechanism remains largely input-based rather than performance-based, thereby reducing allocation efficiency.

The implementation of financial autonomy policies has also been relatively uniform and insufficiently adapted to differences among healthcare levels, leading to disparities within the system. At the same time, existing policies have not created adequate conditions for the diversification of revenue sources, causing healthcare institutions to remain heavily dependent on health insurance payments.

From an objective perspective, limited state budget resources in the context of a developing economy constitute a major constraint. Population aging and changes in disease patterns have increased healthcare expenditure demands, while advances in medical technology have further raised healthcare costs. Regional disparities and the impacts of external shocks such as the COVID-19 pandemic have also contributed to greater financial instability.

These causes indicate the need to improve institutional frameworks, strengthen policy capacity, and enhance the adaptability of the health financing system in the long term.

CHAPTER 5: IMPROVING HEALTH FINANCING POLICY IN VIETNAM THROUGH 2030 WITH A VISION TO 2035

5.1. Perspectives, Orientations, and Objectives of Health Financing Policy in Vietnam through 2030 with a Vision to 2035

5.1.1. International and Domestic Context

During the 2026–2035 period, global health financing will face dual pressures between expanding healthcare coverage and ensuring financial sustainability. The Service Coverage Index (SCI) is projected to reach only around 74/100 by 2030, while approximately 1.6 billion people will still be at risk of impoverishment due to healthcare costs. International aid is expected to decline by around 21%, forcing countries to increase domestic resource mobilization and adopt instruments such as health taxes. At the same time, healthcare expenditure is projected to increase rapidly at approximately 9–11% per year, while the impacts of technological development and climate change will create additional demands for effective expenditure control.

In Vietnam, although the economy continues to achieve relatively high growth, fiscal space remains limited, with state budget revenue accounting for approximately 17.6% of GDP and public debt showing an upward trend. Population aging, the fact that non-communicable diseases account for approximately 74–80% of the disease burden, and persistently high out-of-pocket expenditure at around 44% all place substantial pressure on the healthcare system. These conditions require healthcare financing reforms toward greater efficiency, equity, and sustainability.

5.1.2. *Perspectives on Health Financing Policy through 2030*

Health financing policy through 2030 should be based on comprehensive and sustainable development perspectives. First, healthcare should be regarded as an investment in development that contributes to improving human resource quality and promoting economic growth. Second, the government should maintain its leading role while shifting from direct budget allocation toward “purchasing of services” and performance-based expenditure mechanisms.

Third, equity should be considered the central principle, ensuring that all citizens, especially vulnerable groups, have access to healthcare services. Fourth, fiscal sustainability should be ensured through expenditure control and the integration of healthcare financing funds. Fifth, financial autonomy must be associated with governance reform and stronger accountability mechanisms.

In addition, health insurance should remain the central pillar of the healthcare financing system, with expanded coverage and improved cost control. Socialization policies must be implemented transparently and should not be equated with privatization. At the same time, digital transformation and data-driven policymaking should serve as foundations for improving policy effectiveness.

5.1.3. Objectives and Orientations of Health Financing Policy through 2030

The objective through 2030 is to build a healthcare financing system that is equitable, efficient, and sustainable, ensuring that all citizens can access healthcare services at reasonable costs while reducing out-of-pocket expenditure to below 30%. The vision to 2035 aims toward a modern, digitalized, and multi-tiered healthcare financing system.

In quantitative terms, public healthcare expenditure is expected to increase by 8–9% annually; the proportion of healthcare expenditure within the state budget is targeted to reach 9–10% by 2030; development investment expenditure should account for at least 25%, while preventive healthcare expenditure should account for at least 30%. Health insurance coverage is expected to reach at least 98% and gradually approach 100% by 2035. At the same time, the proportion of financially autonomous healthcare institutions should increase, alongside the expansion of service contracting mechanisms.

Key policy orientations include improving the efficiency of state budget expenditure, reforming health insurance payment mechanisms, improving financial autonomy policies, promoting controlled socialization, and implementing comprehensive digital transformation. Through these measures, Vietnam aims to establish a multi-tiered, flexible, and sustainable healthcare financing system.

5.2. Solutions for Improving Health Financing Policy in Vietnam

5.2.1. Solutions Related to State Budget Expenditure Policy

5.2.1.1. Reforming State Budget Expenditure Management for Healthcare toward Performance-Based Approaches

The allocation of healthcare budgets should shift from an input-based approach toward a performance-based approach in order to improve efficiency and accountability. The National Assembly should improve the legal framework, while the Government should promulgate mechanisms for results-based budgeting. The Ministry of Finance should develop expenditure norms

linked to service outputs, and the Ministry of Health should design output indicator systems. Local governments should implement service contracting and task assignment mechanisms for healthcare institutions, linking disbursement and budget settlement with performance outcomes. The reform should be implemented according to a roadmap consisting of indicator standardization, pilot implementation, and subsequent expansion throughout the healthcare system.

5.2.1.2. Adjusting the Structure of State Budget Allocation for Healthcare toward Prioritizing Public Welfare Functions and Ensuring Regional Equity

State budget expenditure for healthcare should be restructured to prioritize preventive healthcare, primary healthcare, and disadvantaged regions in order to ensure equity. The National Assembly should supplement allocation principles within the legal framework, while the Government should institutionalize these principles within budget planning processes. The Ministry of Finance should develop weighted allocation norms based on population size and disease burden, while the Ministry of Health should provide data on healthcare needs. Local governments should ensure minimum expenditure proportions for primary healthcare levels and avoid excessive concentration of expenditure at higher-level hospitals. At the same time, recurrent subsidies for highly autonomous institutions should gradually be reduced, while investment in infrastructure at lower-level healthcare facilities should be increased.

5.2.2. Solutions Related to Financial Policies at Public Healthcare Institutions

5.2.2.1. Improving Revenue Generation Mechanisms for Public Healthcare Institutions

Revenue sources should be diversified in order to reduce dependence on health insurance, which currently accounts for more than 70% of total revenue. The Government should promulgate a separate decree on public healthcare finance, clearly defining the scope of revenue-generating activities such as on-demand services, joint ventures, and the exploitation of public assets. Limits on the proportion of commercial services should be established while ensuring the provision of public welfare services. Transparency and auditing of partnership and joint venture activities should also be strengthened. Healthcare institutions should develop medium-term financial strategies, control financial risks, and

maintain service quality. Implementation should follow a roadmap consisting of legal framework improvement, pilot implementation, and subsequent expansion.

5.2.2.2. Reforming the Allocation and Utilization of Financial Resources within Healthcare Institutions

The allocation of financial resources should shift from equal distribution toward performance-based allocation. The Ministry of Health should promulgate a performance evaluation system linked to service output, service quality, and patient satisfaction. Additional income payments and expenditure allocation should be based on performance results rather than seniority. Internal expenditure regulations should be standardized in order to enhance transparency and accountability. Information technology should be applied to monitor operational efficiency in real time. The implementation roadmap should include a pilot phase (2026–2027), expansion phase (2028–2030), and completion phase after 2030.

5.2.2.3. Improving Financial Autonomy Mechanisms through Differentiation and Control

Financial autonomy mechanisms should be redesigned according to the capacity and conditions of each healthcare institution instead of applying a uniform model. The Ministry of Health should classify institutions based on autonomy capacity, operational scale, and regional conditions. Institutions with strong capacity should be granted expanded authority in finance and personnel management, while weaker institutions should continue receiving state budget support. Regulatory mechanisms should also be established to reduce disparities among healthcare levels. The implementation roadmap should include review and assessment (2026–2027), differentiated implementation (2028–2030), and adjustment after 2030. The objective is to improve efficiency while maintaining equity within the healthcare system.

5.2.2.4. Reforming Payment Methods and Controlling Healthcare Service Costs

Healthcare payment mechanisms should shift from fee-for-service payment toward total expenditure control and performance-based payment. DRG-based payment should be expanded for inpatient services, while capitation payment should be applied more broadly at the primary healthcare level. Vietnam Social Security should assign expenditure estimates to each healthcare institution and supervise implementation. Healthcare data and electronic medical

records should be standardized to improve cost control. The implementation roadmap should consist of a pilot phase (2026–2027), expansion phase (2028–2030), and system-wide implementation after 2030. These reforms are expected to reduce service overutilization and improve expenditure efficiency.

5.2.2.5. Strengthening Financial Governance and Accountability at Public Healthcare Institutions

Establishing a modern and transparent financial governance system should become a mandatory requirement. Public healthcare institutions should periodically disclose their revenue–expenditure structures and operational results on digital platforms. A system of financial performance indicators linked to service quality should also be developed. Auditing and inspection activities, particularly regarding joint ventures and partnerships, should be strengthened. Information technology should be applied to support real-time supervision and monitoring. The implementation roadmap should include standardization (2026–2028), large-scale implementation (2028–2030), and further improvement after 2030.

5.2.2.6. Ensuring Balance between Financial Efficiency and Equity in Healthcare Service Provision

Regulatory mechanisms should be established to prevent excessive commercialization of healthcare services. The Ministry of Health should define a list of essential healthcare services and minimum service provision ratios. Health insurance coverage should be expanded in order to reduce out-of-pocket expenditure. The State should provide targeted financial support for disadvantaged areas through targeted allocation mechanisms. Monitoring and enforcement measures related to service equity should also be strengthened. The objective is to maintain a balance between financial efficiency and citizens' access to healthcare services, especially for vulnerable groups.

5.2.3. Other Solutions

5.2.3.1. Strengthening Health Insurance and Strategic Support Mechanisms

Health insurance should be reinforced as the central pillar of the healthcare financing system. Sustainable expansion of coverage should prioritize vulnerable groups and workers in the informal sector. Payment mechanisms such as DRG and capitation should be improved, while reimbursement processes should be accelerated and transparency enhanced. The regulatory role of the Health Insurance Fund in resource allocation should be strengthened in

order to encourage the development of primary healthcare. At the same time, the state budget should continue supporting public welfare and high-technology healthcare services. Information technology should be applied to control fraud and ensure transparency in the collection and expenditure of the insurance fund.

5.2.3.2. Improving Mechanisms for Monitoring, Evaluation, and Transparency of State Budget Expenditure in the Healthcare Sector

Monitoring of state budget expenditure should be strengthened in association with professional performance outcomes. An evaluation system combining financial indicators and health outcomes should be established. Public disclosure of budget information should be expanded, including expenditure structures and implementation results. Information technology should be applied to monitor expenditure in real time and integrate financial and healthcare data systems. The accountability of institutional leaders should be strengthened, and official evaluations should be linked to budget utilization efficiency. These measures will help improve transparency, reduce waste, and enhance public trust.

5.2.3.3. Promoting Sustainable Socialization and Public–Private Partnerships (PPP)

The legal framework for PPPs in the healthcare sector should be improved in a transparent and feasible manner. Obstacles related to public asset valuation should be resolved, and approval procedures should be simplified. Selective incentives should be applied to less attractive sectors such as primary healthcare and preventive healthcare. Mechanisms for sharing risks and benefits between the public and private sectors should also be established. Independent supervision and public disclosure of project information should be strengthened. The objective is to mobilize social resources, reduce pressure on the state budget, and improve healthcare service quality.

5.2.3.4. Developing Healthcare Human Resources and Compensation Policies under Financial Autonomy Conditions

Compensation mechanisms should be improved by ensuring that basic salaries are guaranteed by the state budget while additional income is linked to performance outcomes. Greater incentives should be provided for healthcare workers at primary healthcare levels and in disadvantaged regions through allowances, housing support, and training opportunities. Training programs should be aligned with the needs of the healthcare system and associated with

service commitments. Better working environments and career development opportunities should be created to retain high-quality healthcare personnel. In addition, a healthcare workforce database system should be established to monitor workforce mobility and support policy adjustments.

CONCLUSION

The dissertation entitled “Health Financing Policy in Vietnam” has comprehensively examined the two core components of the healthcare financing system, namely state budget expenditure on healthcare and financial policies at public healthcare institutions. Through this approach, the study has clarified the theoretical foundations and provided empirical evidence for improving healthcare financing policy in Vietnam. From a theoretical perspective, the research confirms the complementary relationship between state budget expenditure, which ensures equity and social welfare, and financial autonomy, which enhances efficiency and service quality. Together, these two components form the foundation of a sustainable healthcare financing system.

From a practical perspective, the findings indicate that the state budget continues to play the leading role in healthcare financing, although the expenditure structure remains inadequately balanced. Financial autonomy has generated positive changes within public healthcare institutions, but disparities among different healthcare levels still persist. Based on these findings, the dissertation proposes a set of comprehensive solutions aimed at improving the efficiency of budget allocation, refining financial autonomy mechanisms, and enhancing financial transparency. At the same time, the study identifies key implementation conditions, including institutional improvement, the assurance of adequate financial resources, and the strengthening of governance capacity.

The research findings contribute scientific arguments and empirical evidence for policymaking, with the objective of developing a healthcare financing system in Vietnam that is equitable, efficient, and sustainable.