An institutional analysis of the fiscal autonomy of public hospitals in Vietnam

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Abstract
This paper explores the fiscal autonomy of Vietnam’s public hospitals through analysing the formal autonomy rules and the actual autonomy practices among selected hospitals. We argue that Vietnam’s autonomisation of public hospitals underpins the increasing switch of healthcare costs from the state onto society alongside the transition from the universal and free healthcare services to a mix of state subsidy and fees-for-services. Utilised as a strategic instrument, hospital autonomy is reinforced in service provision, capital mobilisation, and allocation of net revenues, leaving autonomy in other dimensions increase incrementally. Consequently, Vietnam’s hospital autonomisation has occasioned various revenue-maximising practices including the provision of “patient-requested” services, provider-induced supply of unnecessary services, excessive use of high-tech diagnostic equipment, inappropriate prescription of drugs, increase in patients’ length of stay, and receipt of informal payments. While discerning healthcare reform in a country context, this paper expects to offer lessons to policy-makers in developing countries, which reform their healthcare services along the market principle.

KEYWORDS
autonomy, health care, institutions, public hospitals, Vietnam
Hospital autonomisation has been an integral part of a broader health sector reform in many countries. It is the reform approach that involves reducing direct government control over public hospitals and increasing their exposure to the market and market-like incentives (Preker & Harding, 2003a). The principal theoretical underpinning of autonomisation is New Public Management, “a shorthand name for the set of broadly similar administrative doctrines which dominated the bureaucratic reform agenda in many of the OECD countries from the late seventies” (Hood, 1991, p. 3–4).

Vietnam’s healthcare management system embarked on hospital autonomisation in 2002 with the issue of Government Decree 10 that grants public service delivery units varying degrees of autonomy in finance, personnel, and the organisation and management of service provision. This autonomy reform was the result of policies that dramatically shift the state’s role in public services following Đổi Mới (reform) in 1986. Under the central planning system, public services were free, and the state was the sole provider of services. During Đổi Mới that reforms the economy along the market line, public services were opened to private providers, and partial hospital fees were introduced to sustain the healthcare system. These policies were promoted through “socialisation,” a strategy aimed at mobilising social potentials and resources to improve the outcomes of public services.

In this paper, the researchers set out to explore the substance of the autonomy policies and its impacts on the performance of the three Vietnamese case study public hospitals. This study examines the perceptions and experiences of key players in relation to hospital autonomy and its effects on hospital outcomes. Although autonomy is multidimensional, the analysis within the scope of this study focuses on the fiscal autonomy of public hospitals and its implications for hospital performance. Accordingly, we address the following research questions: What is the substance of the hospital autonomy policies? What are the implications of fiscal autonomy for the performance of public hospitals?

We apply a qualitative research design that draws on evidence from legal documents governing Vietnam’s autonomy reforms in public services and in-depth interviews with managers in charge of finance, personnel, and quality assurance, deputy directors, and doctors of three public hospitals in Vietnam. To maximise case diversity, this study selects hospitals on the basis of their organisational and financial differences (hereinafter referred to as Hospital A—a central specialised, fully self-financing hospital; Hospital B—a general, partly self-financing hospital at the provincial line; and Hospital C—a general, partly self-financing hospital at the district line). Besides reflecting on the perceptions of hospitals’ staff, this study examines the perspectives of senior officials from the Ministry of Health (MOH), with the anticipation that their contributions provide additional insights into the autonomy practices of the studied hospitals and help verify the data the hospitals provided.

This study uses the theoretical insights from historical institutionalism and sociological institutionalism in analysing the autonomy policies. The historical approach allows for the search for path dependency effects, especially the impacts of the institutionalised settings and institutionalised public policies made in the past (Pierson, 2000). The emphasis of historical institutionalism on institutional persistence indicates institutional inflexibility and resistance to change. That said, institutions, while being rigid and resilient, display a typical character of adaptability, especially when that entails their survivability (Thelen, 1999). The forms of change that institutions usually take are incremental rather than the abrupt ones that occur at critical junctures when historical developments move onto a new path (Thelen, 2004). Grounded in the
path dependence assumption, historical institutionalists believe that public policies and political institutions provide both opportunities and constraints affecting the behaviour of actors involved in the policy-making process (Béland, 2009). Such approach places an emphasis on the polity. The formal and informal procedures, routines, norms, and conventions embedded in the organisational structure of the polity or the political economy are regarded as the core factors that influence collective behaviour and political outcomes (Hall & Taylor, 1996).

From a different angle, the neo-institutionalism in sociology views legitimacy as the primary source of origin for why organisations take on particular forms and procedures and how such practices are diffused through organisational fields or across societies (Hall & Taylor, 1996). This approach helps explain why organisations adopt many institutional forms and practices even though, while being legitimated externally, they might be dysfunctional in terms of achieving the organisation's formal goals. Meyer and Rowan (1977) argue that many formal structures of organisations strongly reflect the myths of their institutional environments. Organisations ceremonially adopt such rationalised institutional structures because they are legitimated externally, and as such, they may proceed to decouple such structural changes from their actual practices to take into account local circumstances and practical realities.

The theoretical insights of these two institutional approaches allowed the researchers to explore Vietnam's autonomy policies in the light of the national institutional trajectory. Specifically, the researchers, guided by these theoretical lenses, conducted an analysis of Vietnam's autonomy policies in relation to the country's policy-making path dependence and the key features of its political economy. The researchers also examined the autonomy policies through situating the reforms in the context of various internal and external pressures exerted on Vietnam in its attempts to garner legitimacy and resources necessary for the maintenance of the socialist state.

The paper contributes to the existing literature on autonomy in a number of ways. First, it provides a rich narrative of the evolution and substance of the autonomy policies and their implications for the performance of public hospitals. Despite a growing body of research on autonomisation in public services in Vietnam, it is one of the first comprehensive qualitative studies on autonomisation in Vietnam's healthcare management system. Second, previous literature shows that autonomisation in developing countries and transitional economies is “poorly defined territory” (Organisation for Economic Co-operation and Development [OECD], 2002). The study provides empirical evidence to contribute to improving the map by providing a better understanding of the autonomy reform of a developing country, which is transitioning from a centrally planned to a market-based economy. Third, this study triangulates the sources of evidence collected via interviews with a number of key players including executives, middle-level managers, and doctors of hospitals and senior officials of MOH. Fourth, the study gives a clear explanation of the nature of hospital autonomy through situating the autonomy reform in the context of historical and sociological institutional settings. The insights in the research offers to the autonomy reform are thus rich, extending to explaining why hospital autonomy was adopted in Vietnam, how the autonomy policies have evolved over time, and how they affect hospital outcomes. Finally, the study makes a significant theoretical contribution through demonstrating the merit of integrating historical institutionalism and sociological institutionalism in the study of public policies.

2 | HOSPITAL AUTONOMISATION

Hospital autonomisation or the process of giving autonomy to public hospitals is part of the delegation of power and responsibility from executive departments or ministries at the national
level or from the state administration at the regional or local level to another public or private organisation (Overman, 2016). Often, this structural change occurs within the broader public sector reforms that aim to replace the traditional model of public administration largely driven by processes, rules, and hierarchical command and control (Hughes, 2003) with the new model of public management emphasising “results in terms of ‘value for money’, to be achieved through management by objectives, the use of markets and market-type mechanism, competition and choice, and devolution to staff through a better matching of authority, responsibility and accountability” (Keating, 2001, p. 145). Embedded in the model is the New Public Management paradigm, which “attempts to combine modern management practices with the logic of economics, while still retaining core public service values” (OECD, 1998, p. 5).

The core impetus for undertaking autonomisation is to improve the performance of the public sector and to legitimate public decision-making (Laking, 2005). Hospital autonomisation is expected to encourage the hospitals “to achieve the efficiency and structure of private organisations, while still ensuring that social objectives are emphasized in healthcare through the continuation of the public ownership of these services” (Preker & Harding, 2003b, p. 15). In some developing countries, autonomisation is, however, driven by a less noble motive: creating islands of income generation for some certain reasons (Pollitt, Talbot, Caulfield, & Smullen, 2004). For example, hospital autonomisation in China, India, Indonesia, Vietnam, Ghana, and Kenya seem to be motivated by the desire to harness revenue and reduce the budgetary pressure on governments (Govindaraj & Chawla, 1996; Wagstaff & Bales, 2012). Very often, autonomisation is introduced in developing countries as a condition for receiving external aid (Laking, 2005).

To date, the outcomes of hospital autonomisation are often lower than expected, and the evidence is hard to find due to the lack of well-designed scientific evaluation (Braithwaite, Travaglia, & Corbett, 2011). For example, in China, research on the effect of autonomisation is almost non-existent, whereas in the United Kingdom, the evidence existed is contradictory (Ibid). In Chile, the reform driven by the market ideology is found to result in increased costs and reduced equity (Ibid). A recent study of hospital autonomisation in Iran, Tunisia, Lebanon, Pakistan, Dominican Republic, Zambia, Uganda, Indonesia, Malaysia, Ecuador, and Kenya finds that the planned autonomy objectives are only partially achieved, subject to the laws governing state-owned institutions of the country and the historical, political, and cultural imperatives (De Geyndt, 2017).

3 | VIETNAM’S HEALTHCARE SYSTEM

Before Đổi Mới, Vietnam’s healthcare sector was centralised, considered the responsibility of the state, and entirely financed from the state budget generated at all levels of government (London, 2003). Since Đổi Mới, healthcare sector reform has been an important part of the broader economic reform agenda. The reform includes fiscal decentralisation, the legalisation of private medical care, the deregulation of commercial sales of pharmaceuticals, the introduction of user fees at public and private health facilities, and the launch of a national health insurance scheme (Adams, 2005). As local governments have increasingly become the major financer of healthcare activities, the role of the grassroots level in public service provision becomes larger (Lieberman & Wagstaff, 2009; World Bank, 2001). Simultaneously, the number of private health providers and private pharmacies has increased significantly throughout the country, competing with public health providers in primary care and pharmaceutical sales (Tran, Van, Neu, & Dibley, 2005).
The reforms have led to a dramatic increase in the share of out-of-pocket spending in total spending on health care. Although the government continues to play a part in providing fund for healthcare services with the state budget allocation for health accounting for about 1.2% of gross domestic product, out-of-pocket spending makes up about three quarters of total health spending (Lieberman & Wagstaff, 2009). Surprisingly, although out-of-pocket payment is the sole means for financing health care for those not covered by social health insurance, it also is the dominant source for those covered by the scheme (Ramesh, 2013). It is estimated that informal (and usually illegal) payment makes up as much as 20% of healthcare spending for patients receiving “better” quality inpatient care and 7% for those receiving “normal” care (Akram-Lodhi, Chernomas, & Sepehri, 2005). It was reported that in 2010, social health insurance covered 50.8 million people, accounting for around 60% of the population (World Health Organisation, 2011). Enrolment in social health insurance does not, however, mean effective coverage of the insurance scheme, because it accounts for only 17.6% of total health expenditure (MOH and Health Partnership Group, 2011).

4 VIETNAM’S HOSPITAL AUTONOMY POLICIES AND INCENTIVES

4.1 1986–2006: The path dependence of socialist-oriented market economy and implications for autonomy reforms

The year 1986 marked a critical juncture when Vietnam transformed itself from centralism towards market socialism. Prior to this period, the country suffered from a serious and widespread socio-economic crisis as a direct consequence of the establishment of the uniform socialist institutions throughout the country. Economic difficulties and people’s deteriorating living conditions significantly undermined people’s confidence in the Communist Party of Vietnam (CPV)’s leadership and the managerial capability of state agencies. In an attempt to regain its political legitimacy that had been seriously jeopardised, CPV, in its historical 6th Congress in 1986, which marked the inception of Đổi Mới, demonstrated its commitment to move the country onto a new path called market socialism (Le, 2012). The reform directives set out by the 6th Congress denounced the central planning mechanism and recognised the multisectoral commodity economy, operating according to the market mechanism under the management of the socialist state. At the 9th Party Congress in 2001, market socialism was labelled as a socialist-oriented market economy in which the state economy is prescribed to play a decisive role and form the backbone of the economy.

Ultimately, the socialist-oriented market economy is the path CPV has stepped on to develop the Vietnamese economy. This institutional transition demonstrates the changing attitudes and beliefs of the communist leaders in conditions of great risks and uncertainty posed by the serious socio-economic crisis (Riedel & Turley, 1999). The long-term goal of the transition was to generate resources the communists expect of the market economy and to regain people’s trust in the regime that had been exhausted by Đổi Mới (Le, 2012). Underlying these strategies and calculations was the communists’ ultimate desire to maintain and consolidate the political legitimacy indispensable for the Party’s continued monopolistic rule in the country.

The choice of the socialist-oriented market economy continues to be shaped and reshaped over time by both domestic and exogenous forces. With respect to international factors, the early 1990s saw a resurgence in development assistance that Vietnam received from international
financial institutions and bilateral donors. Since then, the international community has been very active in its support for Vietnam's capacity building and development needs. Official development assistance is the country's significant source of finance, accounting for one third of the state’s public budget (Klingler-Vidra, 2014). The international community especially focuses its assistance on Vietnam's transition to a market economy with 63% of the total aid allocated to the economic sector and 14% to governance reform during 2000–09 (OECD, 2012).

The development assistance in Vietnam pushed the country to take policy prescriptions from international donors as a condition for funding (Klingler-Vidra, 2014). In governance reform, the development assistance from such donors as World Bank, International Monetary Fund, and United Nations Development Programme has particularly aimed at accelerating the process of decentralisation from central to local government and autonomisation within public sector organisations including state-owned enterprises (SOEs) and public service delivery units (PSDUs). Public hospitals are defined as PSDUs and thus have been part of this generic institutional reform.

With the support of international aid, Vietnam’s public policies are evolving over time, reflecting the dynamics in CPV’s preferences in the face of the pressure from donors for the adoption of their desired policies. Having said that, CPV does not always adopt these externally devised reform policies compliantly. While recognising that the market economy can generate higher personal incomes and thus help bolster the regime’s legitimacy, rational communists are concerned about the risks of the economic liberalisation to their control and monopolistic position (Thayumanavan, 2001). Vietnam’s reform trajectory thus often faces serious resistance from ideologists who remain committed to the continued heavy presence of the state’s intervention in the economy. In this respect, a statement of the then Minister of Planning and Investment Tran Xuan Gia in response to the International Monetary Fund’s demand for “accelerated Đổi Mới” at the international donors’ Consultative Group meeting in 1999 is worth mentioning: “…you cannot buy reforms with money … no one is going to bombard Vietnam into acting” (Painter, 2005, p. 274). Ultimately, Vietnam’s economic trajectory 20 years subsequent to Đổi Mới is characterised by a combination of liberalisation, marketisation, and privatisation on the one hand and the maintenance of central control on the other. The reform of public services, notably the autonomisation of public hospitals, strictly follows this dependence path.

Hospital autonomy reform began with policies that spark the inception of price liberalisation. Decision 45/HDBT in 1989 identified healthcare fees to include fees for health examination, bed occupation, nursing, drugs, blood tests, X-ray, and other services applied to both inpatient and outpatient care. In 1994, a more detailed fee structure was provided in Decree 95, setting out the range of fees each type of public health facilities could charge for each type of services. The introduction of the partial user-fee principle indicates that by the end of the 1980s, the state had abandoned its commitment to universal service provision (London, 2003). Instead, there has been a transfer of responsibility for public services from the state to citizens alongside the transition from socialism to the socialist-oriented market economy.

Hospital autonomy reform continued with the legalisation of PSDUs’ autonomy in Government Decree 10 issued in 2002 and its replacement, Government Decree 43 issued in 2006. Different from Decree 10 wherein the scope of PSDUs’ autonomy revolves around the use of net revenues and payroll, Decree 43 modifies and extends the autonomy to multidimensions of management including task performance, organisational apparatus, personnel, and financial management. Although Decree 10 is limited to granting fully and partly self-financing PSDUs autonomy in using employees on the state-prescribed payroll, Decree 43 entitles PSDUs that
TABLE 1 Government Decree 43/ND-CP 2006: PSDUs autonomy and constraints

| Task performance                                                                 | Allowed to take initiative in deciding on measures to fulfill the assigned tasks. |
|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| Elaborate plans and organise service delivery in accordance with PSDUs' professional domains and capabilities as well as the provisions of law. |                                                                                  |
| Entering joint ventures or cooperation with organisations and/or individuals to provide services. | PSDUs that fully and partially self-finance their operating expenses are entitled to decide on property procurement, investment, and capital mobilisation according to the plans approved by state management agencies; participate in bidding; use property for joint ventures; or contribute capital to joint ventures with domestic and foreign organisations and/or individuals for construction investment and procurement of equipment in accordance with the state's regulations. |
| Organisational apparatus                                                        | Establish, merge, and dissolve subsidiary units except for PSDUs where, as provided for by law, this power is vested to the Government, the Prime Minister, and ministers or presidents of Provincial People's Committees. |
| Personnel and payroll                                                            | PSDUs that fully self-finance their operating expenses are entitled to decide on their payroll; PSDUs that partially self-finance their operating expenses and fully subsidised PSDUs elaborate annual payroll plans based on their payroll quotas and submit the plans to their overseeing agencies for approval. |
|                                                                                   | The head of PSDUs decide to sign definite employment contracts or package contracts for positions, which need no permanent staff on the payroll, and sign contracts or other forms of cooperation with domestic and foreign experts. |
|                                                                                   | Decide on recruitment of cadres and public employees through examination or consideration; decide on the appointment of public employees (for titles equivalent to senior experts or lower titles); decide on the mobilisation, detachment, retirement, job severance, termination of working contracts, reward, or discipline of cadres and public employees in accordance with the provisions of law; decide on the increase of salary grades on time or ahead of time for cadres and public employees; and receive and transfer holders of titles equivalent to senior experts or lower titles according to conditions and criteria prescribed by law. |
|                                                                                   | PSDUs pay employees wages and remuneration according to the rank and position-based salary schemes stipulated by the State. |
| Financial autonomy                                                               | PSDUs are entitled to retain net revenues (after a deduction is made to distribute to the capital fund) for paying staff additional income: Fully self-financing units decide on staff additional income; partially self-financing units decide on staff additional income, which must not exceed three times the state-regulated basic payroll of the unit; and fully subsidised units decide on staff additional income, which must not exceed twice the state-regulated basic payroll of the unit. |
|                                                                                   | Entitled to open accounts at state treasuries to record sources of revenues categorised as state budget in accordance with the provisions of the State Budget Law; entitled to open deposit accounts at banks or state treasuries to record revenues and expenditures. |
|                                                                                   | Determine the levels of fees and charges, but those fees and charges must not exceed the caps on fees and charges regulated by state management agencies. |

(Continues)
fully finance their operating expenses the right to decide their payroll. Decree 43 also puts less stringent caps on PSDUs’ expenses on staff additional income and allowances. More flexibilities have been given to PSDUs in terms of service activities, capital mobilisation, and joint ventures. All these demonstrate that incremental changes have been made to the autonomy reforms. Nevertheless, these changes are primarily aimed to broaden PSDUs’ autonomy in areas conducive to revenue generation. The changes in many other managerial autonomy dimensions, especially personnel, are insignificant and conditional due to the presence of numerous legal provisions and subject to the approval requirements of the government (see Table 1). As stated in Decree 43, the main objective of autonomisation is to ensure staff incomes, materialising the “socialisation” of service provision through harnessing social contributions to the development of public services, thus reducing the state budget subsidy. Towards this end, PSDUs are granted more flexibility in terms of service provision, borrowing and mobilising capital for service provision and procurement of equipment and establishing joint ventures with individuals and private organisations. PSDUs, especially those more financially autonomous, are given greater autonomy in spending and rewarding employees. These entitlements constitute a structure of incentives, aimed at stimulating PSDUs to generate alternative budgetary revenues.

### 4.2 | 2007–present: Vietnam’s political economy and implications for autonomy reform

After two decades of growth, Vietnam’s economy fell into a lengthy period of macroeconomic turmoil and slow growth in the late 2000s (Tran, 2013). The fiscal deficit for 10 years in a row from 2003 to 2012 stayed at an average of 5.3% with that of the year 2009 soaring to 7.2%, creating a large debt burden on the government (Vuong, 2014). This severe downturn in Vietnam’s economy, while coinciding with the global economic recession in 2008, actually

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**TABLE 1** (Continued)

The head of fully and partially self-financing PSDUs decide on certain levels of operating expenses, which are higher or lower than those set by state management agencies; the head of fully state subsidised PSDUs decide certain levels of expenditure on management and regular operations, which must not exceed the levels set by state management agencies.

| Decide on the mode of assigning package expenditures to subsidiary divisions/units; the decision on construction investment, new procurement, and overhaul of assets must comply with the provisions of law. |
| --- |
| PSDUs are entitled to retain net revenues to set up funds and pay staff additional income. Net revenues must be used in the following priority order: Fully and partially self-financing units deduct at least 25% for setting up the capital fund, pay staff additional income, set up the reward fund, the welfare fund, and the reserve fund for income stabilisation with the maximum deduction level for the reward fund and the welfare fund not exceeding the average 3-month basic payroll and additional income payment; fully subsidised units make expenditure on staff additional income, rewards, welfare, and allowances, maintenance, and set up income stabilisation fund. |
| The remaining sources of revenues allocated from the state budget for activities other than regular operations can be carried over to the subsequent year. |

Note. The parts in italics indicate the constraints on autonomy. PSDUs: public service delivery units.
stems from the country’s socialist-oriented economic structure, which gives primacy to the state sector at the expense of the immature private counterpart (Tran, 2013). Subsequently, SOEs have always been given preferential treatment in terms of critical resources (e.g., credit, land, and natural resources) and lucrative opportunities (e.g., public investment and government procurement; Vu, 2016). Despite all those special favours and advantages, and notwithstanding the many existent reforms to autonomise and modernise the economic sector, SOEs have experienced persistent inefficiency and corruption (Pincus, Thanh Tu Anh, Pham, Wilkinson, & Nguyen, 2012).

Although SOEs’ poor performance is persistent due to the lack of corporate governance, wastefulness, and corruption, from 2007 to the present time, the issue has become more serious with a number of large state conglomerates experiencing huge losses. This is because the Vietnamese government, on the eve of the country’s World Trade Organization accession in 2006, officially adopted policies to turn existing state general corporations into giant, highly diversified conglomerates in order to strengthen the SOE sector. This decision was arguably pushed by many Vietnamese conservative politicians obsessed that the World Trade Organization accession could weaken SOEs, leading to the loss of the sector’s leading role in the domestic market, which in turn threatens the socialist orientation of the regime (Vu, 2016).

The decision to build up state general corporations into state economic groups has led to the formation of diversified businesses including insurance, finance, and banking and created new forms of directed credit and cross-subsidies among SOEs. This move has resulted in rampant investment by many state conglomerates in both their core and non-core business activities. For example, there has been a sharp increase in business investment by state conglomerates from around VND 6,000 billion in 2006 to over VND 22,000 billion in 2012, with investment in banks alone accounting for approximately 60% (Vu, 2016). Irresponsible investment behaviour, coupled with the lack of good corporate governance, has compounded the inefficiency, wastefulness, and corruption in the use of resources in the SOE sector.

Vietnam’s political economy from 2007 to the present indicates the serious limitations in state resources. In this context, the Party highly prioritises infrastructure development, ahead of social security and environment (Government of Vietnam and World Bank, 2017). For instance, in the period 2011–2015, total state budget spending on infrastructure accounted for 29.2% of gross domestic product, increasing from 28.4% in the period 2006–2010 (Government of Vietnam and World Bank, 2017). Also, the administrative wage bill, as a result of an increase in public sector employment, has expanded considerably, accounting for 20% of total public spending (Ibid). Against this backdrop, the financial responsibility for social services, seen as social burdens and economic costs (Forsberg, 2011, 2013), is significantly transferred to households. Consequently, “socialisation” has become a critical political imperative in order to capitalise and privatise public services.

These changes in policy context led to the issue of Government Decree 16 in 2015 that prescribes cost recovery schemes for different types of PSDUs. Self-financing units are entitled to determine service fees and charges according to the market mechanism, whereas units fully and partially subsidised by the state budget are allowed to progressively incorporate full costs in their service fees and charges along a detailed roadmap. The incentive for the increasing financial self-reliance is a higher degree of autonomy in setting up fees and charges, service provision, capital mobilisation, operating expenses, and net revenues distribution. Although these economic incentives were reflected in the preceding autonomy legal documents, they are further reinforced through the entitlement to a full cost recovery followed by the greater discretion to use the revenue results.
TABLE 2  Government Decree 16/ND-CP 2015: PSDUs autonomy and constraints

**Task performance**

Regarding public services not funded by the state budget, PSDUs establish their own plans and report to the overseeing agencies for monitoring, inspection, and supervision; regarding public services funded by the state budget, PSDUs establish their plan and submit it to the overseeing agencies for approval.

Decide on measures for performing duties according to the plan; participate in bidding for the provision of public services; and form joint ventures with organisations or individuals in accordance with laws.

**Organisational apparatus**

PSDUs that self-finance capital and operating expenses and PSDUs that self-finance operating expenses are entitled to decide on establishing, restructuring, and dissolving affiliates, which do not belong to units established under the decision of state management agencies when conforming to criteria, conditions, and standards prescribed in laws, and develop the plan to restructure affiliates, which belong to units established under the decision of state management agencies and submit it to competent agencies for decision.

PSDUs that partially self-finance operating expenses and fully subsidised PSDUs are entitled to set up and submit the organisational apparatus plan to state management agencies for decisions.

**Governing council**

PSDUs that self-finance operational and capital expenses establish the governing council; when necessary, ministries, ministerial-level agencies, and governmental agencies, the People's Committees of centrally run cities or provinces stipulate the establishment of the governing council for PSDUs that are not governed by the above regulation.

The governing council comprises 5 to 11 members including representatives of the line management agency; the Chair and the members of the governing council are appointed by state management agencies granting the establishment decision. Procedures for establishment, position, functions, duties, powers, organisational structure, and approval for the operational regulations of the governing council and the relationship between the governing council and the head of PSDUs and the overseeing agencies conform to the instructions of the Ministry of Home Affairs.

**Personnel and payroll**

Formulate job positions and personnel structure by professional titles to submit to state management agencies for approval; recruit, use, appoint, discharge, reward, discipline, and manage public employees in accordance with regulations; and entitled to sign definite contracts with outside employees to perform tasks.

PSDUs that self-finance capital and operating expenses and those which self-finance operating expenses decide on payroll; PSDUs that partially self-finance operating expenses put forward the payroll proposal to submit to state management agencies for approval; and fully subsidised PSDUs submit the payroll proposal based on the average payroll quotas specified in the preceding 5 years and not exceeding the current payroll to state management agencies for decisions.

PSDUs pay basic wages based on the salary scales and ranks and job positions and allowances in accordance with government regulations.

**Service fees and charges**

Regarding public services not financed by state budget, PSDUs are allowed to set service charges according to market mechanism, ensuring service charges adequate to recover reasonable expenses and to accumulate earnings in accordance with regulations applied to each sector; the charges of medical examination and treatment and education and training services are governed by the state regulations on prices.

The charges of public services financed by state budget are determined on the economic-technical basis and cost norms adopted by state management agencies and the roadmap for calculating a full amount of expenses.
In parallel to Decree 16 applicable to all public services, the healthcare sector also issued Government Decree 85 in a bid to reinforce the “socialisation” of healthcare services amidst the reduced state subsidies for health care. A major shift of this policy is the removal of state

TABLE 2  (Continued)

| in which salary costs are calculated on the basis of the basic salary level, salary coefficients, scales, ranks, and positions and payroll quotas assigned by ministries, central agencies, and Provincial People’s Committees. |
|---|

**Capital mobilisation**

PSDUs are entitled to borrow from credit institutions and mobilise capital from their officials and public employees to invest for the expansion and improvement of services.

PSDUs that finance capital and operating expenses are allowed to borrow and mobilise capital to invest in facility improvement.

**Financial autonomy**

PSDUs that self-finance capital and operating expenses are entitled to establish investment projects to submit to state management agencies for approval and decide which projects to finance and issues related to the construction method and capital source in accordance with regulations on capital expenses.

PSDUs that self-finance operational and capital expenses and PSDUs that self-finance operating expenses decide on the operating expenses higher or lower than the expense limits promulgated by state management agencies, and these expenditure levels must be stipulated in the internal expenditure regulation and comply with state regulations in terms of depreciation of fixed assets.

PSDUs that partially self-finance operating expenses and fully subsidised PSDUs decide on the level of operating expenses, but these expenses must not exceed the expenditure limits stipulated by state management agencies.

Nonoperating expenses must conform to the law on the state budget and applicable laws on each type of budget (i.e., the retained revenue used for procurement, major repair of equipment and assets, and budget for national target programs) and comply with the government’s regulations on spending limits, criteria and norms on using cars, offices, home phones, and mobile phones, and regulations on overseas travels and foreign visitor reception and international conferences organised in Vietnam.

PSDUs are entitled to retain net revenues and must use net revenues in priority order as follows:

- PSDUs that self-finance operational and capital expenses set aside 25% for establishing the capital fund; decide on the staff additional income fund (the level not restricted); set aside the reward fund and the welfare fund of which the maximum level must not exceed the 3-month basic payroll of the unit; and set aside other funds in accordance with regulations.
- PSDUs that self-finance operating expenses set aside 25% for establishing the capital fund; the staff additional income fund must not exceed three times the state-regulated basic payroll; set aside the reward fund and the welfare fund of which the maximum level must not exceed the 3-month basic payroll of the unit; and set aside other funds in accordance with regulations.
- PSDUs that partially self-finance operating expenses set aside at least 15% for establishing the capital fund; set aside the staff additional income fund not exceeding twice the state-regulated basic payroll of the unit; set aside the reward fund and the welfare fund of which the maximum level must not exceed the 2-month basic payroll of the unit; and set aside other funds in accordance with legal regulations.
- Fully subsidised PSDUs set aside at least 5% for establishing the capital fund; set aside the staff additional income fund not exceeding the state-regulated basic payroll; set aside the reward fund and the welfare fund of which the maximum level must not exceed the 1-month basic payroll of the unit; and set aside other funds in accordance with legal regulations.

Note. The parts in italics indicate the constraints on autonomy. PSDUs: public service delivery units.

In parallel to Decree 16 applicable to all public services, the healthcare sector also issued Government Decree 85 in a bid to reinforce the “socialisation” of healthcare services amidst the reduced state subsidies for health care. A major shift of this policy is the removal of state
subsidies to state health facilities by incorporating the full costs of services into the service prices. The Decree specifically provides for a roadmap towards adequate calculation of user fees by 2018.

In general, these policy changes signify the shift in Vietnam’s approach to the autonomy of PSDUs in general and of public hospitals in particular. If CPV previously took a cautious approach to the transition from subsidy to cost recovery, by this time, it has become more determined to step up on the path of switching costs to service users. Consequently, the Party’s resolution to renew hospitals’ operational mechanism is largely associated with this shift, leaving their autonomy almost intact or increasing incrementally in many managerial dimensions (see Table 2).

5 | THE REVENUE-MAXIMISING PRACTICES OF PUBLIC HOSPITALS IN VIETNAM

Interviews with three Vietnamese public hospitals demonstrate that hospital autonomy remains limited in various dimensions (e.g., spending and personnel management) due to the presence of a number of formal and informal rules and norms (see Vo, 2018). The autonomy of partly self-financing hospitals that provide lower level of care such as Hospital C is especially more restrained than that of partly self-financing hospitals that provide higher level of care such as Hospital B and fully self-financing central-level hospitals such as Hospital A (see also Vo, 2018). Meanwhile, autonomy seems to be widened in a range of dimensions including service provision, fees establishment for some services, capital mobilisation, joint ventures, and payment of staff additional income. In the payment of staff additional income, for example, there is no restricting cap on this fund within Hospital A and Hospital B, meaning that the more revenues these two hospitals can generate, the more additional income their staff are paid. These autonomy incentives have resulted in various revenue-maximising practices among public hospitals, which will be discussed next.

5.1 | Two-tier clinical services and charges

Interviews with three hospitals show that all the hospitals provide “patient-requested” services alongside “normal services” assigned by the state. Different from “normal” services, “patient-requested” services are topped up with better equipped hospital accommodation and hygienic facilities, advanced medical equipment, greater choices of medical practitioners and surgery dates, and less waiting time. Although the state imposes stringent caps on normal services, no caps are applied to non-core services such as “patient-requested” services. Some respondents of the three hospitals contend that the formulation of two-tier services and charges is utilised as a mechanism for generating revenues. As such, hospitals tend to place greater weight on “patient-requested” services than on “normal” ones. In this regard, a financial manager of Hospital A connects financial gains to the increased investment in “patient-requested” services, maintaining that “hospitals can become financially autonomous by focusing on this type of services given that the current demands for the advanced services are huge.”

Driven by the strong desire to maximise revenues, hospitals are perceived to push their service users to use “patient-requested” services. With the power of a provider in the service area of which users often have little understanding, hospitals can easily entice their patients to use “patient-requested” services at their will. Hospitals do so through a range of tricks and tactics.
that they can make up in dealing with their service users. For example, doctors may manipulate patients through some of these statements or suggestions: “the state-assigned beds are already occupied, the ‘socialised’ beds are the only option” or “no ‘patient-requested’ operation, then no high-technique, advanced equipment or golden hands” or “if you want prompt services, you need to choose ‘patient-requested’ services” (a personnel manager of Hospital B). Even the most difficult district-level hospitals in deep and remote areas, where a majority of residents are social welfare dependents, manage to offer “patient-requested” services. Furthermore, hospitals can leave their service users in the situation whereby “patient-requested” services are the only option because the “normal” service system is featured by “the dilapidated buildings, the peeling walls, the rickety beds with each bed shared by multiple patients” (a personnel manager of Hospital B).

As the rents from “patient-requested” services are believed to be a significant source of incomes of hospitals, all public hospitals are reported to engage in providing such form of services. According to a deputy director general of MOH, the systematic involvement in the provision of “patient-requested” services indicates that “there are very important persons who agree to such service provision” notwithstanding “a corrective correspondence in which MOH requests public hospitals reconsider the form of services.” The respondent points to the collective responsibility as a shield from the risk of punishment that leads health professionals to provide “patient-requested services” at the expense of “normal” services.

5.2 A systemic distortion of medical services

To maximise revenues, all the three hospitals in this study are found to distort their healthcare services through the overprovision of therapies and tests, the overuse of high-tech diagnostic equipment, and the inappropriate prescription of drugs. According to a doctor of Hospital A, it has become a popular practice that doctors exaggerate patients’ diseases to be able to provide more services. A doctor of Hospital B demonstrates that doctors can determine the diagnosis and treatment protocols, and as such, doctors can suggest patients undergo numerous high-tech diagnostic tests and therapies, many of which might be not so relevant. Because many of hospitals’ facilities including high-tech equipment are procured from investments by their employees and external partners on a profit-sharing basis, doctors often have the stimulus to prescribe the usage of these privately owned facilities (a personnel manager of Hospital B).

Also, inappropriate prescription is the other practice believed to be prominent among public hospitals especially the central-level ones, because “doctors can prescribe any drug they want to.” Doctors, while prescribing medicine, may assume that patients would feel more secure purchasing drugs at the pharmacies owned by, and located at, the hospital even though the hospital’s pharmacies are known to sell drugs at higher prices (a personnel manager of Hospital B). Doctors also might have some suggestions that patients purchase the prescribed drugs at specific pharmacies because doctors and such pharmaceutical companies have some sorts of mutual agreements (interview with a doctor of Hospital B). The trade of drugs is said to relate to not only patients and pharmacies but also “a group of agents,” implying the prescribers—those who get very high commission from pharmaceutical companies (a personnel manager of Hospital B). It is the commissions or kickbacks from pharmaceutical companies to health practitioners for prescriptions that are blamed for the very high prices of medicines, especially in public hospitals (a personnel manager of Hospital B). This practice is “extensive” considering
that even the healthcare facilities at the commune level engage in drug trade because this entails huge interests (a personnel manager of Hospital B).

Besides the overprovision of tests and therapies and the overuse of high-tech equipment, the increase in patients’ length of stay in hospitals is the other tactic hospitals often use to generate revenues. A personnel manager of Hospital B gives an example: “patients should be discharged after 3-5 days, but they are often kept to stay in hospitals longer.”

The distorted medical practices are regarded as pervasive among public hospitals given that medical practitioners can “decide on the technical protocols for medical diagnosis and treatment based on their judgement” (a doctor of Hospital B). The distorted provision of medical services is not spontaneous among the frontline medical practitioners but organised activities because they are “incited” and “pressured” by hospitals’ leaders (a doctor of Hospital B). The practices are even rewarded given that hospitals’ appraisal of staff performance and the size of staff additional income are closely connected with their faculties’ patient attraction and revenue generation (a deputy director of Hospital C). The revenue-generating pressure is so large that central-level hospitals are not enthusiastic in dealing with their persistent overcrowding problem by transferring advanced technology to satellite hospitals because the central-level hospitals themselves are strongly incentivised to attract as many patients as possible to safeguard their revenues (a deputy director of Hospital A).

5.3 | The solicitation and receipt of “envelopes”

The solicitation and receipt of “envelopes” or under-the-table payment are viewed as the persistent issues faced by public hospitals including the interviewed hospitals. This practice is said to be strengthened under the autonomy mechanism because public hospitals are pressured to generate revenues through the various ways including the solicitation of bribery. The solicitation and receipt of “envelopes” are not individual, but collective, often faculty-level, actions in which the money is then shared by members of the faculty (a doctor of Hospital B).

Interviews with three hospitals indicate that this form of informal payment is overwhelmingly seen as a reflection of the Vietnamese gift-giving customs—a tradition that values interpersonal relationships and encourages the exchange of gifts on certain occasions to express respect, appreciation, or gratitude. That said, respondents also admit that the gift giving is not limited to expressing gratitude because there are numerous situations in which patients give “envelopes” to doctors to “speed up processes” or to “receive greater attention and care from doctors.”

There is a shared agreement among respondents that the solicitation and receipt of “envelopes” have become so rampant among public hospitals that the phenomenon is labelled a culture. The “envelope culture” is considered an “inevitable” issue due to the large population impact and the overcrowding problem that leads to situations in which patients have to give “envelopes” to medical practitioners to avoid the supposedly long waiting time (a deputy director of Hospital A).

6 | DISCUSSION AND CONCLUSION

The analysis of the autonomy policies demonstrates that the autonomisation of PSDUs, including hospitals, is part of the broader reforms along the market line that CPV has adopted in a bid to ensure its political legitimacy with the Vietnamese citizens and with international
community alike after the failure of its experiment with central planning. Due to the effects of the country’s path dependence of socialist orientation, the flexibility assigned to public hospitals is limited in many managerial dimensions because autonomy is circumscribed by a set of formal rules and regulations or subject to state-prescribed criteria and state’s approval. In the meantime, CPV appears to be determined to offer public hospitals a range of incentives to generate revenues. The underpinning of this policy approach was in the first place to mobilise resources necessary for the survival of the socialist state in response to the serious socio-economic crisis under the central planning model. This policy approach continues to be reinforced in later time in an attempt to switch the healthcare costs from the state onto society as a reaction to the country’s economic downturn, which primarily stems from the huge losses among a number of key SOEs.

Consequently, Vietnam’s hospital autonomy reform is overwhelmingly about pushing public hospitals to generate alternative nonbudgetary revenues to reduce, and progressively to remove, the state subsidy. The implication of such strategy is the shift of the financial burden onto service users. To realise this material end, public hospitals are provided with both opportunities and incentives to generate revenues. When it comes to healthcare service provision, these incentives have induced public hospitals to maximise revenues with a view to rewarding their employees with higher bonuses. The serious consequence of this policy approach is the occurrence of various rent seeking and corrupt practices including the provision of “patient-requested” services within public wards for higher fees-paying patients, provider-induced supply of unnecessary services, excessive use of high-tech diagnostic equipment, inappropriate prescription of drugs, increase in patients’ length of stay, and the receipt and solicitation of informal payments.

In this light, Vietnam’s hospital autonomisation represents a radical change in the state’s role in Vietnam. Under the socialist political philosophy, the state has a central role in shaping the development of the nation. However, Vietnam’s hospital autonomy reform indicates that the state no longer commits to the socialist principle guaranteeing the citizenry’s universal access to healthcare services. Instead, it expresses its determination to engage deeply in the market economy in which healthcare services are increasingly commercialised.

Hitherto, this diminished role of the state in public services is seldom the result of the belief in the efficacy and efficiency of markets, in economic rationality, and in a move away from large and centralised government towards deregulation and decentralisation. Instead, it denotes that public services such as health care in Vietnam are under-prioritised compared with other economic sectors, especially when considering that public spending on health care remains at very low levels although incomes have grown significantly. In a polity preoccupied with economic growth, healthcare services are considered as social burdens and economic costs rather than a significant component of economic development.

It can be said that Vietnam’s hospital autonomisation is a typical example of how developing countries tailor the borrowed reform ideas of Western countries to local circumstances and practical realities. That is, under both internal and external pressures, countries may adopt the autonomy reforms that are socially legitimate and valued within the wider institutional environment, but this adoption turns out to be dysfunctional in terms of improving flexibility and efficiency. Instead, the political elites have a tendency to reshape the reforms to accommodate their self-interests and preferences.

Vietnam’s reform experiences offer valuable lessons to policy-makers in developing countries, which reform their healthcare services along the market line. Although hospital autonomy is desirable, it requires necessary conditions to succeed. Among others, appropriate incentives
and regulations are crucially important to ensure healthcare providers use their increased flexibility to enhance the wellbeing of the population and not just their own. This indicates the importance of increased state financing for healthcare services. High priority needs to be given to healthcare services instead of leaving public financing in these services to commercialisation and out-of-pocket payment to cover service costs. These structural changes require a profound transformation in the thinking of the state towards the role of healthcare services in economic growth, in which healthcare services should be regarded as an investment in development, rather than an economic burden.

Economic growth, although significant, does not necessarily mean that poverty can be addressed. A welfare state maintaining state investment in healthcare services is vitally important, because poor outcomes of healthcare services can result in people becoming poor and poverty continuing to exist. As Sidney Hillman famously quipped: “Politics is the science of who gets what, when, and why.” Rapid commercialisation of public services cannot replace the role of the state in financing for healthcare services and in improving health outcomes. Here, political choice matters concerning the decision on how much of national income to devote to redistribution and spending on public goods.

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