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Healthcare Financing in Vietnam

A Roadmap for Enhancing Fiscal Space

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Abbreviations

ASEAN	Association of Southeast Asian Nations
APEC	Asia-Pacific Economic Cooperation
CAGR	Compound Annual Growth Rate
CHE	Current Health Expenditure
DALY	Disability-adjusted life year
GDP	Gross Domestic Product
HTA	Health Technology Assessment
LMIC	Low- and middle-income countries
MA	Marketing Authorisation
MEA	Managed Entry Agreements
MoH	Ministry of Health
MSA	Medical Savings Accounts
NCD	Non-communicable Disease
NHA	National Health Accounts
NPISH	Non-profit institutions serving households
NRDL	National Reimbursement Drug List
OECD	Organisation for Economic Co-operation and Development
OOP	Out of Pocket Payments
PAP	Patient Assistance Program
QoL	Quality of Life
ROI	Return on investment
RSA	Risk-sharing arrangements
SCT	Special Consumption Taxes

SHI	Social Health Insurance
SPHI	Supplementary Private Health Insurance
THE	Total Health Expenditure
UHC	Universal Health Coverage
USD	United States Dollar
UN SDG	United Nations Sustainable Development Goals
VND	Vietnamese Dong
VNeID	Vietnam's national digital ID
VPAP	Vietnam Patient Assistance Program
WHO	World Health Organisation

Executive Summary

This report examines Vietnam's potential to expand fiscal space for health in order to achieve the ambitious goals set out in health-related Resolutions 20-NQ/TW (2017) and 72-NQ/TW (2025) – including universal health coverage (UHC), a prevention-centred health system, reduced out-of-pocket (OOP) spending, universal annual health screening, strengthened primary care, and free basic hospital care by 2030.

Vietnam currently enjoys *favourable health outcomes* relative to lower- and middle-income peer countries, underpinned by high social health insurance (SHI) coverage, strong primary care foundations, and *sustained economic growth*. Its comparatively low public debt burden, robust macroeconomic performance, and sound fiscal position create room to *expand health investment without compromising fiscal sustainability*.

At the same time, a fiscal gap of approximately 3% of GDP – equivalent to VND 357 trillion (USD 14 billion) – combined with OOP payments accounting for almost 40% of current health expenditure, points to significant underlying strain. Compounding this, demographic ageing, the rising burden of non-communicable diseases (NCDs), and growing demand for healthcare services are all expected to place substantial pressure on future health expenditure. While Resolution 72 sets out an ambitious health reform agenda, realising it will require a commensurately *significant financing effort* including substantial new investment paired with structural reform.

To address this challenge, this report proposes three non-exhaustive, pillars of mechanisms for expanding fiscal space for healthcare. Pillar one focuses on mechanisms aimed at *public revenue mobilisation*. It includes increased 'sin taxes' associated with consumption of alcohol and tobacco with increased revenue earmarked for healthcare. Our analysis identifies moderate additional income from these consumption taxes with earmarking 85% of any annual gain in revenue from increased taxes on alcohol and tobacco raising an additional VND 7 trillion in 2030, equivalent to 0.04% of GDP, for health. Similarly, earmarking 2% of lottery revenue for health could generate an additional VND 4.99 trillion in 2030, equivalent to 0.03% GDP.

Based on the analysis, *increasing government budget allocation* for health represents the single most important mechanism for expanding fiscal space. Raising the share of government expenditure allocated to health from around 10% in 2025 towards 12–13% could mobilise between VND 69 trillion to 103 trillion in additional resources in 2030, equivalent to 0.41% and 0.61% GDP respectively, substantially exceeding the contribution of other financing instruments. This should therefore form the backbone of Vietnam's health financing strategy. However, achieving long-term sustainability will also require strengthening pooled financing mechanisms capable of generating additional resources and enhancing financial protection.

The second pillar centres on *strengthening pooled financing* through social health insurance (SHI) and complementary financing mechanisms like supplementary health insurance and the utilisation of Medical Savings Accounts (MSAs). Gradual increases in SHI contribution rates could generate meaningful additional resources while supporting expanded benefits under Resolution 72. It is likely that contribution rates will increase from 4.5% to 5.1% in 2027. By 2030, contribution rates are expected to rise to 5.4%, raising revenue of VND 192 trillion. The analysis indicates that enhanced contribution rates could generate approximately VND 32 trillion more annually by 2030 versus 2025, equivalent to just under 0.2% GDP. Given Vietnam's large informal and self-employed workforce, SHI reforms alone are unlikely to generate sufficient fiscal space and should be viewed as one component within a broader financing strategy. Similarly, supplementary health insurance and MSAs are suggested as supportive functions, rather than primary financing solutions, with effective implementation of the former relying critically on robust regulation, affordability safeguards, transparent benefit design, and clear subordination to SHI.

The third and final pillar focuses on *improving efficiency and affordability* through mechanisms such as managed entry agreements (MEAs) and patient assistance programmes (PAPs). These instruments are not major revenue generators but can help improve access to new medicines, reduce financial risk to the healthcare system, and enhance the value obtained from existing healthcare expenditure. Their primary contribution is therefore to *strengthen the effectiveness of health spending* rather than expand fiscal space directly.

Vietnam's favourable economic outlook, strong political commitment to health reform, and comparatively low debt burden create a *unique window of opportunity* to strengthen health

financing. The challenge is therefore not whether additional resources can be mobilised, but how they can be mobilised in a manner that is fiscally sustainable, politically feasible, and aligned with broader health system goals.

A sequenced reform programme that combines expanded public investment, earmarked health revenues, strengthened insurance financing, and targeted efficiency measures offers a credible pathway towards the objectives of Resolution 72. By pursuing this approach, Vietnam can reduce financial barriers to care, strengthen preventive services, improve access to innovation, and build a more resilient and equitable health system capable of supporting universal health coverage for future generations.

1 Introduction

In order to achieve Universal Health Coverage (UHC), outlined in the World Health Organisation's (WHO) agenda for sustainable development (WHO, 2015), governments around the globe need to overcome significant health financing challenges, ensure that existing resources are used as efficiently and effectively as possible, and secure novel funding sources. Most countries are experiencing rising healthcare costs, driven by increasing raw material costs, increases in the proportion of older people and health system inefficiencies. Health systems generally have insufficient government funding for health and UHC, and out-of-pocket (OOP) spending remains high.

Vietnam is no different and the ability to raise sufficient funds for UHC considering these issues is a major challenge. Efforts for improvement in the financing of UHC have so far included the expansion of compulsory insurance with positive effects (Mao et al., 2020), but there is an urgent need for further progress. To this end, the pursuit of UHC was made a binding political commitment established through Resolution 20-NQ/TW (2017) and Resolution 72-NQ/TW (2025). These resolutions mandate a transition toward a prevention-centred health system, a reduction in OOP spending to 20–30% of current health expenditure, and the provision of free basic hospital care for all citizens by 2030. The central question is therefore not whether these reforms should be implemented, but how they can be financed in a manner that is fiscally sustainable and operationally feasible. UHC requires the balancing of health budgets with reduced health inequalities, whilst also enabling patients to access innovative healthcare technologies in a timely manner. Whilst the latter can improve patient outcomes and ultimately reduce overall costs, technology is also one of the key drivers of increasing healthcare costs. Industry and country governments are grappling with finding mechanisms to enable health systems in the region to access clinically relevant medicines at a price that is affordable whilst still enabling continued innovation.

Vietnam presents a striking development paradox; it consistently punches above its weight on health outcomes relative to its level of health spending. As a lower-middle-income country, Vietnam recorded a Human Capital Index score of 0.69, surpassing the global average of 0.56 (World Bank, 2019a), while achieving a UHC service coverage index of 71 out of 100, well

above the South-east Asian average of 59 (World Bank, 2023). Life expectancy reached 76 years in 2024, the highest in the region among comparable-income countries. Despite relatively strong health outcomes, Vietnam continues to exhibit a structurally imbalanced financing profile. Total health expenditure remains broadly stable at around 4.5–5% of GDP in recent years, comparable to or slightly above the low- and middle-income countries (LMIC) average (World Bank, 2025a). However, public spending constitutes less than half of total health expenditure, with private and OOP payments continuing to dominate (WHO, 2025a). In GDP terms, government health expenditure remains low at approximately 2% of GDP (WHO, 2025a; World Bank, 2025a).

The country's strong performance is therefore less a reflection of fiscal generosity than of effective deployment of resources, broad immunisation coverage (96.4% nationally), and decades of primary health system investment. Yet this achievement coexists with stark inequities: full immunisation rates fall to around 70% among ethnic minorities, while under-five stunting exceeds 35% in some remote mountainous provinces, signalling that the paradox has limits, and that sustaining and broadening these outcomes will require confronting both the insufficiency of public financing and the deep unevenness of its reach.

Given the context of Vietnam's current health expenditure and future goals, this report pursues three core objectives: to assess fiscal trends and future financing needs in the context of expanding healthcare capacity towards UHC; to analyse the feasibility and budgetary impact of a range of health financing mechanisms; and to develop a practical roadmap for their implementation. The analysis begins by assessing the current level of fiscal space for health before identifying options to mobilise additional domestic resources and estimating their potential impact. For this we utilise data from the National Health Accounts (NHA) Báo cáo (Ministry of Health, 2024) as the priority data source¹.

Building on this evidence base, the report sets out a phased roadmap to 2030 that links policy objectives to a sequenced set of financing reforms. This includes near-term measures to rapidly expand fiscal space, medium-term structural reforms to strengthen health financing institutions, and complementary mechanisms to support long-term access and system

¹ If specific, required, indicators were not available from the NHA, data was extracted from the World Bank or WHO. If specific indicators were not available in these first two groups of sources, the final priority level was data from Organisation for Economic Co-operation and Development (OECD) reports.

sustainability. Taken together, the report provides a coherent progression from Vietnam's current financing constraints to implementable funding pathways aligned with its UHC commitments.

2 Healthcare in 2030 – Vietnam's Goals

2.1 Demographic Pressure & the Rising Burden of NCDs

Like many countries in the Association of Southeast Asian Nations (ASEAN), and those globally, Vietnam is experiencing a rapidly ageing population. Declines in fertility, reduced mortality and increased life expectancy – average life expectancy reached 75 years in 2023 ("World Bank Open Data - Life Expectancy," 2023) – mean that the World Bank anticipates a significant increase in the share of those aged 65 and over by 2030. Just under 12% of the population is predicted to be aged 65 or over by this point, an increase of around two million over the next four years. This will inevitably lead to increased levels of NCDs and higher levels of multi-morbidity² which carries substantial individual and systemic consequences. At the individual level, patients experience significantly poorer health outcomes, a reduced quality of life (QoL), and increased risk of mortality. At the systemic level, multimorbidity leads to polypharmacy (approximately 70% of affected individuals use at least three regular medications) and increased healthcare resource utilisation. This can lead to spiralling healthcare costs, placing immense and unsustainable financial pressure on national budgets (OECD and European Commission, 2024).

As it stands, most recently available data suggest that 81% of mortality is due to NCD ("World Bank Open Data - Cause of Death," 2019). In line with many comparator countries in the region, NCD are also responsible for the majority of disability-adjusted life years (DALY) in Vietnam. Cardiovascular diseases, including hypertension, stroke and heart disease, cause almost a fifth of the burden, up from 15% in 2000, while cancers cause around 13%, almost doubling in the last quarter century (IHME, 2026). Effectively managing NCD requires healthcare systems to shift from acute care, where systems are designed to respond to

² Multimorbidity is the co-existence of two or more chronic conditions in an individual.

illness, toward more proactive and preventive care. There is strong evidence around the benefit and cost-effectiveness of both primary³ and secondary⁴ prevention (Gill et al., 2026; Hampson and Maberly, 2025; Mennini et al., 2015), but many countries contribute too little to prevention efforts with the majority spending around 5-6% of their healthcare budget on preventive health (Hampson and Maberly, 2025).

The requirement for enhanced prevention has been considered in Vietnam over the last decade or so and at the 6th Meeting of the 12th Central Committee in 2017 and the release of Resolution 20-NQ/TW, it was firmly on the radar. While Resolution 20 laid the initial foundation for modern Vietnamese healthcare reform, Resolution 72, launched in 2025, acts as the critical execution mechanism that operationalises and scales those original goals with specific funding, legal breakthroughs, and strict timelines.

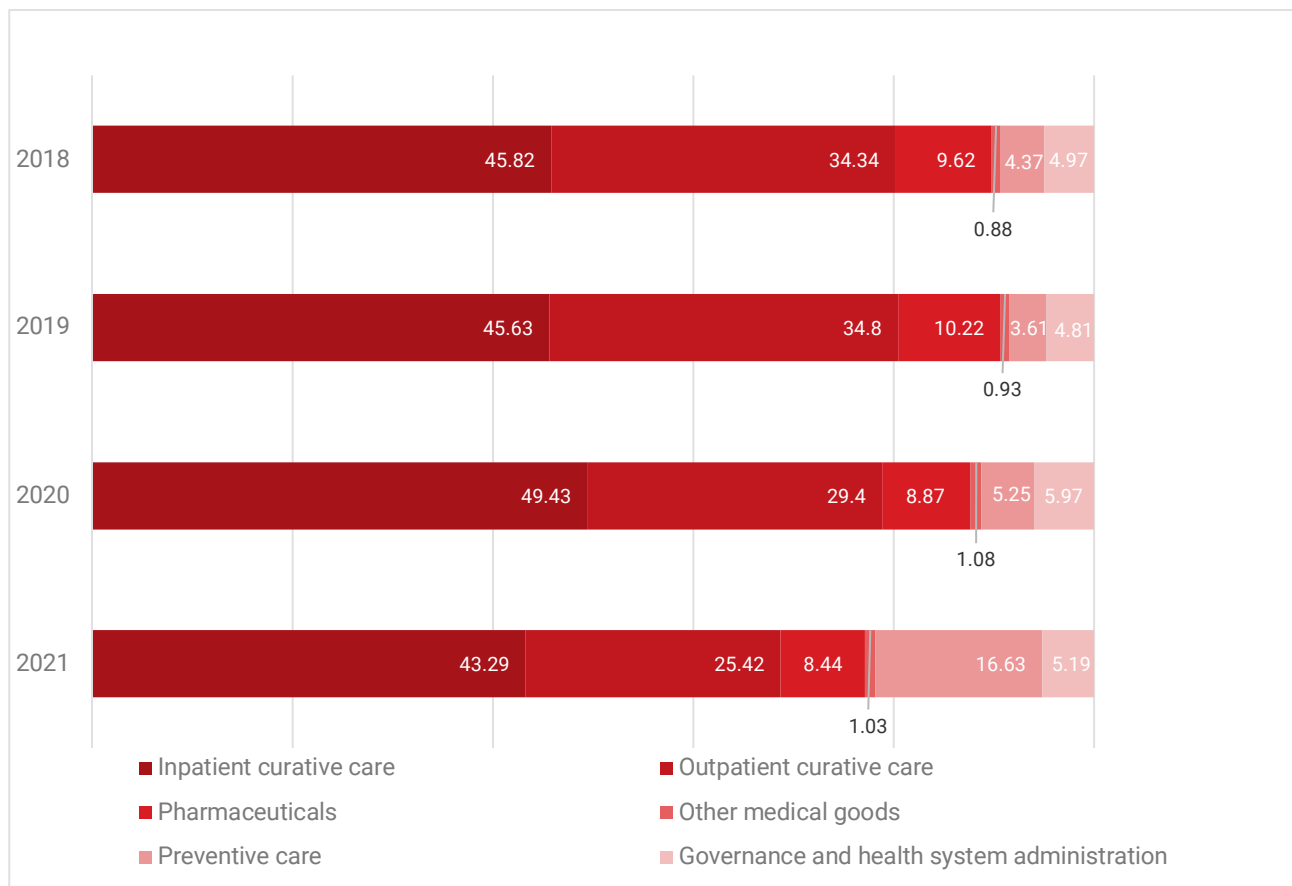
2.2 Resolutions 20 & 72

Resolution 20, adopted in 2017, set the long-term strategic goals for Vietnam's healthcare system with the aim of enhancing the protection, care and improvement of people's health. It focused on improving the physical and mental health, stature, longevity, and quality of life of the Vietnamese people by establishing an equitable, effective, and internationally integrated healthcare system (12th Party Central Committee, 2017). Preventive healthcare and commune-level healthcare were at the foundation of the resolution, and it set a 2025 95% health insurance target, alongside a life expectancy target of 74.5 years, a level reached in 2023 (World Bank, 2026). Despite this, in 2020, only 5% of healthcare spend was allocated to prevention. By 2021, this had jumped significantly to 16% of CHE (Ministry of Health, 2024) (Figure 1). Whilst this was a significant increase from the 5% of 2020, in reality, this increase is due to the impacts of the COVID-19 pandemic and was accompanied by concurrent reductions in medical examinations and treatment in hospital due to lockdowns and general restrictions on movement during this period.

³ Primary prevention aims to stop the disease before it starts.

⁴ Secondary prevention focuses on detecting disease early and managing it effectively to halt progression.

Figure 1: Health Expenditure by Function, 2018-2021



Source: Ministry of Health, 2024.

In line with international experience, the Politburo is now focused on creating a sustainable health system, with effective primary care systems and a focus on prevention, rather than acute care. As such, Resolution 72-NQ/TW 2025, released in September 2025 and enacted on the 1st January 2026 (The Communist Party of Vietnam, 2025), sets highly ambitious targets for the health system over the next 5-20 years, aiming to shift the health system from treatment-focused to prevention-centred, reducing out-of-pocket spending from the current 39% of CHE to between 20 and 30% CHE (News, 2025; Vietnam+ (VietnamPlus), 2025), and improving population health to increase life expectancy to 75.5 years, with at least 68 years of healthy living. By 2045 it is envisaged that life expectancy will exceed 80 years (The Communist Party of Vietnam, 2025). Relevant targets include:

1. **Health Insurance Reforms** - From 2026, 90% of the population will have full access to preventive healthcare services and 100% will be covered by health insurance. Coverage will be raised to 100% of eligible costs for near-poor households⁵ and those aged 75 and over in receipt of social pensions – the Ministry of Health (MoH) estimates the financial impact on the insurance fund could range from VND 455 billion to VND 2.74 trillion (USD 17.8–107.5 million⁶) annually (Shajini, 2025).
2. **Universal Annual Health Check-Up** - From 2026 all citizens will be entitled to periodic or free screening health check-ups at least once per year (The Communist Party of Vietnam, 2025). This will include a physical exam (height, weight, blood pressure and pulse) and clinical examinations likely made up of examinations covering various internal categories (circulatory, respiratory, digestive, renal/urinary, endocrine, musculoskeletal) plus psychiatric, dermatology, obstetrics/gynaecology, ophthalmology, ENT, and dental. Adults will also receive mandatory laboratory tests including blood count, blood biochemistry (glucose, urea, liver and kidney function), urinalysis, and a chest X-ray. They are designed to reduce late-stage diagnosis and lower household healthcare costs. It is anticipated that by 2035, with an expected population of 100 million and an estimated cost of VND 229,500 (USD 9.6) per check-up, the state budget required for these basic health screening check-ups would be VND 24,480 billion (USD 960 million) per year (Vietnam+ (VietnamPlus), 2025).
3. **Free Basic Hospital Care** - By 2030, hospital fees for services included within the basic health insurance package are expected to be waived, reducing OOP spending and supporting the achievement of universal health coverage. Essential inpatient services, including standard procedures and bed costs, would be free at the point of use, mitigating financial barriers that deter timely care. Gradual implementation will mean that this is initially applicable to social policy beneficiaries, vulnerable groups and those

⁵ Near-poor households are households that fall just above Vietnam's official poverty threshold but remain economically vulnerable. Under Vietnam's 2022–2025 multidimensional poverty standards, this corresponds to households with per capita monthly incomes of VND 1.5–2.25 million in rural areas and VND 2.0–3.0 million in urban areas, alongside consideration of deprivation in essential social services. In 2025, near-poor households accounted for 1.7% of all households (MoLISA, 2025).

⁶ All currency conversions in this report are based on - VND 25,500 per USD.

on low income. In 2024, the Health Insurance Fund covered VND140 trillion (USD 5.5 billion) in medical expenses while households were responsible for VND 21.5 trillion worth of OOP costs. Under the new policy, this out-of-pocket amount would become the state's responsibility, equating to an additional annual budgetary burden of around VND 21.5 trillion (USD 845.9 million) ("Vietnam planning to implement the universal hospital fee exemption policy," 2025).

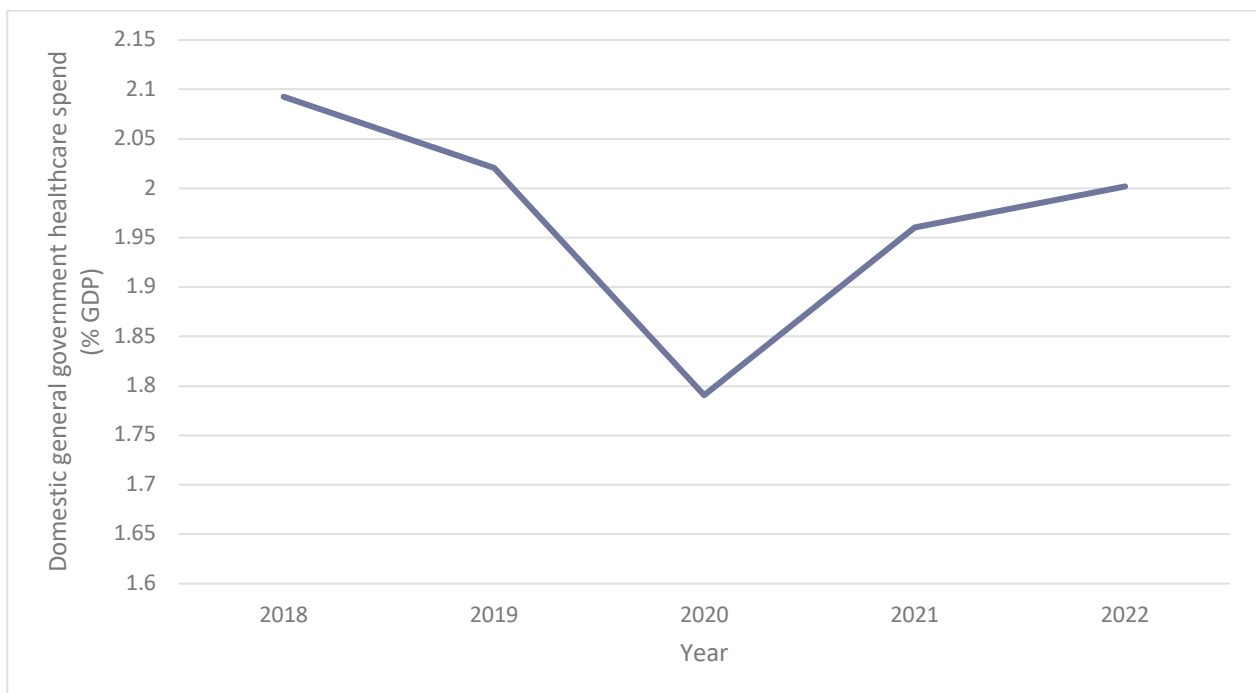
4. **Strengthen Grassroots Health Capacity** - In order to deliver an effective primary care system a robust health workforce is required. Between 2025 and 2030 an additional 1,000 doctors per year will be assigned to grassroots clinics and each commune-level health station will be equipped with basic medical equipment (The Communist Party of Vietnam, 2025). Remuneration enhancements including salary and benefit adjustments will be used to address shortages in disadvantaged and high-risk areas. This is anticipated to cost VND 4.48 trillion (USD 177 million) per year (Shajini, 2025).
5. **Enhanced Focus on Digital Health** - Universal electronic health records (EHRs), linked to Vietnam's national digital ID (VNeID), will provide lifetime health tracking and support continuity of care. This digital backbone is crucial for monitoring screening uptake and identifying high-risk populations
6. **Immunisation Enhancement** - Reinforcement of the immunisation ecosystem with establishment of special financial mechanisms to allow for catch-up vaccination programmes and mass vaccination campaigns to reduce the burden of disease and strengthen the control of health risk factors. The vaccination coverage rate under the Expanded Programme on Immunization will increase to 95% (The Communist Party of Vietnam, 2025).

Whilst these are ambitious targets, it is obvious that they will require significant fiscal reallocation and a multifaceted financing strategy designed to support the expansion of universal preventive services, strengthen primary care, and ensure equitable access across regions. The government anticipates that delivering these reforms will require substantial new investments as well as structural changes to the way healthcare is funded.

2.3 Fiscal Space and the Fiscal Gap

Southeast Asian countries like Vietnam are known to have limited government fiscal space - a government's ability to increase health spending without compromising fiscal sustainability or crowding out priority expenditures in other sectors (World Bank, 2019a) - and limited social health insurance contributions from some aspects of society, such as informal sector workers, agricultural workers, self-employed and migrant workers (Thi Thuy Nga N, 2018). High OOP costs are the norm (Tangcharoensathien V, 2011), restricting progress towards UHC. The growing prevalence of NCDs, which already account for 74% of deaths globally, poses a mounting health challenge. As outlined above, the burden is further intensified by the rapidly ageing population, with the share of people aged 60 and over projected to nearly double from 12% to 22% by 2050 worldwide (OECD, 2025). In light of these issues, the Asia-Pacific Economic Cooperation (APEC) highlighted the urgency of creating sustainable funding for healthcare at their Health Financing Forum in 2023 (APEC, 2023).

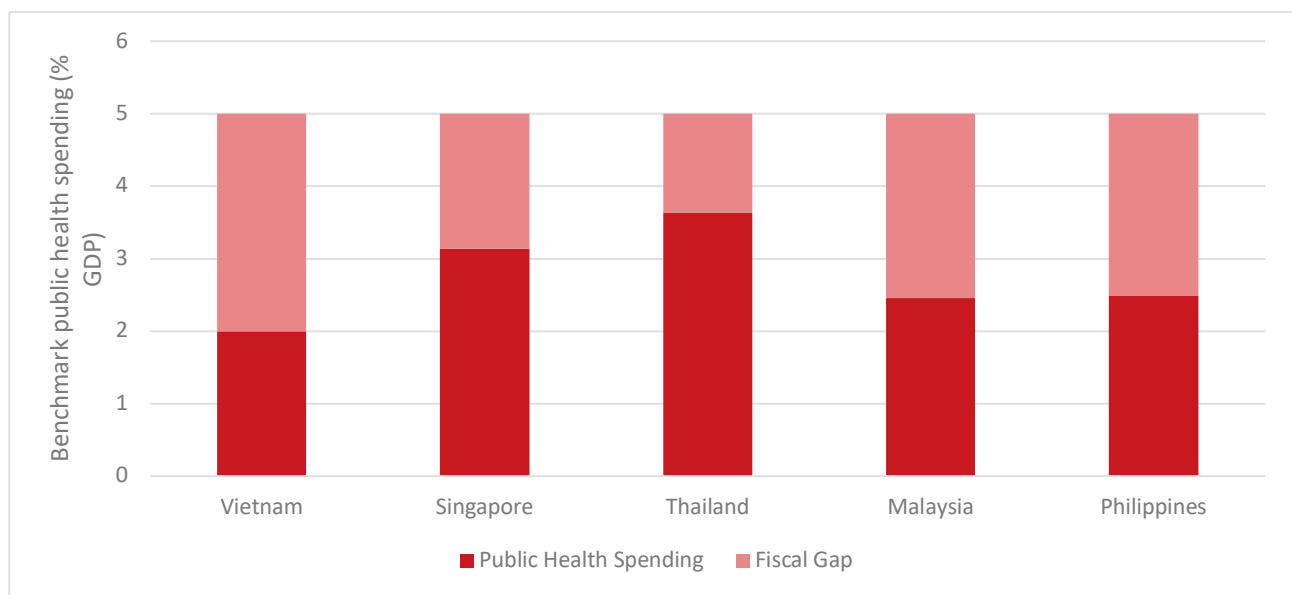
Figure 2: Domestic General Government Health Expenditure as % GDP



Source: NHA 2024.

The most up-to-date statistics from the National Health Accounts (NHA) (Ministry of Health, 2024) highlight that in 2021, domestic general government health expenditure as a proportion of GDP stood at only 2% (Figure 2). In order to provide effective UHC to citizens, it has been suggested that governments should spend a minimum of 5% of their GDP on healthcare as this takes into account a country's relative level of wealth (Mcintyre et al., 2017), this level has subsequently been used as a benchmark in discussions of the public financing required to support UHC. In 2021, the fiscal gap in Vietnam⁷ therefore stood at 3%, equivalent to VND 279 trillion (USD 10.98 billion) (Figure 3), higher than comparator countries Singapore, Thailand and the Philippines, and in line with Malaysia.

Figure 3: Fiscal gap based on domestic general government health spend as % GDP



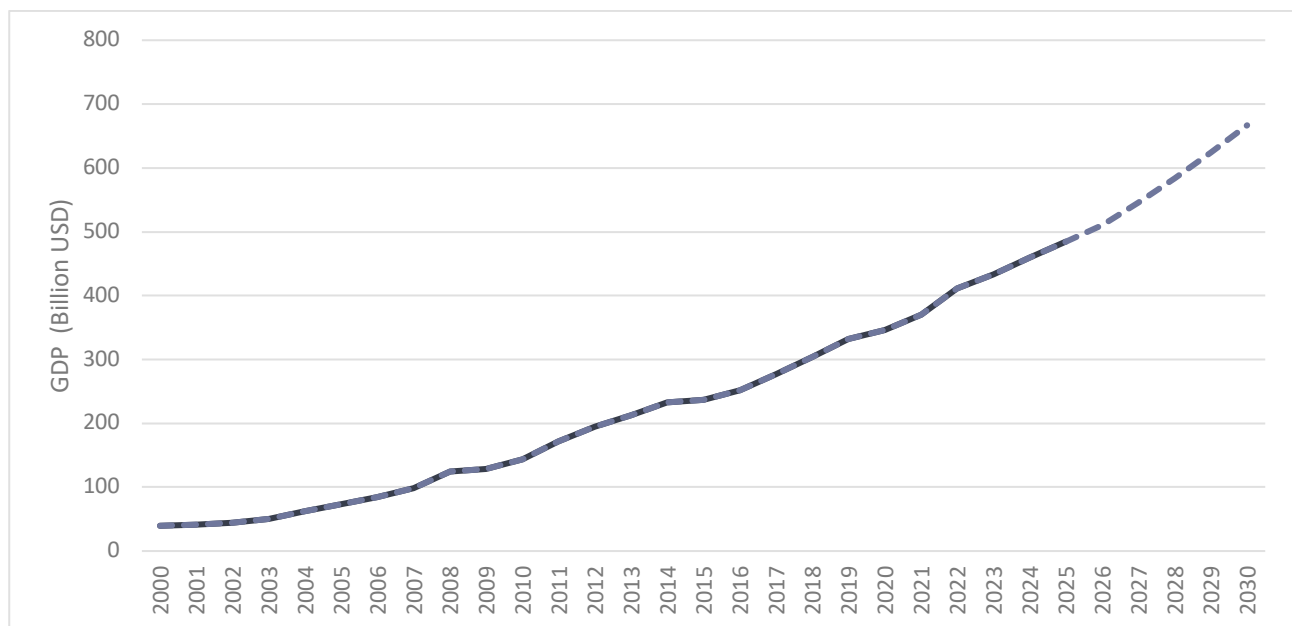
Source: Based on LSE calculations. All data based on 2021 government spend on health. Data for Vietnam from NHA (2024). Data for remaining countries from World Bank, (2022).

If we assume minimal change in government contribution to healthcare to 2024 - when GDP had increased to VND 12,138 trillion (USD 476 billion) (an increase of VND 1606 trillion (USD 63 billion)) - then the current fiscal gap for healthcare could reasonably assumed to be in the

⁷ Fiscal Gap is a measure of a government's total indebtedness. In the present context, it is related to the gap between a government's actual spend on healthcare and the 'ideal' government spend on healthcare.

region of VND 357 trillion (USD 14 billion). IMF Projections anticipate that the GDP will reach VND 17,003 trillion (USD 666.8 billion) by 2030 (Figure 4). If the government contribution to healthcare does not increase beyond 2% by this point, then future fiscal gap could be in the region of VND 510 trillion (USD 20 billion).

Figure 4: Gross Domestic Product (GDP) of Vietnam 2000-2025, Projected to 2030



Source: IMF, 2025a.

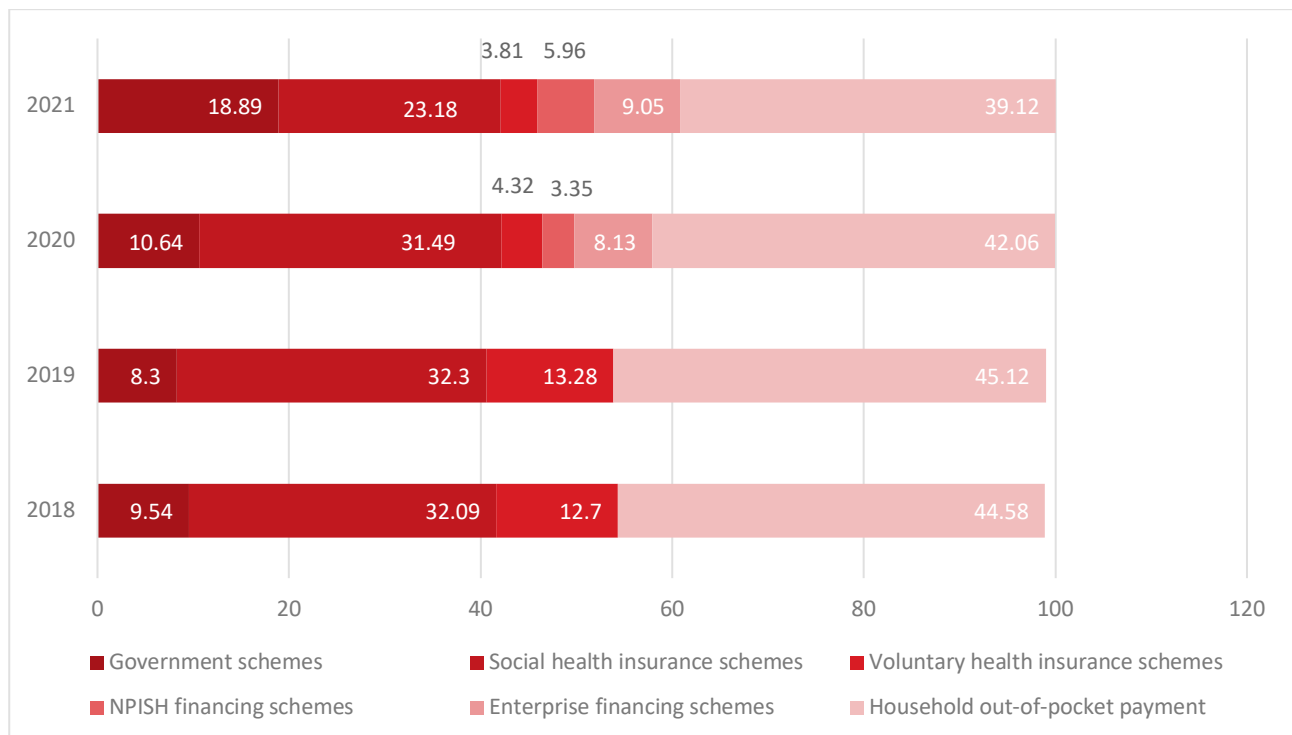
3 Vietnam's Current Health Financing Architecture

The country utilises a three-tiered public health system with central, provincial and commune levels. The central level is responsible for policymaking and the provision of highly specialised care, the provincial level implements national health policies, the commune level is the backbone of primary healthcare delivery, although almost half of healthcare expenditure is in inpatient curative care (Ministry of Health, 2024). Healthcare quality is one of the primary reasons patients bypass primary health facilities to attend those at the central or provincial level (Cai, 2023). As with many health systems around the globe, care is more focused on acute management or emergent issues versus prevention and there tends to be a fundamental mismatch between legacy systems designed for acute, episodic care and a

modern reality defined by multi-morbidity and an aging demographic. Despite this, Vietnam has been lauded globally for its effective response to pandemics like SARS, avian influenza and COVID-19 (Tran et al., 2020), and for reducing the burden of infectious diseases like TB and HIV/AIDS (Kato et al., 2014).

Healthcare is funded from six different sources including government schemes, social health insurance (SHI) schemes, voluntary health insurance schemes, non-profit institutions serving households (NPISH) financing schemes, enterprise financing schemes and household OOP (Figure 5).

Figure 5: Sources of Health Care Revenue (%)



Source: Ministry of Health, 2024.

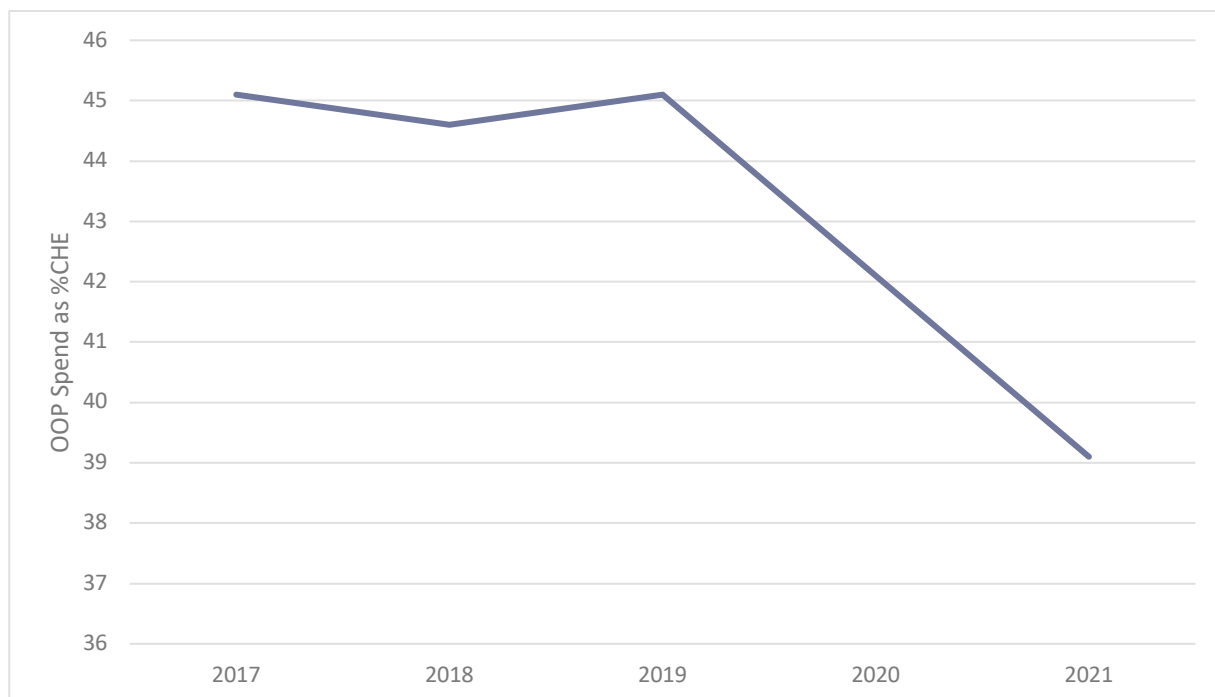
Notes: Data from 2018 and 2019 does not specify contribution from NPISH Financing Schemes or Enterprise Financing Schemes.

SHI contributed almost a quarter of health financing in 2021 (23%) (Ministry of Health, 2024). There is a near-universal health insurance coverage rate of 95.2% (Representative of VSS, 2026), although the country is striving for coverage for the entire population by 2030. The impressive SHI coverage levels have allowed high levels of UHC to be achieved, with a UHC

Service Coverage Index of 71 in 2023 (World Bank 2023). The SHI system is funded by mandatory contributions from formal-sector workers, their employers and the government with the employer and employee paying a proportion of the employee's salary to the insurance fund. Those outside the formal sector, like farmers or freelancers, are able to make voluntary contributions whilst the government subsidises premiums for vulnerable groups like the poor and children under six years old. When accessing healthcare, the health insurance company pays a large portion of the medical bill reducing OOP costs for the patient.

While the inception of the SHI system has had positive impacts on OOP costs, they are still high, making up just under 40% of healthcare spend (Figure 6), more than government schemes which made up 19% of healthcare spend in 2021.

Figure 6 : Out-of-Pocket spend as % of Current Health Expenditure

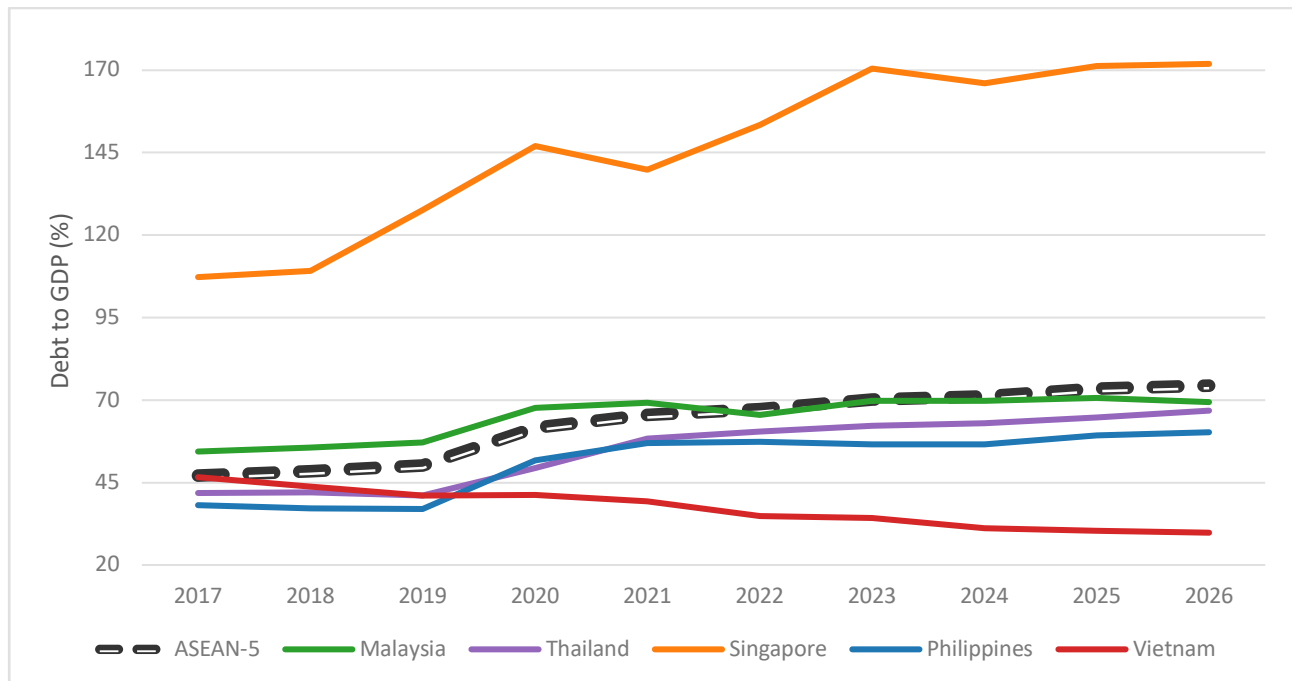


Source: Ministry of Health, 2024.

3.1 Vietnam's Fiscal Position: An Underutilised Advantage

Vietnam's fiscal position provides a comparatively favourable foundation for expanding public investment in health. In contrast to many ASEAN-5 peers, Vietnam maintains a relatively low general government debt-to-GDP ratio, of under 30% of GDP compared to the ASEAN 5 average of 75% of GDP (IMF Data, 2026) (Figure 7). This indicates that borrowing capacity remains available without compromising fiscal sustainability. This is complemented by a broadly balanced net lending/borrowing position in recent years, suggesting that fiscal policy has been managed prudently and is not characterised by persistent structural deficits. Similarly, compared with the Philippines (2.6% GDP (IMF, 2024a)) and Malaysia (2.84% GDP (IMF, 2024b)), Vietnam's interest payments on government debt are low, at just below 1% of GDP (IMF, 2024c). Taken together, these indicators point to the existence of underutilised fiscal space, particularly when viewed against regional comparators that face tighter debt constraints and higher financing pressures.

Figure 7: Debt to GDP (%) ASEAN 5 Members



Source: IMF Data.

From a health financing perspective, this creates a window of opportunity: the government can increase allocations to the health sector, either through direct budgetary expansion or through strategic use of borrowing, particularly for investment purposes, while maintaining macroeconomic stability. Importantly, this fiscal headroom strengthens the feasibility of meeting policy commitments under Resolution 72, including the expansion of preventive services and the reduction of out-of-pocket expenditure.

When combined with projected economic growth and complementary revenue-raising measures, such as increases in SHI contributions, the current fiscal position suggests that achieving a government health expenditure level closer to the 5% of GDP benchmark is attainable within the medium term. As such, Vietnam's relatively strong fiscal fundamentals should be interpreted not merely as a position of stability, but as an enabling condition for scaling up sustainable health financing in line with its universal health coverage objectives.

4 A Framework for Building Fiscal Space for Health

While fiscal space can, in principle, be expanded through multiple channels, including economic growth, budget reprioritisation, earmarked revenues, external funding, and efficiency gains, not all are equally feasible or material in Vietnam's current context. Strong economic performance, existing commitments to UHC, persistently high out-of-pocket spending, and rising healthcare needs together point to a focused set of financing options. Against this backdrop, this section concentrates on mechanisms most relevant for Vietnam, encompassing public revenue mobilisation, demand-side contributions through insurance and complementary arrangements, and efficiency-enhancing approaches to health spending.

The financing options assessed in this report are organised into three complementary pillars that together support Vietnam's roadmap to 2030. This structure links near-term revenue mobilisation to medium-term contribution reforms and longer-term mechanisms that can improve the affordability and sustainability of access to new technologies. It is important to note that these pillars are not mutually exclusive; in practice, different combinations of

measures can be implemented concurrently, with their relative contribution varying according to policy priorities, fiscal circumstances, and implementation feasibility. The three pillars are as follows:

- **Pillar 1 - Public revenue mobilisation:** Centred on measures that expand fiscal space through government-led revenue sources, including sin taxes, higher budget allocations to health, and a potential health lottery.
- **Pillar 2 - Demand-side contributions:** Mechanisms that increase pooled or complementary financing from households and employers, including higher social health insurance premiums, medical savings accounts (MSAs), and supplementary health insurance.
- **Pillar 3 - Access- and efficiency-support mechanisms:** Instruments that can improve the affordability and management of spending on innovative technologies, particularly managed entry agreements (MEAs) and patient assistance programmes (PAPs).

4.1 The Potential of VAT Increases

Before moving on to explore the potential mechanisms Vietnam could adopt, it is first important to address the potential of value-added tax (VAT) increases. VAT is Vietnam's single largest source of tax revenue, accounting for approximately 27–29% of total tax receipts, equivalent to around 3.2% of GDP in 2024 (IMF, 2025b). Against a 2024 GDP of VND 11,717 trillion (USD 459.5 billion), this translates to approximately VND 374 trillion (USD 14.7 billion) in VAT receipts. Given the breadth of the tax base, with VAT levied on the consumption of virtually all goods and services at each stage of the supply chain, even modest changes to the applicable rate carry significant revenue implications. Despite a standard VAT rate of 10%, the actual effective VAT rate has been materially below this level since February 2022, when the government introduced a temporary two-percentage-point reduction, bringing the rate to 8% on most goods and services, as part of its post-COVID-19 economic stimulus programme (Thi Thu Trinh, 2025). This level will stand until at least the end of 2026. Whilst even small VAT raises would certainly raise significant sums which could be earmarked for the health system, VAT is seen as regressive as lower-income households pay proportionally more of their income on VAT than higher income households. It is unlikely, at least in the short term, to be a viable solution for building fiscal space for health in Vietnam.

4.2 Public Revenue Mobilisation

Public revenue building mechanisms constitute the core building blocks of the roadmap, spanning near-term revenue mobilisation, medium-term structural reforms, and longer-term complementary instruments.

Sin Taxes: Tobacco and Alcohol

Well-designed ‘Special Consumption Taxes’ (SCT) or sin tax adjustments can deliver a twofold benefit: mobilising predictable revenue while, through higher relative prices, discouraging use of harmful products such as cigarettes, alcohol, and, in more recent cases drinks that are high in sugar (Blecher and Nguyen, 2024). By dampening risk-factor exposure, such measures can slow incident NCD cases, moderate future utilisation growth, and, over time, ease pressure on health expenditures.

Excise taxes on harmful goods are associated with reduced consumption, as higher prices discourage demand; for example, Colchero et al., (2017) report significant declines in purchases of taxed sugar-sweetened beverages following implementation. Sin taxes also provide a stable source of government revenue, even where consumption falls (Goodchild et al., 2021; Heller, 2006). In addition, empirical evidence links these measures to improved health outcomes, including lower incidence of obesity and non-communicable diseases (Wright et al., 2017). Taken together, the evidence indicates that such taxes can simultaneously influence behaviour, strengthen fiscal capacity, and contribute to improved population health (Miracolo et al., 2021).

Criticism of the implementation of “sin” taxes in Vietnam has focused on shortcomings in both their magnitude and structural design, limiting their capacity to generate substantial revenue and deter consumption. Historically, Vietnam’s SCT on alcohol and tobacco has relied on an ad valorem structure levied on ex-factory prices (Blecher and Nguyen, 2024), a design fundamentally misaligned with public health objectives. The negative externalities of consumption are independent of product value and the value-based model failed to address

the inherent harms of lower-priced goods, inadvertently encouraging consumers to "trade down" to cheaper brands rather than reducing overall use (Blecher and Nguyen, 2024). Furthermore, by implementing the levy on producer ex-factory prices rather than a retail-price base, the system allowed wholesaler and retailer margins to escape taxation, effectively eroding real receipts against rising incomes and inflation (Cashin et al., 2017).

Between 2010 and 2025, Vietnam's tobacco taxation remained at a relatively low level, reflecting underlying structural weaknesses in the implementation of sin taxes. Estimates from the WHO Global Health Observatory indicate that total tobacco taxes accounted for approximately 34% of the retail price, while domestic sources report slightly higher figures of 36–38.8%, well below international best-practice standards. The WHO recommends that total taxes comprise at least 75% of the retail price (WHO, 2025b), a benchmark that is largely met or exceeded by several ASEAN peers, including Thailand (approximately 78.6–81%) and Singapore (around 66–67.5%). In contrast, Vietnam's reliance on a narrow, value-based tax structure constrained the effective tax burden to nearly half of the recommended level. Alcohol excise rates increased between 2010 and 2025 (Table 1). Whilst on the surface these increases seem significant, the application of the tax in the early stages of the supply chain means that the impact on prices for the consumer is small.

Table 1: Evolution of Alcohol Excise Tax Rates in Vietnam Since 2010

Period	Beer	ABV<20% (Wine)	ABV≥20% (Spirits)
2010-2012	45%	25%	45%
2013-2015	50%	25%	50%
2016	55%	30%	55%
2017	60%	30%	60%
2018-2024	65%	35%	65%

Source: Blecher and Nguyen, 2024.

In 2025, the Politburo's Resolution No. 72-NQ/TW marked a decisive pivot in national health strategy, reorienting the system from reactive treatment toward proactive prevention by mitigating the impacts of harmful consumption. On 14 June 2025, Vietnam's National Assembly approved Law No. 66/2025/QH15, which took effect on 1st January 2026 and introduced significant reforms to the SCT and provided for a phased increase in excise rates for beer, wine and spirits and tobacco (Table 2) (National Assembly, 2025).

Table 2: Excise Rates for Alcohol and Tobacco to 2030

Year	Beer (SCT rate)	Wine <20% ABV (SCT rate)	Spirits ≥20% ABV (SCT rate)	Tobacco ad valorem SCT
2026	70%	40%	70%	75%
2027	75%	45%	75%	75%
2028	80%	50%	80%	75%
2029	85%	55%	85%	75%
2030	90%	60%	90%	75%

Source: Ministry of Finance, 2024.

By 2030, it is anticipated that the enhanced SCT levels on alcohol will raise VND 65 trillion (USD 2,553.57 million), versus VND 47 trillion (USD 1,844.3 million) in 2025 (Table 3) whilst increased SCT levels on tobacco (Table 4) could raise VND 38 trillion (USD 1,503.85. million) in 2031. Whilst the approved tax increases will bring Vietnam closer to WHO recommendations, adopting proven design features from abroad such as earmarking for health, could enhance acceptability, improve revenue predictability, and align fiscal gains with measurable health improvements, thereby strengthening both fiscal space and preventive impact.

Table 3: Projected Fiscal Revenue Effects of SCT Modifications on Alcohol

Year	Beer		<20% ABV (Wine)		ABV ≥ 20% (Spirits)	
	Tax Rate	SCT Tax VND Trillion (USD Million)	Tax Rate	SCT Tax VND Trillion (USD Million)	Tax Rate	SCT Tax VND Trillion (USD Million)
2025	65%	46.20 (1,811.96)	35%	0.24 (9.49)	65%	0.58 (22.84)
2026	70%	49.78 (1,952.16)	40%	0.27 (10.78)	70%	0.62 (24.39)
2027	75%	53.36 (2,092.39)	45%	0.31 (12.16)	75%	0.67 (26.11)
2028	80%	56.87 (2,230.08)	50%	0.35 (13.53)	80%	0.71 (27.89)
2029	85%	60.39 (2,368.16)	55%	0.38 (14.9)	85%	0.75 (29.59)
2030	90%	63.90 (2,505.99)	60%	0.41 (16.27)	90%	0.80 (31.31)

Source: Adapted from Report 188/BC -BTC, (Ministry of Finance, 2024)

Table 4: New SCT Rates on Tobacco Products

Year	Tobacco ad valorem SCT	Cigarettes specific SCT (per pack) (USD)	Cigars specific SCT (per cigar) (USD)	Other tobacco specific SCT (per 100g/100ml) (USD)
2026	75%	VND 2,000 (0.08)	VND 20,000 (0.78)	VND 20,000 (0.78)
2027	75%	VND 4,000 (0.16)	VND 40,000 (1.57)	VND 40,000 (1.57)
2028	75%	VND 6,000 (0.24)	VND 60,000 (2.35)	VND 60,000 (2.35)
2029	75%	VND 8,000 (0.31)	VND 80,000 (3.14)	VND 80,000 (3.14)
2030	75%	VND 10,000 (0.39)	VND 100,000 (3.92)	VND 100,000 (3.92)
2031	75%	VND 10,000 (0.39)	VND 100,000 (3.92)	VND 100,000 (3.92)

Source: Ministry of Finance, 2024.

The new tobacco tax excise is projected to raise VND 18.2 trillion (USD 695.6 million) in 2025 to VND 39.1 trillion (USD 1.49 billion) by 2030 (Nhan Dan Online, 2026). Earmarking tax revenues offers a complementary policy option. Defined by the WHO as the allocation of all or part of tax revenue to a designated purpose, earmarking may be “hard” (legally binding) or “soft” (non-binding). Governments use earmarking to secure funding for priority sectors, build political support for taxation, and enhance transparency and accountability. Earmarking for health is well established globally, with over 80 countries adopting such approaches by 2017, and could support more stable and targeted health financing in Vietnam.

Evidence from international peers such as Thailand and the Philippines reinforces the effectiveness of earmarking revenue for health-related purposes. In Thailand, a two per cent surcharge on excise taxes on alcohol and tobacco has been allocated to the ThaiHealth Promotion Foundation (Pongutta et al., 2019) to support sustainable health financing amid rising non-communicable diseases since 2001 (Lane, 2022). ThaiHealth operates in alignment with national health policy, targeting key risk factors such as tobacco use, alcohol consumption, unhealthy diets, and physical inactivity, an approach characterised as

preventive and proactive (Tangcharoensathien et al., 2024). The proportion of people using tobacco decreased from 22.5% in 2001 to 17% in 2021 (Pongutta et al., 2019; Tangcharoensathien et al., 2024) and annual per capita alcohol consumption decreased from 8.1 litres in 2005 to 6.9 litres in 2014 (Pongutta et al., 2019). 85% earmarking of sin tax revenue has generated an extra 150 billion Thai Baht (around USD 5 billion) for the health system (NTRC, 2018).

The Philippines adopted a soft earmarking model to advance UHC through the enactment of the Sin Tax Law (STL) in 2012, avoiding the introduction of new taxes while generating sustainable health financing and discouraging the consumption of health-harming products (Philippine Institute for Development Studies et al., 2023). Excise taxes for tobacco and alcohol products were simplified and increased and resulting STL revenues made a significant contribution to UHC financing, with 85% of incremental revenues earmarked for universal health spending (Republic of Philippines, Department of Health, 2016). These funds supported expanded insurance coverage, strengthened financial protection, and increased investment in health facilities and services (Hoe et al., 2022). Building on this success, in 2018 a tax on SSBs was introduced, set at 10 Philippine pesos per litre for beverages sweetened with domestic sweeteners and 20 Philippine pesos per litre for those containing imported sweeteners and indexed to inflation (Onagan et al., 2019). Earmarking of revenue and implementation of tax reforms tripled the Philippine Department of Health's budget over three years (Kaiser et al., 2016). Total economic savings were estimated at USD 415 million, reflecting reductions in hospitalisations, gains in productivity, and increased tax revenues (Cheng and Estrada, 2021).

Vietnam has a precedent for health-linked earmarking with The Tobacco Control Fund, established under the Law on Prevention and Control of Tobacco Harms in 2012 and becoming operational in July 2013. A compulsory levy on tobacco manufacturers and importers, set initially at 1% of the taxable price and doubled to 2% by 2019, provides the fund's revenue base (Goodchild et al., 2021; World Bank, 2019b). Between 2013 and 2024, the fund disbursed approximately VND 1,511 billion (around USD 60 million), supporting over 100 organisations and a network of hospitals annually (Ministry of Health, 2026). Its activities have spanned public communication campaigns, enforcement of smoke-free legislation, free cessation counselling services, and research, with over 275,000 patients receiving cessation

support between 2015 and 2025. Between 2010 and 2023, the smoking rate in men fell from 47.4% to 38.9%, though attributing this decline solely to the fund would overstate the case given the concurrent role of tax and regulatory measures.

From July 2026, the fund's revenues will transfer to a newly established Disease Prevention Fund under the 2025 Law on Disease Prevention, with proposals under consideration that at least 50% of tobacco contributions to the new fund be ring-fenced for tobacco control activities (Ministry of Health, 2026). The fund's operational track record since 2013 provides an important foundation for any expanded earmarking architecture and should not be overlooked when designing a broader health financing mechanism.

The revenue streams modelled here provide the base for the earmarking scenarios presented. These comprise two components: alcohol (beer, wine, and spirits), projected from the phased rate increases under Law No. 66/2025/QH15 (Ministry of Finance, 2024); and tobacco SCT revenues, modelled using a combined prevalence- and price-elasticity approach anchored to WHO TaxSim projections. Across these two streams, total projected SCT revenue rises from approximately VND 70.64 trillion (USD 2.7 billion) in 2025 to VND 116.87 trillion (USD 4.58 billion) by 2030, reflecting both the step-up in legislated rates and the expanding economic base against which they are applied.

Our scenario analysis below builds on the Philippine framework of applying an earmark of 85% of the annual incremental sin tax revenue. Targeting only new revenue avoids fiscal displacement, ensuring the health sector receives truly additional funds rather than replacing existing budget allocations. Total SCT revenue is defined as the combined annual yield from alcohol (beer, wine, and spirits) and tobacco. The 2025 figure of VND 70.64 trillion (USD 2.7 billion) serves as the baseline. For each subsequent year, the annual increment in total SCT revenue is calculated, and 85% of that increment is designated as earmarked for health. The formula applied is:

$$\begin{aligned} & \text{Earmarked Revenue (Year } t) \\ &= [Total\ SCT\ Revenue\ (Year\ t) - Total\ SCT\ Revenue\ (Year\ t - 1)] \times 0.85 \end{aligned}$$

The SCT revenue projections underpinning this calculation already incorporate two distinct demand-reduction mechanisms: a prevalence-based decline in smoker numbers of 0.4 percentage points per year from a 2024 baseline of 20% (approximately 40% among males

and 0.8% among females), and a price elasticity of demand of -0.165 applied to the consumption of remaining smokers as specific levies raise retail prices (Nguyen and Nguyen, 2021). The aggregate smoker population across 2026–2030, implied by this prevalence trajectory, is approximately 74.42 million. This aggregate assumes prevalence starts at 15 million smokers per year and gradually reduces to 13 million. It is important to note that this figure includes all tobacco users, not just cigarette smokers. However, in the context of Vietnam, this is considered a reasonable proxy, given the dominance of cigarettes in the market. No further behavioural adjustment is applied at the earmarking stage; the earmarked figures reflect the revenue available after these demand effects have been modelled in the underlying SCT projections.

Table 5 outlines the potential value of earmarking in Vietnam. By 2030, the total sin tax revenue per year is anticipated to be VND 116.87 trillion (USD 4.58 billion). If Vietnam adopted a Philippine-style earmarking approach of 85% of the annual increase, the total value of earmarking on sin tax revenue between 2025 and 2030 would be in the region of VND 41.28 trillion (USD 1.6 billion).

Table 5: Potential Value of Earmarking SCT Revenues

Year	Total Alcohol Revenue Annual – VND Trillion (USD Million)	Total Tobacco & SSB Tax VND Trillion (est. USD Million)	Total Tax Revenue VND Trillion (USD Million)	Proposed Philippines style Earmark– 85% of annual gain VND Trillion (USD Million)
2025	47.05 (1,844.93)	22.57 (885.00)	69.92 (2,770.00)	-
2026	50.70 (1,988.04)	29.50 (1,157.00)	80.20 (3,145.00)	8.99 (319.00)
2027	54.35 (2,131.43)	35.88 (1,407.00)	89.50 (3,510.00)	9.87 (387.00)

2028	57.94 (2,272.28)	41.69 (1,635.00)	99.63 (3,907.00)	8.62 (338.00)
2029	61.54 (2,413.52)	46.97 (1,842.00)	108.50 (4,255.00)	7.55 (296.00)
2030	65.14 (2,554.51)	51.71 (2,028.00)	116.87 (4,583.00)	7.11 (279.00)
		Total VND Trn (USD m)	565.34 (22,170)	41.28 (1,619)

Policy Assessment – Tobacco and Alcohol Taxes

Fiscal Gap Contribution: MODERATE – Could generate an additional VND 7 trillion in 2030, equivalent to 0.04% GDP, assuming an 85% (of annual gain) earmark.

Political Feasibility: HIGH - Reforms have already been legislated and are aligned with public health and NCD reduction priorities.

Overall Assessment: A useful tool that would benefit from *earmarking revenue for health* to enhance acceptability, improve revenue predictability, and align fiscal gains with measurable health improvements, thereby strengthening both fiscal space and preventive impact.

Lottery Tax as a Supplementary Revenue Instrument

Health lotteries are one example of how governments and organisations generate supplementary funding for health and social programmes. In the UK, for instance, around 20% of each Health Lottery ticket is directed to health-related projects, supporting areas such as chronic disease, disability, and community wellbeing. More commonly, national lotteries

allocate a broader share of proceeds to “good causes”. For example, roughly 28% of UK National Lottery revenue goes to a central fund, part of which supports health alongside sectors like education and the environment. A recent initiative in Angola sees 40% of the gross revenue from concessioned social games and unclaimed prize money allocated for initiatives related to health (VerAngola, 2026). While such mechanisms can provide visible and politically attractive funding streams, they typically play a complementary rather than core role in health financing.

In Vietnam, lottery revenues represent a significant potential financing stream. In 2025, the Southern Vietnam lottery generated approximately VND 155 trillion (around USD 6 billion) (Tạp chí Tài chính Doanh, 2026), broadly comparable to revenue from SHI contributions, and projected to grow by around 10% annually. While a nominal increase in ticket prices, for example from VND 10,000 to 12,000, with the additional VND 2,000 earmarked for healthcare, could be considered, this may be difficult to implement in practice given the importance of the current denomination. A more feasible alternative would be to earmark a fixed proportion of lottery revenues within provincial budgets for health, for example to subsidise SHI coverage for disadvantaged groups, including many of the informal workers involved in lottery ticket distribution.

Table 6: Predicted Lottery Revenue

	Projected Lottery Revenue VND trillion (USD billion)	2% Earmarked for Health VND trillion (USD billion)	5% Earmarked for Health VND trillion (USD billion)
2025	155.0 (6.08)	--	--
2026	170.5 (6.69)	3.41 (0.13)	8.53 (0.33)
2027	187.6 (7.36)	3.75 (0.15)	9.38 (0.37)
2028	206.4 (8.1)	4.13 (0.16)	10.32 (0.41)
2029	227.0 (8.9)	4.54 (0.18)	11.35 (0.45)
2030	249.7 (9.79)	4.99 (0.20)	12.49 (0.49)
Total	1196.2 (46.91)	23.92 (0.94)	59.82 (2.35)

If we assume a 10% CAGR on southern lottery revenue, by 2030, predicted revenue will be VND 249.7 trillion per year. A 2% earmark would equate to VND 4.99 trillion in 2030, and a cumulative value of VND 23.92 trillion between 2026 and 2030. If a 5% earmark is used, equivalent values are VND 12.49 trillion and VND 59.82 trillion (Table 6).

Policy Assessment – Lottery Taxes

Fiscal Gap Contribution: MODERATE - Could generate an additional VND 4.99 trillion in 2030, equivalent to 0.03% GDP, assuming a 2% earmark.

Political Feasibility: HIGH - Earmarking lottery revenues does not require increasing taxes or insurance contributions and is unlikely to impose additional financial burdens on households. The approach has been used in several countries to fund social programmes and may therefore be politically attractive.

Overall Assessment: A politically feasible source of additional funding, but unlikely to materially reduce the fiscal gap on its own. Best considered as a complementary rather than a primary financing mechanism.

Increased Budget Allocation to Health

The most effective way to expand fiscal space for health in Vietnam is through increased government healthcare allocation. Unlike VAT or sin taxes, this primary budgetary decision requires no new legislation or institutions. Its implementation depends on political will, which evidence indicates is now favourable for progress.

The Abuja Declaration, adopted by African Union member states in 2001, committed governments to allocating at least 15% of total government expenditure to health (Abuja Declaration, 2001). While this target was developed in the African context, it is frequently cited

internationally as a benchmark for prioritising health within public budgets. Vietnam's health share of government expenditure is approximately 10.5 percent, amounting to around VND 268 trillion (USD 10.5 billion) in 2025.

Health spending scenarios for 2025–2030 are modelled by applying alternative allocation rates to projected total government expenditure, held at 20% of GDP, consistent with IMF fiscal assessments (IMF, 2025). GDP projections follow the same series used throughout this report, rising from VND 12,360 trillion (USD 484.7 billion) in 2025 to VND 17,003 trillion (USD 666.8 billion) by 2030 (IMF, 2025b). Three scenarios are considered: a 10 percent floor as a baseline, and 12 and 13 percent allocations reflecting the regional peer benchmark.

Incremental fiscal space is the difference from the current 10.5% health share, isolating additional resources. Raising the share to 12% would have added ~VND 48.45 trillion (USD 1.9 billion) in 2025 (equating to 0.30% of GDP, 1.8% of government spending); 13% would have added ~VND 76.5 trillion (USD 3 billion) (equating to 0.70% of GDP, 3% of spending) (IMF, 2025b).

Analysis results are shown in Table 7. Under the 10% floor scenario, health spending rises from VND 247.35 trillion (USD 9.7 billion) in 2025 to VND 339.15 trillion (USD 13.3 billion) in 2030, tracking GDP growth but providing no real increase in the health share and falling short of the WHO benchmark of 5% of GDP (VND 617.1 trillion (USD 24.2 billion) in 2025; VND 849.15 trillion (USD 33.3 billion) in 2030). The 12% and 13% scenarios deliver stronger gains.

Table 7: Government Health Expenditure Scenarios, 2025–2030

Year	GDP VND Trillion (USD Billion)	Govt Budget – VND Trillion (USD Billion)	10% Floor VND Trillion (USD Billion)	12% Target VND Trillion (USD Billion)	13% Target VND Trillion (USD Billion)	WHO 5% GDP Benchmark VND Trillion (USD Billion)
2025	12,359.9 (484.7)	2,470.9 (96.9)	247.3 (9.7)	295.8 (11.6)	321.3 (12.6)	617.1 (24.2)
2026	13,033.0 (511.1)	2,606.1 (102.2)	260.1 (10.2)	313.6 (12.3)	339.1 (13.3)	652.8 (25.6)
2027	13,902.6 (545.2)	2,779.5 (109.0)	277.9 (10.9)	334.1 (13.1)	362.1 (14.2)	696.1 (27.3)
2028	14,884.4 (583.7)	2,975.8 (116.7)	298.4 (11.7)	357.0 (14.0)	387.6 (15.2)	744.6 (29.2)
2029	15,914.5 (624.1)	3,182.4 (124.8)	318.8 (12.5)	382.5 (15.0)	413.1 (16.2)	795.6 (31.2)
2030	17,003.4 (666.8)	3,401.7 (133.4)	339.1 (13.3)	408.0 (16.0)	441.1 (17.3)	849.1 (33.3)

Notes: GDP projections based on data from IMF (2025).

Allocating 12% of government expenditure to health raises health spending to VND 295.8 trillion (USD 11.6 billion) in 2025 and VND 408 trillion (USD 16.0 billion) in 2030, with cumulative incremental resources of roughly VND 260.1 trillion (USD 10.2 billion) over 2025–2030. At 13%, spending reaches VND 321.3 trillion (USD 12.6 billion) in 2025 and VND 441.2 trillion (USD 17.3 billion) in 2030. These increases are achieved through reallocation within existing revenues, not new fiscal instruments.

The proportional adjustments required are modest. Raising the health share from 10.5% to 12% shifts 1.5 percentage points of the budget (equivalent to 0.30% of GDP), while 13% requires 2.5 points (equivalent to 0.50% of GDP). The increase in allocations would correspondingly reduce the fiscal gap whilst being within normal budgetary reprioritisation observed in the region, achievable without emergency financing or structural adjustment.

Policy Assessment – Increased Budget Allocation to Health

Fiscal Gap Contribution: HIGH – An increase to 12% of government expenditure allocated to health (from the 10% floor) would equate to an additional VND 69 trillion in 2030, equivalent to 0.41% GDP. An increase to 13% would equate to an additional VND 103 trillion or 0.61% GDP in 2030.

Political Feasibility: MODERATE/HIGH - Recent political commitments to increase health spending suggest a favourable policy environment. However, implementation requires sustained prioritisation of health relative to competing public expenditure demands.

Overall Assessment: One of the most important financing mechanisms in the reform package. While requiring strong political commitment, it offers by far the largest potential contribution to expanding fiscal space for health.

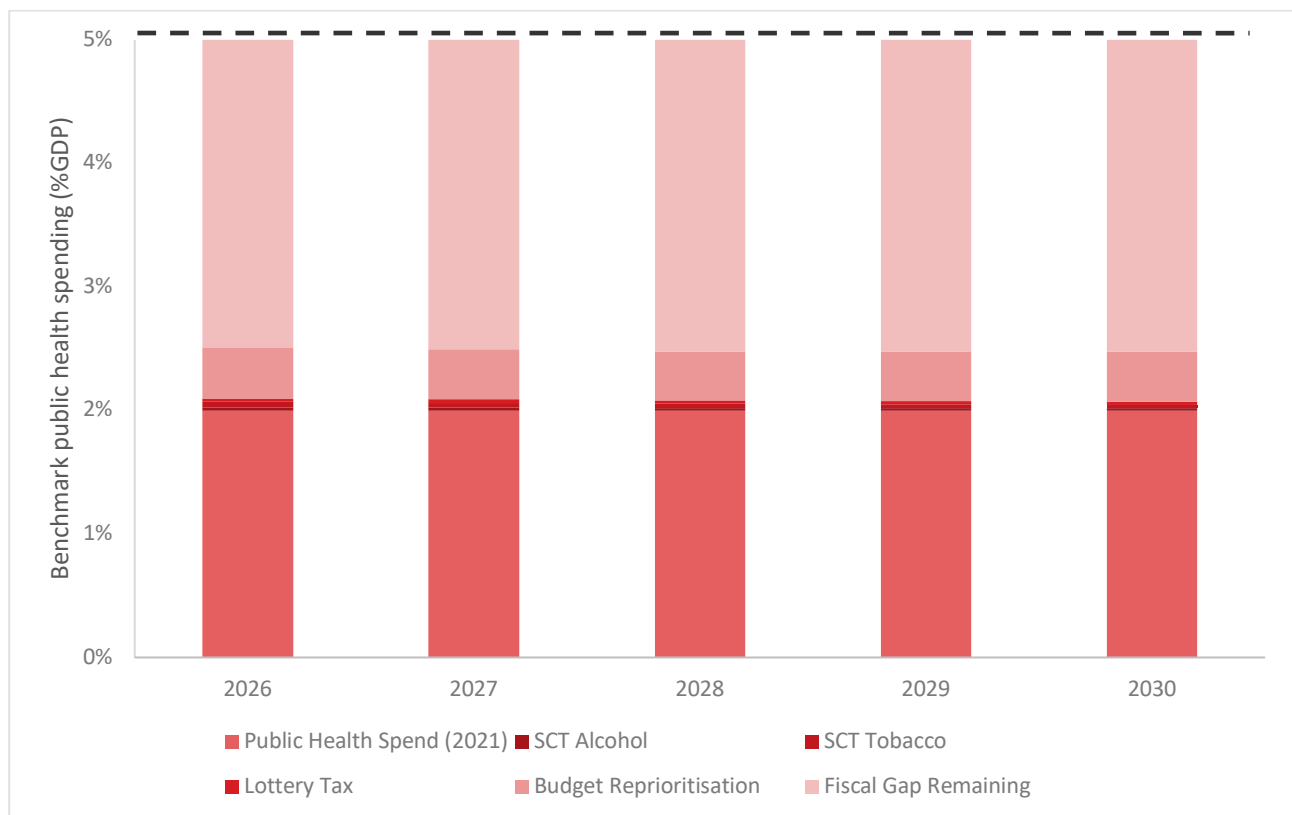
Role in the Roadmap

The supply-side mechanisms discussed here form the core public revenue pillar of the proposed roadmap. They should be adopted in a sequenced manner, according to their scale, feasibility and policy role. Practically, this means using earmarked gains from alcohol and tax reform as an early source of additional funding, exploring lottery revenues as a supplementary and politically visible stream for targeted priorities and progressively increasing the share of government expenditure allocated to health as the main structural driver to reduce the fiscal gap for health over the medium term. Simulations presented here indicate that, with an IMF predicted GDP of VND 17,003 trillion in 2030, the fiscal gap for health could reach VND 510

trillion in 2030, assuming that the domestic general government contribution to health remains at its 2021 level of 2% of GDP. The policy recommendations presented in this analysis could reduce this gap to approximately 2.53% of GDP (Figure 8), representing meaningful progress towards closing the health financing gap, although this would still fall short of the WHO-recommended benchmark of 5% of GDP for public health expenditure (WHO, 2003). This reflects the limitations of the proposed earmarking approach, while more ambitious earmarking of revenues for health could narrow the gap further and move the country closer to this benchmark.

Section 5 sets out how these measures could be phased over time, beginning with near-term revenue mobilisation and moving toward deeper budgetary reform to support Vietnam's health financing goals to 2030.

Figure 8: Public health spending (% GDP) using supply-side options



Notes: Calculations based on available domestic general government spend on healthcare (% GDP) figures in 2021 from the NHA (Ministry of Health, 2024). For the budget reprioritisation scenario, we assume an increase in

government health spending from the 10% baseline to the proposed 12% of total government expenditure. SCT values assuming 85% earmarking of annual increase. Lottery tax revenue assumes 2% earmarking.

4.3 Demand-Side Contributions

Here we examine mechanisms that increase pooled or complementary financing from households and employers, including higher social health insurance premiums, MSAs, and supplementary health insurance.

Social Health Insurance Contribution Reform

As mentioned previously, in 2025 an impressive 97.65 million people were covered by the SHI system – equivalent to 95.16% of the population. In 2026, the spend on medical examination and treatment from the health insurance fund was allocated as VND 166 trillion (Representative of VSS, 2026), with contribution rates of 4.5%.

While the Politburo has formally mandated universal hospital fee exemption and comprehensive health-financing reform under Resolution 72-NQ/TW (2025), it has not stipulated specific health insurance contribution rates. Subsequent National Assembly resolutions and Government roadmaps explicitly envisage contribution increases from 2027 onward to sustain expanded benefits, with exact rates to be determined through implementing legislation. It is likely that the contribution rate will be increased from 4.5% to 5.1% in 2027. By 2030, contribution rates are expected to rise to 5.4% before reaching 6% in 2033 (The Government of Vietnam, 2026). Such reforms are considered essential to offset rising healthcare costs associated with population ageing, increasing reliance on imported medical equipment and pharmaceuticals, and expanding preventive service coverage. Projected revenue, assuming contribution rates increase as predicted could reach VND 192 trillion in 2030 (Table 8). This assumes no wage growth or coverage expansion and ignores any potential demographic shifts which may affect revenue. It is therefore likely to be an underestimate.

World Bank data from 2025 suggest that over half of employed people in Vietnam are classed as self-employed (53%), higher than the Philippines (36%), Singapore (12%), Malaysia (25%)

and the Republic of Korea (22%) (World Bank, 2025b). This high proportion of self-employed workers can limit the revenue-raising capacity of the SHI system as contributions cannot be reliably collected through payroll. Although it is worth pointing out again that Vietnam already has impressive levels of SHI coverage, despite the high level of self-employed people. Despite this, it is likely that SHI alone should not serve as the primary vehicle for expanding health spending. Rather, it should be part of a wider package of mechanisms – including alternative revenue sources and other budgetary transfers – aimed at increasing fiscal space for health.

Table 8: The Value of Increasing SHI Contribution Rates

	SHI rate	SHI revenue VND Trillion (USD Billion)	Gain from 2025 Base VND Trillion (USD Billion)
2025	4.5%	160 (6.27)	–
2026	4.5%	160 (6.27)	0
2027	5.1%	181.3 (7.11)	21.3 (0.84)
2028	5.1%	181.3 (7.11)	21.3 (0.84)
2029	5.1%	181.3 (7.11)	21.3 (0.84)
2030	5.4%	192 (7.53)	32 (1.25)
Total	-	1077.3 (42.25)	-

Notes: These conservative figures exclude wage growth, coverage expansion and demographic shifts which may affect revenue. 2025 SHI revenue figure based on data from Government of Vietnam, (2025) and again, assumes no wage growth, coverage expansion and demographic shifts which may have affected revenue between 2022-2025.

Policy Assessment – Increased SHI Contribution Rates

Fiscal Gap Contribution: MODERATE - Could generate approximately VND 32 trillion more annually by 2030 (around 0.19% of GDP) versus 2025, making a meaningful but modest contribution to expanding fiscal space.

Political Feasibility: MODERATE - Vietnam's high SHI coverage provides a strong foundation for contribution increases. However, raising contribution rates may face resistance from households and employers and is complicated by the large self-employed and informal workforce.

Overall Assessment: An important medium-term financing mechanism, but one that is best implemented alongside broader health financing reforms rather than relied upon as the primary source of additional funding.

Supplementary Health Insurance

The introduction of Supplementary Health Insurance (HI) has emerged as an element of recent policy proposals by the MoH, aimed at offering more diverse healthcare options beyond the basic state-managed benefit package. Within Vietnam's SHI system, supplementary HI is envisaged as a complementary layer to public coverage rather than an alternative to it.

The literature distinguishes three principal forms of voluntary health insurance: supplementary, complementary, and substitutive. Supplementary insurance provides additional choice or faster access for publicly covered services; complementary insurance covers cost-sharing or gaps in the public benefit package; and substitutive insurance replaces access to public coverage for defined groups. In health systems pursuing UHC, substitutive models are relatively uncommon and frequently discouraged due to risks of risk-pool fragmentation and reduced equity (Stabile and Townsend, 2014).

In this context, supplementary HI may play a supporting role for achieving UHC in Vietnam. By covering selected services or co-payments, it has the potential to improve access for

certain population groups, enhance perceived service quality, and alleviate out-of-pocket expenditure at the margin (Askarzade et al., 2024). Evidence from countries that have achieved high levels of UHC, such as France, Japan, and Thailand, suggests that a strong mandatory public or social insurance system has typically formed the foundation, with supplementary HI serving a complementary role in filling coverage gaps and mobilising additional resources. On the other hand, experience in China, indicates that rapid expansion of supplementary insurance in the presence of gaps in public coverage can exacerbate inequities unless tightly regulated (Wu et al., 2020).

Recent policy discussions in Vietnam reflect this cautious positioning. During 2024 and 2025, draft proposals have focused on supplementary HI packages that would primarily cover SHI co-payments, typically in the range of 5% to 20% of service costs, as well as selected high-demand services not currently reimbursed by the state (VietnamNews, 2024). These proposals emphasise complementarity with mandatory SHI and seek to preserve the principle of universal coverage while allowing individuals with greater ability to pay to access convenience-enhancing services.

From a policy perspective, supplementary HI could mobilise additional private resources within the health system and potentially reduce pressure on public financing for specific services, enabling public funds to be more tightly targeted toward vulnerable groups such as the elderly and the near-poor (Nguyen et al., 2023). Proposals to allow employer-paid premiums to receive favourable tax treatment further frame supplementary HI as an employment-linked benefit rather than a substitute for public coverage, aligning with the broader national objective of achieving universal health coverage by 2030 (VietnamLaw, 2026).

Nevertheless, supplementary HI also entails important risks and limitations. If poorly designed or regulated, it may contribute to a two-tier system, exacerbate inequalities in access, and incentivise providers to prioritise privately insured patients. Evidence from other countries highlights risks of adverse selection, moral hazard, and weakened competition within basic insurance schemes (Balqis-Ali et al., 2023). There is also evidence that supplementary insurance coverage may reduce consumer willingness to switch between basic insurance providers, potentially limiting competitive pressures and system responsiveness (Lamiraud, 2014).

For these reasons, the feasibility of supplementary HI in Vietnam depends critically on robust regulation, affordability safeguards, transparent benefit design, and clear subordination to SHI. International experience suggests that private and voluntary financing mechanisms can contribute positively to UHC objectives only when embedded within, and secondary to, a strong public financing and social insurance strategy, rather than when relied upon as a primary source of system financing.

Policy Assessment – Supplementary Health Insurance

Fiscal Gap Contribution: LOW - Could mobilise additional private resources and reduce pressure on public financing for selected services but is unlikely to make a substantial contribution to closing the overall health financing gap.

Political Feasibility: MODERATE/HIGH - Recent policy proposals suggest growing government support, although strong regulation would be required to prevent inequities and ensure supplementary coverage remains secondary to SHI.

Overall Assessment: A useful complementary financing mechanism that can improve access and choice, but not a major source of fiscal space expansion.

Medical Savings Accounts

MSAs are personalised accounts funded through either compulsory or voluntary contributions, specifically designated for medical expenses. In the Vietnamese context, MSAs are not proposed as a substitute for SHI but rather as a complementary mechanism, one designed to supplement public health financing by mobilising private savings, particularly among the informal sector which often struggles to maintain consistent insurance coverage despite government subsidies (Do et al., 2014). By addressing persistently high OOP healthcare expenditure, currently exceeding 40%, MSAs may incentivise personal responsibility and cost-effectiveness.

With this complementary role in mind, the international evidence on MSA performance warrants careful examination. By promoting personal accountability in place of third-party

insurance, MSAs enhance price awareness among users and help to mitigate moral hazard (Lim, 2017; von Eiff et al., 2002). Through this mechanism, individuals can manage the financial risks associated with illness over their lifetime, accumulating savings during their healthy, productive years to offset higher medical costs typically encountered in old age (Hsu, 2010). Internationally, MSAs have been adopted with varying degrees of success, functioning as either public mandates or private incentives. State-led models, such as Singapore's Medisave and China's public accounts, aim for universal coverage, whereas market-driven approaches like Health Savings Accounts (HSAs) in the USA and private options in South Africa focus on individual management of healthcare costs.

In Singapore, Medisave has been credited with helping to contain Singapore's national healthcare expenditure, which stood at approximately 2.6% of GDP in 1999, among the lowest of any high-income country, by shifting the focus from third-party insurance to individual responsibility, thereby discouraging moral hazard (von Eiff et al., 2002), whereby patients might over-utilise services simply because they are insured (Lim, 2017). However, a 2025 study reported a 13% rise in expenditures associated with MSA usage, challenging the assumption that MSAs necessarily reduce moral hazard and raising significant doubts about their effectiveness as a cost-containment mechanism (Sun, 2025).

In China, MSAs shifted healthcare utilization from high-cost inpatient and emergency settings toward outpatient services, they failed to curb the upward trajectory of overall healthcare utilization and expenditure per insured patient. These findings suggest that MSAs may exert stronger income effect whereby available funds encourage greater consumption, than the intended substitution effect aimed at incentivizing cost-conscious behaviour. Research from 2025 found MSAs effective at covering routine, lower-cost medical expenses and encouraging preventive check-ups, but with limited impact on high-cost, catastrophic medical expenses (Yang et al., 2025).

In the United States, Health Savings Accounts (HSAs) reduced spending on discretionary services like pharmacy and outpatient visits by approximately 5% to 9%, but they often failed to reduce total aggregate expenditures because savings in one area are frequently offset by higher costs in others, such as inpatient care for those with multiple chronic conditions (Lo Sasso et al., 2010). Furthermore, HSAs disproportionately benefit higher-income populations, with account holders skewed toward upper-income groups who are better positioned to

utilise the triple-tax advantage as a long-term wealth-building mechanism (Ding and Glied, 2024).

Based on the evidence above, MSAs could play a limited but complementary role in increasing fiscal space for health in Vietnam. Their primary contribution would lie in mobilising additional private resources and potentially reducing OOP expenditure for routine care, particularly among populations not fully covered by SHI, such as the informal-sector workers. However, their effectiveness as a fiscal space instrument is constrained by several context-specific factors in Vietnam.

Firstly, limited saving capacity among large segments of the population may restrict the ability of MSAs to generate meaningful financial protection. Vietnam has a sizeable informal sector, with workers experiencing irregular and often low incomes, reducing their ability to make consistent contributions to individual savings accounts. This undermines the accumulation function that is central to the MSA model. Secondly, existing high OOP expenditures reflect immediate financial pressures rather than inadequate saving mechanisms. Households often prioritise short-term consumption needs over long-term savings, particularly in lower-income groups. As a result, MSAs may have limited uptake or may simply reallocate, rather than increase, private health spending. Thirdly, equity concerns are particularly salient in the Vietnamese context. As observed in other countries, MSAs tend to disproportionately benefit higher-income groups with greater capacity to save. In Vietnam, this could exacerbate existing disparities in healthcare access and financial protection, particularly between formal and informal sector workers and between urban and rural populations (Wouters et al., 2016).

Overall, MSAs may be best considered as a supplementary policy option rather than a central pillar of health financing reform in Vietnam. While they could contribute modestly to increasing private financing for health and improving cost awareness for routine care, they are unlikely to generate substantial fiscal space or improve financial protection at scale.

Policy Assessment – Medical Savings Accounts

Fiscal Gap Contribution: LOW - May increase private financing for routine healthcare and improve cost awareness but unlikely to generate substantial fiscal space or significantly reduce high-cost healthcare expenditure.

Political Feasibility: LOW/MODERATE - Implementation may be challenging given Vietnam's large informal sector, limited household saving capacity, and concerns regarding equity and financial protection.

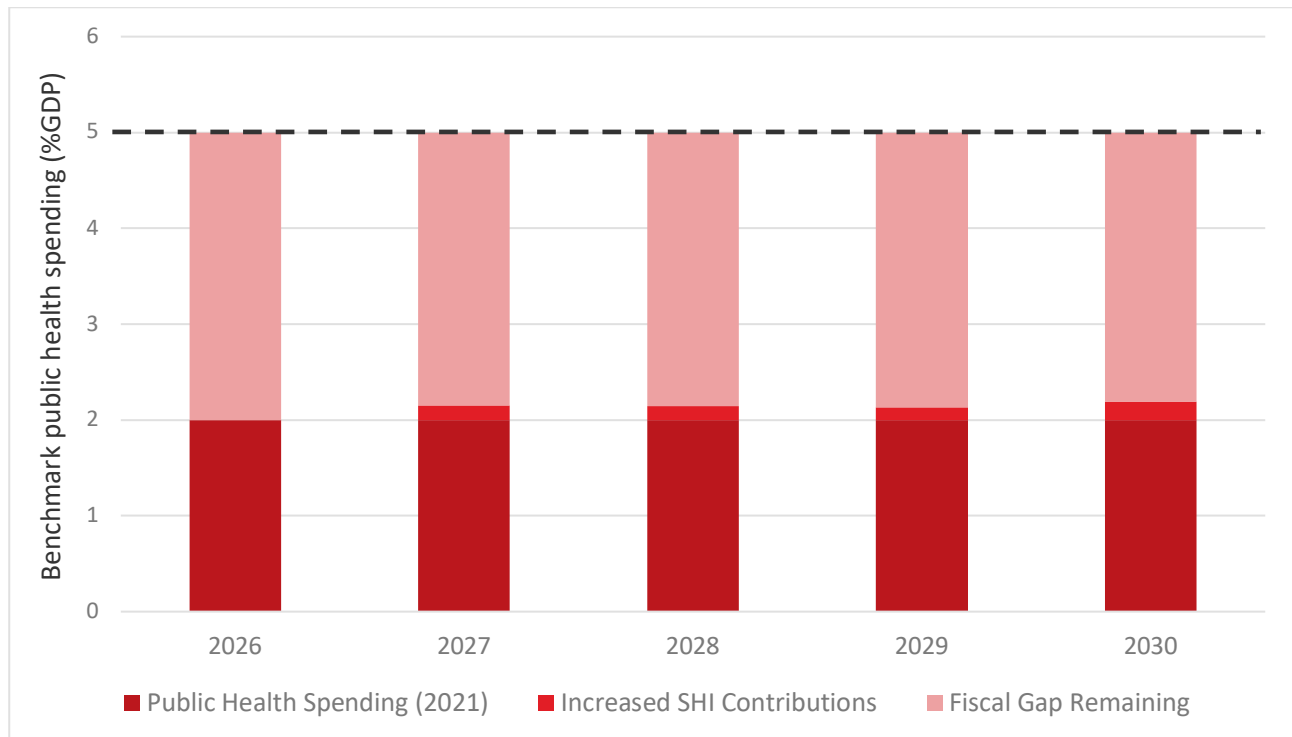
Overall Assessment: Best viewed as a supplementary financing tool with limited system-wide impact rather than a core component of health financing reform.

Role in the Roadmap

Figure 9 highlights the potential impact on the fiscal gap of increasing SHI contribution rates between 2026 and 2030 (compared with 2025 base rates), clearly showing that relying primarily on increased SHI rates will not substantially reduce the fiscal gap. We therefore suggest that the demand-side mechanisms discussed here are incorporated into the roadmap as secondary and carefully sequenced tools that complement, rather than drive, fiscal space expansion. In practice, this means using SHI contribution reform as a medium-term measure to strengthen pooled financing once early public revenue gains have been secured, while recognising that its revenue potential is constrained by Vietnam's large self-employed and informal workforce. Supplementary health insurance may play a limited supporting role in improving access and reducing co-payments for some groups, provided it remains tightly regulated and clearly subordinate to SHI, whereas MSAs should be approached cautiously and, if considered at all, treated as a targeted or exploratory mechanism rather than a central financing pillar. It is important to note that the three scenarios considered here should be interpreted as alternative policy pathways rather than additive options. As they reflect different levels of health budget allocation, they are mutually exclusive and cannot be implemented simultaneously.

Section 5 builds on the logic outlined here by showing how demand-side contributions can be phased into the broader roadmap to support sustainability and access, without displacing the primacy of stronger public financing.

Figure 9: Public health spending (% GDP) following SHI contribution rate increase



Notes: Calculations based on available domestic general government spend on healthcare (% GDP) figures in 2021 from the NHA (Ministry of Health, 2024). Value of the increased SHI contributions are based on increased revenue per year compared to 2025 benchmark of VND 160 trillion (Government of Vietnam, 2025). Calculations assume no wage growth, coverage expansion or demographic shifts which may affect revenue.

4.4 Efficiency-Support Mechanisms

Managed Entry Agreements

Although this analysis does not focus primarily on access to innovative medicines, Vietnam's current access landscape is highly relevant to assessing the potential role of Managed Entry Agreements (MEAs) in healthcare financing. Vietnam currently appears to have more limited

access to innovative, high-technology medical products than several comparator countries in South-East Asia. Innovative pharmaceuticals represent only around 20% by value and approximately 11% by volume of the prescription market, and the relatively slow access pathway means that at least 80% of products classified as “innovative” are already off-patent by the time they become available (IQVIA, 2022).

According to EuroCham Vietnam, it can take four to five years for new medicines approved in major reference markets to become available in Vietnam, while updates to the National Reimbursement Drug List (NRDL) occur only every three to four years, contributing to substantial delays in patient access. In practice, the infrequent updating of the NRDL can extend the period from initial submission to broad social health insurance coverage to six to eight years (American Chamber of Commerce in Vietnam HCMC, 2024; EuroCham, 2023). During this period, limited public reimbursement increases reliance on OOP payment for medicines, contributing to inequalities in access across the country. This challenge is particularly acute for high-cost therapies, including treatments for cancer and rare diseases.

Of the 460 innovative molecules registered globally between 2012 and 2021, only 9% were registered in Vietnam by 2022. For some, there is no on-market alternative in the country, meaning that patients miss out on effective treatment for acute and chronic disease (American Chamber of Commerce in Vietnam HCMC, 2024). Insufficient access to treatment is also one of the factors associated with patients seeking care abroad. In 2014, Vietnamese citizens spent VND 51 trillion, equivalent to approximately USD 2 billion, in healthcare facilities abroad, mainly in Singapore and Thailand, in addition to the VND 124.95 trillion, equivalent to approximately USD 4.9 billion, spent out of pocket in Vietnam (IQVIA, 2022).

These access delays occur against a backdrop of growing pressure on healthcare budgets and ongoing efforts to strengthen health technology assessment (HTA). While HTA principles increasingly inform reimbursement decisions, implementation remains constrained by limited availability of local data, technical capacity, and financial resources. As a result, uncertainty surrounding clinical effectiveness, cost-effectiveness, eligible population size, and budget impact is often managed through delayed or restrictive access rather than through structured mechanisms to share financial and evidence-related risk between payers and manufacturers. At present, Vietnam lacks a formal framework for MEAs or risk-sharing arrangements (RSAs), and alternative health financing mechanisms remain largely absent.

MEAs are formal arrangements between payers and manufacturers that allow access to selected health technologies under defined financial, clinical, or evidence-generation conditions. They are described in the literature using different terms, including MEAs, Patient Access Schemes, Performance-Based Agreements, and risk-sharing arrangements. In this report, MEA is used as an umbrella term to capture both financial-based arrangements, such as confidential discounts, rebates, price-volume agreements, expenditure caps, and dose or utilisation caps, and performance-based arrangements, where payment or continued coverage is linked to observed outcomes or additional evidence collection (Ferrario and Kanavos, 2013). MEAs should therefore be understood as targeted instruments for managing specific reimbursement uncertainties, rather than as a substitute for HTA or as a general solution to access constraints. Their relevance is greatest where a medicine has potential clinical value, but uncertainty remains around long-term effectiveness, cost-effectiveness, eligible population size, uptake, or budget impact.

The feasibility of MEAs will depend on the complexity of the agreement and the systems required to administer it. Simpler financial-based MEAs may be more feasible in the near term, particularly where they rely on confidential discounts, rebates, price-volume agreements, expenditure caps, or manufacturer-funded treatment initiation schemes. These approaches can support price negotiation and budget predictability without requiring complex patient-level outcome tracking. By contrast, performance-based agreements, coverage with evidence development, and outcome-linked reimbursement models would require stronger HTA processes, clearly defined clinical endpoints, reliable patient registries, routine data collection, legal and contracting capacity, and mechanisms for monitoring and enforcing agreement terms (Ferrario and Kanavos, 2013). In this context, simpler financial-based MEAs may be more feasible in the short term, while outcome-based agreements should be approached as medium- to longer-term options that depend on further institutional and technical capacity-building.

International experience suggests that MEAs and RSAs can support access to high-cost medicines while protecting budget sustainability. In South Korea, RSAs have been used as a non-conventional reimbursement framework for high-cost medicines, particularly where no therapeutic alternatives exist. A peer-reviewed evaluation based on a government and Health Insurance Review and Assessment Service (HIRA) scenario analysis found that, for an initial

set of 11 RSA-covered medicines, patient OOP spending was reduced by approximately KRW 130 billion per year (around USD 150.7 million in PPP terms, 2016) (Lee et al., 2021). Additional analysis suggests that refund-type RSAs, typically set at 30-50 percent, could generate KRW 78-130 billion annually in paybacks. Importantly, despite their visibility, RSA medicines accounted for only a small share of total pharmaceutical expenditure (around 1.6 percent in 2017), indicating that such arrangements can mitigate financial risk without posing a major threat to overall system sustainability (Mundy et al., 2019).

Experiences from health systems facing more comparable financing and implementation constraints may be particularly relevant for Vietnam. Malaysia has introduced formal guidelines for Patient Access Schemes, explicitly outlining both financial-based and performance-based arrangements for medicines with high budget impact (Ministry of Health, 2018). In Thailand, analytical work in the literature has proposed a framework for applying confidential discounts and risk-sharing mechanisms, although net savings are typically not publicly reported (Butani et al., 2023).

Downstream ‘savings’ because of MEAs may be realised by allowing treatments to enter the market earlier, before full evidence on real-world effectiveness is available, ensuring patients benefit sooner. Timely treatment may slow disease progression, prevent costly complications, and reduce the need for expensive hospital care or long-term interventions. However, calculating these is beyond the scope of this report.

The literature suggests that the principal value of MEAs lies in their ability to facilitate access to medicines under conditions of uncertainty. Their main advantages include enabling earlier or broader access to selected high-cost therapies, allowing reimbursement decisions to proceed despite uncertainty, and, in some cases, linking coverage to additional evidence generation, treatment response, or more targeted patient use (Castro et al., 2019; Ferrario and Kanavos, 2015; Wenzl and Chapman, 2019). MEAs may also reduce OOP expenditure for patients where they allow otherwise unaffordable medicines to become covered (Lee et al., 2021). However, the literature also highlights important disadvantages. MEAs can be administratively burdensome, particularly when they require outcome monitoring, patient registries, or complex contractual arrangements; they may reduce transparency where discounts and agreement terms remain confidential; and they should not be assumed to be a cost-saving policy tool. Available evidence suggests that their overall impact on expenditure

control is often modest and uncertain, while in some cases they may increase covered pharmaceutical spending by enabling the reimbursement of medicines that would otherwise not have been funded (Trotta et al., 2023).

Policy Assessment – Managed Entry Agreements (MEA)

Cost Containment Potential: MODERATE - Can facilitate access to innovative medicines while reducing financial risk to payers through mechanisms such as price-volume agreements, outcome-based contracts, confidential discounts, and expenditure caps. They are particularly valuable for high-cost therapies, including oncology treatments, biologics, and medicines for rare diseases, where uncertainty regarding budget impact and long-term affordability is often greatest.

Political Feasibility: MODERATE - Used increasingly globally as a mechanism for improving access to innovative medicines while managing budget impact, making them broadly aligned with Vietnam's objective of expanding access to new health technologies. However, successful implementation would require further strengthening of HTA capacity, data and monitoring systems, and negotiation expertise within government agencies to support the design, implementation, and evaluation of these agreements.

Overall Assessment: MEAs are unlikely to generate substantial new revenue but can significantly improve affordability and budget predictability, making them an important tool for managing pharmaceutical expenditure growth.

Patient Assistance Programmes

Pharmaceuticals accounted for around 29% of expenditure (by factor of provision) in 2021 (Ministry of Health, 2024). In 2016, 83% of pharmaceutical spend was in the private sector – both via the retail pharmacy sector but also the result of patient's OOP spend on medicines

that are either not available at public facilities or as part of treatment costs not covered by public funds, or for off-formulary medicines prescribed by doctors (World Bank, 2019a). High treatment costs and limited access to advanced therapies have negatively impacted patient access to effective treatment. Patient Support Programmes (PSP) and Patient Assistance Programmes (PAP), including financial assistance programmes, help to bridge these gaps by making costly cancer treatments more affordable to the patients receiving them with the input of the pharmaceutical companies developing them.

Specifically, PAP can improve medication access for vulnerable patients, acting as a critical safety net for both uninsured and underinsured patients providing medication to those who would otherwise go without treatment. PAP and PSP have also been shown to increase adherence to medication (Brixner et al., 2019; Ganguli et al., 2016), reducing the risk of disease progression and acute complications and other costly downstream events. There is also evidence that PAP can help health systems save money with one analysis suggesting a PAP programme utilised in America helped a hospital save 1-11% of their drug spend (McKesson Health Systems Editorial Team, 2024).

One of the first PAPs to be launched in Vietnam focused on supporting patients with chronic myeloid leukemia (CML) and gastrointestinal stromal tumours (GIST) who had had health insurance for less than 36 months by giving them access to Glivec (imatinib) free of charge. Globally, this programme, which was co-ordinated by the Max Foundation and supported by Novartis, has supported patients in 80 low- and middle-income countries since 2002. The Vietnam Patient Assistance Program (VPAP) was implemented between 2005 and 2019 in seven hospitals, allowing patients with CML or GIST to access Glivec or Tasigna (nilotinib) free of charge. Health insurance funds were responsible for 40% of the medicine costs while Novartis supported the remaining 60%. Between 2010 and 2018, 8000 patients with CML and GIST benefited from the programme.

Similar programmes have since been developed to benefit patients. For example, in its first year of implementation, the PAP managed by Bright Future Fund (BFF) and sponsored by Bayer SEA, supported 258 patients with hepatocellular carcinoma and 13 patients with renal cell carcinoma across 19 hospitals and medical centres (Eurocham, 2017). In 2022 the Ministry of Health officially approved a Takeda-supported PAP, for Brentuximab (vedotin) in the treatment of lymphoma (Vietnam News, 2023) and the Ministry of Health has additionally

approved eight drugs for coverage with a PAP in a few select hospitals in Vietnam. These drugs include Tagrisso (osimertinib), Imfinzi (durvalumab), Lynparza (olaparib), Perjeta (pertuzumab), Keytruda (pembrolizumab), Ofev (nintedanib), Tecentriq (atezolizumab) and Calquence (acalabrutinib) (FV Hospital, 2023).

The impact of PAP in Vietnam has increased steadily over the past 15 years. By 2024, the 19 active PAPs operating nationally had supported a total of 10,652 patients, with a cumulative programme value of approximately VND 2.83 trillion (USD 111 million) (Health Insurance Department, Ministry of Health, 2025). As Vietnam faces a rising burden of non-communicable diseases and growing demand for specialised and innovative medicines, the role of PAP is expected to expand further.

Based on observed historical growth, PAP expenditure is projected to increase at a compound annual growth rate (CAGR) of 11.45%, reaching an estimated value of approximately VND 0.5 trillion (USD 19.69 million) by 2030 (Research and Markets, 2025). This projected growth highlights the increasing importance of PAP as a mechanism to support patient access to high-cost medicines during periods of health system transition.

From a policy perspective, PAP can be considered a complementary instrument that helps bridge access gaps while broader reforms to health financing, insurance coverage, and procurement are implemented. As need-based projections indicate rising demand for advanced therapies, careful planning will be required to ensure PAPs are aligned with national priorities, targeted effectively at vulnerable patient populations, and coordinated with ongoing efforts to strengthen universal health coverage and sustainable medicines financing.

One important point to consider is potential changes as a result of the recent Circular 16/2026/TT-BYT (the 'New PAP Circular'), which took effect on the 10th of July 2026 and introduced several significant changes compared to the existing legal framework - Circular No. 31/2018/TT-BYT. The concept of PAP, previously implemented by industry and outlined above, will no longer be possible. As a result, alternative PSP mechanisms (including financial and non-financial) will need to be introduced.

Policy Assessment – Patient Assistance Programmes (PAP)

Cost Containment Potential: MODERATE - Can reduce both patient and payer expenditure by providing manufacturer-supported access to medicines, helping to lower treatment costs and improve affordability. By reducing the financial burden associated with high-cost therapies, PAPs can enhance access to essential treatments while limiting the impact on government budgets and social health insurance resources, particularly in areas where unmet clinical need remains high.

Political Feasibility: HIGH - Already an established mechanism in Vietnam, with experience gained through a range of existing manufacturer-supported access initiatives. Can often be implemented relatively quickly and with limited legislative or regulatory change, making them a politically feasible option for improving access to medicines in the near term. However, future implementation will likely be affected by new Circular 16/2026/TT-BYT.

Overall Assessment: PAPs provide a practical mechanism for improving affordability and patient access, although their contribution is generally limited to specific products or disease areas rather than system-wide expenditure management.

Role in the Roadmap

The efficiency-support mechanisms discussed in Section 4.4 should be incorporated into the roadmap as complementary tools that improve affordability, access, and value for money rather than as primary sources of fiscal space. In practice, this means treating MEAs as a medium- to longer-term mechanism for managing uncertainty around high-cost medicines, supporting earlier or broader access while containing budget risk, and using PAPs as targeted transitional instruments to reduce patient financial barriers where public coverage remains incomplete. Their role in the roadmap is therefore to strengthen the effectiveness of new and existing health spending, particularly in relation to innovative therapies, rather than to replace the need for higher pooled public financing. Section 5 builds on this logic by positioning these

mechanisms within the later phases of reform, where they can support sustainability and equitable access alongside stronger public funding and insurance-based coverage.

5 Roadmap to 2030

Vietnam's current fiscal and policy environment creates a strong case for treating health expenditure not simply as recurrent social spending, but as a form of strategic public investment. Resolution 20 and Resolution 72 together commit the country to a prevention-centred health system built on expanded screening, immunisation, digital integration, stronger commune-level care, and reduced OOP spending. Delivering these reforms will require sustained investment in physical, digital, and institutional health infrastructure, but these should be understood as investments in human capital, labour productivity, social protection, and long-term economic resilience rather than as narrow sectoral costs.

This framing is important because it helps clarify how fiscal space reforms should be sequenced. Vietnam is relatively well placed to increase investment in health, given its favourable fiscal position, continued economic growth, and the high-level political commitment now attached to health reform. The most practical route to 2030 is therefore not a single financing instrument, but a phased approach that combines early revenue mobilisation with deeper structural reform over time. In the near term, earmarked gains from alcohol and tobacco taxation, alongside possible lottery earmarks, can help finance visible priority commitments. Over the medium term, larger and more durable gains will need to come from increasing the share of government expenditure allocated to health, supported by cautious expansion of SHI contributions. Complementary tools such as MEAs and PAPs can then help improve affordability, access, and value for money as the financing base strengthens. In parallel, consideration could be given to establishing a dedicated rare disease and orphan medicines fund under the Vietnam Fatherland Front. Drawing on a model previously utilised in Vietnam to mobilise resources during the COVID-19 pandemic, such a fund could receive voluntary contributions from private sector partners and other donors to support access to high-cost orphan therapies. While not a major source of fiscal space, this mechanism could provide a practical and targeted approach to improving access for patients with rare diseases while broader health financing reforms are being implemented.

Figure 10 summarises the proposed sequencing of fiscal space reforms across three phases to 2030, linking each phase to a distinct strategic objective, the main financing levers, and the indicative scale of resources that could be mobilised based on the analysis in Section 4. In the first phase (2026–2027), the emphasis is on generating early and visible fiscal gains through measures that are politically and operationally feasible in the near term. These include earmarking incremental revenues from higher alcohol and tobacco taxes, alongside possible lottery earmarks, to finance prevention, grassroots health services, and additional support for vulnerable groups. This phase is intended to create momentum, demonstrate tangible progress, and begin reducing financial barriers without relying immediately on more complex structural reforms.

The second and third phases shift toward deeper and more sustained expansion of pooled public financing. In Phase 2 (2028–2029), the roadmap centres on increasing the share of government expenditure allocated to health and gradually strengthening SHI contributions, thereby moving from supplementary revenue mobilisation to more structural reform of the health financing base. By Phase 3 (2030), the aim is to consolidate these gains into a more stable and equitable financing architecture capable of supporting universal basic hospital fee exemption and wider UHC commitments. At this stage, higher public budget allocations remain the core source of fiscal space, while earmarked revenues, SHI reform, and supporting mechanisms such as MEAs and PAPs play complementary roles in improving affordability, access, and long-term sustainability.

While the proposed reforms are expected to make a substantial contribution towards increasing public health expenditure and reducing the fiscal gap, they do not fully achieve the 5% GDP benchmark by 2030. The roadmap should therefore be viewed as a phased progression towards a longer-term financing objective. By 2030, the more immediate achievement is likely to be improved financial protection and progress towards reducing out-of-pocket spending below 30%, alongside a strengthened foundation for continued expansion of public health financing thereafter.

An important consideration when assessing options to increase health expenditure, particularly public investment in health, is that such spending should not be viewed solely as a fiscal cost. Investments in health yield both consumption and investment benefits. On one hand, good health directly enhances quality of life. On the other, it improves productivity and

earning capacity, thereby contributing to economic growth. This duality makes health a unique form of capital that influences both individual welfare and societal outcomes.

Although estimating the return on investment (ROI) of increased public health expenditure in Vietnam is beyond the scope of this study, evidence from other settings highlights the broader economic value of health investment. For example, reviews of public health interventions find that the median return is approximately \$14 for every \$1 invested (Masters et al., 2017). Similarly, broader analyses of public health programmes show that each dollar spent can generate roughly \$14 in combined medical savings and economic benefits (Wenderoff, 2025). Large-scale investments in health systems also produce substantial returns. The World Health Organization estimates that every \$1 invested in UHC can generate up to \$9 in economic and social returns and broader investment in global health institutions may yield returns as high as \$35 per \$1 invested when long-term benefits are included (WHO, 2022).

More broadly, investment in health is increasingly recognised as an investment in economic and social development and this is stated clearly in Resolution 72: *'Health is the most valuable asset of every person, the most important foundation for the happiness of all, for the survival of the nation, and for the prosperous and sustainable development of the country. Protecting, caring for, and improving the People's Health is a goal, a driving force, a top political task, holding priority status in development strategies and policies; it is the responsibility of the entire political system, the whole society, and every citizen'* (The Communist Party of Vietnam, 2025).

It is well known that higher levels of public health expenditure can improve population health outcomes, increase workforce productivity, reduce out-of-pocket spending and the incidence of catastrophic health expenditure, and strengthen human capital. These benefits extend beyond the health sector, contributing to greater economic resilience, labour market participation, and long-term economic growth. As such, efforts to increase public investment in health should be considered not only in terms of their budgetary implications, but also in terms of the wider economic and societal returns they can generate.

Figure 10: Roadmap to Enhancing Fiscal Space for Health



Key recommendations

Taken together, the simulations used here suggest that no single intervention is sufficient to close the gap between current and desired levels of public health spending. Rather, the most credible pathway to reduce the fiscal gap and increase fiscal space combines increased government budget allocations as the primary financing lever, supported by SHI contribution reforms, earmarked consumption taxes, and targeted complementary financing and efficiency-enhancing measures. Specific recommendations include:

- **Prioritise increased government budget allocation to health** as the main driver of fiscal space, with a medium-term target of moving toward 12% of government expenditure by 2028. *Contribution to Fiscal Gap (2030) = 0.41%*
- **Use earmarked tobacco and alcohol tax revenues as a complementary financing source**, focusing first on prevention, grassroots care, and financial protection for vulnerable groups. These revenues can make a meaningful contribution to closing the fiscal gap while supporting broader public health objectives. *Contribution to Fiscal Gap (2030) = 0.04%*
- **Deploy lottery earmarking only as a supplementary funding mechanism**, ideally through provincial budget allocations linked to clearly defined health priorities. While politically feasible, its contribution to narrowing the fiscal gap is likely to be modest. *Contribution to Fiscal Gap (2030) = 0.03% (2% earmark); 0.07% (5% earmark)*
- **Implement SHI contribution increases gradually and cautiously**, recognising the constraints imposed by high levels of self-employment and informal work. SHI reforms can provide an important secondary source of financing but are unlikely to generate sufficient resources to close the fiscal gap independently. *Contribution to Fiscal Gap (2030) = 0.19%*
- Treat MEAs, PAPs, MSAs and supplementary health insurance as **supporting tools to improve affordability and access**, not as substitutes for stronger pooled public financing.

6 Conclusion

Vietnam enters the next phase of health system reform from a position of both achievement and strain. The country has delivered strong health outcomes relative to its income level, expanded social health insurance coverage to near-universal levels, and demonstrated a long-standing commitment to UHC. Yet the analysis in this report shows that the current financing model is not sufficient to meet the ambitions now embedded in Resolution 20 and Resolution

72. High OOP spending, low government expenditure on health relative to need, the growing burden of NCD, and the transition toward a prevention-centred system together create a substantial fiscal challenge that cannot be addressed through incremental adjustment alone.

The report finds that the most credible route to expanding fiscal space for health lies in a combination of stronger government budget allocation and carefully sequenced complementary measures. Among the options assessed, increasing the share of government expenditure allocated to health offers the greatest scale and the clearest alignment with Vietnam's policy commitments. Earmarked gains from higher alcohol and tobacco taxes could provide an important early source of additional funding while also supporting prevention objectives, and lottery revenues may offer a useful supplementary stream if channelled through clear budgetary arrangements. By contrast, reforms to social health insurance contribution rates can contribute additional pooled financing but should be approached cautiously given the country's large self-employed and informal workforce. Instruments such as supplementary insurance, MSAs, MEAs, and PAPs may play supporting roles, particularly in improving affordability and access, but they are not substitutes for stronger public financing.

Taken together, the evidence supports a phased roadmap to 2030 in which Vietnam first secures early fiscal gains, then scales structural reform, and finally consolidates a more equitable and sustainable financing mix capable of underpinning universal basic hospital coverage. The central policy message is therefore not simply that more money is needed, but that the right sequencing of financing reforms matters. If Vietnam uses the current window of political commitment and fiscal headroom to increase pooled public investment in health, while aligning new revenues with prevention, primary care, and financial protection, it will be far better placed to meet its 2030 goals and to sustain progress beyond them. In this sense, expanding fiscal space for health should be understood not only as a financing exercise, but as a strategic investment in human capital, social protection, and long-term economic resilience.

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