Vietnam Journal of Community Medicine, Vol. 67, English version No. 1, 2026, 376-383

DIVERGENT FINANCIAL PERFORMANCE UNDER PUBLIC HOSPITAL AUTONOMY: COMPARATIVE EVIDENCE FROM VIETNAM'S TERTIARY CARE SECTOR

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Received: 15/05/2026
Revised: 17/05/2026; Accepted: 26/05/2026

ABSTRACT

Objective: This study explores how hospital type mediates financial performance within a shared financial autonomy framework, highlighting organizational and structural factors that influence financial outcomes under quasi-market conditions.

Methods: A comparative institutional case study was conducted at two tertiary public hospitals in Ho Chi Minh City from 2022 to 2024: a general hospital and a specialized pediatric hospital. Using a mixed-methods approach, audited financial statements were analyzed to examine trends in revenue, expenditure, operating surplus, and revenue composition. Qualitative data were collected through semi-structured interviews with hospital managers and analyzed thematically.

Results: Both hospitals reported substantial revenue growth exceeding 50% over the study period. However, their financial trajectories diverged markedly. The general hospital demonstrated stable revenue–expenditure alignment and a diversified income structure. In contrast, the specialized hospital exhibited narrowing margins driven by cost escalation and heavy dependence on social health insurance reimbursements. Qualitative findings suggested that expenditure rigidity and purchaser dominance constrained managerial autonomy, particularly in the specialized setting.

Conclusion: Hospital financial autonomy does not generate uniform outcomes. Revenue concentration and cost rigidity may produce divergent financial trajectories even under a shared policy framework. Financial autonomy models should therefore be adapted according to hospital type and financing structure.

Keywords: Hospital financial autonomy; Public hospitals; Revenue concentration; Cost rigidity; Social health insurance; Vietnam.

1. INTRODUCTION

Public hospital financial autonomy has become a prominent feature of health system reforms in many low- and middle-income countries (LMICs), aimed at improving efficiency, accountability, and sustainability in service delivery [1–3]. By granting hospitals greater discretion over revenue generation, expenditure management, and surplus use, autonomy reforms seek to reduce reliance on central budgets and enhance managerial responsiveness. However, the outcomes of such reforms have varied across settings, reflecting differences in institutional context, financing arrangements, and regulatory frameworks [2,3].

In Vietnam, financial autonomy for public hospitals has evolved significantly since the early 2000s, culminating in a structured classification system that assigns varying degrees of managerial and financial discretion to hospitals based on autonomy "groups" [4,5]. These reforms have taken place in parallel with the rapid expansion of the country's social health insurance (SHI) scheme, which has become the dominant purchaser of hospital services [4,6]. As a result, public hospitals operate within a hybrid environment—formally autonomous but financially dependent on regulated, insurance-based payments. This policy configuration has raised questions about how autonomy is exercised in practice and how institutional characteristics shape hospitals' ability to translate formal autonomy into effective financial performance.

Emerging evidence from Vietnam suggests that autonomy has contributed to increases in hospital revenues and service outputs [7,8]. However, multiple studies highlight persistent constraints, including fixed fee schedules, delayed reimbursements, and limited pricing flexibility under SHI arrangements [4,6,9]. These constraints may differentially affect hospitals depending on their size, service portfolio, and revenue composition. While some hospitals may achieve financial gains under autonomy, others—particularly specialised and tertiary facilities with narrow service scopes and high fixed costs—may face heightened financial risks [9,10]. International studies from LMICs have reported similar dynamics, where autonomy reforms enhanced resource mobilisation but failed to ensure financial sustainability when not supported by responsive purchasing and flexible expenditure management [1–3].

Despite the growing literature, most existing studies remain descriptive, focus on single institutions, or lack comparative analysis across hospital types. In particular, little empirical

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work has examined how formal autonomy interacts with hospital-specific factors—such as revenue concentration and cost structure—to influence financial outcomes within a shared policy framework [5,7–10]. Understanding these mechanisms is essential for designing autonomy arrangements that support financial resilience across a heterogeneous hospital system.

This study addresses critical gaps in the literature by conducting a comparative mixed-methods institutional case study of two tertiary public hospitals in Ho Chi Minh City—a general hospital and a specialised paediatric hospital—operating under the same national financial autonomy framework between 2022 and 2024. By integrating audited financial data with qualitative interviews from hospital managers, the study investigates how differences in revenue composition and expenditure rigidity influence financial performance under conditions of formal autonomy. The findings contribute to ongoing policy discussions by identifying institutional factors that shape the effectiveness of autonomy reforms, particularly in insurance-dominated health systems.

Conceptual contribution

Rather than focusing solely on whether hospital autonomy leads to increased revenue, this study advances the conceptual understanding of how autonomy is operationalised into financial performance through specific institutional mechanisms. Drawing on comparative institutional analysis, it examines how hospital type mediates the relationship between formal autonomy arrangements and financial outcomes. In particular, the study highlights the mediating roles of revenue concentration and cost rigidity—two structural factors that condition financial trajectories within a shared regulatory and purchasing environment. By comparing a general and a specialised tertiary hospital under identical autonomy conditions, the study offers explanatory insight into why similar levels of revenue growth may yield divergent financial outcomes across hospital types. These relationships are illustrated in the conceptual framework presented in Figure 1.

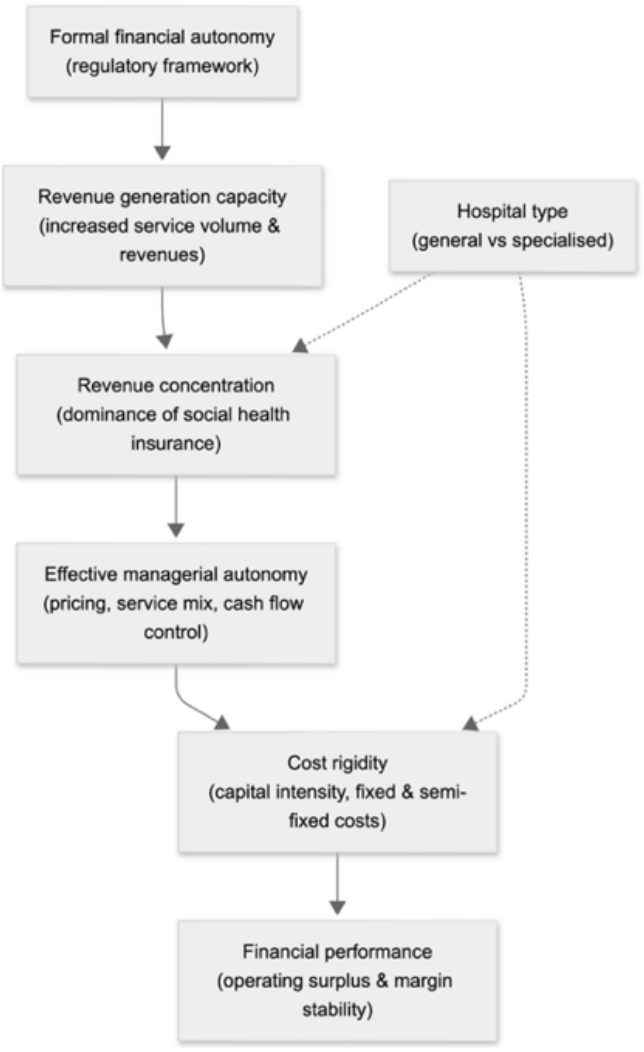


Figure 1. Conceptual pathways linking hospital financial autonomy to financial performance.

2. METHODS

2.1. Study design

This study employed a comparative mixed-methods institutional case study design to examine financial performance under hospital financial autonomy in Vietnam. The design was selected to explore mechanisms shaping financial outcomes, rather than to estimate causal effects or produce statistically generalisable results. Quantitative financial data were analysed descriptively to identify patterns and trends, while qualitative data were used to contextualise and interpret observed financial trajectories.

This approach aligns with the study's conceptual framework (Figure 1), which posits that hospital type mediates the relationship between formal autonomy arrangements and financial performance through intermediate mechanisms of revenue concentration and cost rigidity.

2.2. Study setting and case selection

The study was conducted in Ho Chi Minh City, Vietnam's largest metropolitan health system, during the period 2022–2024. Two tertiary public hospitals operating under the same national financial autonomy regulations and local purchasing environment were purposively selected:

1. Trung Vuong Hospital, a general tertiary public hospital with a diversified service portfolio; and

2. Children's Hospital 1, a specialised tertiary paediatric hospital with a narrow service scope and high dependence on social health insurance reimbursements.

Both hospitals belonged to autonomy group 2, indicating self-financing of recurrent expenditures, and were subject to the same regulatory framework, health insurance payment rules, and provincial oversight. Selection of contrasting hospital types within a shared institutional context enabled comparative examination of how hospital characteristics shape financial outcomes under autonomy.

2.3. Data sources

Quantitative data

Quantitative data were obtained from audited hospital financial statements and internal management reports for fiscal years 2022, 2023, and 2024. Data extracted included:

- Total revenue;

- Revenue by source (social health insurance, user fees, and other revenues);

- Total expenditure;

- Expenditure by major cost categories;

- Operating surplus.

All financial data were reported in million Vietnamese Dong (VND) and analysed at the institutional level.

2.4. Qualitative data

Qualitative data were collected through semi-structured, in-depth interviews with hospital managers involved in financial and operational decision-making. Participants

included hospital directors, deputy directors, financial managers, and department heads responsible for budgeting, financial management, and service delivery.

The interview guide was specifically developed for this study based on a review of the literature on hospital financial autonomy and health service financing, as well as the study objectives. The guide covered key domains including experiences with the implementation of financial autonomy, revenue generation strategies, expenditure management practices, interactions with the health insurance purchasing system, and perceived financial and institutional constraints.

An English-language version of the interview guide is provided as Supplementary file 1.

Interviews were conducted face-to-face by trained researchers between 2022 and 2024 and continued until thematic saturation was achieved. All interviews were audio-recorded with participants' informed consent, transcribed verbatim, and anonymised prior to analysis to ensure confidentiality.

2.5. Financial indicators and measures

To enhance comparability across hospitals of different scale, the analysis focused on proportional and relational indicators, rather than absolute financial values alone. Key indicators included:

- Revenue growth over time;
- Revenue composition by source (% of total revenue);
- Expenditure growth over time;
- Operating surplus and revenue-to-expenditure ratios;
- Broad expenditure structure by cost category.

These indicators were selected to reflect dimensions central to the conceptual framework, particularly revenue concentration and cost rigidity, and to support interpretation of financial performance under autonomy.

2.6. Data analysis

Quantitative analysis: Quantitative data were analysed descriptively. Trends in revenue and expenditure were examined across the three-year period and visualised using line charts (Figure 2). Revenue composition and operating surplus indicators were summarised using tables.

No inferential statistical analyses were conducted, as the study did not aim to test causal hypotheses or estimate treatment effects.

Qualitative analysis: Qualitative data were analysed thematically using an iterative coding process. Initial codes were developed deductively based on the conceptual framework and inductively refined as analysis progressed. Themes were identified relating to revenue generation, purchaser dependence, expenditure constraints, and managerial discretion.

Integration of methods: Quantitative and qualitative findings were integrated during interpretation using a context–mechanism–outcome lens. Quantitative results identified financial patterns, while qualitative findings were used to explain how institutional characteristics and managerial experiences contributed to observed trajectories.

Reporting standards: The qualitative component of the study was reported with reference to the Consolidated Criteria for Reporting Qualitative Research (COREQ). The quantitative observational component was reported in line with STROBE principles, adapted for an institutional case study design.

Methodological limitations: The study focused on two hospitals within a single metropolitan health system, which may limit generalisability. Quantitative analysis was descriptive and did not assess technical efficiency or causal effects. The three-year observation period may be insufficient to capture longer-term financial impacts of capital investments. These limitations are consistent with the study's aim to explain mechanisms rather than estimate causal impacts.

3. RESULTS

3.1. Institutional characteristics of the study hospitals

Two tertiary public hospitals operating under the same financial autonomy framework in Ho Chi Minh City during 2022–2024 were included in the analysis: Trung Vuong Hospital, a general tertiary hospital, and Children's Hospital 1, a specialised paediatric hospital. Both hospitals belonged to autonomy group 2, indicating self-financing of recurrent expenditures, and were subject to the same regulatory and purchasing environment. Despite these shared conditions, the hospitals differed substantially in service scope, revenue structure, and cost characteristics. Key institutional characteristics of the two study hospitals are summarised in Table 1.

Table 1. Key characteristics of the study hospitals (2022–2024)

Characteristic	Trung Vuong Hospital	Children's Hospital 1
Hospital type	Tertiary general public hospital	Tertiary specialised paediatric hospital
Ownership	Public	Public
Autonomy category	Group 2	Group 2
Location	Ho Chi Minh City	Ho Chi Minh City
Main revenue source	Health insurance and service revenues	Predominantly health insurance
Service mix	Diversified	Highly specialised
Study period	2022–2024	2022–2024

3.2. Trends in total revenue and expenditure

Total revenue increased substantially at both hospitals over the study period (Table 2). At Trung Vuong Hospital, total revenue increased from 419,596 million VND in 2022 to 649,176 million VND in 2024, representing a growth of 54.7%. Total expenditure increased from 417,300 million VND to 642,800 million VND over the same period.

At Children's Hospital 1, total revenue increased from 1,083,364 million VND in 2022 to 1,661,455 million VND in 2024, corresponding to a growth of 53.4%. Total expenditure increased concurrently from 830,057 million VND to 1,388,089 million VND.

Although revenue growth rates were broadly similar between the two hospitals, expenditure growth patterns differed. As shown in Figure 2, expenditure at Children's Hospital 1 increased more rapidly relative to revenue in later years, whereas Trung Vuong Hospital maintained a closer alignment between revenue and expenditure growth.

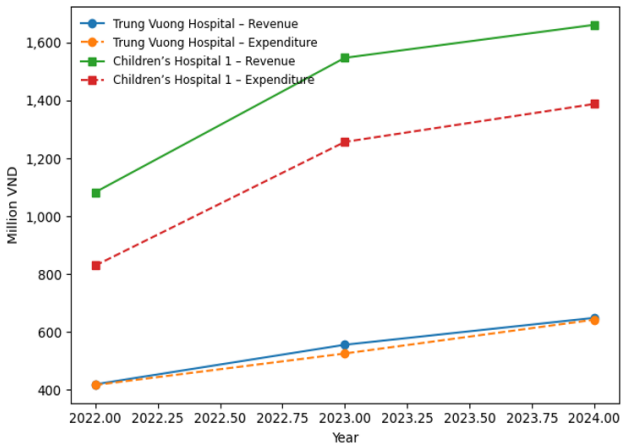


Figure 2. Revenue and expenditure trajectories at Trung Vuong Hospital and Children's Hospital 1, 2022–2024

Table 2. Total revenue and expenditure, 2022–2024 (million VND)

Hospital	Year	Total revenue	Total expenditure
Trung Vuong	2022	419,596	417,300
	2023	556,177	526,000
	2024	649,176	642,800
Children's Hospital 1	2022	1,083,364	830,057
	2023	1,547,480	1,257,034
	2024	1,661,455	1,388,089

3.3. Operating surplus and financial performance indicators

Operating surpluses remained positive at both hospitals throughout the study period, but temporal patterns differed (Table 3).

At Trung Vuong Hospital, the operating surplus was minimal in 2022, increased in 2023, and declined again in 2024, with the revenue-to-expenditure ratio fluctuating around parity. In contrast, Children's Hospital 1 maintained substantially higher operating surplus levels in absolute terms but exhibited a progressive decline in operating margins. The revenue-to-expenditure ratio decreased from 130.5% in 2022 to 119.7% in 2024, indicating a narrowing operating buffer despite continued revenue growth.

Table 3. Operating surplus indicators

Hospital	Year	Operating surplus (million VND)	Revenue / expenditure (%)
Trung Vuong	2022	~2,296	~100
	2023	~30,177	~106
	2024	~6,376	~101
Children's Hospital 1	2022	243,671	130.5
	2023	276,893	123.1
	2024	256,878	119.7

3.4. Revenue composition

Revenue composition differed markedly between the two hospitals (Table 4).

At Trung Vuong Hospital, revenue sources were relatively diversified. Social health insurance reimbursements accounted for approximately 73.0–76.0% of total revenue across the study period, while user fees and other service revenues contributed around one-fifth. Other revenue sources remained marginal.

In contrast, Children's Hospital 1 relied overwhelmingly on social health insurance reimbursements. Health insurance consistently accounted for more than 92% of total revenue across all three years, while non-insurance revenues remained below 8%. This highly concentrated revenue structure remained stable over time.

Table 4. Revenue composition by source (% of total revenue)

Hospital	Source	2022	2023	2024
Trung Vuong	Health insurance	73.0	76.0	75.0
	User fees & services	23.5	20.8	21.9
	Other sources	3.5	3.2	3.1
Children's Hospital 1	Health insurance	93.3	92.6	93.1
	Other revenues	6.7	7.4	6.9

3.5. Expenditure structure and cost rigidity

Expenditure patterns also differed across hospital types. At Children's Hospital 1, operational and professional service costs accounted for approximately 86.2–91.3% of total expenditure across the study period, and capital-related costs increased over time, contributing to a high proportion of fixed and semi-fixed expenditures.

At Trung Vuong Hospital, expenditure growth was more evenly distributed across cost categories, and the overall expenditure structure remained relatively stable over the three-year period.

3.6. Qualitative findings

Qualitative interviews with hospital managers provided contextual insights into the observed quantitative patterns. Managers at Trung Vuong Hospital reported greater flexibility in reallocating resources across departments and adjusting service provision in response to financial conditions.

In contrast, managers at Children's Hospital 1 emphasised constraints associated with specialised service provision, high dependence on social health insurance reimbursements, and increasing capital-related costs linked to advanced paediatric services and medical equipment. These factors were perceived to limit the hospital's capacity to adjust expenditures in line with revenue changes.

3.7. Cross-case comparison and alignment with the conceptual framework

Cross-case comparison highlighted divergent financial trajectories under a shared autonomy framework. While both hospitals achieved similar revenue growth over the study period, Trung Vuong Hospital demonstrated greater financial stability, characterised by diversified revenue sources and relatively stable expenditure growth. Children's Hospital 1 experienced increasing financial pressure over time, reflected in revenue concentration and rising fixed and semi-fixed costs, leading to declining operating surplus margins.

These observed patterns correspond to the conceptual pathways illustrated in Figure 1, which summarises how

hospital type mediates the relationship between financial autonomy and financial performance through mechanisms of revenue concentration and cost rigidity.

4. DISCUSSION

4.1. Principal findings

This comparative mixed-methods institutional case study examined how hospital financial autonomy translated into financial performance in two tertiary public hospitals in Vietnam operating under an identical regulatory and purchasing framework between 2022 and 2024. The analysis demonstrates that substantial revenue growth under financial autonomy was not accompanied by uniform financial outcomes across hospital types. Although both hospitals achieved revenue increases exceeding 50% over the study period, their financial trajectories diverged in important ways.

The general hospital (Trung Vuong Hospital) maintained a relatively stable balance between revenue and expenditure, with operating results fluctuating around parity across the three years. This pattern suggests a capacity to absorb revenue expansion without proportional escalation in costs. In contrast, the specialised paediatric hospital (Children's Hospital 1) experienced a progressive erosion of operating margins, despite consistently higher absolute revenue and operating surplus levels. The declining revenue-to-expenditure ratio observed at this hospital indicates increasing financial pressure over time, as expenditure growth gradually outpaced revenue growth.

Taken together, these findings highlight that revenue growth alone is an insufficient indicator of financial sustainability under hospital autonomy. Operating performance depended not only on the scale of revenue mobilisation but also on how revenues interacted with hospital-specific expenditure structures and service profiles. The results therefore underscore the importance of examining financial trajectories, revenue composition, and expenditure dynamics jointly, rather than relying on aggregate revenue indicators when assessing the effects of financial autonomy reforms across heterogeneous public hospitals.

4.2. Revenue growth under autonomy: necessary but insufficient

The divergent financial outcomes observed across the two hospitals in this study are broadly consistent with prior research on hospital financial autonomy in both Vietnam and international settings. In the Vietnamese context, previous studies have documented that autonomy reforms have contributed to notable increases in hospital revenues and service volumes, particularly through expanded billing under social health insurance and fee-for-service models [7,8]. These findings align with the present study, where both the general and specialised hospitals achieved revenue growth of over 50% during the study period.

However, similar to earlier Vietnamese evidence, this study also reveals that revenue growth did not automatically translate into improved financial stability, especially for hospitals with rigid expenditure structures. Previous studies have shown that rising personnel and operational costs, combined with inflexible spending frameworks, often erode the financial gains from autonomy reforms [7,9,10]. The narrowing operating margins at Children's Hospital 1, despite continued revenue growth, exemplify this pattern. These results reinforce existing concerns that revenue growth under autonomy may be offset by cost escalation, particularly in specialised settings with limited cost flexibility.

Internationally, mixed experiences with hospital autonomy have also been reported. For example, evidence from countries implementing performance-based financing or decentralised autonomy arrangements, such as Kenya and Zambia, has shown that while hospitals often improve revenue mobilisation, they continue to face constraints in expenditure control and purchaser relations [1–3]. These international studies echo the present findings by highlighting that hospital autonomy reforms—particularly in insurance-dominated systems—may enhance resource mobilisation without necessarily improving financial resilience unless complemented by flexible financial management mechanisms and responsive payment arrangements.

This study's comparative design also aligns with international literature suggesting that institutional context and hospital characteristics significantly mediate the outcomes of autonomy reforms. Studies from both high-income and LMIC settings report that tertiary and specialised hospitals often struggle more under activity-based or regulated payment systems, due to higher fixed costs and constrained pricing flexibility [1–3]. The contrast between the general and paediatric hospitals in this study supports this observation, illustrating how hospital type shapes the translation of formal autonomy into financial performance.

4.3. Interpretation of mechanisms and policy relevance

The comparative findings of this study underscore the critical role of revenue composition and cost structure in shaping the financial effects of hospital autonomy. Although both hospitals operated under the same formal autonomy and purchasing framework, their financial outcomes diverged sharply, driven by differences in revenue concentration and cost rigidity—two institutional mechanisms that mediate the relationship between autonomy and financial sustainability.

Children's Hospital 1 exhibited extreme dependence on social health insurance (SHI), with over 92% of revenue consistently derived from this single source. This high degree of revenue concentration exposes hospitals to purchaser-induced financial risk, particularly in contexts where reimbursement is governed by regulated fee schedules, capped payment mechanisms, or delays in claims settlement. Previous Vietnamese studies have identified the SHI system's dominant market position and inflexible tariff structures as key barriers to the effective exercise of financial autonomy [4,6,9,11]. In such settings, formal autonomy may provide legal discretion over expenditure and service planning, but effective autonomy—defined as the practical ability to make financially consequential decisions—remains constrained.

International literature further supports this interpretation. Studies from Kenya, Ghana, and China have reported that public hospitals operating under purchaser-dominated financing models often face limited scope for strategic financial management, with restricted pricing authority and inflexible resource allocation mechanisms [2,3,16]. These constraints are magnified in highly specialised facilities, where the narrower scope of services limits opportunities for revenue diversification or cross-subsidisation.

In contrast, Trung Vuong Hospital maintained a more balanced revenue structure, including greater contributions from user fees and other sources. This diversification likely contributed to greater resilience, enabling more flexible adjustment of expenditure in response to revenue conditions. Such institutional adaptability has been emphasised in the literature as a core determinant of successful financial autonomy implementation in LMIC health systems [17,18].

The findings also highlight the policy-relevant distinction between de jure and de facto autonomy. While both

hospitals enjoyed the same statutory classification (autonomy group 2), the general hospital demonstrated greater financial flexibility in practice. This divergence suggests that effective autonomy is not merely a function of regulatory designation but also of institutional context, including revenue diversity, service scope, and expenditure flexibility. Policymakers aiming to strengthen hospital financial sustainability should therefore consider not only formal autonomy classifications but also the structural conditions under which autonomy is exercised.

4.4. Implications for public hospital governance and financial autonomy

The findings of this study carry several implications for the governance of public hospitals operating under financial autonomy frameworks, particularly in health systems dominated by social health insurance. The contrast between the two hospitals examined demonstrates that formal autonomy provisions alone are insufficient to ensure financial sustainability or effective resource stewardship, especially for hospitals facing high fixed costs and limited revenue diversification.

Children's Hospital 1, as a highly specialised tertiary institution, experienced financial strain due to cost rigidity—driven by high proportions of professional service costs and increasing capital investments. This structural cost profile restricts expenditure flexibility and heightens vulnerability to fluctuations or limitations in revenue flows. When combined with near-total reliance on a single payer (SHI), such rigidity impairs the institution's ability to exercise financial discretion, even under a nominal autonomy framework. These findings reinforce prior Vietnamese analyses warning that uniform autonomy arrangements applied across diverse hospital types may exacerbate existing vulnerabilities rather than resolve them [10,12].

Governance strategies should therefore move beyond uniform classification schemes and instead adopt differentiated autonomy models tailored to hospital function, revenue composition, and cost structure. For example, specialised hospitals may require supplementary capital financing mechanisms, risk-adjusted reimbursement models, or negotiated budgetary safeguards to protect against the adverse effects of rigid costs under standardised tariffs. In international settings, differentiated autonomy and financing models have been adopted to accommodate institutional heterogeneity—for instance, in Thailand's Universal Coverage Scheme and in France's hospital payment reforms—whereby high-cost tertiary facilities are provided with strategic purchasing protections or earmarked budget allocations [19,20].

Furthermore, governance frameworks must attend not only to internal managerial discretion, but also to the alignment between hospital-level autonomy and macro-level purchasing policy. Even well-intentioned autonomy reforms can generate financial instability if not supported by responsive and flexible payment systems. In Vietnam, where SHI remains the dominant purchaser, rigid fee schedules and delays in reimbursement have been widely documented as sources of fiscal stress for autonomous hospitals [4,6,9,11]. Therefore, policy coherence between hospital autonomy and health financing reform is essential to ensure that autonomy delivers its intended outcomes in efficiency, accountability, and financial resilience.

Strengths and limitations of the study

This study contributes to the empirical literature on hospital financial autonomy in low- and middle-income countries (LMICs) by using a comparative mixed-methods institutional case study design to explore how different hospital types experience financial autonomy under a shared policy and regulatory environment. A key strength lies in its integration of longitudinal financial data with qualitative insights from managerial stakeholders. This combination allows for a mechanism-oriented interpretation of financial trajectories, enhancing the explanatory depth beyond purely descriptive or single-method studies. By analysing both a general and a specialised tertiary hospital under the same autonomy classification, the study is also able to isolate institutional variables—such as revenue concentration and cost structure—that condition the real-world effects of autonomy reforms.

Another strength is the study's explicit alignment with recognised reporting frameworks. The qualitative component follows COREQ principles, ensuring methodological transparency in interview design, recruitment, and analysis. Similarly, the quantitative analysis, although descriptive in nature, applies proportional financial indicators in line with STROBE guidelines adapted for institutional analysis. This attention to reporting standards supports the robustness and replicability of findings in other LMIC health systems pursuing similar autonomy policies.

However, several limitations must be acknowledged. First, the study is confined to two hospitals within a single urban health system, which may limit the generalisability of findings to other regions or lower-level facilities. While the case selection was purposive and theoretically informed, the small sample precludes statistical inference or claims of representativeness. Second, the observational time frame of three years may not fully capture long-term financial consequences, particularly those related to capital depreciation or major service reconfiguration. Third, the study did not incorporate patient-level or clinical outcome data, which would be necessary to assess whether financial changes under autonomy translate into service quality or health outcomes—key concerns for comprehensive health system evaluation.

Finally, while the qualitative data provided rich contextual interpretation, responses may be subject to social desirability or institutional defensiveness, especially given the managerial positions of interviewees. Although triangulation with financial data helps mitigate this concern, future research could benefit from a broader respondent base including clinicians, frontline staff, and external stakeholders.

5. CONCLUSIONS

This comparative mixed-methods study provides evidence that hospital financial autonomy in Vietnam yields divergent financial outcomes across hospital types, even under a shared regulatory and purchasing framework. While both hospitals demonstrated substantial revenue growth, financial performance was shaped by institutional factors—particularly revenue concentration and cost rigidity—that mediated the translation of formal autonomy into effective financial discretion.

By comparing a general and a specialised tertiary hospital, the study highlights how hospital type, service scope, and financial structure influence the operational consequences of autonomy reforms. The findings reinforce the need for differentiated approaches to financial autonomy and underscore the importance of aligning autonomy arrangements with cost structures and purchasing environments. As Vietnam and other LMICs continue to pursue health system reforms, this study contributes to a growing evidence base supporting the design of context-sensitive governance and financing models that can sustain financial resilience across diverse public hospitals.

6. STATEMENT OF SCIENTIFIC CONTRIBUTIONS

Pham Dinh Nguyen contributed to study conceptualization, data analysis, interpretation of findings, and manuscript drafting. Thai Hoang Hanh Nhung and Lam Hoang Cat Tien contributed to data collection, institutional analysis, and manuscript revision. Nguyen Thu Ha supervised the study, critically reviewed the manuscript, and approved the final version for publication. All authors read and approved the final manuscript.

7. CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

8. ACKNOWLEDGMENTS

The authors thank Children's Hospital 1, and Trung Vuong Genereal Hospital for providing the facilities for data acquisition.

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