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POTENTIAL FOR THE DEVELOPMENT OF VIETNAM'S HEALTHCARE SECTOR IN THE NEW ERA: PRIVATE HEALTH ECONOMICS AS A NEW PILLAR OF VIETNAM'S SOCIAL SECURITY

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Abstract

Amid Vietnam's ongoing transition toward a two-tier local government model, social security is increasingly positioned as a central pillar in the national strategy for sustainable development. This paper examines the rising role of the private healthcare sector within Vietnam's social security system. Drawing on the theoretical lenses of quasi-public goods, new institutional economics, and dynamic comparative advantage (Samuelson, 1954; Balassa, 1965; North, 1990), the paper analyzes market potential, key barriers, and policy directions for developing private health economics in Vietnam for the period 2025–2035. Using empirical evidence from the WHO Global Health Expenditure Database and industry datasets (WHO, 2023; Ken Research, 2023; IQVIA Vietnam, 2024), together with policy review (Communist Party of Vietnam, 2017; National Assembly of Vietnam, 2023; Ministry of Health, 2020), the paper argues that private healthcare can become a dual growth engine—improving population health outcomes while also supporting local economic growth during the post-merger administrative restructuring process.

Keywords: *private healthcare; health economics; social security; digital transformation; Vietnam.*

1. Introduction

Vietnam is entering a major turning point in healthcare reform. As local governance shifts toward a two-tier model, enhancing quality of life—both materially and spiritually—has become a strategic priority. Healthcare, especially primary care, is the frontline of public service delivery and a foundation of social security. However, Vietnam's per-capita health expenditure remains modest—about USD 173 per person per year—equivalent to around 30% of Thailand and 12% of Japan (WHO, 2023). This situation is both a challenge and a major "policy and investment space" for private healthcare in the new era.

2. Theoretical Foundations

2.1. Quasi-public goods

According to Samuelson (1954), pure public goods are non-excludable and non-rivalrous. In practice, healthcare services—particularly primary care-often exhibit char-

acteristics of quasi-public goods: they can be socialized (i.e., delivered by non-state actors) while still requiring strong state stewardship to ensure equity, quality, and access.

2.2. Dynamic comparative advantage

Balassa (1965) argued that countries can create comparative advantage in higher-technology and higher-value sectors through strategic policy and targeted investment. Applied to healthcare, Vietnam may build dynamic advantages in areas such as regenerative medicine, community health, AI-assisted diagnostics, and specialized hospitals—provided that supportive policies and enabling ecosystems are in place.

2.3. New institutional economics

North (1990) emphasized that institutions—laws, fiscal policies, licensing procedures, and digital data infrastructure—are critical determinants of economic development. In healthcare, institutional reform is a necessary condition for private providers to develop transparently and sustainably, while aligning market incentives with social security objectives.

3. Methodology

The paper applies a synthesis-based analytical approach. Quantitative evidence is drawn from industry and international datasets (Ken Research, 2023; WHO, 2023; IQVIA Vietnam, 2024), while qualitative insights are derived from observed local healthcare models in provinces and major cities (e.g., Thanh Hoa, Ho Chi Minh City, and Binh Duong). Key policy documents—including Resolution No. 20-NQ/TW (Communist Party of Vietnam, 2017), the Law on Medical Examination and Treatment (amended) (National Assembly of Vietnam, 2023), and the Medical Digitalization Program to 2025 with orientation to 2030 (Decision No. 5316/QD-BYT) (Ministry of Health, 2020)—are reviewed to establish the legal and strategic context.

4. Results and Analysis

4.1. Market potential

4.1.1. Low per-capita health spending: USD 173 per person per year

Regional and international comparison (WHO, 2023):

Table 1.

Country	Health spending per capita	Share relative to Vietnam
Vietnam (2023)	USD 173	100%
Thailand	~ USD 600	~ 347%
Malaysia	~ USD 730	~ 422%
Japan	~ USD 4,500	~ 2,600%

Source: WHO (2023)

Vietnam's per-capita health expenditure is significantly lower than that of ASEAN peers and OECD countries, indicating: Substantial room for market expansion, especially among the growing urban and middle-income population with a higher willingness to pay for quality healthcare; Strong potential for high-end and specialized services – particularly in the non-public sector, which is often more flexible in service design and pricing.

4.1.2. Private outpatient visit share is 15–20%, yet growing at ~14% per year

Trend assessment: Vietnam's private visit share remains far below countries with mature mixed healthcare models (e.g., Thailand ~40%, Singapore ~60%, the U.S. >70%). However, a ~14% annual growth rate is very high – exceeding overall health-sector GDP growth (~7–8%)—suggesting a gradual shift from public to private providers, especially for high-tech services (imaging, laboratory testing, outpatient treatment).

Implications: Private healthcare is not yet dominant in total visits, but it is gaining a growing share of revenue by focusing on higher-quality, higher-value services; Private enterprises have significant opportunities to scale integrated models: hospital–satellite clinics–diagnostic centers–pharmacies; Segments such as periodic health checkups, fast-track services, and telehealth are increasingly attractive to technology-oriented investors.

4.1.3. Rapid population ageing: ≥20% of the population will be aged 60+ by 2035

Demographic dynamics:

+ 2024: about 13% of the population aged 60+ (~13 million people).

+ 2035 (projection): about 20% aged 60+ (~21 million people).

Rapid ageing is expected to drive: Higher demand for continuous care, rehabilitation, nursing, and end-of-life care; Higher average health spending among the 60+ group (approximately 3–5 times higher than the under-60 group); Growing demand for personalized care, home-based care, integrated nursing and hospital services.

Strategic development directions: Community health models, family medicine, and premium nursing-care centers are likely to become high-growth markets; Integration of healthcare with insurance and personal finance (e.g., retirement–health–life bundled products) may become a strategic product line for banks, insurers, and healthcare providers.

4.1.4. Private healthcare as a "high-control, high-potential investment lowland"

The notion of a "high-control, high-potential investment lowland" reflects three core characteristics:

Table 2.

Feature	Explanation
Large market space	Low spending, large population, and a rapidly changing market structure.
Fast growth	High growth rates in the non-public sector and in high-technology service segments.
Manageable policy risk	Policy environment is becoming more transparent: new law, PPP mechanisms, digital transformation agenda, and incentives for socialized healthcare investment (National Assembly of Vietnam, 2023; Ministry of Health, 2020).

Source: Authors' synthesis

For investors and policymakers, the private healthcare sector is no longer merely an "auxiliary" to public healthcare; it is increasingly becoming a dual pillar—supporting social security while also contributing to regional economic growth.

4.2. Growth outlook

Table 3.

Indicator	2024	2035 (Forecast)
Hospital industry size	USD 11.5 billion	≥ USD 22 billion
International investment into healthcare	USD 400 million/year	> USD 1 billion/year
Number of private hospitals	384 facilities	≥ 600 facilities

Source: Industry synthesis (Ken Research, 2023; IQVIA Vietnam, 2024).

4.3. Formation of a private health-economy ecosystem in Vietnam

4.3.1. Cluster-based models of private healthcare services

Modern private healthcare ecosystems are increasingly moving from standalone units (single hospitals/clinics) toward cluster-based integrated service models. A typical integrated value chain includes:

Table 4.

Component	Role in the ecosystem
Private hospital	Center for high-technology treatment and specialized care.
Satellite clinics	Provide initial services, screening, and routine follow-up.

Component	Role in the ecosystem
Laboratory & diagnostic imaging centers	Standalone or integrated units supporting rapid clinical decision-making.
Private pharmacies	Medication logistics, counseling, and home-care support.
Rehabilitation units	Post-treatment care, nursing, and physiotherapy.
Digital technology platforms	Electronic health records, telehealth, and internal management.
Health care centers	Family health support and preventive care.
Community service centers	Elderly care and recovery/wellness centers.

Source: Authors' synthesis.

Key advantages: Extends the customer journey: prevention – treatment – long-term care; Optimizes management costs through shared technology, data, and supply chains; Enhances scalability and replication across provinces; Facilitates integration with insurance, finance, and aftercare services.

Illustrative examples (as observed in practice):

Hoan My: network of general clinics connected with tertiary hospitals and integrated HIS platforms.

Medic Group: hospital–clinic–pharmaceutical–technology ecosystem with internal operational platforms.

Medipha: integration of medical supplies distribution, pharmaceutical supply, and EMR/IT solutions.

4.3.2. M&A activities: reshaping private healthcare ownership

Notable developments (2020–2024):

Table 5.

Year	Transaction	Notes
2020	Thomson Medical Group (Singapore) acquired 100% equity in FV Hospital (Ho Chi Minh City).	Cross-border investment in premium hospital assets.
2021	Hoan My Group acquired Dong Nai International Hospital.	Strengthening treatment capacity in the Southeast region.
2022	JPE Partners (Korea) invested in Vietlife.	Technology and operational process upgrades.
2023	SK Group invested in Vinmec (Vingroup).	Development of high-quality hospitals, AI and robotics support.
2024	Investment negotiations in specialty clinic chains in Hanoi and Da Nang.	Focus on dentistry, ophthalmology, endocrinology.

Source: Authors' compilation from industry information (2020–2024).

Key observations:

International capital increasingly prioritizes healthcare chains with established technology and data foundations.

Private equity/venture capital investors not only provide capital but also participate in governance and strategy.

M&A can help standardize service quality, improve bargaining power with insurers/suppliers, and optimize multi-site operations.

Risks that require governance attention:

Market concentration may raise localized monopoly risks.

Ethical risks may arise if investors prioritize profit over community health outcomes.

4.3.3. Healthcare–Technology–Education alliances as a sustainability foundation

Modern private healthcare ecosystems increasingly integrate both horizontally (multi-service) and vertically (multi-sec-

tor), enabling systems that can: Self-supply, self-train, and self-operate within integrated chains; Use technology to personalize care pathways and improve outcomes; Secure human resources through internal training systems or partnerships with universities.

Illustrative alliance models:

Table 6.

Consortium	Alliance components	Value created
Vinmec – VinUni – VinBrain	Hospital – university – AI diagnostics	Training – care – research – technology transfer
Medic Group	Hospital – clinics – pharmaceuticals – technology – training	Closed ecosystem; cluster-based local governance
Medipha	Pharmaceutical & equipment distribution – health IT – maintenance services	Supply-chain optimization; public–private operational integration
TTH	Hospital – clinics – pharmaceuticals – technology – training	Closed ecosystem; cluster-based local governance
Hung Vuong Healthcare System	Hospital – clinics – pharmaceuticals – technology	Closed ecosystem; cluster-based local governance

Source: Authors' synthesis.

Overall, Vietnam's private healthcare ecosystem is shifting from single-unit models to integrated cluster-based systems. Key drivers include (1) changing patient demand for convenience, comprehensive packages, and quality; (2) M&A-driven restructuring and digital integration; and (3) cross-sector alliances with technology and education to build endogenous capabilities for workforce development and digital transformation.

5. Discussion

5.1. Major barriers

Overlapping public–private policies (bed planning, land allocation, social health insurance); Limited availability of "clean land" and unclear PPP models in practice; Shortage and uneven distribution of high-quality healthcare human resources across provinces.

5.2. Notable policy directions that may reshape sector quality

Digital transformation: electronic health records, AI-assisted diagnosis, and surgical robotics (Ministry of Health, 2020).

Development of specialized medical zones in major cities. Policy "nudges" to encourage routine health checkups among the population.

6. Policy Recommendations

6.1. Establish a comprehensive healthcare ecosystem with public–private coordination to deliver multi-tier services and universal coverage.

6.2. Optimize existing public assets and healthcare workforce to reduce post-merger inefficiencies. Idle public healthcare assets may be leased for private operation of primary care under clear conditions (e.g., 10–20 years lease–operate contracts, preferential lease fees tied to serving social health insurance at commune level, prioritizing domestic healthcare enterprises).

6.3. Attract domestic and foreign private investment to form internationally accredited high-quality medical centers.

6.4. Ensure policy fairness without discrimination by ownership type (public vs. private). Allocation should be based on capability, technical standards, and contribution to social security and community needs. Enable flexible arrangements such as rotational public doctors serving private facilities and regulated dual practice after hours, alongside targeted training funds for nurses and technicians.

6.5. Codify the principle of avoiding redundant public investment where private investment already meets regulatory requirements.

6.6. Transform the role of the state from direct provision to supervision, regulation, and market creation.

6.7. Improve interoperability of health and population databases. Consider opening secure

APIs to connect national databases and health-demographic maps, enabling private providers to update data for social health insurance and national statistics while ensuring data security and shared connectivity standards.

7. Conclusion

In the new development phase, healthcare is not only a domain of public spending but also a strategic economic sector with strong profitability and social spillovers. With an appropriate institutional framework, investment-friendly policies, and robust digital transformation, private healthcare can become a key pillar of Vietnam's social security system while simultaneously serving as a driver of regional economic development in the period 2025–2035.

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