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STATE BUDGET EXPENDITURE FOR PRIMARY HEALTH CARE DEVELOPMENT IN VIETNAM

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INTRODUCTION

1. Rationale of the Dissertation

Health constitutes a foundation for the sustainable development of the nation, with primary health care (PHC) serving as the *"gate keeper"* for the provision of primary health-care services, reducing the burden on higher - level facilities and ensuring social equity. PHC contributes to early disease detection and community health management at low cost, thereby supporting the achievement of national social security objectives. PHC is the *"first line of defence"* of the national health system. A country that seeks sustainable development cannot build its health system primarily on hospitals; rather, it must build on a strong PHC network that is appropriately financed and invested in. The PHC system provides frontline health - care services, ensuring that people can access services at the earliest stage, detect diseases early, prevent disease progression and manage population health while people are still healthy. It also helps reduce overload at higher levels of care and saves social costs in community - based medical examination and treatment.

However, Vietnam's PHC system still faces numerous shortcomings: the service package remains incomplete; screening activities are limited; higher - level facilities are overloaded as patients bypass lower levels; regional disparities persist; human resources are insufficient in both quantity and quality (grassroots doctors meet only 62% of the standard); and infrastructure remains weak. In particular, state budget expenditure for PHC development during 2017 - 2025 increased from VND 14,280 billion to VND 31,485 billion, but accounted for an average of only 21.75% of total public health expenditure, lower than the Government's 30% target. Disbursement remained slow (82.4%), the expenditure structure was biased toward higher - level care, and the efficiency of resource use was not yet high.

Existing research still lacks a systematic analysis of state budget expenditure for PHC during 2017 - 2025 based on budget evidence, including expenditure scale, structure and priority, responsiveness to requirements, and expenditure efficiency, as well as a roadmap toward 2030 with a vision to 2045. The allocation of financial resources, including the state budget, for PHC development responds to both theoretical and practical needs, providing a scientific basis for improving policy, removing financial bottlenecks, and contributing to the construction of a healthy and prosperous Vietnam. In particular, state budget expenditure for PHC development is directly linked to the need to restructure health financing after the COVID-19 pandemic, in the context of public financial reform and the reorganisation of the PHC system under the two-tier local government model in Vietnam, consistent with the Party's and the State's priority orientation for PHC.

On the basis of the above theoretical and practical considerations, the PhD candidate selected the topic ***"State budget expenditure for Primary health care development in Vietnam"*** as the subject of the doctoral dissertation.

2. Research Objectives

The dissertation aims to formulate viewpoints and orientations and to propose effective solutions for state budget expenditure for PHC development, grounded in both theory and practice, with high feasibility, thereby promoting PHC development toward universal health-care coverage and social security in Vietnam.

3. Research Tasks

First, the dissertation clarifies the theoretical foundations and experiences regarding state budget expenditure for PHC development, including an overview of PHC and PHC development; the theory of state budget expenditure for PHC development; the contents and evaluation criteria of such expenditure; factors affecting state budget expenditure for PHC development; and international experiences and lessons for Vietnam.

Second, the dissertation synthesises and analyses the current situation of state budget expenditure for PHC development, including the formation and development of Vietnam's PHC system; the current state of state budget expenditure for PHC development in Vietnam; achievements, limitations and causes of limitations in both the PHC system and state budget expenditure for PHC development in Vietnam.

Third, the dissertation proposes improvements to state budget expenditure for PHC development in Vietnam, including viewpoints and orientations for PHC development; viewpoints and objectives for improving state budget expenditure for PHC development to 2030 with a vision to 2045; solutions for improving state budget expenditure for PHC development in Vietnam; and conditions for implementing these solutions.

4. Research Subject and Scope

Research object

The research object of this dissertation encompasses the theoretical and practical aspects of state budget expenditure on the development of the grassroots healthcare system, analyzed through the lens of public financial management. Specifically, it focuses on the state budget management activities of competent state authorities across the budget cycle, including budget formulation, allocation, execution, and monitoring and evaluation (M&E), aimed at developing the grassroots healthcare infrastructure and services. The scope of this dissertation excludes the internal financial management or expenditure control of individual grassroots healthcare units acting as budget-using entities

Research scope

Scope of research contents

In terms of content, the research scope focuses on state budget expenditures for the development of grassroots healthcare from a state management perspective, encompassing both recurrent and capital expenditures. The managing authorities of these state budget expenditures include the Government, the Ministry of Finance, the Ministry of Health, the People's Councils, the People's Committees at all levels, and

governing line agencies in accordance with the budgetary delegation hierarchy. Conversely, communal health stations, district health centers, and other facilities within the grassroots healthcare network are defined merely as budget-using units responsible for executing their assigned budget estimates; they do not constitute managing authorities of state budget expenditures within the defined scope of this dissertation.

Spatial scope

Before 1 July 2025, PHC in this dissertation refers to commune health stations and district health centres, because from 1 July 2025 Vietnam shifted to a two-tier local government model consisting of commune and provincial levels, abolishing the district level. From 1 July 2025 onward, following the merger of local administrative units in Vietnam, PHC is studied as commune health stations performing primary health-care functions for the population.

With respect to international experience, the dissertation studies PHC in Thailand, Singapore and Australia during 2017 - 2025. These are countries in the region with certain similarities in culture and PHC system characteristics.

Temporal scope

The dissertation evaluates the current situation in Vietnam and international experience during 2017 - 2025. Viewpoints, orientations, solutions and recommendations are proposed for application to 2030, with a vision to 2045.

5. New contributions of the dissertation

First, the dissertation systematises the theoretical foundations of state budget expenditure for PHC development, including an overview of PHC and PHC development; concepts, characteristics, principles, contents and evaluation criteria of state budget expenditure for PHC development; factors affecting state budget expenditure for PHC development in Vietnam; international experiences and lessons for Vietnam.

Second, the dissertation synthesises and analyses the current situation of state budget expenditure for PHC development, including the formation and development of Vietnam's PHC system; the current state of state budget expenditure for PHC development in Vietnam, covering both capital investment and recurrent expenditure; achievements, limitations and causes of limitations in the PHC system and in state budget expenditure for PHC development during 2017 - 2025.

Third, the dissertation develops viewpoints and orientations for PHC development and viewpoints and objectives for improving state budget expenditure for PHC development to 2030, with a vision to 2045. These are grounded in theoretical and practical scientific bases, consistent with the shift from medical examination and treatment toward comprehensive health care that is early, remote and delivered from the grassroots level. They also aim to remove bottlenecks and reform the management of state budget expenditure in an optimal, efficient and modern direction, in connection

with public financial reform and the reorganisation of the PHC system under the two-tier local government model in Vietnam, thereby meeting the requirements of primary health care at the PHC level. On this basis, the dissertation proposes recommendations and solutions for improving state budget expenditure for PHC development in Vietnam and the conditions for implementing such solutions based on theory linked with practice. The research results are not only a reference for Vietnam's PHC system, but also useful material for the Government, ministries and sectors in formulating and improving mechanisms and policies on state budget expenditure for PHC development in Vietnam.

6. Structure of the Dissertation

In addition to the Introduction and Conclusion, the dissertation consists of three chapters:

Chapter 1: Theoretical foundations and experience in state budget expenditure for PHC development.

Chapter 2: Current situation of state budget expenditure for PHC development in Vietnam.

Chapter 3: Improvement of state budget expenditure for PHC development in Vietnam.

CHAPTER 1
THEORETICAL FRAMEWORK AND INTERNATIONAL EXPERIENCE IN TATE BUDGET EXPENDITURE FOR PRIMARY HEALTH CARE DEVELOPMENT

1.1. OVERVIEW OF PRIMARY HEALTH CARE AND PRIMARY HEALTH CARE DEVELOPMENT

1.1.1. Primary health care

1.1.1.1. Concept of Primary health care

PHC constitutes the level of care closest to the population and serves as the foundational pillar of the health system. It directly delivers primary health care services, including disease prevention, health promotion, first - contact medical care, chronic disease management, rehabilitation, and community - based health care.

1.1.1.2. Characteristics of Primary health care

Firstly, PHC serves as the first point of contact between individuals and the healthcare system, primarily through commune-level healthcare facilities. It is characterized by short waiting times, geographical proximity to residents, and close integration with local living environments, thereby ensuring accessibility and responsiveness to the actual healthcare needs of the population.

Secondly, PHC is comprehensive in nature, providing an integrated package of PHC services ranging from health promotion and disease prevention to outpatient medical examination and treatment, rehabilitation, and palliative care.

Thirdly, PHC performs a care coordination function by organizing healthcare delivery and facilitating two - way referral mechanisms with higher - level specialized healthcare institutions, while also ensuring the maintenance of unified individual health records.

Fourthly, PHC ensures continuity of care through long-term monitoring and management of households and patients with chronic diseases.

The functions of PHC include *"the provision and delivery of professional and technical services in the fields of disease prevention; medical examination and treatment; community health management and health promotion; maternal and child healthcare; healthcare for older persons and persons with disabilities; social protection; population services; food safety; pharmaceuticals; medical equipment; and other healthcare services in accordance with the provisions of law"*.

1.1.1.3. Functions and roles of Primary health care

The functions of PHC include:

Firstly, PHC undertakes health promotion and disease prevention activities, including the early detection and control of communicable and non-communicable diseases; immunization against major infectious diseases; prevention and control of endemic diseases; health communication and education; school health services; promotion of adequate nutrition and food safety; and environmental health activities, all of which contribute to the implementation of PHC for the population.

Secondly, PHC provides basic medical examination and treatment services, as well as outpatient care management.

Thirdly, PHC performs public health and community health governance functions, including epidemiological surveillance and timely reporting; outbreak management to ensure early detection and rapid response; household health management; and the maintenance and management of individual and household health records.

The roles of PHC are as follows:

Firstly, PHC serves as the gateway and coordinating hub of the healthcare system, enabling early access to healthcare services at the community level and contributing to the reduction of overcrowding at higher-level healthcare facilities through the management of common diseases and close monitoring of community health conditions.

Secondly, PHC ensures the provision of essential health service packages that address the majority of common healthcare needs, particularly chronic disease management and continuous healthcare services, thereby contributing to universal health coverage, improved health outcomes, and enhanced health security. This includes the management of hypertension and diabetes, ensuring regular follow-up care, and providing services related to health promotion, disease prevention, treatment,

rehabilitation, and palliative care.

Thirdly, PHC promotes equity and financial protection by prioritizing vulnerable and disadvantaged population groups and reducing out-of-pocket healthcare expenditure for patients.

Fourthly, PHC constitutes the foundation of the public health system and strengthens resilience against epidemics and public health emergencies by ensuring timely disease reporting, rapid outbreak response, and comprehensive immunization coverage at the community level.

1.1.2. Development of Primary health care

1.1.2.1. Concept of Primary health care Development

PHC development refers to the process of strengthening the overall capacity of the primary-level health system to ensure the delivery of essential health services that are accessible, high-quality, continuous, coordinated, and equitable, while maintaining socially acceptable costs.

1.1.2.2. Content of Primary health care Development

Firstly, PHC development involves the establishment and strengthening of a community-based healthcare system aimed at providing comprehensive, equitable, and efficient healthcare services.

Secondly, PHC development plays a central role in achieving universal health coverage (UHC) and health-related Sustainable Development Goals (SDGs). This requires flexible financing mechanisms, including results-based allocation of state budget resources, strategic purchasing of essential health service packages, and enhanced financial autonomy in order to improve the efficiency of resource utilization.

1.1.2.3. Criteria for Evaluating Primary health care Development

Firstly, indicators assessing the number of PHC facilities and hospital beds on an annual basis.

Secondly, indicators assessing the growth in the number of healthcare personnel working within PHC facilities.

Thirdly, indicators assessing the proportion of commune health stations with physicians nationwide and across provinces and centrally governed cities.

Fourthly, indicators assessing improvements in the quality of PHC services.

1.2. STATE BUDGET EXPENDITURE FOR PRIMARY HEALTH CARE DEVELOPMENT

1.2.1. Concept, characteristics, and principles of state budget expenditure for Primary health care Development

1.2.1.1. Concept of state budget expenditure for Primary health care development

State budget expenditure for PHC development constitutes a component of public expenditure on health, comprising state budget allocations aimed at performing the State's functions and responsibilities in relation to PHC at grassroots healthcare

facilities.

Accordingly, state budget expenditure for PHC development refers to the process of allocating and utilizing public financial resources to finance recurrent expenditures and healthcare development activities, thereby ensuring the efficient allocation and utilization of financial resources for PHC services.

State budget expenditure for PHC development aims to strengthen the capacity of PHC facilities to deliver high-quality healthcare services at the grassroots level, ensure universal access to healthcare services, and promote preventive healthcare in order to meet community healthcare needs in a financially sustainable manner.

1.2.1.2. Characteristics of state budget expenditure for Primary health care Development

Firstly, state budget expenditure for PHC development constitutes a component of national public expenditure implemented by the State to provide public healthcare goods and services, thereby fulfilling the objectives of population healthcare while ensuring equity, efficiency, and socio-economic stability.

Secondly, state budget expenditure for PHC development is characterized by its large scale, nationwide coverage, and close association with political and socio-economic objectives in each stage of national development.

Thirdly, state budget expenditure for PHC development is non-recoverable in nature, and its outcomes are often difficult to quantify in the short term.

Fourthly, state budget expenditure for PHC development generates comprehensive and long-term socio-economic impacts and possesses a strong public service and public welfare orientation.

1.2.1.3. Principles of state budget expenditure for Primary health care Development

Firstly, the principle of consistency with the healthcare system development strategy and the orientation toward strengthening PHC.

Secondly, the principle of compliance with budget estimates approved and assigned by competent authorities, in association with output-based contracting and performance-oriented task assignment mechanisms.

Thirdly, the principle of compliance with expenditure standards, norms, and financial regulations promulgated by competent authorities.

Fourthly, the principle of adherence to the annual budget framework, thereby ensuring fiscal discipline and transparency throughout the budget cycle.

Fifthly, the principle of ensuring openness, transparency, and equity in access to essential healthcare services.

1.2.2. Contents of state budget expenditure for Primary health care Development

1.2.2.1. Recurrent expenditure of state budget for for Primary health care Development

Firstly, personnel-related expenditure, including salaries, allowances, mandatory

salary-based contributions, and incentive schemes for healthcare workers at the grassroots level, as well as expenditure on training, capacity building, and professional and managerial development.

Secondly, expenditure on professional healthcare activities, including primary medical examination and treatment services and preventive healthcare services.

Thirdly, expenditure on administrative management and the operation of the healthcare system.

1.2.2.2. Capital expenditure of state budget for for Primary health care Development

Firstly, expenditure on the construction, renovation, and upgrading of healthcare infrastructure facilities.

Secondly, expenditure on the procurement and modernization of medical equipment.

Thirdly, expenditure on technology investment and digital transformation within the PHC system.

1.2.3. Criteria for evaluating state budget expenditure for Primary health care Development

1.2.3.1. Indicators for Assessing the Scale of State Budget Expenditure for Primary health care Development

Firstly, the proportion of state budget expenditure for PHC relative to Gross Domestic Product (GDP).

Secondly, the proportion of state budget expenditure for PHC development relative to total state budget expenditure on healthcare.

Thirdly, the growth rate of state budget expenditure for PHC development over time.

1.2.3.2. Indicators for Assessing the Structure and Priority of State Budget Expenditure for Primary health care Development

Firstly, the structure of recurrent and capital expenditure for PHC development.

Secondly, the structure of recurrent state budget expenditure for PHC development.

Thirdly, the structure of capital state budget expenditure for PHC development.

1.2.3.3. Indicators for Assessing the Adequacy of State Budget Expenditure for Primary health care Development

The PEFA indicator is calculated based on the ratio of actual state budget expenditure for PHC development to the approved budget estimate (actual expenditure/approved estimate × 100%). This indicator is used to assess budget compliance and the credibility of budget estimates.

First, the disbursement rate of recurrent state budget expenditure for PHC development relative to the approved budget estimate (%).

Second, the disbursement rate of capital state budget expenditure for PHC

development relative to the approved budget estimate (%).

Secondly, per capita expenditure on PHC services

1.2.3.4. Indicators for Assessing the Efficiency of State Budget Expenditure for Primary health care Development

Firstly, indicators assessing hospital bed occupancy and utilization rates.

Secondly, indicators reflecting the level of state budget investment in PHC development.

Thirdly, indicators assessing efficiency and resource allocation through the expenditure structure across different levels of healthcare provision.

1.2.4. Factors affecting state budget expenditure for Primary health care Development

1.2.4.1. Objective Factors Affecting State Budget Expenditure for Primary health care Development

Firstly, the legal framework and fiscal decentralization mechanisms.

Secondly, macroeconomic conditions and fiscal space.

Thirdly, population size and epidemiological characteristics.

Fourthly, health insurance (HI) coverage and healthcare service utilization behavior.

Fifthly, geographical conditions, accessibility to healthcare services, and the availability of external resources.

Sixthly, the level of community and social participation.

1.2.4.2. Subjective factors influencing state budget expenditure for Primary health care Development

Firstly, budget allocation mechanisms at both sectoral and local levels.

Secondly, budget management processes.

Thirdly, institutional financial management capacity. The financial management capacity of governing agencies and PHC facilities constitutes a key determinant of the efficiency and effectiveness of state budget utilization.

Fourthly, information systems and the level of digitalization in management and administration.

Fifthly, human resources and the organizational structure of the Primary health care system.

Sixthly, leadership capacity and policy prioritization orientation.

1.3. INTERNATIONAL EXPERIENCE IN STATE BUDGET EXPENDITURE FOR PRIMARY HEALTH CARE DEVELOPMENT AND LESSONS FOR VIETNAM

1.3.1. International experience in state budget expenditure for Primary health care Development

1.3.1.1. Thailand's Experience

Firstly, with regard to investment, the state budget allocates resources for the construction, upgrading, and provision of infrastructure and equipment for commune health stations and district health centers.

Secondly, regarding human resources, the Thai government has established specialized committees to enhance the efficiency of recruitment, training, and management of healthcare personnel.

Thirdly, preventive healthcare is given high priority, with at least 30% of the national health budget allocated to this sector in order to protect public health, strengthen disease prevention and control, and improve community health education.

Fourthly, from the perspective of Public Expenditure Review (PER) evaluation, Thailand applies Performance-Based Budgeting/Public Expenditure Review (PBB/PER) indicators to link PHC expenditure with output-based Key Performance Indicators (KPIs), similar to the Balanced Scorecard (BSC) model applied in Thailand. This approach provides valuable experience for evaluating state budget expenditure for PHC development in Vietnam, thereby contributing to the development of a more effective, sustainable, and efficient PHC system.

1.3.1.2. Singapore's Experience

Firstly, with regard to investment, the state budget prioritizes investment in healthcare infrastructure, medical equipment, and fixed assets in order to ensure the efficient operation of clinics, hospitals, and Primary health care facilities, thereby meeting the healthcare needs of the population.

Secondly, regarding human resources, the Government of Singapore allocates substantial budgetary resources to improve salaries and welfare benefits for healthcare workers in order to maintain and enhance service quality.

Thirdly, in terms of preventive healthcare, the state budget is allocated to key preventive healthcare activities such as PHC services, disease prevention programs, and financial assistance schemes for low-income and vulnerable groups through mechanisms such as Medifund, thereby improving population health outcomes and reducing emergency treatment costs.

Fourthly, Singapore applies Performance-Based Budgeting/Public Expenditure Review (PBB/PER) indicators to link PHC expenditure with institutional performance through organizations such as the Health Promotion Board (HPB) and the Ministry of Health. This approach is used to assess the effectiveness of PHC expenditure in relation to life expectancy, healthcare service coverage, and the overall efficiency of state budget expenditure for PHC development.

1.3.1.3. Australia's Experience

Firstly, with regard to investment, the state budget is utilized to develop and maintain Primary health care infrastructure, including clinics, medical equipment, and supporting technologies.

Secondly, regarding human resources, a substantial proportion of the state budget is allocated to salaries, training, and workforce development for Primary health care personnel, including general practitioners, community nurses, and other Primary health care workers.

Thirdly, in terms of preventive healthcare, the state budget is extensively invested in preventive healthcare programs, including PHC services, disease prevention and control initiatives, community health education, and support programs for vulnerable population groups.

Fourthly, Australia applies Performance-Based Budgeting/Public Expenditure Review (PBB/PER) indicators to link PHC expenditure with output-based Key Performance Indicators (KPIs), following an approach similar to Australia's Balanced Scorecard (BSC) model. This approach provides valuable experience for evaluating state budget expenditure for PHC development in Vietnam, with the aim of reducing hospitalization rates and inpatient treatment costs, alleviating pressure on higher-level hospitals, and enhancing the effectiveness of PHC service delivery.

1.3.2. Lessons learned for Vietnam

Firstly, strengthening the mobilization of both public and private financial resources for PHC development.

Secondly, reforming and innovating healthcare financing and financial management mechanisms.

Thirdly, enhancing the efficiency of state budget expenditure management through performance evaluation and monitoring tools such as PER.

CONCLUSION OF CHAPTER 1

In Chapter 1, based on theoretical studies on PHC and state budget expenditure for PHC development, the author has clarified several key issues as follows:

Firstly, the theoretical foundations of PHC and PHC development have been clarified in terms of concepts, characteristics, and principles of state budget expenditure for PHC development.

Secondly, the theoretical framework of state budget expenditure for PHC development has been systematized with respect to concepts, characteristics, principles, expenditure contents, evaluation criteria, and influencing factors.

Thirdly, the contents of state budget expenditure for PHC development have been systematized in accordance with principles aligned with the healthcare system development strategy and the strengthening of PHC; state budget allocation based on approved estimates; output-based contracting and performance-oriented task assignment mechanisms; compliance with standards, norms, and financial regulations; adherence to fiscal-year principles; and the assurance of transparency, accountability, and equity.

Fourthly, key evaluation criteria for state budget expenditure have been synthesized in order to demonstrate the relevance of reforming state budget expenditure for PHC development in the context of the revised State Budget Law, the restructuring toward a streamlined two-tier local government system, and the implementation of the national PHC network development plan toward 2030 with a vision to 2045, thereby contributing to the sustainable development of the healthcare system in the new era of national transformation.

Fifthly, international experiences in state budget expenditure for PHC development in Singapore, Thailand, and Australia have been examined, from which important lessons applicable to PHC development in Vietnam have been derived.

CHAPTER 2
CURRENT SITUATION OF STATE BUDGET EXPENDITURE FOR PRIMARY HEALTH CARE DEVELOPMENT IN VIETNAM

2.1. OVERVIEW OF PRIMARY HEALTH CARE IN VIETNAM

2.1.1. The Formation and development of the Primary health care system in Vietnam

The first stage (1945 - 1954), the initial establishment period: building the foundation of the revolutionary healthcare system.

The second stage (1954 - 1975), the period of resistance against the United States and the development of Northern Vietnam: expansion of the Primary health care network.

The third stage (1976 - 2000), the period of national reunification and early reform: consolidation and initial reform of the healthcare system.

The fourth stage (2001 - 2020), the period of integration and modernization: standardization and emerging challenges.

The fifth stage (2021 - present), the period of comprehensive reform: a new phase characterized by digital transformation and sustainable development.

2.1.2. General assessment of the Primary health care system in Vietnam

During the period from 2017 to June 30, 2025, the PHC system in Vietnam was characterized by a unified model of multifunctional district health centers, with commune health stations operating under the direct management of district health centers. In several localities, pilot models and organizational adjustments of commune health stations were also implemented.

From July 1, 2025 onward, the PHC system in Vietnam has undergone significant restructuring in line with the two-tier local government model, under which the district administrative level in healthcare governance has been abolished. This restructuring has led to the reorganization of public healthcare units to improve management efficiency and adapt to the new governance framework.

In recent years, the PHC system has achieved important progress; however,

several limitations and challenges remain, including:

Firstly, shortages in both the quantity and quality of healthcare human resources.

Secondly, inadequate infrastructure and medical equipment that fail to meet healthcare service demands.

Thirdly, limitations in healthcare financing mechanisms and social health insurance policies.

Fourthly, weaknesses in digital transformation and healthcare information management systems.

Fifthly, overcrowding at higher-level hospitals due to the limited effectiveness of PHC facilities.

Sixthly, comprehensive challenges arising from the implementation of the two-tier local government model.

The causes of these limitations and shortcomings include:

Firstly, insufficient investment in PHC relative to development requirements, particularly in economically disadvantaged and remote areas.

Secondly, the lack of consistent and sufficiently strong policies to promote PHC development, especially regarding financial mechanisms and the financial autonomy of commune health stations.

Thirdly, shortages of healthcare personnel in both quantity and professional qualifications due to inadequate training capacity, heavy workload pressures, and difficult working conditions.

Fourthly, incomplete and inconsistent administrative restructuring and healthcare system reorganization, thereby affecting governance capacity and operational efficiency.

2.2. CURRENT SITUATION OF STATE BUDGET EXPENDITURE FOR PRIMARY HEALTH CARE DEVELOPMENT IN VIETNAM

2.2.1. Current situation of state budget expenditure for Primary health care development

2.2.1.1. Current situation of the scale of state budget expenditure for Primary health care

Firstly, the proportion of state budget expenditure for PHC development relative to GDP.

Secondly, the proportion of state budget expenditure for PHC development relative to total state budget expenditure on healthcare.

Thirdly, the growth rate of state budget expenditure for PHC development over time.

2.2.1.2. Current situation of the structure and priority level of state budget expenditure for Primary health care development

2.2.1.3. Current situation of the responsiveness of state budget expenditure for Primary health care development

2.2.1.4. Current situation of the efficiency of state budget expenditure for Primary health care development

Firstly, the hospital bed utilization rate.

Secondly, indicators reflecting the level of state budget investment in PHC development.

Thirdly, indicators assessing efficiency and resource allocation through the expenditure structure by level of healthcare facilities.

2.2.2. Current situation of recurrent state budget expenditure for Primary health care development

2.2.2.1. Structure and growth of recurrent expenditure

2.2.2.2. Responsiveness and efficiency of recurrent expenditure

2.2.3. Current situation of capital state budget expenditure for Primary health care development

2.2.3.1. Structure and growth of capital expenditure

2.2.3.2. Responsiveness and efficiency of capital expenditure

2.3. ASSESSMENT OF THE CURRENT SITUATION OF STATE BUDGET EXPENDITURE FOR PRIMARY HEALTH CARE DEVELOPMENT IN VIETNAM

2.3.1. Achievements of state budget expenditure for Primary health care development

2.3.1.1. Scale of state budget expenditure for Primary health care

Firstly, the scale of state budget expenditure for PHC development has maintained relatively stable growth, with an average annual growth rate of approximately 9.4% and a cumulative increase of 119% over the entire study period.

Secondly, in terms of fiscal discipline and budget implementation efficiency, state budget expenditure for PHC development has achieved a very high level of compliance, with a budget execution rate of approximately 99.4%, significantly higher than that of many countries in the region.

Thirdly, regarding contributions to the healthcare system, state budget expenditure has contributed to expanding PHC coverage and improving access to healthcare services, as reflected in the increase in social health insurance coverage to more than 95% of the population.

Fourthly, there has been a positive shift in the expenditure structure, reflecting a gradual reallocation of financial resources toward prioritizing PHC development.

Fifthly, in terms of overall public expenditure efficiency, state budget expenditure for PHC development is considered relatively effective in maintaining healthcare system operations and ensuring social welfare, as reflected in a PER score of approximately 8.5 out of 10.

2.3.1.2. Structure and priority level of state budget expenditure for Primary health care Development

Firstly, regarding the structure and trends of resource allocation, state budget

expenditure for PHC development has maintained stable growth, reflecting the Government's policy commitment to strengthening PHC and progressing toward universal health coverage.

Secondly, there has been a structural shift toward increasing capital investment expenditure for PHC development.

Thirdly, in terms of budgetary priority, state budget expenditure for PHC development has been maintained at a relatively stable level and has increased in absolute terms, demonstrating the Government's sustained commitment to this sector.

Fourthly, with respect to contributions to healthcare system objectives, state budget expenditure for PHC development has played an important role in expanding PHC coverage, improving access to healthcare services, and gradually reducing out-of-pocket healthcare expenditure for the population.

Fifthly, regarding fiscal sustainability, the scale of state budget expenditure for PHC development during the 2017 - 2025 period has shown a steady upward trend over time.

2.3.1.3. Responsiveness of state budget expenditure for Primary health care Development

Firstly, regarding the capacity to meet expenditure needs, state budget expenditure for PHC development has played an important role in ensuring financial resources for key healthcare tasks, particularly in the context of epidemics and public health shocks.

Secondly, with respect to the timeliness of budget expenditure, the system has initially ensured relatively stable financial flows throughout the budget cycle, thereby contributing to minimizing disruptions in PHC service delivery.

Thirdly, regarding budget credibility, the PEFA indicator during the 2021–2025 period ranged from -22% to -30%, reflecting a significant discrepancy between approved budget estimates and actual state budget expenditure for PHC development.

Fourthly, in terms of resource allocation efficiency, the increase in state budget expenditure for PHC development during the 2017–2025 period demonstrates that PHC has received increasing policy attention and financial prioritization.

Fifthly, regarding responsiveness on a per capita basis, per capita expenditure on PHC services has shown a stable upward trend, reflecting efforts to expand investment and improve access to healthcare services.

2.3.1.4. Efficiency of state budget expenditure for Primary health care development

Firstly, regarding input efficiency, state budget expenditure for PHC development has maintained stable growth accompanied by a high degree of fiscal discipline, particularly with respect to recurrent expenditure.

Secondly, in terms of output efficiency, state budget expenditure has substantially contributed to improving infrastructure, medical equipment, and service

delivery capacity at the grassroots level, especially during the post-COVID-19 period.

Thirdly, regarding outcome efficiency, state budget expenditure has contributed to improving population access to healthcare services, as reflected in the increase in per capita healthcare expenditure and the expansion of coverage of essential healthcare services.

Fourthly, in terms of impact efficiency, state budget expenditure has contributed to improvements in selected health indicators and the expansion of PHC coverage.

Fifthly, with respect to the efficiency of recurrent expenditure, this can be considered one of the major strengths of the healthcare system.

Sixthly, regarding the efficiency of capital expenditure, the scale of investment has increased and has approached internationally recommended benchmark levels.

2.3.2. Limitations and shortcomings

2.3.2.1. Scale of state budget expenditure for Primary health care

Firstly, the scale and growth of state budget expenditure for PHC development continue to reveal several structural constraints. Although total expenditure has increased over time, per capita expenditure remains relatively low compared to other countries in the region, amounting to only around half of Thailand's level, thereby reflecting limited fiscal capacity.

Secondly, the budget allocation mechanism remains predominantly input-based rather than output- or performance-based.

Thirdly, capital expenditure for PHC development remains insufficiently sustainable, with relatively low disbursement efficiency. Despite the increasing scale of investment, the disbursement rate has remained at approximately 82.4%, lower than the expected benchmark level of around 95%, thereby leading to capital accumulation and reducing the efficiency of state budget utilization.

2.3.2.2. Structure and priority level of state budget expenditure for Primary health care Development

Firstly, the share of state budget expenditure on healthcare relative to GDP remains at only approximately 1.14%, which is lower than internationally recommended levels, thereby indicating limited fiscal space for the healthcare sector. This situation requires improvements in expenditure efficiency, a transition from an *"expenditure expansion"* approach toward an *"efficiency enhancement"* approach, and the diversification of financing sources for PHC development.

Secondly, the allocation structure of state budget expenditure within the healthcare sector remains heavily concentrated on higher-level hospitals. Public financial resources continue to be primarily directed toward central and provincial hospitals, while PHC facilities responsible for delivering PHC services still depend largely on low and relatively rigid recurrent expenditure norms. These funding

mechanisms have not undergone substantial reform during the 2017 - 2025 period and remain insufficiently flexible and responsive to actual healthcare needs.

2.3.2.3. Responsiveness of state budget expenditure for Primary health care Development

Firstly, the scale of state budget expenditure for PHC development remains relatively low and has not fully met the requirements for healthcare system development.

Secondly, the proportion of the state budget allocated to PHC development has not yet achieved policy targets, and the level of budgetary prioritization for PHC remains limited.

Thirdly, the timeliness and flexibility of budget allocation, budget approval, and budget disbursement processes remain inadequate.

Fourthly, the quality of budget planning remains relatively low, as reflected in the significant discrepancies between approved budget estimates and actual expenditure execution.

Fifthly, the efficiency of state budget utilization for PHC development remains inconsistent with the scale of allocated financial resources.

Sixthly, financial protection for the population remains limited. The share of state budget expenditure on healthcare relative to GDP remains low compared with international benchmarks, while out-of-pocket healthcare expenditure by households remains high.

Seventhly, the budget allocation mechanism for PHC development has not yet kept pace with modern trends in public financial management and performance-based budgeting

2.3.2.4. Efficiency of state budget expenditure for Primary health care development

Firstly, the efficiency of transforming public investment capital into healthcare service delivery capacity within the PHC system remains limited.

Secondly, the operational efficiency of the PHC system has not yet achieved sustainability, as the utilization rate of healthcare services at the grassroots level remains relatively low.

Thirdly, the effectiveness of reducing overcrowding at higher-level healthcare facilities and narrowing healthcare disparities remains limited.

Fourthly, the efficiency of resource allocation remains relatively low due to an imbalanced expenditure structure. State budget resources for healthcare continue to be concentrated primarily at provincial and central hospitals, accounting for approximately 78% of total public healthcare expenditure, while PHC receives only around 21.75% of total state budget expenditure on healthcare.

Fifthly, the internal expenditure structure remains imbalanced, with recurrent expenditure accounting for an excessively high proportion of total expenditure.

Sixthly, the efficiency of public investment remains limited due to fragmented investment, lack of synchronization, and slow budget disbursement.

Seventhly, the system of state budget allocation norms remains outdated and fails to create sufficient incentives for improving expenditure efficiency and service performance.

Eighthly, the budget allocation mechanism remains largely equalized and insufficiently responsive to local characteristics and healthcare needs.

Ninthly, budget planning quality and fiscal discipline remain inadequate, as reflected in the persistent discrepancies between approved budget estimates and actual expenditure execution.

Tenthly, expenditure management remains relatively inflexible, while budget settlement and financial control procedures continue to be complex and time-consuming.

Eleventhly, the fiscal sustainability of state budget expenditure for PHC development remains limited.

Twelfthly, there remains a lack of a comprehensive medium- and long-term financial strategy for PHC development.

2.3.3. Causes of limitations

2.3.3.1. Objective causes

Firstly, limitations in the legal framework and fiscal decentralization mechanisms.

Secondly, constraints arising from the macroeconomic context and limited fiscal space.

Thirdly, pressures associated with demographic structure and changing disease burden patterns.

Fourthly, the impacts of health insurance coverage and healthcare service utilization behavior.

Fifthly, geographical constraints and regional disparities in healthcare access and resource allocation.

Sixthly, limited community participation in healthcare activities and public health programs.

Seventhly, the dual impacts of scientific and technological development.

2.3.3.2. Subjective Causes

Firstly, limitations in the state budget allocation mechanism for PHC development.

Secondly, inadequacies in the budget planning, allocation, and execution process.

Thirdly, limitations in financial management capacity.

Fourthly, weaknesses in information systems and digital transformation.

Fifthly, limitations in human resources and the organizational structure of the

PHC system.

Sixthly, uneven leadership capacity and inconsistencies in policy prioritization.

CONCLUSION OF CHAPTER 2

Firstly, this chapter provides an overview of the PHC system in Vietnam from two perspectives, namely the historical formation process and the development trajectory of the PHC system.

Secondly, the chapter presents a general assessment of the current situation of state budget expenditure for PHC development in Vietnam during the 2017 - 2025 period.

Thirdly, through the analysis of state budget expenditure for PHC development, the author applies a system of evaluation indicators to assess the current status of the PHC system and public financial investment in its development, including achievements, limitations, and the underlying causes of these limitations.

CHAPTER 3
IMPROVING STATE BUDGET EXPENDITURE FOR PRIMARY HEALTH CARE DEVELOPMENT IN VIETNAM

3.1. PERSPECTIVES AND ORIENTATIONS FOR PRIMARY HEALTH CARE DEVELOPMENT, AND PERSPECTIVES AND OBJECTIVES FOR IMPROVING STATE BUDGET EXPENDITURE FOR PRIMARY HEALTH CARE DEVELOPMENT IN VIETNAM TOWARD 2030, WITH A VISION TO 2045

3.1.1. Perspectives and orientations for the development of the Primary health care system toward 2030, with a vision to 2045

3.1.2. Perspectives and objectives for improving state budget expenditure for Primary health care development in Vietnam toward 2030, with a vision to 2045

Firstly, state budget expenditure for PHC development must be regarded as a strategic priority, consistent with the foundational role of PHC within the national healthcare system.

Secondly, state budget expenditure for PHC development should be allocated based on healthcare needs and the principle of equity in access to healthcare services, taking into account population size, demographic structure, disease burden, and socio-economic conditions of each locality.

Thirdly, state budget expenditure should be reformed toward output-based and quality-oriented financing mechanisms, gradually shifting from input-based allocation to performance-based resource allocation.

Fourthly, state budget expenditure for PHC development must ensure timeliness, stability, and flexibility while complying with modern public financial management

principles, including transparency, openness, and accountability.

Fifthly, state budget expenditure for PHC development should be closely coordinated with other healthcare financing sources, particularly the social health insurance fund, mobilized social resources, and international assistance, in order to optimize total investment resources for PHC development.

Sixthly, state budget expenditure should prioritize core components of PHC development, including healthcare workforce development, modernization of infrastructure, and acceleration of digital transformation, thereby enhancing service delivery capacity and improving healthcare system management efficiency.

Seventhly, improving state budget expenditure for PHC development must be closely associated with healthcare governance reform and fiscal decentralization, in line with the restructuring of the healthcare system under the two-tier local government model following the removal of the district level. Such decentralization should be accompanied by strengthened accountability and more efficient budget utilization.

Eighthly, in the long term, state budget expenditure for PHC development should move toward performance-based and value-based allocation mechanisms, shifting from a traditional *"expenditure"* mindset toward an *"investment in health"* approach, thereby improving the quality of PHC services, reducing social costs, and ensuring the sustainable development of the healthcare system.

Specific Objectives for Improving State Budget Expenditure for PHC Development

Firstly, increasing the proportion of state budget expenditure for PHC development to at least approximately 30% of total public healthcare expenditure; ensuring that social health insurance financing for PHC services accounts for more than 40% of total expenditure at this level; and guaranteeing that 100% of commune health stations receive a minimum per capita budget allocation sufficient to support preventive healthcare and effective healthcare service delivery.

Secondly, through social health insurance mechanisms, state budget expenditure should expand the coverage of the essential healthcare service package at commune-level healthcare facilities, while reducing out-of-pocket co-payment rates to 10% or lower in order to alleviate the financial burden on households and improve access to PHC services.

Thirdly, in order to ensure regional equity, particularly in disadvantaged, border, and island areas, strong fiscal transfer and subsidy mechanisms should be established, including the possibility of up to 100% state budget support for both recurrent and capital expenditures, thereby ensuring adequate financial resources for PHC development and narrowing regional disparities in healthcare service quality.

Fourthly, expenditure efficiency should be strengthened through the establishment of monitoring, supervision, and evaluation systems for PHC expenditure

in all provinces nationwide, thereby creating a transparent and evidence-based foundation for policy adjustment and improving financial management capacity within the PHC system.

Fifthly, targets should include achieving social health insurance coverage for more than 95% of the population, ensuring that 100% of PHC services provided at the grassroots level are covered by social health insurance, and establishing electronic health records for the entire population.

Sixthly, the PHC financing system should operate in a self-sustaining, financially sustainable, and accountable manner, closely linked to PHC performance outcomes.

Seventhly, the completion of a national healthcare expenditure database constitutes a key factor in improving governance efficiency. This includes the development of an integrated information system for social HI claims assessment and state budget settlement at the grassroots level, thereby enhancing financial transparency, reducing waste, and improving the efficiency of resource allocation.

3.2. SOLUTIONS FOR IMPROVING STATE BUDGET EXPENDITURE FOR PRIMARY HEALTH CARE DEVELOPMENT IN VIETNAM

3.2.1. Solutions for improving the scale of state budget expenditure for Primary health care development

Firstly, developing a medium-term and predictable roadmap for gradually increasing state budget expenditure for PHC development in a stable manner.

Secondly, progressively increasing per capita state budget expenditure for PHC development based on the principle of prioritizing frontline healthcare services and disadvantaged areas.

Thirdly, expanding fiscal space for PHC development through mechanisms for resource mobilization and the integration of multiple financing sources.

Fourthly, linking the expansion of state budget expenditure with the control of out-of-pocket healthcare payments and the strengthening of financial protection for the population.

Fifthly, utilizing state budget expenditure as a policy instrument to reduce overcrowding at higher-level hospitals by strengthening the actual service delivery capacity of PHC facilities.

3.2.2. Solutions for improving the structure and priority level of state budget expenditure for Primary health care development

Firstly, restructuring state budget allocation within the healthcare sector toward a substantive prioritization of PHC development.

Secondly, reforming budget allocation criteria by shifting from input-based approaches toward needs-based and results-based allocation mechanisms.

Thirdly, adjusting the structure between recurrent and capital expenditure toward a more balanced, sustainable, and efficient composition.

Fourthly, prioritizing state budget capital expenditure for the targeted upgrading of healthcare infrastructure and medical equipment within the PHC system.

Fifthly, prioritizing budget allocation for components that generate long-term added value, particularly the development, retention, and maintenance of the PHC workforce.

Sixthly, reforming recurrent expenditure norms for PHC development toward greater flexibility, regular updating, and responsiveness to actual healthcare needs and local conditions.

3.2.3. Solutions for improving the responsiveness of state budget expenditure for Primary health care development

Firstly, comprehensively reforming the budgeting process for PHC development in order to ensure closer alignment with actual healthcare needs and implementation capacity.

Secondly, improving the timeliness of budget allocation, approval, and disbursement processes.

Thirdly, accelerating the digital transformation of budget management processes in order to reduce delays caused by multilayered administrative procedures.

Fourthly, strengthening absorptive capacity and financial management capacity at the grassroots level.

Fifthly, improving fiscal decentralization mechanisms while ensuring continuity and intersectoral coordination of state budget expenditure under the two-tier local government model.

Sixthly, improving the institutional framework and organizational model of the PHC system in line with the two-tier governance structure.

Seventhly, strengthening the integration between state budget financing and social health insurance financing mechanisms in order to improve service responsiveness and ensure sustainable financial resources for PHC development.

3.2.4. Solutions for improving the efficiency of state budget expenditure for Primary health care development

Firstly, shifting from procedure-based expenditure management toward results-based and output-oriented expenditure management.

Secondly, improving the efficiency of capital expenditure through appropriate project selection and enhanced budget disbursement performance.

Thirdly, improving the utilization efficiency of invested infrastructure and medical equipment within the PHC system.

Fourthly, enhancing the efficiency of recurrent expenditure by increasing the proportion of spending on professional healthcare activities while gradually reducing rigid administrative costs.

Fifthly, linking expenditure efficiency with the improvement of equity in access to PHC services.

Sixthly, strengthening inspection, supervision, independent evaluation, and accountability mechanisms for state budget expenditure outcomes in PHC development.

3.3. CONDITIONS FOR IMPLEMENTING THE SOLUTIONS

3.3.1. Ensuring macroeconomic stability and fiscal discipline

3.3.2. Improvement of institutional frameworks and the two-tier local government model

3.3.3. Improvement of human resource conditions and remuneration policies

3.3.4. Improvement of financial conditions, health insurance, and payment mechanisms (operational conditions)

3.3.5. Development of infrastructure, digital transformation, and healthcare data systems

CONCLUSION OF CHAPTER 3

Firstly, based on the perspectives and orientations for the development of the PHC system and state budget expenditure for PHC development in Vietnam toward 2030, with a vision to 2045, the dissertation proposes six guiding perspectives and four major development orientations for the PHC system in Vietnam. In addition, the dissertation identifies five perspectives, short-term objectives, two long-term objectives, and five major measures for improving state budget expenditure for PHC development toward 2030 and 2045. These constitute important theoretical foundations for the formulation of policy solutions.

Secondly, the dissertation proposes four groups of practical solutions aimed at improving state budget expenditure for PHC development in Vietnam, including: solutions for improving the scale of state budget expenditure; solutions for improving the structure and priority level of expenditure; solutions for improving expenditure responsiveness; and solutions for improving expenditure efficiency.

Thirdly, the dissertation identifies key conditions necessary for implementing the proposed solutions, including five major conditions intended to ensure the effective implementation of solutions for improving state budget expenditure for PHC development in Vietnam in the coming period. These conditions are particularly important in the context of the country's new development era and the ongoing process of national transformation, contributing to comprehensive healthcare provision for the population in line with the strategic orientations of the Party and the Government.

GENERAL CONCLUSION

In the context of administrative unit consolidation, the implementation of the two-tier local government model following the removal of the district level, the reform of public financial mechanisms, and the evolving functions of the PHC system in Vietnam, the dissertation entitled *"State Budget Expenditure for Primary health care Development in Vietnam"* carries significant theoretical and practical implications. The dissertation aims to strengthen the PHC system in order to improve the operational efficiency and service quality of the *"gate keeper"* level of the healthcare system, thereby ensuring the provision of essential healthcare services to the population.

Through the application of appropriate research methodologies, the systematization of theoretical foundations, and the analysis of empirical evidence, the dissertation addresses several key issues as follows:

Firstly, the dissertation systematizes and further develops the theoretical framework relating to the PHC system and state budget expenditure for PHC development. It also reviews international experiences from representative countries regarding state budget expenditure and derives valuable lessons applicable to Vietnam.

Secondly, based on a detailed and evidence-based analysis of the current situation of the PHC system, including both recurrent and capital state budget expenditure for PHC development in Vietnam, the dissertation evaluates major achievements, limitations, and the underlying causes of these limitations during the 2017 - 2025 period.

Thirdly, based on the identified limitations, underlying causes, and development orientations of the PHC system in Vietnam, the dissertation defines perspectives and objectives for improving state budget expenditure for PHC development and proposes four groups of solutions for the period toward 2030, with a vision to 2045.

LIST OF THE AUTHOR'S PUBLISHED WORKS
RELATED TO THE DISSERTATION

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