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Mechanism for Paying Health Insurance Payment for Public Hospitals

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Abstract
Despite healthcare insurance being recognized as one of the most important social security policies in modern society, there are still some shortcomings in the current healthcare insurance system. This affects all parties involved, primarily the insured individuals, followed by hospitals - the providers of medical services, and insurance agencies. Finding a balance between the interests of these three parties: Patients (healthcare insurance participants), financial providers (healthcare insurance agencies), and hospitals (providers of medical services) is truly challenging. This leads to ineffective utilization of healthcare insurance resources, unless there are monitoring activities to oversee the use of healthcare insurance resources and the quality of healthcare services provided to insured patients by public hospitals.
This article delves deep into the current payment mechanism for healthcare insurance in public hospitals under the Ministry of Health, highlighting both the advantages and challenges in this system. It also proposes solutions to innovate the payment mechanism for healthcare insurance in public hospitals.

Keywords: Payment Mechanism, Healthcare Insurance, Public Hospitals

1. Introduction
The public hospital system in Vietnam plays a crucial role in providing healthcare to the people. Over time, these public hospitals have been adapting to the country's development needs in each phase. In terms of expertise, the hospitals continuously strive to expand and improve the quantity and quality of medical services, aiming to provide better services that meet the needs of the population. In terms of financial management, the hospitals have been actively mobilizing legal sources of revenue, diversifying financial resources for investment, upgrading equipment and infrastructure, and improving the income of healthcare workers, thus partially covering the costs of the regular activities of the units.
Despite achieving many results, public hospitals still face many shortcomings and challenges in hospital management, especially financial management. External sources of revenue are limited in both scale and scope, and the management of expenditures is not yet effective. There is still a significant amount of waste and loss in financial management, along with unwanted impacts from the market economy and uncontrolled development. These shortcomings have existed in public hospitals for a long time, causing dissatisfaction in society. In addition, the new conditions of social development during Vietnam's integration and development process have placed great pressure on reform and innovation in the financial management of public hospitals. Financial management is an important part of the overall activities of hospitals, aiming for effective quality goals for public hospitals. Among them, "hospital financial management mechanisms" are a decisive factor in creating conditions for hospital development and improving the effectiveness of healthcare services provided to society. Recently, the operation mechanism of public hospitals, including the financial management mechanism, has received special attention from society. The financial management mechanism of public hospitals has also undergone many changes to meet the requirements of socio-economic development at each stage. However, alongside the advantages brought about by this mechanism, there are still many shortcomings and obstacles, especially in the payment mechanism for health insurance at public hospitals. In order for this mechanism to have a positive impact, fully utilize its strengths, overcome existing issues, and bring practical benefits to the public hospital system, there needs to be innovative leverage for the development of activities within the public hospital system.

2. The Foundation of Theoretical Knowledge
Public hospitals are institutions that provide medical services to society and carry out professional medical tasks in accordance with regulations, under the management and control of competent government agencies.

The operational characteristics of public hospitals are similar to those of public enterprises and are closely related to the unique nature of hospitals, which serve the healthcare needs of society. Public hospitals are owned by the government and distributed based on administrative decentralization by region, territory, and specialized technical lines. The primary objective of public hospitals is to provide healthcare and protect the health of the people, prioritizing their well-being over profit. State budget funding has been and continues to be one of the most crucial resources for public hospitals. Public hospitals are also responsible for implementing social policies assigned by the government.

Source of Health Insurance

Health insurance is the collective effort of the community, including both healthy and sick individuals, to pay for medical treatment through insurance so that the community can share risks to stabilize life. Health insurance is like the contribution of an entire community, including both healthy and sick individuals, to pay for medical treatment. Health insurance is a social policy that mobilizes contributions from labor users, workers, organizations, and individuals in need of insurance to form an insurance fund. This fund is used to pay for medical expenses. For each individual, health insurance is considered a prepayment for medical expenses because health insurance policies are calculated based on the income ratio of workers, while benefits are enjoyed not based on contributions but on the need for medical treatment. Health insurance will help improve the quality of healthcare services provided by the system of hospitals through the relationship between three parties: healthcare service users, healthcare service providers, and health insurance. All healthcare activities for insured patients involve managing relationships between three parties: health insurance, hospitals or medical facilities, and patients.

The health insurance fund is defined as "a financial fund formed from health insurance premiums and other legal sources of revenue, used to pay for medical expenses, manage the healthcare system, and cover other legal expenses related to health insurance". Therefore, the insurance organization will directly collect fees from individuals while also signing healthcare insurance contracts with hospitals based on scope, professional nature, and applicable payment methods, as agreed upon in the contract. All public and private healthcare facilities that meet the necessary technical qualifications can sign healthcare contracts for insured patients, allowing participants to choose a suitable and convenient initial healthcare provider and ensuring equality between public and non-public hospitals. Between the health insurance organization and public hospitals, temporary advances, payments, and settlements for healthcare expenses are carried out. Thus, the source of health insurance is the financial resource that the health insurance agency uses to reimburse hospitals based on the number of medical services provided to insured individuals.

The Payment Mechanism for Health Insurance with Hospitals

This mechanism mainly relates to payment procedures and payment methods between the health insurance agency and hospitals.

The payment process between the health insurance agency and hospitals: Hospitals enter into contracts with the health insurance agency for medical treatment. Then, the health insurance agency provides advance funding to the hospital based on their agreement and communication. The hospital provides medical services according to the terms of the signed contract, and periodic payments must be sent to the health insurance agency for settlement reports. The agency will then settle the payments based on the specified periods in the contract and provide advances for the next period.

The payment method between health insurance and hospitals has a strong impact on all parties involved. This method directly affects healthcare costs and the quality of healthcare services provided. It is essential to determine the payment mechanism between parties that is suitable for economic development and social conditions. The payment method is one of the important factors in obtaining quality and efficient healthcare services from hospitals.

There are various methods of payment for healthcare service providers, with the three most commonly used methods worldwide being fee-for-service, capitation, and diagnosis-related group (DRG) payment.

Each method has its strengths and weaknesses and can have different impacts on the behavior of hospitals as well as health insurance funds. Innovating and reforming payment methods is essential to ensuring appropriate methods of payment for healthcare services while also ensuring control over healthcare costs, ensuring the quality of healthcare services, and meeting management requirements. With the unique advantages and disadvantages of each method, being able to apply all three methods helps to limit the disadvantages and enhance the advantages of each method, contributing to improving the quality of healthcare and helping hospitals manage and allocate resources more effectively.

3. Research Methodology

By implementing the statistical research method, we collect and analyze various documents such as policy documents, laws, summary reports, evaluations of the healthcare sector, and financial statements of public hospitals under the Ministry of Health.

To evaluate the mechanism of allocating healthcare budgets to public hospitals under the Ministry of Health, we conducted a survey to gather assessments and perspectives from relevant groups involved in this mechanism. Specifically, we used survey questionnaires to investigate and compile issues related to the allocation of healthcare budgets to public hospitals in order to gain a deeper understanding of our research topics. The data from the survey questionnaires was processed using SPSS.

The author conducted a survey with 220 participants, categorized by gender, education level, and field of work. The author focused on classifying the participants based on their field of work. Out of the 220 participants, 134 were from university level, accounting for 60.9%, while 62 participants were above university level, accounting for 28.2%. The remaining participants were from higher vocational and intermediate levels. In terms of the respondents' field of work, the group with the highest number was financial planning officers from hospitals, with 111 participants, accounting for 50.5%. This was followed by hospital staff with 41 participants, accounting for 18.6%. There were also 22 respondents who were hospital

management leaders, making up 10% of the sample size. The remaining two groups were officials from the Ministry of Finance (16 participants-7.3%) and officials from the Ministry of Health (30 participants-13.6%), who directly provide advice and develop financial management mechanisms for hospitals.

Table 1: Statistical analysis of the research sample

	Characteristics of the research sample	Quantity of samples	Percentage ratio within the sample
1	**Gender**	**220**	**100%**
	Male	85	38.6%
	Female	135	61.4%
2	**Educational level**	**220**	**100%**
	At university	62	28.2
	University	134	60.9
	Vocational college	5	2,3
	Intermediate level	19	8,6
3	**Field of work**	**220**	**100%**
	Officials from the Ministry of Finance	16	7.3
	Officials from the Ministry of Health	30	13.6
	Officials from the finance and planning department at the hospital	111	50.5
	Leaders and managers at the hospital	22	10, 0
	Hospital staff	41	18.6

4. Status of the Health Insurance Payment Mechanism for Public Hospitals

4.1 The Legal Basis of the Health Insurance Payment Mechanism

Along with the general development trend of society, health insurance has become an important financial source for healthcare activities, especially for public hospitals. According to the amended Health Insurance Law, health insurance is a mandatory form of insurance applied to specified individuals for healthcare purposes, not for profit. The financial resources from health insurance payments to public hospitals are stable and gradually increasing, which is particularly significant in reducing the burden on the state budget, reducing dependence on state funding for public hospitals, and alleviating the financial burden on patients. Thanks to this financial resource, hospitals have the conditions to invest in developing infrastructure to serve their operations. The financial resources from health insurance in the overall financial structure of public hospitals are increasingly dominant based on the advantages of this resource, making health insurance an important source of public finance for healthcare. The financial resources from the health insurance fund play an important role in ensuring fairness in healthcare financing through risk-sharing mechanisms. It is a stable and strategic source because it ensures effective and equitable goals in providing healthcare services to the people in a humane spirit.

The future plan aims to provide comprehensive healthcare coverage for all citizens, making healthcare insurance the main source of funding for healthcare. With the gradual transition from regularly funding healthcare facilities to directly funding beneficiaries through state-provided healthcare insurance, there is a clear shift in the model of financial resource allocation for healthcare services, ensuring accurate cost calculation and transferring funding from healthcare facilities to service beneficiaries. Balancing the interests of all parties involved is challenging because everyone wants to maximize their own benefits and avoid losing even a small portion of them. Therefore, everyone wants to maximize their benefits or sometimes find ways to exploit the fund for their own gain. In reality, the quality of healthcare services is not solely determined by healthcare insurance but also by the hospitals that provide these services. Hence, hospitals play a central role in resolving this complex web of interests among healthcare insurance participants (patients), financial providers (healthcare insurance), and themselves. Therefore, healthcare insurance serves as an intermediary agency that can monitor and require hospitals to ensure the quality of healthcare services provided to users.

4.2 Implement the Healthcare Insurance Payment Mechanism with Hospitals under the Ministry of Health

Financial resources from healthcare insurance: Over time, financial resources from healthcare insurance have become a crucial and decisive source for the entire operations of public hospitals under the Ministry. In the long run, healthcare insurance will also be the main funding method for healthcare services, replacing direct payments from service users.

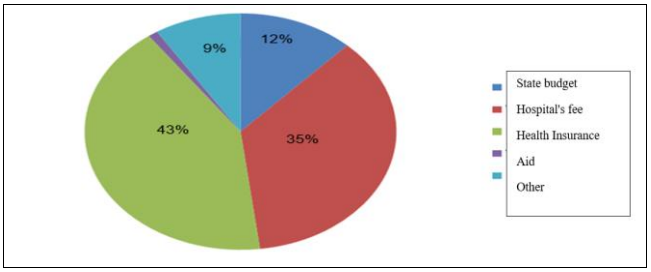

Fig 1: Proportion of financial resources for public hospitals under the Ministry of Health in 2022

Health insurance policies directly impact the finances of public hospitals in terms of financial resources, healthcare cost management, quality of healthcare services provided, and financial plans for the development of public hospitals. Health insurance is a special social security policy for modern society that will be a long-term direction to generate financial resources for healthcare with the goal of fairness and efficiency through risk sharing mechanisms.

The proportion of financial resources from health insurance in public hospitals under the Ministry ranges from 38% to 62% and is expected to increase in the future. According to health insurance payment data, this source also increases on average annually. For public hospitals, this has become a significant and decisive source. As for psychiatric hospitals, they mainly rely on funding from the state budget rather than health insurance.

Table 2: Health insurance payment sources at 3 hospitals from 2018-2022

Unit: 1,000,000 VND

Year	National Children's Hospital		Endocrine Hospital		Bach Mai Hospital	
	Number	%	Number	%	Number	%
2018	794,679	39	470,127	38	1,890,000	39
2019	712,926	40	461,145	45	1,826,000	42
2020	709,235	41	418,273	51	1,837,000.	51
2021	738,907	43	465,506	53	1,848,982.	54
2022	850,000	42	471,804	41	1,960,000	40

Source: Financial Planning Department - Ministry of Health data

The payment mechanism of health insurance with the main hospitals mainly relates to the payment process and payment methods between the health insurance agency and the hospitals.

The payment process between the health insurance agency and hospitals: For hospitals that sign their first medical insurance contract, with initial registration for medical treatment covered by health insurance, they will receive an advance payment of 80% of the allocated funds used at the hospital, according to the initial notification from the health insurance agency. As for hospitals that are implementing the contract, within 5 working days from the date of receiving the previous quarter's settlement report from the hospital, the health insurance organization will make a one-time advance payment of 80% of the medical examination and treatment costs covered by health insurance, based on the previous quarter's settlement report from the hospital.

The payment and settlement between hospitals and the health insurance agency are currently carried out in the following steps: (1) Within the first 15 days of each month, hospitals are responsible for sending a comprehensive request for payment of healthcare expenses covered by health insurance for the previous month to the health insurance agency for consolidation. Within the first 15 days of each quarter, hospitals are responsible for submitting a report on the settlement of healthcare expenses covered by health insurance for the previous quarter to the health insurance agency. (2) Within 30 days from the date of receiving the hospital's report on the previous quarter's settlement, the health insurance agency is responsible for notifying the assessment results and the settlement amount for actual medical examinations and treatments costs within the scope of healthcare benefits and reimbursement rates for the hospital. (3) Within 10 days from the date of notification of the settlement amount for medical examinations and treatment costs covered by health insurance, the health insurance agency must complete the payment with the hospital. Monthly, hospitals must submit a comprehensive request for payment of medical examination and treatment costs to facilitate control by the health insurance agency and payment on a quarterly basis within 10 days from when notified of the settlement amount, creating favorable conditions for hospitals to receive timely payment from health insurance to ensure financial resources for their operations. These are very convenient aspects of the payment mechanism between the health insurance agency and hospitals. However, there needs to be consensus between this mechanism and its implementation in order to truly maximize its effectiveness.

The current payment method between the health insurance agency and public hospitals is as follows:

Currently, public hospitals under the Ministry of Health mainly use a fee-for-service payment method with the health insurance agency. Specifically, the health insurance agency assigns inspectors to check the number of patients coming for examination and hospitalization, and inspectors monitor the quantity of drugs and medical services provided to patients to ensure they are appropriate for the specific condition and type of illness, while also evaluating the rationality of diagnostic and treatment indications for health insurance. Hospitals are paid for each medical service they provide to patients at regulated prices, which are determined based on specific price levels for each service after consulting with the competent authority. The previously regulated price framework was based on Circular 14 and Circular 03, but now it is based on Decree 04/2012. The fee-for-capitation payment method is mainly reserved for some hospitals that have registered initial medical examination and treatment, such as Hospital E and Hospital Huu Nghi. These hospitals are paid a predetermined amount in advance each quarter based on the number of initial medical examination and treatment cards registered at that hospital. In addition, there is the payment method based on diagnosis groups, which is a payment method widely used in many developed countries but is currently being researched and invested in Vietnam to be applied extensively in health insurance payment for public hospitals.

Appraisal work is one of the important activities in the settlement of medical insurance claims, but when asked about the appropriateness of appraisal work and payment by insurance agencies to hospitals, more than half of the respondents evaluated it as inappropriate (55.9%), while the remaining percentage believed it to be appropriate or very appropriate.

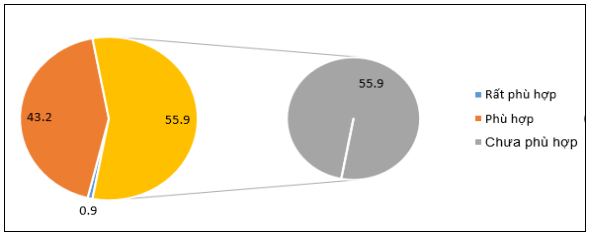

Fig 2: Conformity in inspection and payment of the insurance agency with the hospital (%)

There is a difference in the evaluation of the appropriateness of appraisal and payment work between the insurance agency and hospitals among different groups. The majority of officials from the Ministry of Finance and financial planning officers at hospitals believe that the current appraisal and payment work by the insurance agency is appropriate (50%), (61.3%). On the other hand, the majority of officials from the Ministry of Health, hospital leaders and managers, and hospital staff have opposite opinions, stating that it is not appropriate, with percentages of (96.7%), (63.6%), and (75.6%) respectively.

Table 3: Appropriateness in appraisal and payment work by the insurance agency with hospitals according to the evaluation of different groups (%)

	Ministry of Finance officials	Ministry of Health officials	Financial and planning staff at the hospital.	Leadership and management staff at the hospital.	Hospital staff.
Highly suitable.	6.2	0	0.9	0	0
Suitable.	50.0.	3.3	37.8	36.4	24.4
Not suitable.	43.8	96.7	61.3	63.6	75.6

In addition to suitability, the study also investigates the timeliness of assessment and payment by insurance agencies in the present. When evaluating the timeliness of assessment and payment by healthcare insurance agencies, 64.5% of respondents perceive it as untimely. This is also an opinion that needs to be taken into account in the future in order to make changes in the assessment and payment process of healthcare insurance agencies with hospitals that are appropriate and timely. Although different stakeholders such as financial officers, medical personnel, management leaders at various levels, or hospital staff have different roles, they all share the same perspective on the untimeliness of assessment and payment by healthcare insurance agencies with hospitals today.

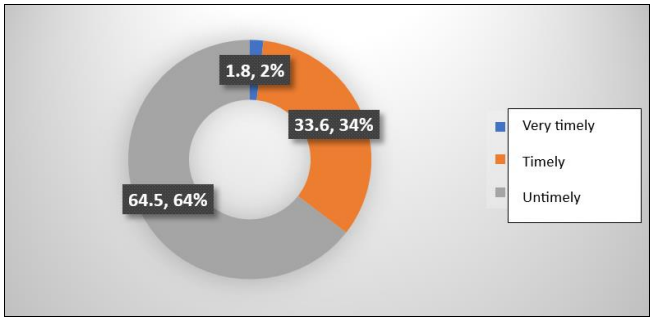

Fig 3: Timeliness in the appraisal and payment work of the insurance agency with hospitals (%)

When asked specifically to the group of hospital officials, "Does your hospital have a phenomenon of outstanding debts in payment with health insurance?", nearly two-thirds of the officials in the survey sample answered that there is still a phenomenon of outstanding debts at the surveyed hospital, accounting for (60.5%), while the remaining (39.5%) answered that they do not have this situation. Research on the causes of slow health insurance payments for hospitals yielded the following results:

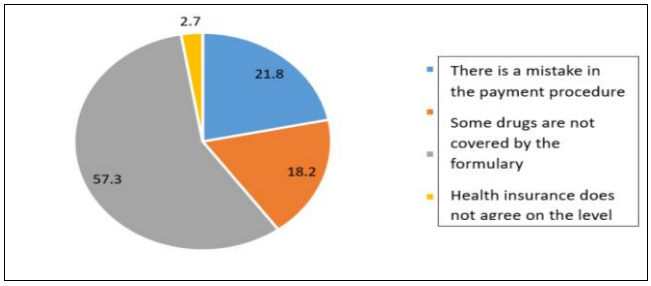

Fig 4: Main causes of slow health insurance payment for public hospitals (%)

The results of the survey show that the main reason for the delayed payment of medical insurance to hospitals, as chosen by the majority of respondents, is the lack of payment consistency in healthcare insurance (57.3%). This is considered to be the main cause of this delay. While most financial, medical, planning, and leadership personnel at hospitals believe that the main reason for the delay is the lack of payment consistency in healthcare insurance, only the hospital staff group believes that it is due to payment procedures being flawed. Therefore, it can be seen that the main reason mentioned by all groups is still the lack of payment consistency from healthcare insurance.

In reality, the number of insurance claims denied accounts for approximately 2% to 3% of the total insurance payments made to hospitals from 2018 to 2022.

The number of medical visits covered by the public health insurance fund is divided into outpatient visits and inpatient visits, with a higher proportion allocated to inpatient visits but a lower number of visits compared to outpatient visits. Public healthcare facilities reimbursed by the health insurance fund are also categorized into different levels.

Table 4: Number of medical visits covered by public health insurance during the period of 2018-2022

Unit: billion VND

Target	Year 2018	Year 2019	Year 2020	Year 2021	Year 2022
Number of medical examination and treatment expenses covered by public health insurance	97,748	105,088	98.525	82.907	97.568
Outpatient	37.754	40.144	39.118	36.068	37.173
Inpatient	59.994	63.944	62.816	62.850	60.395
Central Hospital	19.556	21.858	19.902	16.422	20.586
Provincial healthcare facility.	43.944	47.184	43.449	39.712	43.125
District healthcare facility.	30.856	33.838	32.513	25.120	31.612

Source: Report on health insurance fund 2018-2022

Table 5: Medical examination and treatment records and the amount paid, denied payment, and requested re-evaluation by public hospitals under the Ministry of Health

Unit: 1,000,000 VND

Year.	The hospital recommends.		Insurance payment.		- Insurance refuses payment.		Insurance requires reevaluation.	
	Number of medical visits.	Amount of money.	Number of medical visits.	Amount of money.	Number of medical visits.	Amount of money.	Number of medical visits.	Amount
2018	1,859,651	3,641,196	1,834,760	3,592,460	24,891	48,736	24,891	3,543,723
2019	2,274,775	4,828,792	2,249,024	4,793,965	25,751	34,827	2,223,273	4,759,138
2020	2,968,217	6,208,957	2,966,009	6,197,750	2,208	11,207	2,963,801	6,186,542
2021	3,235,113	7,118,784	3,234,768	7,115,939	345	2,845	3,234,423	7,113,093
2022	3,526,273	8,756,104	3,558,244	7,850,532	402	3,620	3,512,212	8,059,795

Table 6: Main reasons for delayed health insurance payment for public hospitals according to the assessment of different groups (%)

Content	Ministry of Finance officials	Officials Ministry of Health	The planning department staff at the hospital.	The hospital leadership staff.	The hospital staff.
There are errors in the payment procedure.	0	6.7	18.9	22.7	48.8
Some medications and techniques are not covered by insurance.	50	13.3	13.5	18.2	22.0
The healthcare insurance is not uniformly paid.	50	80.0	62.2	59.1	29.3

The main reason for payment denial is determined as above: The method of healthcare payment plays a role in connecting healthcare financing and healthcare service provision, with its main function being to ensure costs and improve the quality of healthcare services. Currently, the innovation of healthcare financing mechanisms in general, and the innovation of healthcare payment methods in particular, are identified as key solutions to promote the development of the healthcare sector in a fair, efficient, and sustainable manner.

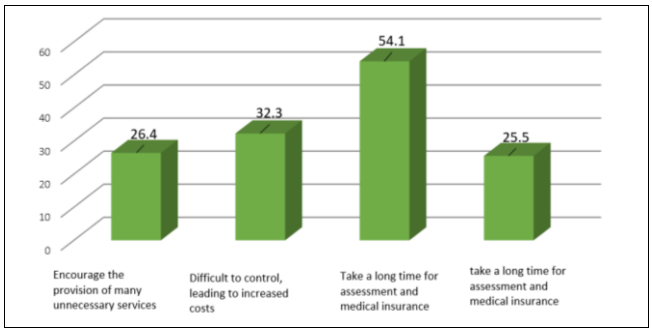

Fig 5: Impact of fee-for-service healthcare payment method for hospital management (%)

According to the survey results, the biggest inconvenience of this payment method is the time-consuming process of verifying and paying for health insurance (54.1%), as well as the difficulty in controlling medical costs (32.3%), which poses a risk of misusing the health insurance fund and causing it to be depleted due to the increasing costs that are hard to control. With this method, hospitals tend to provide more services than necessary, using expensive services, especially those that bring them more benefits in order to increase their financial resources and not feel pressured to save costs. The financial resources of the health insurance fund are not used effectively and cannot avoid the misuse of funds from service providers' fees as well as users' fees. Due to the nature of healthcare services, patients have limited information about them, do not know when they need to use them, do not know the specific total cost, and have difficulty bargaining for service prices. The use of and decision-making regarding healthcare services are mainly determined by hospitals. Therefore, hospitals always tend to increase the provision of services in order to increase revenue for their own hospital, which leads to widespread service abuse in public hospitals under the Ministry.

4.3 Evaluation of the Payment Mechanism for Public Healthcare Insurance with Hospitals

Achieved Results

The payment mechanism for healthcare insurance has been adjusted to address several unreasonable points, creating convenience for participants in healthcare insurance and payment between the healthcare insurance agency and hospitals.

Especially since the introduction of the Health Insurance Law and accompanying guidelines, the Health Insurance Law allows for the application of appropriate payment methods to facilitate convenient payment for public hospitals during health insurance transactions. The step-by-step experimentation and implementation of payment methods based on predetermined rates for initial hospital visits have had a positive impact on cost control, encouraging hospitals to use resources efficiently and save costs. In other words, it has shifted the responsibility of cost control from the health insurance fund to healthcare facilities. This method helps reduce or eliminate the need for monitoring and supervision of health insurance fund usage, as there is no longer a need to monitor abuse when hospitals are given a fixed amount. It also limits unnecessary services and keeps administrative costs low, especially compared to fee-for-service payment methods. Additionally, in line with the spirit of the decree on autonomy mechanisms, healthcare service prices aim for accuracy and sufficiency by 2018. This reality requires innovation and coordination of health insurance payment methods for medical examinations and treatment to address the shortcomings of fee-for-service payment methods while ensuring fairness, effectiveness, and quality in health insurance medical care. The coordination of payments between the health insurance agency and hospitals has significantly improved processing time and resolved

issues during payment. The increase in reassessment cases reflects stricter supervision, but the decrease in rejected claims and payments demonstrates tighter control over health insurance reimbursement and fewer errors.

The Shortcomings and Limitations of the Mechanism:
The payment mechanism for public hospitals in health insurance still contains many obstacles, as the survey results at public hospitals indicate the obstacles in the work of health insurance payment with public hospitals are: lack of standard basis for health insurance assessment (44.5%), payment level for medical services between health insurance and hospitals (28.6%), assessment and payment time for health insurance (21.8%); payment method (17.7%) and assessment experts (15.9%).

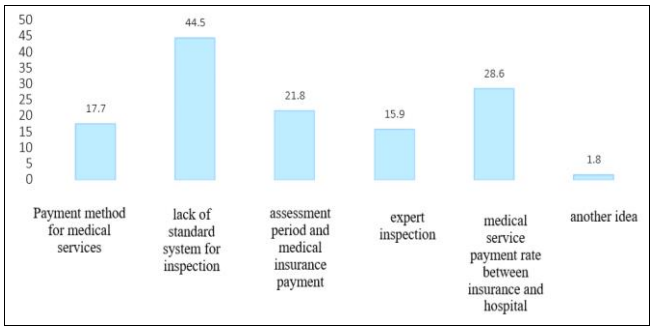

Fig 6: Obstacles in the work of health insurance payment for public hospitals (%)

The process of health insurance assessment is not truly suitable and timely for the payment of medical services due to errors in the payment procedures, inconsistencies in the number of medical service categories, medications, and techniques between health insurance and public hospitals, as well as inconsistencies in payment levels.

The payment method between insurance agencies and public hospitals is still limited, and the most common payment method based on service fees is also one of the main reasons for the shortcomings in the current healthcare insurance payment mechanism. This is because the payment method for service fees always carries risks: The reason mentioned here is that there is an application of a payment method without a standardized system to assess medical services and a lack of appropriate monitoring mechanisms. Payments exceeding the limit and exceeding the health insurance fund are delayed due to waiting for annual settlement reports to be submitted to the Board of Directors for review and resolution; the assessment and payment of unused costs according to the pricing standards are not yet complete, while there are still many costs that have not been calculated or calculated insufficiently within the standards, which is not appropriate.

Solution
Building a basic healthcare package paid for by health insurance
The goal of building a basic healthcare service package paid for by health insurance is to ensure fairness in healthcare for insured individuals, regardless of their ability to pay. It aims to provide equal treatment and not rely on financial capacity, guaranteeing the rights of the majority and working towards comprehensive healthcare for all. This will be achieved by balancing the resources of the health insurance fund, improving efficiency in resource allocation for healthcare, ensuring transparency, and increasing accountability. To develop a basic healthcare service package paid for by the health insurance fund, it is necessary to clearly define the essential healthcare services and the total healthcare costs provided according to the appropriate list of essential healthcare services that align with the fund's payment capacity.

Implementing the integration of various health insurance payment methods
In order to effectively manage the relationship between the three parties (hospitals, insured patients, health insurance agencies) in healthcare insurance payment, it is necessary to develop an appropriate method of healthcare insurance payment. According to studies on healthcare payment methods, there are various forms: fee-for-service payment, capitation payment, group diagnosis payment... When considering and deciding on the payment method, it is advisable to combine suitable methods instead of relying solely on one method. However, priority should be given to methods that can control costs, such as capitation payments and diagnosis group payments.

Establishing an independent and scientific mechanism for monitoring and evaluating health insurance
Establishing a closely monitored payment mechanism among the three parties to ensure the rights and responsibilities of each party. Despite providing favorable conditions for healthcare insurance agencies, hospitals, and participants in healthcare insurance to carry out medical examinations and pay expenses, it is necessary to have appropriate monitoring and management mechanisms. Specific regulations and close alignment with actual activities help promote transparency regarding the rights and responsibilities of all parties involved in healthcare services and the allocation and use of financial resources. This facilitates close coordination among the three parties to effectively provide healthcare services to the population with fairness and efficiency.

5. Conclusion
The mechanism of health insurance payment has been adjusted in many unreasonable ways, creating convenience for participants in health insurance and payment between health insurance agencies and hospitals. Especially since the Health Insurance Law and the guiding documents were introduced. The Health Insurance Law allows the application of appropriate payment methods to create favorable conditions for public hospitals in the process of health insurance payment. The step-by-step pilot implementation of payment methods based on predetermined rates for initial medical examination and treatment has had a positive impact on cost control, encouraging hospitals to use resources efficiently and save costs or, in other words, transferring the cost control function from the health insurance fund to healthcare facilities. This method helps reduce or eliminate the need for monitoring and supervision of fund utilization because there is no longer a need to monitor abuse when hospitals are paid a lump sum, limiting unnecessary services along with low administrative costs compared to fee-for-service payment methods. In addition, according to Decree No. 60/2-21/NĐ-

CP on autonomy mechanisms, healthcare service prices are calculated accurately and sufficiently. This reality requires innovation and coordination of healthcare payment methods under health insurance to overcome the shortcomings of fee-for-service payment methods while ensuring fairness, effectiveness, and quality in healthcare under health insurance.

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5. The government, Decree 60/2021/ND-CP dated June 21, 2021, regulates the financial autonomy mechanism of public non-business units.
6. The government, Decree 62/2009/ND-CP dated July 27, 2009, of the government stipulates in detail and guides the implementation of certain provisions of the Health Insurance Law, 2009.
7. The government is amending and supplementing certain provisions of the Health Insurance Law No. 46/2014/QH13.
8. The National Assembly, Health Insurance Law, 2008.
9. The National Assembly, State Budget Law, 2015.
10. The National Assembly, Procurement Law, 2005.
11. The National Assembly has regulated the Medical Examination and Treatment Law. The National Assembly, Health Insurance Law No. 25/2008/QH12.