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Direct Payment Mechanism from Medical Service Users for Public Hospitals in Vietnam

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Abstract

The article explores a state-of-the art analysis of payment mechanisms directly from healthcare users to public hospitals in Vietnam. The mechanism of direct payments from healthcare users to public hospitals has also been modified to meet the demands of phased socio-economic development. But in addition to the advantages of the mechanism, there are still many shortcomings and obstacles. In order for this mechanism to have a positive impact, take advantage of its strengths, overcome existing ones, and bring practical benefits to the public hospital system, the paper has proposed a number of solutions, such as building a proper health care pricing route, transparency of payment mechanisms directly from healthcare users, etc.

Keywords: Direct Payment Mechanisms, Medical Service Users, Public Hospitals, Vietnam

1. Introduction

Our party and state have always sought to achieve the goal of a fair and efficient health system. Equity in health care is the desire for all people in society to have equal access to health services when they need to recover and improve their health. A fair, efficient, and developing healthcare system has always been a goal for nations.

The Vietnamese public hospital system plays an important role in the implementation of public health care. Public hospitals have been changing over time to adapt to the conditions of the country's development at each stage. In their professional work, hospitals are constantly interested in expanding and improving the quantity and quality of medical services in order to provide better and better services to meet the needs of the people. In their financial management work, hospitals have proactively mobilized legal sources of income, diversified financial resources for investment, upgraded equipment and infrastructure, facilitated the increase in workers' income, and covered some of the cost of the unit's regular operations. Despite the many achievements that have been achieved, public hospitals today still have a lot of inaccessibility and are facing no fewer difficulties and challenges in financial management, especially in implementing the mechanism of direct payments from users of medical services to hospitals. Besides the advantages of the mechanism, there are still many shortcomings and difficulties. In order for the mechanism of payments directly from users of health services to public hospitals to be able to develop the strengths, overcome the existing ones, and bring practical benefits to the public hospital system, we need innovations that leverage the development of the operations of the public hospital system.

2. Theoretical Basis

Revenue from health service users

The source of revenue for healthcare users is the amount of money that they have to pay directly to public hospitals for the medical services they use. This is a method of direct payment from recipients of medical services to hospitals based on the principle that "whoever uses the service, he pays". If the funding of hospitals through the allocation of state budgets and health insurance funds is considered to be the funds that make it easier for people to access the most health services and deliver a fair and effective goal in public health care, And those that are paid directly from the pockets of the sick to buy medical services—these are the direct sources of income from sick people who have been identified as a financial source that can easily lead to difficulties in accessing medical services, even if it brings a loss of qualification in public health care. If a greater proportion of the total health expenditure of society is paid directly by healthcare users, the more unfair healthcare finance is manifested. Although, from a purely financial management point of view, this mechanism of paying for medical services directly from health users is especially effective when the price of medical services is adequately calculated to maintain the volume and

quality of health services. But this is also supposed to be the policy that generates the most unfair financial resources in health. Because the possibility of direct payment from the sick creates a huge cost burden for those who have already been at risk of illness, it is a barrier to accessing medical services for groups of people who have difficulty paying for medical services. In addition, people with middle and low living standards are often the ones who need more health care. To date, financing directly from healthcare users has remained a controversial issue in many countries around the world about effective equity and its impact on society.

Policy-making requires understanding the nature of the provision of health services and the need for people's health care to have the right regulatory mechanisms, first of all ensuring that the direct flow of money from the sick is minimized to prevent poverty from becoming ill and reduce access to health services for people. At the same time, it must be determined that the flow of money from the community must be strong enough to ensure that resources are available for the provision of medical services and that money flows to hospitals must be controlled. We should boost the flow of money from the community, focusing primarily on the sources from insurance institutions and their advantages of sharing in the community, so that all citizens have equal access to and benefit from health services. Health care is a special kind of service because it has a direct impact on human health, so the quality of the service must be the top priority, and the price of the health care must be the main priority. Because health services are relevant and affect most people in society, this is also a very sensitive issue, and health services need to be publicly transparent about the prices of specific health services and the cost components that make up the price.

The mechanism of payment of medical services directly from the user based on the price criterion of the medical service is divided into two categories: part-payment of the price of medical services and full payment of the cost of health services.

A partial payment mechanism for medical services is a mechanism of direct payment by the employer for the use of medical services based on the principle that only part of the total cost of a medical examination is collected. Thus, the cost of the medical services paid by the user is not sufficiently compensated for the direct and indirect costs that constitute the medical service because part of the cost constitutes the price of the health services that the state compensates directly for the hospitals. The price of medical services needs to be clearly defined as the amount that the state has spent if the hospital is not collected by the sick, and the amount that the state does not invest must be accurately calculated, sufficient to ensure the funding of operating hospitals in order to ensure and improve the quality of the medical services.

3. Research Methods

Implementing the statistical research method involves collecting and analyzing existing documents, including policy documents, laws, summary reports, evaluations of the healthcare sector, and financial statements of public hospitals.

To evaluate the mechanism of payments directly from healthcare users to public hospitals, the authors conducted a survey to gather assessments and perspectives from relevant groups directly or indirectly involved in this mechanism. Specifically, the authors 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 the research topics. The data from the survey questionnaires was processed using SPSS.

The author used a survey of 220 samples, in which they were classified by sex, by qualification, and by field of work. In terms of the sphere of work of the respondents, the planned financial officers of the hospitals accounted for the largest number of 111 units, followed by the staff of the hospital's staff of 41, the hospital management of 22 units, the Ministry of Finance of 16 units, and the Ministry of Health of 30 units.

4. Reality

4.1 Overview of Public Hospitals

So far, the hospital system in Vietnam has grown in both quantity and quality. The current Vietnamese hospital system consists mainly of public hospitals (over 93%). The public hospital system is regarded as the backbone of the medical industry, organized under the Vietnamese health system, with decentralized administrative and technical management from central to local. However, the development of our country's public hospital system has also undergone several periods of rise and descent with the history of the country along with the growth of the national health system.

By 1955, after the end of the French colonial resistance, the North had completely liberated 57 hospitals of all kinds, 17 hospitals, 3 camps, and 4 nursing facilities. During the period from 1955 to 1975, the hospital system continued to grow in terms of both the number and size of beds serving the construction of socialism in the North and the struggle for national unification. The number of hospitals in the North increased 10 times more in 1975 than in 1955. In 1976, the number of hospitals of all kinds increased; since 1980, no more forms of sickness have occurred, and many new hospital facilities have been built, specifically district-lining hospitals, to meet the needs of people's medical examinations in the new phase. So far, the number of our public hospitals has grown to over 1,000. At the same time, public hospitals have been constantly changing and developing in both quantity and quality to meet the needs of people's medical examinations as well as the changing patterns of disease. The treatment system is also clear and more scientific, from the front lines of the district to the city, and the end lines are the medical hospitals, specialized hospitals at the last stage of the treatment staircase with in-depth specialized interventions with modern and sophisticated techniques.

Public hospital classification

The system of public hospitals is decentralized along technical lines from low to high, ensuring continuity at the professional level. Each hospital is responsible for providing medical examination services to a population group.

Line 1: Includes class III hospitals, including district, municipal (collectively district hospitals), inter-district regional multi-disciplinary hospitals, a number of sector hospitals, and private hospitals. These are typically small-scale hospitals, equipped with simple investment equipment, providing basic medical examination services, and receiving patients from the community or from basic medical stations. It also provides basic medical services and treatments for

simple diseases to the people in their areas of responsibility. The size of the 1st gland beds ranges from 50 to 200 beds and depends on the conditions of the population and the geographical conditions that balance the number of beds by the ratio of 1st beds serving 1,500 to 1,700 people.

Line 2: Includes Class II hospitals, such as clinical, provincial, municipal, and private hospitals, and a number of clinical hospitals in central cities that are Class II or higher. These hospitals are guaranteed to provide medical examination services with specialized, more sophisticated techniques to meet most of the needs of the local population, as a practice base for students of pharmaceutical schools in the city province. Each province has at least one multi-patient hospital with a size of 300 to 800 beds, defined with a ratio of 1 bed serving between 1,600 and 1,800 people.

Line 3: Includes hospitals of the first class or special class, which is the line for conducting in-depth specialized techniques and scientific research. These are end-of-the-line hospitals in the staircase of treatment, providing intensive, complex medical services, demanding high-tech, specialized medical staff, well-equipped... It's usually big, regional, or national-specialized BVs. At the same time, it is also an internship facility for students at pharmaceutical universities.

4.2 Mechanisms of Direct Payments from Healthcare Users to Public Hospitals

The legal basis of the mechanism of direct payments from users of medical services to public hospitals

Pricing policy for medical services: From the limitations and imperfections of the "partial-cost" policy, it is evident that this policy needs to be revised to ensure transparency, to be compatible with the socio-economic system, and to encourage the operation of public hospitals to ensure public, public, and non-governmental objectives. The adjustment of the price of medical services is one of the contents of the innovation of the operating mechanism, the financial mechanism for the units. Public health careers can be in public hospitals that require innovation in the funding mechanisms aimed at: improving the quality of health services, better responding to demand, healing people's illnesses, creating transparency in the financial mechanisms of hospitals to implement self-rule, self-responsibility, etc. In addition to adjustments in the direction of correct calculation, taking into account the costs directly serving the patient, the state needs to have policies to help low-income people and people with special difficulties, to mobilize more contributions from those who are able to pay, while having a practical mechanism of exemption, to reduce the fees for politicians, the poor, and the near-poor, and to stimulate the elimination of all grants in career activities in practice. It's better than social justice.

Prices for medical services: Circular 13/2019/TTBYT dated July 5, 2019 of the Ministry of Health amending and supplementing some articles of Circular 39/2018/TT-BYT of November 30, 2018 of the Department of Health on the regulation of unification of the price of medical examination services, treatment of medical insurance between hospitals of the same class across the country and guidelines for the application of prices and payment of medical expenses in some cases; Circular No. 34/2014/TT-BTC dated March 21, 2014 of the Ministry of Health regulating the income, collection, payment, management and use of judicial assessment fees in the field of Forensic Medicine; Circular No. 240/2016/TT-BTC dated November 11, 2016 of the Ministry of Finance on the fixing of maximum prices for medical clearance and preventive medical services at public health facilities; Circular No. 35/2017/TT-BTC dated August 18, 2017 of the Ministry of Finance on the specific pricing regulation for testing services for samples of medicines, medicinal materials and medicines.

Implement payment mechanisms directly from healthcare users to public hospitals.

With the mechanism of direct payments from users of medical services to hospitals that have generated revenue, the revenue of hospitals under the Ministry has increased considerably. h. Increase the level of central finance to direct income for healthcare and insurance users. Healthcare. Of these, direct income from healthcare users is identified as the largest source of income in public hospitals and is one of the largest sources of income for the operation and development of public hospitals.

Table 1: Direct payment sources from health service users of some public hospitals

Unit: *million dong*

Year	Bach Mai Hospital			National Children's Hospital		
	Total revenue	**Direct revenue from service users**	**%**	**Total revenue**	**Direct revenue from service users**	**%**
2018	3.997.987	2.251,136	56%	2.189.000	903.000	41%
2019	2.798.533	1.457.890	52%	1.796.500	694.892	39%
2020	2.307108	1.010.896	43%	1.213,000	510,685	42%
2021	2.383.307	1.035.631	44%	1.209.082	526.755	44%
2022	4.216.272	2.383.307	57%	2.314.000	919.000	40%

Source: Author's own compilation

Hospitals have increased the number of new types of services to mobilize more career income, such as: on-demand examination services such as medical examinations outside of administrative hours; doctor selection services (patients are chosen for examination and treatment and are charged extra fees when performing such selection; specific fees prescribed by the hospital and public announcement); high-quality treatment room services (room type 1 bed, 2 beds) for high-income persons; the service deals with hospitalization procedures and exits outside office hours. With these services contributing to improving the quality-of-service delivery, the increase in hospital revenues is one of the bases for implementing the mechanism of self-government in the current hospitals.

Prices for medical services

First of all, the cost of the built-in healthcare still inherits the principle of "part of the hospital fee". The new price framework only has a maximum ceiling on the basis of all three factors that do not give a minimum ceiling. The price framework has no floor level, and the calculations like this are relatively appropriate and practical and enable the provinces to calculate and balance specifically in their local conditions to build the most appropriate price frameworks for services that benefit the people and facilitate public hospitals with sufficient funding to improve the quality of medical examinations. The price of medical services is determined in three groups.

Group one for medical examination: divided into five groups based on hospital and community health.
Group 2: The price of a day bed is also detailed by hospital category and department.
Group 3: Framework for technical and testing services
The price of on-demand medical services in public hospitals will have to cover all costs, ranging from direct costs to indirect costs. The state will never give any money to the public hospital for this operation. The results of the survey showed that the implementation of the price of medical services on demand, including direct and indirect costs, accounted for the highest percentage of the direct costs as part of medicines, chemicals, consumable supplies, replacement supplies (91.8%), and indirect costs to the indirect part of the largest level (40%).

Table 2: Implementation of prices for medical services on demand, including costs

S. No		Ratio (%)
a) Direct costs		
1	Cost of drugs, chemicals, consumables, and replacement supplies	**91,8**
2	Costs of electricity, water, fuel, waste treatment, and environmental sanitation	91,8
3	Salaries, allowances, and contributions according to the regime; labor hire costs	31,8
4	Costs for maintenance, repair, and maintenance of assets	29,1
5	Depreciation of fixed assets	20
b. indirect costs:		
1	Indirect department costs	**40**
2	Cost of training for scientific research to apply new technology	14,5
3	Other legal expenses	21,8

Source: Author's own compilation

Organize medical examinations on request.
Most of the public hospitals surveyed provide on-demand medical services. In the survey of the implementation of on-demand health care in hospitals, the majority of respondents chose the form of management of health services on demand separately from conventional health services, accounting for the highest percentage (67.7%), non-separate forms (27.7%), and non-organized forms (4.6%).

The department's pricing for medical services is on demand.
In principle, the price of the requested medical services for the active building of the hospital has been agreed upon by the leadership and the hospital union, and the prices of the required medical services will have to fully encompass all costs, from direct costs to indirect costs. The assessment of the price framework for on-demand medical services in public hospitals is currently in place, and the results show that the majority of the surveyed hospitals are applying the pricing framework established by hospitals, leadership, and trade unions and approved by the Ministry of Health (62.3%). This is high because most of the public hospital staff (98%) and the hospital's planning finance staff (42%) opted for it. Implement the organization providing medical services on demand.
The state of implementation of the provision of on-demand medical services in public hospitals is one of the topics discussed in the survey. The results of the survey show that, in reality, the implementation of the organization of the provision of medical services on demand in public hospitals is mainly focused on "payment of taxes for the delivery of health services on request" (49.5%), followed by "management of the separation of revenue and expenditure" (46.8%). Although the price of on-demand health services must necessarily include the cost of depreciation of fixed assets, the fact that public hospitals that provide on-demand health care operations have not deducted fixed property for this activity is because many of the fixed properties that the state budget invests in are used in the provision of medical services on demand. Hospitals are not clearly managed to get separate receipts for requested health care operations (separate receivables are managed, but all expenditure is aggregated), and there are no clearly defined separate income differentials. In fact, hospitals want to be transparent about these expenses and revenues because they're more beneficial to the hospital.

4.3 Evaluation of Direct Payments from Healthcare Users to Public Hospitals

Properties:
The mechanism of direct payments from healthcare users is simple and rapidly implemented, and it is now a mechanism that generates large revenues for public hospitals. At the same time, the mechanism also creates competitive pressure on public hospitals, forcing them to pay attention to the quality and quantity of medical services offered on the market.

Trouble
The mechanism of direct payments from patients who use health services generates additional revenue for hospitals but also reduces the fairness of providing this kind of public service to society. The policy of direct payments from healthcare users also increases inequality in the public hospital system itself.
For hospitals that have the potential to mobilize large, non-national financial resources, potentially increasing revenues, one of the greatest risks and constraints is the abuse of high-income incentive services to keep up with the target. Profit.
The price policy for health services is slow to innovate and is still not transparent and fully accountable for costs. In fact, the sick don't know how much a portion is or how much the state has allocated to them. This directly affects the transparency and clear calculation of the management and use of financial resources from the hospital fee policy. Despite the adjustment, the cost of public hospitals' medical services remains only a fraction of the total cost of medical examinations. The new level of health care charges only part of the direct cost, which does not fully cover the entire cost associated with the patient's medical examination.
The price policy for health services, along with the strengthening of the mechanism of autonomy, facilitates the over-provision of more universal essential services. With the service-based calculation that exists in hospitals, it has led to the abuse of overservicing, especially high-tech services. This allows hospitals to increase the cost of compensating for low-cost services.
The demand-based health care pricing policy itself in hospitals is unavailable due to a lack of transparency. Interestingly, the majority of respondents indicated that the price of the medical services did not fully include the costs (62.3%), followed by the lack of transparency between the state support and the paying users (26.8%). These are two of the five misspellers selected with the highest percentage

given by the study. Different groups of subjects have different views of inaccessibility.

In the position of the Ministry of Health, the finance officer, the planning officer at the hospital, as well as the management officer in the hospital, recognized the lack of access and the constraints in the price of medical services as not fully covered (80 percent), (80.2 percent), and (45.5 percent). Meanwhile, the majority of finance officials say that the current price policy for healthcare will lead to abuse of healthcare to increase hospital revenue (81.2%), while BV officials point out that there is a lack of transparency in the costs that make up healthcare prices (36.6%).

Table 3: Obstacles and inadequacies in the current medical service pricing policy as assessed by target groups (%)

	Staff of the Ministry of Finance	Staff of the Ministry of Health	Finance and planning staff at the hospital	Leadership and management staff at the hospital	staff at the hospital
1. Medical service prices do not fully include component costs.	6,2	80	80,2	45,5	31,7
2. There is no transparency in the costs that make up the price of medical services.	18,8	73,3	6,3	31,8	36,6
3. There is no clear connection between the state's support and the portion of health service users must pay.	62,5	53,3	14,4	13,6	34,1
4. Easily leads to abuse of medical services to increase hospital revenue	81,2	36,7	8,1	18,2	22,0
5. Causes inequity in people's health care	0	70	4,5	9,1	24,4

Source: author's own compilation

Solutions

Create a suitable healthcare price plan.

The state retains the role of pricing these services, but in the direction of issuing the service price framework, hospitals have to decide on their own rates of receipts for the medical services they provide within the price frame. This reduces costs, increases competition among hospitals, and encourages the development of high-quality health services.

The factors that make up the price of medical services need to be specified: (1) Cost of salary, salary allowance; (2) Medicines, expenditure, blood, transfusions; (3) Examination costs, photography...; (4) Costs of depreciation of medical equipment and infrastructure; (5) Costs of electricity, water, communications, disinfection, environmental hygiene; (6) Fixed property renovation and maintenance costs; (7) Costs of training and scientific research; (8) Administrative costs, indirect costs of medical examinations, etc., as prescribed by the state;

Construct a circuit to specify the route of this price calculation and take into account the balance and suitability.

Transparency of payment mechanisms directly from healthcare users

Prices for medical examination and treatment services on request are determined by the directors of public hospitals, but do not exceed the maximum price limits prescribed by the Ministry of Health and Finance or by the Department of Health, after agreement with the Finance Ministry. In the case of clinical facilities, which operate according to the business model, they are entitled to determine the price and must list and declare the price in accordance with the provisions of the law on prices.

Public hospitals need to establish a center or department under the hospital. This center or department needs to be independent in accounting, separate in financial management, and independent as an enterprise with the full amount of income generated. This department fully deducts all expenses and accountability to the state (payment of taxes as prescribed). It is essential that there be transparency, that is, the separation of management in all financial collection activities for the provision of this service.

5. Conclusion

Paying for health services is one of the policies that brings important revenue to the operations of public hospitals and contributes to improving the quality of health services that meet the needs of health care but contain a lot of inaccessibility and uncertainty. Because of the "part of the fee," it is not clear how much the fee is specifically, including what the costs make up and the amount of funding for the house. Despite the failure to accurately calculate the cost of health care, the difference is still compensated by the state, so it is a fact that the state has covered people with even high incomes who are capable of paying the entire pension. This is why it is necessary to be transparent and clear in the calculation, collection, and use of the fee resources to redefine the concept of "cost" and the cost elements that make up the "cost including which items are collected and which items are from the state budget. But given the long-term and overall development of the health system, the direct payment of medical services by the sick cannot become a financial resource. o Healthcare. The possibility of direct payment for the use of healthcare at the "service price" will promote the positive aspects of intersecting and harmonizing with other policies of medical finance.

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