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INTERNATIONAL REVIEW OF DIAGNOSIS-RELATED GROUP (DRG) CONTRACTS

Local Health System Sustainability Project

Task Order 1, USAID Integrated Health Systems IDIQ

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Local Health System Sustainability Project

The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support access to universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year, $209 million project will build local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

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CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACRONYMS

BR	Base Rate
CMI	Case-mix Index
DOH	Department of Health
DRG	Diagnosis-Related Group
EHIF	Estonian Health Insurance Fund
FFS	Fee for Service
HHS	Hospital and Health Services
ICD10	International Classification of Diseases, Tenth Revision
LHSS	Local Health System Sustainability project
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NHRA	The National Health Reform Agreement
NHS	National Health Service
NSQHS	National Safety and Quality Health Service Standards
PhilHealth	Philippine Health Insurance Corporation
RW	Relative Weight
SHI	Social Health Insurance
UHC	Universal Health Coverage
UK	United Kingdom
US	United States
USAID	United States Agency for International Development
VSS	Vietnam Social Security

EXECUTIVE SUMMARY

INTRODUCTION

Contracting and provider payment is an important part of healthcare purchasing functions. If carefully designed and implemented, it will support more effective management and use of resources, meeting healthcare needs of the public. The design of contracts between a purchasing agency and healthcare providers creates a common understanding about their obligations and rights. Health care service purchasing contracts may include multiple provider payment methods for different services provided by the same facility. Under all payment types, contracts must clearly specify the conditions that will regulate the relationship between purchaser and provider, including accountability and conflict resolution mechanisms. As Vietnam undertakes provider payment reforms, including use of Diagnosis-Related Groups (DRG), learning about contracting from countries that already use DRGs is critical. These lessons will help the Government of Vietnam design its own DRG provider payment mechanism.

This report includes: 1) an overview of contracting and its role in enhancing the performance of the health system with regard to the features of the DRG payment method; 2) summary findings from an international literature review on contracting mechanisms in countries that have adopted the method; 3) an evaluation of the current status of social health insurance contracting in Vietnam against international reviews using a situational analysis and key informant interviews; and 4) recommendations for developing and revising the existing legal framework for contracts and appropriate content based on international experience and actual practice in Vietnam.

The literature review looks at examples of health care service contracting where DRG has been used for multiple years including the United Kingdom, the United States, Estonia, Thailand, and the Philippines, with a focus on contract implementation relative to DRG payment systems, overall budget control through payment or volume caps, quality of care, and monitoring mechanisms to control for gaming behavior. The contracts situation analysis focused on a review of legal normative documents, and reports from the Ministry of Health (MOH) and the Vietnam Social Security (VSS). In-depth interviews were conducted with government stakeholders to identify challenges in implementing contracts as Vietnam transitions to the new DRG system.

KEY FINDINGS FROM THE INTERNATIONAL LITERATURE REVIEW

- In Australia, the United Kingdom, the United States, and Estonia, contracts are continuously developed and modified to suit the DRG payment method to ensure the effectiveness of the DRG policy in achieving national health objectives.
- For most of the countries reviewed, the legal framework and contract contents were developed on the basis of their respective legal normative documents (e.g., health insurance law, law on the protection and care for the public health) and national health care goals.
- The scope and volume, payment level, and payment conditions of contracted services are clearly defined in laws and sub-legal documents. Some countries specify scope and volume of contracted services as an annex to the contract (Australia, Estonia), while others refer to other legal documents (Thailand, the Philippines). The mechanism for controlling hospital activity (i.e., admissions) paid under a DRG mechanism is often specified.
- Health care purchasing contracts in DRG systems pay substantial attention to quality of care. Standards/eligibility criteria for contracting are set strictly and health facilities

contracted for public service provision must meet accreditation requirements and maintain them annually. Most contracts also stipulate specific quality outcomes that are monitored and the consequences if poor quality is detected, such as greater regulatory supervision or financial penalties.

- Measures to detect and prevent adverse behaviors of hospitals, such as upcoding, are generally specified in the contract. Hospitals may practice such behaviors to maximize profit, so contracts must explicitly state what is not allowed and how those prohibitions will be enforced. Contracts require that hospitals be accountable for the quality of their clinical coding and use coding auditing systems to detect statistical patterns likely to identify incorrect coding, and the steps to investigate systematic upcoding.
- Contracts between purchasers and health care providers specify the information they will share for contract enforcement, including information to assess a provider's eligibility to sign a contract and assign episodes to DRG, quality standards, and quality outcomes. Contracts may refer to specific policies that stipulate this information or may include it in appendices to the contract itself. They also stipulate how this information will be used. Finally, they generally include the timeline and process of data processing for claims review.
- Conflict resolution mechanisms in health care purchasing contracts are quite detailed because of the potential for conflict regarding clinical appropriateness. The type of conflict depends on the specific policy regulations. For example, conflicts arise about appropriateness of admissions and upcoding of cases when hard budget caps do not exist. When caps exist, conflicts may focus on under-provision, cream skimming, and cost shifting. Regardless of the system, contracts should clearly specify procedures for conflict resolution between the parties, and when third-party conflict resolution is required. The third-party organization also should be specified.
- Appropriate incentives, penalties, and stipulations are regulated routinely and continuously through contract monitoring, supervision, and evaluation.

KEY FINDINGS FROM THE SITUATIONAL ANALYSIS

- Vietnam's health services purchasing contracts are regulated by the Civil Code, the Law on Examination and Treatment and Law on Health Insurance, Decree 146, and Guidance Circulars. Contracts include: the legal basis of the contract; scope and volume of services; service quality conditions; payment method; rights and obligations of the parties; contract term; liability for breach of contract; and conditions for change, liquidation, or termination of the contract. Compared with other countries, however, the provisions on contracts in Vietnam's legal documents are insufficiently specific and clear to serve as a basis for contract development. How the contract can be adjusted or revised, what happens if the contract is terminated, how conflicts are to be resolved, or what to do in cases of force majeure are not addressed.
- Vietnam's current prototype health care purchasing contract and regulatory framework were developed for fee-for-service (FFS) payment. Contracts and regulations for DRG and capitation payment, as well as policies to regulate hospital behavior under incentives for DRG or capitation payment, are not fully developed. As such, they do not explicitly address the scope of services to be paid under DRG, capitation and FFS. The current contract does not explicitly state the amount of services and of payment to be made and how these will be adjusted if services are over- or underproduced. Contracts do not adequately specify the required quality of care standards that must be maintained, or how quality of care will be monitored to minimize the risk of stinting or early discharge, which can harm patient well-being. A national clinical coding standard is not yet in place and hospitals are not held

accountable for the accuracy of coding in either regulations or the contract. In fairness to the hospitals, there is a lack of standards/criteria to assess service quality and payment cost, lack of monitoring and evaluation (M&E) and audit supporting tools, such as care pathway, standard regimen, and standard treatment guidelines, needed to assess the appropriateness of services and reimbursement costs.

- The role and authority of the service purchaser in strategic purchasing is not set. Unlike in other countries, the VSS is a passive buyer of services. The agency cannot act as an independent strategic purchaser and is dependent on MOH regulations and guidelines. For example, it cannot select the medical facilities with which it contracts—it is required to sign contracts with all Ministry/Department of Health (DOH)-approved facilities, so roles of strategic purchasing like "market power" and price negotiation are not available to it. Nor can the VSS penalize health facilities by terminating a contract; it can only propose a fine.
- Accountability between parties is limited because contracts do not address it. For example, there are no sanctions for late payment by the VSS or for health facilities that fail to provide information and data. As a result, advance and settlement of payment for reimbursed services is late in most provinces.
- Conflicts between purchasing agencies and providers are a major problem in Vietnam. Lack of explicit regulations, contract stipulations, and monitoring mechanisms to identify, for example, overproduction of services and the consequences hospitals should face, results in a large number of disputes and long delays in resolving them. Vietnam is still focused on resolving FFS conflicts and has not put sufficient effort into developing needed policies for DRG and capitation payments.
- Health insurance contracts do not include mechanisms to monitor, supervise, and assess contract compliance. The MOH/DOH is responsible for monitoring and supervising contract performance but gives this insufficient attention. By contrast, other countries emphasize regularly and continuously monitoring, evaluating, and measuring of health facility performance and patient satisfaction, and making public the results of these activities.
- Planning capacity and contract negotiation skills are limited among both purchasers and providers. This results in problematic performance, leading to conflict, disagreement, and disputes.

KEY RECOMMENDATIONS

- The reimbursed health service provision contract must be considered a civil contract and thus be designed/adjusted according to the regulations of the Civil Code.
- The MOH should work with the VSS to adjust/supplement regulations on contracting in the Health Insurance Law, Decree 146, and sample contract 07 Annex of Decree 146. For example, the sample contract 07 does not address topics such as punitive measures for contract violations; settlement of contract disputes; responsibility for violation of contract; right to temporary unilateral contract termination; and exemptions from contract obligations due to force majeure.
- To avoid conflict between the purchaser and provider, the MOH should establish a clear and adequate legal framework for DRG payment, and a step-by-step process for DRG contracting. It must issue full and synchronized regulations; instructions on the scope and volumes of services to be provided; service quality standards/criteria; prerequisites for signing contracts (licensing, certifying the practice of medicine, and moving toward compulsory accreditation to achieve a standard quality of care across health facilities); provider payment methods and amounts; and accountability of both parties.

- The VSS purchases health services for insurance cardholders through a reimbursed service contracting mechanism. To make the health insurance fund more effective, the VSS should be given more authority in price negotiation and other financial incentive measures (e.g., to award service quality-related bonuses or levy penalties) to achieve value-based purchasing.
- The MOH should work closely with the VSS to reform provider payment methods with DRG payment adopted for inpatient services, to strengthen service quality and effective use of the health insurance fund. Regulations on DRG design and the payment process for inpatient services need to be institutionalized in a circular that is annexed to service contracts. Contracts should set activity or budget caps and a claims management and dispute resolution process. Clinical coding standards should be developed and used to support hospital documentation of care provided in a way that avoids errors and reduces the risk of being denied payment.
- The MOH should strengthen accountability between the purchaser and provider by including contract terms and conditions for securing advance payment, settlement of payment and information requirements. These include the minimum data that a facility must provide the VSS when it is making a claim, as well as the mandatory coding it must do, data exchange standards, and the deadline by which the coded data must be provided. It also includes deadlines for the VSS to provide feedback on the claim and to make payment. The contract must also lay out timing of information provision from health facilities and data format requirements (minimum data set, data exchange standards, mandatory coding); timing of feedback sent from the social security agency; and the consequences of sending delayed, incomplete, or erroneous data or payment.
- The MOH should clearly define the roles and responsibilities for monitoring, supervising, and evaluating contract performance to achieve set targets and ultimately secure benefits for insured people. M&E indicators must be developed to measure performance in general and in regard to the DRG mechanism in particular.
- The MOH should strengthen health facility information systems and their interoperability with the VSS and MOH systems. Provincial and central health agencies should play a stronger role in building capacity to design IT systems and use information to enhance efficient and effective use of resources, and therefore better quality of care for the insured.
- The MOH should map/study options—both ideal and realistic ones—for transition to DRG contracts to know how a DRG contract might look based on existing regulations, what can be changed/improved quickly, and what are the trade-offs and minimum requirements to start DRG contracting.
- The MOH should enhance skills and knowledge about contracting, and contract negotiating and problem-solving for key staff of the MOH, VSS and provincial social security agencies, and service providers.

1. INTRODUCTION

Strategic purchasing of health services is receiving attention from countries around the world because it can improve health system performance and facilitate progress toward universal health coverage (UHC). One of the Government of Vietnam's key priorities is to increase public spending on health in order to achieve the goals of equity, efficiency, and quality as set out in the Resolutions of the Party and the Government. Particularly, funding from social health insurance (SHI) is considered the key source of funding for the Vietnamese health system. The Vietnam Social Security (VSS) agency is responsible for managing the SHI fund and implementing health insurance policies, and it is the single payer of medical services purchased through the fund.

The Ministry of Health (MOH) and VSS are trying to reform the current fee-for-service (FFS) provider payment method and transition to the Diagnosis-Related Group (DRG) method for inpatient services to effectively manage and use the SHI fund. This transition necessitates developing an appropriate legal framework for contracting. Many countries have adopted the DRG payment method for inpatient services. The United States was the first to introduce DRG in 1992, followed by a number of countries in Europe and Oceania, and then middle-income countries in Asia such as Thailand, Indonesia, and the Philippines (where all payment is case based). A review of contractual or alternative arrangements used in these different countries provides useful guidance as Vietnam moves toward DRG-based payment.

To respond to this need, the VSS requested the USAID-funded Local Health System Sustainability (LHSS) Activity in Vietnam to conduct a review of international experiences in contract arrangements in countries with several years of DRG experience. In addition, USAID requested that LHSS assess the implementation of SHI contracts in Vietnam to identify gaps and inadequacies in policy development and implementation and to propose appropriate adjustments to the contracting legal framework based on international experience and Vietnam's socio-economic context.

This report includes: 1) an overview of contracting and its role in enhancing the performance of the health system with regard to the features of DRG payment method, 2) summary findings from a literature review on contracting mechanisms used in countries that have adopted DRG; 3) an evaluation of the current status of SHI contracting in Vietnam versus internationally, using a situational analysis and key informant interviews; and 4) recommendations for developing and revising the legal framework and appropriate contract contents based on international experience and actual practice in Vietnam.

1.1 METHODS

LHSS conducted the international literature review using documents from multiple countries that have applied the DRG payment method and have publicized information in English on the websites of service buyers, including: the United States (US), Australia, the United Kingdom (UK), Estonia, Thailand, and the Philippines. Data sources are research documents, analysis or assessment reports, and legal documents related to contracts signed between buyers and providers of medical services of different countries (including contract templates). The assessment of the current situation of domestic contracts included a review of legal documents and relevant MOH and VSS reports. LHSS also conducted key informant interviews with MOH and VSS officials and health service providers to better understand difficulties in contract development and implementation between social security and health care facilities. These informed the recommendations in support of transitioning to the new DRG payment method.

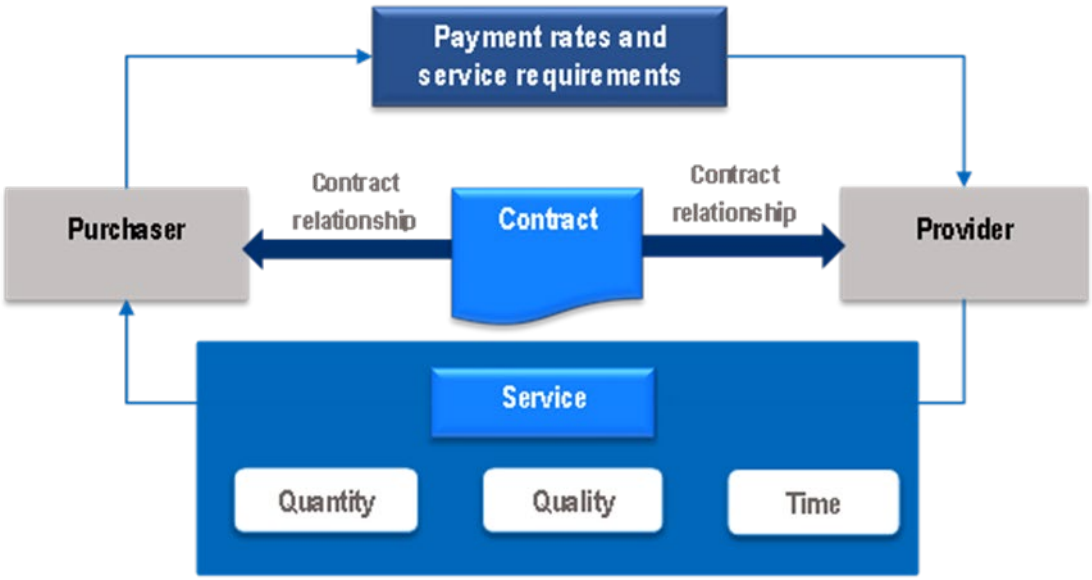
2. OVERVIEW OF INTERNATIONAL EXPERIENCE IN DRG CONTRACTING

2.1 CONCEPTS AND DEFINITIONS

2.1.1 DEFINITION OF CONTRACT

For the purposes of this report on the purchasing of health services, a contract is a document that formalizes an agreement between the buyer and the service provider. A contract clearly defines the rights and obligations of the two parties; the scope, definition, and volume of services to be purchased/sold; payment rates; minimum acceptable quality of service; and administrative arrangements used to fulfill the contractual obligations of the two parties (The World Bank and USAID 2009) (Figure 1).

Figure 1: Contractual mechanism between the buyer and health care provider



Source: Loevinsohn and Harding 2005

2.1.2 ROLES OF CONTRACTS

Contracting is an important component of strategic purchasing of health services. A contract is the basis for effective purchasing, no matter the provider payment method, by defining the relationship between the "purchaser" and the "provider" of services. By clarifying which services will be provided and on what terms, contracts help achieve the goals of promoting health and addressing people's health care needs.

In countries with a clearly defined purchaser-provider “split” (functions/responsibilities of purchaser and provider are clearly enumerated), contracts are the platform for the delivery of health care services by:

- Linking funding sources to health care outputs and outcomes;
- Clarifying the rights and responsibilities of buyers and service providers and improving accountability;

- Focusing on the delivery of prioritized health care services of health service buyers and users;
- Specifying risk-sharing arrangements between the purchaser and provider in case an unexpected issue arises;
- Allowing periodic adjustment and renegotiation of type, quantity, and quality of health care services to suit supply and demand (Figueras, Robinson, and Jakubowski 2005).

Contract execution, implementation and management, and monitoring processes are key to successful purchasing and effective allocation of health care resources. Therefore, the contract and its terms must reflect strategic goals of the purchaser and the provider of health care services. This will be most successful when the relationship does not maximize commercial benefits or risks of one party. Experience from the UK shows that maximum benefits are achieved when:

- For the buyer, the goals are clearly defined in terms of vision and health benefits and are reflected in specific goals and action plans for people's health improvement.
- Service provision is clear so that the buyer can see that the services provided meet the buyer's goals in both quantity and quality (The World Bank and USAID 2009).

2.1.3 TYPES OF CONTRACTS

The literature review of service purchase in European Union countries shows that the contents of the contract are flexible (adjustable). The basic contents of a contract are type of service provided; service volume (fixed); payment rates; contract validity; additional contracts or contract addendums; contract conditions; requirements on organizational and human resources; requirements on contract compliance monitoring; requirements on information provision and confidentiality; and regulations on incentives and sanctions. The quality standard requirement is an important component of the contract.

In European Union countries, three types of contracts are commonly used based on the payment method selected by the purchaser to pay the service provider (Figueras, Robinson, and Jakubowski 2005). They are:

- Block contracts – which are based on a fixed payment (capitation) that provides a certain amount of funding to perform a certain volume of services for a period of one year. The payment is usually based on the previous year's provider costs or the level of provider inputs. Other standard rates such as bed occupancy or staff per patient ratio are also considered.
- Cost and volume contracts – which pay for specified services that are more or less based on the number of inpatient and outpatient patients. They determine the service volume and average payment for each service, and also are known as service fee and volume contracts. They can be seen as a combination of the complex block contract and cost-per-case contract.
- Cost-per-case contract (or DRG) – which are based on an inclusive package cost per treatment course, typically calculated by the number of cases and the average cost per case for each DRG.

2.2 DRG-RELATED DEFINITIONS AND TERMINOLOGIES

2.2.1 DRG-RELATED DEFINITIONS

DRG is defined as a system to classify hospital cases according to the diagnosis and other characteristics of the patient such as age, gender, severity of disease, comorbidities, and medical procedures performed during the course of treatment. Two main components of the DRG payment system are patient case classification system (such as DRG system) and a payment formular, which is based on the base rate multiplied by a relative cost weight specific for each DRG in collaboration with resource utilization (Mathauer and Wittenbecher 2012).

DRG-based payment, case-based payment, case-mix payment, and activity-based funding are different names but a similar approach. The common feature is the grouping of individual services to pay one sum for the entire treatment course, not for each individual service (FFS).

2.2.2 DRG-RELATED TERMINOLOGIES

Relative weight-RW: is a unit that reflects the relative resource consumption associated with a specific DRG. The higher the RW, the larger the resource used, and the higher the amount of payment. RW is established based on average costs or reflects the cost of care.

Base rate-BR: is a global average cost per case. Service providers are paid for each DRG based on RW multiplied by BR (e.g., RW of a DRG is 2.55; BR is VND 1,000,000, so the provider is paid 2.55x 1,000,000 = 2,550,000 VND).

Principal diagnosis: The primary illness or medical condition that is the reason for the medical care provided during a period defined by ICD-10 code. Only one primary diagnosis is assigned for an inpatient treatment course.

Secondary diagnosis*:* Diseases or conditions that occur during treatment at the treatment facility and do not include the principal diagnosis. There may or may not be an associated diagnosis. Secondary diagnoses are also classified by ICD-10 code.

Case-mix index (CMI): CMI is the weighted average of the case-group weights of all cases treated in that facility, for example, all patients treated in a medical facility in one year. CMI reflects the complexity of cases treated in a medical facility; the higher the CMI value, the more complicated the disease pattern at the facility. The CMI multiplied by the number of cases is used to determine resource allocation for each facility.

Procedure: Medical activities or interventions performed during the course of patient care. The surgical DRG classification is mainly based on the types of intervention performed in the operation room, while some non-surgical interventions are added to the primary disease codes to classify internal medical cases. Medical procedures are coded according to the ICD-9CM codes.

DRG Grouping*:* Determining hospital outcomes by grouping/classifying care and treatment courses into groups with relatively similar clinical characteristics and resource use. It is a classification algorithm, which is the set of instructions for assigning a particular case to a specific group according to the patient classification logic.

Global budget*:* Setting a limit on the total budget allocated by DRG. This total budget is usually decided by the government, based on an estimate of the resources needed for health care.

2.2.3 DRG CHARACTERISTICS THAT MUST BE CONSIDERED FOR CONTRACTING

Although the use of DRG can help improve resource efficiency and standardization of services among health care facilities for similar cases, it can also incentivize adverse behaviors by health care providers. In particular, paying a fixed amount per case based on an average cost could encourage service providers to increase unnecessary hospitalizations or cut back on services, drugs, supplies, and inpatient days. DRG may encourage overtreatment leading to hospital-acquired complications or incidents, affecting the quality and safety of care. Discharging patients early can increase readmission rates. DRG payments may encourage some forms of gaming behavior, such as systematically coding diagnoses as more severe diseases without any evidence of these severe conditions in patient documentation, in an effort to receive a higher DRG payment. Measures to mitigate these behaviors need to be incorporated into regulations, contracts, and purchasers' business processes including claims review and a provider performance monitoring system.

2.3 INTERNATIONAL EXPERIENCES IN DRG CONTRACTS

2.3.1 LEGAL BASIS FOR CONTRACT ARRANGEMENT BETWEEN PURCHASER AND HEALTH CARE PROVIDER

The literature review shows that the contracts signed between purchasers and providers are usually governed by law and subsidiary regulations of a given country (e.g., Law on Health Care and Protection; Law on Health Insurance; Law on Quality Control; Law on State Budget Savings). For example, in Australia, the contract between a purchaser and a provider of health services is governed by the general provisions of the National Health Reform Agreement (NHRA) (Australian Government Department of Health, 2022). and The Hospital and Health Boards Act, 2011) (The Hospital and Health Boards Act 2011). The NHRA requires Australian states to establish contractual agreements with hospitals and health services (HHS) for the purchase of health services and to comply with a regulatory framework of efficiency and accountability to address inefficiencies in contract performance. The law also clearly states that service contracts are enforced and bind the responsibilities of each individual in it, including Chief Executive Officer, Chairman of the Medical Council, and Hospital Director. The Act also recognizes and applies to the principles and goals of the national health system and is agreed upon by the Commonwealth Government, states, and territories, and the principles of the Medicare Program and health system. The goal of the Act is to establish a public health care system that includes a network of high-quality HHS in all states that are consistent with the principles and goals of the national health system. Contract provisions are therefore an integral part of the implementation of the goals and principles of the national health system (Annex 2) (Central Queensland Hospital and Health Service 2029).

In Estonia, contracts signed between buyers and suppliers are governed by the Law and subsidiary documents (Estonia Health Insurance Act 2002). In the Philippines, contracts are governed by the General Law of Contracts as part of the Civil Code and the Health Insurance Law, whereby the contracting parties may establish rules, terms, and conditions as they see fit, as long as they are not contrary to Philippine law, morality, custom, public order, or public policy (Bultman et al. 2008).

2.3.2 SCOPE OF SERVICES AGREED IN CONTRACTS

In the countries reviewed, the scope of services provided, fixed budget, and base rates are specifically and clearly agreed upon in the contract signed between the purchaser and provider. Contracts in some countries (Australia, UK, Estonia) specify planned activity amounts for each health care facility, and the actions to be taken if the facility produces too little or too much. These list of services and other conditions are often included as addendums to contract (Australia, UK, Estonia, Philippines) or by reference to regulations.

In Estonia, a list of the minimum services to which the insured is entitled, and the financial scope are agreed upon in the contract between the purchaser and provider. This list is specified in Article 30 - List of health services under the Estonian Health Insurance Fund (EHIA), Chapter 3 - Section 2 on Health insurance benefits of the Health Insurance Law, and the appendices to the contract signed between the buyer and provider. Estonia's contract is valid for one year. The amount of services and financial obligations are usually negotiated on a semi-annual basis; the following half-year period is planned based on the performance of the previous half-year. Contract monitoring also is carried out semi-annually and providers can submit to the health insurance agency requests for amendment for the following half-year period. Any changes are specified in the annexes attached to the contract. Boxes 1 and 2 below are sample appendices to Estonia's service contract. Box 1 gives detailed regulations on reimbursable DRGs in the contract – medical receipts related to drug classes and drug-exempt items, specialized medical RTAs under DRG group. Box 2 lists services that are subject to price caps for complex diagnostic services (DRGs). The cases where complex diagnostic services can apply maximum rates and the conditions applicable for these services are identified. The Health Insurance Law also specifies the list of drugs (Estonia Health Insurance Act 2002).

Box 1: Estonia DRG-specific details in the health insurance contracts

TREATMENT BILLS BELONGING TO THE DRG GROUP AND DRG EXEMPTIONS
Specialist medical RTAs belonging to the DRG grouping:
RTA funding source with the code “RA” or “MK” or “VA”, the service type of which is ‘2’ and ‘15’; except for medical bills with TTL code:

	Reimbursable DRGs	Amount in Euros
1	Ensuring round-the-clock readiness	2280K
2	Providing specialist medical and nursing care per month	2294K
3	Antiretroviral therapy council work quarter	2292K
4	Ensuring 24-hour readiness of the transplant center in the quarter -	2295K
5	Providing emergency assistance per month (North Estonian Regional Hospital Foundation)	2305K
6	Providing emergency assistance per month (Tartu University Hospital Foundation)	2306K
7	Providing emergency assistance per month (Tallinn Children's Hospital Foundation)	2307K
8	Providing emergency assistance per month (AS Ida-Tallinna Keskhaigla)	2308K

Box 2: Limit prices for complex diagnostic services (DRG) Name of health service	Code	Marginal price in euros	Range of total prices for other services provided at the same time	
Intracranial surgery for central nervous system tumor	001A	5592.22	3657.80	9281.97
Other intracranial vascular surgery	001B	11,035.97	8164.85	16,818.63
Surgery for intracranial aneurysm, vascular abnormality, or hemangioma	001C	8511.08	4345.28	16,572.96
Intracranial cerebrospinal bypass surgery	001D	4039.39	1575.70	9810.99
Craniotomy other than trauma	001E	4240.14	2417.56	8093.55
Craniotomy in case of trauma	002A	8247.15	3396.40	15,449.02
Surgery for chronic subdural hematoma	002B	2720,42	1744.89	6061,43
Stereotactic intracranial radiotherapy, short treatment	003O	2140.70	1020.31	3340.32
Spinal and spinal surgeries, short treatment	004O	952.43	783.63	1288.88
Spinal and spinal cord surgeries	004	3093.95	1062.32	6590.26
Extracranial vascular surgery, short treatment	005O	1534.72	284.41	2910.76

In Australia, each State enters into a contract between the Department of Health (DOH) and the State's internal health care network, including HHS. The DOH is responsible for purchasing health services from HHS. The scope of services is listed in the contract with a list attached to the contract, but excludes services purchased by HHS from the DOH, such as clinical, sub-clinical, and emergency services of the State (Central Queensland Hospital and Health Service 2019).

In the Philippines, PhilHealth selects qualified health care providers with whom to sign contracts. The scope of services provided is included in the benefit package to which the insured are entitled and specified in detail in the Health Insurance Law of the Philippines. Benefit packages include: 1) inpatient care; 2) outpatient care; 3) emergency services and hospital transfers; and 4) other health care services that PhilHealth sees as appropriate and cost effectiveness (Bultman et al. 2008).

In Thailand, the scope of services provided and the conditions and payment rates for inpatient services by DRG are specified in the National Health Insurance Fund Management Manual (there is no contract). Specifically, service providers are reimbursed by the National Health Security Organization for all inpatient services except those covered by another institution/ elsewhere and they are paid a fixed budget. The base rates are adjusted depending on total activity (National Health Security Office 2019).

In summary, the scope of services agreed upon in the contract between the purchaser and provider may be included directly and in detail in the contract or in contract addendums or reference to legislation. The mechanism for controlling hospital activity (i.e., admissions) paid under a DRG mechanism is often specified in contracts. Contracts in some countries specify concrete planned activity amounts for each health care facility, and the actions to be taken if the facility produces too little or too much.

2.3.3 CONDITIONS TO ENSURE THE QUALITY OF SERVICES DELIVERED

Health care purchasing contracts in DRG systems also pay substantial attention to quality of care. Under DRG payments, hospitals are incentivized to reduce inputs for each episode of

care, requiring more attention be paid to quality of care than in an FFS system. Most of the contracts reviewed include the requirement that hospitals meet basic quality standards before the contract can be signed. In some countries, accreditation is required, but other standards also are used, all of which are stipulated in the contracts. Most contracts also stipulate quality outcomes that are to be monitored and the consequences if poor quality is detected, such as greater regulatory supervision or financial penalties. Important quality outcomes are monitored, including sentinel events and hospital-acquired complications and infections, but other process indicators are also used (e.g., sepsis screening of hospitalized patients in the UK). The purpose of quality control is to make health care organizations focus on improving efficiency (Scrivens 2002). One quality control mechanism, accreditation of service providers, was first required in the US nearly 100 years ago; it expanded to other higher-income countries in the 1980s and 1990s and then to middle- and low-income countries such as Thailand, the Philippines, and Malaysia. In Europe, quality control requirements are initiated in some European countries (Heaton 2000; Shaw and Kalo 2002). Initially in the UK, accreditation was voluntary, but the government's accreditation program made it mandatory; service providers are required to participate if they want to enter into a contract to provide public services (Bultman et al. 2008). However, in most contracts reviewed, the purchasers help facilities located in geographically disadvantaged areas or smaller hospitals to make improvements required to achieve quality accreditation. Following are examples of conditions to ensure the quality of services provided in some countries:

***In Queensland, Australia*:** Health care facilities strictly adhere to accreditation regulations. All public hospitals, health care centers, and daycare services within the State's network of medical facilities must be accredited and maintain the accreditation under the Australian Health Service Safety and Quality accreditation scheme (Australian Commission on Safety and Quality in Health Care [B]). Starting in January 2019, accreditation has been based on National Safety and Quality Health Service (NSQHS) standards, second version (Australian Commission on Safety and Quality in Health Care [A]). Mental health services within the HHS system will continue the accreditation based on NSQHS standards and National Standards for Mental Health Services)Australian Commission on Safety and Quality in Health Care [C]). Residential aged care facilities will maintain Australian Aged Care Quality accreditation. These regulations also refer to the regulations, and legislative roles and responsibilities of the MOH and HHS in accordance with the Hospital and Health Boards Act, 2011 and provide a legal framework and joint commitment to support the operation of the Queensland health system.

In the Philippines, PhilHealth has established criteria for selecting participating providers, such as the need of the population groups to be served, the epidemiological profile of such populations, and the prices offered by the provider. While price is not the sole selection criterion in most cases, if the quality of care provided is equal among providers, then price may be the deciding factor. In terms of service volume, PhilHealth may favor service providers that are able to provide a large volume of services with lower quality and prices. It also considers accessibility for the insured. There is a trade-off between price, quality, and service accessibility. For example, PhilHealth will not contract with or pay unaccredited facilities. However, it does work with the MOH to determine which health facilities need improvements to achieve the quality accreditation required to be covered by PhilHealth, especially small and medium-sized health facilities (≤50 beds), or those in remote, isolated, or disadvantaged areas (Bultman et al. 2008).

***In Estonia*:** In addition to the regulation prescribing the minimum number of services that a health facility must provide to insured patients and the range of services, the contract details conditions that a facility must meet to ensure service quality (Estonia Health Insurance Fund Management Board 2014). These terms of service quality must be within the scope of the Health Insurance Law. When entering into a contract with the Health Insurance Agency, service

providers guarantee the availability and quality of services they will provide throughout the term of the contract (Estonia Health Insurance Fund Management Board 2014). The key quality requirements for service providers are as follows:

- Ensure they provide services to insured patients according to quality, scientific, and technical standards, based on the principles of good clinical practices and evidence of cost effectiveness;
- Ensure they have infrastructure and medical equipment as prescribed by Estonian law;
- Ensure they have established a quality management system, codes of practice, document templates and performance standards (including clinical indicators), along with an analysis mechanism and regular compliance control, based on the Health Quality Assurance Regulations of the Minister of Social Affairs under Article 56 of the Estonian Health Care Service Organization Act;
- Ensure they support and cooperate with the Clinical Guidelines Advisory Board, develop treatment guidelines appropriate to the context of Estonia, and have available treatment guidelines, codes of conduct, and patient instructions.

In the UK: Quality can be specified in the contract by referring to the requirements in the National Health Service Frameworks. Frameworks have been issued for areas of disease, such as coronary heart disease, cancer, mental care, and services for the elderly. These frameworks are used as tools for implementing guidelines and contracts. Hospitals commit to comply with contracts and develop quality development plans that include quality improvement goals, quality-centered job descriptions, audit arrangements, reporting, monitoring, and patient satisfaction (Figueras, Robinson, and Jakubowski 2005).

In Thailand: Thailand also had progressive changes with the introduction of a step-by-step quality assurance process in 2004 and patient safety goals in 2006 (Smits, Supachutikul, and Mate 2014). The 2010 conference on accreditation in Bangkok reported widespread concern about the quality of health care delivery at health facilities under health insurance schemes. To encourage "pay for quality," health insurance companies have offered financial incentives such as paying bonuses to providers who exceed accreditation standards (Smits, Supachutikul, and Mate 2014).

2.3.4 PROVISIONS ON THE ACCOUNTABILITY OF PURCHASERS AND PROVIDERS OF MEDICAL SERVICES

Purchasers are the intermediary between people/insured patients and providers. They are responsible for allocating resources entrusted by people/insured patients who seek good health care and financial protection. Thus, buyers and suppliers share responsibility for ensuring the quality of health services. The buyer's role in ensuring quality is defined in the contract, and the contract is used as a tool to enforce quality (Figueras, Robinson, and Jakubowski 2005).

The provision of medical goods and services takes place within a clear, transparent, accountable and enforceable contract system (Somanathan et al. 2014). The purchaser is responsible for 1) negotiating and agreeing on contract language on behalf of the insured, including the contract’s requirements for service quality and the provision of high-quality information by the provider; 2) contract monitoring, including tracking the receipt and accuracy of the aforementioned reports on quality; taking punitive action for poor-quality services; receiving complaints directly from people/insured patients; collecting feedback from people about satisfaction with service delivery; and 3) contract review: quality performance review, agreement on changes to improve quality, recommendations for contract adjustments if the

quality of services provided is not acceptable, and availability of alternative services (Figueras, Robinson, and Jakubowski 2005).

Accountability is an important element in the relationship between purchaser and health care provider. Performance monitoring tools are developed so that purchasers can evaluate provider performance, in other words, monitor whether their objectives are achieved. In this way, purchasers are no longer “passive” payers of the health services provided to the patients they represent; they are now “active” payers. Purchasers promote the role of market power in negotiating prices of drugs and medical services to achieve reasonable and cost-effective prices without affecting service quality. For example, Thailand’s National Health Security Office used its purchasing power to negotiate discounts on drugs and medical services, specifically reducing the price of hemodialysis from $67 to $50 per treatment, saving US$170 million per year (Somanathan et al. 2014). The buyer can rely on the results of a health technology assessment to negotiate the lowest prices for drugs/medical services and to monitor the achievement of objectives and amend or terminate the contract as needed if objectives are not achieved. In addition, buyers must ensure timely advance payment and settlement for health care providers. They also can refuse to pay if the provider requests payment after the time limit specified in the contract (Estonia; Thailand).

The responsibilities of health care providers also are clearly stated in their contract with a purchaser. Service providers must comply with the provisions of the contract as well as laws on health care and health insurance. They must provide quality services; enhance the geographical and financial access to health services for the people/the insured; protect patients from high out-of-pocket payments; enhance satisfaction of health service users; meet health care sector goals; and provide information about efficacy to all relevant parties. The specifications for providing information to the purchasing agency include all data/information required to enforce the contract, such as information to assess the provider's eligibility to sign a contract, quality standards, quality outcomes, activity, and information to assign episodes to DRGs. The service providers are also required to provide the purchasers or MOH/DOH with efficacy/performance and other relevant data, on a routine or ad hoc basis, for the purposes of payment, verification, monitoring, and supervision. The contract stipulates how provider must submit the data, for example, in paper or electronic form. In Estonia, guidelines and formats for electronic data exchange with the health insurance agency are published on the EHIF website (http://www.haigekassa.ee/raviasutusele/toru/) in the menu “For partners - IT solutions” (Estonia Health Insurance Fund Management Board 2014).

2.3.5 SETTLEMENT OF DISPUTES

In most countries, the settlement of disputes between the buyer and the provider is agreed upon in the contract. In Queensland, Australia, the dispute-handling process in a contract is designed to settle disputes between the parties to the contract in a final and binding manner. The process must comply with provisions of the Hospital and Health Boards Act and guidelines for disputes.

If a contractual dispute arises, such as in the interpretation of the contract’s terms, either party may provide the other party with a written Notice of Dispute, which must contain the following information (Central Queensland Hospital and Health Service 2019):

a. A summary of the matter in dispute;

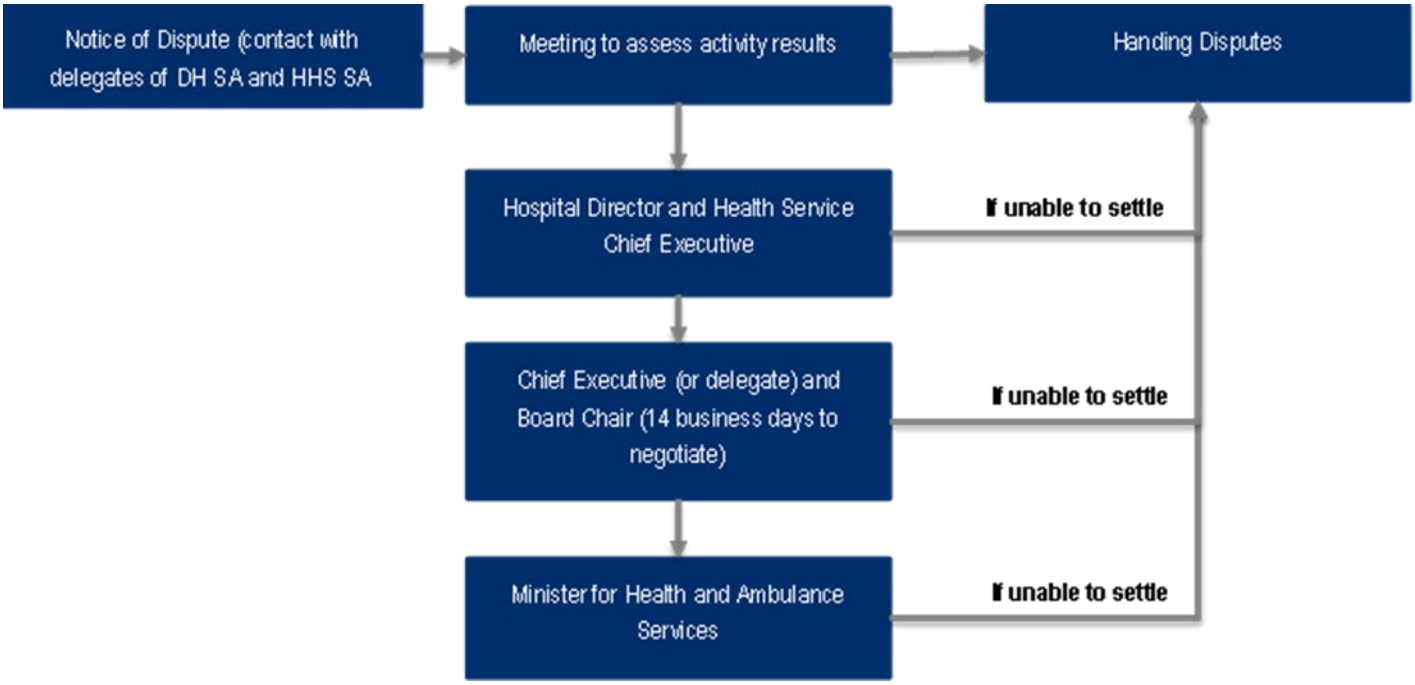
b. An explanation of how the party giving the Dispute Notice believes the dispute should be resolved and the reasons to back that belief;

c. Any information or documents in support of the Notice of Dispute; and

d. A definition and explanation of any impact of the dispute on finance or service provision.

This process should only be used after all reconciliation efforts have been made. It starts at the lowest level of dispute and moves to a higher authority only if lower levels cannot settle (Figure 2).

Figure 2: Contractual dispute settlement process of Queensland, Australia



2.3.6 AMENDMENT, SUSPENSION, AND TERMINATION OF CONTRACT

Contracts also contain provisions on the amendment, suspension, and termination of the contract. The following list comprises provision ***in Estonia*** (Estonia Health Insurance Fund Management Board 2014):

- The contract will be modified according to the written agreement of all parties, except for some conditions that have also been specified in the contract.
- EHIF and health service provider may request amendment of the contract terms for appropriate and efficient use of health insurance funds, taking into account any changes in the implementation or quality of services due to the merger, split, or change of suppliers.
- If the provider loses the legal basis to provide the service, EHIF may terminate the contract by giving the provider reasonable advance notice.
- EHIF will suspend the performance of the contract if the provider is unable to start delivering the agreed services within 30 days of contract signing. If the provider does not begin delivering services after receiving written notice from EHIF, EHIF may withdraw from the contract.
- EHIF may unilaterally reduce the number of agreed DRGs and the amount allocated if the service provider fails to implement the financial appendices of the contract to a significant degree (at least 10 percent).

- In addition to the grounds prescribed by law, a serious breach of contract is construed as a repeated breach of any contractual obligations during the term of contract, as well as a failure of the service provider to take action to deal with the aftermath of the breach.
- A written notice giving reasons for the suspension of a part, or all of the contract is sent to the other party at least 30 days before the suspension.
- If either party wants to terminate the contract, it must notify the other party in writing at least 60 days in advance.

In Australia: HHS are required to provide the services outlined in the contract. Any changes to service delivery should ensure continuity of care and minimize disruption to patients. The DOH and HHS may terminate or temporarily suspend a service by mutual agreement with the following obligations:

a. any proposed termination or suspension of services must be given in writing to the other party;

b. when there is a proposal to terminate or suspend a service provided throughout the state or region, the HHS receiving such service must also be consulted;

c. all parties agree to a notice period before the termination or temporary suspension takes effect; and

d. patient needs, workforce impact, relevant government policy and HHS sustainability should be considered.

The DOH, as administrator of the state health system, may not support the proposed termination or temporary suspension and require HHS to maintain the service. HHS will:

e. work with the DOH to ensure continuity of care and smooth transition of services to an alternative provider when needed; and

f. minimize any risk or inconvenience to the patient that is associated with the termination, temporary suspension, or transfer of service.

If a sustainable alternative provider cannot be identified and the service is compulsory, the HHS must continue to provide the service to the related patient group (Central Queensland Hospital and Health Service 2019).

In the US (Ellison 2021)*:* Compliance with the terms of the contract is very strict; any health facility violating the terms will be reminded to address the violations. If the facility fails to do so, the contract will be suspended or terminated. For example, based on findings in an assessment report published in June, the Medicare program announced in July that it would terminate its contract with a hospital in October if the hospital did not fix the problems the assessment identified. The report pointed to the failure of hospital leadership to properly manage hospital operations and noted that the nurse/patient ratio had failed to comply with regulations several times earlier in the year. The staffing shortages caused clinical errors, including at least four cases of not providing drugs to intensive care patients as prescribed by doctors. This demonstrates that contract termination or suspension is strictly enforced. If a hospital fails or is slow to comply with the contract, despite reminders, the contract will be suspended or terminated.

2.3.7 COMPENSATION FOR DAMAGE AND LIABILITY FOR BREACH OF CONTRACT

Compensation for damage and liability for breach of contract is specified in the contract as agreed between the two parties to ensure the sanction and enforcement effect of the contract. Any such agreement must be in accordance with the law. In Estonia, for example, EHIF may require the service provider to pay a penalty of up to 0.05 percent of the total contract amount payable by the EHIF to the provider for one year, but not exceeding 5,000 Euros, when it detects violations such as insufficient service delivery, provision of services below the prescribed fee, provision of services without a basis for payment, or unreasonable prescription of services. If EHIF is late in providing payment, it must pay the service provider interest at the rate of 0.05 percent of the late payment amount per day, but not exceeding 1,600 euros. EHIF must compensate a provider if it (EHIF) loses health records, medical histories, and other documents that the provider submits to verify a claim (Estonia Health Insurance Fund Management Board 2014).

2.3.8 FORCE MAJEURE

For countries like Australia and Estonia, there is a force majeure provision in the service agreement in the following cases [5,10]:

- Parties are exempted from their contractual obligations if they fail to perform the obligations in part or in full when such failure is a result of rare events that the parties could not foresee or prevent, and the contract includes a force majeure clause. Force majeure refers to incidents occurring beyond the control of the parties, and for which the parties are not liable.
- If the affected party wishes to claim the benefit of this force majeure clause, it must give prompt written notice of the force majeure to the other party of:
    a. the occurrence and nature of the force majeure;
    b. the anticipated duration of the force majeure; and
    c. the effect the force majeure has had (if any) and is likely to have.

2.3.9 MONITORING AND SUPERVISION OF CONTRACT PERFORMANCE

Monitoring and supervision are an integral part of contract performance to ensure fairness, quality, and transparency. The purchaser of health services must evaluate the contract performance of the service provider and is accountable for reporting to higher regulatory/independent government agencies about contract performance and compliance.

***In Australia*:** State DOHs have established a Monitoring and Supervision system for contract performance that includes:

- A routine data provision system to evaluate contract compliance;
- A contract supervision system (routine evaluation, supervision, contract amendment, if needed);
- A routine communication channel for early detection of possible problems;
- A contract results evaluation framework.

The government or its purchasing party is responsible for contract supervision (market analysis, compliance of contract provisions, financial management) and reporting benefits and disadvantages to policy makers.

In the Philippines: PhilHealth considers monitoring and supervision of contract performance to be critical. Monitoring and supervision must be carried out by both service purchasers and providers. Hospitals are required to provide monthly data to the health insurance agency so it can evaluate hospital performance and compare that performance with other providers. Parties jointly analyze successes and shortcomings and propose adjustments that are then attached to the contract. Results of contract performance monitoring, supervision, and evaluation must be able to answer the following questions: 1) Has accessibility to services improved (financially and geographically)? 2) Has the contract affected quality, efficiency, and equity (improved access for the poor)? 3) Has efficiency of business procedures improved? 4) Have out-of-pocket payments by the insured been reduced? (Bultman et al. 2008).

2.4 LESSON LEARNED FOR VIETNAM

Based on the literature review, Vietnam can draw the following lessons about contracting:

- Legal frameworks should be detailed and specified in laws and secondary documents so that they lay a sound legal foundation for establishing contracts agreement between purchasers and providers of health services.
- A contract should clearly indicate the scope and volumes of services to be provided and excluded.
- A health facility should be mandated to have certain conditions related to service quality in order to sign a contract. These conditions include being accredited, licensed, and certified to practice medicine, and observing quality standards and clinical guidelines for both private and public sector. Health facilities in disadvantaged, hard-to-reach areas should receive technical and financial support that enables them to meet quality requirements for reimbursement.
- A mix of provider payment methods (capitation + global budget + FFS + DRG) with details of method design; authority/role of the purchaser in price negotiation, cost containment should be adopted.
- A contract should further:
    - Ensure a mechanism is in place to secure accountability between the purchaser and provider through a timely advance payment for the service provider and requiring the provider to submit information/data appropriate for monitoring, supervision, and auditing.
    - Ensure a mechanism is in place to monitor and supervise contract performance to ensure compliance or adjust as appropriate.
    - Include punitive measures for poor service quality, delayed payment, incomplete data, fraud, and so forth.
    - Clearly define regulations (mechanism, stakeholders, timing) on adjustment, revision, termination of contract, settlement of disputes, and compensation for losses due to breach of contract.

3. CURRENT REIMBURSEMENT OF HEALTH CARE SERVICES BY SOCIAL HEALTH INSURANCE IN VIETNAM

3.1 CURRENT IMPLEMENTATION OF REIMBURSED SERVICE PROVISION CONTRACTS

3.1.1 TOTAL NUMBER OF HEALTH FACILITIES ENTERED INTO REIMBURSED SERVICE PROVISION CONTRACTS

According to the VSS, the number of health facilities that have signed reimbursed service provision contracts is increasing. At the end of 2020, Vietnam had 2,612 contracted health facilities, 1,717 (about 66%) of them public and 895 (about 34%) private (Table 1). Most are district- and province-level facilities; contracts for commune-level providers are signed through district facilities.

Table 1: Number of contracted service providers, 2016–2020

Contracted providers reimbursed by SHI	2016	2017	2018	2019	2020
1. By ownership					
Public health facilities	1,676	1,608	1,669	1,651	1,717
Private health facilities	418	561	647	795	895
2. By level of care					
Central	70	44	44	42	42
Province and equivalent	572	645	656	528	535
District and equivalent	1,195	1,242	1,407	1,709	1,879
Commune and equivalent	257	240	211	167	156
3. Total	**2,094**	**2,169**	**2,316**	**2,446**	**2,612**

3.1.2 LEGAL RATIONALE FOR THE REIMBURSED SERVICE PROVISION CONTRACT IN VIETNAM

Similar to other countries, health service purchasing in Vietnam is implemented through a contracting mechanism between the purchaser (VSS) and a service provider (health facility) at district, provincial, and central levels. VSS is the sole service purchaser (via SHI). The MOH, as a state management agency for SHI, issues regulations, circulars, and decisions on health care services reimbursed by SHI. The provincial DOH grants licenses, certificates to practice medicine, re-verifications of scopes of service provided by health facilities, and it settles disputes between social security agencies and health facilities.

The legal rationale for reimbursed health service provision contracts is included in Civil Code no.91/2015/QH13 (24/5/2015); Health Insurance Law no.25/2008/QH12 ((14/11/2008); Revised Law on Health Insurance no.46/2014/QH13 (13/6/2014); Medical Examination and Treatment Law no.40/2009/QH12 (23/11/2009) and secondary documents such as: Decree no.146/2018/NĐ-CP (17/10/2018) detailing and guiding enforcement of the Health Insurance

Law and Decrees; Decree no.109/20l'16/NĐ-CP (01/07/2016); Circular no.48/2017/TT-BYT (30/11/2018); Circular no.56/2017/TT-BYT (29/12/2017); and Circular no. 09/2019/TT-BYT.

The main contents of the contract are stipulated in Article 25 of the Health Insurance Law no.25/2008/QH12. The law stipulates that a reimbursed health service provision contract is an agreement between the health insurance agency and health facilities for provision of services and reimbursement for claimed health care costs. The law also stipulates major contents of contracts: a) Object of service and requirement for provided service quality; b) Provider payment methods; c) Rights and obligations of parties; d) Contract duration; đ) Liability due to breach of contract; and e) Conditions for change, liquidation, and termination of contract. The contents of Article 25 are specified in Chapter V (Articles 16-23) of Government Decree no.146/2018/NĐ-CP, dated 17/10/2018, which details and guides enforcement of the Health Insurance Law (Vietnam Social Health Insurance Law 2008). The MOH is assigned to develop the contract form. Based on an annex of Decree no. 146/2018/NĐ-CP, the MOH issued Form 07 – Contract Template for reimbursed services. This annex includes detailed contract provisions as already stipulated in Health Insurance Law and Decree no.146. The contract template also clearly indicates that, depending on conditions of the health facility, the social security agency and health facility agree to add contents to the contract, but the changes cannot be contrary to the health insurance law. This provides room for health facilities and local service purchasers to conduct price negotiation without violating regulations of the law.

To consolidate the arrangements for contracted service provision (contracted services) under Government Decree no.146 and MOH circulars, the VSS issued an official Letter no.95/BHXH-CSYT, dated 08/01/2019, on implementation arrangements for contracted service provision under Decree 146. To ensure contracting and contract performance follow the regulation, on 10 November 2020, the VSS issued an official letter no. 3537/BHXH-CSYT guiding the arrangements for signing and implementing reimbursed health service provision contracts starting in 2021.

3.1.3 SCOPE OF CONTRACTED SERVICE

Currently, the scope of reimbursement benefits is stipulated fairly fully and comprehensively in the Health Insurance Law, Decree 146, and MOH-issued Circulars. The contents and scope of contracted services are regulated by Decree 146 and Contract Form 07. The provider is accountable for providing reimbursed health care services, sufficient medicines, medical supplies within the scope of medical professionals working at the health facilities, and within the scope of reimbursement benefits of insured persons. Regulations on scope of services, medicines, laboratory chemicals and other supplies, and other benefits are referred to in corresponding MOH circulars.

3.1.4 CONTRACTING REQUIREMENTS

At present, social security agencies at all levels execute reimbursed service provision contracts with at all levels of public and private health facilities, from central to district levels according to the list of health facilities approved by MOH/DOH. (As noted earlier, commune health stations deliver services contracted via agreements signed by the district hospital or district heath center.) Health facilities must secure an operational license and certification of practice of medicine approved by a competent authority (MOH/DOH). Quality control of care in health facilities in Vietnam lags that of other countries; "accreditation" of service quality is voluntary and not mandatory. A health facility quality assessment is currently reviewing 83 hospital quality criteria issued by the MOH in Decision no.6858/QĐ-BYT, dated 18/11/2016. If the hospital is approved to perform additional functions, tasks, scope of medical professional work, or change

the technical classification of the hospital, it must notify the social security agencies to update the reimbursed service contract.

3.1.5 PROVIDER PAYMENT METHOD

The current provider payment method applicable to all health facilities throughout Vietnam is FFS, stipulated by Article 24 of Decree 146. Prices of services, and chemicals and other medical supplies follow the joint Circular on pricing issued by the ministries of Health and of Finance. All hospitals of the same class charge the same price for the same service. Medicine and other supplies costs—if not already counted under the service price—are paid at the price according to the regulation on bidding; costs for blood and blood products are reimbursed under guidance of the Minister of Health. Reimbursed costs paid to health facilities should not exceed the total payment level of the health facilities. Calculation of total payment level is stipulated in Clause 4, Article 24, of Decree 146. The current service price is not fully costed as it constitutes only five cost items; it does not include management, training, and depreciation of fixed assets. The capitation method for outpatient services and DRG for inpatients is currently being piloted by the MOH and VSS and will be adopted at national scale in the near future.

3.1.6 ADVANCE, SETTLEMENT OF PAYMENT

Advance payments and settlement of payments for reimbursed costs are made under Article 32 of the Health Insurance Law. The appropriate social security agency is responsible for making a monthly advance payment to the health facility in the amount of at least 80 percent of settled reimbursement costs of the previous quarter. If the agency has not yet approved the previous quarter's reimbursement costs due to some disagreement, an advance payment is nevertheless made to health facilities and is delayed only under rare circumstances. For example, payments may be delayed if the purchaser and health provider do not agree on the price of a medicine or service, or if the contract does not provide for repercussions when a breach of contract results in ineffective enforcement.

3.1.7 RIGHTS AND OBLIGATIONS OF THE PURCHASER AND PROVIDER

Rights and obligations of the purchaser and provider are clearly stipulated in the Contract Form 07 annexed to Decree 146. It indicates obligations of the purchaser and provider to secure advance payment and settlement of payment by the due date, comply with regulations of the law; provide a paper or electronic list of primarily registered enrollees in health facilities to Party B according to the Form 8 Annex of Decree 146 and that Party B is to provide Party A with relevant documents to support auditing work. Relevant documents include medical records and other health care documents of insured patients; joint-venture agreements on providing medical techniques; labor contracts between the health facility and practitioners (if any); decision of competent authority on implementation of project or contract on technical transfer, or technical support for lower level facilities; list of technical services; list of medical services and price of medicines, chemicals, and medical supplies used at the health facilities.

3.1.8 OBLIGATIONS DUE TO BREACH OF CONTRACT

Health insurance disputes are regulated by Article 48 of the Health Insurance Law. The article clearly states that disputes are resolved in the spirit of cooperation, agreement, under provisions of clause 3, Article 22 of Decree 146. If the dispute cannot be resolved, either party has the right to litigate in court according to provisions of Article 48 of the Health Insurance Law. Court decisions are final. While the dispute is being settled, the two parties must ensure insured

patients continue to receive health services. If there is any change in or a termination of the contract, the parties must follow point e, Clause 2, Article 25 of the Health Insurance Law, and Articles 22 and 23 of Decree 146.

However, there is no regulation on contract-related penalty, for example, for late submission of insurance claims by the health facility or a late advance payment or settlement of a payment dispute by the social security agency. Additional circumstances are when there is a violation of the scope of medical practice, or fraud is detected in service provision, such as provision of unnecessary services. At present, the social health insurance agency cannot penalize the provider by withholding reimbursement, thus resulting in poor contract performance. If any dispute arises between the social health insurance agency and health facility, litigation claims are sent to their management agency (MOH/DOH, VSS) for resolution.

Agreed or unilateral termination of contract is not regulated in laws and Decree 146. Force majeure and compensation for violation of contract are not yet regulated.

3.2 CHALLENGES WITH REIMBURSED SERVICE CONTRACT

A review of legal documents and actual performance of reimbursed health service contracts has revealed gaps in contracting:

AMBIGUITY, INCONSISTENCY, AND INADEQUACY OF CURRENT LEGAL DOCUMENTS ON REIMBURSED HEALTH SERVICE PROVISION CONTRACTS

Senior MOH and VSS officials indicated that the reimbursed health service contract in Vietnam is ambiguous as it does not indicate contract status as *"civil contract"* or *"responsibility contract."* However, according to Article 402 of the Civil Code, this is a civil contract because a *"contract for the benefit of a third party requires the contracting parties to perform an obligation as the third party is benefited by the performance of such obligation"* (Vietnam National Assembly 2015). The contract structure is clearly defined in the Civil Code, and fully embraces terms and conditions of a civil contract, including contract dispute settlement, and change, adjustment, cancellation, termination, unilateral termination, compensation for damage, and force majeure provisions. It defines punitive measures (e.g., penalties on late payment or advance). However, current legal normative documents do not mention certain provisions: financial penalties if the contract conditions are not met and result in poor contract performance, chronic late reimbursement, and settlement of payment.

The VSS lacks tools to assess service quality and payment cost, or to do M&E and audit support. The tools, such as care pathways, standard regimens, and standard treatment guidelines, are instrumental for assessing the appropriateness of services and reimbursement costs. Thus far, the MOH's standard treatment guidelines are approved for many diseases, but they are not yet incorporated into algorithms for claims processing (Health Strategy and Policy Institute 2015). Nor has the MOH developed M&E indicators to assess contract compliance, performance, and service quality, or principles for the medical audit of claims.

Reform of provider payment methods is proceeding slowly, and meanwhile it is hard to contain rising health care costs as FFS payment is inefficient and costly. Because many legal documents are unspecific or ambiguous, disputes between parties arise, affecting patients. Policies to regulate hospital behavior under incentives for DRG or capitation payment have not been fully developed. The current contract and regulatory framework are incomplete and inconsistent in this respect. Regulations and contracts do not explicitly state the scope of services to be paid under DRG, capitation, and FFS. The current contract model does not explicitly state the amount of services and of payments to be made and how these will be

adjusted if services are over- or underproduced. Contracts do not adequately specify the required quality of care standards that must be maintained, or how quality of care will be monitored to reduce the risk of stinting or early discharge, which risk patient well-being.

THE ROLE AND AUTHORITY OF THE SERVICE PURCHASER IS NOT SET IN THE PRINCIPLE OF STRATEGIC PURCHASING

According to the Health Insurance Law, the VSS is the only reimbursed service purchaser. However, it is a passive purchaser, without authority to choose the quality health facilities with which it wishes to contract; instead, it has to sign contracts with all MOH/DOH-listed public and private facilities. Nor can it choose services to purchase at which price, which provider payment method to adopt, or even the contract agreement template it will use—the MOH makes these decisions. Because the VSS must follow MOH regulations and guidelines, it cannot operate as an independent strategic purchaser. This denies it some roles/powers of strategic purchasing, such as using "market power" and price negotiation to reduce service prices. The VSS also lacks the authority to penalize health facilities other than to propose fines. It does not have the authority to terminate a contract unilaterally when health facilities are in violation.

THERE IS NO SYSTEM TO MONITOR AND EVALUATE CONTRACT PERFORMANCE

Although supervision, evaluation, and measurement of operational efficiency of health facilities are important, they remain overlooked. Supervision of contract performance is the responsibility of MOH/DOH inspectors, who sometimes work with VSS/provincial social security agencies. However, the inspectors only investigate when something goes wrong (e.g., abuse of SHI fund, or a violation of health policy). There is no regular supervision of contract performance and compliance (e.g., number or terms) to adjust as needed. Neither the MOH nor the VSS has developed a system of M&E indicators to measure contract performance.

PLANNING SKILLS AND CONTRACT NEGOTIATION SKILLS REMAIN LIMITED

Contracting is a fairly complicated process, but it is designed quite simply in Vietnam. Key MOH and VSS staff have limited awareness and capacity in contract negotiation and management, and oversight of contract performance. Contract and negotiation skills need to be improved[1] (ADB 2019). Lack of such capacity leads to contract inadequacies and disputes during implementation.

[1] Opinions from key informant interviews of MOH and VSS

4. RECOMMENDATIONS

Based on analysis of findings from the international literature review and key informant interviews about the current situation in Vietnam, LHSS proposes that the MOH consider the following:

- Reimbursed health service provision contracts should be deemed civil contracts; service provision contracts designed/adjusted according to the regulation of the Civil Code.
- Work with the VSS to adjust/revise/supplement some regulations on contracting in the amended Health Insurance Law; Decree 146, and the sample contract 07 that is annexed to Decree 146. Specifically, articles should be inserted in the sample contract to address issues such as penalties for violation of contract; and procedures for settlement of contract disputes including the court of dispute settlement, for adjustment of the contract, for unilateral termination of the contract, and for seeking contract exemptions due to force majeure (mechanism, relevant agencies, time, sanctions, etc.).
- Establish a clear and adequate legal framework to avoid potential conflict between the purchaser and provider. Doing so needs to be carried out step-by-step and move from the simple to comprehensive approaches for DRG contracting. Specifically, it should start by issuing full and synchronized regulations; instructions on the scope and volumes of provided services; standards/criteria for service quality; conditions for contract signing (licensing, certification of practice of medicine, and moving toward compulsory accreditation to fill gaps in standardizing quality across health facilities); methods and payment levels for paying providers; and procedures for ensuring accountability between purchasers and providers.
- Social security agencies have a duty to purchase health services for insurance cardholders through a reimbursed service contracting mechanism. To that end, the agencies should be given authority in price negotiation and other financial incentive measures (e.g., service quality-related bonuses or penalties, value-based purchasing) to make the health insurance fund more effective.
- Reform the provider payment method, with DRG for inpatient services to strengthen service quality and effective use of the health insurance fund. Regulations on design of DRG payment need to be completed step by step, institutionalized in a circular on DRG payment for inpatient services, and annexed to the service contract. Prototype DRG contracts should be designed that include activity or budget caps and procedure for claims management and dispute resolution, and development and use of clinical coding standards to support hospital documentation of care in a way that avoids errors and reduces the risk of payment being denied.
- The MOH should strengthen accountability between the purchaser and provider regarding advance payments, settlement of payments, and requirements for information provision. The contract terms and conditions should include timing of information provision from health facilities; timing of feedback sent from the social security agency; and consequences of late data submission and data errors.
- Clearly define and align the MOH and VSS's roles/functions and responsibilities for monitoring, supervision, and evaluation of contract performance to achieve targets and secure benefits for the insured. M&E indicators should be developed to support contract performance monitoring and supervision in general and DRG in particular.
- Strengthen the information system in health facilities and interoperability of the MOH and

VSS systems to improve quality of care and use resources more effectively. Provincial and central health agencies should play a stronger role in designing health care systems and build their capacity to use information to enhance efficiency and effectiveness, and secure benefits for the insured.

- Conduct analytical work to map/study options (ideal and realistic) for transition to DRG contracting in order to know what a DRG contract might look like based on existing regulations, what can be changed/improved quickly, what are the trade-offs, and what are minimum requirements to start DRG contracts.
- Enhance the capacity and knowledge of contracting as well as contract negotiation and problem-solving skills for key staff of the MOH, VSS and provincial social security agencies, and service providers.

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ANNEXES

Annex 1: Summary of service purchasing mechanism in selected countries where DRG is applicable, and practice in Vietnam

Country	Australia	Estonia	UK	US	Thailand	The Philippines	Vietnam
Financing schemes	Government Medicare scheme	National Health Insurance Scheme	National Health Service (NHS)	Medicare for people 65 and older and people with disability	Universal Coverage Scheme	National Health Insurance Scheme	Vietnam Social Security (VSS)
Purchaser (contracting)	State Departments of Health	Estonia Health Insurance Fund (EHIF)	NHS trusts in different regions	Centers for Medicare and Medicaid Services	National Health Security Office	PhilHealth	VSS
Beneficiaries	Universal	Universal	Universal	Older people and people with disability aged 18 yrs and older	Lay people who are not public/civil servants or salaried staff	Universal	Universal
Funding source	National tax-based system	Social Health Insurance	National tax-based system	Government budget and contributions to social security by employees and employers. Government (taxes, annual contributions to social security until 65 yrs old)	General tax through annual budget bill to the National Health Security Office	Multiple: fully subsidized premium for the poor; premium contributions by public and private employees and the informal sector	Contributions of employers and employees; state budget for subsidized premium for some groups; households
Provider payment method	Activity based Funding (ABF) – DRG + block grants	DRG + FFS	DRG + Value-based purchasing – payment by result or Pay for performance	DRG – Prospective Payment DRG + Value based purchasing	Global budget+DRG for DRG for inpatient (IP) services, reimbursed to hospitals	Case- based payment + capitation + FFS	FFS

Annex 2: Legislative and regulatory framework of Service Agreement 2019/20–2021/22, Central Queensland Hospital and Health Services[2]

3.1. This Service Agreement is regulated by the National Health Reform Agreement and the provisions of the Hospital and Health Boards Act 2011.

3.2 The National Health Reform Agreement requires the State of Queensland to establish Service Agreements with each HHS for the purchasing of health services and to implement a performance and accountability framework including processes for remediation of poor performance. The Hospital and Health Boards Act 2011 states under section 35(3) that the Service Agreement executed between the Chief Executive and the Hospital and Health Board Chair binds each of them.

3.3 The Hospital and Health Boards Act 2011 recognises and gives effect to the principles and objectives of the national health system agreed by the commonwealth, state and territory governments, including the Medicare principles and health system principles set out in section 4. Section 5 of the Hospital and Health Boards Act 2011 states that the object of the Act is to establish a public-sector health system that delivers high-quality hospital and other health services to persons in Queensland having regard to the principles and objectives of the national health system. This Service Agreement is an integral part of implementing these objectives and principles.

[2] Central Queensland Hospital and Health Service - Australia. Service Agreement 2019/20 – 2021/22

Annex 3: List of health services of health insurance fund of Estonia [3]

§ 30. List of health services of health insurance fund

(1) The list of health services of the health insurance fund (hereinafter list of health services) will be established by a regulation of the Government of the Republic on the proposal of the minister responsible for the field to which the written opinion of the supervisory board of the health insurance fund concerning the proposal is appended.

(2) The following is entered in the list of health services:

- the name of the health service;
- the code of the health service;
- the reference price of the health service;
- the limits for the payment obligation of an insured person assumed by the health insurance fund;
- the extent of cost-sharing by an insured person;
- the conditions for application of the reference price of the health service, the limits for the payment obligation of an insured person assumed by the health insurance fund, and the extent of cost-sharing by an insured person.

(3) The extent of cost-sharing by an insured person is that part of the reference price of a health service for which the payment obligation is not assumed by the health insurance fund. The same extent of cost-sharing applies to all insured persons and the extent must not exceed 50 per cent of the reference price of a health service.

(4) A reference price set out in the list of health services covers all expenses necessary for the provision of the health service, except for expenses on research and the training of pupils and students.

[3] Estonia Health Insurance Act. 2002