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IMPLEMENTING DRGs: THE FINANCIAL CONDITIONS FOR AND CONSEQUENCES OF USING DRGs AS A MEDICAL REIMBURSEMENT SYSTEM

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Implementing DRGs:

Consideration of the Financial Conditions for and Financial Consequences of implementing DRGs as a basis for medical cost reimbursement

Preamble

This report has been written by the ITAT member responsible for financial management Mr Grayson Clarke as a supplement to the earlier reports produced by Dr Lars Kyburg and Professor Hu Mu under the DRG workstream for the project. Its purpose is to provide additional and complimentary information and discussion on the financial implications of adopting DRG based reimbursement drawing on the recent of the UK.

Introduction

This document sets out briefly what conditions need to be in place governing the financial environment in which hospitals operate for a DRG based system of cost reimbursement to operate in the medical insurance environment. It takes as its key lessons the experience of the UK in moving from a budget based system at the beginning of the 1990s to the current situation where almost all hospital elective services, many non-elective and some community services are provided under standard cost –based standard reimbursement rates – a system known as Payment by Results..

The paper starts by briefly explaining what DRGs are and their role in a system of standard cost based reimbursement, before looking at the financial steps necessary for their implementation (and the financial consequences of doing so). The paper looks briefly at where the Chinese urban health system is in relation to implementing these steps albeit given the diversity of China (and the different systems and level of financial sophistication between different localities) this can only represent a very general overview.

What are DRGs

DRGs are the acronym for a classification system known as Diagnostic Related Groups. Developed in the United States in the 1970s, the classification system seeks to group treatment based on a combination of the nature of the inherent disease or condition, the medical intervention(s) necessary to remedy or ameliorate the condition and the cost intensity of those interventions.

In short it is a way of classifying the outputs of a hospital into a grouped and manageable number of product lines (treatment diagnoses). This is important because potentially every patient of a hospital constitutes a different type of output (differentiated by the type of condition, complications, the response time to treatment etc). By contrast in a

manufacturing or service environment there is basically a limited range of standard products (which may be altered in a certain number of pre-defined options e.g different size of engine or interior trim for a car). This range of standard products provides the basis for the attribution of standard costs, the calculation of prices and the management of costs to increase profitability.

Without such a similar product classification system in healthcare, there would be no possibility to move to a system based on standard prices. In a fee for service system each patient is essentially a separate product with a separate price. Indeed each treatment may comprise a different mix of services and drugs giving a separate price. The problem with this fee for service system is that there is no sharing of risks between purchaser and provider. All the costs of patients responding negatively to treatment interventions, inefficiencies in hospital treatment and administration and indeed corrupt practices are passed to the purchaser. The asymmetric information problem of health care (ie the differential knowledge between the medical practitioners and those purchasing health care further accentuate the skewing of risk to the benefit of the providers. The introduction of a standard price reimbursement model based on standard DRG related costs offers purchasers a chance to more effectively share risk.

Although most health systems which have introduced DRG reimbursement have found it appropriate to do so on a gradual basis (and indeed to retain especially for very complex high cost cases some capacity to charge additional variable costs), DRG implementation must have the objective of covering virtually all final outputs produced by a hospital. The experience of all business regulation is that costs are always moved from the price regulated aspect of business operations to the unregulated part. Similarly even if prices are controlled, unless volume and quality aspects are controlled also, businesses will attempt to address the adverse financial consequences of price controls through reducing volume and/or quality of service. Although contracting and quality control considerations are not further discussed in this paper, they need to be borne in mind

Current Systems of Reimbursement in China

To date there has been some experimentation with case payment reimbursement in some cities notably in Beijing¹ and Shanghai and some provincial locations such as Mudanjiang City in Heilongjiang Province, although to what extent these have been based on a proper DRG classification system is not really clear. In addition to case payments, reimbursement payments tend to fall under the three main types:

- 1) Fee for Service based reimbursement with patient costs the aggregation of services drugs and equipment charged on the basis of the three price lists. This constitutes the principal basis of reimbursement (covering around 99 % of medical expenditure compared to 1% for case payments)²

2) A budget based monthly allocation system based on expected volumes with some reconciliation (although how detailed is unclear) to actual patient costs and volumes charged on an FFS basis

3) A series of unit based charges for long term treatments such as kidney dialysis or psychiatric care which represents a form of case payment

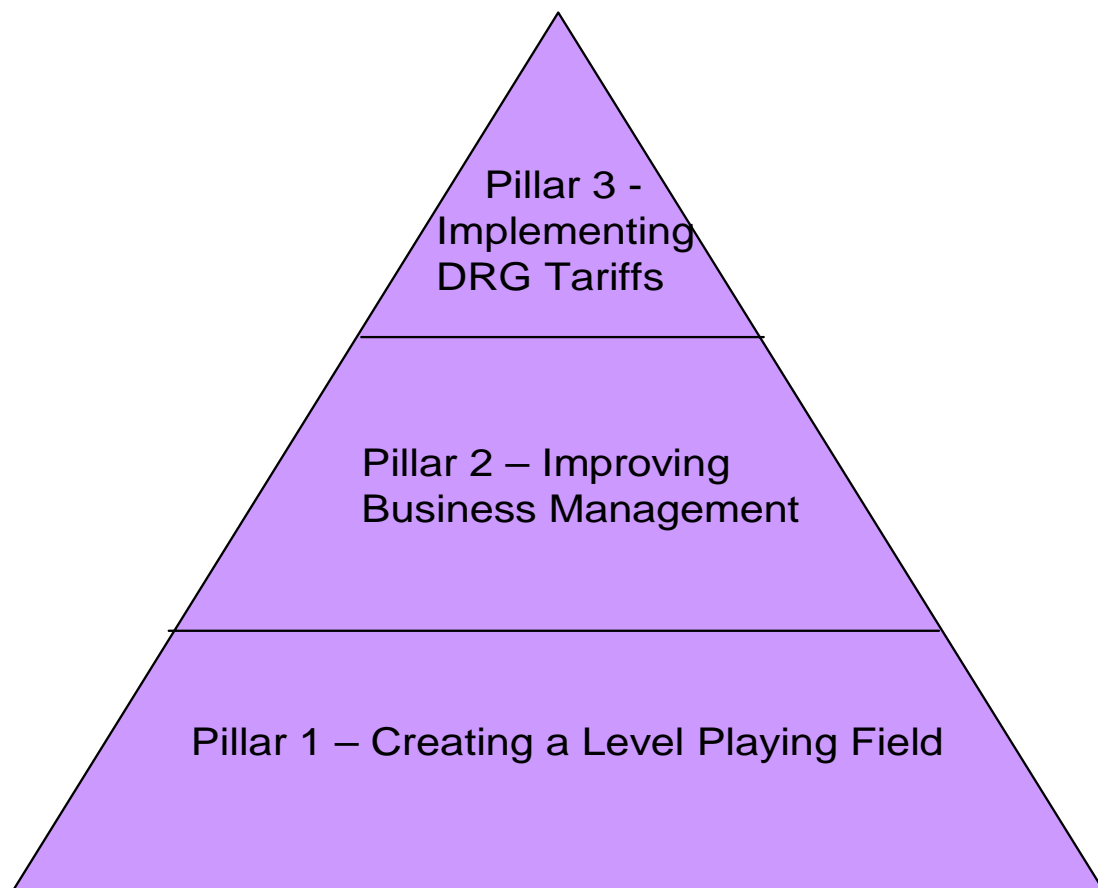
There are three other important aspects to note about the current reimbursement system. The first is that reimbursement is claimed separately from medical insurance department and the patient (usually in the form of an initial deposit based on expected treatment costs and adjusted at discharge). This has important implications in that the medical insurance agency is not in a position to manage overall case costs and the possibility of the provider to shift costs to patients is therefore present.

Second this problem is further complicated by the division of reimbursement responsibility between in-patient costs (largely the social pool and outpatient costs (largely individual account except for certain chronic long term illness) means that the medical insurance will not know the beginning of a treatment episode. To the extent that DRGs comprise both inpatient and outpatient treatment this may further complicate the introduction of this system⁴.

Third there are no medical guidelines or pathways – no standardised processes of production - so that even if medical insurance departments had the capacity to monitor and check costs, they have no benchmarks to check against

Creating the Financial Conditions for DRG implementation – a 3 pillar approach

Introducing DRG based reimbursement will require a long and complex series of reforms which may be expected to take up to 10 years. These reforms can be broken down into three main pillars, the completion of which (in the sense of completing the critical transformation elements) provides the essential support for the next pillar. However the work contained in each pillar is by its nature ongoing and is subject to a continual process of learning and improvement.



Pillar 1 - Creating a Level Playing Field

The first main step is to ensure that all hospitals working within the State medical insurance system are operating to the same financial requirements. This is to ensure that some hospitals do not have unfair advantages over others by virtue of privileged access to separate funds or less difficult financial objectives “Creating a level playing field” involves 4 basic steps

1) *Business Re-engineering and Separation*

The first important process is to identify which parts of the organization and under which circumstances will the organization be involved in the medical insurance market, and to identify those parts of the business that will be funded through separate channels. This contributes to creating a level playing field by eliminating additional overheads that are incurred by virtue of performing other roles; or alternatively preventing cross-subsidization of services provided through organisations that may be in receipt of large funding from other channels. In addition this process may also be used to identify and secure charitable and other funds provided for specific purposes (eg research into particular diseases) and not to be used to support general hospital operations.

In China the main areas where business re-engineering and separation may be necessary are for medical education at pre-clinical and clinical level, specific research programmes and hospitals owned run and partly financed by the People's Liberation Army but treating members of the general public. In addition a large part of administration of the medical insurance function (in terms of managing and verifying reimbursement) is effectively outsourced to the hospitals themselves who may not necessarily have the interests as the medical insurance department at heart. System administration needs to be redefined to ensure those that work in hospitals do so only for the provider and those who are responsible for the administration of medical insurance packages are employed and managed by the MI Department (even if they may be outposted in hospital)

In the UK a new organization model for the overall management of the hospital was created on the basis of a long established charitable trust model. This involved the separation of the hospital from its sponsoring government entity (which in China for most hospitals would be the Bureau of Health but could also be LSSBs or universities). While in China hospitals have been essentially operating independently on a quasi commercial basis, a revised legal status reflecting ownership, the responsible supervising entity, management and financing arrangements is essential.

2) *Preparation of Hospital Financial Accounts According to International Accounting Standards*

Since DRG tariff data is ultimately reliant on accurate financial accounts, these need to be prepared on the basis of agreed international accounting standards as applied to the hospital sector. At the present time under joint regulations issued by the Ministry of Finance and Ministry of Health in 1999, hospitals are considered as government entities and therefore use a simple form of cash accounting with no proper balance sheet.

The biggest single change that will be necessary as part of moving to international accounting standards will be to introduce and maintain proper asset registers recording appropriate valuations and accumulated depreciation for all assets (buildings, plant vehicles and equipment). In addition there will be considerable work improving the classification and recording of stores, debtors and creditors (which are at the moment for example classified as other income). Consideration may also need to be given to the recording of tax liabilities such as VAT.

In the UK the introduction of international accounting practices was underpinned by extensive retraining and the development of a new accounting manual (which made specific adjustments to private sector accounting to meet the circumstances of the Health Service eg treatment of medical negligence costs, and introduced standard financial reports⁵. Based on the UK experience, introduction of commercial accounts may be expected to take a minimum of two years.

3) *Introduction of independent qualified financial audit*

There would be little point in introducing common standards of commercial accounting unless there is the capacity to verify independently that accounts have been prepared on a basis consistent with manuals and regulations and also consistent in their assumptions and bases of reporting over time. This can only be ensured by a competent external audit function that is knowledgeable about both the business and accounting requirements and has the legal backing to challenge senior management over their treatment of financial transactions and accounting figures.

While hospital accounts are currently audited by staff from the sub-national government's audit bureau, their audit is focused on the probity and scope of transaction recording, and not on producing an overall view of the truthfulness of the hospital's financial position as given by the financial circumstances (which is not required under audit law). Auditors will also therefore need to be retained to understand international hospital accounting and at the same time develop knowledge of a wider range of audit processes including transaction sampling and evaluation of controls that will enable them to draw opinions on the veracity or otherwise of financial statements.

4) *Creating a transparent and equitable funding regime*

Central to realizing the objectives of DRG based reimbursement – namely cost containment and improved productivity - is the introduction of a funding regime in which all significant income is derived transparently from the sale of medical services at regulated prices. To the extent that hospitals may have different access to funds from government or other channels or be given different financial objectives may distort competition and undermine productivity improvement

In the UK, this meant ceasing direct budget based recurrent allocations to hospitals and reallocating funds to purchasing authorities (the equivalent of medical insurance agencies). Similarly while capital allocations were and are provided as cash amounts in Government budgets, these were given to hospitals in the form of loans not grants, under commercial rates of interest.

In China, bureaus of health commonly make annual grants to hospitals in respect of the basic salary costs of doctors and for capital expenditure. While these on average do not contribute more than 10 – 15% of hospital revenue, the fact that allocations may be provided on a differential basis (eg different patient-doctor staffing ratios) and may change from year to year clearly introduces inequities into the financing system. These potential inequities are made more likely given that hospitals do not know each others allocations). Therefore it seems sensible to move existing recurrent funding from hospitals to the medical insurance system (probably to augment the new urban residents scheme) although this may involve some institutional difficulties. It may also require establishing a capital health development fund operating on a revolving basis with loan allocations being prioritised by reference to the state of the hospital estate or asset stock as well as its commercial ability to repay loans.⁶

The financial regime needs to specify financial objectives. This may be simply breaking even on a full commercial accounting basis (ie after taking account of depreciation and loan interest) or it may mean generating a financial surplus. In the UK government organisations are generally given an additional financial objective, namely to generate a surplus equal to a certain percentage return on the net assets or capital employed in the business (ROCE)⁷. This is intended to reflect the opportunity cost of investing in healthcare as opposed to another public good. Other financial objectives may also require setting limits to the amount of money organisations can draw down for borrowing (an external financing limit) in a particular year and requirements on the prompt payment of debts.

Pillar 2- Improving Business Management

The second pillar of reforms is concerned with strengthening strategic and business management of the health system. While the system has been working on a quasi commercial basis for some time, the implications of DRG implementation is that risks will need to be much better managed since the possibility of passing cost overruns onto the

medical insurance system and/or patients will be greatly reduced, and therefore the risk of financial instability will be much greater. Similarly for medical insurance the current system of merely administering claims needs to be replaced by a more strategic approach to the managing of medical demand and commissioning services. These changes comprise the following four steps

1) *Improving Cost Accounting Systems*

While it is difficult to know exactly how hospitals account for their costs because of the secrecy surrounding their financial operations, most hospitals currently seem to work on a crude contribution based accounting system. In this system direct costs (notably drugs and medical supplies and some salaries) are attributed to clinical departments who are then expected to generate surpluses of revenues above direct costs that will pay for central overheads and contribute to overall surplus.

This system may have its advantages for relatively small businesses with a few product lines and with a high ratio of direct to indirect / overhead costs. However in hospitals where a large proportion of costs lie in overheads (including medical related support services such as pathology and operating theatres), this system is not really appropriate. Furthermore it may exaggerate the profitability of services where costs are reflected mainly in overheads or in the case of capital intensive services (not at all since the equipment was supplied under grant).

The development of DRG costs and tariffs requires a proper activity based costing system including full attribution of all direct costs (medical salaries, drugs, supplies) and overheads to medical treatment services based on a DRG classification. This will include settling a hierarchy of charging overheads (including general hospital overheads to support services and then to services) to avoid circular charging and the development of IT systems that can generate these charges automatically on a daily basis. The UK NHS has produced a large costing manual freely available on the internet which could be used as a template for developing a Chinese manual. A manual is important to try and standardize the bases for cost allocation and standardization, so that reference costs more closely reflect genuine differences in cost rather than differences in how costs are allocated

The UK experience is that developing DRG related costs data takes place over a long period and involves the intermediate stage of charging costs initially to medical specialties (lower than department level but above individual DRG level) in order to gain experience in proper cost attribution.,

2) *Improving Financial Management*

The introduction of a DRG based reimbursement system (combined with changes in financial accounting) will necessitate extensive improvements in financial management practice and expertise. The Audit Commission in the UK has identified the following areas as critical to the successful implementation of DRG implementation, both for purchasers (medical insurance) and providers)

- Knowledge of costing techniques and cost behaviour (how costs respond to changes in activity levels)
- Generation of accurate meaningful and understandable financial information – particularly monthly financial and activity reports for departments
- Benchmarking (of costs within the hospital and against outside bodies)
- Financial forecasting and modeling – being able to predict accurately in year cost overruns and being able to model different business scenarios
- Balance sheet management – being able to ensure adequate cash flow, , on time payment of suppliers and collection of arrears and management of the estate including identification of surplus assets for disposal
- Corporate Financial skills including longer term financial planning, development of business cases, management of large capital projects and investing reserves and surpluses to generate maximum return within a given risk tolerance

One particular important area will be the need to engage clinicians more actively in managing the financial aspects of caseload and activity management, because they effectively manage the budgets of the hospital. This will require appropriate incentivisation (.ie additional payment to reflect added responsibility, financial management training and the development of interpersonal skills by finance staff in order to explain .sometimes complex financial issues to their medical colleagues

3) Strengthening Overall Strategic Management and Corporate Governance

Improvements in financial management at the operational level need to be matched by better strategic management at senior management level for both medical insurance and hospital providers

For medical insurance this fundamentally means taking a more strategic approach to the commissioning process and assuming much greater responsibilities for managing the overall cost and quality of treatment. This enhanced strategic role will involve among other things:

- Better medium and long term planning including setting clear objectives underpinned by relevant performance targets, developing appropriate financial models to ensure financial sustainability and developing performance databases
- Negotiating tighter contracts on volume, price and quality and with appropriate penalty clauses for wrongful charging, and working with community health clinics to ensure that referrals follow contracted patterns rather than purely patient choice.
- Better identification and management of risks in particular that associated with unexpected changes in demand in year
- Better communication with contributors on entitlements and greater accountability in terms of reporting performance
- Developing business cases for local governments to support additional management related expenditure so that medical insurance can manage and audit costs more effectively
- Linking state medical insurance policies to additional benefit packages offered by private medical insurance

These issues will be replicated albeit from a different perspective on the provider side. One particularly important issue for hospitals to grapple with will be the need to ensure that doctors are both sufficiently well remunerated and involved in decision making as to engage medical staff support to meet corporate objectives. Another likely emerging area will be the need to overhaul Corporate Governance structures to ensure that the strategic direction “tone from the top” is the right one, that hospitals can access appropriate business expertise and have independent channels to deal with complaints, financial irregularities and medical negligence cases

4) *Changing Reimbursement Mechanisms to ensure Whole Cost Management*

One inevitable consequence of DRG based reimbursement will be the need to change the way reimbursement occurs. At the present time reimbursement is sought separately from both the medical insurance and the patient, and therefore medical insurance is not in charge of ensuring the overall cost, only the portion that falls to be paid by MI.

Under a DRG system hospitals will calculate gross cost DRGs (ie before the deduction of any deductible or co-payment) and costs will need to be monitored on this gross basis. It will be impossible to operate a deductible/ co-payment ceiling based on a % of cost since even in a DRG system, there may be 1,000 to 2,000 different tariffs. The opportunity for mistakes or deliberate misleading of the patient by charging different higher cost DRG from the actual one is therefore very high.

The following are three possible options for the changing of the system

1) A very simple fixed co-payments based on a 1 (inexpensive) to 5 (very expensive) grouping of DRG costs. (A system currently applied for out of pocket contributions to NHS Dentistry in the UK). This will make it far easier for patients to monitor which DRG cost group their treatment relates to, although some post audit checking will be required to ensure consistency between the category identified to the patient and the relevant DRG charged to MI.

While this system retains the present dual charge system with reduced possibilities for over-charging and fraud, using a simple tariff structure may produce large differences in cost recoveries within the basic tariff group (eg DRG treatments achieving a fixed co-payment of 7,500 Yuan could cost between 20,000 and 40,000) and this may present an unacceptable financial risk to suppliers.

2) A separation of the 'hotel' cost from the medical cost of service provided. The former would form the basis of a daily charge to the patient as a co-payment and the latter would form the basis of the DRG case payment. The principal difficulty with this will be the basis on which overheads are absorbed by the hotel charge and DRG charge respectively which could vary significantly from institution to institution. It would also make any international comparisons of tariffs more difficult.

3) MI pays the gross cost and then recovers the excess from the patient. This may be done as currently through a combination of up-front deposit and a post treatment adjusting payment. To aid certainty for patients needing to provide out-of-pocket co-payments a grouped fixed price system could also be introduced as in option 1 but with more categories. Alternatively DRG tariffs could be earmarked with fixed co-payment percentages, which would also introduce certainty on prices but may cause difficulties to understand which DRG category they were placed in and why.

One of the major impact of changing the reimbursement system to the second option will be to significantly raise administration costs. This is considered more in the conclusion below

Pillar 3 Establishing the DRG Tariffs

Introducing DRG based reimbursement involves a fundamental reform of the entire health system. In the words of the NHS code of conduct on for Payment by Results (March 2007), DRG based reimbursement "introduces a degree of transparency in financial flows that is almost unprecedented (as well as creating) incentives for increasing productivity and making efficient use of resources". (However) effective implementation will depend on constructive relationships between all parties operating within the system. It goes on to list in paragraph 14 some of the key features of that constructive relationship. These include

- Putting patients interests first , balancing the needs of individuals with those of the wider population
- Ensuring care is delivered efficiently with the best possible outcome
- Providing appropriate and transparent information for patients and the wider public
- Working together to innovate and develop better services
- Behaving and treating each other transparently openly and fairly
- Sharing information with each other wherever appropriate
- Working together to anticipate and resolve problems
- Consulting and involving each other in decisions and changes wherever appropriate.

These conditions are not currently present in the Chinese healthcare system which characterized as being excessively secretive and competitive to the point where the overall objectives of the healthcare system are being compromised. The secrecy about financial management and accounting figures belies the fact that hospitals involved in the state medical insurance system are Government owned and that the majority directly or indirectly comes from Government funding. Changing this culture of secrecy into one of transparent and constructive “regulated competition” is central to the implementation of DRGs within a public health system

This constructive relationship has four important financial aspects

1) *Contributing to Tariff Setting*

DRG tariffs need to be based on the actual costs incurred by hospitals in the system however they may be adjusted for expected improvements in productivity or changes in treatment techniques. Furthermore while international costs may provide a useful benchmark (particularly if adjusted for purchasing power parity (PPP), they cannot be used given that cost structures and even treatment regimes will vary from country to country.

The development of tariffs first therefore requires the submission of DRG based reference cost data from all participating organisations on an annual basis and its adjustment to reflect technical problems of cost allocation. Secondly it requires the negotiation of standard tariffs and adjustment parameters v(eg for long lengths of stay) on the understanding the agreed tariff structures cannot and will not benefit all organisations. Ultimately the largest

funding agencies – medical insurance and bureaus of health must reach agreement on the tariff structure that will be in place.

2) *Linking Tariff and Cost Changes to Clinical Pathways*

A key aspect of improving productivity and driving down cost is the re-examination of how patients are diagnosed, treated and discharged. While the primary purpose of developing clinical pathways is for medical reasons, namely to enhance the effectiveness of medical treatments, clinical pathways also offer significant opportunities for cost reduction and productivity improvements (eg through reducing the amount of in-patient care or the use of generic as opposed to patent drugs).

The implementation of clinical pathways and its relationship with the issue of professional judgement is a matter for individual hospitals. Nevertheless the development and dissemination of clinical pathways and their potential cost implications is important for improving productivity in the health system as a whole and for ensuring that tariffs can be set not merely to replicate historic prices but also to incorporate realistic productivity improvements

3) *Billing and Payment*

One of the key elements in making any financial system work fairly is to ensure the prompt raising and settlement of invoices and payments. In the UK at Government level this has been driven by the Better Payment Practice Code (1998) which requires all government organisations to settle undisputed accounts within 30 days. It is therefore no longer possible for government organisations including hospitals to crudely manage cash flows by imposing payment delays on suppliers.

In contrast in China while hospitals may invoice medical insurance departments weekly or monthly, it may take in excess of 2 months to be paid. In addition it is unclear whether there are any mechanisms for resolving disputes may not be in place. Consideration therefore needs to be given to specifying mandatory payment periods and the procedures for clarifying disputes in standard contract terms and to set up robust dispute resolution procedures for large sums. i

4) *Audit of Patient Data and Reimbursement Claims*

A critical aspect of the DRG system is the accurate DRG coding of patient data. One of the major issues in a DRG based system of reimbursement is to ensure that DRG coding is done accurately and in accordance with clinical information provided in the patients record. In the UK and Australia DRG coding errors of 12% and 10% respectively have been detected in audit samples of reimbursement claims.

It is also important to recognize that DRGs create incentives for fraud in two particular respects. The first is in claiming a higher value DRG than is in fact merited; and the second is to discharge and readmit as new cases for patients whose length of stay exceeds the target los. (This is because lengths of stay over a maximum are either not remunerated or only on a marginal cost basis). There is some early evidence from the UK that DRG coding error is higher where the coding teams work directly to the Director of finance which may betray either ignorance or manipulative practice).

In either event, the only remedy is to ensure regular audit by the medical insurance body with full access being guaranteed under contract.

Conclusion

Several key conclusions emerge from this paper and the practice of those countries which have opted to implement a DRG system.

The first conclusion is to recognize the time dimension of change. Implementing DRG necessitates wide ranging financial and other changes, and the experience of a number of developed countries including Germany and the UK is that even accepting a relatively smooth policy change, full implementation of a DRG system is only likely within an 8 to 10 year period.

The second conclusion is to recognize the institutional dimension of change. Implementing DRGs will necessitate changes in relationships to a certain extent weakening existing vertical relationships (eg between universities and university hospitals) and the strengthening of others (especially medical insurance). It will require much closer working between the main players in the government, bureau of finance audit health and labour and social security (and the medical insurance agencies). It will also necessitate changes of governance and management style within hospitals – much less reliance on the decisions a single person the President and a much more corporate style in which independent members may have a role to play. These changes are likely to necessitate a new legal status clarifying the ownership governance and financial structure

The third conclusion which really relates to the second is the need for a major culture change – from one where supposedly not for profit hospitals work in a highly competitive environment with negligible transparency to one where hospitals recognize at least as regards core health care they are operating in a highly regulated market with the requirement both to share information and to work together.

Finally there needs to be some recognition of the high administrative costs of change and the implications of DRGs for more and better qualified staff and more sophisticated IT in both medical insurance and providers. There needs to be a recognition in particular that if the benefits of DRG based reimbursement for cost containment are to be realized, this task cannot be handed over to provider units to manage it (as largely happens at present). As a consequence of this the current policy of financing the costs of administration from taxpayers budgets rather than from scheme revenues needs to be re-evaluated. The costs of private insurance fund management are covered from fund revenues and realistically there needs to be at least partial contribution from the revenues of state schemes, especially as the benefits of better cost management should return to the members.

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¹ In Beijing the case payment covers six common diseases like Appendectomy, Cataract, Tonsillectomy etc. under a pilot project of the MoLSS and three planned diagnosis

² Medical Insurance have to use approximately 5.000 services which cover traditional Chinese/Western medical services and out- and inpatient The list of services is developed by the Ministry of Health and the prices are set by the NDRC, **but lists and prices are amended by the relevant provincial bodies to reflect economic conditions**

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⁴ **DRGs generally in the UK apply to inpatient care but it is recognized that extending them to cover outpatient treatment may be important to promoting innovation and productivity**

⁵ All UK accounting manuals are generally publicly available on the internet. By contrast the current MOH/ MOF regulations only run to around 6 pages and part is available on a restricted site

⁶ **Removal of grant funding may not remove the need to provide working capital on a revolving basis to ensure that hospitals have sufficient liquidity to support operations**

⁷ This is also known as public dividend and is currently set at 3.5% of net assets (ie assets less donated assets less liabilities, with the opening and closing balance sheet figures used to derive the average assets employed in a financial year)