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ASIE/2004/3252

EU-China Social Security Reform Co-operation Project

for The People's Republic of China

Impact of DRGs on the co-payment policies in China

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2008

…t jointly funded and
undertaken by the People's Republic of China
and the European Union

Abbreviations:

BMI	Basic Medical Insurance
CHEI	China Health Economic Institute
CHIRA	China Health Insurance Research Association
CT	Computer Tomography
DRG	Diagnosis Related Groups
GBP	Great Britain Pound
GDP	Gross Domestic Production
HIS	Hospital Information System
LSSB	Labour and Social Security Bureau
MoH	Ministry of Health
MoLSS	Ministry of Labour and Social Security
NDRC	National Development and Reform Commission
PLSSB	Provincial Labour and Social Security Bureau
PTF	Project Task Force
RCMS	Rural Cooperative Medical System
SIA	Social Insurance Agency
SIAC	Social Insurance Administration Center
TCM	Traditional Chinese Medicine
TORs	Terms of References

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EU-CHINA
Social Security Reform Co-operation Project
中国-欧盟社会保障合作项目

Comparative study on co-payments system of China and Europe

Introduction

The following study should enlighten the differences between the Provincial, Municipal and other Basic Medical Insurance Schemes in China and compare the Chinese system with selected European countries. As a result the main stakeholders receive a tool to steer into an appropriate co-payment system, which includes the aspect of social fairness (poverty, disability or vulnerability). The side effects could be a process of unification and standardization of the Medical Insurance System, the Healthcare System and as well have implications on the introduction of the DRG System.

There are various reasons for introducing DRGs or case payments into the healthcare market like cost containment, improved quality of service, complaints of patients, or the missing incentives for providers mentioned by Medical Insurance Funds, Health Care Authorities, Patients and Hospitals. There is a grown common interest in the healthcare system, which has to be satisfied by new mechanisms and regulations.

However, the government of China represented by the Ministry of Health and the Ministry of Labour and Social Security wants to introduce the DRG provider payment mechanism in the healthcare sector. The calculation of the DRG single case payment will have an influence on the hospital finance system, which is financed at the current stage by out the public budget, medical insurance funds – Fee for Service - and the patients Co-payments. As for know, the co-payments of the patients varies from 20% up to around 70%. This can be considered as an important financing source of the Chinese healthcare sector.

Summary

The ongoing Chinese health care financing reform aims to introduce Diagnoses Related Groups (DRG) for reimbursing hospitals' inpatient services. In parallel the Chinese health policy is targeting on increasing transparency of hospital financing. In this context co-payments become an essential financing tool.

Theoretical background

Under the current insurance scheme(s) in China, as in many other countries, there is a lack of incentives for (a) patients not to utilise more medical services than necessary: individual costs are socialised. (b) On the other hand health care providers tend to prescribe as many services as possible in order to maximise their profit/salaries in an under-financed fee for service system. In general three groups of co-payments can be distinguished:

- User Fees: direct co-payments according to a fixed tariff for the used health care service.
- Flat Rates: fixed co-payment per service regardless the service's price.
- Deductibles: fixed percentage of the health services' price. This type of co-payment is currently used in China.

One of the major problems is the financing system of the public funded hospitals in China. Around 95% of the hospitals in the Chinese healthcare system are organized under the ownership of the central and local government. However, the Chinese government allocates subsidies to support financing the salaries of the hospital staff. The major financing sources are the basic medical insurance funds and private individuals' funds. High co-payments in China are caused by: (a) Invalid governmental price regulation, (b) Lack of standards in health services, (c) Unnecessary treatment.

China has developed and introduced a system of deductibles and ceiling lines for the insurance schemes established so far. Further more, the benefit package is described by (a) a list of 4170 service items, by (b) a State Scheme Drug List for Basic Medical Insurance, and by (c) a List of Standards to be met by medical services.

The review of regulations of deductibles and ceiling lines in European countries does not give a clear direction concerning co-payments for inpatient hospital services: some countries charge patients (e.g. France, Germany, Hungary) and other countries are free of those co-payments (e.g. United Kingdom, Poland). However, all these countries use DRGs for hospitals' services remuneration.

The assessment of the European "standard" system in terms of co-payment reveals a focus on solidarity based structures; no matter how the health care system is organized. The main principle is to reduce the burden for defined target groups, e.g.

for people below the poverty line or just above the poverty line, in accessing health care service

Theoretical Background of different types of co-payments

Definition of co-payment

For the purpose of this report we will discuss selected issues of the co-payment policy, which has to be considered by the Chinese authorities during the preparation of the case payment mechanism, DRGs in particular. However, co-payments are a significant financing source within the Chinese healthcare financing system Co-payments are well known from the medical insurance funds. But what should be considered as a basic definition for co-payments?

Why to introduce deductible and ceiling lines and why do they have an influential impact on moral hazard?

Patient related moral hazard

The moral hazard is a risk of insurance companies defined as an over-consumption of services, prescription of drugs, lab test, etc. A phenomenon according to which insured patients take undue advantage of the health services covered by the scheme because of two reasons: (i) they know they are insured against the cost of such services and (ii) having paid their premiums/contributions to the health insurance the insured persons want to balance their individual payments with their individual utilisation of medical services. Thus, their utilization of health care exceeds the standard used as an input for determining premiums apparently combined with a lack of incentives not to over-utilize health care services. In economical terms: individual costs are socialised in order to maximise individual welfare.

Provider related moral hazard

Considerably the moral hazard concept also includes abusing drugs' prescription by health care providers, or the risk of over-prescription. As a example, particular misuse of providing medical services could be considered that the health care provider guiding the patient into usage of expensive services which do not correlate to the diagnosis, for example "Headaches and the use of Computer Tomography (CT)". Based on an under financed health care the system the providers try to maximize their revenues. Different payment mechanisms - like Fee for Services system - cause or lead to an over consumptions in terms of providing and charging as many services and fees as possible; whether they are necessary or needed does not influence the provision of these services. They are rather profit driven. In

economic terms: Providers maximise their revenues or profit on the cost of the patients and/or taxpayers.

Firstly, the introduction of deductible lines, ceiling lines or co-payments in general serve as an incentive for the patient in his/her decision to use or not use medical services or drugs. A well-calculated co-payment mechanism guides to use the medical services more rational. But it should be mentioned that high co-payments reduce the usage of services and the patient will bypass the health care providers. The patients will treat their illness by themselves as a result. The increase of social welfare in terms of a healthy population would be at risk in case the disincentives for the patients would outbalance the incentives of patients for professional medical treatment.
Secondly, the patient is sometimes not able to understand the problem due to the illness like mental diseases or mental problems. However self-treatment or non-treatment may cause a significant higher degree of illness of the population and with this a loss of productivity of the country – an overall decrease of welfare. By passing the official health care system supports the “black market”, corruption, fraud, etc. in all facets. All these issues are unwanted implications.

User fees

The patients pay directly, according to a set tariff, for the health care services they use. There is no insurance element or mutual support. This is the most common way of paying for privately provided services in many countries, and is also used as a component of financing for public sector services.

The concept of *direct payments* is that individuals have a direct incentive to look after their own health. They are unlikely to use services ‘frivolously’ because they, rather than society, bear the costs of ill health.

On the negative side, direct payments generate problems of equal accessibility to health care services - unless the state is able to finance contributions for disadvantaged groups. Direct payment systems do not pool risks to any large extent, though some do spread risks over time.

User payments are direct, out-of-pocket payments made by patients for use of health facilities (both public and private). In contrast to informal payments, they are officially sanctioned. This means that they can be monitored, in terms of amounts collected and how they are used. Policies can also be set for how much is paid, and who, if anyone, is except from paying.

The key feature of *informal payments* is that they are payments by patients, which are neither officially recognized nor authorized. Unofficial payments are usually paid to health staff, but also sometimes to other support staff in health facilities.

Flat rate co-payments

The Flat rate co-payments are calculated as a fixed amount for every service, regardless of its price. For example, the patient might have to pay the first RMB 100 Yuan per service. It does not matter whether the full price of the service is RMB 200 Yuan or RMB 1,000 Yuan.

One effect of flat rate co-payments is that they discourage the use of those services, which are not valued as highly as the amount of the co-payment. However, since all patients face the same charge, regardless of the actual cost of the service, flat rate charges do little to encourage them to use lowest-cost services.

It is possible to incorporate differentials to provide the appropriate signals to patients. For example, in the German Health Insurance Scheme, patients pay an additional co-payment for non-approved drugs (combination of flat rate co-payment and deductible co-payment discussed below).

Flat rate co-payments can be expected to deter the use of healthcare services by the poor more than by the rich, but this can be offset by reducing the level of co-payments to be met by lower income groups. Again, the German Health Insurance Scheme is an example of charging significantly less co-payments from patients or exempts them from the co-payments if the insured belong to the defined poor population.

Deductible co-payments

Proportionate or deductible co-payments require patients to pay a fixed percentage of the cost of the particular services. For example, if the proportion were 10%, the patient would pay RMB 100 Yuan if the price were RMB 1,000 Yuan. This type of co-payment regime is currently used in China.

Deductible co-payment is often used in private or public orientated health insurance systems as a means for limiting "moral hazard". Deductible co-payments require full service price information to the patient about the actual cost of services. Thus, it is argued that deductible co-payments should encourage patients to be more selective in choosing lower-cost services – but in many instances patients (i) do not have the clinical information to enable them to make this choice and (ii) do not understand their illness or health problem.

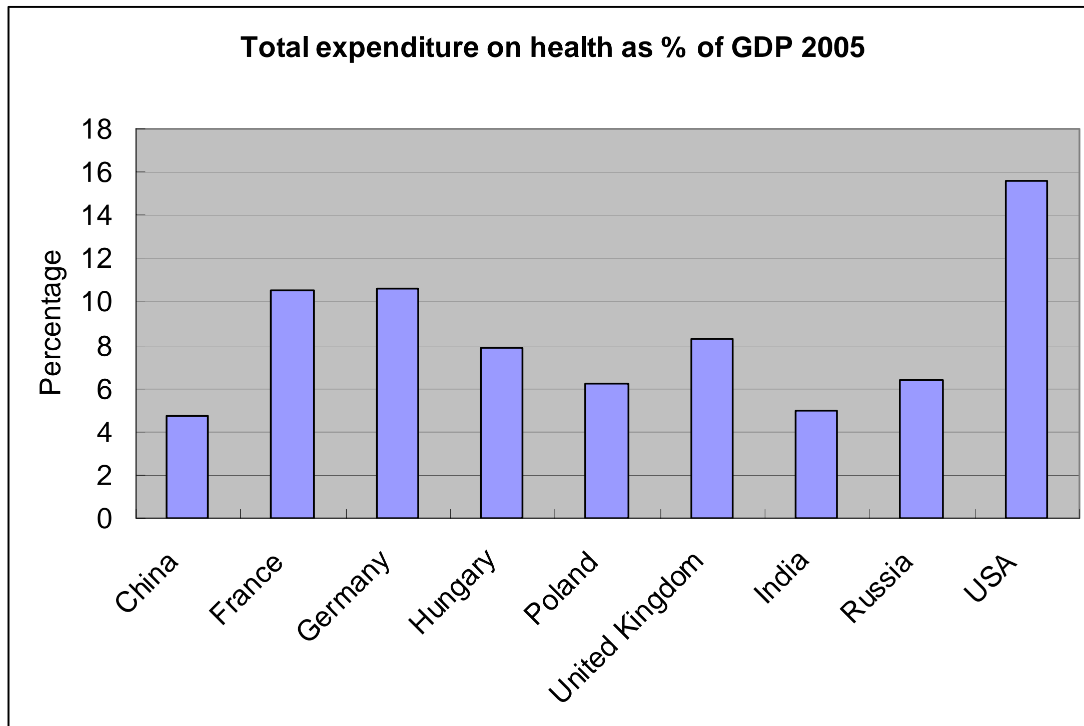
The impact of deductible co-payments on the consumer depends very much on the actual percentage of the service the patient is due to pay. Unless accompanied by private coinsurance for high-income groups or governmental subsidies for poor and vulnerable target group's deductibles will result in higher healthcare bills.

Periodically co-payment became a useable tool in Germany to create an easier mechanism for chronic diseases. However, the patients are paying a flat rate for a certain defined period of the year in advance to the provider or as well to the health insurance fund. Nevertheless patient with chronic diseases and poorest population could be exempted according to the regulations in Germany.

General government and private sector expenditure on health by 2005[1] in China, Europe and selected countries

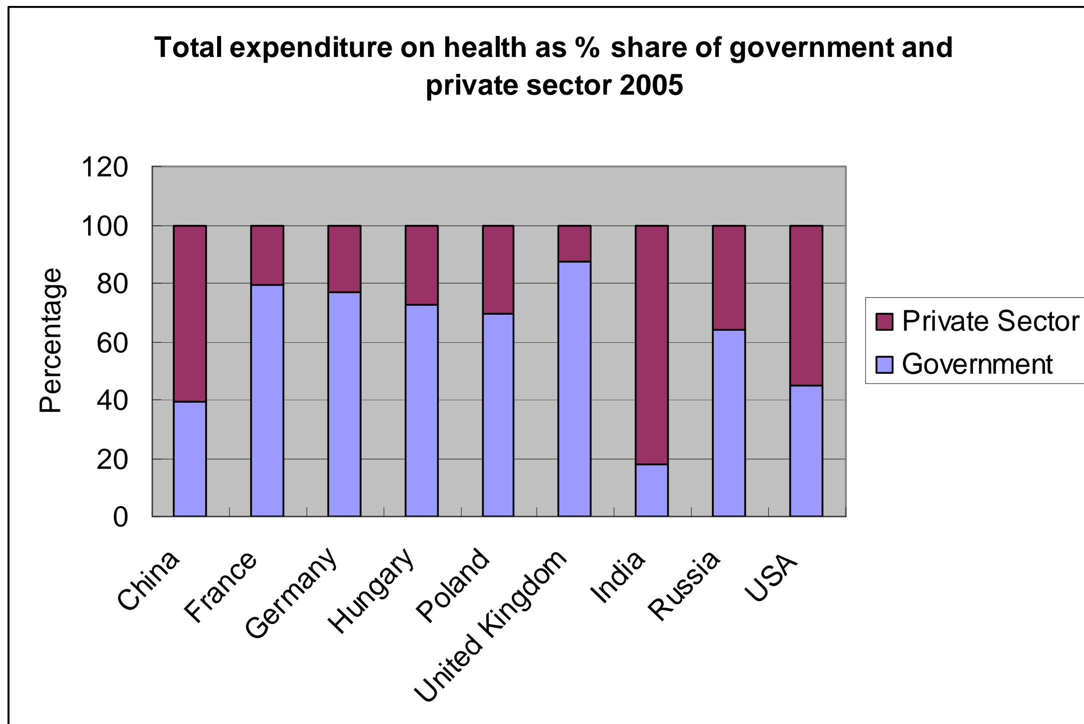
The total expenditure on Health Care as % of the GDP (Picture 1) varies between different countries and is related according to the spending power of the individual state and the private sector. Having in mind both government targets on the health care sector and the private sector in financial terms and the so called demand of patients in western countries like France, Germany and USA the total expenditure on health reached more the 10% of the GDP. The opposite effect applies for India and China having a significant lower power on the total expenditure due to lower income and taxation levels, which do not reach more the 5%. Transitional countries like Russia, Poland and Hungary as example are still stabilising their spending for the health care sector between 6% and 8% of the GDP.

[1] WHO Internet country profile – National expenditure on Health 2005



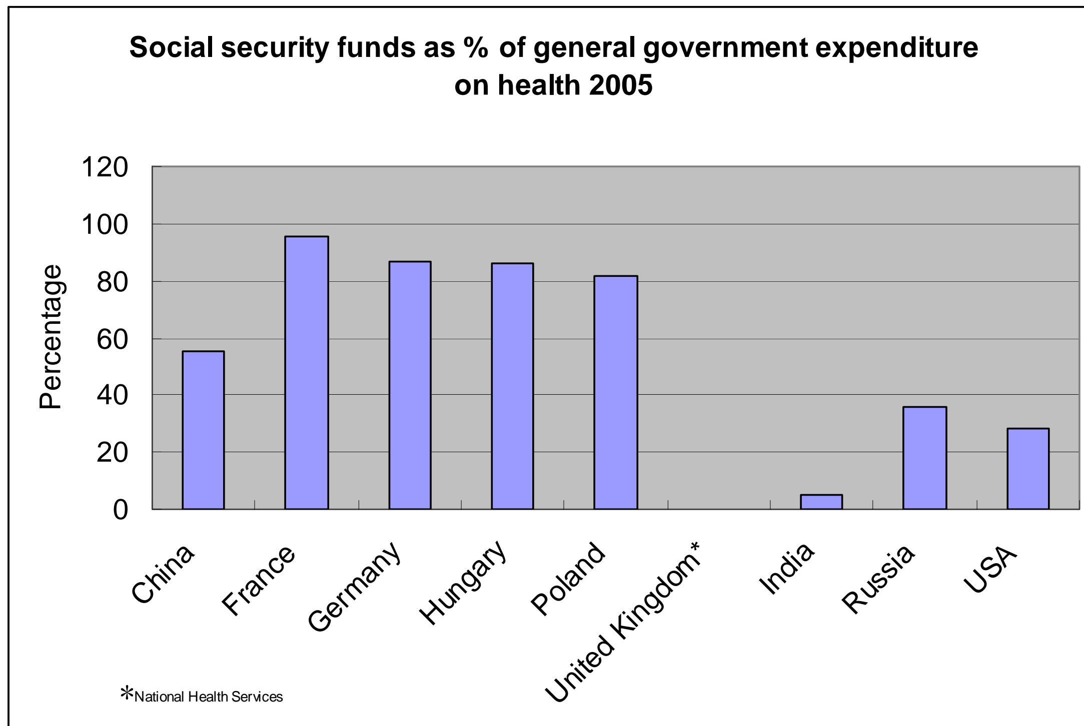
Picture 1 - Total expenditure on health as % of GDP 2005

The total expenditure on health as % share of government and private sector (Picture 2) highlights the significant difference between European countries and China, India, Russia and USA. The European countries operate and maintain the health care system trough out the governmental scheme and public medical insurance schemes. The private sector is playing a minor role in order to finance the health care expenditure. As for China, India and USA the private sector spending dominates and has an important role in financing the health care expenditure. Russia follows at most the public approach combined with private market mechanism, but with limited resources allocation. We suppose the transitional period takes a longer part in Russia.



Picture 2 - Total expenditure on health as % share of government and private sector 2005

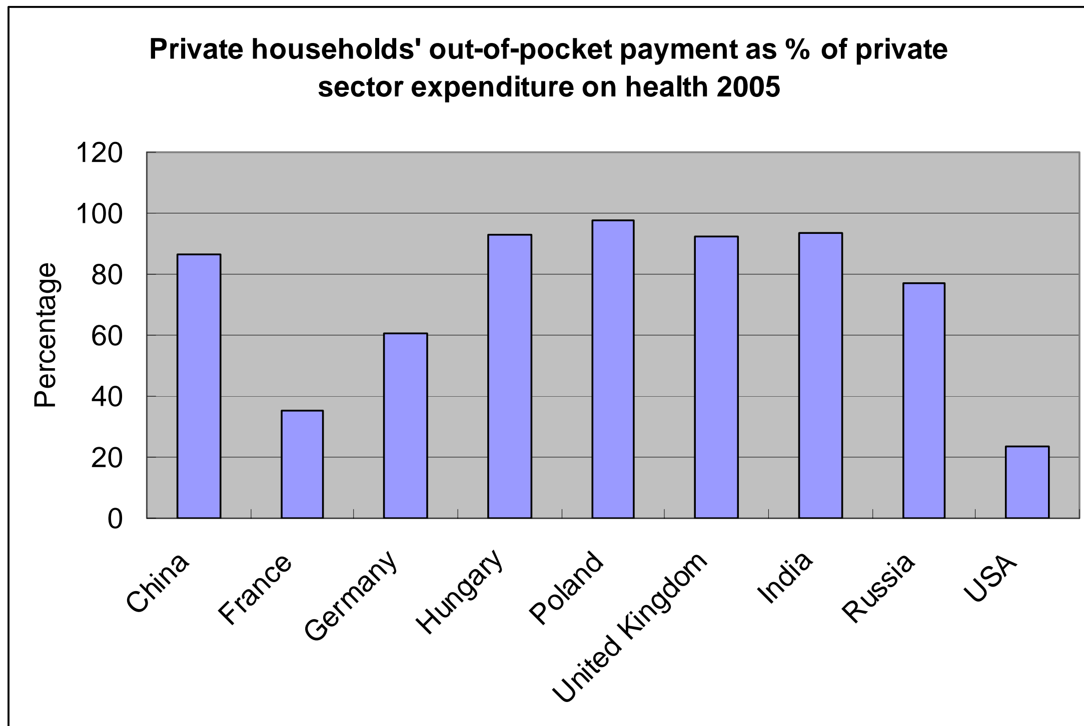
Taking a look on social security funding (Picture 3) the European scheme is almost financed by the public medical insurance system. Exception has to be considered for UK because the inexistence of a public medical insurance scheme and the health care expenditure is at most financed trough National Health Service Scheme by Taxation.



Picture 3 – Social security funds as % of general government expenditure on health 2005

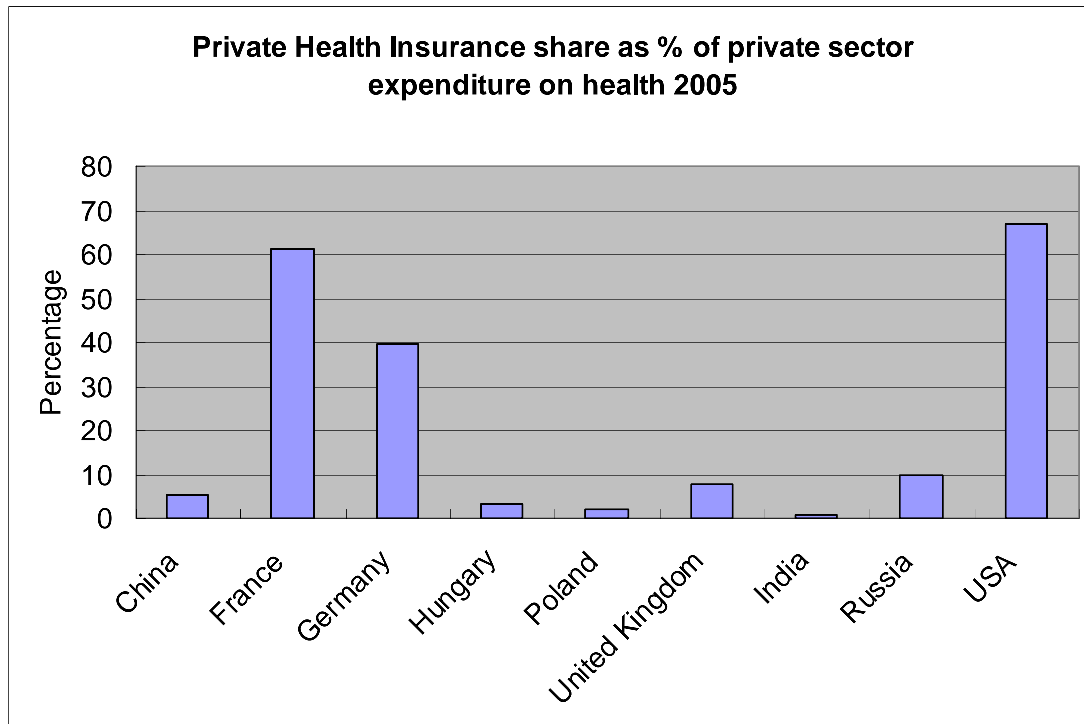
(Please note: UK is not quoted because there is no public funded medical insurance system in the field of social security. In UK the system is financed by the government through the National Health Services - NHS)

In India and China the lower coverage of population and smaller benefit packages as it is defined in the particular fee for service lists tends to result in high co-payment. As for France and Germany high coverage of population and comprehensive benefit packages lead into lower co-payments as a consequence of governmental policy. The coverage of population in Hungary, Poland and UK is to be affected by high participation, but the benefit packages seem to be smaller then in France and Germany. (Picture 4)



Picture 4 – Private households' out-of-pocket payment as % of private sector expenditure on health 2005

Only for the USA the private sector plays an important role to finance the health care system through private health insurance system paid by individuals or companies. As for France and Germany the population uses an additional private medical insurance to cover the excluded cost for those services, which are not covered by the public medical insurance system. The private health insurance funds play a minor role in financing the health care sector in all transitional countries like Hungary, Poland and Russia but as well China and India at the current situation. (Picture 5)



Picture 5 – Private Health Insurance as % of private sector expenditure on health 2005

Various funding sources are utilised to finance the health care sector in China (see picture 5a). The situation differs from urban to rural areas. Self-payments play a major role for financing the Chinese health care system and account for nearly 80% in rural areas and about 45% in urban areas. Basic insurance covers some 30% in urban areas whereas in rural areas basic insurance is significantly low at some 1-2%. Both, Cooperative Insurance and Commercial Insurance sum up for less than 10% in urban and rural areas. However, they stand for a larger percentage in rural areas. The smallest funding sources derive from the government and Labour Insurance with some 5% each.

However, one of the major problems is the financing system of the public funded hospitals in China. Around 95% of the hospitals in the Chinese healthcare system are organized under the ownership of the central and local government. Never the less the Chinese government allocates only subsidies to finance fully or as well partly the salaries of the hospital staff. The major financing sources are the basic medical

[2] National Survey on Health Service in 1998 & 2003

insurance funds and as well private individuals. The causes of high co-payments in China are described by Gong Sen, (DRC) as follows[3]:

1. Invalid governmental price regulation

Improper regulation on service prices results in invalidation of financial disciplines in hospitals. According to a survey made during the mid 1990s[4] price regulation standards lag behind market price changes. Thus, the prices of most medical services regulated by government at that time were lower than the services costs, which forced those hospitals under survey to collect more money through overpriced service items paid by patients actually higher than cost. In recent years, relevant departments have increased rates of the medical service (labour) and reduced the rates for using large and expensive diagnosis and treatment equipment; but the general situation of disorder in terms of charges in hospitals has not been changed, and the sum of some medical bills is surprisingly high. For example, in the case of extremely high medical bills charged by. No.2 Hospital of Harbin Medical University investigated by the Ministry of Health and the State Council Office for Rectifying Malpractices in April 2006, the hospital violated applicable medical service price regulations and fee collecting rules set up by both the central government and Heilongjiang Provincial government, overcharged RMB 200,000 Yuan by creating new service items, breaking down items, increasing services rates, collecting fees repeatedly, as well as charging for lab test items, check-up items, treatments not actually conducted and for materials and drugs not actually used. This case is not exceptional.

2. Lack of standards in health services

There lacks effective clinical diagnosis and treatment guidance. In many developed economies, clinical diagnosis and treatment guidelines (including nursing standards and guidelines for drugs use) are used to direct and supervise medical service behaviours. In order to encourage medical professionals to obey the guidelines, the service purchaser sets up stipulations for those following the guidelines to be exempt from responsibilities in case of medical malpractice. In China, diagnosis and treatment guidelines are used to serve merely as teaching materials in medical colleges, while service regulations overly relied on moral continence of the doctors. At the end of 2002, the Ministry of Health entrusted some professional associations to set up clinical diagnosis and treatment guidelines by subjects and specialities

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[3] Gong Sen; China Development Review Vol. 9 Supplement 1; An analysis of Healthcare Regulations in China and Policy Recommendations; August 2007; page 92,92 and 94

[4] Liu, XZ, Liu, YL and Chen, NS. (2000). The Chinese experience of hospital price regulation, Health Policy and Planning; 15(2): 157-163.

(including nursing standards and guidelines for drugs use). In 2005, the clinical applicative principle of antibacterial drugs was laid down, together with the founding of a monitoring network for the application of antibacterial drugs. But according to medical insurance department in charge, the published diagnosis and treatment guidelines are not practical and rather difficult to put into practice; moreover, healthcare administration is reluctant to combine diagnosis and treatment guidelines with economic incentives such as medical insurance cost settlement.

"Unnecessary checkups" and "large-dosage prescriptions" have become common practices in hospitals. Due to the lack of clarified diagnosis and treatment guidelines (including nursing standards and guidelines for drugs use), hospitals find a shortcut of making more money through increasing checkups items other than those required and prescribing unnecessarily drugs. As for these practices, the public shows strong dissatisfaction. In order to solve the problem of "large-dosage prescriptions", the healthcare administration made regulations to separate drugs' revenues and service accounts in medical institutions and to examine the proportion of their drugs' revenues in total income; only parts of revenues from drug prescriptions deemed reasonable can be handled over to hospitals. In case the proportion is higher than standard, the exceeding part of the drug income will be confiscated by healthcare administration to reward those hospitals doing a good job in drug cost control. But this measure has obvious defects. Due to information asymmetry, medical service institutions can bring over the proportion of drug income by increasing total revenues through "overall checkups". Therefore, in early 2007, the Ministry of Health released measures on the management of prescriptions, requiring to evaluate and compare prescriptions of medical service providers and to adopt the system of eliminating the last on the evaluation list. This might be a beneficial practice.

Additionally, the China International Business Magazine[5] report by Lewis Husain mentions two aspects, which are related to the co-payments in the Chinese healthcare system:

1. Unnecessary Treatment

The way in which doctors and nurses are paid also serves to undermine the system. Under normal conditions, healthcare providers are expected to represent the interest of both the hospital and the patient, and medical ethics and codes of practise have an important function in ensuring this separation of roles. However, this ideal of clinical behaviour breaks down if the wrong incentives are built into the system.

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[5] Healthcare System –Intensive Care- How to heal a healthcare system that is responsible for one-fifth of the world's population by Lewis Husain; China International Business/February 2008

In most medical facilities in China, healthcare workers' salaries are composed of a basic wage, supplemented by performance-related bonuses. During the 1990s there was considerable experimentation with different bonus systems, and most facilities now operate on a system of bonuses pegged to overall hospital revenues.

It is widely recognized that this approach has had an impact on the clinical behaviour of doctors in China, encouraging over-prescription of procedures and treatments that generates money for the hospital, while discouraging the use of cheaper drugs and procedures. A study released earlier this year by researchers from the Ministry of Health and the UK's Liverpool School of Tropical Medicine concluded: "In such circumstances, the oversupply of services and drugs and the overuse of advanced clinical technology became commonplace."

Tales of "irrational" prescriptions in China have abounded for years. A late-1990s study found less than 2% of village- and township-level prescriptions in Chongqing and Gansu to be medically justifiable, while similar studies from Shandong classify roughly 20% of expenditure related to appendicitis and pneumonia as unnecessary. Similarly, a 2006 World Bank study found that in 10-15% of cases, inpatient stays could be shortened without adverse health effects.

In most cases patients are reluctant to object to hospital procedures, even if they suspect that they are being given unnecessary treatments or medication. With no way of judging a hospital except on appearance and cost, most patients understandably cough up to cash, especially for major conditions.

2. Can't pay, Won't pay

Increasing numbers of patients find themselves either unable to afford or unwilling to pay for healthcare. Despite economic growth, rising income have not kept up with healthcare costs. While income has increased between five- and seven-fold since 1990, healthcare costs have risen faster- between ten- and twelve-fold for inpatient and outpatient services, respectively.

According to the 2003 National Health Service Survey (NHSS), 75% of respondents in rural arrears and 56% in urban areas who were not hospitalised after referral by a doctor made this choice due to financial reasons. Equally, the NHSS reports that high medical expenditure is the main cause of poverty in China in 30% of cases (though the State Council's Development Research Center puts this figure higher, at 50%).

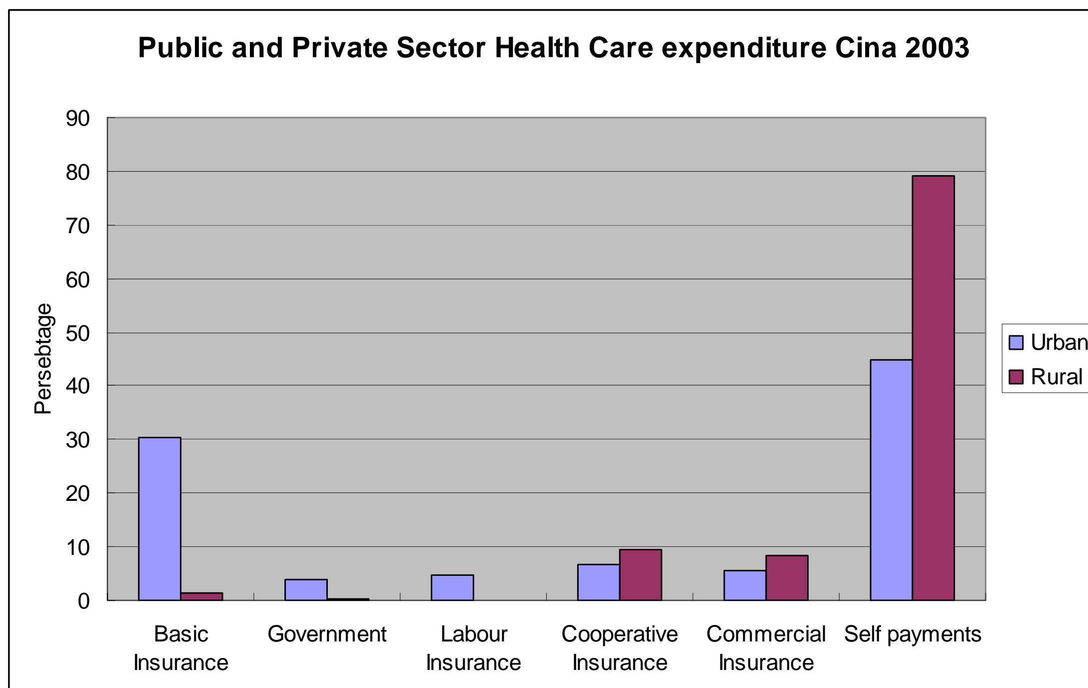
The government has attempted to redress this by establishing price controls, introducing maximum inpatient times for certain treatments and by bringing down

costs of some essential medicines. Last year, the government reduced the prices for some 260 drugs by an average of 19%.

However, both healthcare institutions and pharmaceutical firms have been adept finding ways around these measures. Many manufacturers simply stopped supplying the drugs covered by the price controls, switching to more profitable drugs instead. Hospitals began unbundling fixed-price services in order to be able to charge for individual components and increase revenues. When regulations on maximum length of hospital stays were introduced for certain conditions, many hospitals quickly spotted a loophole and simply discharged and re-admitted patients on the same day, while those patients even did not have to leave their beds.

Resume:

The research paper of Gong Sen and the article by Lewis Husain represent several major problems in the area of the healthcare. The problems reflect the co-payment system of the medical insurance funds in China and the population if they need to use healthcare services of the Chinese hospital system. In the next section we will clarify the co-payment mechanism of the medical insurance funds in China and link the co-payment mechanism with the DRG policy.



Picture 6 – Public and Private Sector Health Care expenditure China 2003

Deductible and Ceiling lines under Basic Medical Insurance System in China[6]

Within the article 3 of the regulation the Chinese government stipulated the establishment of the social pooling funds and individual accounts for medical insurance and set up the deductible and ceiling lines.

The scope for payments for the pooling funds and the individual accounts of the medical insurance funds shall be respectively defined and the two parts shall be separately accounted for and not be commingled. The deductible line and the ceiling line for the payment from the pooling funds shall be defined. In principle, the deductible line for payment shall be equal to approximately 10% of the local annual wages, and the ceiling for payment shall be set at approximately 4 times that of the local average annual wages. Individuals shall pay from the individual accounts or medical expenses below the deductible line, while expenses above the deductible line and below the ceiling shall be mainly paid from the pooling funds, while individuals shall also pay a certain percentage of the expenses. The specific deductible line, ceiling and percentage for payment by individuals for the medical expenses above the deductible line and below the ceiling shall be determined by the pooling area based on the principle of balancing medical fund revenues and expenditures.

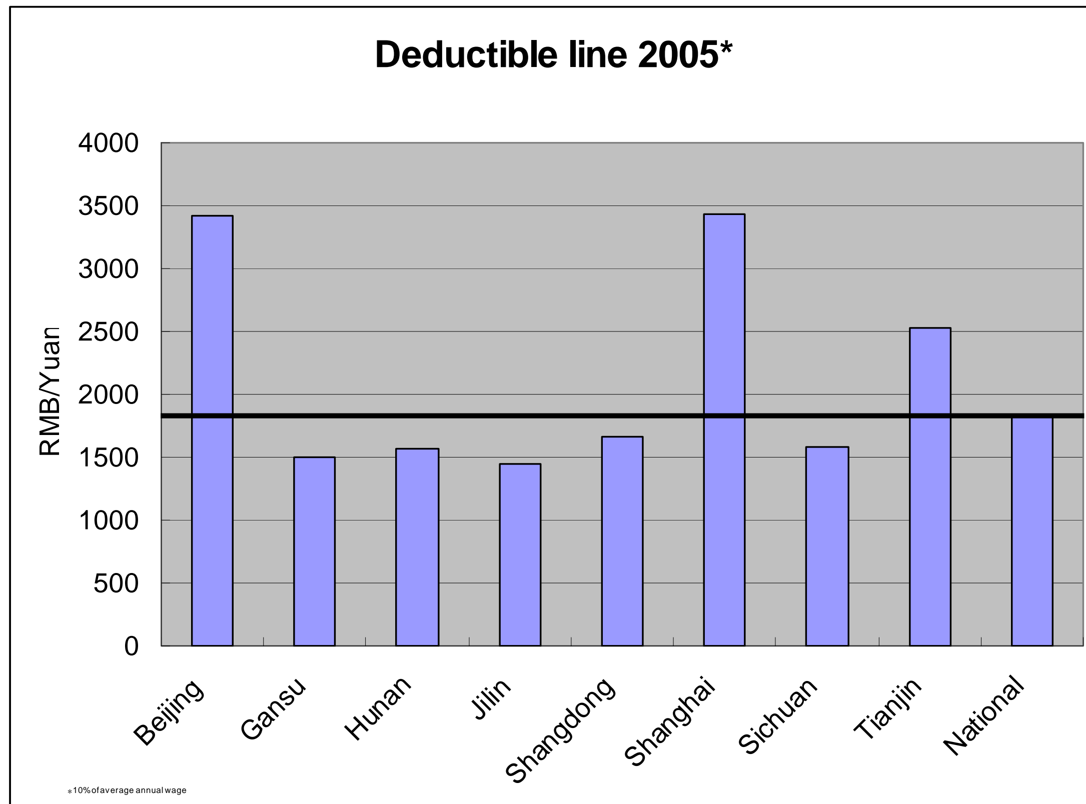
The deductible line of basic medical insurance social pooling funds and individual accounts shall in principle be set at approximately 10% of the local annual average wage. The implementation of basic medical insurance social pooling schemes for catastrophic diseases in recent years revealed that it is quite common to set the deductible line at approximately 5-15% of the local annual average wage, which seems at the first view affordable for the insured. In 2005 for instance, the national annual wage[7] in was RMB 18.364, thus the deductible line set at approximately 5-15% of the local average wage would be RMB 918,20 – 2.754,60. Considering regional differences in economic development and medical demand, it would be

[6] Promulgated by the State Council GUOFA 1998 No. 44

[7] China Statistical Yearbook 2006; Average Wage of Staff and Workers and Related Indices (2005); Page 157

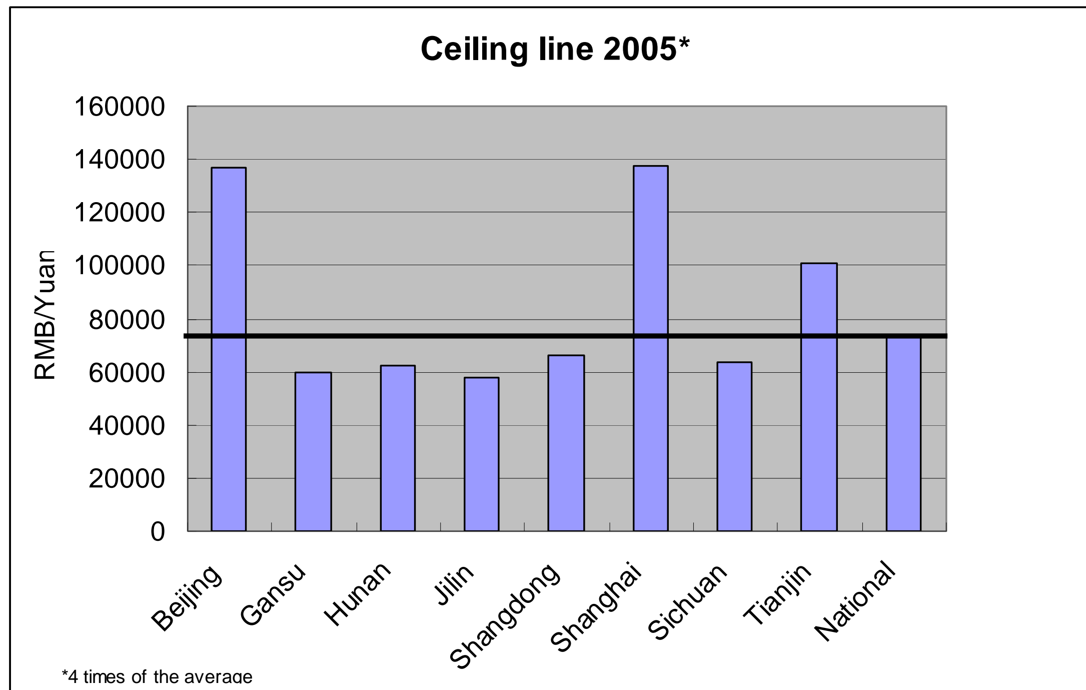
plausible to set basic medical insurance deductible line at 10% of the local annual average wages for employees, i.e., approximately RMB 1.836,40, which leaves certain space for adjustment for localities.

Table 1: Using the national standard of 10% deductible line



The basic medical insurance reimbursement ceiling line shall be set at approximately four times the local annual average wage for employees, which is put forward on the basis of the distribution of patients who get catastrophic diseases. In 2005, four times the national average for employees was RMB 73.456. In accordance with a sample survey in forty cities in China, the majority of the insured sick had annual medical fees below RMB 30,000, while the percentage of the insured sick whose annual medical fee were higher than RMB 30.000 was only 0.4%. Therefore, it can meet the medical demands of the majority of employees if the basic medical ceiling line set at four times the local annual average wage. However, taking a look on serious diseases like cancer, kidney transplantation, etc. the individual may pay more then RMB 73.456 still they have to finance the medical services by themselves.

Table 2: Using the national standard of four times local annual average wage as ceiling line



The Ministry of Labour and Social Security, in collaboration with the Ministry of Health and the Ministry of Finance has issued the guidance on the application of the List of Drugs, the List of Medical Treatment Services that are covered reimbursable by the medical insurance, as well as the List of Standards to be met by medical service providers. The principles are to make medical services and drugs to meet the clinic needs, to be secure and effective, priced at a reasonable level with easy access and ensured market supply.

While assessing the services by the medical service providers, the availability of listed drugs, the uses of listed drugs and other self-financing drugs, cases of abuses of antibiotic drugs or other listed drugs are reviewed. Reviews over the direct and indirect costs of the medical treatment services are also made, along with checks on medical services to see if they are appropriate and applicable to the specific syndrome of the patients, if the use of large scale medical equipment is proper, if the lab tests are consistent with medical treatment. With regard to the management of medical service facilities, reviews will be conducted on whether these facilities meet the reimbursement requirement under the medical insurance scheme, and whether they have followed standards in the cases that patients have their special

requirement. In the meantime, medical service providers are also encouraged to explore new ways in their management over consumption goods, call for tendering in their purchases of high value consumption goods. The prices of one-off consumption goods should be disseminated on regular basis.

The Ministry of Health defined a standard list of Services, which includes 4.170 services items. However, the basic medical insurance could set up their list of service but the main list prepared by the Ministry of Health will be the max-version.

The basic medical insurance will only reimburse expenses for drugs on the State Scheme Drug List for Basic Medical Insurance, which is based on clinical need, safety and efficacy, reasonable pricing, ease of use, and the desire to maintain a balance between Western and TCM products.

The basic medical insurance and at-work injury insurance of 2004 cover 832 traditional Chinese medicines, up from 415 in 2000; the number of chemical medicines covered by the insurance systems increase from 725 to 1031 from year 2000 to 2004, some of which are patent-protected new drugs of Western companies.

For example, more then 99% of the budget of the Beijing Medical Insurance covers fee for services. As for 2006 the Medical Insurance of Beijing use approximately 5.000 service items based on the standard lists ("Three Lists") which cover traditional Chinese/Western medical services and out- and inpatient care. The Medical insurance has to reduce the service items down to 3.900 services based on the national list prepared by the MoH and NDRC till the end of 2006. The new list has to be adapted by all Medical Insurances in China. However it is very unclear if this has deep impact of rational utilisation of services, reduction of misuse of services or whatever. In any case the hospitals have to meet their financial needs and therefore they increase their revenues through private services and the out of pocket payments.

The Chinese benefit package covers only those kinds of services, which are included in the service item list and as well as in the drug list. We have to mention here that non-covered services provided by the hospitals still have to be paid by the patient.

Changchun Medical Insurance "Urban Dwellers"

The municipality of Changchun established the medical insurance “Urban Dweller fund” as a social pooling fund. There are no individual accounts for urban residents and all contributions by the urban residents and subsidies of the local governments feed into the social pool fund.

The scope for payments from the pooling funds and the other medical insurance funds are defined and the funds are separately accounted for and not commingled. The deductible line and the ceiling for the payment from the pooling funds are defined as follows:

Medical expenses below the deductible line shall be paid by individuals, while expenses above the deductible line and below the ceiling are mainly paid from the pooling funds, while individuals shall also pay certain percentage of the expenses. The specific deductible line, ceiling and reimbursement rate is determined by the medical insurance urban residents of Changchun City based on both the income level of city dwellers and the principle of balancing medical fund revenues and expenditures.

Deductible line 2007 of Changchun City:

	Hospital level	**Deductible**
1	Provincial hospital	900 RMB
2	Municipal hospital	600 RMB
3	District hospital	300 RMB

Ceiling line 2007 of Changchun City

	Coverage	**Ceiling**
1	Ordinary population	45.000 RMB
2	Students of elementary and secondary school	50.000 RMB
3	Cancer and leukaemia patients	60.000 RMB

1st level Medical Insurance reimbursement rates (%) between deductible and ceiling line 2007 of Changchun City for ordinary residents

Reimbursement level	Hospital level	%
Up to 5.000 RMB	Provincial hospital	30%
	Municipal hospital	40%
	District hospital	50%
5.001 to 45.000 RMB	Provincial hospital	40%
	Municipal hospital	50%
	District hospital	60%

2nd level Medical Insurance reimbursement rates (%) between deductible and ceiling line 2007 of Changchun City for students of elementary and secondary schools

Reimbursement level	% to all level hospitals
Up to 5.000 RMB	65%
5.0001 to 10.000 RMB	70%
10.001 to 30.000 RMB	75%
30.001 to 50.000	80%

3rd level Medical Insurance reimbursement rates (%) between deductible and ceiling line 2007 of Changchun City for students of elementary and secondary schools and serious diseases – tumour/cancer and leukaemia

Reimbursement level	% to all level hospitals
50.001 to 60.000 RMB	80%

Medical Insurance for Urban Employees Beijing

According to Art 35 and 36 of the Rules of the Beijing Municipality for Basic Medical Insurance (the "Beijing Medical Insurance Rules"), promulgated on 20 February 2001 as Decree No. 68 of the Beijing Municipal People's Government and effective as of 1 April 2001, a system of settlement periods is implemented for the payment of medical costs from the Basic Medical Insurance Central Fund. A settlement period is that period of time during which an employee or retiree either receives inpatient treatment, or receives radiation or chemotherapy for a malignant tumour, or dialysis or immunosuppressant medication following a kidney transplant operation. Responsibility for the payment of medical costs accumulated within any given settlement period will be appointed between the Basic Medical Insurance Central Fund and the individual employee or retiree in question on a tiered basis, according to the following regulations:

Outpatient care services

The current deductibles are 2,000 Yuan for urban employees and for retirees 1,300 Yuan. The ceiling line is set up by 70,000 Yuan a year. Migrant workers and self employed persons are not entitled to outpatient care services.

Samples of deductible calculations:

1. *Individual account filled up to 1,000 Yuan; Invoices of outpatient care services 1,500 Yuan:* The worker or retiree could receive not more then the available amount of 1,000 Yuan and 500 Yuan remains by them as out-of-pocket payments. The deductible line could not apply in this case because the invoices do not reach the deductible line.

2. Individual account filled up to 3,000 Yuan; Invoices of outpatient care services 2,500 Yuan: The worker could use 2,000 Yuan to reimburse the outpatient care services and 500 Yuan remains as out-of-pocket payments because the deductible line is settle by 2,000 Yuan. Additional 50% of the 500 Yuan could be reimbursed if the employee is covered by the supplementary medical insurance. The retiree could use only 1,300 Yuan to reimburse the outpatient care services and 1,200 Yuan remains as out-of-pocket payments. Additional 50% of the 1,300 Yuan could be reimbursed if the retiree is covered by the supplementary medical insurance.

Inpatient care services

The current deductibles are 2,000 Yuan for urban employees, migrant workers and self-employed and for retirees 1,300 Yuan. The current ceiling line is fixed by 70,000 Yuan. In case of a second settlement period the deductibles are reduced down to 650 Yuan for all insured persons.

Current Ratios for payment of employees' medical costs during a first single settlement period:

Amount of Medical costs (RMB)	% payable from central fund	% payable by individual
Grade III Hospital		
First settlement period 2,000 Urban Worker/1,300 Retirees and Second settlement period 650 – 30,000	85%	15%
30,000 – 40,000	90%	10%
40,000 – 70,000	95%	5%
Grade II Hospital		
First settlement period 2,000 Urban Worker/1,300 Retirees and Second settlement period 650 – 30,000	87%	13%
30,000 – 40,000	92%	8%
40,000 – 70,000	97%	3%
Grade I Hospital		
First settlement period 2,000 Urban Worker/1,300 Retirees and Second settlement period 650 – 30,000	90%	10%
30,000 – 40,000	95%	5%
40,000 – 70,000	97%	3%

Samples of deductible and ceiling calculations:

First settlement period:

1. Grade I Hospital - inpatient care service invoice 10,000 Yuan: The medical

insurance covers the following amount: 10,000 Yuan minus 1,300 Yuan (deductibles) = 8,700 Yuan x 90% = 7,830 Yuan in case of an urban employee. The out-of-pocket payment is 2,170 Yuan. The ceiling line does not apply for this case because the amount is below the line of 70,000 Yuan.

2. Grade I Hospital – inpatient care service invoice 50,000 Yuan: The medical insurance covers the following amount 50,000 Yuan minus 1,300 Yuan (deductibles) = 48,700 Yuan x 97% = 47,239 Yuan in case of an urban employee. The out-of-pocket payment is 2,761 Yuan.

As for the second settlement period and the following period (two episodes or more) the calculation method is the same but the deductibles are reduced to 650 Yuan for all participators.

Several episodes (settlement periods) and invoicing above the ceiling line:

1. Grade I Hospital – inpatient care service first invoice 25,000 Yuan, second 20,000 Yuan and the third 40,000 Yuan: The following calculation applies for the urban employee, retiree, migrant worker and self employed person

   (1) 25,000 minus 1,300 = 23,700 x 90% = 21,330 Yuan
   (2) 20,000 minus 650 = 19,350 x 90% = 17,415 Yuan
   (3) 40,000 minus 650 = 39,350 x 95% = 37,382.5 Yuan

   76,127.5 Yuan
   Minus Ceiling 70,000 Yuan
   (4) Co-payment 6,127.5 Yuan

   Out-of-pocket payments in total (1+2+3+4) 8,727.5 Yuan

2. Same example, but the last treatment episode starts in December of a year and ends in January of the new year

   (1) 25,000 minus 1,300 = 23,700 x 90% = 21,330 Yuan
   (2) 20,000 minus 650 = 19,350 x 90% = 17,415 Yuan
   (3) 40,000 minus 1,300 = 38,700 x 95% = 36,765 Yuan (New Year case)

   No ceiling line
   Out-of-pocket payments in total (1+2+3) 3,250 Yuan

Remark:
The co-payment system of Beijing Medical Insurance Fund leads into the usage of cheaper hospitals as long as the same medical quality is anticipated by the patients. But the co-payments create a financial burden for low-income patient groups, if we compare the individual income with the deductible and ceiling lines. Higher-income groups remain wealthy. In any case the social pooling is a cost related pooling system (i.e. not income related), which should reduce the hazard moral of patient demand.

Basic Medical Insurance Tianjin City

According to Art 27/2001 of the Regulations for Basic Medical Insurance for Urban and Township Employees in Tianjin the disbursement threshold of basic insurance fund under the integrated planning shall be 10% (deductible) of the annual employee salary of Tianjin in the previous year. Where the employee or retiree is hospitalized for more than once in a year, his disbursement threshold from the second hospitalization shall be 3% (deductible) of the average annual employee salary of Tianjin in the previous year. Disbursement threshold shall vary for different levels of medical institutions. The maximum amount of disbursement from basic medical insurance fund under integrated planning per year shall be four times (ceiling) the average annual employee salary of Tianjin in the previous year.

Year 2006	RMB/Yuan
Deductible 10%	2.527,10
Deductible 3%	758,13
Ceiling	101.084,00

Medical Insurance for Urban Residents in Zhenjiang

The Medical Insurance for Urban Residents in Zhenjiang is co-financed by the local government, rural and urban residents and the collective economy entity. The government introduced the new scheme mainly to share the risk of catastrophic diseases and hospitalization. The scheme is implemented in Zhenjiang city and three other districts around the city.
The principles of the medical insurance are the same like the basic medical insurance for urban employees and retirees which are characterized by sharing the account settlement mechanism, covering the whole population in the catchments area; adapting to the same productivity standards of the basic medical insurance and last but not least the covering of the expenditures by a balanced or cost-recovery finance system.

Zhenjiang Center of Medical Insurance Fund Administration (MIFA) and Zhenjiang Center of Medical Insurance Payment and Settlement (CMIPS) are public service agencies. Responsibility of MIFA: coverage service, fund operation, information management, fund status publication. Responsibility of CMIPS: payment and settlement implementation; supervision, inspection and examination on contracted hospitals.

Benefit package:
The benefit package of the Basic Medical Insurance is defined in three lists, pharmaceutical, equipment and diagnosis & treatment and the contracted medical institution administration have to follow the regulations. The scheme covers only inpatient care and some cases of catastrophic diseases in terms of outpatient care. Students and children receive 50% of the expenditures for outpatient care back from the medical insurance scheme.

Deductibles, ceiling lines of the insured people and reimbursement rates of the medical insurance scheme:

The insured patients receive a discount of 15% for community, district and town level outpatient services and 10 % for district and town level inpatient services in case they use this type of low cost healthcare facilities.

Payment for adults (except students and children)

- Deductible: 300 RMB

Payment by fund in %: >300 RMB and <=1000 RMB 20%

>1000 RMB and <=5000 RMB 30%

>500 RMB and <=10000 RMB 40%;

>10000 RMB and < =30000 RMB 50%;

>30000 RMB 50%.

- Ceiling: 30000 RMB.

Payment for student and employee's children:

Hospitalization

- Deductible: 300 RMB

Payment by fund in %:

Range	Payment by fund
>300 RMB and <=1000 RMB	40%;
>1000 RMB and <=5000 RMB	50%;
>5000 RMB and <=10000 RMB	60%;
>10000 RMB and <=30000 RMB	70%;
>30000 RMB and <=50000 RMB	80%;
>50000 RMB and <=100,000 RMB	90%;
>100,000 RMB	95%.

- Ceiling: 100,000 RMB

Outpatient and Emergency: 50%

Regulations on deductible and ceiling lines in selected European countries[8]

Germany

Outpatient care services:

The patient pays a practice fee of 10 Euro per quarter at his first visit to the doctor in each quarter (certain medical check-ups are excluded).

The patient's participation for medical aids (e.g. massages, baths or physiotherapy) which are part of the medical treatment is 10% and 10 Euro per prescription.

[8] Missioc 2006

There are no co-payments for children. Entitled patients receive exemption of participation for expenses above 2% (1% in case of chronic diseases) of the gross income. Health Insurance Funds may establish reduction of co-payment for early-detection measures and bonus models.

Inpatient care services:
Insured receive free hospitalization in a shared room with exception of participation of 10 Euro per calendar day during a maximum of 28 days per calendar year.

No charge for children and in hardship cases.

Dental prosthesis:
As of 1st January 2005 the insured person is entitled to receive diagnosis-related fixed subsidies for dental prosthesis, which correspond to 50% of the fixed standard care determined by the Joint Federal Committee. No contribution for medically conservative treatment and for denture radiography. When the insured person takes measures to maintain healthy teeth, the benefit is increased by a bonus of 20% or 30%.

Pharmaceutical products:
Insured person's participation for pharmaceutical products: A 10%-participation of the dispensing price, at least 5 Euro and a maximum of 10 Euro and not more than the price of the product, except for children and hardship cases. If there are fixed-price pharmaceutical products, the amount of contribution payable depends on this fixed price. If the price of the product exceeds the fixed price, the patient must pay the difference between the fixed price and the prescribed product, in addition to the set prescription charge.
Non-prescribable drugs are not paid for by the insurance. Exceptions: children up to the age 12 showing developmental disability and the exceptions determined by the Joint Federal Committee in its guidelines for such cases, where non-prescriblable drugs are part of the standard therapy for the treatment of serious diseases. Insured persons must pay for over-the-counter drugs (OTC) and life-style drugs. Certain uneconomical drugs are not paid for by the insurance.
Members of family: as for insured persons.
Pharmaceuticals are free of charge during hospitalisation.

Prosthesis, spectacles, hearing-aids and remedies:
When fixed amounts are established for medical supplies, costs are covered up to this amount; otherwise prices for supplies are set in agreement with the health care suppliers:

10% of the cost for aids, at least 5 Euro, 10 Euro at most, not more than the price of the product. 10% of the costs for remedies plus an additional 10 Euro per prescription; children and cases of hardship are exempted.
The entitlement to vision aids is limited to children and young persons up to children of the age of 18 and to insured persons with severe vision impairments. Therapeutic vision aids used for treatment of eyes injuries or eye diseases are excluded from this restriction.

Other benefits:

- *Home care:* Basic nursing and treatment as well as household assistance. Participation: 10% of the daily costs for the first 28 days in the calendar year, plus 10 Euro per prescription, except for children and hardship cases.
- Household aid, in general replacement in the household, or payment of costs of household assistance. Participation: 10%, at least 5 Euro and 10 Euro at most. Never more than the actual cost. Except children and hardship cases.
- In certain cases the cost for rescue and transport to the hospital or the doctor are covered; Participation per journey: 10%, at least 5 Euro and 10 Euro at most. Never more than the actual cost.
- Payment of medical services for ambulatory preventive or rehabilitation services; contribution to the other costs of ambulatory preventive services (accommodation, nursing, transportation) up to 13 Euro or 21 Euro for chronically ill infants per day.
- Full compensation with a 10 Euro co-payment by the insured patient per day for preventive and curative services for mothers, except for children and insured persons, once a critical limit has been exceeded.
- Full compensation for institutional preventive or rehabilitative services, except for co-payment of insured person of 10 Euro per day, except for children and hardship cases.

The German healthcare system is mainly characterised by the mandatory health insurance funds based on solidarity principles: the rich subsidies the poor, the healthy subsidies the sick population. Those principles were embedded into the health care law and in the health care financing system.
The DRGs as a reimbursement system covers a comprehensive price which includes the whole range of hospital services during the treatment process including medicines, remedies, physiotherapy and prosthesis (for example hip replacement) if necessary. The patient has to pay only the flat rate, which is set up by the healthcare law within the social security law. Medicines, remedies, physiotherapy and prosthesis, which are incorporated into the DRG causes no additional co-payments because those items are included into the DRG price. Children, poor or other vulnerable groups are exempted from the flat rate.

United Kingdom

Outpatient care services:
None

Inpatient care services:
No charge, except where the patient asks for special amenities or for extra treatment, which is not clinically necessary.

Dental care and prosthesis:
There are proportional charges for NHS dental treatment in the General Dental Service, including examination. 80% of expenditures of a course of treatment (= a case) up to a maximum of GBP 390 (568 Euro) should be paid by the covered population.
No charge for:

- Women who are pregnant, or who have had a baby in the preceding 12 months, when the course of treatment starts,
- People under 18,
- Those under 19 in full-time education,
- People and their partners who are receiving Income Support or Income-based Jobseekers' Allowance, Pension Credit Guarantee Credit and named on a Tax Credit NHS Exemption Certificate with an income below GBP 14,600 (21,267 Euro) or War pensions.

People on a low income may be able to get help with the cost of treatment. Dental treatment in the hospital and Community Dental Services, however, is free except for dentures and bridges.

Pharmaceutical products:
Covered population are charged of GBP 6.40 (9.32 Euro) per prescribed item – GBP 5 (7.28 Euro) in Wales.
An annual (or 4 months) prescription prepayment certificate can be bought which offers considerable savings to those who need regular medication. The cost of the certificate is GBP 33.40 (49 Euro) for 4 months and GBP 91.80 (134 Euro) for one year – GBP 26.17 (38 Euro) and GBP 71.84 (105 Euro) in Wales.
In England and Scotland, there is no charge for children under 16, people aged 16-18 and still in full-time education, people aged 60 or over, pregnant women and women who have given birth in the last 12 months, War Pensioners (for their accepted disability), people and their partner receiving Income Support or Income-based Jobseekers' Allowance, Pension Credit Guarantee Credit, or Tax Credit (and named on a Tax Credit NHS Exemption Certificate), some other people suffering from specific conditions. In addition to those listed above, in Wales those aged 18-25 are entitled to free prescription.

Prosthesis, spectacles, hearing-aids and remedies:
None

Other benefits:
None

The UK healthcare system is organized as a National Health Service System and covers the whole population. The State guarantees and finances the whole range of hospital services through taxation. As a result the DRGs as a financing system cover a comprehensive price that includes the whole range of hospital services during the treatment process including medicines, remedies, physiotherapy and prosthesis (for example hip replacement) if necessary. The patients do not need to pay any co-payments for all necessary and appropriate treatment procedures. Medicines, remedies, physiotherapy and prosthesis, which are incorporated into the DRG do not cause additional co-payments, because those items are included into the DRG price.

France

Outpatient care services:
Share borne by insured person:
- 30% for ambulatory treatment (GP or specialist, in consulting room or in hospital),
- Flat-rate co-payment of 1 Euro per visit a doctor within a limit of 50 Euro per person and per year,
- 25% for ambulatory health care in hospitals
- 40% for analytic laboratory tests.

General scheme for employees covers costs completely at 100% of the responsible rate:
- Beneficiaries of an invalidity pension,
- Beneficiaries of a work injury pension at a rate >66.66% together with their family member
- Persons suffering from certain diseases, for those diseases only,
- Persons with recourses under a certain ceiling line.

Exemption from the 1 Euro flat-rate co-payments for:
- Children under 18 years of age,
- Women pregnant since more than 6 months,
- Persons with recourses below a certain limit.

Inpatient care services:
Daily ambulant hospital services of the insured it's almost around 20% in general.

Hospitalization fee 14 Euro (10 Euro in a psychiatric unit) per day, including the day of discharge.

General scheme for employees exempted the participation from 31st day of hospitalization and for certain surgery treatments,
Holders of an invalidity pension or a work injury at a rate >66.66% are covered 100% together with their family member,
Persons with recourses under a certain ceiling,
Persons suffering from certain diseases are exempted but only for those diseases.

Dental care and prosthesis:
Refund according to fixed rate as for medical care. Share borne by the insured person: 25-30%

Pharmaceutical products:
Insured persons share:
85% - low effectively (orange label drugs)
65% - specific drugs (blue label drugs)
35% - specific drugs (white label drugs)
100% - for ease drugs

No share required from long-term patient only for the illness concerned.

Prosthesis, spectacles, hearing-aids and remedies:
It's the subject to sickness fund's prior approval refund of established fees (60-70%) and for major fittings (100%).

Other benefits:
None

The French healthcare system includes the mandatory and supplementary health insurance funds based on the solidarity principles in analogy of the German system. The French type of DRGs as a financing system covers a comprehensive price that includes the whole range of hospital services during the treatment process including medicines, remedies, physiotherapy and prosthesis (for example hip replacement) if necessary. The patient has to pay only the flat rate, which is set up by law. Medicines, remedies, physiotherapy and prosthesis, which are incorporated into the DRG do not cause additional co-payments, because those items are included into the DRG price.

Poland

Outpatient care services:

None

Inpatient care services:
None

Dental care and prosthesis:
None, but the dental prosthesis is covered by insurance once every 5 years.

Pharmaceutical products:
Official list of medicines divides pharmaceutical products into 3 categories:
- Basic medicines: standard price (patient pay a fixed price – maximum of 0,5% of lowest salary determined by the Minster of Health;
- Special additional medicines: 30% to 50% of price paid by the insured person;
- Other medicines: 100% of the price paid by the insured person.

Medicines are free of charge in hospitals.

Prosthesis, spectacles, hearing-aids and remedies:
Free or part payment (once every 3 or 5 years); prostheses, hearing aids and wheelchairs are free, but 30% to 50% of the price of spectacle frames and lenses is paid by the insured person.

Other benefits:
None

During stay in a hospital operations, diagnostic tests and medicines are provided free of charge but they are only free if the patient provides a referral from the outpatient sector. However, the National Health Insurance Fund purchases the healthcare service list and all those services which are not covered have to be paid by the patients.

Hungary

Outpatient care services:
Co-payments are only charged in the following circumstances:
- Obtaining prescription treatment without a referral from a primary health care provider (unless exemption see "Access to Specialists"),
- Using a health care provider other than the one specified by the prescribing doctor,
- Unnecessarily changing the content of prescription treatment, causing extra costs,
- Extra services (better room, meal condition etc.),
- Accommodation, nursing, pharmaceuticals and meal costs for those suffering

from designated ailments, confirmed by primary health care provider.

The amount of the co-payment is fixed by the service provider.

According to the equity principle the burden of co-payment can be reduced. This discretion is explicitly exercised by the Director of Administration of the National Health Fund according to limits set in the annual budget of National Health Insurance Fund.
According to the equity principle the Director of the NHIF can:

- Undertake the full or partial burden of co-payment of medical treatment from patients,
- Raise the percentage of the subsidy for pharmaceuticals, prosthesis and services,
- Offer subsidies for medicines and prosthesis which are not normally subsidized by the Health Insurance Fund,
- Raise the frequency of subsidies for therapeutic prosthesis.

Those in an economically vulnerable position (typically low income elderly people) whose needs are acknowledged by the local government and certified by a special card are exempt from certain co-payments.

Inpatient care services:
Co-payments are only charged in the following circumstances:

- Obtaining prescription treatment without a referral from a primary health care provider (unless exemption "Access to Specialist"),
- Using a health care provider other than one specified by the prescribing doctor,
- Unnecessarily changing the contents of prescription treatment, causing extra costs,
- Extra services (better room, meal condition, etc.),
- Accommodation, nursing, pharmaceutical and meals costs for those suffering from designated ailments, confirmed by primary health care provider.

Reduction of co-payments can be partly or entirely provided by the General Director of the National Health Insurance Fund, on individual basis, as a discretionary competence.

Dental care and prosthesis:
Co-payments made with respect to the costs of certain materials used and to certain treatments.
Co-payments are charged in the following circumstances:

- Orthodontic brace (under age 18),
- Dental prosthesis (needed to restore the patient's ability to chew).

Amounts are fixed by service providers.

Pharmaceutical products:
The Health Insurance Fund pays 50% - 100% of the price of out-patient medicines appearing on a set list (the percentage of the subsidy depends on a decision made by a professional body based on the type of drug and not the circumstances of the patient). Low-income, elderly or disabled persons receive a special card entitling them to receive medicine for free.

Prosthesis, spectacles, hearing-aids and remedies:
The Health Insurance Fund subsidises 50%, 70%, 80%, 95% or 100% of the price depending on the type of the prosthesis device in question. Based on their therapeutic benefit, a group of certain devices can be subsidies with fixed amounts.

Other benefits:
None

The Hungarian government stipulated the Act LXXXIII of 1997 and related decrees define health services, which are free of charge, covered but require some co-payments, or excluded from social health insurance coverage. The Act defines a negative list, since the starting point is that all health services are fully covered and exclusions are stipulated (1997/9). Co-payments are required for medicines (1995/1), medical aids and prostheses (2000/5), balneotherapy (1997/5), dental prostheses, treatment in sanatoria, long-term chronic care and some "**Hotel**" services in hospitals[9]. However, the definition of so-called "hotel" services in hospitals is very vague and needs to clarify in a further stage if necessary. Medicines, remedies, physiotherapy and prosthesis, which are incorporated into the DRG causes no additional co-payments because those items are included into the DRG price.

Conclusions

Studies of the effects of prices and charges on health care usage show that demand for health care is generally price inelastic – that means, demand is not greatly affected by price. However, the evidence also shows that these effects vary greatly depending on income: understandably, people on low incomes are more likely to be deterred from using services because of higher prices than those of high incomes. It is therefore important to calculate how the financing rules are likely to affect the amount which different population groups pay for health care. In general, an

[9] European Observatory, Health Care Systems in Transition, Hungary 2004, page 40 and 41

insurance-funded scheme will be less expensive at the point of service than a pay-as-you-go, fee-for-service system, and may thus be expected to lead to higher utilization among poorer groups[10].

Among the implementation of DRG's the Chinese authorities will be enabled to reconsider the deductible and ceiling line system which was initiated as a first step to ensure the financial sustainability of the newly established medical insurance funds for urban workers. Nowadays the Basic Medical Insurance Funds Urban Employees and Retirees are generating surplus whereas the pilots of the Medical Insurance Fund Urban Residents have to be subsidised. However, the implementation of DRG's will be a good opportunity but as well challenge to revise the historical deductible and ceiling system of the Basic Medical Insurance which introduces first aspects of solidarity. The Chinese authorities might consider the following aspects:

- Equity – Income related deductibles and ceilings which equalize poor population in the usage of inpatient care
- Affordability – DRG's calculated as a full services package enables all enrolees of the medical insurance to use the inpatient care
- Accessibility – DRGs enables all medical insurance participants to receive the same services

Personal strains in terms of pre-payments or payments in advance could be eliminated which reduces the administrational affords of the patients like registration fees, purchase of listed services or other arrangements.

Hospital and clinics receiving fixed flat rates "DRGs" according to the medical procedures and pathways which reflects the real costs of the treatment process. Those kind of incentives reduce the underpay of the current system and provide an appropriate incentive towards the hospital. Furthermore the administration of pre-payments could be reduced.

As for the medical insurance the providers do not need to check-up the co-payments of the patients, which reduces the administrational afford.

[10] Social Health Insurance "A Guidebook for Planning" by Charles Normand and Axel Weber, page 90 and 91

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