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Payment Methods for Palliative Care in China: Current Status, Challenges, and Countermeasures

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Abstract: With the accelerated aging of the population and the subsequent increase in cancer incidence, the development of palliative care services has gradually become a societal hotspot. By analyzing the existing issues in payment methods for palliative care in China, such as unreasonable division of payment standards, incomplete coverage of beneficiaries and services, and difficulties in ensuring equity in palliative care benefits, this paper further proposes that the government should expedite the legislative process, improve top-level design, promote the inclusion of palliative care within the scope of long-term care insurance, enhance the cross-regional settlement system, and increase auxiliary services and social support.

Keywords: Palliative Care; Payment Methods; Hospice Care

1. Settlement Method for Palliative Care Based on Per Diem Payment

Palliative care institutions designated by the authorities must admit patients requiring such care into designated palliative care wards. The medical expenses of insured individuals are settled as per regular hospitalization, with individual self-payment borne by the insured. When the medical insurance department settles the payment of medical insurance funds with designated institutions, it adopts a per diem payment method. Each pilot city comprehensively considers the baseline data such as historical expenses, number of visits, and survival periods for the treatment of terminal illnesses like cancer and tumors in designated medical institutions within the city in recent years, taking into account the fund payment capacity and socioeconomic development level, to determine the annual per diem standards and payment days for palliative care. Based on the number of days of palliative care services provided by institutions to insured patients within a certain period, the determined per diem payment standards, and referring to the current medical insurance reimbursement policies in each pilot city, the medical insurance pooling fund and the payment limit for insured patients are determined, converted into daily points, and included in the DRG (Diagnosis-Related Groups) payment to pay for the services provided by palliative care institutions. Currently, the per diem payment method for palliative care includes three items: the per diem cost quota standard, the “double quota” payment algorithm, and the total per diem quota standard for pilot institutions.

1.1 Introducing Price Comparison Relationships and Establishing a DRG Payment Method for Palliative Care

Based on the total bed days, average hospital stay bed days, total medical expenses, and per diem medical insurance costs of palliative care services in pilot institutions over the past two years, some pilot cities in China have finally adopted a fixed-amount form to pay for palliative care bed days according to hospital grades or illness severity, ensuring more rational and standardized patient admission by medical institutions. As one of the first pilot cities to include patients with terminal cancer in palliative care services, Panzhihua City converts the standard cost of palliative care bed days into benchmark points based on the price comparison relationship, determines case points based on the number of hospital days for inclusion in DRG payment, and settles payments on a per diem basis. In Changsha, Ya’an, and Zigong, the medical expenses incurred by insured individuals within the specified standards at medical institutions are all included within the scope of medical insurance policies, without deductibles or item-specific self-payment ratios. Different payment and collection standards are set based on the severity of illness, with the insured individual’s burden being calculated based on the lower of the total actual medical expenses incurred and the palliative care fee standards.

1.2 Implementing the “Double Quota” Algorithm for Per Diem Payment in Palliative Care

The standard for palliative care bed days includes two parts: medical insurance fund payment and self-payment by insured patients. The medical insurance fund payment = bed day standard × actual number of hospital days × medical insurance payment ratio, and the patient’s self-payment = bed day standard × actual number of hospital days × personal self-payment ratio. If there is a difference between the sum of

the medical insurance fund payment and the personal burden and the actual cost of hospitalization, the surplus is retained by the medical institution, while the overspending is borne by the medical institution. For instance, Dezhou City stipulates that if the average actual medical expenses per bed day during hospitalization for palliative care patients are less than 90% of the average per diem cost standard for settlement, the medical insurance fund payment standard and personal burden are settled at a ratio of 85% and 15% of the average daily actual medical expenses, respectively. The hospitalization time is included in the settlement period of the palliative care pooling fund, and the proportion of bed fees in the actual medical expenses incurred by palliative care patients during hospitalization must not exceed 20%.

1.3 Clarifying the Total Per Diem Quota Standard for Palliative Care Pilot Institutions

The annual maximum limit for the total bed days of hospitalization in palliative care pilot institutions is determined by multiplying the number of palliative care beds approved by the health authorities by 365 days. Payments are settled based on the actual total bed days if they are below the maximum limit; otherwise, the medical insurance fund will not cover the excess. Changsha City stipulates that after the medical insurance fund for palliative care is settled on a per diem cost basis, if the annual medical expenses of the palliative care ward in the medical institution are less than 80% of the total annual bed day expenses, the medical insurance fund will settle by item, and the medical expenses exceeding the payment and collection standards will be borne by the medical institution. Dalian City stipulates that if the annual medical expenses of the palliative care ward in designated medical institutions are lower than the total annual bed day expenses, the medical insurance pooling fund will settle based on the actual medical expenses.

2. Issues in Payment Methods for Palliative Care

Firstly, the palliative care team comprises not only doctors (general practitioners and specialists) and nurses but often also pharmacists, nutritionists, physiotherapists, social workers, lawyers, family members, and other collaborators. Most pilot units lack corresponding fee standards for services such as assessments, psychological counseling, and grief support, which fails to truly reflect the labor value of medical staff and significantly dampens hospitals' enthusiasm for implementing palliative care services. Additionally, terminal-stage patients often avoid costly tests and high-priced medications, making nursing the primary focus of palliative care. Consequently, the Case Mix Index (CMI) tends to be low, and due to performance appraisal, medical staff in palliative care wards receive lower salaries than those in other departments, with narrower promotion paths, hindering their career development.

Secondly, regarding medical insurance eligibility criteria, cities like Panzhihua, Zigong, Changsha, and Qinzhou only include patients with advanced cancer in their settlement scope, while Xingtai and Dezhou limit this payment method to patients with malignant tumors. Such stringent eligibility criteria have led to a shortage of palliative care services. In terms of settlement items, the non-medical services of palliative care, such as psychological counseling and spiritual care, as well as expenses for medications, diagnostic and treatment items, and service facilities outside the basic medical insurance coverage, are excluded from the settlement, thereby reducing the medical security level for insured patients. Furthermore, some pilot cities have yet to clarify the settlement standards for per diem payment for palliative care, with only a few specifying the proportion of medical insurance reimbursement.

Thirdly, palliative care necessitates the participation of multiple parties, including public hospitals, community-based medical service institutions, private medical institutions, other elderly care facilities, and home-based care services. However, China's current medical insurance payment policies are still unable to address this complex payment relationship. Therefore, refining the payment methods for palliative care medical insurance based on local conditions and improving the payment standards through scientific research and actuarial calculations are crucial steps in advancing the development of palliative care in China.

3. Countermeasures and Suggestions

Firstly, the improvement of the medical insurance system plays a pivotal role in the development of palliative care in China. It is essential to actively explore and promote the gradual inclusion of home-based and institutional palliative care services into the scope of basic medical insurance, long-term care insurance, and other supplementary medical insurance. Legislation should be enacted to ensure that long-term care insurance covers palliative care, further expanding the scope of beneficiaries and covered items. In terms of beneficiaries, both urban and rural residents who contribute to medical insurance should be included. Regarding covered items, pilot programs for long-term care insurance that already cover palliative care can enhance the range of health-related protection projects by purchasing services from medical, elderly care, and combined medical-elderly care institutions through government procurement, while also incorporating psychological counseling and spiritual comfort services into the coverage.

Secondly, legislation should be enacted to lower the eligibility criteria for per diem payment for palliative care and supplement assessment indicators for disability levels, addressing the issue of unfair treatment due to unreasonable eligibility systems and payment standard classifications for palliative care recipients. In terms of the eligibility system, on the one hand, pilots should fully consider the uniqueness of

palliative care recipients and appropriately relax eligibility criteria, particularly those related to the duration of disability. On the other hand, the assessment of disability levels can be enriched by adding indicators such as behavioral disorders and psychiatric conditions like depression, forming a comprehensive indicator system covering activities of daily living, cognitive abilities, sensory perception and communication skills, behavioral manifestations, and psychiatric conditions.

Thirdly, the problem of cross-regional settlement for palliative care can be resolved by establishing a "national-provincial-pilot-city or county" long-term care insurance cross-regional payment model. On the one hand, provinces should uniformly manage the payment and reimbursement standards of their provincial pilots, achieving unified planning, collection, and expenditure of medical insurance funds throughout the province. On the other hand, they can refer to the cross-regional settlement method of medical insurance, utilizing "Internet + Long-Term Care Insurance" to collect and promptly update information on designated institutions and electronic health records of insured individuals. Additionally, information technology can be employed to modify the cross-regional settlement system's docking ports, updating insured individuals' cross-regional care records and expense settlement in real-time, realizing online cross-regional payments.

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