POLICY AND PRACTICE UPDATES

卫生部：京深医改初步缓解看病贵
来源：财新网　2012 年 09 月 29 日
http://china.caixin.com/2012-09-29/100443539.html

新华网“权威访谈”9 月 28 日发表文章《人民群众得实惠、医务人员受鼓舞——卫生部副部长马晓伟谈公立医院改革》，卫生部副部长马晓伟 28 日接受新华社记者专访时表示，破除以药补医的公立医院改革在北京和深圳推行两个多月来，在“人民群众得实惠、医务人员受鼓舞”两方面取得了初步成效。

针对“取消药品加成”的公立医院改革在深圳、北京推行两个多月来给老百姓带来了哪些实惠，马晓伟指出，一是患者就医负担逐步减轻，二是诊疗行为得到规范。北京友谊医院医保门诊病人次均医疗费用较上半年下降了 69.8 元，降幅为 15.5%，次均自付费用下降了 70.2 元，降幅为 39.96%；医保出院病人例均医疗费用较上半年下降了 2467 元，降幅为 13.2%，个人自付费用下降了 396 元，降幅为 9.4%。深圳市门诊次均费用与去年同期相比下降了 4.3%，与今年 6 月相比下降了 2.1%；每门诊人次个人账户支付减少了 12 元。北京友谊医院和深圳市药品收入占业务收入的比重分别比改革前下降了 12.9%和 4.1%。深圳市公立医院门诊患者抗菌药物处方比例下降到 13.7%，低于 20%的国家标准。

在如何调动医务人员参与改革的积极性方面，马晓伟介绍此次京深试点中，北京友谊医院将医事服务费收入的60%分配给医务人员，深圳市明确医院提高的诊查费等收入纳入医务人员的绩效工资予以分配，医务人员收入水平普遍提升。马晓伟进一步指出，在改革中，有利于医院健康发展的长效补偿机制不断完善。通过调整医疗服务价格、增设医事服务费，初步理顺了对医务人员的激励，促进医务人员通过提高技术水平、提供优质服务获得回报；同时，配合医保支付方式改革，推动医院控制成本、提高效率，减轻了患者负担。

马晓伟还表示，我国医务人员收入待遇与多数国家相比有相当大的差距。提高医务人员收入待遇，主要是通过不断提升医疗机构人员经费占业务经费的比重予以实现。虽然提高医疗机构人员收入待遇经费占医院总支出的比例是当前医院内部管理的一项举措，但也需要双管齐下、内外兼修：一方面，要落实政府保障公立医院基本建设、设备购置等方面的财政投入政策，使公立医院转变支出结构，将支出着重用于改善医务人员收入待遇水平；另一方面，要提升医院管理的科学化、精细化水平，提升效率，节约成本。

Ministry of Health: Hospital Reform in Beijing and Shenzhen Begin to Alleviate High Cost of Medical Care

Vice Minister of Health, MA Xiaowei, talked about progress made by public hospital reform during an interview with Xinhua News Agency on September 28. Two months after abolishing medicine markups in public hospitals in Beijing and Shenzhen, the general population is already benefiting from lowered medical care costs and better regulated care provision.

In Beijing Friendship Hospital, insured patients saw their costs per visit decrease by ¥69.8 (15.5%) and out-of-pocket costs per visit decrease by ¥70.2 (39.96%). In Shenzhen, cost per visit was reduced by 4.3% when compared to the same time period from last year. In both cities, the percentage of hospital income that came from medicine sale was reduced by 12.9% and 4/1%, respectively.

As part of the reform, hospitals in both cities increased staff income by redistributing service fees as bonuses, encouraging staff to provide better care. Patients also have reduced financial burdens since hospitals are syncing with the new insurance payment plan, and are in the process of reducing or controlling operational costs while increasing efficiency.

Medical staff in China earn much less than their counterparts in other countries, and their income need to be adjusted through hospital budget restructuring. With government funding infrastructure

and equipment, hospitals could spend higher percentages of income on staff expanses. Hospital management also needs to improve to increase efficiency and reduce costs.

我国出台医疗机构药品监管办法

来源：新华社　2011 年 10 月 17 日

http://news.xinhuanet.com/society/2011-10/17/c_111102424.htm

新华社北京 10 月 17 日电（记者胡浩）记者 17 日从国家食品药品监督管理局了解到，为加强医疗机构药品质量监管，进一步规范医疗机构使用药品行为，国家食药监局近日发布实施了《医疗机构药品监督管理办法（试行）》。据国家食药监局有关负责人介绍，《办法》对医疗机构药品的购进、储存、调配、使用等行为提出了规范要求，并对相关法律责任做了具体规定。据介绍，《办法》针对医疗机构药品使用的薄弱环节重点加强药品调配和药品拆零等方面的质量管理，鼓励医疗机构通过实施药品电子监管实现药品流向的全程可追溯，同时对药品召回提出了具体要求，以适应药品监管有关规定。

《办法》明确，医疗机构发现假药、劣药，应立即停止使用、就地封存并妥善保管，并及时向所在地药品监督管理部门报告；发现存在安全隐患的药品，应立即停止使用，通知药品生产企业或者供货商，并及时向所在地药品监督管理部门报告；需要召回的，医疗机构应当协助药品生产企业履行药品召回义务。

《办法》要求，医疗机构使用的药品应当按照规定由专门部门统一采购，禁止医疗机构其他科室和医务人员自行采购；因临床急需进口少量药品的，应按有关规定办理；医疗机构配制的制剂只能供本单位使用，未经省级及以上药品监督管理部门批准，不得使用其他医疗机构配制的制剂，也不得向其他医疗机构提供本单位配制的制剂；医疗机构不得采用邮售、互联网交易、柜台开架自选等方式直接向公众销售处方药。

《办法》还要求，药品监督管理部门应当根据实际情况建立医疗机构药品质量管理信用档案，记录日常监督检查结果、违法行为查处等情况。

China Announces Plans for Administering and Managing Drugs

Chinese Food and Drug Administration recently unveiled “Medical Facilities Drug Monitoring and Management Plan (Pilot)” to deepen and strengthen drug regulation.

The Plan listed specific requirements for purchasing, storing, distributing and using drugs in medical facilities. The Plan encourages medical institutes to establish electronic record systems to fully monitor distribution of drugs. Any counterfeit or low-quality drugs, once detected, should be taken out of circulation locally, safely stored, and reported to local drug regulatory agencies. Drugs used in medical institutes should be purchased in bulk by responsible agency and never be purchased by any individuals or departments in the medical institutes. Drugs constituted in medical institutes can only be used within that institute.

The Plan also requires drug management agencies, resource permitting, to set up file system to record medical institutes’ history of drug use and management, to document results from regular monitoring process, and to detail punishments for violations.

中国卫生事业发展“十二五”规划公布

来源：中国新闻网　2012 年 10 月 19 日

http://www.chinanews.com/gn/2012/10-19/4261451.shtml

中国政府网 19 日公布《卫生事业发展“十二五”规划》，规划要求，到 2015 年，初步建立覆盖城乡居民的基本医疗卫生制度，使全体居民人人享有基本医疗保障，人人享有基本公共卫生服务，医疗卫生服务可及性、服务质量、服务效率和群众满意度显著提高，个人就医费用负担明显减轻，地区间卫生资源配置和人群间健康状

况差异不断缩小，基本实现全体人民病有所医，人均预期寿命在 2010 年基础上提高 1 岁(2010 年人均预期寿命为 74.83 岁)。

规划强调优化配置医疗资源，坚持非营利性医疗机构为主体、营利性医疗机构为补充，公立医疗机构为主导、非公立医疗机构共同发展。遏制公立医院盲目扩张，切实保障边远地区、新区、郊区、卫星城区等区域的医疗资源需求，重点加强儿科、妇产、精神卫生、肿瘤、传染病、老年护理、康复医疗、中医等领域的医疗服务能力建设，新增医疗卫生资源重点投向农村和城市社区等薄弱环节，保证基本医疗服务的可及性。在区域卫生规划和医疗机构设置规划中，为非公立医疗机构留出足够空间。需要调整和新增医疗卫生资源时，在符合准入标准的条件下，优先考虑社会资本。优先建设发展县级医院，提高服务能力和水平，使 90%的常见病、多发病、危急重症和部分疑难复杂疾病的诊治、康复能够在县域内基本解决，继续加强乡镇卫生院和村卫生室建设，积极推进乡镇卫生院和村卫生室一体化管理。

规划指出，加快建立和完善覆盖城乡居民的多层次医疗保障体系，逐步提高政府对新农合和城镇居民医保的补助标准，到 2015 年，达到每人每年 360 元以上，个人缴费水平相应提高，逐步提高基本医疗保险最高支付限额和费用支付比例。探索建立重特大疾病保障机制，积极开展城乡居民大病保险工作，利用基本医保基金向商业保险机构购买大病保险，减轻参保(合)人的高额医疗费用负担。发挥基本医保、大病保险、医疗救助、多种形式补充保险和公益慈善的协同互补作用，统筹协调基本医保、大病保险和商业健康保险政策，有效提高保障水平。此外，规划还对实施慢性病防控策略、推进医药卫生信息化建设等多方面提出具体要求。

Twelfth “Five-Year Plan” for Health Care in China

The twelfth “Five-Year Plan” for Health Care calls for the establishment of a medical health care system by 2015 that covers both urban and rural residents. Under this system, all Chinese citizens will be provided with basic medical insurance, a medical service that is greatly improved in quality, efficiency, and patient satisfaction. With lowered out-of-pocket costs to the general public, disparities between regional medical care resources will be reduced, allowing people are seeking medical care to receive it, eventually increasing average life expectancy by one year when compared to 2010 figures (average life expectancy in 2010: 74.83 years).

The plan emphasizes the importance of optimizing medical resource allocation, maintaining public non-profit medical institutes as the core service provider, with support from private for-profit medical institutes. Reckless expansion of public medical care institutes has be avoided, to secure equitable medical resource allocation for remote, newly established, rural, or satellite regions. Infrastructure needs to be built and improved to provide better service in areas of children’s and women’s health, old age care, mental health, cancer, communicable and chronic diseases, physical disabilities, and Chinese medicine.

New medical resources need to be allocated to traditionally resource-poor areas such as rural communities, to ensure universal basic care. Non-public medical institutes should be part of regional or local medical care planning. Qualifying societal funds should be given priority when considering health care reform or searching for new medical resources. Regional hospital development and construction should be given preference, to improve quality and efficiency of regional medical care, allowing 90% of patients with common illnesses, sudden sickness, and some serious illnesses to be locally diagnosed and treated.

The Plan also points to the need to increase the pace of building and improving the multi-level medical care insurance system to urban and rural residents. By 2015, annual reimbursement per capita should reach above ¥360, gradually increasing the ratio between maximum reimbursement amount and patient out-of-pocket costs. The Plan indicates that insurance against serious diseases needs to be developed and recommended to urban and rural residents.

In addition, the Plan also points to the need for an informatics system for chronic disease control and health education information dissemination.

卫生部部长解读《卫生事业发展“十二五”规划》
来源：新华网 2012年11月04日
http://news.xinhuanet.com/politics/2012-11/04/c_113598384.htm

国务院日前印发的《卫生事业发展“十二五”规划》，勾画出我国卫生事业的“十二五”发展蓝图，提出到2015年初步建立覆盖城乡居民的基本医疗卫生制度、基本实现全体人民病有所医的发展目标。围绕这一目标，卫生部部长陈竺接受专访，解读卫生事业“十二五”发展蓝图。

陈竺指出，本次规划与以往的发布形式不同，“十一五”以前的卫生事业发展五年规划都是部门规划，《卫生事业发展“十一五”规划纲要》是由国务院批转印发的，而此次《卫生事业发展“十二五”规划》则是由国务院印发的，体现了党中央、国务院对卫生事业改革与发展的重视。而从《规划》涵盖的内容上看，已不仅仅涉及卫生服务领域改革和发展的目标和重点工作，而是从“大卫生”的角度出发，包括了其他与促进人民健康相关的内容，如医疗保障、食品安全、医疗救助、药品供应保障、医学教育、科技发展、健康产业等方面。

对于此次规划为何将“人均预期寿命”纳入指标体系，陈竺指出，《国民经济和社会发展第十二个五年规划纲要》首次将“人均预期寿命”纳入经济社会发展的主要指标体系。《规划》因而将“人均预期寿命在 2010 年基础上提高 1 岁”作为核心指标，并围绕其构建“十二五”时期卫生事业发展指标，研究提出了健康状况、疾病预防控制、妇幼卫生、卫生监督、医疗保障、卫生资源、医疗服务和卫生费用等方面的 23 个指标。这些指标全面体现了“十二五”期间需要着力加强的重点卫生工作。

陈竺进一步指出，对于医疗资源配置不均衡、农村地区医疗资源薄弱等现状，《规划》提出加强农村三级卫生服务网络建设，优先建设发展县级医院，提高服务能力和水平。《规划》还提出，切实保障边远地区、新区、郊区、卫星城区等区域的医疗资源需求，重点加强儿科、妇产、精神卫生、肿瘤、传染病、老年护理、康复医疗、中医等领域的医疗服务能力建设，新增医疗卫生资源重点投向农村和城市社区等薄弱环节。引导患者合理就医，保障群众就近获得高质量的医疗服务。

此外，陈竺还提到：为了充实基层医疗卫生人才队伍，《规划》提出，到 2015 年，通过转岗培训、在岗培训和规范化培养等多种途径培养 15 万名全科医生，使每万名城市居民拥有两名以上全科医生，每个乡镇卫生院均有全科医生。要为农村定向免费培养医学生，为县级医院培养骨干医生，制定优惠政策鼓励和引导医务人员到基层工作。

Minister of Health Interpreting the Twelfth Five-Year Plan

Zhu Chen, Minister of Health, interpreted the Twelfth Five-Year Plan during a recent interview.

In the past, Five-Year Plans for healthcare system development had been produced by responsible ministries. This latest Five-Year Plan was directly published by the State Council, demonstrating our country's focus on healthcare reform and development. Judging from topic areas covered by the new Plan, future work will be concentrated on building a comprehensive health care system: not just reforming and developing medical services, but also improving public's health through better medical insurance, food safety, Medicaid, drug supply security, medical education, scientific development, and health industry.

The "Outline of the Twelfth Five-Year Plan for National Economic and Social Development", for the first time, included life expectancy as part of the main index system evaluating national economic and social development. To achieve the goal of increasing life expectancy by one year, 23 target areas were listed, such as disease prevention, women and children health, health management, and medical service.

Zhu Chen talked about inequalities in medical resource allocation between urban and rural healthcare system. The new Plan singled out strengthening rural healthcare system as an important goal, giving preference to developing county level hospitals, and increase quantity and quality of services provided.

The Plan calls for training of an additional 150,000 general practitioners to provide at least 2 general practitioners for every 10,000 urban residents, and 1 general practitioner for every township hospital.

卫生部：国家基本药物目录适用范围将扩至大医院

来源：证券时报网 2012 年 11 月 21 日

http://stock.stcn.com/common/finalpage/edNews/2012/20121121/406805005162.shtml

11 月 20 日，由中国药学会主办的 2012 年中国药学大会暨第十二届中国药师周在江苏省南京市开幕。卫生部部长陈竺出席会议并讲话。陈竺透露，今年将发布 2012 版国家基本药物目录，其适用范围将从基层医疗机构走向城市大医院；卫生部正在遴选重大疾病防治所需的基本用药，并将其纳入国家基本药物目录管理。

陈竺说，目前，卫生部联合发改委、财政、民政等有关部门共同推进的农村居民重大疾病医疗保障工作正不断走向深入，为保障这项惠及千万家的民生工程顺利进行，卫生部正按照“防治必需、安全有效、价格合理、使用方便、中西医并重”的原则，科学遴选重大疾病防治所需的基本用药，将其纳入国家基本药物目录管理，并将根据不同情况对药品、耗材等实行分类管理，实现“一药一策”，组织以省为单位的集中采购，以保障药品、耗材的质量和供应。“一药一策”是指在药品分类管理的基础上，针对一类药品制定相应的政策，以保证药品供应。

陈竺指出，在医改中，药学人员在保基本、强基层、建机制，促进合理用药，维护百姓健康方面发挥着生力军的重要作用。但我国还存在着药学人才队伍数量不足、分布不均、专业素质差异大、基层药学服务基础薄弱等问题，应抓住国家“十二五”人才发展规划将药师作为紧缺人才的良好机遇，落实药师队伍发展规划，注重加强药师队伍建设，重点增强农村基层药学人员的专业技术服务能力，提高药师队伍整体素质。

Ministry of Health: National Essential Drug List Will Be Used in Large Hospitals

Minister of Health, Zhu Chen, revealed that the updated National Essential Drug List will be used in large hospitals in urban areas in addition to primary health care facilities. Ministry of Health is in the process of selecting essential drugs for treating and preventing severe diseases and adding them to the list.

According to Minister Chen, Ministry of Health is collaborating with Development and Reform Commission, Ministry of Finance, and Ministry of Civil Affairs to strengthen and broaden the ongoing work of insuring urban and rural residents against severe diseases. Choosing essential drugs to treat and prevent these severe diseases will help ensure the insurance scheme's success. These essential drugs will be chosen based on scientific data, satisfying selection criteria such as "essential for prevention and treatment; safe and effective; reasonably priced; convenient usage; equal importance placed on choosing western and Chinese medicine".

Health care reform has greatly benefited from pharmacists' expertise in providing safe and reasonable drug use among the general public. However, China still lacks well-trained pharmacists, resulting in inequitable distribution of limited professionals. The Twelfth Five-Year Plan provides an excellent opportunity to accelerate the training of necessary professionals, especially to strengthen capacities of rural areas to deliver quality medical care.

药品流通体制次优选择

来源：财新《新世纪》 2012 年 11 月 23 日
http://china.caixin.com/2012-11-23/100464448.html

新医改即将进入第五个年头之际，一份试图以药品流通体制改革根治“以药养医”的方案也在紧密筹措。此项改革早在上轮医改即作为重头内容推出，却因路径变形，最终未能成功实施。今年 9 月，国务院医改办已将其起草的改革方案送至卫生部、商务部等医改相关部委商榷。11 月初，商务部又召开内部会议深度研讨。据财新记者了解，方案涉及药品流通的诸多领域，包括重建药品流通秩序、杜绝药品回扣，改革药价形成机制、推动医药分开等。各部委在内部讨论时，均表示这一方案可以试行。对于人社部门而言，“二次议价”降低医疗费用，有利于医保控费；对于卫生部门而言，药品折扣阳光化，也有利于加强对公立医院的监管，同时为提高医疗服务价格留出空间。目前，各部委已分别围绕方案展开调研，待意见汇总后将由国务院出台正式文件。

在不少学者看来，这轮重启药品流通体制改革的最大亮点，不过是让一项关键的定价规则退回上一轮医改之前。具体措施也被业内称为“二次议价”，即在现阶段通过各省级政府招标采购议定的最高零售价基础上，再允许医院自主和药企进一步谈判议价，将以往药企留给医生的回扣翻明，医院直接受益。

尽管此次改革方案只是在现有药价管制下的局部调整，但在不少专家看来，至少可能推动公立医院进一步的改革，乃至放开对药品价格的管制。不过，放开“二次议价”能否达到这样的改革初衷，显然还需要一系列的政策配套。专家指出，如果没有卫生行政部门和公立医院的配套改革，目前的改革阻力都无法转化为改革动力。国务院医改专家咨询委员会委员李宪法认为，此法旨在实质性降低虚高的药价，由此逐步撬动“以药养医”机制。李宪法告诉财新记者，卫生部部长陈竺在 2012 年 10 月 19 日的全国药品集中采购工作会议上，已经明确提出药品采购应向阶梯式报价、量价挂钩探索，即根据不同的采购量、回款时间议定药品采购价。“这都不可能以政府为主体来做，必须以药品的实际采购方医院为主体，把采购决策权还给医院。”

但中国社科院经济所公共政策研究中心主任朱恒鹏则对财新记者表示：“在政府不愿放开药价管制的情况下，‘二次议价’是一个次优选择。”中国医药企业管理协会会长于明德也指出，在医院作为事业单位未能改制的情况下，“二次议价”解决药品回扣的作用都十分有限。按照财政部现行规定，事业单位的人员支出不能超过总支出的 30%，如果医院院长不能把挤出的回扣部分用来激励医生提供更好的医疗服务，改革必然不会成功。此外，即便“二次议价”在最理想的状态下推行，药品回扣问题得到抑制，也不能改变医院主要收入仍来自药品的事实。“提高医生收入和提高医疗服务价格是两个概念。”

Second Best Option for Drug Distribution System

In this fifth year of New Health Care Reform, a new plan under intense discussion is circulating in responsible ministries, aiming to permanently abolish the practice of using drug sales to fund medical services. This new plan will cover a range of areas such as re-establishing the order of drug distribution, ending drug sale kick-backs, reforming drug price negotiation process, and pushing for separation of medical services provision and drug sale.

For many scholars, the most important change in this plan is the so called “second bargaining”: after provincial government negotiation with pharmaceutical companies, allowing each hospital to do a second round of negotiation. This way, hospitals can directly benefit from a lower price.

Even though this is a partial adjustment under current drug price regulation, it could possibly push for much needed progress in the reform. However, for any meaningful changes to occur, responsible ministries and public hospitals have to implement supporting policies. Otherwise, current reform resistance cannot be transformed into reform motivation.

Many scholars labeled this new plan as the “second best choice”. Currently, medical care provision and drug sales are still tied up in hospitals. Since any reduction in drug price eats into hospitals’ profit margin, it is unlikely the new plan could substantially reduce drug over-pricing.