

## Calculation of Health Management-Oriented Capitation Payment Standards for Chronic Diseases in Primary Care Outpatient Settings: A Postprint Study

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### Abstract

Outpatient medical services represent a crucial component of medical insurance payment method reform. As comprehensive reform of medical insurance payment methods for inpatient medical services is advanced nationwide, the reform of diversified outpatient payment methods—such as capitation payment and the APG points method—will gradually be placed on the agenda. Exploring capitation payment focused on chronic diseases aligns with the evolving health paradigm shifting from disease-centered treatment to health-centered management. This study, based on capitation payment practices from various countries and regions domestically and internationally, uses Beijing's C District and H District as case studies. Through analysis of basic medical data (including healthcare and medical insurance data) and basic public health service funding, it estimates capitation payment standards for major chronic diseases in primary care outpatient settings, thereby providing references for advancing outpatient chronic disease capitation payment reform.

### Full Text

#### Study on the Measurement of Capitation Payment Standards for Chronic Disease Management in Primary Care Outpatient Settings: A Case Study of Districts H and C in Beijing

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## Abstract

Outpatient medical services constitute a critical component of medical insurance payment system reform. As China comprehensively advances payment reform for inpatient services, diversified outpatient payment methods such as capitation and the APG points-based system will gradually be implemented. Exploring capitation payment focused on chronic diseases aligns with the evolving health paradigm shifting from disease-centered treatment to health-centered management. Drawing upon capitation practices from various countries and regions, this study uses Districts C and H in Beijing as case examples. By analyzing basic medical data (medical treatment and insurance) and essential public health service funds, we calculate capitation payment standards for major chronic diseases in primary care outpatient settings, providing a reference for promoting chronic disease capitation payment reform.

**Keywords:** Medical insurance payment reform; Chronic diseases; Outpatient capitation payment; Health management; Standard measurement

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## Introduction

Against the backdrop of the Healthy China strategy, the medical model is transitioning from disease treatment to health promotion, necessitating a corresponding shift in China's healthcare security model from disease financial protection to health management. In 2017, the General Office of the State Council issued "Guiding Opinions on Further Deepening the Reform of Basic Medical Insurance Payment Methods" (Guobanfa [2017] No. 55), proposing the implementation of capitation payment for primary care services and actively exploring payment methods that integrate capitation with chronic disease management. In July 2019, the State Council released "Opinions on Implementing Healthy China Actions" and "Healthy China Action Plan (2019-2030)," emphasizing the critical role of chronic disease prevention and treatment and calling for reform of chronic disease insurance payment methods to improve the healthcare security system. In February 2020, the Central Committee of the Communist Party of China and the State Council issued "Opinions on Deepening Healthcare Security System Reform," proposing the establishment of an efficient medical insurance payment mechanism and advancing capitation payment for outpatient special chronic diseases. Chronic diseases represent a major public health issue affecting national economic and social development. Reforming chronic disease payment

through capitation will support the realization of the Healthy China strategy and represents an inevitable trend in China's medical insurance payment system reform.

China's existing chronic disease insurance system primarily provides ex-post compensation for patient expenses, playing only a passive role in payment and risk control. Unreasonable insurance systems accelerate the growth of chronic disease medical costs, placing heavy pressure on basic medical insurance funds. Meanwhile, the treatment-focused medical model neglects health management and chronic disease prevention, resulting in poor patient compliance and increasing chronic disease prevalence. Capitation payment, a prospective payment system, calculates per capita quotas based on the number of patients served by medical institutions. The total fund is determined according to the institution's revenue and expenditure situation using a "revenue-based expenditure" approach. Medical expenses are prepaid periodically to institutions following a "annual prepayment, year-end assessment, surplus reward, and shared overspending" model. This payment method helps medical institutions control medical costs while fostering a health-oriented medical model that incentivizes healthcare providers to deliver high-quality chronic disease management services, ultimately achieving effective chronic disease control and improved health outcomes.

Many countries have adopted capitation payment to control rising medical costs. For example, the United Kingdom uses capitation in its family doctor gatekeeper system; the United States employs capitation in its "managed care" model under HMO arrangements; and some developing countries in Southeast Asia, such as Thailand, have implemented the "30 Baht Plan." Some regions in China have also begun exploring chronic disease management integrated with payment reform, including Tianjin's implementation of capitation for special chronic disease outpatient categories, Zhenjiang's exploration of diversified chronic disease payment methods, Changde's implementation of capitation coordinated with a first-visit system, and Jinhua's reform combining outpatient capitation with APG points-based payment. These domestic and international practices provide valuable references for this study. Using Districts C and H in Beijing as examples, this study analyzes basic medical data and essential public health service funds to calculate capitation payment standards for major chronic diseases in primary care outpatient settings, providing a reference for promoting chronic disease capitation payment reform.

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## 1.1 Study Site Selection

Research shows that chronic disease characteristics and healthcare-seeking behaviors differ between suburban and urban patients. Therefore, this study selected one urban district and one suburban district in Beijing as research sites: District C (urban) and District H (suburban). District C passed accreditation in 2011 as one of the first 39 national chronic disease demonstration zones in

China. During its establishment as a national chronic disease comprehensive prevention and control demonstration zone, District C implemented multiple prevention and control initiatives, including establishing organizational and financial safeguards; conducting community diagnosis and various chronic disease surveillance activities; carrying out health education and promotion campaigns; using “blood pressure measurement at first visit for individuals over 35” and “family doctor contracted services” as entry points for high-risk population identification and intervention; and using hypertension, diabetes, and weight self-management groups as entry points for patient management.

District H created the “Beijing Chronic Disease Comprehensive Prevention and Control Demonstration Zone” in 2013 and the “National Chronic Disease Comprehensive Prevention and Control Demonstration Zone” in 2017. Leveraging these opportunities, District H made beneficial explorations in chronic disease comprehensive prevention and control, including establishing a district government-led demonstration zone construction leadership group, creating multi-departmental collaboration mechanisms, integrating chronic disease prevention and control into economic and social development plans, incorporating chronic disease prevention into departmental policies and regulations, and establishing effective performance management and evaluation mechanisms. Under the organization of the district health commission, District H established a comprehensive chronic disease prevention and control system with the district health commission’s community management center, district CDC chronic disease department, and three secondary-grade hospitals as leaders, 16 community health service centers as links, and community stations or village clinics as the foundation, featuring integrated prevention and treatment, collaborative division of labor, and coordinated linkages. Community health service centers and village clinics provide six-in-one services for community residents centered on health records, including prevention, healthcare, health education, chronic disease management, rehabilitation, and medical treatment, while conducting inspections, guidance, and evaluation work. They manage and provide follow-up services for chronic disease patients such as those with hypertension and diabetes within their service areas. Both Districts C and H have conducted extensive explorations and practices in chronic disease prevention and management in recent years and possess relatively comprehensive chronic disease insurance-related data, making them suitable sample areas for this study.

## 1.2 Disease Selection

Based on current national and Beijing municipal requirements for chronic disease management, this study selected four major chronic diseases as research subjects: hypertension, diabetes, coronary heart disease, and stroke.

## 1.3 Data Sources

We collected three years (2017-2019) of data from both districts on incidence rates, health expenditures, average compensation costs per visit, and out-of-

pocket payments for the four chronic diseases. These chronic disease case data were organized and analyzed to provide data support for capitation payment calculation (data from 2020 were used only as reference due to COVID-19 impacts).

## 1.4 Calculation Methods

**1.4.1 Basic Medical Care Calculation Methods** Regarding the calculation of total outpatient pooling funds and benchmark capitation fees, the World Bank recommended two methods in its report: bottom-up costing and top-down allocation. The bottom-up approach calculates the total funds required for outpatient pooling and benchmark capitation fees by estimating individual health service expenditures. The top-down approach extracts a predetermined proportion from the total medical insurance fund as outpatient pooling funds, then calculates the amount allocated to each insured individual (i.e., the benchmark capitation fee) based on the total number of insured individuals.

Based on chronic disease outpatient insurance data from the community management centers and community health service centers in the two selected districts, this study used the bottom-up method to calculate the benchmark rate for chronic disease basic medical care in District C. The formulas are as follows:

Calculate per capita expenses based on historical data to determine the three-year average per capita expense:

Formula (1)

Where represents the per capita expense level for a certain chronic disease in the past three years,  $n$  represents the year, and  $X_n$ ,  $X_{n-1}$ ,  $X_{n-2}$  represent per capita expenses in the past three years.

Calculate the benchmark capitation fee:

Where represents the annual per capita expense level for a certain chronic disease in the past three years,  $M$  represents the benchmark capitation fee, and  $D$  represents the per capita out-of-pocket payment.

The top-down method was used to calculate the benchmark rate for chronic disease basic medical care in District H. The formulas are as follows:

Formula (2)

Determine the total fund:

Calculate the benchmark capitation fee:

Total Fund = Total Expenses  $\times$  Reimbursement Rate  $\times$  (1 + Growth Rate) Formula (3)

$$\text{Benchmark Capitation Fee} = \frac{\text{Total Medical Insurance Fund}}{\text{Number of Patients with Certain Chronic Disease}} \quad \text{Formula (4)}$$

$$\text{Number of Patients} = \frac{\text{Number of Visits}}{\text{Average Number of Visits}} \quad \text{Formula (5)}$$

**1.4.2 Essential Public Health Service Components** The purpose of chronic disease capitation payment is to shift primary care providers' focus from disease treatment to disease management, thereby improving residents' overall health status. Under a disease treatment model, chronic disease patients primarily seek medication services at the primary care level. However, under a health-oriented disease management model, the current medical services provided by primary care institutions cannot meet chronic disease patients' needs. Primary care institutions must provide not only medical services but also health education, physical examinations, health monitoring, and other health management services for chronic disease patients. Based on preliminary literature review and field research, essential public health projects include chronic disease health management services. Therefore, when calculating chronic disease capitation fees, we included both the portion of essential public health service funds allocated to chronic disease management and Beijing's current compensation for contracted family doctor services for key populations (chronic disease patients). Additionally, to enable early detection of chronic disease patients and timely intervention, regular auxiliary examination items for different chronic diseases should also be included.

**1.4.3 Chronic Disease Capitation Payment Calculation Standard** In summary, the chronic disease capitation fee standard should be the sum of the basic medical care benchmark capitation fee, chronic disease management-related funds from essential public health service projects, family doctor contracted service fees, and regular auxiliary examination fees for chronic disease patients. The formula is as follows:

$$\text{Chronic Disease Capitation Fee Standard} = \text{Basic Medical Care Benchmark Capitation Fee} + \text{Chronic Disease}$$

## 2.1 Calculation of Basic Medical Care Benchmark Capitation Fee in District C

**2.1.1 Basic Chronic Disease Management Situation in District C** District C is located in the central-southern part of Beijing's main urban area, with a permanent population of 3.45 million, including 49.4% males and 50.6% females. The population aged 60 and above totals 708,869, accounting for 20.5%.

In 2014, the diabetes prevalence rate among residents aged 18 and above in District C was 14.9%, and the hypertension prevalence rate was 37.2%. Figure 1 [Figure 1: see original paper] shows the number of chronic disease patients in each age group served by District C's health service centers in 2019. The figure indicates that among the four chronic disease patient groups, the 60-74 age group accounts for the largest proportion, followed by the 45-59 and 75-89 age groups.

**2.2.2 Bottom-Up Calculation of Chronic Disease Outpatient Benchmark Capitation Fee in District C** Based on data provided by District C's Community Management Center from 2017-2019, we calculated per capita expenses for each chronic disease. Because the 2020 data were affected by the pandemic and outpatient expenses differed from non-pandemic periods, we did not use 2020 data to calculate per capita expenses.

**Table 1** 2017-2019 Annual Per Capita Outpatient Expenses for Hypertension, Diabetes, Coronary Heart Disease, and Stroke (Yuan)

Using Formula (1), we calculated that District C's three-year average per capita outpatient expense was 3,253.94 yuan for hypertension, 4,008.04 yuan for diabetes, 1,420.13 yuan for coronary heart disease, and 1,397.76 yuan for stroke.

**Table 2** 2017-2019 Per Capita Out-of-Pocket Payments for Hypertension, Diabetes, Coronary Heart Disease, and Stroke (Yuan)

Using Formula (2), we calculated District C's benchmark capitation fees as 2,559.18 yuan for hypertension, 3,227.63 yuan for diabetes, 1,139.93 yuan for coronary heart disease, and 1,147.66 yuan for stroke.

### 2.2.1 Basic Chronic Disease Management Situation in District H

District H is a remote suburban district of Beijing, located in the city's northeast, with a permanent population of 440,000, including 53.3% males and 46.7% females. The population aged 60 and above totals 86,216, accounting for 19.5%. According to a 2016 survey, the prevalence rates of the four chronic diseases among adult residents in District H were, in order: hypertension (49.19%, standardized rate 31.57%), diabetes (17.12%, standardized rate 12.32%), coronary heart disease (9.10%, standardized rate 5.94%), and stroke (5.93%, standardized rate 3.58%). The "Report on Chinese Residents' Nutrition and Chronic Disease Status (2015)" released by the State Council Information Office in June 2015 indicated that the national prevalence rates among adults aged 18 and above were 25.2% for hypertension and 9.7% for diabetes. Both hypertension and diabetes prevalence rates in District H exceed national levels, making chronic disease prevention and management in District H extremely urgent.

### 2.2.2 Top-Down Calculation of Chronic Disease Outpatient Benchmark Capitation Fee in District H

This study estimated the total chronic disease medical insurance fund in District H by multiplying the 2020 expenses for the four chronic diseases at a community health service center in District H by the reimbursement rate and growth rate. According to data from District H' s Medical Insurance Bureau, the outpatient expense growth rate at community hospitals in 2019 was 8%. In 2021, the outpatient medical insurance reimbursement rate at Beijing community hospitals was 90%.

**Table 3** Total Medical Insurance Fund for Hypertension, Diabetes, Coronary Heart Disease, and Stroke (Yuan)

Using Formula (3), we predicted that District H' s 2021 medical insurance fund totals would be 8,601,659.71 yuan for hypertension, 9,349,253.55 yuan for diabetes, 570,872.06 yuan for coronary heart disease, and 458,120.53 yuan for stroke.

Under normal circumstances, chronic disease patients visit community health service centers monthly for medication. However, in 2020, Beijing introduced long-term prescription services for chronic diseases during the pandemic. On February 20, 2020, the National Healthcare Security Administration issued a notice allowing patients with stable conditions requiring long-term medication, including those with hypertension, diabetes, coronary heart disease, cerebrovascular disease, and chronic obstructive pulmonary disease, to receive prescriptions for up to 12 weeks. We estimated the average number of visits in 2020 to be 7.

**Table 4** Benchmark Capitation Fees for Hypertension, Diabetes, Coronary Heart Disease, and Stroke

Using Formula (4) and the top-down method, we calculated District H' s benchmark capitation fees as 2,368.11 yuan for hypertension, 3,864.70 yuan for diabetes, 3,050.46 yuan for coronary heart disease, and 3,698.78 yuan for stroke.

### 2.3.1 Essential Public Health Service Fees

Currently, the national essential public health service subsidy is 79 yuan per person, with an increasingly comprehensive service scope. China' s essential public health services comprise 14 items, and the chronic disease capitation payment service package should include health record management, health education, physical examinations, and chronic disease health management from essential public health service projects.

### 2.3.2 Family Doctor Contracted Service Fees

In the 2019 notice "On Improving Performance-Based Salary Policies in Primary Medical and Health Institutions to Ensure Family Doctor Contracted Services" jointly issued by the Beijing Municipal Human Resources and Social Security

Bureau, Beijing Municipal Finance Bureau, and Beijing Municipal Health Commission, contracted residents were divided into key populations and general populations. Key populations include children, pregnant women, individuals aged 65 and above, chronic disease patients, and patients with severe mental illnesses. In 2019, the contracted service fee for key populations was 70 yuan per person per year.

### **2.3.3 Regular Auxiliary Examination Fees for Different Chronic Diseases**

Regular auxiliary examinations for chronic disease patients should be included in chronic disease health management projects under essential public health services. Patients with stable or rehabilitated chronic diseases share the common characteristic of requiring long-term medication and regular health monitoring. However, different chronic diseases have different rehabilitation or treatment protocols, requiring different regular auxiliary examination items. Based on literature review and expert interviews, we determined the necessary auxiliary examination fees for different chronic disease patients. Examination fee standards reference the medical service price standards published on the official website of the Beijing Municipal Medical Insurance Bureau.

According to the “National Guidelines for Primary Hypertension Prevention and Management (2020 Edition),” all hypertensive patients should undergo 1-2 evaluations annually, with necessary auxiliary examinations including blood routine (15 yuan), urine routine (35 yuan), three biochemical items (12 yuan), and dynamic electrocardiogram (200 yuan). For those with access, optional examinations include ambulatory blood pressure monitoring (150 yuan), echocardiography (300 yuan), carotid ultrasound (220 yuan), urine albumin/creatinine ratio (100 yuan), chest X-ray (140 yuan), and fundus examination (6 yuan). Calculating two hypertension evaluations annually, the required auxiliary examination fee is 2,176 yuan per hypertensive patient per year.

The “National Guidelines for Primary Diabetes Prevention and Management (2018)” recommends measuring fasting blood glucose and two-hour postprandial blood glucose at least weekly (6 yuan), and checking glycosylated hemoglobin every three months (80 yuan). For diabetic kidney disease screening, primary care institutions should conduct at least annual screening for all diabetic patients, including urine routine (35 yuan) and serum creatinine (20 yuan) tests, with UACR testing (100 yuan) in areas with conditions. For fundus disease, diabetic patients should undergo fundus examination every six months (6 yuan), including fundus fluorescence angiography (400 yuan) and color Doppler ultrasound angiography (40 yuan). For vascular disease, annual vascular ultrasound is recommended, including carotid ultrasound (380 yuan), bilateral lower extremity arterial ultrasound (290 yuan), cranial CT (400 yuan), abdominal ultrasound (140 yuan), and cardiac CT every four years (300 yuan). The cost for diabetic patients receiving systematic and comprehensive regular examinations is 2,584 yuan.

For stable coronary heart disease patients, the “Guidelines for Primary Diagnosis and Treatment of Stable Coronary Heart Disease (2020)” recommends re-examination every 3-6 months, including blood routine (15 yuan), thyroid function (180 yuan), electrocardiogram (200 yuan), chest X-ray (120 yuan), and echocardiography (300 yuan). Calculating re-examination every four months, the annual auxiliary examination fee for coronary heart disease patients is 2,445 yuan.

The “Chinese Guidelines for Diagnosis and Treatment of Acute Ischemic Stroke (2018)” recommends that stroke patients in the stable sequelae stage undergo re-examination every six months, including blood routine (15 yuan), four lipid items (60 yuan), liver function (220 yuan), neck vascular color ultrasound (300 yuan), and brain MRI (700 yuan). The total annual auxiliary examination fee for stroke patients is 2,590 yuan.

## 2.4 Capitation Fee Standards for Districts C and H

**Table 5** Capitation Fee Standards for Four Chronic Diseases in Both Districts

Using Formula (6), we calculated District H’s capitation fee standards as 4,693.11 yuan per person for hypertension, 6,597.70 yuan for diabetes, 5,644.46 yuan for coronary heart disease, and 6,437.78 yuan for stroke. District C’ s standards were 4,884.18 yuan for hypertension, 5,960.63 yuan for diabetes, 3,733.93 yuan for coronary heart disease, and 3,886.66 yuan for stroke.

**Figure 2 [Figure 2: see original paper]** Comparison of Benchmark Capitation Fees for Four Chronic Diseases in Both Districts

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## 3.1 Comparison of Capitation Fees for Four Chronic Diseases

Figure 2 shows that the benchmark capitation fees for diabetes and hypertension are similar between Districts H and C, but District H’ s fees for coronary heart disease and stroke are significantly higher than District C’ s. This may be because hypertensive and diabetic patients are more inclined to visit community hospitals, while coronary heart disease and stroke patients prefer secondary and tertiary hospitals. District H is a remote suburban area of Beijing with relatively fewer medical resources. District C, located in the urban area, has relatively abundant medical resources with numerous secondary and tertiary hospitals, so coronary heart disease and stroke patients in District C choose to visit large hospitals, resulting in lower expenses at community hospitals. However, the number of patients is fixed, leading to lower calculated benchmark capitation fees than in District H. Research shows that urban chronic disease patients are more inclined to visit large hospitals, possibly because urban chronic disease patients have higher incomes, and over half of urban chronic disease patients have urban employee medical insurance or public medical insurance, making

them less sensitive to community hospital costs than suburban patients and resulting in lower willingness for community first visits.

### 3.2 Factors Affecting Capitation Fee Standard Calculation

The calculation method directly affects the benchmark capitation fee. This study used both bottom-up and top-down methods to calculate capitation fees for different regions, each with advantages and disadvantages. The bottom-up method calculates total outpatient pooling funds and benchmark capitation fees by estimating individual health service expenditures. This method better reflects actual health expenditure but may underestimate actual needed expenditures due to weak health maintenance awareness, insufficient medical resources, or underdeveloped local economies. The top-down method first determines the total fund amount, then calculates benchmark capitation fees based on the total number of insured individuals. Total prepaid budgeting is a prerequisite for top-down capitation calculation, and the reasonableness of total fund calculation affects chronic disease capitation payment standard measurement. The top-down method was used for District H because it has implemented total budget control for basic medical insurance, making fund determination relatively straightforward.

Furthermore, basic medical expenses for chronic diseases vary according to age, gender, health status, and other factors. Therefore, capitation fees should be risk-adjusted based on chronic disease patients' health status, presence of multiple chronic conditions, geographic location, and historical medical expenses. Epidemiological evidence of relationships between specific risk factors and chronic disease incidence and mortality forms the basis for selecting risk adjustment factors, enabling risk adjustment of "capitation fees" based on different population risk levels using regression models. In a study by Ai Lihuan on risk-adjusted capitation payment standard measurement using Shenzhen as an example, a two-part model was used to select risk adjustment factors, and a logistic regression model identified factors affecting individual outpatient visit probability, including gender, age, insurance tier, community health service center location, and presence of chronic or serious diseases. The U.S. HMO capitation payment model uses age, gender, systolic blood pressure level, serum cholesterol level, glucose tolerance level, left ventricular hypertrophy, smoking status, gender-glucose tolerance interaction, and age-cholesterol interaction as indicators of individual health status. Risk adjustment for chronic disease capitation should also consider disease severity and comorbidities. Different disease severity levels involve vastly different costs, so chronic disease populations should be categorized by severity when defining service packages. Different severity levels should have different payment standards, though defining severity criteria for each patient is difficult and data acquisition is challenging. Additionally, when defining capitation payment service packages, the issue of patients with multiple chronic conditions should be considered, with corresponding adjustments to capitation standards to ensure insurance fairness and avoid duplicate purchasing of health

services.

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#### **4.1 Provide Personalized Basic Medical and Public Health Service Packages for Different Chronic Disease Patients**

Different chronic disease populations require different health services. Therefore, personalized service items should be designed according to chronic disease type and severity. For example, stroke patients have different prognoses and complications, requiring different regular auxiliary examinations and follow-up treatment items with significant cost variations. Consequently, personalized capitation payment service packages should be designed based on chronic disease type and severity, adjusting capitation payment standards at the individual level for different chronic diseases.

#### **4.2 Further Enhance Chronic Disease Management and Service Capacity of Community Health Service Institutions to Improve Contract Rates**

Currently, most community health service institutions have insufficient service capacity and quality, unable to meet patient needs, resulting in low patient trust. Even for minor illnesses, patients prefer large hospitals. The first-visit system at the community level is the foundation for implementing capitation payment. Only by integrating family doctor contracted services with capitation payment can community family doctors leverage their proximity advantages and emotional connections with residents to provide proactive, continuous diagnosis, treatment, and health management services, thereby enhancing residents' trust in primary care. Based on establishing contractual relationships between residents and primary care institutions, personalized contracted service packages should be explored to meet residents' health needs and strengthen their compliance with primary care institutions. The capitation payment mechanism involves patients selecting medical institutions, so primary hospitals can only increase capitation payment funds by improving service quality and chronic disease health management capacity to raise patient contract rates, maximizing the utility of limited "capitation fees."

#### **4.3 Establish Effective Incentive and Assessment Mechanisms for General Practitioners to Reasonably Allocate Capitation Payment Surpluses**

The 2019 notice "On Improving Performance-Based Salary Policies in Primary Medical and Health Institutions to Ensure Family Doctor Contracted Services" issued by the Beijing Municipal Health Commission proposed establishing a primary care performance-based salary growth mechanism, creating family doctor contracted service incentive mechanisms, and improving tiered performance assessments to enhance community health service capacity and quality. Under

the capitation payment model of “annual prepayment, year-end assessment, surplus reward, and shared overspending,” medical institutions are incentivized to strengthen chronic disease patient management, delay disease onset and progression, ultimately achieving medical insurance fund savings and improved patient health. When medical institutions improve insured individuals’ health levels, service volume decreases, creating surpluses in capitation payment funds. Therefore, robust assessment methods matching outpatient capitation payment should be established, along with effective fund surplus allocation mechanisms, to integrate family doctor services with capitation payment contract management and collaboratively promote high-quality development of payment reform and family doctor contracted services.

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