frequencies were available. Shares of tests by therapies (OAD/INSULIN) were 10% and 20% respectively, and patients performed 2.8 (47.5%). For OAD/INSULIN the frequencies were 2.8 and 2.2. Doctors rated the SMBG adherence as good or very good in 43% of cases. CONCLUSIONS: In community centers the vast majority of patients have type 2 diabetes. FPG values were broadly documented, but the therapy quality marker HbA1c was not available in most of the patients. SMBG was more common with insulin users, but clearly below guideline recommendations. It needs to be deter-
mained which measures could potentially improve the current practice in diabetes care in order to strengthen the role of community health centers in managing the diabetes epidemic in China.

**PHP114** FAILING TO SHARE INCOME FROM THE SALE OF HEALTHY LANDS IN INDI

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**OBJECTIVES** With high costs of some oncology and biological therapies, manufactu-
\[...\]

**PHP115** INFLUENCE OF THE NEW RURAL COOPERATIVE MEDICAL SCHEME (NRCMS) ON ACCESS TO MEDICATIONS IN MONGOLIA

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**OBJECTIVES** The purpose of this survey was to provide health cover for outpatients with chronic diseases. The NRCMS has begun to provide health care to outpatients with chronic diseases. The NRCMS has been designed to improve the health care situation of the Mongolian population. In response to this situation, the New Rural Cooperative Medical Scheme (NRCMS) has begun to provide health cover for outpatients with chronic diseases, mainly possible by the increased risk pool of recent years. We compared the differences between benefit packages for chronic disease outpa-
tients in 32 counties, in order to assess their population reach, equity and cost implications and to formulate recommendations for policy makers. METHODS: To evaluate the various benefit packages that were being run by the National New Rural Cooperative Medical Scheme Websites in the Chinese at the end of 2009. We developed a conceptual frame-
work based on the three main criteria: 1) population coverage; 2) service coverage; and 3) costs with various subcategories to compare benefit packages in 32 counties across China. Chronic diseases were classified according to the ICD-10. RESULTS: With the exception of avoiding “moral hazard” certain measures were developed complex processes to define benefit packages for chronic diseases. These have resulted in substantial differences in benefits: good equity and cost between counties. In most counties chronic disease patients find it very difficult to become beneficiaries. Forty chronic disease packages were identified in the 32 counties, varying between 4 and 28 per individual county. We also found large discrepancies in co-payment rates, deductibles, ceilings, coverage of drugs and tests, accredited hospitals and reimbursement frequency. CONCLUSIONS: Reimbursement proce-
dures are remarkably diverse in different counties. Population coverage, service coverage and cost of benefit packages for chronic diseases vary substantially in the 32 counties studied. This reflects the new policy of decentralization of decision making to the county-level resulting in a “postcode lottery” of patient benefits. National regulation to redress these inefficiencies and inequities is urgently needed.