

# Options for a Drug Reimbursement Scheme for primary care in Tbilisi (Family Medicine Centers)

DFID Georgia Primary Care Project  
WHO in collaboration with IHSD

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## Table of Contents

1.	Introduction.....	2
2.	Situation analysis .....	2
	2.1. Primary Care Funding .....	2
	2.2. Burden of disease .....	3
	2.3. Drug requirements .....	5
	2.4. Family Medicine Centres .....	6
	2.5. Drug use management mechanisms .....	7
	2.6. Preconditions with regard to the drug reimbursement scheme .....	7
	2.7. Conclusions .....	10
3.	Drug reimbursement options.....	11
	3.1. Objectives .....	11
	3.2. Option A - Kutaisi Model.....	12
	3.3. Option B - Selected social groups .....	13
	3.4. Option C - Selected drugs.....	13
	3.5. Option D - FMC model with differentiated benefits (groups/diseases).....	14
4.	Recommended next steps.....	15

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## 1. Introduction

This Options Paper is part of the DFID funded project to establish a Family Medicine concept in 5 pilot primary care centers in Tbilisi. This paper will discuss the possibility of developing and implementing a drug reimbursement scheme for pharmaceutical products within this DFID funded primary health care project in Tbilisi.

During the development and implementation of the scheme DFID funding foresees in investments in the management and training of this drug reimbursement scheme and will contribute to improved drug prescribing and use through training and monitoring.

In addition this paper will look at the possibilities of involving the Tbilisi City Health Committee and municipal funding in this reimbursement concept with the aim to broaden the scheme

As the current discussion is about options and budgetary allocations, this paper does not contain a full description of one concept, but presents different options, including the Kutaisi-experiment. Once decisions are made on which model to choose, a more detailed 'Concept Paper' will be produced that will form the operational basis of the scheme's implementation. Large parts of this concept paper are already available, in particular background material like drug lists, calculation tables, etc.

## 2. Situation analysis

This situation analysis evaluates current drug financing levels in Georgia, the financial burden of outpatient care for the population, the current position of the family medicine centers, and tools used for drug management. It also includes an evaluation of the current health care setting in which the scheme should function and assess whether the initial necessary conditions for a successful implementation of the scheme are in place.

### 2.1. Primary Care Funding<sup>1</sup>

Public sector financing for Primary Care flows through a number of different state programs, which are administered by the State Medical Insurance Company (SMIC), Municipalities and the Public Health Department. Government funding for health care in Georgia is very low (app. US\$5.57 per capita or 13% of total health expenditure). Furthermore this amount is spread over a wide range of programs and is disbursed in a very complicated and non-transparent way. By far the most common source of private health expenditure are unregulated and unaccounted for payments made direct to providers. On average 15%<sup>2</sup> of Tbilisi municipal funding was actually spent on Primary Health Care services; that is 2.9 Lari in per capita terms<sup>2</sup>.

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<sup>1</sup> Source: Financing of Primary Health Care in Georgia; DFID February 2001; George Gotsadze, Sara Bennett

<sup>2</sup> Average figure for the period 1997-1999

The introduction of the ACP program within the municipality program per 1 October 2002 foresees the following contributions on a per capita basis:

- For age groups of 65 years and older: ..... 15.25 Lari per capita
- For 14 to 65 years: ..... 1.39 Lari per capita
- For 3-14 years: ..... 7.46 Lari per capita

There is no indication that drugs are included in these per capita amounts.

With regard to drug financing the following programs are active:

**Table 1 Health financing programs and drug coverage**

Program	Current status	Beneficiaries	Drug cover
SMIC program	Active	Cost of 3 pharmaceuticals only for 3 groups of patients:	Direct procurement or reimbursement pharmacies:
		300 patients with Diabetes Insipidus	Desmopressin
		55 patients with kidney transplants	Cyclosporin
		15,400 patients with Diabetes Mellitus	Insulin
PHD Program	Active	Expanded Program of Immunization	Vaccines
Municipality Program	Active	Oncology Patients	Direct procurement or reimbursement of pharmacies of Painkillers for terminal oncology patients
	Intended	Program for vulnerable groups (200 to 400,000 Lari)	Unknown
	Intended	Drug reimbursement scheme contributions (1 Lari per capita = 1.2 million Lari for Tbilisi)	Scheme under discussion (this Options Paper)

The current active programs only cover a very limited of drugs for very selective target groups. The main purpose of the current health financing mechanisms is therefore to finance an inefficient health care system, while 50% or more of the patient's health expenditure is spent on drugs (covering more than 95% of all drug costs in the country).

## 2.2. Burden of disease

### Household survey<sup>3</sup>

The average fee paid per outpatient consultation was 48.22 Lari. Care provided by specialists was significantly more expensive than that provided by district doctors and nurses. Care provided in the hospital setting was significantly more expensive than that provided in the polyclinic. The outpatient fee contains the cost of medicines (54.45%), i.e. 24 Lari per capita.

The costs of health care services, which are born by patients on an out-of-pocket basis, are a significant barrier to accessing care. Nearly 40% of people falling sick during the

<sup>3</sup> Source: Health Service Utilization and Expenditures in Tbilisi – 2000 ; Report of a Household Survey; Curatio; July 2001

past 30 days refused to seek care, self-treated rather than sought professional help, or had to stop treatment prior to completion due to financial reasons (in 20% of the households).

More than half of the outpatient illness burden is caused by the *cost of pharmaceuticals*. In addition, in case of hospitalization, many people will need to buy their medication out-of-pocket in pharmacies. The burden of disease therefore increases substantially when people are hospitalized after a period of outpatient treatment, or vice versa, when outpatient treatment follows a hospitalization period. The average expenses per treatment period then are 108 Lari per case, but with significant differences per diagnosed disorder or disease and income group.

Health conditions with above average cost-per-case and high total costs<sup>4</sup>, accounting for 52% of the total expenditure, are:

**Table 2 Highest cost of care per illness episode by diagnosis**

Diagnosis	Number of cases	Expenditure per case	Total expenditure
Cancer	9	1,107	9,960
Other chronic diseases	22	255	5,605
Pregnancy related problems	7	582	4,073
Neurological	23	173	3,981
Gallstones	7	405	2,837
Other acute illness	18	137	2,459
Check-up or preventive services	15	131	1,968
Total this group	101	306	30,883
Total for all diagnoses	552	108	59,886

Other conditions with above average cost per case (however with a relative low prevalence) are: psycho-emotional disorders (273 L.), ulcers (165 L.), harm purposely inflicted by others (159 L.), car accidents (150 L.), and rheumatism (148).

**Table 3 Variation of household expenditures by group and type**

Group	Type	Number of cases	Health expenditure per case
All respondents	Health expenditure over treatment period	552	108 lari
	Cost of outpatient treatment	622	48 lari
All except richest quintile (67% of population)	Health expenditure over treatment period	371	53 lari
	Cost of outpatient treatment	417	29 lari
All respondents	Pilot districts		+7%
	Chronic conditions		+44%
	Pregnancy		+107%
	Hospital specialist		+100%
	Alternative provider		+80%
	Specialist home visit		+46%

<sup>4</sup> [Number of cases] x [Patient expenditure per case]

When excluding the richest people from the survey results, the expenses are almost half of the average. Certain health conditions and care providers substantially increase the costs for patients.

The Household survey leads to the following conclusions about care-seeking behavior of low-income population groups:

- They prefer home-visits, ambulance and other forms of free or low-cost care (alternatively: no care).
- They choose more often a GP over a specialist than other population groups.
- They have their own informal risk-pooling mechanism through borrowing from friends and relatives, while at the same time having low confidence in insurance mechanisms (unless the state is assuming this function).

### 2.3. Drug requirements

Based on the Standard Treatment Guidelines (STG) that are used in the family medicine practice in Georgia (and incorporated in the Family Physician training curricula) the drug requirements per 1,000 population has been calculated. The list of required drugs as derived from these STG was corrected by including only items that are on the Essential Drugs List of *Georgia* and of the *World Health Organization*. A further correction was made to include forms that are more commonly used in Georgia (although not on the essential drugs list). The diagnosis for which the drug is required and the ICD-10 diagnostic code have completed this list.

In addition the pharmacy retail price of each drug was added to the list and the total cost per drug treatment, based on required quantities per STG. This gave indications of (a) the consumer price per treatment case, and (b) the total cost per drug in a population of 1,000 people.

**Table 4 Cost categories of required drugs for adults and children<sup>5</sup>**

Price category	Adults			Children		
	Nr.	Total costs	Share	Nr.	Total costs	Share
Drugs < 5 Lari per treatment	74	71.584	91,3%	37	1.941	54,9%
Drugs 5-10 Lari per treatment	6	3.233	4,1%	7	848	24,0%
Drugs > 10 Lari per treatment	3	3.548	4,5%	3	748	21,1%
Total	83	78.365	100,0%	47	3.537	100,0%

For adults drugs priced at 5 Lari or more account for 9% of the total requirements, for children this percentage is higher, namely 45%.

When looking at the total cost of the required drugs, this adds up to 82,000 Lari per 1000 inhabitants per year. This would imply that for outpatient drugs the market would be 400 million Lari per year. This is not in line with the current estimations of the total market in Georgia, which is assessed at 60 to 80 million USD, i.e. 130 to 175 Lari. Therefore we have to conclude that the current drug requirements (in terms of cost) are a clear

<sup>5</sup> Full lists not included, but available upon request

overestimation by 7-8 times. This also illustrates the level of under-consumption of drugs in outpatient care and the potential for growth in case these drugs would be fully reimbursed.

## 2.4. Family Medicine Centres

The Family Medicine Centres (FMC's) started in April 2002 with the registration of patients. Since then attendance has increased to higher levels than before. The development is also depending on the organisational and competitive situation per FMC. In two districts FMC's completely cover the district's population, in two other districts the FMC's are in a more competitive situation with another (or more) polyclinics.

**Table 5 Family Medicine Centres in Tbilisi**

District	Households in district <sup>6</sup> HH	Family Medicine Centres					
		Name	Households served		Registered FMC <sup>7</sup>		
			Nr.	% of HH	Nr.	% of HH	
Chugiureti	20,600	Nr. 17 Adult & Family Medicine Training Centre	10,300	50%	F: ? R: 16,740 C: 1,029	41%	
Mtacminda	15,800	Adults polyclinic Nr.9 Vere21	10,000	63%	F: 5,120 R: 15,000 C: ?	80%	
Saburtalo	13,700	Preventive Medicine Centre Nr.1	13,700	100%	F: 1,513 R: 4,850 C: 1,000	29%	
Vake	19,000	Polyclinic Nr.28			F: ? R: 22,150 C: ?	58%	
		Children polyclinic Nr.9	19,000	100%	F: 1,960 R: 7,900 C: 3,480	31%	
Tbilisi TOTAL	400,000		53,000	13%	F: 42,000	11%	

F: Families; R: Residents; C: Children

The number of registered patients is promising; although there is no guarantee that registered patients actually seek health care at the FMC's. Registration is at no cost and bares no obligation for the patient. At this point in time, the FMC's have to compete with other primary care providers, like other adult and children polyclinics, specialized out-patient facilities (maternity care, oncology, emergency care) and with private practitioners (which may or may not be employed in polyclinics). This may have several implications:

- Registered patients of one facility may actually receive care somewhere else – most likely from a variety of providers. The same is true for families or family members.
- The patients visiting the FMC's may likely to be heavy users of health care.

<sup>6</sup> Source: Household Survey

<sup>7</sup> Status per June 2002

- Non-users or light-users of primary care do not contribute to the cost of disease and thus increase the financial burden for the heavy users.
- The scarce capitation-based funds are continued to be thinly spread over an excessive number of facilities and physicians, by this keeping the revenues too low for all facilities, physicians and specialists (and encouraging the direct patient payments to physicians).

For the purpose of the drug reimbursement scheme, the actual attendance rates per registered family would be more relevant. It also would be relevant to know the actual registration of complete families and the characteristics of these families. This to estimate the potential use of health care (FMC's) as well as to assess the risk of negative selection within the FMC population (i.e. possible overrepresentation of heavy users like chronic patients, elderly and families with young children attend the facilities).

## 2.5. Drug use management mechanisms

In a well-organized health care system drug lists, formularies, treatment protocols (or guidelines), drug use monitoring, monitoring or prescribing and the use of prescription forms to follow the drug and/or the patient are common. They either are part of the health care system or managed by an insurance fund. In Tbilisi the situation is as follows:

**Table 6 Drug use management mechanisms in Tbilisi**

<b>Mechanism</b>	<b>Available</b>	<b>Comment</b>	<b>Implication for drug scheme</b>
Drug lists	Yes	Especially developed for FMC's	Will be reimbursement list
Formularies	Yes	Developed recently for primary care specifically	Determines the drug list and improves compliance
Treatment protocols	Some available	Others are used from other countries (UK)	Determines the drug list and improves compliance
Drug use monitoring	No	-	Drug scheme records can be an excellent basis for monitoring
Prescribing monitoring	No	On ad hoc basis	Drug scheme records can be an excellent basis for monitoring
Prescription forms	No	Only for narcotics	Introduction is necessary precondition. Shopping around of patients is a complicating factor.

Introducing prescription forms is major and necessary precondition for any drug scheme to function and to avoid misuse or fraud. The fact that patients shop around for outpatient care is a complicating factor – when they would stick to the FMC's this could be easily managed.

## 2.6. Preconditions with regard to the drug reimbursement scheme

The environment in which a drug reimbursement scheme can successfully be implemented is determined by more than drug system characteristics alone. Therefore it is useful to see whether the original assumptions are still valid and whether external factors are sufficiently in favor of a successful implementation of the scheme.

**Table 7 Assumptions, status and implications for drug reimbursement scheme**

Precondition / assumption	Current status	Implications for the drug reimbursement scheme
1. <u>Initial assumptions within the DFID project definition:</u>		
a. Initial phase of drug reimbursement scheme connected with the five pilot Family Medicine Centers (FMC's).	Requirements of the Tbilisi Municipality demand that the scheme will be made available also to other polyclinics.	<ul style="list-style-type: none"> <li>• This gives the FMC's only a limited head start.</li> <li>• Complications to be foreseen in scheme management (prescriptions, benefits, entitlements, groups, etc.)</li> <li>• Too demanding task within the current budgets from DFID (covering initial management of the scheme)</li> </ul>
b. Draw heavily on experiences with a pilot system by WHO in 1996-2000 in Kutaisi.	Current discussions revisit the extensive discussion around the Kutaisi pilot; alternative schemes are again considered.	Even with adoption of another scheme, the starting point preferably should be a Kutaisi-like concept that can be modified over time to fit the needs of patients, the FMC's, the Municipality and others.
c. Strong emphasis on poverty relief, including poor and vulnerable groups of the population.	One conclusion from the Kutaisi-experiment (see also other sources) is that any scheme should be based on middle income groups, and attract the vulnerable through special discounts (funded by community or scheme)	<ul style="list-style-type: none"> <li>• The primary targets of the scheme will be middle-income groups.</li> <li>• Special discounts for vulnerable are second.</li> </ul>
2. <u>Regarding the FMC's the assumptions were:</u>		
a. FMC's are a starting point of new primary care in Georgia, rolled out in other districts of Tbilisi in the coming years.	<ul style="list-style-type: none"> <li>• Today the FMC's are to develop their practice in a competitive environment (as old polyclinics remain), with an evaluation in 2003.</li> <li>• Further development only after positive evaluation.</li> <li>• No funds foreseen for rollout after 2004.</li> </ul>	<ul style="list-style-type: none"> <li>• Development of the FMC concept limited to 5 centers for the coming years. Basis for growth of an FMC-connected drug scheme limited.</li> <li>• FMC's are not the only option for outpatient care; Patient loyalty the only connecting mechanism; System does not stimulate staying with one doctor.</li> <li>• Complications for drug scheme due to choice and lack of system encouragement</li> </ul>
b. FMC's organized and preferred legal and financial treatment by health authorities	<ul style="list-style-type: none"> <li>• No common FMC organization has been established;</li> <li>• No preferential legal and financial treatment of FMC's foreseen.</li> <li>• Other polyclinics remain in operation, keeping inefficiencies intact and allowing big differences in quality of care.</li> </ul>	<ul style="list-style-type: none"> <li>• Separate organization for drug scheme to be established</li> <li>• Individual contracts with each FMC.</li> <li>• Complex scheme management and control due to lack of structure and organization in primary care; minimum conditions by contract.</li> </ul>

Precondition / assumption	Current status	Implications for the drug reimbursement scheme
3. <u>With regard to the financial situation the assumptions were:</u>		
a. Comprehensive financing mechanism for primary care initiated (allowing reduced patient contributions service for essential care)	<ul style="list-style-type: none"> <li>• APC services introduced per 1-10-02.</li> <li>• Financing mechanisms remain scattered and funding through different channels.</li> <li>• No inclusive share for drug treatment foreseen.</li> </ul>	<ul style="list-style-type: none"> <li>• Patient contributions remain substantial</li> <li>• Drug expenditure remains burden for patient</li> <li>• Access to primary care problematic due to direct payments</li> <li>• Membership fees for drug scheme will form a big barrier (together with other patient payments)</li> </ul>
b. Funds available for drugs (1 Lari per capita pledge from Minister)	<ul style="list-style-type: none"> <li>• Pledged funds for drugs still only an intention.</li> <li>• No budgets allocated.</li> </ul>	<ul style="list-style-type: none"> <li>• <u>In view of lacking other financing mechanisms this is the only budget that can relieve the burden of drug expenses for certain groups.</u></li> <li>• In case this funds are not made available the drug scheme will have a very narrow coverage and focus on middle-income groups / families only. No room for participation or discounts for vulnerable people.</li> </ul>
4. <u>Other issues</u>		
a. Prescription forms used	Currently prescription forms are only used for narcotics.	<ul style="list-style-type: none"> <li>• Depending on the method of reimbursement, prescriptions probably need to be reintroduced.</li> <li>• This can only be done when collaborating with FMC's or policlinics that agree on using prescription forms (at no additional cost for patients); to be included in contracts.</li> </ul>
b. Active involvement of the Tbilisi Municipality Health Authority	Tbilisi Municipality Health Authority has become an active partner in development of the scheme. Programs under their management are APC (no drugs), painkillers for oncology, budget for vulnerable, possibly the 1 Lari budget (see 3.b.)	<ul style="list-style-type: none"> <li>• Involvement is a big support, but also complicates the start-up by demanding citywide approach.</li> <li>• Organizational questions to be resolved</li> <li>• Coverage can be widened</li> </ul>
c. Include Ministerial Program	Provision of selected chronic patients with pharmaceuticals (diabetes, kidney transplants): Insulin, desmopressin and cyclosporin.	<ul style="list-style-type: none"> <li>• Inclusion probably at a later stage after initial introduction.</li> <li>• Drug scheme will not be involved in procurement; only reimbursement</li> </ul>

Positive conditions and developments are: (1.b.) the availability of a tested scheme that can be reviewed and lessons of a pilot included in the Tbilisi design; (3.b.) the pledged 1 Lari per capita for drugs is still being considered – a necessary condition for the scheme to reach out to vulnerable patients; (4.b.) the active involvement of the municipality (when materialized) allows for improvements in the concept, funding organization and coverage of the drug scheme.

On the other hand many of the conditions and assumptions are not very much in favor of a successful development and implementation of a drug reimbursement scheme. The environment is less organized than expected; foreseen improvements have not been achieved or were only partly realized.

*The main concern is that no progress has been made to improve the solidarity (healthy pay for sick; rich pay for poor) and risk pooling within the health system. This implies that the risk of negative selection for the reimbursement scheme remains very high when the scheme has to work on a voluntary basis (resulting in the scheme to go bankrupt at an early stage). A compulsory system would be ideal to avoid this negative selection. A contribution from the state/community may make a drug scheme attractive and accessible for vulnerable people (poor groups or heavy users of health care / drugs).*

*The other concern is that the current setting makes the introduction a more demanding task than initially foreseen with regard to organization and management, financing and to achieve an acceptable coverage.*

## **2.7. Conclusions**

In summary the above described situation analysis results in the following conclusions with a certain impact on the feasibility of one or more drug reimbursement options.

1. Primary care funding (including the FMC's) is still very low (and financing an inefficient oversupply of services and facilities) and almost no contributions for drugs are made. The intention to include 1 Lari per capita for drugs is a necessary and welcome start, and a necessary precondition to attract poor people to the scheme. The ACP program could in addition make available a certain % of the per capita funds for drugs.
2. Half of the expenses on outpatient care are drug expenses. On average 54 lari for the treatment period and 24 lari for outpatient treatment. When excluding the richest (with the highest expenses) these figures are 26 lari and 15 lari respectively. (This last figure comes close to the 13 lari average expenditure in the Kutaisi survey).
3. The household survey illustrates that certain providers and certain conditions can substantially increase the cost of care (and drugs). The drug reimbursement scheme should take special notice of these unfavorable situations.
4. Low-income population groups have special ways of avoiding risks and find in family and friends their own risk pooling mechanism (for the lucky ones). They avoid insurance like schemes (no priority when not sick).

5. The drug requirements as derived from Standard Treatment Guidelines used in FMC's by far exceed the current consumption levels. One may expect that patients will avoid these expenses and will show low levels of compliance with prescribed medication.
6. The FMC's are up and running and registration is promising. However, there is no guarantee that attendance will substantially increase, while at the same time they are now based in a competitive situation where patients remain to make their own choice regardless of where they are registered. For the drug scheme this implies that there are more prescribers and pharmacy outlets than the GP's connected to the FMC or the pharmacies close to the FMC's.
7. Administering any drug scheme requires the use of prescription forms. Reintroduction however seems complicated if patients should be allowed to receive reimbursable care outside their FMC.
8. The current preconditions for introducing a drug reimbursement scheme are less favorable than originally anticipated. The lack of solidarity mechanisms in the current health care system (insurance principle), together with the lack of public funds, increases the risk of negative selection of only (chronic) sick patients entering the scheme. A state or community contribution is absolutely necessary to make any drug scheme accessible for poor people.
9. The low degree of organization in the current setting requires more efforts from the scheme to function and to manage enrollment (coverage, attractive package) and benefits (financing).

### **3. Drug reimbursement options**

#### **3.1. Objectives**

The objectives of a primary care drug reimbursement scheme is not to compensate all patients for all drugs, but rather to provide compensation for people for whom the drug costs (whether per case or over time) are too high and a barrier for seeking health care or taking the advised medication (resulting in ineffective care and increased morbidity and mortality). In particular a drug reimbursement scheme should:

1. Compensate people for high drug expenses.
2. Reduce barriers for seeking outpatient care and encourage compliance with a rational drug treatment.
3. Socially fair. Covering a wide range of people with the possibility to compensate within the system (include healthy and/or wealthy people to improve benefits for sick and/or poor people).
4. Relatively easy to implement and administer in the current situation: for patients, doctors, management as well as pharmacists.
5. Possibility to eventually include state programs and/or hospital drugs and to be able to operate under a future health insurance system

6. Be able to provide accurate information on drug use, benefits, and financials.

The reimbursement scheme should NOT compensate drugs that are supposed to be provided through state programs and hospitals, unless the state or the patient pays extra to perform this function.

The options presented here are not accompanied by a budget calculation (to justify the 1 lari per capita expenses), because in any model the benefits can be defined in such a way that any budget can be absorbed by the scheme in a relevant and justifiable way. This budgeting exercise will be done after choices are made.

### 3.2. Option A - Kutaisi Model

The Kutaisi reimbursement system (called *Drug Polis*) is a voluntary drug insurance system, under which people are not charged a premium payment related to their salary but a fixed participation fee (the price of the booklet), regardless of their income.

During 1996–1997, a new drug reimbursement concept (Drug Polis) was developed by the WHO Special Project for Newly Independent States (NIS) in collaboration with the Georgian health authorities, and tested in Kutaisi since October 1997. This new concept is a voluntary insurance scheme, for which a fixed participation fee (the price of a booklet i.e. 2 Lari) is levied regardless of income. Benefits are: 20% reduction in the fee for visiting a doctor, 10% discount on prescription drugs below an accumulated annual expenditure of 100 Lari, and 50% reimbursement for all additional prescription drugs per year<sup>8</sup>.

The pilot showed that a comprehensive drug reimbursement system appeals to two thirds of the population. This system, where benefits increase with growing drug expenditure, can be financially feasible and well managed in the Georgian setting. It is however less viable as a voluntary independent scheme (negative selection) and should be incorporated in a health insurance scheme or primary health care package. The public appreciated the fixed premium or fee per insured person, independent of income. This is useful knowledge for other areas of health insurance. It was recommended that this scheme should be continued in a wider setting, preferably in combination with health insurance funds or an integrated primary health care project.

The scheme's benefits are based on prescription forms, a drug list (widely available), and patient's booklet (for registration of all listed drugs purchases).

*A separate report and evaluation survey (patient responses) are available.*

The suggested model allows certain variations, such as:

- Discounts on the participation fee (price of booklet) for certain vulnerable groups.
- Higher discounts for certain groups.

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<sup>8</sup> Suggested changes were to calculate the discount levels on expenses per month or quarter rather than year and to offer different discount levels at different booklet prices.

- Higher discounts for certain drugs.

Public sector contributions can be used to increase discounts on the listed drugs or to reduce the participation fee for certain selected groups (as was the intention in Kutaisi, where the Imireti Health Authority would bear the participation costs of a identified vulnerable families).

**Table 8 Kutaisi model – example**

Example	Participation fee	Benefits	Financed by
Kutaisi pilot	2 Lari per person	1. 10% discount on prescription drugs till 100 lari annual expenditure	Participants Pharmacies
		2. 50% discount on prescription drugs expenses above 100 lari annual	Scheme
		3. 20% discount on fee for GP	Polyclinics

### 3.3. Option B - Selected social groups

Another option is only to seek compensation for excessive drug costs for patients that belong to a certain well-defined group of the population. Such as: identified vulnerable people, elderly, single parent families, or children.

This automatically implies negative selection and the scheme then becomes a single financing mechanism of public funds that are made available for this purpose.

The positive element is the targeted approach to these families that are certainly in need of assistance. This however can only be realized when the identification of these patients is easy and simple (for example age).

A potential problem is the identification of the groups and the avoidance of misuse and fraud. When including poor families, this approach may very well not work, as these groups tend to avoid special programs targeted at them. They generally prefer to belong to a commonly accepted and used system, in which they can obtain special benefits.

**Table 9 Group based model – example**

Example	Participation fee	Benefits	Financed by
Group based model	Free entry for selected defined groups	1. x% discount on prescription drugs	Municipality
		2. y% discount on fee for GP	Polyclinics / FMC's

### 3.4. Option C - Selected drugs

Options C can be based on either a list of diseases or a list of drugs. Based on the household survey a reimbursement scheme could be targeted at:

List of diseases (see Table 2 page 4):

- Pregnancy related problems
- Oncology
- Chronic diseases

Neurological  
Gall stones  
Other acute illnesses

List of drugs (see Table 4, page 5): Drugs costing more than 5 Lari per pack; i.e., 9% of the drugs for adults and 45% of the drugs for children.

A drug reimbursement scheme based on one or both of these lists could compensate a certain percentage for every FMC patient or depending on population group or age.

For administrative reasons it would be easy to differentiate according to drug price and listed drugs rather than to differentiate according to disease (difficult to judge at the pharmacy counter).

**Table 10 Drug based model – example**

Example	Participation fee	Benefits	Financed by
Drug based model	All registered patients free entry	<ol style="list-style-type: none"> <li>x% discount on on drugs priced &gt; 5 Lari</li> <li>y% discount on fee for GP</li> </ol>	<p>Municipality</p> <p>Polyclinics / FMC's</p>

### 3.5. Option D - FMC model with differentiated benefits (groups/diseases)

The Kutaisi model could be modified in such a way that a more differentiated scheme of benefits is offered per population group and depending of the price of the drug, bt based on family participation. For example:

**Table 11 FMC model (modified Kutaisi model) – examples**

Example	Participation fee	Benefits	Financed by
FMC scheme standard	4 Lari per family	<ol style="list-style-type: none"> <li>20% discount on drugs priced &gt; 5 Lari</li> <li>50% discount on prescription drugs when expenses above 25 lari per quarter</li> <li>10% discount on GP fee in FMC</li> </ol>	<p>Participants</p> <p>Municipality / pharmacies</p> <p>Scheme</p> <p>FMC</p>
FMC scheme vulnerable	1 lari per family	<ol style="list-style-type: none"> <li>20% discount on all prescription drugs</li> <li>60% discount on prescription drugs when expenses above 25 lari per quarter</li> <li>50% discount on GP fee in FMC</li> </ol>	<p>1 lari by participants, 3 lari by municipality</p> <p>Municipality / pharmacies</p> <p>Scheme</p> <p>FMC</p>
FMC scheme elderly	2 lari per family	<ol style="list-style-type: none"> <li>20% discount on on drugs priced &gt; 5 Lari</li> <li>50% discount on prescription drugs when expenses above 15 lari per quarter</li> <li>20% discount on GP fee in FMC</li> </ol>	<p>2 lari by participants, 2 lari by municipality</p> <p>Municipality / pharmacies</p> <p>Scheme</p> <p>FMC</p>

As we are working within a Family Medicine development program the drug scheme should preferably be based on family participation. This implies that single persons may

join the scheme, but at a family price level. This will encourage families to join, by which we will include healthy people in the scheme.

#### **4. Recommended next steps**

This paper is meant to offer options and is part of a decision making process. It is clear that main variables for this decision making process are:

1. Evaluate whether the external factors can be changed in a way that the setting becomes more favorable for the successful implementation of the drug reimbursement scheme.
2. Set priorities on which groups and items to reimburse and choose an adequate model to do so.
3. Allocate adequate funds and arrange proper payment mechanism
4. Create a simple, but efficient organization to manage the drug reimbursement scheme in close collaboration with the city health authorities and the Family Medicine Centers.
5. Work out the complete reimbursement system based on the choices made.
6. Make an action plan for implementation.

It is recommended to evaluate this paper and the options that have been presented in a workshop with the main stakeholders, in any case including the city health committee, the family medicine centers and representatives of the department of pharmacy of the ministry of health.

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