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**Reform of the Health Care Financing System in Georgia**

GVG

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# Financial Master Plan for Kakheti Region

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## 1. Introduction

The Financial Master Plan is our proposal for the organisation and financing of the planned Family Medicine (FM) facilities and services in Kakheti Region. The Master Plan aims to support the necessary political decisions that lie ahead with relevant and appropriate data.

The Financial Master Plan for Kakheti Region has been elaborated within the framework of the EU/Tacis project "Support to Primary Health Care Development in Georgia: Reform of the Health Care Financing System". The project is being implemented by a consortium of the companies GVG and EPOS.

The overall objective of the project is to support reform of the health care financing system towards sustainable financing of Primary Health Care (PHC) services, with an emphasis on provision of sustainable and affordable access to PHC services for the poorest section of the population and guidance of the reform of financial mechanisms and administrative processes required for PHC. The proposals elaborated by the project have to be piloted in Kakheti Region, with the intention of a nationwide roll-out in the future.

One of the targets to be achieved by the project is elaboration of this Regional Health Care Financing Master Plan for Kakheti Region, which will feed into the creation of a National Health Care Financing Master Plan.

During the first year of the EU project, a sound conceptual framework regarding the main financial and administrative mechanisms to be implemented in PHC has been developed by international and local experts. The Master Plan harnesses the maximum available information concerning costing, remuneration and health care provision and builds upon previous analytic work within the project as well as on mutual exchange of information with domestic analytical staff and the staff of other projects.

The background document to the Financial Master Plan for Kakheti describes different options for various aspects of FM development, and detailed calculations of the financial consequences of each option. On the basis of this background information, this Master Plan presents only the preferred options.

This Master Plan proposes options for a sustainable situation in Kakheti after the transition period is completed, but it also presents cost tables for the transition years 2006-2008. It is valid not only for Kakheti, but for all regions where FM will be introduced, and eventually for the whole country.

The Master Plan is based on the results achieved by the project team, on mutual cooperation with other project teams acting in this field – EU/HLSP, DFID/OPM, USAID/CoReform and the World Bank – and on preliminary decisions taken by the PHC Board and the Ministry of Labour, Health and Social Affairs (MoLHSA).

### *The Master Plan advocates the following policies:*

## 2. Development of the FM network

Catchment areas of 2,000 patients and travel times up to 15 minutes have been used for planning the PHC network. For Kakheti, this means that 57 institutions should be refurbished and 206 teams (each comprising a doctor and a nurse) should be retrained. We propose that 206 doctor-nurse teams would work in these 57 facilities, plus a small number of family nurses would work alone (but be co-ordinated by the nearest FM practice) in remote villages. Non-refurbished institutions should be removed from the public system in the medium-term future.

***Table 1. Facilities and Teams***

| | Type of Networking | | Number of Facilities | Number of Retrained FM Teams |
|---|---|---|---|---|
| | Catchment Area | Travel Time | | |
| **1. Current Situation** | Unspecified | Unspecified | 159 | 585 (not retrained) |
| **2. GVG Proposal** | 2000 | Max. 15 min | 57 | 206 + several family nurses |

## 3. Legal status of FM facilities and PHC staff

Most FM institutions should become non-profit or for profit legal entities detached from polyclinics. Independent FM practices can choose to operate under various legal statuses: as a limited liability company, entrepreneurship, union or foundation.

The FM doctors should become executive managers (directors) of these legal entities in the case of solo and dual practices contracted by respective local governments and/or MoLHSA. Professional executive managers may be hired for larger group practices and paid out of costs foreseen for management functions. Other non-medical staff should be hired by these legal entities. Certain functions (cleaning, accounting, security) may be out-sourced.

The FM institutions will be (at least at the start of the reform) mainly state-owned. However, private FM practices – paid by the public purchaser according to non-discriminatory terms and leasing state-owned or using private facilities – have to be considered as an option.

## 4. Management of PHC

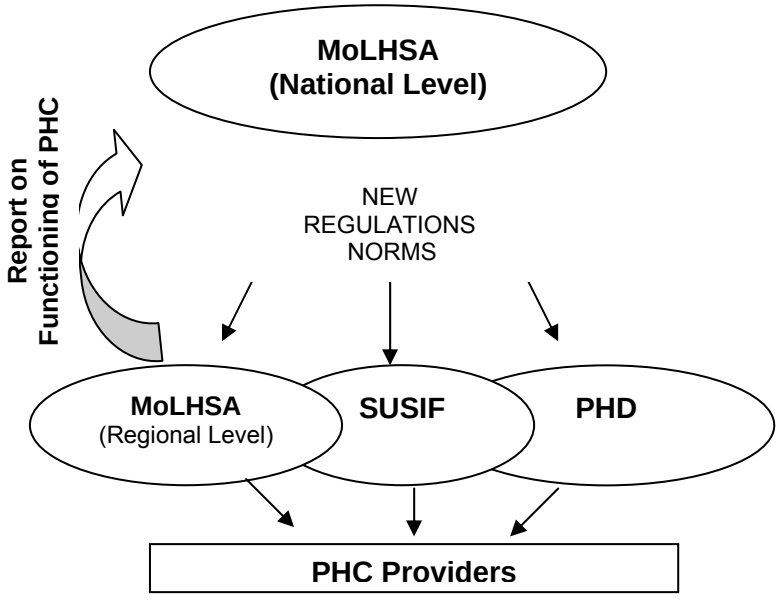
MoLHSA, within the state budget allocation, decides on the allocations for each state health programme. This includes in particular the PHC budget and the content of each programme. MoLHSA issues licenses to health care providers to deliver particular health care services and sets the norms for accreditation of facilities.

The State United Social Insurance Fund (SUSIF) will be in charge of implementation of the PHC programmes through several major functions: by contracting the providers, commitment control, monitoring and budget execution, including remuneration of the providers. The regional SUSIF administration will be directly in charge of contracting the selected FM-based PHC institutions. The regional SUSIF office should reimburse the FM practices after verification of their invoices. There should be no direct relation between the Ministry of Finance and the FM providers.

The national Public Health Department (PHD) and the regional PHD centres should inform the providers and the regional MoLHSA office about statistical health reports and local health needs.

The FM practices will be obliged to report all legally-required data to MoLHSA, SUSIF and the PHD according to the official time schedule.

***Scheme 1. Management***

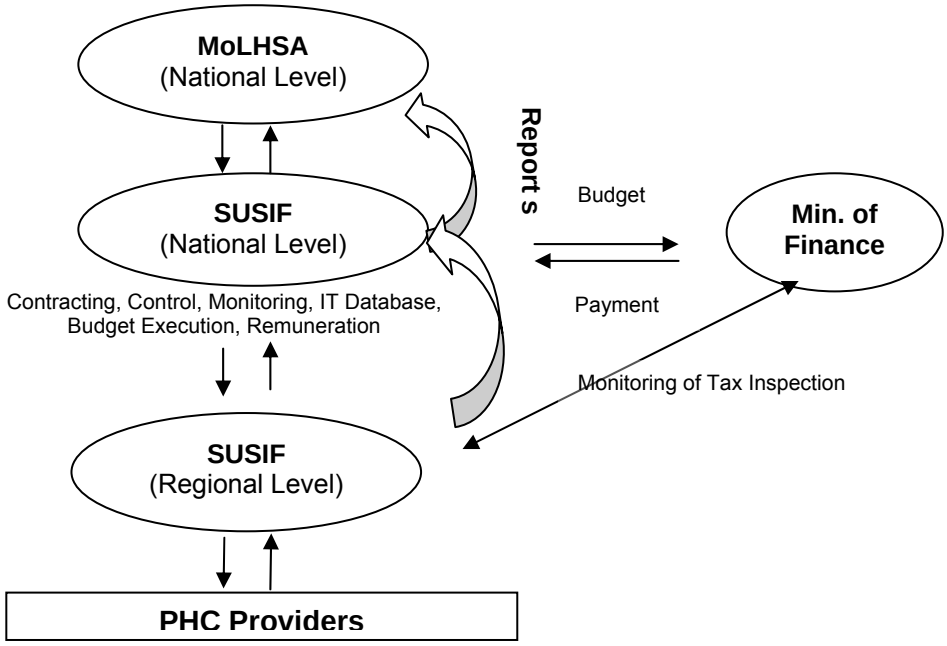


## 5. Contracting of PHC

The service delivery contract will be concluded between the PHC provider as a legal entity and the public purchaser (SUSIF) for implementation of the benefits package. The contract will also stipulate conditions for working times, reporting, quality assurance and payment methods.

The contract period should be a fiscal year. A leasing contract will be concluded between the PHC provider as a legal entity and the relevant representative of state or municipal property in cases where the legal entity will be separate from the real estate.

***Scheme 2. Contracting***




## 6. Basic Benefit Package

The Basic Benefit Package (BBP) defines what the population is entitled to under full or at least partial public coverage.

The BBP for the new PHC system has the following main components: preventive, curative, laboratory, drugs.

Preventive component

- health promotion activities
- standard list of immunisations and check-ups
- health check-ups for military draftees

Curative component

- all visits for any complaint to the practice during working hours
- all urgent visits to the practice outside working hours
- all urgent home visits
- follow-up of TB patients

Laboratory component

- standard list of laboratory tests

Drugs component

- positive list of live-saving medicines.

Equity, accessibility and long-term financial sustainability of PHC are criteria that should be well thought-out for the final decision as to whether the BBP is provided free or with certain co-payments. A drugs benefit scheme, with substantial contributions from patients' out-of-pocket payments, also has to be considered.

Services that are not included in the BBP but can still be provided by PHC physicians have to be paid for by a patient. The FM practice must give cash receipts to patients for co-payments and for services outside the BBP, and also for services to non-registered patients.

All inhabitants with permanent residence in Georgia should be entitled to the BBP.

The organisation and financing of the free FM services must be described in a legally-binding document. Presently, this is the annual State Ambulatory Programme. In the medium-term future, a law approved by Parliament should define the framework of these developments.

## 7. Provision of the Basic Benefit Package

Residents will have to register themselves at the provider of their choice. If a citizen is not registered, he or she will have to pay for PHC services according to the tariffs of the provider without any public subsidy.

A patient will be entitled to public subsidy of elective care at the secondary or tertiary level only on referral by the PHC provider he/she is registered with (the "gate-keeping" function).

## 8. Costs of FM practices

Salaries of medical personnel should be increased to 250 Lari per month for a PHC doctor and 150 Lari per month for medical nurse, with 20% social insurance tax in addition.

Office space for PHC practices is assumed to be worth 500 Lari per $m^{-2}$. An office space of 70 $m^2$ is considered sufficient for a solo PHC practice.

Annual running costs for a solo PHC practice (without depreciation, drugs and laboratory costs) are reckoned to be 10,778 Lari for 2006 and 11,800 Lari for 2008[1]. Depreciation of facilities has to be covered by the contract between the PHC provider as a legal entity and the public purchaser (SUSIF) in cases where the facilities are owned by the practice.

It is assumed that one laboratory will serve five medical teams on average. Therefore, one-fifth of the costs for a laboratory have been allocated to the costs of a solo FM practice. The assumption was also made that one computer per PHC health care facility will be sufficient during the transition period.

[1] an annual inflation rate of 5% is assumed

***Table 2. Costing of FM Solo Practice for 2006***

| *Cost item* | *Unit costs for practice* | *Share of total costs (%)* |
|---|---|---|
| *Medical personnel* | *5,760* | *31.2* |
| *Non-medical functions (managerial etc)* | *504* | *2.7* |
| *Training* | *510* | *2.7* |
| *Medical supplies for practice* | *989* | *5.3* |
| *Office supplies* | *435* | *2.4* |
| *Communications* | *211* | *1.1* |
| *Utilities* | *875* | *4.7* |
| *Fuel for generators* | *263* | *1.4* |
| *Services* | *633* | *3.4* |
| *Maintenance* | *598* | *3.2* |
| *(Total running costs)* | *(10,778)* | *(58.1)* |
| *Laboratory personnel* | *562* | *3.0* |
| *Medical supplies for laboratory* | *242* | *1.3* |
| *Medical supplies for immunisations* | *587* | *3.2* |
| *Medical supplies for preventive check ups* | *314* | *1.7* |
| *Laboratory operational costs* | *595* | *3.2* |
| *Non-recurrent costs (practice)* | *4,587* | *24.8* |
| *Non-recurrent costs (laboratory)* | *810* | *4.4* |
| *Total (Lari)* | *18,475* | *100.0* |

*Table 3. Costing of FM Group Practice (5 Teams) for 2006*

| Cost item | Unit costs for practice | Share of total costs (%) |
|---|---|---|
| Medical personnel | 28,800 | 37.3 |
| Non-medical functions (managerial etc.) | 2,520 | 3.3 |
| Training | 1,684 | 2.2 |
| Medical supplies for practice | 4,666 | 6.0 |
| Office supplies | 1,969 | 2.6 |
| Communications | 528 | 0.7 |
| Utilities | 3,666 | 4.8 |
| Fuel for generators | 413 | 0.5 |
| Services | 2,031 | 2.6 |
| Maintenance | 1,933 | 2.5 |
| (Total running costs) | (48,210) | (62.5) |
| Laboratory personnel | 2,811 | 3.6 |
| Medical supplies for laboratory | 1,209 | 1.6 |
| Medical supplies for immunisations | 2,937 | 3.8 |
| Medical supplies for preventive checks up | 1,572 | 2.0 |
| Laboratory operational costs | 2,976 | 3.9 |
| Non-recurrent costs (practice) | 13,370 | 17.3 |
| Non-recurrent costs (laboratory) | 4,050 | 5.3 |
| Total (Lari) | 77,135 | 100.0 |

## 9. Remuneration of FM

A combination of budgetary financing and remuneration per capita (per enrolled patient) is considered as the best option. Maintenance of the facilities may be covered from budget funds. Labour costs and medical supplies may be partially or fully covered by the capitation element.

The remuneration system has to provide a financial incentive for medical personnel to work in all practices (including those established in remote areas) as well as create motivation for the productivity and efficiency of FM providers. The proposal is to cover personnel costs, managerial and support services and medical supplies by capitation and office supplies, communications, utilities, maintenance and depreciation by a budget fixed for each type of institution (solo practice, dual practice …. up to a group practice composed of 5 teams). An example of the break-down of funding for a solo practice is presented in Table 4.

***Table 4. Remuneration of FM Solo Practice in 2006***

| | ***Costs*** | ***Capitation per 1 enrolled*** |
|---|---|---|
| ***Capitation for personnel costs, managerial and support services, medical supplies*** | ***7,815*** | ***3.9*** |
| ***Budget for other recurrent costs and non-recurrent costs (depreciation)*** | ***10,073*** | |
| ***Total costs (Lari)*** | ***17,888*** [2] | |

The combination of budgetary financing and remuneration per capita allows for a reasonable level of maintenance of facilities as well as certain incentives for productivity. Economies of scale may be achieved if the practice manages to attract more then 2,000 enrolees; see Table 5:

***Table 5. Remuneration of FM Solo Practice for Different Catchment Populations in 2006***

| | ***Per 1 enrolled*** | ***Per 1,000 enrolled*** | ***Per 2,000 enrolled*** | ***Per 3,000 enrolled*** |
|---|---|---|---|---|
| ***Capitation for personnel costs, managerial and support services, medical supplies*** | ***3.9*** | ***3,900*** | ***7,800*** | ***11,700*** |
| ***Budget for other recurrent costs and depreciation*** | | ***10,072*** | ***10,072*** | ***10,072*** |
| ***Total costs per practice (Lari)*** | | ***13,972*** | ***17,872*** | ***21,772*** |
| ***Total costs per 1 patient enrolled*** | | ***14.0*** | ***8.9*** | ***7.3*** |

The health care needs of different demographic groups vary significantly. Health care delivery costs in remote (especially mountainous) areas usually are higher in comparison to those in larger settlements. It is recommended to adjust capitation payments according to the age of the enrolled population as well as geographical criteria. An example of adjustment according to the age of the population served is presented in Table 6:

***Table 6. Adjustment by Age Category*** [3]

| Age category | 0-1 | 1-3 | 3-15 | 15-65 | 65+ |
|---|---|---|---|---|---|
| Index (age adjuster) | 3.3 | 2.1 | 1.2 | 1.0 | 1.1 |

[2] Medical supplies for immunisations (costed at 587 Lari for a solo FM practice) were not included as it is assumed they will be provided to FM practices in kind (as is presently the case). This accounts for the difference between this figure and the total costs given in Table 1.

[3] The age indexes are based on the utilisation data from SUSIF for 2003 (all Georgia except Tbilisi). However, the age adjuster for elderly people is very small and should be recalculated once newer data is available. Should the unrealistic value persist, an adjustment based on information from other sources must be made. The age adjuster for people aged 65+ should be around 2.5.

MoLHSA has to establish a positive list of drugs to be included in the BBP as well as reference prices for reimbursed drugs, thereby setting the maximum amount the public purchaser will pay for a selected group of drugs.

## 10. Implementation of the Master Plan

- A national consensus on the main aspects of PHC financing reform has to be achieved (this Master Plan will have to be adjusted according to information generated during the consensus-building activities)
- All legislation and decrees necessary for implementation of the reform at all levels of the public administration (Parliament, Government, MoLHSA, SUSIF) should be in force and operational
- Training of civil servants as well as medical staff to be engaged in the reform process should be completed
- Proper management of the reform implementation should be in place. A PHC Implementation Unit should be established within MoLHSA and be responsible for fulfilment and co-ordination of all implementation activities. Such a unit should act directly under the Minister or a Deputy Minister and should report to the PHC Board
- The implementation of the new FM model will be facilitated by giving additional training in management and administration to the major partners: FM doctors, regional SUSIF staff and regional staff of MoLHSA. If necessary, regional offices of MoLHSA can be strengthened by adding specific facilitators
- Additional financing for PHC development should be allocated in the budget for 2006 and consecutive budgets for 2007-2009.

A preliminary calculation of the additional funding required shows that the operational budget for PHC should be increased by 45% compared to current funding of PHC through the State Ambulatory Programme (or by 15% in the case of maximum optimisation of PHC – i.e. 3,000 patients being served by one FM team).

The full additional budgetary expenditures will be required once the new PHC system is operational throughout the country, which is supposed to occur by 2011. However, the process of building up the new system will be continuous, so there will need to be gradual increases in funding in the years before then.

## 11. Conclusion

This Master Plan for Kakheti is a comprehensive proposal for organising, managing and financing the provision of Family Medicine services by newly-trained and equipped FM teams. Although various FM management models exist, we have chosen the model that has the best chance of promoting Family Medicine as the foundation of the Georgian health care system, and offers the best possible compromise between limited funding and cost-effectiveness of services provided to the population.

It is based on independent FM practices providing the Basic Benefit Package of services under contract with the main public purchaser (i.e. SUSIF). This model can be rolled out from the pilot regions to the whole country as the retraining and refurbishment of primary care is continued.

Sustainable financing – especially in the medium and long term – is also an important feature of the model. For an explanation of all calculations, including those of alternative solutions, the reader is referred to the background document.