Georgia Primary Health Care Reform Programme

HEALTH SERVICES AND HUMAN RESOURCES WORKSTREAM
OPM-DFID PHC Reform Support Programme

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Introduction

The importance of drugs in the access to PHC cannot be underestimated. Affordable drug treatment is one of the important preconditions for patient's access to primary care, but also a necessary condition for the effectiveness of this care and for patients to recover. Without the affordable vital and essential drugs, most primary care interventions, like diagnosis, testing, and advice are only costly activities without much real health impact. This paper offers some conceptual options for defining a drug benefit scheme in Georgia.

The Minister of Labour, Health and Social Affairs issued a Roadmap for Primary Health Care reform in November 2004. In addition to a policy statement on the context and process of PHC reform, it should be seen as a policy management tool to better coordinating and managing reform proposals. Such is the context in which the present document has to be understood.

This document is a draft for discussion and should be read in conjunction with other documents prepared by the HR and HS workstream. It has two parts:

- Part I is a review of the Road Map from the viewpoint of Pharmaceuticals
- Part II is a proposal of how a Drug Benefit Scheme could be organised in Georgia

PART I

Review of the Road Map for Primary Health Care Reform in Georgia from the perspective of pharmaceuticals

1. Pharmaceuticals and the concept of the Roadmap

The issues described in the Roadmap regarding the assessment of the PHC situation are true also for pharmaceuticals. From a patient point of view, pharmaceuticals are an important component of the access to health care in general (and to PHC in particular). Surveys over the past years have indicated that many patients in Georgia avoid PHC and doctor's visits because of the cost of medication that these visits may generate. Often people visit the pharmacy only for "more serious" conditions without seeing a doctor or after consulting a medically trained family member.

The PHC situation as characterized in the MOLHSA Roadmap and its parallel regarding pharmaceuticals is as follows:

PHC	Pharmaceuticals
- A complex combination of high public expectations with severe economic difficulties.	- Expect free drugs, but lack of budget and lack of personal income make even simple treatment unaffordable
- An unstable situation with frequent changes in government.	- Unstable availability of free drugs in State programs; unregulated sector with annual sales growth rates of 15-30%
- A context in which the main stakeholders (doctors, citizens, universities, etc.) have not been properly involved in the process of reform.	- Outdated practices, lack of rational prescribing, brand name prescribing, lack of quality in pharmacies, substandard outlets and products; commerce before health care
- A series of well meant reform initiatives that have been either not properly implemented and/or not necessarily compatible with each other.	- Different 'free' drugs and reimbursement initiatives. Unsustainable and uncoordinated; various financing and budget allocations (thinly spread)
- A severe institutional weakness by which the MoLHSA has found it difficult to play a proper leadership in the process so far.	- Regulatory Agency not functioning, policy department involved in supply and control, no balance of powers.
- **Pharmaceuticals not seen as part of PHC → often not clearly included in PHC strategies**	

2. Pharmaceuticals and the objectives of the Roadmap

The Roadmap stated objectives are applicable to the field of pharmaceuticals. As one of the major health technologies, pharmaceuticals should be seen as a variable that should enable Primary Care (and Hospital Care!) to function properly. As indicated, the lack of affordable pharmaceutical products to large parts of a population may limit access to (primary) care and reduce or nullify the impact of any health care intervention.

3. The role of Stakeholders

The positive impact of a sustainable pharmaceutical policy for PHC can only be achieved when all stakeholders subscribe to the importance of this health technology. For this decision makers must be prepared to include a pharmaceuticals component in their plans, and recognize that for the citizens of Georgia, access to affordable pharmaceuticals is a prime concern. Stakeholders also must be aware that pharmaceutical expenditure currently is largely private, thus largely out of influence of any cross-subsidization between those who have and those who have not. State budget and Health Insurance Fund budget contributions are minimal. A sustainable system of pharmaceutical care should find ways to mobilize the available private funds with some level of redistribution.

4. Pharmaceuticals and the Management of the Roadmap

The Road Map rightfully distinguishes between '*Quick wins*' and '*Longer-term solutions*'. Possible measures in the field of pharmaceuticals should make the same distinction:

PHC	Pharmaceuticals
Tangible immediate achievements (Quick wins)	
- The investment plans of our donors offer us the opportunity to refurbish, equip and staff a number of premises in the regions of Kakheti, Imereti and Adjara. We want to build on that opportunity and reform around 100 facilities in total, re-train those doctors, nurses and PHC managers involved and offer a set of services that would have an impact on the health status and the satisfaction of the population concerned. At the same time, they will serve as	- Assess the pharmaceuticals component in the donors' proposals for the reformed areas. - Design and test a simple Drug Scheme addressing priority PHC interventions fundable trough combined financing (donor contribution, state budget, patient' co-payments). - Support this by: a) including rational prescribing in PHC curricula, b) including quality pharmacies in the program (develop criteria by Agency), c) training of pharmacists

PHC	Pharmaceuticals
demonstration sites.	(GPP, generics, etc.). - The scheme should make use of existing drug supply system (private), using and encouraging high quality services (licensing).
Mid- and long-term solutions	
- A list of policy options for reforming PHC with clear indication of advantages and disadvantages will be proposed that will build on the tangible achievements referred to above and will pave the way for a sustainable PHC system in Georgia. The MoLHSA will then choose the most suitable alternatives in agreement with interested stakeholders.	Pharmaceutical policy development for PHC: 1. Role of DRA, MoLHSA, and other 2. Drug financing: a. Role of State funding b. PHC – co-payment, c. Hospitals – include in treatment costs but with separate budget line 3. Licensing of pharmacies, removal of non-licensed outlets (substandard quality, false competition, adverse health effects)
Ways of solving critical problems	
The decisions regarding both of the above areas of development will have to be taken with a three-pronged approach: - Policy leadership to be provided by the MoLHSA and its support structures, including the Health Policy Unit, through the Georgian PHC Coordination Board, - Broad involvement and consensus of both national and international stakeholders throughout the process, - Process management by a set of four Working Groups in line with the above, and under the responsibility of the National PHC Reform Coordinator and the Director of the National Institute of Health and Social Affairs. The working groups will deal with (i) Human Resources and Service Production, (ii) Financing, (iii) Health Management Information Systems, and (iv) Health Promotion and Public Relations, respectively.	Solving critical problems: 1. Raise awareness about the role of pharmaceuticals in access to/ outcome of care. 2. Redefine the policy leadership roles and responsibilities of key institutions: DRA, MoH 3. Strengthen the MoH Policy Department to coordinate international interventions. 4. Add pharmaceutical expertise to each reform working group. 5. Key attention points in pharmaceuticals are: - HR: Continuous training, licensing, GPP, generic prescribing and supply. - Financing: mixed financing, role & duties of the HIF, budgeting, co-payments, pricing, and reimbursement mechanisms. - Information: essential drug list, prescribing and consumption information, pricing. - Health Promotion: use pharmacies for health promotion campaigns; fight irrational prescribing & use (reporting). - Regulation: a proper functioning regulatory framework, enforcement (non-licensed pharmacies and pharmacists), balance of powers (Ministry, Agency, private supply).

5. Expected outputs

The expected outputs for pharmaceuticals will be partly depending on the choices and priorities of the PHC plan. Prioritization on the basis of population groups, disease groups or a family medicine concept will have implications on how the pharmaceuticals component is organized. In agreement with the output categories of the Roadmap, suggestions for pharmaceuticals (with an indication where pharmaceutical policies are linked with PHC choices and proposals) are:

5.1. Proposal regarding immediate action.

PHC	Pharmaceuticals	Link
- Selection of the precise approximately 100 facilities for refurbishment, in which one doctor and one nurse will work,	- Selection of facilities → Will determine locations and areas of intervention for: a. Drug financing b. Pharmacy involvement	YES

PHC	Pharmaceuticals	Link
- Standards for reconstruction and equipment of those facilities,	- Standards for pharmacies to be included in a program	
- List of services to be provided / that those facilities should be able to provide in the short term and which will be funded from the state budget,	- List of services → list of pharmaceuticals to be provided free or in a cost-sharing system - Develop Drug Scheme concept matching the PHC priorities and selected services	YES
- Curriculum for re-training the staff concerned in line with the services that will be provided,	- Rational drug prescribing in staff CVs - Training component for continuous education program in licensing pharmacists	
- Organizational structure and management of those PHC centres, including the HMIS needed to make them work properly,	- Link with pharmaceutical care (therapeutic groups or committees)	YES
- Financial aspects of the proposed arrangements, including sources of funds and methods as well as levels of staff payment, be it time-based, service based, or a combination of both, and how payments will be managed,	- Free of charge and cost-sharing → depending on PHC priorities and proposals. - A general pharmaceuticals system concept will have to be developed.	YES
- Public relations and health promotion-related activities, with emphasis on a public information campaign to inform the population and the political forces about the meaning and implications of the proposed changes.	- Use pharmacies in health promotion and disease prevention. - Include pharmacists (licensed) in PHC programs	

5.2.Proposal of critical steps to achieve substantial progress.

A proposal of the critical steps needed to achieve substantive progress in PHC reform in the months and years ahead (two to five years) for pharmaceuticals should include:

Critical steps	In pharmaceuticals:
- The areas in which decisions are needed, with mention of the key stakeholders and institutions involved	- Role of Ministry, Drug Agency and the Health Insurance Fund in pharmaceuticals - Drug financing - PHC – co-payment; reimbursement scheme (MoH, MoF, HIF) - Hospitals – drugs in treatment costs, separate budget line - Licensing of pharmacies; control and law enforcement (DRA, MoJ)
- The measures to be adopted as well as their sequence	- On how to trigger off a process for longer-term improvements, see Part II, section 4 of this document
- The policy alliances needed to make the above feasible	- A coherent approach to be adopted by MoH, DRA and HIF. - Acceptance by international donors and national stakeholders / consensus-based introduction of new concept in pilot areas.
- The recommended mechanisms and institutions to govern those steps	- PHC-CB present solutions and supervise their implementation - Drug policy conference with high-level national and international participation - Clear mandate and powers to DRA, MoH and HIF to implement

PART II
Drug Benefit Scheme for Primary Health Care in Georgia
Conceptual Options, Draft for discussion

1. Introduction

An accessible primary care system is of great importance to the health of a population and the most cost-effective way of providing health care. Effective and widely accessible primary care permits early interventions when patient conditions are at an early stage, and so it may prevent patients from seeking unnecessary expensive specialist care and hospital care. Access to primary care in Georgia has been identified as a critical issue and is mostly determined by a few key factors:

- The expected (official and non-official) payments for a visit. This barrier is significant in Tbilisi but far worse in rural areas[1].
- The perceived level of expertise in a PHC facility (specialist care is generally preferred above general practice in all former Soviet countries, partly due to a wrong perception of general practice).
- The drug cost a doctor's visit may generate (useless to see a doctor when you have no money for drugs anyway).
- Access to and availability of alternative forms of care. Such alternatives are offered by a) direct access to specialist care in hospitals and polyclinics, b) a high number of doctors or other medically trained persons in the population (family, friends) that provide advise for free or against delayed payment or payment in kind, and c) private medical centers (mostly set up by foreign companies).

2. Objectives of a Drug Benefit Scheme

The objectives of a Drug Benefit Scheme in the abovementioned context should address two fundamental questions:

1. How can the MOLHSA improve access to pharmaceuticals in PHC in the 100 facilities to be immediately reformed?
2. How to generate money in a sustainable way from different sources to reduce the financial burden of the patient?

2.1. Tangible immediate achievements (Quick wins)

A pharmaceuticals component in the 100 reformed PHC sites (as part of the renewed PHC-service package) in the regions of Kakheti, Imereti and Adjara would have an impact on the health status and the satisfaction of the population concerned. At the same time, they will serve as demonstration sites for longer-term development. The approach is as follows:

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[1] See Household Survey, DFID I, 2001. *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 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. The interaction of high medical expenditures and low incomes also appeared to affect choice of provider and likelihood of completing treatment for hospitalized patients. Although financial barriers were most significant for the poor population, they can also create problems for the wealthiest. It was quite common for respondents to report that there was insufficient money available in the household to cover the costs of outpatient services.*

a. Use (and if needed[2] modify) the state financed free drugs program to facilitate an extended drug supply for priority services as identified for the 100 facilities.
b. Design and test a simple Drug Scheme addressing high priority PHC interventions fundable trough combined public financing and/or cost sharing (donor contribution, state budget, patient co-payments).
c. Support this by: a) rational prescribing in PHC curricula, b) quality pharmacies in the program, and c) training of pharmacists.
d. The scheme should make as much use as possible of existing drug supply system (private), while encouraging high quality services (licensing).

This *immediate action* requires:
- Determine in the 100 selected PHC locations.
  - List of drugs and their coverage
  - Supply mechanism
  - Procurement mechanism
  - Dispensing procedure
  - Involvement of existing pharmacies (standards)
- Design the Drug Cost Sharing Concept and pilot it in a limited number of locations of the 100 facilities (ultimately this concept should be run through a health financing structure.
  - Concept development
  - Select pilot sites
  - Set-up pilot management unit, supervisory group.
  - Run pilots, monitor, evaluate

3. Include rational drug prescribing in the PHC staff curriculum; set up regional Drug & Therapeutic Groups to monitor and improve drug prescribing and use.

2.2. Mid- and long-term solutions

A list of policy options for reforming PHC with clear indication of advantages and disadvantages is proposed in this document intended to build on the tangible achievements referred to above. The MoLHSA will then choose the most suitable alternatives in agreement with interested stakeholders and pave the way for a sustainable PHC system in Georgia. The first and most important issue is discussing policy options in the area of drug financing; the lack of a functioning health financing structure has made it impossible for years to develop premium collection or cost sharing – also in pharmaceuticals.

Other key attention points in pharmaceuticals are:
a. Improving prescribing (and use of prescription forms), as well as removing non-licensed outlets (substandard quality, false competition, adverse health effects.
b. Information: essential drug list, prescribing and consumption information, drug formulary.
c. Continuous training, licensing, GPP, generic prescribing and supply.
d. It is important to raise the awareness of the critical role of pharmaceuticals in the success of treatment and access to care (perception of health professionals and the people). Use pharmacies for health promotion campaigns, rational prescribing & use (reporting).

[2] An assessment should be made of the current state program offering free drugs. Recommendations should be produced for performance improvements and the feasibility of expanding it with limited number of extra items to serve patients in the 100 facilities.

3. Pre-conditions

When designing a pharmaceuticals component for Primary Health Care the following dimensions should be taken into account:

3.1. Mixed financing (cost sharing) will raise the amount of money that is available for the Drug Scheme. No doubt about it, in the short run the State will continue lacking sufficient funds to finance all prescription drugs in a free-drugs program. The patient will also not have sufficient income (certainly in the case of serious illness) to afford drug treatment. A fee-for-service scheme (or its equivalent in drug supply) puts the burden of disease largely on the patient, while no money is raised from the wealthy and healthy. Mixed financing for drug treatment in priority PHC interventions will reduce the financial burden for each of the contributors and improve access to drug treatment (and the success of primary care).

3.2. A Drug Scheme should be set up with the patient at the center. A Drug Scheme that is patient driven according to PHC priorities will offer a certain level of reimbursement of drugs regardless of who is financing the remaining part. The state or health insurance budget contribution then depends on a) the priority of the treatment in PHC, b) the financial burden for the patient, c) the budget available from the state, and d) possible contribution of a Health Insurance Fund or equivalent institution.

As the economic situation in Georgia will continue to be insecure and budgets as well as personal income levels may grow only gradually, state and insurance budgets for PHC and related pharmaceuticals will also grow only gradually. Different from countries and systems where full financial coverage is applied, a Georgian PHC linked Drug Scheme should be designed to facilitate different levels of reimbursement. Certain components may receive full funding through the state budget; others will be partly financed by a Health Insurance (or possibly donors). Reimbursement levels can also be linked to a certain reference price and a list of drugs adequate for this PHC intervention. Ideally it should be possible to vary patient contribution by population group (elderly, children under 4, etc.), or by patient category (chronic patients).

3.3. The supply of pharmaceuticals is now largely in the hands of the private sector. Although it is tempting to think in concepts of centralized public drug supply systems (in the assumption that this is cheaper and better controlled), such supply systems have shown in many countries a number of disadvantages: a) it behaves as a parallel system, leaving the good pharmacies out and often destroying the regular supply system, b) it requires a new organization and separate financing of the procurement, logistics, and staff that is currently not available (to be separately contracted), c) it often suffers from wrong needs assessments and irrational procurement, d) it is vulnerable to corruption and e) it could be suitable to supply 'free drugs' but it never is suitable for cost sharing and variable co-payments. In view of this, setting up a separate public drug supply system is not the recommended option.

Using a private supply system has of course its own disadvantages such as: a) supervision and price control is required, b) quality of services and products needs to be controlled, and c) efficient delivery concepts may become more complex to implement. However, involvement of the private sector drug suppliers can work as long as the following measures are implemented: a) licensed and controlled pharmacies, b) with maximum reimbursement prices for listed prescription-only drugs, and c) action taken against

substandard products and illegal pharmacy selling points (false competition, adverse health effects).

3.4. Past experiences. As a result of the technical assistance provided to Georgia under DFID-I and in collaboration with WHO EURO, use can be in fact made of a trained drug reimbursement team formed by the five pilot sites for Family Medicine in Tbilisi. Such team is currently on stand-by, has undergone training in Latvia and Denmark, and has a fully equipped office available located in one of the Family Medicine Centers. It should also be noted that part of the mentioned WHO/DFID-I intervention has been the development and publication of a comprehensive Drug Formulary for Primary Care. This formulary will be published by April 2005.

4. PHC drug benefit options

4.1. Global options

Global options for drug benefit schemes include logistics of the drug supply system (public / private), the preferred mix of free drugs and (co-)paid drugs, and elements of cost-sharing between the patient, the state, a health insurance fund and sharing the burden of disease (by the wealthy and healthy).

A) Free drug options

- The State runs a drug supply system in primary care facilities through State run dispensaries (inside or outside the facilities).
- The State contracts a free drug supply system to existing suppliers through a tender procedure.
  - Contract the whole supply out to a wholesaler, including agreed prices for listed drugs and the complete distribution (for example Azerbaijan – Unicef)
  - Contract suppliers and distribution separately, where free drugs are dispensed in a separate window in existing pharmacies (for example Kosovo).
- The State agrees the reimbursement of free drugs at agreed prices on a contractual basis with existing pharmacies (for example through health insurance fund contracts).

B) Cost-sharing options

- Co-payment schemes for listed drugs. Co-payment rate is:
  - Flat rate for each item (or each prescription) dispensed.
  - Percentage of the drug costs.
    - Irrespective of the price (in several central European countries)
    - With maximum or minimum cumulative amount (in some Scandinavian countries)
  - Decreasing co-payments with growing drug consumption
- Membership fees. Participation per family or per person in a given scheme, on an annual, quarterly or monthly basis.
  - Voluntary membership
  - Compulsory membership (health insurance premium payment included)
  - Deductibles. The first expenses with a higher co-payment (or full payment); above a certain level of expenditure per year, co-payment is less (or zero).
- Corporate contributions. This source is often overlooked, but it has a useful potential in the Georgian context. Companies, corporations and institutions may be offered collective benefit schemes, which may partly compensate for the limited public resources available.

- Corporate memberships and adjusted benefits
- Donations from various domestic and foreign sources (but will require a comprehensive program and program management unit). Such donations are more likely when a well-managed transparent cost-sharing scheme is operated with the support of the Ministry of Health, a Health Insurance Fund and international organizations.

4.2. Evaluation of the above global options in the Georgian context

Short term time frame. It is understood that offering a certain group of drugs under a free drugs program will substantially lower the financial barrier to utilize the primary care services and improve access to this level of care. Including a free drugs component should therefore be recommended in the 100 reformed PHC centres. Of course such an offer is limited by budget constraints, which need to be calculated in detail.

Currently the Georgian state provides certain drugs for free within the Health State Program, managed by a state-run pharmaceutical wholesaler. In essence, drugs included cover: vaccines (largely financed through UNICEF), oncology drugs for outpatients and TB-drugs. In recent years, however, such State supply has proved unable to cover the demands for these items in any consistent way and patients have needed to buy the concerned pharmaceuticals in pharmacies. In this context, the top priority seems to be that the current state supply of drugs under the State Programs for priority conditions (e.g. immunization or TB) is guaranteed in the 100 reformed PHC centres. A short investigation of the current functioning of this system is required to assess its shortcomings (see Annex I, where an appraisal of the PHC funding for PHC I 2003-04 is included). A re-design and/or re-tendering of the suppliers and services under this programme may be necessary.

Additionally, it may be possible to include other drugs in this free drugs program (current or redesigned) that are directly linked with priority services and treatments in the reformed 100 facilities. Unless otherwise proved, the available information suggests that there are no resources available for this now.

Mid- to long-term time frame. In a longer-term perspective, the above short-term priorities should evolve to the design and piloting of a drug benefit scheme that is able to do the following:

- Share costs between patient, some form of health insurance fund and/or the state for essential treatments (in particular for care that may prevent patients from seeking or needing more expensive health care forms);
- Raise private payments and contributions from the healthy and wealthy (get the burden of disease away from the sick). In other words to increase the willingness to pay with the people that are able to pay. This may also include contributions from companies, institutions, donors, NGO's, etc.

Ideally, the most convenient evolution would be that the above mentioned short-term arrangements could lead to a co-payment-based drug benefits scheme run as one single comprehensive PHC program in which those who can contribute would do so and the State would finance those who cannot pay at all. Here some important discussions will emerge, as it generally is more difficult to manage a co-payment scheme under a state budget-run programme than with an executive agency or a health insurance scheme.

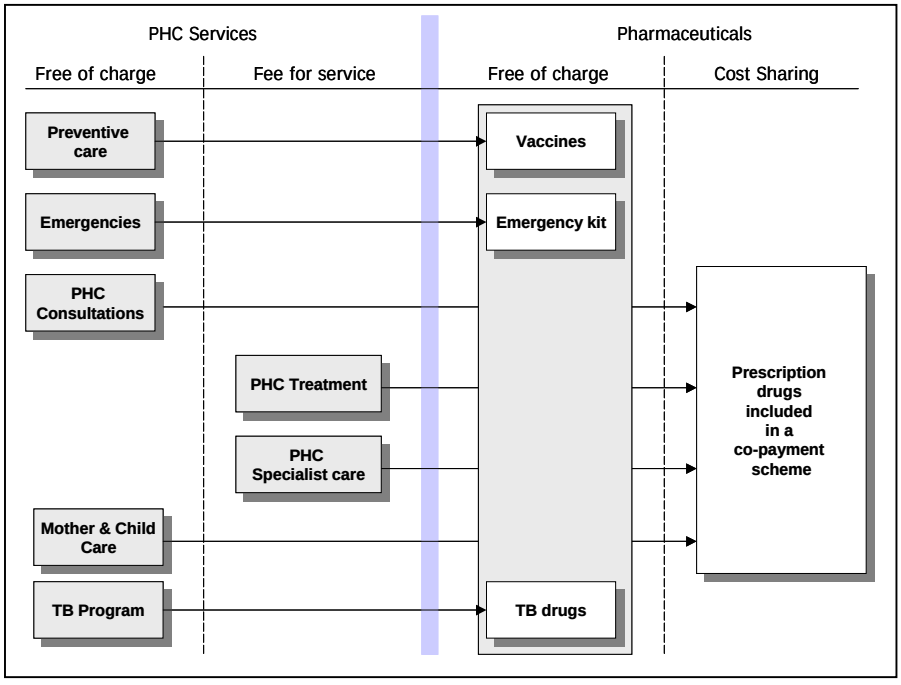
4.3. A proposal of PHC pharmaceutical services in Georgia

In line with the OPM-paper presented to the Working Group on PHC services, the scheme below shows the possible relationship with a pharmaceutical benefit scheme.

PHC Services	Conditions	Payment	Pharmaceuticals	Conditions	Payment
Preventive care	Immunization	Free of charge	Vaccines available in the PHC	Immunization program	Free of charge
	Other preventive services	Fee for service	-		
Emergency care	Only real emergencies	Free of charge	In emergency kit	-	Free of charge
	'Fake' emergencies	Fixed charge (fine)	Prescription drugs in co-payment scheme	Prescription	Cost-sharing scheme
PHC consultation	Unconditional	Free of charge at certain hours	Prescription drugs in co-payment scheme	Prescription	Cost-sharing scheme
PHC treatment	List of services	Free of charge	Prescription drugs in co- payment scheme	Prescription	Cost-sharing scheme
	Remaining treatment	Fee for service			
Specialist care in PHC centers	Agreed patient / doctor	Fee for service	Prescription drugs in co-payment scheme	Prescription	Cost-sharing scheme
Mother & child care	Child < 1 year	Free of charge	Vital drugs	-	Free of charge
			Essential drugs	Prescription	Cost-sharing scheme
TB		Free of charge	Drugs available in PHC facility		Free of charge

Thus in principle patients in primary care can obtain medicines in three ways: a) free drugs in the PHC for immunization, emergencies and tuberculosis, b) partly reimbursed products in selected pharmacies using a drug co-payment scheme for serious conditions and for vulnerable groups, and c) fully privately paid prescription and non-prescription drugs for non-priority conditions as well as for non-vulnerable groups of the population.

Presentation of primary care services and related pharmaceutical benefits



The chart shows how certain primary care services can be moved from the free-of-charge to the fee-for-service (or co-payment) category, while independently the pharmaceuticals related to these services or conditions can be moved either from or to the free drugs program or the drug cost-sharing scheme. Of course, the relationship between free services and free drugs can be maintained for health policy or primary care access reasons.

5. Articulating drug benefits in the mid- to long-term; main approaches

5.1. Fundamental choices

In the Georgian case, where budgets are hardly sufficient to cover the services and salaries of medical staff, some fundamental choices must be made as to what priority diseases or population groups the highest drug benefits should be rewarded. Principally the choice is between one of the following three coverage methods, or a combination of the three:

- Horizontal coverage (population – entire or groups) – Insurance principle. This option requires a certain element of compulsory membership. Membership can be against a flat rate (x Lari per participant per year) or relative to a person's official income. In the Georgian situation with its large number of unemployed and large gray economy, a flat rate is probably more feasible.
- Vertical coverage (disease based) – Negative selection, budget principle. As a disease-based coverage is (by definition) generating negative selection, such a system can only be based on state subsidies.
- Health care cost coverage (combine economic and disease burden) – Increase benefits with growing health care costs relative to income.

The last option in fact combines the burden of disease (second option above) and the low income of certain vulnerable groups (first option above) into one concept.

5.2. Free drugs program

As already indicated, the Georgian state has run a free drugs program for several years, with variable success. Problems were caused by instable funding and by inefficiencies. However poorly run, the current free drugs' State program seems to be the only available source of drugs for many patients.

In general, a – state financed – free drugs program works better as disease or drugs based (firstly because of the uninsurable risks of some diseases, secondly because it is easy to contain costs as the medication for such conditions can easily be listed according to Standard Treatment Guidelines). With the limited finances available in Georgia there is a dilemma on which priority diseases to include in this program. It is probably impossible to reduce the current free drugs programs by substituting certain disease categories (like oncology drugs) with others. This implies that any change will generate a cost increase in the free drugs coverage program.

In case a free drugs program was population group based, the implication would be that a lot of people get very little benefits. This implies that the impact of such a system would be negligible. Some people could probably afford to pay such small contributions, while others are in need of much higher benefits to maintain their health.

Coverage. Linked to the Services Concept (see 4.3), and including the current free drugs for outpatients, the following pharmaceuticals would be covered by a Free Drugs Program:

- Immunization → Vaccines. Currently vaccines are largely supplied through UNICEF and also the financing of basic vaccines is partly done by UNICEF.
- Mother & Child care → Various drugs. This requires building up a special package of drugs commonly used in these circumstances. However, mother & child care is also an area where people are willing to invest and a good entry point for joining and using a Drug Cost Sharing Scheme based on co-payments. The inclusion of various drugs in a completely free drugs program in this area therefore needs to be discussed in view of the feasibility of a new cost sharing system (see an example in Annex II).
- TB Program → TB drugs. The existing TB program is according to the available information heavily relying on international aid and NGO's. It is unclear whether including such program in the regular primary care will lead to additional costs for the State compared with keeping the management of this program under the same NGO's.
- Emergency services → Emergency Kit. Such emergency drug kits should be available in every PHC facility and in the ambulances. The abuse of emergency care should be discouraged, partly by limiting the number of drugs in such an emergency kit, partly by fining people that make unfair use of these free services for ordinary medical care (like antibiotic treatment, etc.)

Possible additions would resources permit (ACP program – see Annex I) may be:

- Oncology → Painkillers for terminal patients. This group of chronic patients will not be able to finance their care and exclusion of this group seems politically not feasible.
- Diabetes → Desmopressin and/or Insulin.
  - Patients with diabetes insipidus receiving desmopressin (approximately 300 cases)
  - Patients with diabetes mellitus receiving insulin (15,400 cases)
- Kidney transplants → Cyclosporin. This covered 55 patients as per the end of 2003

Cost. The total cost of the abovementioned package is currently unknown. It is possible to calculate the cost based on the prevalence and cost per treatment, but in the Georgian situation this may well not come particularly close to the real annual expenditure. The OPM financing analyses are expected to shed some light on the current costs, but one needs to be careful here, as in several occasions the State Program was not realized 100% resulting in shortages in supply. It is thus necessary to collect information on the expenditure and budgets for the current State Programs of free drugs (formerly SMIC), the current financing levels of primary care drugs (previous ACP) and the drug treatment costs per case for mother & childcare. In addition it is necessary to determine the efficiency of the state program and to see whether the program can be made more cost-effective.

5.3. Cost-sharing drug program

As it has already been mentioned, while free drugs programs heavily rely on the scarce state budget funds, and fee-for-service heavily rely on direct patient contributions (often from very low or non-existing personal incomes), a cost-sharing mechanism spreads the financial burden over more participants and in time. The main question here is how money can be generated from a low-income population, and from other sources (companies, employers, and co-payments from patients). It is unlikely that the healthy people will contribute voluntarily (for example on a monthly basis) to a system with zero or very little immediate benefits for themselves. This is only possible in an approach with either a) compulsory membership, or b) guaranteed benefits for all members. At the same time the

reality is that the Georgian pharmaceutical market is growing by 15-30% per year (according to sales of major multinational companies), indicating that people anyway does spend an increasing amount of money on pharmaceuticals.

Compulsory membership. Although compulsory membership schemes exist and operate successfully in several countries, introducing such a concept in Georgia would face serious problems. Firstly it needs to overcome the general mistrust with the population of any new system that looks like taking money without offering anything in return. Secondly, collecting the membership fee will be a difficult task, especially in rural areas and from the vulnerable population. However difficult, it may be the most reliable source if income for a system to function in the mid-term. The alternative is that employed people would pay the premium (flat fee) themselves or through employers, while the vulnerable and non-employed fees be paid by the state (or some health insurance fund). Experience shows that in the Georgian setting however, it is likely that the state will not have the necessary resources and the vulnerable will not pay, so the money generation potential from such a scheme – except patient co-payments – is very little.

Voluntary membership. Voluntary schemes should offer real and immediate benefits to their members in the form of priority access to certain forms of care, substantial discounts on essential or listed prescription drugs, or discounts on other drugs or items bought in a pharmacy. Voluntary schemes work best in specific family areas (for example for mother and child care, and older children care). Of course such schemes rely on the ability to pay relative to the anticipated risk-reduction and benefits. In the present context of Georgia, voluntary schemes could be an addition but not the only basis for a drugs benefits program.

5.4. Three basic options for a cost-sharing drug benefits program

Option I. Drug- or disease-based system

This option is 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:	Oncology Chronic diseases Neurological Gall stones	Or	List of drugs:	Drugs costing more than 5 Lari per pack; i.e., 9% of the drugs for adults and 45% of the drugs for children.[3]

A drug reimbursement scheme based on one or both of these lists could compensate a certain percentage of a listed drug for every case, or benefits may be 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.

Drug based model – an example

Example	Participation fee	Benefits	Financed by
Drug based model	All registered patients free entry	1. x% discount on drugs priced > 5 Lari 2. y% discount on fee for GP	State Policlinics / FMC's

A cost-sharing system for PHC in Georgia focusing on diseases will largely depend on State contributions and patients' co-payments. It is difficult to see how membership fees can be collected for that other than through compulsory fees (some form of taxation).

[3] Based on Drug Requirements Analysis carried out by the Family Medicine Centers (pilots) in Tbilisi, 2004

Option II Selected social groups

The approach here is to only seek compensation for excessive drug costs for patients who belong to a certain well-defined population group, such as: identified vulnerable people, elderly, single parent families, or children. This automatically implies negative selection so the scheme 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. But this can only be realized when the identification of patients is easy and simple (for example, age). A potential problem is the identification of the concerned groups and the avoidance of misuse and fraud. Experience shows that when including poor families, this approach may very well not work, as these groups tend to avoid special programs targeted at them and generally prefer to belong to a commonly accepted and used system, in which they can obtain special benefits.

Population group based model – an example

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

Also in this option it is difficult to generate contributions from groups other than the vulnerable. Instead of negative selection of patients with an excessive burden of disease (Option I a negative selection of patients with a low ability to pay (due to their socio-economic situation) has to be created.

Option III Family Medicine model with differentiated benefits (groups/diseases)

This option offers a more differentiated scheme of benefits per population group based, depending of the price of the drug, on family participation. The idea is that the system must be attractive for population groups who today spend money on drugs and have an (official or non-official) regular income. Although many of these groups are currently not using the official primary care facilities, certain groups do, for example mothers and children. Linking a (compulsory) enrollment fee to the drug scheme could generate extra income for the scheme. Such enrollment fees may vary and the State may finance certain vulnerable groups. This scheme also may provide differentiated benefits and – with sufficient coverage (avoiding negative selection) – offer higher benefits for people with higher drug expenditure. These differences can be simplified into easy-to-understand drug benefit packages. For example:

Family Medicine model – examples

Example	Participation fee	Benefits	Financed by
Family scheme standard	4 Lari per family		Participants
		1. 20% discount on drugs priced > 5 Lari	State / pharmacies
		2. 50% discount on prescription drugs when expenses above 25 lari per quarter	Scheme
		3. 10% discount on GP fee in FMC	FMC
Family scheme vulnerable	1 lari per family		1 lari by participants, 3 lari by State
		1. 20% discount on all prescription drugs	State / pharmacies
		2. 60% discount on prescription drugs when expenses above 25 lari per quarter	Scheme
		3. 50% discount on GP fee in FMC	FMC

Family scheme elderly	2 lari per family		2 lari by participants, 2 lari by State
		1. 20% discount on all drugs priced > 5 Lari	State / pharmacies
		2. 50% discount on prescription drugs when expenses above 15 lari per quarter	Scheme
		3. 20% discount on GP fee in FMC	FMC
Family scheme Corprate	4 Lari per family		Company
		1. 20% discount on all drugs priced > 5 Lari	State / pharmacies
		2. 50% discount on prescription drugs when expenses above 25 lari per quarter	Scheme
		3. 10% discount on GP fee in FMC	Company
		4. 10% discount on all prescription drugs	Company

As the PHC reform is intended to have a Family Medicine approach 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 healthy people could be included in the scheme.

5.5. Definition of Benefits

In all options, the benefits should be based on an agreed list of drugs and an agreed price per product. When including regular pharmacies the options are:

- Prices of listed drugs to be fixed by the Ministry of Health. This may be difficult in Georgia, in view of the larger political setting which encourages free market development not interfering in the pricing of products.
- The reimbursement price of listed drugs to be set at a certain level. This level could be equal to the average of the 2 or 3 lowest priced items in a generic group. Such (reference) price is then the basis of all calculations (co-payment, state payment, etc.). If patients demand a higher priced item, they need to pay the difference with the set reimbursement price in addition to their regular co-payment.

Additional benefits may come from contracted pharmacies. They may be willing to provide a discount on the listed drugs, possibly compensating this by increasing the prices (margins) of other items. Such extra benefits can be negotiated when contracting the pharmacies or pharmacy chains (wholesalers) to join the Drug Scheme. In the framework of testing a pilot scheme under DFID-I, some distributors offered to finance plastic membership cards for easy identification of patients as well as the administrative maintenance of the system through adjustments on their pharmacy computers. This offer is more likely to succeed in Tbilisi than in rural areas.

5.6. Financial evaluation of the above presented options

The financial picture of each of the presented options needs to be worked out in detail by the Financing Working Group. Some work has been done in the past during the DFID I project (see Annex III). However, the policy choices on what to include in the Free Drugs Component and then which Drug Benefits Cost Sharing model to be chosen will influence the financial picture substantially. Once there is more clarity on the most favored options and solutions, the calculations could be done in more detail. The basis of such calculations should NOT be prevalence data and standard treatment guidelines. Instead estimates and budgets should be based as much as possible on the actual situation in PHC in Georgia (not only in the 100 PHC centers to be reformed but for example on the number of cases per

1000 enrolled in the Family Medicine Centers in Tbilisi, their actual prescribing patterns and real drug costs).

For this work the WHO financed team in Tbilisi (formed under the DFID I program) can be used to collect the necessary information. Information from rural areas could be obtained in collaboration with the Kakheti PHC manager and the EU program.

5.7. Running the scheme

Schemes like the ones presented above may be run by state departments or by specialized departments in a Health Insurance Fund. As the future status of the health insurance fund in Georgia is not yet clear, its role in financing primary care, drug schemes and in managing such schemes is also unclear. *Action on this is urgently needed.*

Bluntly speaking, it is questionable whether such a scheme can even be launched within the MOLHSA, as the trust of the population in a scheme directly managed by the Ministry of Health will probably be rather limited. The preferable organizational setting is to place the management of the scheme in a specialized department within some sort of Health Insurance Fund or PHC Executive Agency. In case such a Fund will not be operational in Georgia, a separate Drug Benefits Scheme Management Unit outside the MoLHSA may be needed as an indispensable arrangement to collect co-payments or enrollment fees.

5.8. 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 either in the context health care delivery or monitored/managed by an insurance fund. In Tbilisi the situation is as follows:

Drug use management mechanisms in Tbilisi

Mechanism	Available	Comment	Implication for drug scheme
Drug lists	Yes	Especially developed for FMC's	Is 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.

Introducing specific *prescription forms* is a major precondition for any drug scheme to function avoiding misuse or fraud. The fact that patients shop around for outpatient care is a serious complicating factor. In the case of the newly reformed 100 PHC centers, should patients stick to those institutions this approach would be made easier.

6. Discussion and recommended actions

Discussion. Developing simple technical solutions in pharmaceuticals in PHC in countries like Georgia can be misleading. For example: allocating budgets for free drugs or free care, refurbishing the facilities, and subsidizing chronic patients or vulnerable groups are efforts

which focus on the people most in need. While certainly logical from a social perspective, these solutions are clearly not systemic solutions, but rather measures addressing various problems with services targeted at the poor. What is needed as soon as circumstances permit is rather a system that will last and can be developed into a comprehensive and financially sustainable concept. Such a pharmaceuticals system needs to include services that are attractive for people who are willing to or asked to pay (compulsory). In due course, such system will include the services and benefits for the poor and for chronic patients without any substantial extra cost, as the bulk of the system's running cost are already covered. (In other words, the free drugs program and the cost-sharing program can be merged into one).

Part of the success of such a systematic approach is to include a gatekeeper function. In particular in the Georgian situation there is a lot of non-professional advice, free access to specialists and to hospitals, etc. all of which goes against stable solutions in the field of realistic cost-sharing for pharmaceuticals. A drug benefit scheme for PHC should definitely exclude patients who received care outside the regular PHC system. This implies strict lists of drugs, use of prescription forms and certified prescribers, a referral system that works, etc. An additional difficulty stems from the fact that previous experience has shown that it is quite difficult to ask the public's opinion about the above schemes. The only way to find out whether something would work or not in reality in Georgia is to put it to a test in the field and give the scheme management team enough freedom to change, in order to adjust and to communicate as appropriate.

Recommendations. This Note is intended to make Primary Care more attractive and accessible for patients in Georgia assuming that a well-designed drugs benefit scheme can contribute to these goals. However, as pharmaceuticals are a health technology that is dependent on the way the services are designed and financed, decisions on pharmaceutical services and benefit schemes should only be taken after the PHC services concept is better defined. Once this is the case, the following is recommended:

- Assess the suitability of the current free drugs program for wider application in the PHC reform program (investigate whether the current way of supply, distribution and financing can be improved or made more transparent).
- Define the free drugs package (list of drugs and the way they are supplied), in conjunction with the defined priority list of health services in the 100 facilities.
- Decide on which department should manage the drugs programs (whether this is the MOLHSA, a Health Insurance Fund – that is, whether the scheme is financed by state budget or by member premiums - is not relevant in this case)
- Make a basic choice in the cost sharing drug benefit package or indicate which of the presented options should be rejected.
- Present a financial picture of the favored options, including:
  - Define list of drugs (or conditions)
  - Estimated cost of treatment per 1000 population for the listed drugs
  - Estimate revenues from enrollment fees, co-payments, state and/or health insurance fund contributions, and employer's contributions (corporate).
- Present a full description of each option and package, including costs and revenues, benefits, as well as the administrative mechanisms to run the scheme.
- Decide which option(s) or parts of it to:
  - Implement on a national or regional scale (including the organizational arrangements for such an implementation)
  - Test in rural as well as urban environments preceding a later up-scaling

Annex I.
Primary Care Funding 2003/4 and pharmaceuticals

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 disbursed in a very complicated and non-transparent way. By far the most common sources of private health expenditure are unregulated and unaccounted for payments made direct to providers. On average 15%[4] of Tbilisi municipal funding was actually spent on Primary Health Care services; that is 2.9 Lari in per capita terms[4].

The introduction of the *ACP program* by the Tbilisi municipality as per 1 October 2002 contained budget contributions on a per capita basis (Drugs are not included in these per capita amounts):

- 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

With regard to drug financing the following programs were active:

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: 300 patients with Diabetes Insipidus 55 patients with kidney transplants 15,400 patients Diabetes Mellitus	Direct procurement or reimbursement of pharmacies: Desmopressin Cyclosporin Insulin
PHD Program	Active	Expanded Program of Immunization	Vaccines
Municipality Program	Active	ACP Program for Primary Care	No
	Active	Oncology Patients	Painkillers for terminal patients
	Intended 2004	Program for vulnerable groups (200 to 400,000 Lari)	??
		Drug reimbursement scheme for Family Medicine Centres (pilots)	Essential Drugs Scheme ??
		Scheme under discussion	

The current active programs only cover drugs for selective target groups. The main purpose of the current health financing mechanism is financing primary care services, 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). 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 hospital setting is significantly more expensive than 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 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).

[4] Average figure for the period 1997-1999

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 vise 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 (up to 1,107 Lari per case).

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 have 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.

Cost categories of required drugs for adults and children

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 whereas 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 million Lari. Therefore we have to conclude that the current drug requirements (in terms of cost) are an overestimation by 7-8 times. This also illustrates the level of under-consumption of outpatient care and the potential for growth in case these drugs would be fully reimbursed.

Summary of conclusions

Issue	Status	Impact
Primary care funding	Primary care state funding is still very low and the ACP program could make available a certain % of the funds for drugs.	High patient payments High % drug costs Less effective treatment
Drug funding	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.	People avoid seeing a doctor Policy makers do not see pharmaceuticals as an essential health care intervention Vulnerable people have no access to effective primary care

Issue	Status	Impact
Drug expenses	Half of the patient expenses on outpatient care are on drugs. Certain providers and certain conditions increase substantially the cost of care (and drugs).	Drug scheme to focus on high cost categories Drug scheme to exclude certain providers and existing programs (avoid duplication)
Vulnerable	Low-income 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).	State contribution essential Drug scheme to include short term benefits Scheme to work with middle class and not with vulnerable alone
Family Medicine Centers	Registration and attendance figures are promising. But they are in a competitive situation with alternative providers of care. Expansion of the concept is sluggish.	Positive synergy between FMCs and Drug Scheme Expansion of the scheme to other districts dependant on speed of primary care reform Scheme be competitive, attractive and simple (coverage, package, financing)
Coverage	The lack of solidarity in the health care system (insurance principle), and the lack of public funds, increases the risk of negative selection of only chronic patients.	A community contribution necessary to make any drug scheme accessible for poor people and to cope with negative selection

Annex II
An example: Mother & Child Care

Prenatal and antenatal period for prevention - Folic acid

Pregnancy (local data) 0,8% (8)

- Folic acid -1mg tab (average dose per day 200-500 micrograms) 1/2 tab during 3 months

0,5x90x8=360 tab

- Folic acid - 5mg tab 2 patients need to be treated with anemia, average dose 1 tab in a day during 4 months.

1x160x2=320 tab

Drug requirements for adults per 1000 population based on Standard Treatment Guidelines

Generic name	Dosage Form	Quantity for standard treatment (per 1000 pop.)	Pharmacy price in lari	Total Pharmacy cost	WHO list	GEO list	State Progr. 2004	Indication
Folic acid	1mg Tab	360	0.01	2.15	+	+	Municipal Federal	Prenatal and Antenatal Period
Folic acid	5mg Tab	320	0.06	18.59	+	-	-	Prenatal and Antenatal Period
				20.73				

Source: Family Medicine Centers Tbilisi, 2004

Annex III

Financial overview of a drug benefits program (cost-sharing)

During the development and implementation of the scheme WHO/DFID funding was foreseen in the management and training in running this drug reimbursement scheme. It was expected that doing so might contribute to improved drug prescribing and use through training, monitoring and the introduction and use of a comprehensive Primary Care Drug Formulary (currently in print). The (voluntary) Drug benefits program (cost-sharing) itself is budgeted for 2 options:

- No contribution from the State, regional or municipal budget (Public Funds)
- With a contribution from State, regional or municipal budget of 1 GEL per capita.

The financial details are presented on the next page. A summary of the differences with and without the Public Funds is presented below. Figures are based on Pilot FMC's in Tbilisi and the results of a limited scale pilot scheme. The basis of the calculations is the frequency distribution of drug costs over a population (in simple terms: 85% of all outpatient drug costs are borne by 15% of a population), and an ABC/VEN analysis.

Drug scheme with and without Public Funds contribution (catchment area 100,000 pop.)

Feature	Without Public Funds	With Public Funds
Family Package		
- Member families	6,000	9,000
- Reduced membership fee children	-	YES
Elderly Package		
- Members (nr. of people)	4,000	8,000
- Reduced membership fee members	-	YES
- Increased reimbursement percentage	-	YES
Vulnerable Package		
- Member families	500	1,000
- Reduced membership fee members	-	YES
- Increased reimbursement percentage	-	YES
Total potential no of participants (persons)	30,000	48,000

Remarks

- The total *number of participants* is less than the population, under the assumption that not all families enroll. In particular in the situation that an enrollment fee was levied, there are very few possibilities to enforce membership. Participation estimates were based on indications of the Pilot FMC's in Tbilisi. In case the scheme was part of an obligatory health insurance fund and membership fees are included in a premium payment mechanism, the financial overview needs to be recalculated.
- Adding *Public Funds* to the scheme allows (a) more members to participate, (b) higher compensations for these members, and (c) lower membership fees for children, elderly and vulnerable people. All Public Fund additions were to be spent on patient benefits.
- *Risk management* is done through limiting the list of reimbursable drugs, and fixing the reimbursement price in agreement with the participating pharmacies (wholesalers or pharmacy chains).
- *Simplicity.* Although the scheme seems complicated, it is simple for patients in reality. Patients receive a card or booklet of a certain color, indicating their benefit level. The rest is managed by pharmacies back-office (either by printed lists, or by a computer

system the software of which the Benefits Management Program provides). Lists of reimbursable drugs (and their max reimbursable price) are displayed in pharmacies.

- *Membership cards.* Early negotiations with interested wholesalers indicate that they might be willing to take the costs of membership cards. In any case, an external donor should probably finance the membership booklets or cards (budget allocation within WHO programme foreseen for pilot scheme). Memberships could be issued by Primary Care Centers or by the participating pharmacies.
- *External funds.* Additional benefits could be offered with increased external funds. These funds and donations are not included in the financial overview. However, introducing a cost-sharing benefit scheme that is properly managed may very well be an attractive fundraiser to support the poor and vulnerable and increase the list of reimbursable drugs.
- *Benefits.* X% discount (to be negotiated by pharmacies) on all prescription drugs priced above 5 GEL per pack. For drugs above a certain level of expenditure (example threshold 25 GEL per quarter) the reimbursement was 50%. Extra reimbursement, lower threshold or reduced enrollment fees for certain groups depending on the Public Funds available.

Financial overview drug cost-sharing program (Family based package)

In Lari (GEL)		Without Public Funds			With Public Funds			
		#	Debit	Credit	#	Debit	Credit	Budget
General revenues								
External funds	Anticipated funds for social marketing and promotional discounts to early members			23,200			23,200	
Pharmacies discounts	10% discount pharmacies on >5GEL drugs			20,000			20,000	
Program accounts								
Family Program								
	Basis = nr of families	*6,000*			*9,000*			
	Participants	*24,000*			*36,000*			
Member contributions Family Program	1 lari per participant; max 4 Lari/fam			24,000			31,500	
50% reimbursement family members	For above baseline expenses		48,000			72,000		
Reduced membership fee children			0			18,000		
Contribution Public Funds				0			26,000	26,000
Elderly Program								
	Basis = nr of elderly	*4,000*			*8,000*			
	Participants	*4,000*			*8,000*			
Member contributions Family package				8,000			4,000	
Reduced membership fee			0			12,000		
Contribution Municipality	For reduced membership fee			0			12,000	12,000
50% reimbursement family members	For above baseline expenses		16,000			32,000		
Extra 10% reimbursement						8,000		
Contribution Public Funds	For extra reimbursement			0			42,000	42,000
Vulnerable Program								
	Basis = nr of families	*500*			*1,000*			
	Participants	*2,000*			*4,000*			
Member contributions Family Program	1 lari per participant; max 4 Lari/fam			2,000			500	
Reduced membership fee			0			3,000		
Contribution Public Funds	For reduced membership fee			0			3,000	3,000
50% reimbursement family members	For above baseline expenses		4,000			9,000		
Extra 10% reimbursement						4,000		
Contribution Public Funds	For extra reimbursement			0			17,000	17,000
Reserve	Minimum 10% of total		9,200			21,200		
Grand totals		-	77,200	77,200	-	179,200	179,200	100,000