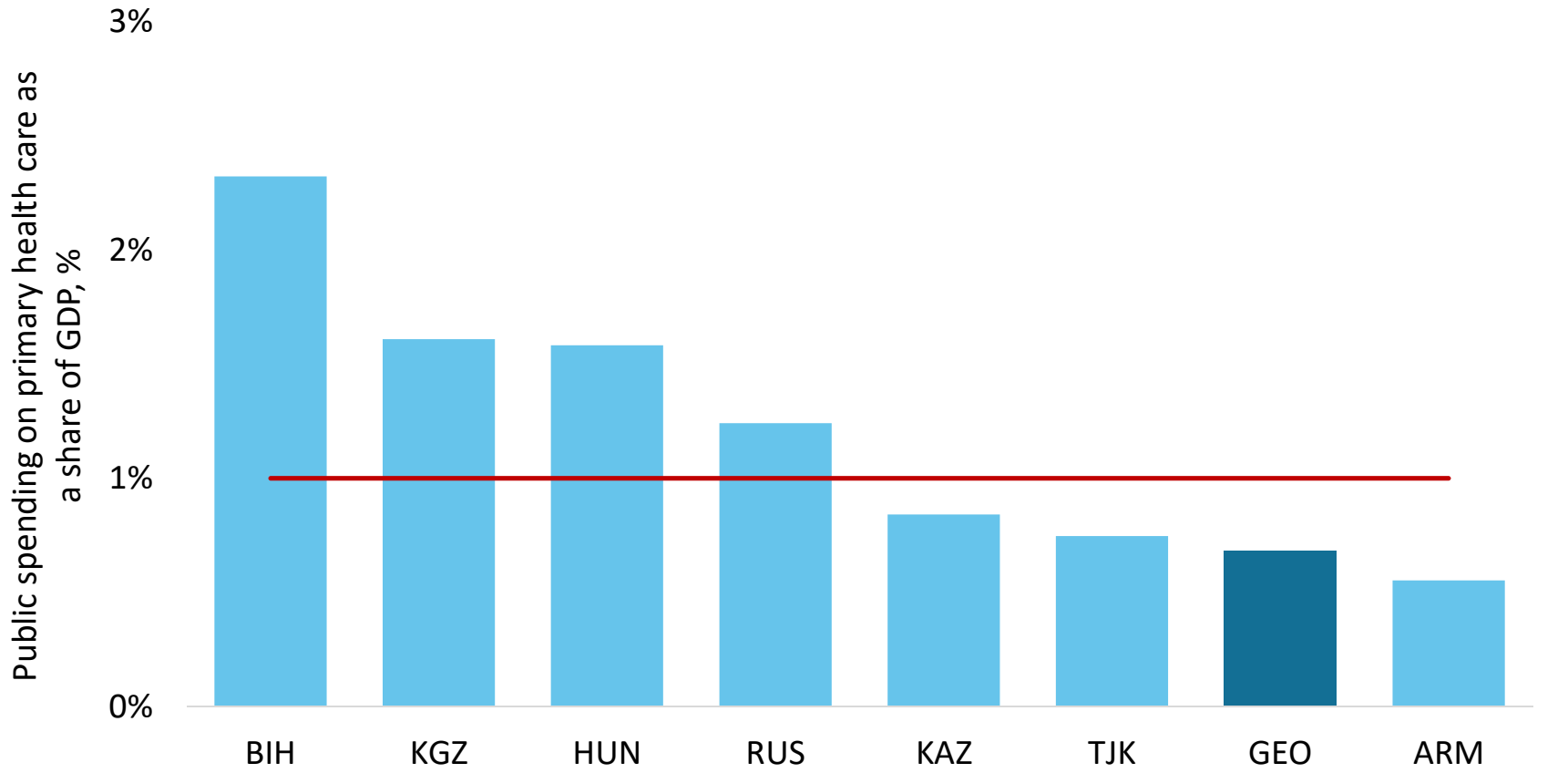
Refined PHC package of services for Georgia

World Health Organization
REGIONAL OFFICE FOR Europe

Progress of work by end of July

30.07.2020

Georgia spends less than WHO recommended 1% of GDP from public sources to PHC



Source: 2016/17 data, Global Health Expenditure Database

Refined PHC service delivery model

Key elements of the design of PHC services

Holistic, patient and people centered PHC

- Gradual transition towards networks of **multidisciplinary PHC teams accountable for performance outcomes**
- **Narrow specialists'** services are not part of the core PHC model, remain as a **separate packages for out-patient specialized services**

Increased role of family nurse

- In short term at least **one family nurse per family doctor**
- Enhance **competences and increase autonomy**
- Engage in **individual risk assessment** and provision of **brief interventions on behavioral change**
- Enhance role in **preventive and patronage services**

Unified PHC model

- Unified PHC model **applied universally to urban and rural practices**
- Some differences should be acceptable for **better alignment of services to priority health needs** of empaneled population

Chronic diseases management

- In short term focus on better outcomes of selected priority conditions: **hypertension, diabetes type 2, asthma**
- **Adjust PHC interventions** towards evidence based
- Introduce education and **counselling services for better engagement of patients in self-management**
- Implement **new patient pathways**

Expanded scope of PHC services through functional integration

Strengthening population health management

- **Integration with public health specialists**
- Re-profile public health specialists from regional public health institutes
- Introduce more bottom up and intersectoral approaches in health need assessment
- Synergize PHC and public health intervention to priority health needs

Strengthening patronage services

- **Integration with social care financed by Social Services Agency**
- Assess and address health and psychosocial risks of pregnant women and children 0-5 (short term)
- Develop and implement joint care plans for elderly with comorbidities and complex health needs (mid-term)

Essential PHC services

- Population health management and preventive services for adults
- Preventive services for children and adolescents
- Common acute health problems and urgency
- Noncommunicable diseases
- Elderly care
- Cancer and palliative care
- HIV/HCV/TB screenings and HIV/TB referral services

In the mid-term proposed integration to the PHC benefit package

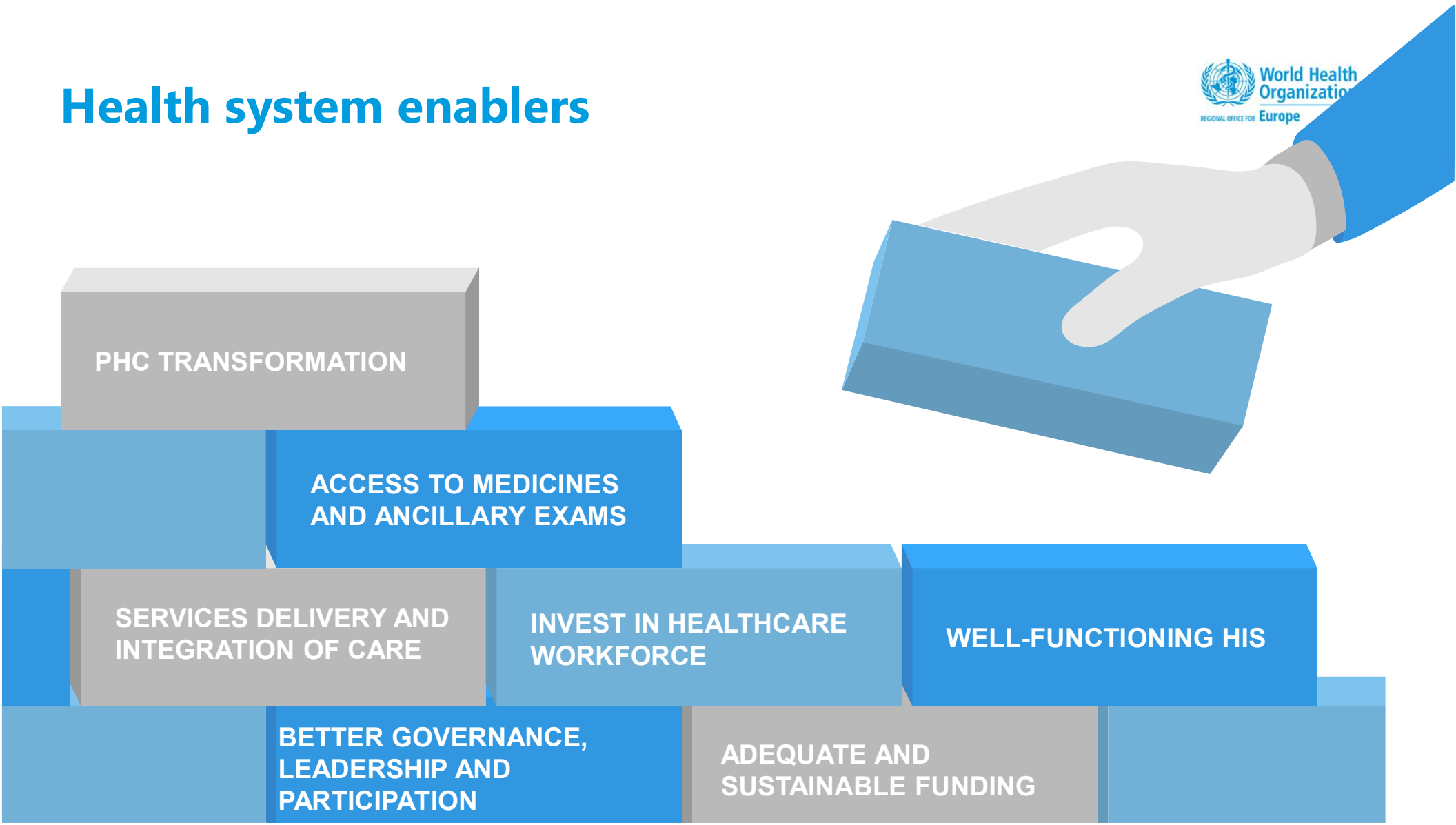
- Mental health
- Management of outpatient TB/HCV cases
- Women's health and antenatal care

Priority areas: preventive services for children 0-5y

Less but better targeted doctor and nurse visits on site, additional remote consultation and home visits

Years	1 year					2 years	3 years	4 years	5 years
Months	2 weeks	1-3 moths	4-6 months	6-8 months	9-12 months	18-24 months	30-36 months		
Doctors visits on site		1	1		1	1	2	1	1
Nurse visits on site		2	1		1	1			
Family Doctor's supervision (remote consultation)			1	2	1	1			
Remote nurse consultation							1	1	
Doctor’s home visit	1								
Nurse home visit	1					1	1	1	1

Health system enablers



BETTER GOVERNANCE, LEADERSHIP AND PARTICIPATION

Establish coordination structure (e.g. ministerial task force)

Develop phased implementation plan to manage transition

Develop national PHC facilities investment plan

Strengthen licensing requirements and/or selective contracting

Establish a plan for operational research

ADEQUATE AND SUSTAINABLE FUNDING

Develop long-term and prudent fiscal scenarios (with MoF)

Identify gaps between available funding and projected costs

Use financial protection studies as a tool to monitor progress

Institutionalize SSA costing function and continuous revision of tariffs and payment methods

Promote the PHC gatekeeper role

SERVICES DELIVERY AND INTEGRATION OF CARE

Undertake cross programmatic efficiency analysis

Develop patient pathways for the major conditions

Revise population empanelment and registration procedures

Revise referral mechanisms

INVEST IN HEALTHCARE WORKFORCE

Assess the adequacy of the overall healthcare workforce, envisioning 1 nurse per doctor

Identify the root causes limiting the performance and composition of the PHC workforce and prepare an action plan aligned with the country health plan

Prioritize training interventions aligned with the service delivery model (e.g. NCDs management, mother & child, PHC management)

Introduce a mandatory continuous professional development plan and competencies

WELL-FUNCTIONING HIS

Prioritize PHC specific HIS that features electronic health records, patient and population health management, and performance monitoring

Define minimum data set to support implementation of the refined PHC model and develop relevant IT system

Develop M&E plan for implementation of the new PHC service package

ACCESS TO MEDICINES AND ANCILLARY EXAMS

Assess the level of access to quality medicines and health products according to the PHC basket of services and introduce necessary amendments

Introduce price regulation for medicines and enhance the outpatient medicines benefit program to increase affordability of medicines

Regular update of prescription guidelines and monitoring

Mandatory disclosure system for healthcare professionals receiving any benefit from pharma and medical devices industry and ancillary exams

PHC costing and new payment model

Principles of new payment model

The new payment model aims to be applicable for **all PHC providers** offering the essential PHC package in **rural and urban settings**

- The calculated rates **cover all necessary costs** for a **single practitioner** working together with **one nurse**
- The costs of **laboratory tests** that minimally should be available at primary care level are considered
- **Motivational component for key priority areas**: hypertension, asthma, diabetes type 2 and child health

NB! Costing model is flexible to amend underlying assumptions

Inputs for costing

Cost information

- Service providers **actual cost** information (9 PHC providers)
- **Expert opinion** if accurate cost information was not available
- **Market prices** (lab tests) provided by local experts

Service standards

- National **guidelines**
- Available **standards** for facilities and equipment
- **Expert opinion**

In the mid-term:

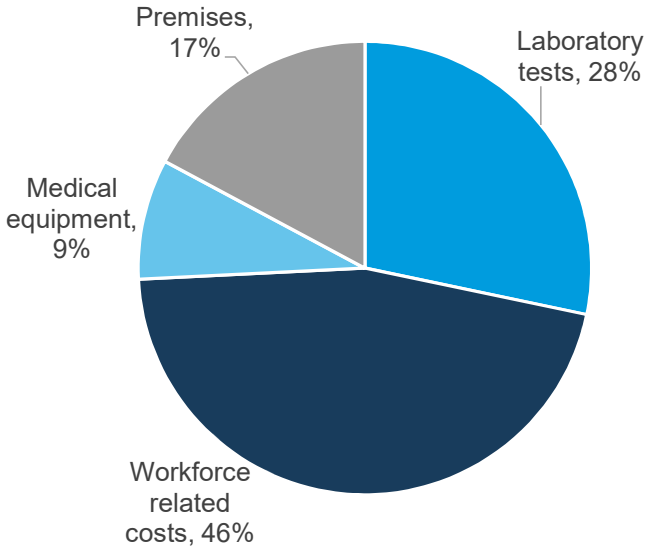
- Develop a more detailed bottom-up costing for laboratory tests
- Set up a procedure for regular collection of cost information and renewal of the costing model

Assumptions for the baseline scenario

Baseline scenario	Assumptions
Population coverage	100%
Patient list size	2500
Doctor monthly salary is the salary paid to rural providers with taxes	927,00
Nurse monthly salary is the salary paid to rural providers with taxes	685,98
Weekly working hours	40
Working days annually	242
Holidays annually	24
Room rent and capitalization costs	Allowance
Costs related to premises	Included
Costs related to medical equipment	Included
COVID related PPE costs	Included
m2 per FD and nurse	52
Training days	10
Specialist services	Excluded
Share of co-payments	0%
Management and supporting staff	Excluded

Basic capitation and room costs

Capitation covering basic costs	Total annual costs per FD and nurse	Monthly cost per enrollee	Total annual cost (GEL)	% of total capitation
Basic costs	43 045	1,43	64 054 174	72%
Laboratory tests	16 980	0,57	25 267 598	28%
Total	**60 025**	**2,00**	**89 321 773**	



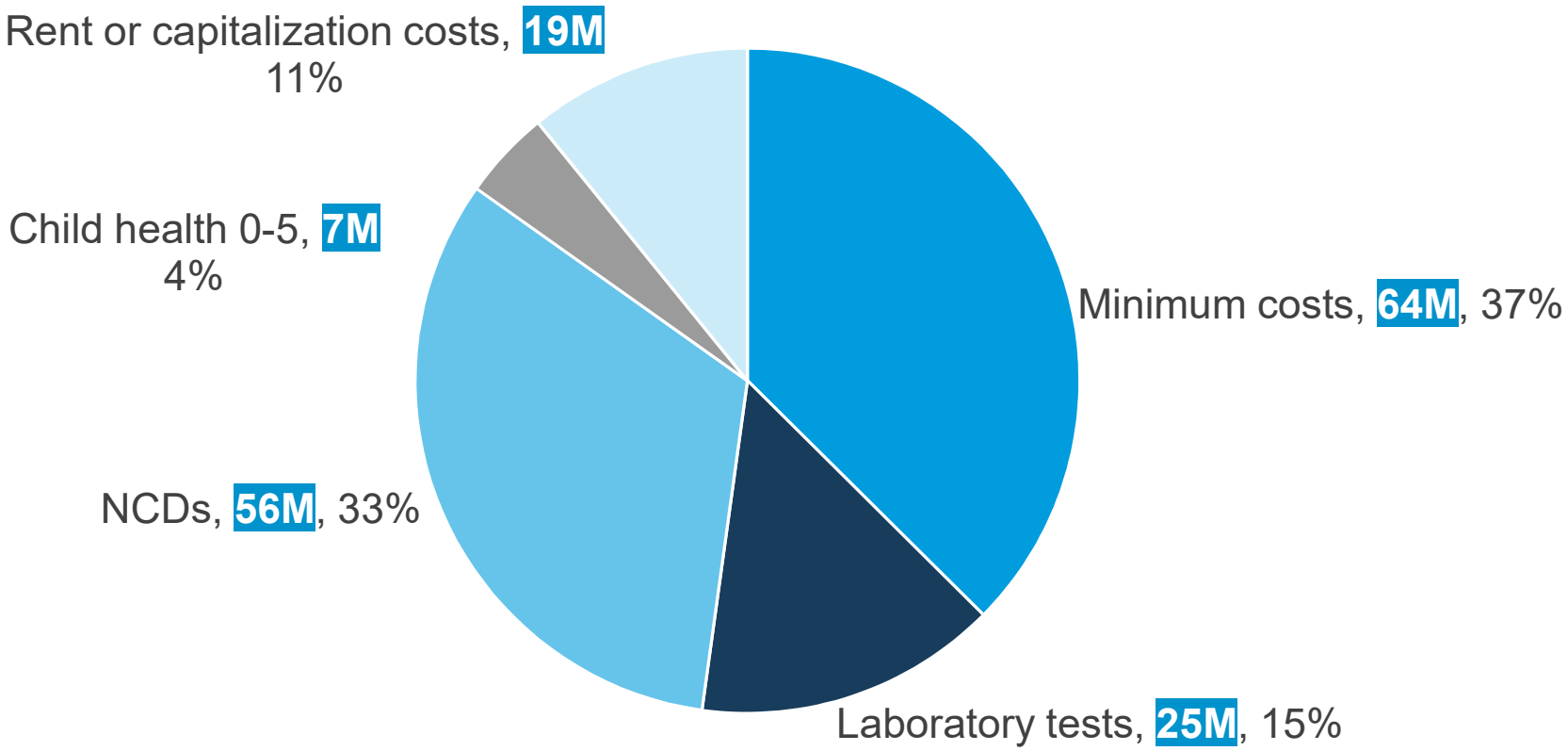
	Average m2 per FD and nurse	Rent/capitalization per m2 monthly	Total rent costs per FD and nurse monthly	Providers	Annual budget prognosis	% of basic capitation
Rent or capitalization costs	52,00	20,00	1 040	1 488	18 571 238	21%

Priority service packages

	Target group	Coverage %	Share of total population	Weighted monthly per capita cost	Persons per FD and nurse on average	Averge payment per practice per year	Total budget prognosis	% of basic capitation
Asthma	11 774	50%	0%		8			
Diabetes	76 672	70%	2%		52			
Hypertension	1 117 792	70%	30%		751			
Total NCDs	1 206 238		32%	6,09	811	37 529	**55 846 673**	**63%**

	Target group	Coverage %	Share of total population	Total costs	Per capita monthly	Persons per FD and nurse on average	Averge payment per practice per year	Budget prognosis	% of basic capitation
Child health 0-5	273 200	95%	7%	7 796 891	2,38	109	3 119	**7 407 047**	**8%**

Total budget impact (M GEL) and share of payment components



Payment model design

Baseline scenario	Sub-packages	Average population per FD and nurse	Monthly cost per enrolee	Unified per capita cost	Annual budget per FD and nurse	% of total annual budget
Basic capitation*	Minimum costs	2500	1,43	2,00	60 025	38%
	Laboratory tests		0,57			15%
Priority packages	NCD package (asthma, diabetes and hypertension)	811		6,09	37 529**	33%
	Child health (0-5) package	109		2,38	2 963	3%
Room rent or capitalization allowance					12 480	11%
Total annual budget					**112 997**	

*if FD works without a nurse, a coefficient of 0,75 could be applied to the minimum cost part of basic capitation (revised basic capitation 1,63 GEL)
**takes into account coverage for hypertension and diabetes 70% and asthma 50%

Scenario analysis

Laboratory tests	Per capita	Budget	Impact compared to basic capitation
Scenario 2. Actual need for tests to be covered at PHC level (population in need is 20-30% higher than baseline scenario)	1,31	58 670 034	132%
Scenario 3. Minimum need with a 30% copayment (excluding vulnerable)	0,40	20 457 787	-19%
Scenario 4. Actual need with a 30% copayment (excluding vulnerable)	0,92	35 286 220	40%
Scenario 5. Minimum need with a fixed copayment according to the priority of the test (excluding vulnerable)	0,48	22 941 984	-9%
Scenario 6. Actual need fixed copayment according to the priority of the test (excluding vulnerable)	1,04	38 707 903	53%

Specialist services	Per capita	Budget	Impact compared to current basic capitation
Scenario 2. Listed specialist included (as today) with 30% copayment (except vulnerable)	0,42	21 840 518	-19%
Scenario 3. Listed specialist included (as today) with fixed copayment 10 lari (except vulnerable)	0,36	22 234 039	-18%

Way forward with the new costing and payment model

Before implementing the new payment model, it is essential to develop **in short term** :

- patient **enrolment system**
- **system and criteria** to define patients for the **add on payments** of priority service areas
- describe the **technical details** of the **add on payment instalments** and **minimum data set**
- system to define the **room rent or capitalization costs** for providers
- **co-payment regulation** (small fixed co-payment or unified tariffs to apply percentage co-payment)
- further develop the **costing model for group practices and remote areas**
- review and align **outpatient medicines benefit** programs to ensure affordability of medicines for key priority conditions

Next steps

- **Costing and payment model** – we can developed it further depending on Ministry's feedback and expectations (see previous slide for details)
- **Technical report on PHC service package** – draft version to be available by end of August

- Implementation of the refined PHC model is a complex task and requires Ministry's leadership, **multidisciplinary (clinical, IT, financial, legal) task-force and phased implementation plan** with primary focus on short-term activities