Cost Containment and Eficientization of State Health Programs

REPORT (I)

Global Alliance for Health and Social Compact

CONSULTANCY ASSIGNMENT

According to the Agreement of State Procurement of Advisory Services between Ministry of Labour, Health and Social Affairs of Georgia and Global Alliance for Health and Social Compact, dated 07 April 2015

Objectives covered	(i)	Elaboration of methods for containment Universal Health Care State Program's (UHC program) and other state health programs' expenses
	(ii)	Creation of mechanisms for efficient implementation of UHC program and other state healthcare programs and relevant normative framework
Implementation/Development	Global Alliance for Health and Social Compact	
Date of report	October 30, 2015	

Global Alliance for Health and Social Compact

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DISCLAIMER

The current report was produced as a result of the Consultancy mission evaluation and analysis conducted in the period April - August 2015. Thus, all the calculations, figures and respective assumptions are based on the data available at the time of the assessment.

Especially, this is the case for the budgetary figures, which were provided as a preliminary planed and does not reflect the reality and any modifications made after August 2015. Therefore, some of the respective calculations might no longer be valid in time. However, some of the recommendations provided by the current Report might have been already included in the final approved budget as they do reflect general phenomenon and challenges specific to the Georgian context of the health care system.

At the same time, it has to be highlighted that the Consultancy mission views and recommendations, provided in this Report, does not necessarily reflect the Ministry of Labour, Health and Social Affairs of Georgia and Global Alliance for Health and Social Compact. It aimed to provide an independent oversight meant to underpin informed based decisions.

Content

PREFATORY NOTE

This Report of the consultancy assignment, under *Agreement of State Procurement of Advisory Services between Ministry of Labour, Health and Social Affairs of Georgia and Global Alliance for Health and Social Compact, dated 07 April 2015,* presents an exhaustive and comprehensive description of the Objective 1.1 and Objective 1.2:

(i) Elaboration of methods for containment Universal Health Care State Program's (UHC program) and other state health programs' expenses

(ii) Creation of mechanisms for efficient implementation of UHC program and other state healthcare programs and relevant normative framework.

The following component of the Objective 1.1 *Elaboration of pay for performance and its implementation plan* will be presented in the framework of the next report covering this Objective.

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INTRODUCTION

This report was prepared as part of an analysis and evaluation of risks, losses and containment methods for Universal Health Care and other state health programs to improve the cost effective delivery in Georgia.

The specific goal of the Consultancy Mission was to assess Universal Care Program and other state health programs and recommend feasible and applicable, for the existing specific context, cost containment and efficiency interventions. The Consultancy Mission was to accomplish this task by drawing on expert knowledge regarding health care reform and state health programs, with a particular focus on cost containment strategies that have a high likelihood of achieving savings that also minimize any negative impact on providers, health care quality and access.

This analysis focuses on all UHC sub-programs and vertical health programs. The Consultancy Mission used the encounter data to thoroughly examine cost savings potential under current managed care programs.

Solutions that improve care, improve the health of populations and reduce per capita costs are the goal of reform efforts throughout the health care system.

In the short term, the Government will likely need to reduce costs by focusing on more blunt options offering quicker savings. Long-term solutions to bend the curve will require concentrated, coordinated care management, as well as payment and service delivery reforms.

Options for immediate, short term savings are limited but not unavailable. Trying many different approaches could spread current resources, including personnel and funding. Even in case of short-term interventions, any options choose to pursue should be part of a comprehensive strategy to reform payment and service delivery, addressing key issues identified in this report and aligning incentives for providers to control costs and offer effective primary health care programs to avoid higher-cost care. A clear, strategic approach that links all initiatives together to expected outcomes and anticipated, measurable savings could provide a useful roadmap for Ministry of Labor, Health and Social Affairs.

METHODOLOGY LIMITATIONS

The Consultancy Mission Report examines risks and losses in UHC and other state health programs and the cost containment and efficiency measures to be adopted in order to address those challenges. Specifically, it recommends clarifying and strengthening the deterrent role of the UHC Program, crafting UHC procedures to maximize UHC effectiveness, and networking between UHC and other regulatory entities to enhance program effectiveness.

The assessment of risks/losses of the UHC and other state health programs has faced some methodological limitations, which should also be considered as the limitation for cost containment and efficiency interventions designed for the Georgia health authorities. The major challenge was possibility to apply well-established assessment methodologies, including econometrics, since existing data availability and existing regulations about data generation and collection formats – although, rigorous, still limit complex analytics.

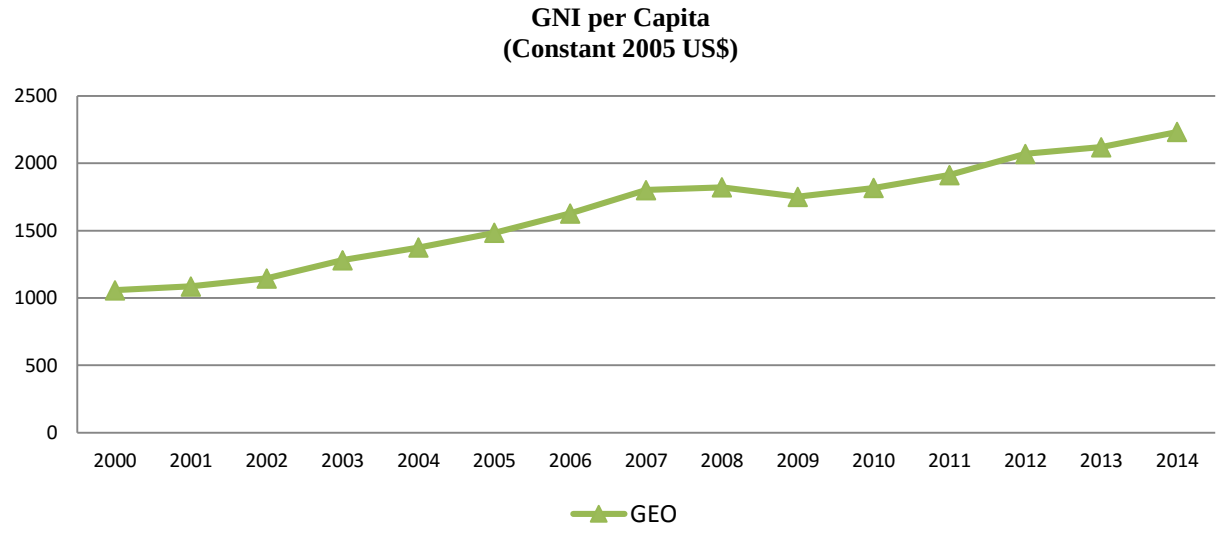
However, as a part of the comprehensive set of recommendations developed within the scope of collaboration among MoLHSA, GAHS and expert community, those limitations should be lifted in subsequent implementation phases.

FINANCING OF UNIVERSAL HEALTH COVERAGE IN GEORGIA: AS-IS ANALYSIS

Macroeconomic Context

During the last decade, Georgian economy has seen a transformative growth. GNI per capita have increased by 211% from 2000 to 2014 (
Fig. 1). High economic growth in the past years was largely driven by strong consumption and large investments in infrastructural projects. As the result, the country's economic stability reflected in single-digit inflation rate and stable exchange rates. As country's economy remained robust with a strong economic growth, it created favorable environment for the expansion of socially oriented public investments.

Fig. 1. GNI per capita, Georgia 2000-2014



Source: World Bank

Poverty in the country remains high. Different studies identify significant vulnerabilities of households with 3 and more children and single pensioner households. Overall, current social vulnerability database at the Social Service Agency (SSA) holds the record for 520 231 households (1 613 252 individuals) being assessed for cash assistance, which is 48% of total population, while only less than 25% of those qualified for cash assistance (SSA, June 2015).

Number of Pensioners has increased from 2012 to 2015 from 682 886 to 696 779 (December, 2012 to January, 2015), while monthly expenditures for pensions have increased by 30% from 825 52 840.83 GEL to 105,434,211.00 GEL (December, 2012 to January, 2015) (SSA).

Besides age-based pensions, Georgia has a few different monetary assistance programs for socially vulnerable groups. Targeted Social Assistance is a type of financial support given to poor households. Notably, individual below a scoring line of 70 000 points also receive differential medical assistance package. In December 2012 there were 1 672 115 individuals registered in the database, while only 501 445 qualified for financial assistance. This is 11% of total population. Meanwhile, over 741 211 individuals also qualified for targeted medical assistance. By January, 2015, the number of individual receiving cash benefits has dropped to 418 717 (9.3% of total population according to www.ssa.gov.ge, however, if recalculated for the resent census data, the figure is 11.3%), the number eligible for medical assistance program also decreased to 632 604.

General Information about Universal Health Coverage

Universal Health Coverage had been one of the leading themes in health systems debate for the past few decades titled as “the third global health transition”. As a health systems model, universal coverage is projected to improve wellbeing and equity of country's population and generate additional economic grows. Already, number of wealthiest nations as well as middle and low-income countries has joined their efforts to provide healthcare coverage to the entire population of their respective countries.

Georgia had also joined this effort and in 2013 declared a launch of publicly funded Universal Healthcare Program.

Georgia’s Progress to Universal Health Coverage

Public health spending in Georgia has been low for the past few decades. Unlike many of its neighboring countries, Georgia's public budget had been limited creating insufficient bases to comprehensively fund healthcare from general taxation.

In 2007, country made a decision to direct limited public funds to purchase targeted and means tested private health insurance for the poor. At a later stage the program was expanded to cover other groups (teachers, internally displaced individuals, children, pensions, etc.). Overall, publicly funded and private health insurance covered over half of the population.

However, since 2013, country made a radical change in its healthcare financing policy and instead of publicly funding private health insurance for specific groups, launched a program – Universal Healthcare Program, which would provide health coverage for rather comprehensive package for all the population.

Notably, country maintained its public funding for what is referred to as «vertical programs» -- number of public health and curative interventions mostly targeted to either prevention or management of chronic conditions.

Universal Healthcare Program (UHP) was initially launched to provide coverage for only uninsured population. Gradually, individuals insured with private insurance companies through state-funded health insurance programs were transferred into UHP. Furthermore, individual who hold private insurance (and pay for the insurance themselves) also may benefit from UHP.

UHP Benefit Package

Benefit package under UHP varies according to the beneficiary groups, but can be shortly summarized the table below.

Universal Health Care

	Coverage	Beneficiary									
		Poor	**Groups, which were covered earlier by state insurance 218***	**Children up to 5**	**Retirees**	**People With Disabilities (up to 18)**	**People With Disabilities (1 group)****	**Students**	**Veterans**	**Minimum Package*****	**Basic Package********
1	**Primary health care**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
1.1	**family doctor/nurse (examination, treatment, vaccination, giving of prescriptions etc.)**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
1.2	**Specialists (all)**	✓	✓	✓	✓	✓	✓	✓			
	Endocrinologist								✓		Co-payment: 30%
	Ophthalmologist								✓		Co-payment: 30%
	Cardiologist								✓		Co-payment: 30%
	Neurologist								✓		Co-payment: 30%
	Otorhinolaryngology								✓		Co-payment: 30%
	Gynecologist								✓		Co-payment: 30%
	Urologist								✓		Co-payment: 30%
1.3	**Laboratory research**										
	General blood test	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	General urine test	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Glucose (in blood)	✓	✓	✓	✓	✓	✓	✓	✓		✓
	Creatinine	✓	✓	✓	✓	✓	✓	✓	✓		✓
	Hemoglobin	✓	✓	✓	✓	✓	✓	✓			
	Fecal test for occult blood	✓	✓	✓	✓	✓	✓	✓	✓		✓

	Pregnancy test	✓	✓								
	Cholesterol (in blood)			✓	✓	✓	✓	✓	✓		✓
	Lipids in Serum			✓	✓	✓	✓	✓	✓		✓
	INR								✓		✓
	ALT, AST								✓		Co-payment: 30%
	TSH								✓		Co-payment: 30%
1.4	**Instrumental research**										
	ECG	✓	✓	✓	✓	✓	✓	✓	✓		✓
	US	✓	✓	✓	✓	✓	✓	✓	Only the Trans-abdominal		Only the Trans-abdominal Co-payment: 30%
	Radioscopy	✓	✓	✓	✓	✓	✓	✓	Only the chest		Only the chest. Co-payment: 30%
	X-ray radiography	✓	✓	✓	✓	✓	✓	✓	Only the chest		Only the chest. Co-payment: 30%
	Mammography	✓	✓	✓	✓	✓	✓	✓			
	CT			Co-payment 20%	Co-payment 10% Without co-payment: veterans	Co-payment 20%	Co-payment 10% Without co-payment: veterans	Co-payment 20%			
1.5	**Study for disability obtaining (except for high-tech)**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2	**Emergency outpatient care**	✓	✓	✓	✓	✓	✓	✓	Only included in the list	Only included in the list	Only included in the list
3	**Emergency hospital care**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

	Critical situation	✓	✓	✓	✓	✓	✓	✓	At therapeutic hospitalization limit is 5 days	At therapeutic hospitalization limit is 5 days	At therapeutic hospitalization limit is 5 days
	Other Emergencies	✓	✓	Co-payment: 20% Without co-payment: palliative care and neonatology	Co-payment 10% Without co-payment : veterans	Co-payment: 20% Without co-payment: palliative care and neonatology	Co-payment 20% Without co-payment: veterans	Co-payment 20%		Included in the list: without co-payment. Limit (Case): 15 000	Included in the list: without co-payment. The rest: co-payment 30% limit(Case): 15 000
4	**Planned operations (includes oncology)**	15 000 Annual Limit	15 000 Annual Limit	Co-payment: 20% The annual limit : 15 000 No co-payment: palliative care and neonatology, oncology, cardiac surgery Co-payment of 20% The annual limit: 15 000 Without co-payment: palliative care and neonatology,	Co-payment : 10% The annual limit: 15 000 Without co-payment : veterans	Co-payment: 20% The annual limit: 15 000 Without co-payment: palliative care and neonatology, oncology, cardiac surgery"	Co-payment: 20% The annual limit: 15 000 Without co-payment: Veterans	Co-payment: 20% The annual limit: 15 000	The annual limit: 15 000		Co-payment: 30% The annual limit: 15 000 except: neonatology, oncology and cardio and for persons up to 18

				oncology, cardiac surgery							
5	**Oncology (chemotherapy , hormone therapy and radiotherapy) *****	12 000 the Annual limit	12 000 the Annual limit	The annual limit: 15 000	Co-payment : 10% The annual Limit: 15 000 Without co-payment : veterans	The annual limit: 15 000	Co-payment: 20% The annual limit: 15 000 Without co-payment: veterans	Co-payment: 20% The annual limit: 15 000 Without co-payment: veterans	The annual limit: 12 000		Co-payment: 20% (except the people up to 18) The annual limit: 12 000
6	**Birth**					500 Lari					
6.1	Physiological birth	Limit 500	Limit 500						Limit 500	Limit 500	Limit 500
6.2	Caesarean section	Limit 800	Limit 800						Limit 800	Limit 800	Limit 800
7	**Medicine**	For retirees - 200 Lari. The annual limit and co-payment 50% For other groups - 50 Lari. The annual limit and co-payment 50%		The annual limit 50 Lari and co-payment 50%	The annual limit 100 Lari and co-payment 50%	The annual limit 100 Lari and co-payment 50%	The annual limit 100 Lari and co-payment 50%		The annual limit 50 Lari and co-payment 50%		

Benefit Package

Levels and sources of financing

An increasing share of resources is dedicated to healthcare in Georgia. After breakup of the Soviet Union, the largest share of those resources had been out-of-pocket spending, nearly 70-75% of Total Healthcare Expenditures. Starting from 2013, country launched Universal Healthcare Program that provided coverage to the whole population and significantly increased public allocation for health and based on the findings of Healthcare Utilization and Expenditures Survey in 2015, this increased public spending, has resulted in reduction of out-of-pocket spending.

Despite the fact that there is not "golden standard" for what level of public spending is "good" for health, with the recent increase in public allocation, Georgia started to "catch up" with European countries through share or resources from public budget (7%).

Public Budget

Currently, Georgia has Universal Healthcare Program and 22 additional health programs. Allocation from state budget is used to finance those programs, while additional funds to fully cover service changes are mobilized by the providers themselves from patients (or their private insurance). Only one sub-program (epidemiological surveillance at a municipal level is co-funded from local budget (also funded to those budget are derived through earmarked transfer from central budget).

Starting from 2013, when country launched a Universal Healthcare Program (UHP), allocation from state budget had increased and nearly doubled in the following years.

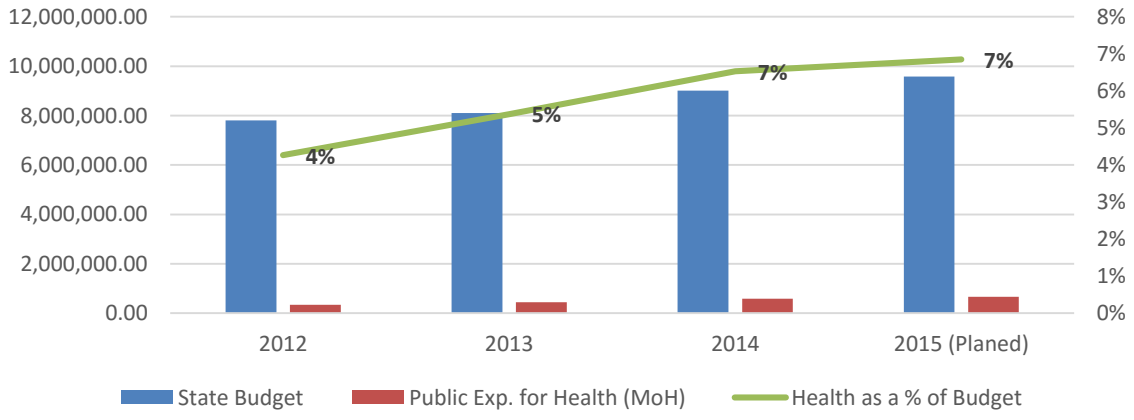


Fig. 2. Public Expenditures for health Programs

Overall, compared to 2012 allocation for health programs, public budget had increased by 50% in 2015. Largest increase in public allocation for health in 2015 was made under UHP. The program's budget increased by 39% (131 526.9 million GEL). Nevertheless, out of additional 22 programs, budgetary increase is observed in case of 15 programs.

Notably, besides healthcare programs, the MoLHSA maintains internal organizational structures responsible for policy development/planning and program administration. Policy development, which also includes process of program planning and budgeting, is done by the designated departments of the Ministry, while all the programs are administered and managed by the designated LLPs – the National Center of Disease Control and Public Health, Social Service Agency and Ambulance Management Center. Allocation for those functions (administrative functions) had also increased. Compared to 2012, this portion of public budget had increased by 6% amounting 52.55 million GEL.

Private Insurance

Private insurance had been one of the predominated sources of healthcare financing in Georgia. Before the launch of the UHP, large share of public budget was diverted to private insurance companies to purchase private insurance for targeted groups, such as poor, elderly, children and others. After the launch of UHP, share of private health insurance market started to shrink.

UHP states that the program should serve as a "safety net" for those citizens who do not have private health insurance.

Despite reduction of the market size, health insurance is still one of the predominant parts of insurance market in the country. According to LEPL Insurance State Supervision Service of Georgia data, in 2015 share of health on the total insurance market is 58% and nearly 553 thousand individuals are privately insured. One should bear in mind that most of the owners of private health insurance policies can still benefit from UHP. Basically, private health insurance will use UHP to cover costs of emergency in-patient, planed surgical in-patient, cardiac surgery and treatment of cancer for their privately insured individuals. .

International donors

Currently, share of international donor funding for health is relatively small in Georgia and further declining. Furthermore, potential to attract additional funding is also limited, as the Georgia's economy has grown and country is already classified as low-middle income country and projections are made that country would shortly move on this scale.

Increased reliance on local funding is projected to increase as more international donors step out especially from funding of healthcare services and goods. E.g. GAVI and GF support to be gradually ending during the recent years creating additional burden to the public budget.

Private (Out-of-pocket)

Currently, we do not have sufficient information about private spending in Georgia. Historically it has been high and comprised over 70-75% of Total Healthcare Expenditures. Start of UHP had a potential to reduce private expenditures and as the preliminary findings from 2015 Healthcare Utilization and Expenditure Survey show, households do report lower out-of-pocket spending.

However, UHP has limitations in all 3 dimensions of coverage leaving space for unregulated OOP spending:

- Breadth of coverage: Although, UHP is quite large in terms of who is covered, there are still individuals who don't use services – are excluded. On one hand, those are the individuals who have not registered with PHC provider and therefore do not use primary and preventive care, but can use emergency inpatient and planned surgical care components. On the other hand, there are individuals who are explicitly excluded from the programs. Those include people who had private health insurance as of July 1, 2013 and are in the master list of insured population (which was formed on that date) and still continue to have an insurance; if there insurance for terminated for any reason during this time, those individuals are eligible for so called "minimum package" under UHP.
- Depth of coverage: UHP covers limited outpatient services (primary care and emergency out-patient), most of the emergency in-patient care and surgical care, but with copayment, delivery and oncology treatment with co-payment. Number of services still remains uncovered and there is a variation in coverage between different groups of beneficiaries. Most significantly, UHP largely does not cover outpatient drugs.
- Height of coverage: UHP requires contribution towards fees for services and goods in the form of copayments from the users. Notably, UHP does not set upper limits for the cost of treatment or for pharmaceutical covered under the program (excluding few services); therefore, besides stated rate of copayment (e.g. 20%, 10%, 30% or 50%), the users also have to pay difference between UHP rate for the service/goods and price charged by the provider.

Composition of state health programs expenditures

State Health Programs are represented by the Universal Healthcare program and additional 22 vertical programs. Budgetary allocation of the programs is provided below:

in thousands

Code	Component	2013 (Actual)	2014 (Actual)	2015 (Projections)	% of change (2014-2015)
35 03	**Health Programs**	**435,516.2**	**588,279.2**	**656,161.0**	**12%**
35 03 01	***Universal Healthcare Program***	***69,916.9***	***338,473.1***	***470,000.0***	***39%***
35 03 02	***Public Health Program***	***31,125.4***	***52,802.9***	***52,362.0***	***-1%***
35 03 02 01	Early diagnosis and Screening	1,463.7	1,475.1	2,000.0	36%
35 03 02 02	Immunization	5,974.7	4,430.8	8,340.0	88%
35 03 02 03	Epidemiological Surveillance	651.8	918.7	1,000.0	9%
35 03 02 04	Safe Blood	817.0	1,073.4	1,502.0	40%
35 03 02 05	Occupational Health	266.7	270.0	270.0	0%
35 03 02 06	Infectious Disease Management	1,255.5	7,381.7	10,000.0	35%
35 03 02 07	Tuberculosis	8,653.5	15,699.4	11,850.0	-25%
35 03 02 08	HIV/AIDS	3,136.7	11,310.3	6,400.0	-43%
35 03 02 09	Maternal and Child Health	4,914.1	6,052.9	6,000.0	-1%
35 03 02 10	Drug Addiction	3,991.7	4,190.6	4,800.0	15%
35 03 02 11	Healthy Life Promotion	0.0	0.0	200.0	New
35 03 03	***Provision of services to the population in priority areas***	***94,933.9***	***123,839.4***	***132,799.0***	***7%***
35 03 03 01	Mental Health	14,570.2	15,093.5	15,000.0	-1%
35 03 03 02	Diabetes	4,855.4	5,748.3	6,500.0	13%
35 03 03 03	Children Oncohematology	1,674.4	1,625.1	2,000.0	23%
35 03 03 04	Dialysis and Kidney Transplantation	22,136.0	25,131.9	29,465.0	17%
35 03 03 05	Palliative Care for Incurable Patients	2,354.4	1,409.3	2,500.0	77%
35 03 03 06	Rare Diseases and Substitution Therapy	3,824.2	4,206.4	6,000.0	43%
35 03 03 07	Ambulance and Medical Transportation	15,148.5	29,658.6	30,000.0	1%
35 03 03 08	Village Doctor	11,293.2	20,377.6	25,334.0	24%
35 03 03 09	Referral Services	17,924.4	19,692.7	15,000.0	-24%
35 03 03 10	Medical Check-up for Army Recruits	1,153.3	896.2	1,000.0	12%

Payment mechanisms by level of health care

Primary Healthcare

PHC services in the country are mostly funded from public sources. There are at least two types of payment method used for reimbursement.

a. Capitation: Capitation is reimbursement method used by UHP to pay for PHC services in the cities (Tbilisi and other municipalities); At the point of service, patients receive care by a family physician (according to Georgian legislation, this can be a pediatrician and therapist as well) and a nurse free of charge, however they have to co-pay for specialist consultations, laboratory and other exams integrated into the PHC benefit package, (except of vulnerable groups, pensioners and children 0- to 6) . The labs, exams and specialists that are not a part of the benefit package have to be paid based on fee-for-service. Same might apply on non-necessary home visits by the doctor or a nurse.

b. Global budget: PHC services, namely services provided by family doctor and a nurse in rural areas are funded through a state program called Village Doctor's program. The program allocates monthly budget per doctor and per nurse. This amount is often understood as salary, although it is supposed to cover utilities and medical goods and other costs related to service provision. All the services that are provided by those practitioners should be free of charge.

c. Fee-for-service (FFS): Services beyond basic benefit package of UHP are paid on a fee-for-service basis. We cannot estimate volume of such payments.

Different payment methods under UHP and village doctor's program crease uneven financial flows for PHC services in rural and urban areas.

In case of rural doctors, on average most of the rural doctors serve catchment areas significantly below 2000. Most likely, there is a venue for optimization.

Specialized outpatient care

Specialist consultations covered by the UHP includes 7 specialists. However, beneficiaries that moved into the program from previous health insurance programs are eligible for all specialist consultations per their family doctor's referral. Other specialty outpatient is mostly paid FFS.

UHP covers the full cost of emergency outpatient for a positive list of services.

Limited number of specialized outpatient services is covered from other state healthcare programs, such as mental health, TB and HIV, diabetes, dialysis, etc.

Capitation rate for PHC component does not reflect full costs of all specialized care or additional labs and exams, neither is it adjusted for higher utilization by children and elderly as the rate was not recalculated when additional services were added, as well as new groups of population to the program.

In-patient care

UHP covers significant portion of inpatient care services. This includes full cost of intensive in-patient care under the limit. The limit is usually sufficient for large share of the patients, but there are instances when the limit can be exhausted. Notable, UHP introduced limits per case limit for most of the hospitalizations unlike previous health insurance programs or current private health insurance that offer annual limits for those services within the same amount or less. It will potentially be unpopular to step down from this benefit offering and change per case limits to annual limit, but the decision has a significant potential to improve cost-containment within the program.

Emergency in-patient services can be divided into two categories: fully covered and covered with copayment.

For fully covered services (under the positive list), SSA reimburses FFS rate of the facility, while for services with co-payment, SSA calculates the tariff, while patients covered copayment from the tariff as well as difference up to the price of the facility.

Similar is the approach to panned surgical services.

Clearly, the amount of spending depends upon the number of beneficiaries. For PHC services paid through capitation, number of beneficiaries directly influences the volume of payment. For emergency inpatient the link is not that obvious, however, number of individuals in the pool, and directly influences the number of claims.

One of the aspects of the UHP is that the program does not allow proper identification of individuals with private health insurance who have the same befits covered by the private plan. As a result, private insurance company ends up free-riding UHP, e.g. not paying the claim at all or paying just for copayment.

Therefore, database of privately insured individuals have to updates frequently and access to UHP should be limited. Currently, over half a million individuals in Georgia are privately insured.

In case of PHC services, registration with village doctor should become mandatory. This will change number of individuals who live in rural areas, but are registered with municipal PHC provider for GP services. Currently, only formal registration address of an individual is used for this differentiation. Although, formal registration address is not required in Georgia and often it does not match with the residential address of an individual.

HEALTH PROGRAMS RISK MAPPING

Risk mapping is needed to identify uncertainties and other factors that may threaten initiatives to strengthen UHC program and other state health programs and consequently hinder service delivery performance. Such risk is likely to arise from governance, policy process, regulatory, contracting and purchasing, clinical practice, resource availability and control features.

This risk mapping is tantamount to a problem-driven (or problem-centric) review of the UHC Program and vertical programs and development of entry points for strengthening its systems and processes and cost containment. The process started with a diagnosis of the main observed constraints to better UHC Program, then disaggregates these factors into tractable problem sets, and finally develops possible solutions that are compatible with the prevailing context and government policy objectives.

The Consultancy Mission, given the fundamental constraint of limited resources, is acting from the premise that MoLHSA and SSA cannot eliminate every possible risk, thus risk mapping is providing a methodical way to identify and prioritize risks. The methodological focus of the Consultancy Mission was on identifying the most probable and potentially damaging risks, risk assessments help guide the allocation of limited resources toward addressing the risks that are most likely and have the largest containment impact first.

Risk Mapping

Risk 1: Duplication of services and/or parallel systems that do not ensure efficient and effective use of existent resources to achieve declared objectives, and that were generated by the fragmentation and uncoordinated provision of healthcare services
• Fragmentation of PHC organization and financing - PHC financing in parallel with universal coverage program under the vertical program "Rural Doctor" Fragmentation of drug compensation under different healthcare programs (ANNEX C)
Risk 2: Organization and financing of the healthcare system is oriented towards delivering acute care services and disregards long-term care and prevention services.
• Disproportionate financing of primary healthcare compared to hospital healthcare • Lack of the “gatekeeper” family doctor in the health system (incentive health package for patients) • Limited access to compensated drugs (per approved list) • Prevailing financing of healthcare based on medical technologies to the detriment of prevention and screening interventions

Risk 3: Unclear defining definitions of the categories of program beneficiaries and of the allocated/reimbursed package of services
Risk 4: Overproduction of low quality health services, by forcing the demand of healthcare services by providers and orientation of production to services that generate higher profits
Risk 5: Delivery of healthcare services in "wrong" locations (e.g. planned outpatient care received at hospital setting)
Risk 6: Reduced prioritizing in the financing of interventions from vertical programs and of the universal coverage program
Risk 7: Scaling up practices from the private insurance system to the level of the universal coverage program resulted in the transfer of risks to the public budget
Risk 8: Lack of a transparent and legitimate mechanism of formation of tariffs for healthcare services at a provider level (mostly on fee-for-service bases)
Risk 9: Health programs do not provide "terminals" and "checkpoints" for efficacy
Risk 10: Healthcare programs are oriented towards resource allocation and do not generate results (dependence on expenditures reported by provider)
Risk 11: The predominant model based on payments per service or *bundle fee-for service* stimulate the delivery of large volume of healthcare services to the detriment of efficiency and quality (inadequate financing mechanisms)
Risk 12: Fragmentation of the treated case financing
Risk 13: Contracting/procurement mechanisms are extremely fragile to control supply and demand
• Regulations around health programs are weak have regulatory vacuums, providing a framework of double standards for healthcare providers • Misreported cases (unjustified complications of the case, etc.) • Uncontrolled access of providers to healthcare delivery • The phenomenon of “incomplete contract” with healthcare providers (unspecified volume of services, etc.) Excessive reimbursement - lack of a system of expenditure reimbursements in accordance with a standardized volume of services
Risk 14: Reduced capacity and performance of e-Health systems
• Lack of integral reporting by healthcare providers of all cases treated in the healthcare facility (e.g. country does not have universal EMR) • Lack of a system of personified reporting of beneficiaries

Much of the growth in the cost of the UHC Program during the period 2013 - 2015 is attributed to the use by UHC of inpatient services and cost- and charge-based (bundle fee-for-service) reimbursement. Under these methods, UHC Program reimbursed hospitals for their “reasonable” reported costs. Cost- and charge-based reimbursement methods proved duplication of services segregation of case financing. Analysis of SSA data regarding financial

resources reimbursed to medical facilities concludes that the highest share of all transferred financial resources fall on hospital services: in 2014 - 77.6%; 6 months 2015- 82.3%. In 2014, financial resources transferred for emergency hospital care rank first with 43.6%, and planned surgeries rank second with 26.8%.

During the first 6 months of the Consultancy Mission, it identified negative trends in directing cases towards healthcare with the highest costs. Thus, emergency hospital care registers a significant increase from 43.6% in 2014 to 54.87% in 2015 (6 month-period); this negative trend in continued by a decrease in planned surgeries from 26.8% to 22.49% and by a decrease in amounts for PHC from 12.1% to 7.38%.

The second important conclusion is that the applied financing mechanism (case-based) **is a hidden fee-for-service payment.** Thus, in the financing of the hospital care exists an incomplete or false case payment mechanism, determined by the segregation of the case to be treated, which leads to a phenomenon of bundling fee-for-service for the respective component of the case – inpatient emergency care (UHC Component 3) and planned surgery (UHC Component 4).

The calculation formula for payment for cases of *Critical Conditions* (excluding ICU treatment) and *Planned surgery* does not contribute to improving technical efficiency of financial resources allocated to inpatient care. This calculation method for payment for the treated case is not based on a clear methodology that would take into account the elements of tariffs for healthcare services, the composition of consumption/costs, included in the cost of services for calculating tariffs, as well as on ensuring the transparency in tariffs establishment and nondiscrimination of healthcare providers and consumers. The calculation methodology is only based on obtaining the difference between the Maximum Cost, which can be extremely high, and the Minimum Cost, which, again, can be extremely low; thus, the reliability of cost calculation by these providers is not ensured. Thereby, there is the risk of obtaining an overestimated or an underestimated cost. This risk increases especially when there is monopoly or oligopoly of service providers. Hence, overestimated costs generate overspending by the Social Services Agency. At the same time, underestimated costs produce risks of case underfinancing and, implicitly, low quality of services and their delivery under the level of minimum standards of quality. An analysis of Maximum and Minimum costs, presented by providers of Social Services Agency, reveals that the difference between the Maximum Cost and the Minimum Cost differs from twice to up to 1228 times.

Table 3. Calculation of the case cost paid by the Social Services Agency under NCSP codes for which the difference of <100 times between the Maximum tariff and the Minimum tariff is registered

Case profile	Number of facilities	Max. tariff	Min. tariff	Tariff for payment	Difference between Maximum and Minimum Tariff
Oncosurgery	91	5830	50	1495	117
General surgery	43	7000	60	1795	117
General surgery	28	7326	40	1861.5	183
General surgery	6	19052.5	75	4819.375	254
Oncosurgery	55	35000	120	8840	292
General surgery	41	3000	5	753.75	600
General surgery	135	12276	10	3076.5	1228

Table 4. Difference between the maximum and the minimum tariff proposed by providers and the number of NCSP codes that register these differences

Difference between the maximum and the minimum tariff	Number of NOMESCO Classification of Surgical Procedures
2	1724
3	1058
4	629
5	369
6	191
7	159
8	103
9	92
10 – 19	335
20 – 29	94
30 – 39	49
40 – 99	47
<100	7

Fragmented funding of hospital care generates a low technical efficiency of spending for inpatient care. Thus, the financing mechanism, per groups of service, which provides for separate funding for inpatient emergency care and planned surgery allows the providers to misuse payments included in Component 3 (inpatient emergency care) for cases financed under

the Component 4 (*Planned surgery*). Thus, there is the risk of leakages due to the fact that hospital providers hospitalize on an emergency basis patients with chronic conditions and receive financial resources for the same case, both from Component 3 and from Component 4. Worth to be mentioned is that the share of sums obtained from Component 3 for financing the same planned surgery hospitalization case is, basically, the same or even exceeds the value of payment obtained from Component 4. Below are presented examples of cases of chronic diseases that required hospitalization and were paid under Component 3 and Component 4.

Table 5. Share of payments made from Component 3 and 4 for the same treated case

Code ICD-10	Total amount paid to the same provider from UHC Component 3 and 4 (GEL)	Share paid from UHC Component 3	Share paid from UHC Component 4
C44.3 Skin cancer and unspecified parts of the face	1194,75	65,2%	34,8%
I84.9 Hemorrhoids without complications, unspecified	1924,33	51,4%	48,6%
H44.5 Degenerative conditions of the eyeball	1890,64	85,5%	14,5%
B67.8 Echinococcosis of liver, unspecified	3640,83	74,7%	25,3%
K26.9 Duodenal ulcer specified as acute or chronic, without haemorrhage or perforation	3262,5	39,8%	60,2%
K60.4 Rectal fistula	3983,51	78,9%	21,1%

Further, an analysis of data available in the electronic reporting system, for the period trimester III 2013 - trimester I 2015, concludes on the fact that the phenomenon of case financing fragmentation generates duplication of services and unjustified losses, as presented in the table below.

IMPORTANT

Estimation of exact losses registered by the UHC Program, as a result of case fragmentation and duplication of health services, based on correlation between services provided by each UHC component for the registered health condition, and of the reimbursed costs is not possible to be done due to methodological limitations. It is

necessary to be mentioned that the exact figures, counted without ambiguity, involves mandatorily clinical audit component (clinical audit of the reimbursed cases is not objective of this assignment). Thus, the figures bellow shall be interpreted and analyzed as possible limits and not exact value of losses. Even in these conditions, negative effects generated by losses are evident and significant.

Table 6. Number of patients hospitalized and discharged, simultaneously, through UHC Component 3 and 4, and the payments made for the same hospitalization case, 2013-2015

Year and trimester	Number of patients	Sum paid from UHC Component 3 (GEL)	Sum paid from UHC Component 4 (GEL)	Total amount paid from both subprograms, (GEL)
Year 2013, trimester III	31	167951.97	124918.36	292870.33
Year 2013, trimester IV	51	155914.4	224067.34	379981.74
Year 2014, trimester I	51	159473.36	200057.53	359530.89
Year 2014, trimester II	71	189052.82	230070.2	419123.02
Year 2014, trimester III	74	177224.1	220121.61	397345.71
Year 2014, trimester IV	124	659974.04	470995.91	1130969.95
Year 2015, trimester I	154	451606.41	568133.52	1019739.93
Total	**556**	**1,961,197.1**	**2,038,364.47**	**3,999,561.57**

Annex A presents the audit on cases (depersonalized) of hospitalized and discharged patients, simultaneously through Component 3 and 4, and the sums paid for the same hospitalization case, for the period trimester III 2013 - trimester I 2015.

Another area of risk and loss generator is represented by readmissions within 30 days from discharge. The phenomenon is increasing in terms of quality and quantity. Thus, the number of readmissions has increased during trimester III, 2013 and trimester I, 2015 by 8.4 times. The high rate of readmissions within 30 days shows on a low performance of hospitals, as well as on the low quality of intra-hospital services. The constant increase of readmissions demonstrates the lack of hospital motivation to decrease this parameter through the implementation of strategies aimed at reducing, primarily, the overall risk of readmission. Also, it cannot be neglected the fact that the high share of readmissions is encouraged by payments made within

UHC Component 3 (inpatient emergency care) and UHC Component 4 (planned surgery), which have increased by 8.7 times in the same period.

Table 7. Number of readmissions within 30 days through UHC Component 3 and 4, and payments made for admission and readmission, 2013-2015

Year and trimester	Number of patients	Sum paid from UHC Component 3 (GEL)	Sum paid from UHC Component 4 (GEL)	Total amount paid from both subprograms, (GEL)
Year 2013, trimester III	43	52104,32	146149,78	198254,1
Year 2013, trimester IV	63	86503,71	200766,46	287270,17
Year 2014, trimester I	133	147239,12	398159,64	545398,76
Year 2014, trimester II	199	222943,17	631408,64	854351,81
Year 2014, trimester III	217	241200,86	572484,23	813685,09
Year 2014, trimester IV	298	329940,02	890594,57	1220534,59
Year 2015, trimester I	362	469086,75	1251982,38	1721069,13
Total	**1315**	**1,549,017.95**	**4,091,545.7**	**5,640,563.65**

Annex B presents the audit on cases (depersonalized) of readmitted patients, simultaneously through Component 3 and 4, and the sums paid for the same hospitalization case, for the period trimester III 2013 - trimester I 2015.

Service demand induced by providers causes excessive delivery of services. The bundling fee-for-service payment favors providers to induce the demand for services. Thus, the payment method has very large implications upon the total costs for health programs - universal coverage program, vertical programs, etc. It results in unnecessary expenditures within the program determined by overproduction of services, including by forcing the demand. The analysis of this risk in terms of economic efficiency concludes on the following aspects. Service providers are paid each time they deliver services for certain components of the case (i.e. emergency care, etc.), regardless if the service is necessary or efficient. This fact does not encourage efficiency in using services for treating the patient or a disease episode. The incentive offered by the universal coverage program to providers is resource-oriented (negative effect upon the quality

of service), rather than result-oriented; thus, there is the tendency to offer more health services than necessary, which compromises he alocative efficiency of the UHC Program.

The bundling fee-for-service payment associated with an inequitable structure of tariffs per service (another critical aspect of the universal coverage program) influences the providers to deliver certain services and neglect others. This aspect is supported by the structure of services provided within the universal coverage program. Also, the absence of clinical protocols stimulates excessive delivery of medical procedures and treatments. The subprogram "Critical conditions in the hospital", which has registered an excessive increase in services in the period 2013-2015, lacks clinical protocols that can avoid excessive procedures and treatments.

The payment per service or bundle fee-for-service is considered efficient in the case of services that require the stimulation of demand and supply of these services, in terms of their importance for public health (for e.g., screening services aimed at detecting oncologic diseases, cardiovascular diseases, malnutrition in children, etc.).

The mechanism of financing hospitals included in the Universal Healthcare Program stimulates unjustified delivery of services that have a negative impact upon public health. According to World Health Organization, the share of caesarean section births must not exceed 10-15% of total births. Thus, the share of caesarean section births, of the total number of births, paid in the Universal Healthcare Program has increased from 34.1%, in trimester III, 2013, to 41.6% in trimester I, 2015. Simultaneously, in the above mentioned period, the share of payments made for caesarean section births has also increased from 43.4% (trimester III, 2013) to 50.2% (trimester I, 2015).

Another critical issue identified by the Consultancy Mission consists in the increase of the health program budget at a higher rate than the increase of the state budget. This situation is due to the fact that the engagements of the public sector for estimated expenditures are not formalized under a legal commitment - the medium-term expenditure framework and the state budget on health are not synchronized.

For 2014, the total amount approved for health constituted 577,464.7 thousand GEL of which 338,480 thousand GEL accounted for the universal coverage program (58.6% of the total) and 165,381.96 thousand GEL (28.6% of the total) for vertical and other programs.

Table 8. Dynamics of physiological births, caesarean section births and payments made from UHC for them, on trimesters, 2013-2015

Year and trimester	Total number of births	Share of physiological births, %	Share of caesarean section births, %	Total amount for births	Share of payments for physiological births, %	Share of payments for caesarean section births, %
Year 2013, trimester III	9307	65.9	34.1	5391416.31	56.6	43.4
Year 2013, trimester IV	9400	64.5	35.5	5448627.65	55.4	44.6
Year 2014, trimester I	9768	62.6	37.4	5715273.71	53.2	46.8
Year 2014, trimester II	11761	60.8	39.2	6931994.67	51.4	48.6
Year 2014, trimester III	13737	60.6	39.4	8083775.35	51.1	48.9
Year 2014, trimester IV	12796	59.2	40.8	7537784.57	49.8	50.2
Year 2015, trimester I	11811	58.4	41.6	7020078.22	48.8	51.2

In 2015, as well, is registered a high discrepancy between the approved and executed budget of UHC Program. Thus, during the 8 months were executed approx. 80% (470,000.0 thousand GEL) compared to the annual estimated plan. This condition is generating high risks due to excessive delivery (due to demand forcing) and acceptance of services for reimbursement, as described further in the report.

For 2016 the planned budget for health care is 868,949.0 thousand GEL with an increase of 32% compared to the amount planned for 2015, including for the universal program - 620,000 thousand GEL (71.4%), and for vertical programs - 247,949 GEL (28.5%). This was due to an increase of the universal program budget by 31.9% and of the vertical programs budget - by 32.4%. As a conclusion, the dynamics of the initially planned amounts for the universal program registers, in the period 2014-2016, an increase from 200,000 thousand GEL to 620,000 thousand GEL, which is more than 3 times. This situation is due to hospital care, which held in 2014 77.6% of the total budget, and in the first 6 months of 2015 - 82.3% of the total budget. UHC Program requires a better predictability both in planning budget and in their execution.[1]

Table 9. Healthcare Budget, corrected budget 2014-2015 and planned budget 2016

Health programs	2014	2015	2016
Universal Coverage Program	338 480 000	470 000 000	620 000 000
Vertical Programs	165 381 955	187 238 800	247 949 000
Other Programs	73 602 735	1 240 000	1 000 000
TOTAL	**577 464 690**	**658 478 800**	**868 949 000**

Health programs	% of the total			Growth rate (%)	
	2014	2015	2016	2015	2016
Universal Coverage Program	58,6	71,4	71,4	38,9	31,9
Vertical Programs	28,6	28,4	28,5	13,2	32,4
Other Programs	12,7	0,2	0,1	-98,3	-19,4
TOTAL	**100,0**	**100,0**	**100,0**	**14,0**	**32,0**

In the framework of hospital care, the share of resources allocated for inpatient emergency care is the highest (56.3% in 2014, 66.7% in the first 6 months of 2015), followed by financial

[1] The figures are preliminary, since during the assignment period and Report writing, final budget was not approved.

resources allocated for planned surgeries, including oncology (34.6% in 2014, 27.3% in the first 6 months of 2016), and financial resources allocated for births (9.2% and 6.0%, respectively).

It has already been mentioned that hospital care consumes most financial resources, reaching in the first 8 months of 2015 a dramatic share of 82.3% of the total expenditures of the universal program. In turn, the primacy in hospital care is held by emergency hospitalizations, which registered in 2014 expenditures of 66,7% of the total expenditures incurred for hospital care, which is more than 10% increase. Therefore, expenditures made for planned surgeries and births diminished from 34.6% to 27.3%, and from 9.2% to 6.03%, respectively. The trend of increasing expenditures for hospital care is an alarming one, being to the detriment of primary health care.

Table 10. UHC Program Financing, GEL

	2014			6 months, 2015		
UHC Components	**Total amount requested**	**Amount paid by SSA**	**% total**	**Total amount requested**	**Amount paid by SSA**	**% total**
Primary healthcare	46 055 833	46 055 833	12,1	26 865 809	26 865 809	7,38
Ambulatory emergency care	27 229 294	26 518 244	7,0	27 309 268	26 619 102	7,31
Inpatient emergency care	171 904 684	165 741 600	43,6	204 221 188	199 849 860	54,87
Planned surgery, including oncology	103 115 153	101 814 993	26,8	83 256 835	81 909 362	22,49
Oncology (chemotherapy, hormone therapy and radiotherapy)	12 691 287	12 589 908	3,3	10 949 142	10 924 689	3,00
Births	27 147 675	26 994 506	7,1	18 196 077	18 073 989	4,96
Drugs	26 269	26 269	0,01	9 042	9 042	0,002
TOTAL	388 170 194	388 170 194	100	370 807 362	364 251 853	**100**

With its focus on rapid scale-up of UHC Program, the Consultancy Mission concludes that the designed interventions were detrimental and established parallel primary care systems, both for financing and service delivery, within the health system, rather than strengthening and pooling

the complex health systems that exist in the country and build capacities for primary health care.

At first glance, this would appear to divide one long line-up into several, thus weakening all the dimensions of primary health care – financing, service delivery, different degrees of access for patients, human resources, etc. The elements concerning the duplication of health care services included in vertical programs and the Universal Coverage Program are presented in the table below.

Program title	Activities according to HG 308 (Health care programs)	Planned amount, GEL, in HG 308 2015	Activities according to HG 36 (Universal Coverage Program)	Amount paid by SSA, GEL, 2015 (6 months executed) from UHC
Rural doctor (Code 35 03 04 08)	Visit made by the family physician or nurse	**25,333,000.00**	Visit made by the family physician or nurse	
	Immunization of the target population for an adequate coverage of the national immunization schedule		Immunization of the target population for an adequate coverage of the national immunization schedule	
	Checking the health status of healthy people and new patients in accordance to approved guidelines		Checking the health status of healthy people in accordance to approved standards	
	Tracking the development of children and adolescents in accordance with approved guidelines			
	Home visits made by the family physician or nurse to children up to 3 years in accordance to approved guidelines		Home visits made on the basis of health service needs (within the competence framework)	
	Home visits made 4 times per year by the family physician or nurse to a immobile patients (bed-bound) in accordance to approved guidelines			
	Home visits to incurably persons.		Monitoring of incurably patients and individuals with diabetes	
	Prevention, detection and monitoring of chronic and acute diseases (including: hypertensive disease,		Prevention, detection, monitoring and referral of chronic and acute diseases;	**26,865,809.11**

	diabetes, ischemic heart disease, asthma, terminally ill patients). This includes: a) diagnostic services including laboratory services and minimal necessary examinations, and b) management and referral as needed		express tests: urine and glucose in peripheral blood	
	Detection and monitoring of tuberculosis according to DOTS standards		Detection and monitoring of patients with tuberculosis, patients with mental and endocrine diseases	
	Medical assistance in emergency situations		Medical assistance in emergency situations	
	Issuing medical certificates, completion of medical documentation (including completion of statistical reports), as well as indication for treatment with the prescription of drugs		Issuing medical certificates, completion of medical documentation (including completion of statistical reports), as well as indication for treatment with the prescription of drugs	
	Emergency outpatient care and provision of drugs and medical supplies in accordance with the Ministerial decree – goods included in the "doctor's bag"			
Mother's and child's health (Code 35 03 02 09)	Prenatal care during pregnancy. Visits to family physician (4 prenatal visits)	**6,000,000.00**	Visits to medical specialists: obstetrician-gynecologist and therapist	
	Visits to medical specialists: obstetrician-gynecologist and therapist		Laboratory investigations, which include: general blood and urine test	
	Laboratory investigations, which include: general blood and urine test		In ambulatory settings, based on health needs, issuance of medical certificates, as well as indication for treatment with the prescription of drugs	

Vertical Programs Risk Mapping

Before the introduction of Universal Healthcare Programs, vertical programs, plus state funded health insurance program were the sole means of providing coverage to population. While state health insurance program was designed to target only selected groups of population, vertical programs always remained to be universal by design.

Therefore, due to methodological limitations the Consultancy Mission assessed the vertical programs in terms of:

- Methods used for their effectiveness evaluation;
- Fiscal pressure they generate.

Ideally, all healthcare programs should have clear sets of objectives and measures in place to assess effectiveness in terms of achieving those objectives. Moreover, in order to ensure fiscal stability of public health expenditures growth rate should be within reasonable margins and finally, with consideration of major expansion of public health spending through Universal Healthcare Program, vertical programs should be scrutinized to minimized fiscal pressure and increase their cost-effectiveness.

For 2015-2016 MoLHSA has 22 vertical programs planned. Each program consists of multiple components. Targets and indicators for the programs are already approved as part of BBD formulation process. Summarizing the results of the vertical programs assessment the Consultancy Mission concludes the following:

- Budget allocation request has increased by 100% (doubled) from 2014 to 2016. Furthermore, increase will be 170% compared to 2014 in 2017. 29 million GEL from the increase amount is attributable to new initiatives introduced within the program budgets (11%).[2]
- Numbers of new components were created as a part of vertical programs.
- Due to devaluation of national currency funds necessary for procurement of drugs increased significantly.

[2] The figures are preliminary, since during the assignment period and Report writing, final budget was not approved.

- Programs do not measure effects of their investments (e.g. indicators only count number of beneficiaries, but impact in terms of improved health or other quality indicator is not available). Cost-containment measures should be enacted for all components.
- Lack of preventive care or funding for services with higher cost-effectiveness created and will further create funding pressure for number of programs, e.g. diabetes, dialysis, etc.

Provision of medical services in high priority area (Program Code: 35 03 03)

The sub-programs under this program are targeted to provide individual services to the population. Budget of the program is growing each year after the launch of Universal Healthcare Program. It is notable that those programs have highest potential to be integrated as a part of the Universal Healthcare program, or be influenced by the program.

Distribution of components and they budgetary allocations are provided program by program and the rationality of the increase is discussed (Annex D).

COST CONTAINMENT & EFFICIENCY INTERVENTIONS

The incipient assessments identified a list of topical areas for the MoLHSA to consider that appear to provide opportunities for containing costs and increase efficiency of UHC Program and vertical programs. Further, the Consultancy Mission developed the short-list by reviewing the interventions considering specific Georgian context – organization of the health care system, past cost-cutting measures, relationship framework with the private sector, feasibility of more deep legal interventions, as well as holding discussions with Government officials and health authorities and managers, assessing the country's current economic and political environment.

The Consultancy Mission, also, evaluated the health care reform framework with an eye on how can take advantage of the new provisions to engage in cost containment and efficiency; and to ensure a compatibility and a soft transition to the new organization model.

This report explores all the possible interventions to be applied and develops more in depth the areas with a high potential for viability and savings. To identify the cost containment solutions that move UHC Program and state vertical programs toward meeting the target objectives.

The cost containment solutions identified include a combination of cost avoidance measures and budgetary measures. The cost avoidance measures represent sustainable cost reduction actions the MoLHSA can implement through both operational changes and normative changes. The budgetary measures represent cost savings that can be achieved through actions that would require only normative support and excluding supplementary funding.

Spending for health care spending might be defined as a function of five basic factors: (i) population needs or morbidity: (ii) access to services; (iii) propensity to seek services; (iv) volume, nature, or intensity of services provided, and (v) price of services.

For the purpose of this Report, "cost containment" will be defined as any set of policies or measures intended to affect any one or more of these factors. **The used scenario is exclusively based on containment solutions that do not generate reduction in financing, taking into consideration funding landscape, and do not sacrifice the MoLHSA ability to maintain health care provision, improving health and protection from the financial consequences of illness and especially the financial consequences of having to obtain medical care.**

Therefore, measures those are designed to reduce splitting in health programs and by types of care and reallocation of resources/savings will be considered here.

Cost containment and efficiency measures identified to be applicable to the specific Georgia context cover two dimensions of the health system, namely:

- Governance
- Financing.

The implementation of measures in the area of health system governance will ensure a more efficient use of financial resources, as well as mobilization from interior, which would allow their reallocation to other funding lines of health programs. In turn, financing interventions - diversification of payment mechanisms, etc. - generate positive changes in health service delivery. Thus, this design of cost containment and efficiency interventions cause an echo impact upon the dimensions of governance and funding.

To realize this vision, the Consultancy Mission puts forth the following Roadmap to Cost Containment and Efficiency. The Roadmap contains discreet strategies that Consultancy Mission, if implemented strategically, will allow the MoLHSA to meet its goal of sustainably containing costs growth in health care. Specifically, the Consultancy Mission recommends:

Governance	Effect	Financing
		
Unification of same type health services from the universal coverage program with vertical programs at the sub-program or program level	**Modifying provider behavior**	- Establish expenditures targets and/or caps - Centralization of service package on types of healthcare and definition of reimbursed health services
Increasing funding for outpatient care	**Reducing need for services**	- Allocation to primary healthcare of 30% of total expenditures of the UHC Program - Reformulate Payment Rates for Primary Care Services - Allocation to specialized outpatient care of 10% of total expenditures of the UHC Program

		- Increase access to affordable medicines through re-designing the Drug Reimbursement Program
Establishing clear mechanisms for procuring health services	**Modifying provider behavior**	- Establishment of the system of volume indicators for eligibility of funding
An integrated approach to health system design, combining roles of purchased and provider under a single framework	**Modifying provider behavior**	- Develop and implement the national integrate eHealth systems
Governance	**Effect**	**Financing**
		
Integrated approach to case management (Clinical governance)	**Modifying provider behavior**	- Bundling current „case-based payment" provider mechanism
An integrated approach to health system design, combining roles of purchased and provider under a single framework	**Controlling prices**	- Implementation of the system of reference tariffs for the procurement of health services (National Reference Tariffs)

INTERVENTIONS 1 and 2: Unification of same type health services and Increasing the financing for outpatient care

Broadly defined, universal health care/coverage (UHC) means all people receiving the health services they need, including health initiatives designed to promote better health, prevent illness and to provide treatment, rehabilitation, and palliative care of sufficient quality to be effective while at the same time ensuring that the use of these services does not expose the user to financial hardship. Thus UHC comprises three dimensions – (effective) health services, finance, and population – which are answering to three questions *Which services are covered? Who is covered? Direct costs: proportion of the costs covered?*

The Government has created a mechanism to protect every citizen from catastrophic expenses on medical care, when from February 2013 all citizens, not covered by state or private insurance, became beneficiaries of the State Universal Healthcare Program (minimum service package). In July 2013 UHC Program was expanded and currently comprises planned outpatient,

emergency outpatient and hospital, planned surgical services, treatment of oncologic diseases and deliveries (basic package).

To achieve its desideratum the UHC Program should mandatorily include the pre-hospital emergency and palliative care. This conclusion is in line with the World Health Organization recommendations and programmatic documents regarding achieving universal health coverage. It is necessary to mention a very important aspect, namely - Georgia has all the premises in this sense: (i) first phase of very positive reforms in universal health care; (ii) strong need in resource optimization and ensuring financial sustainability; (iii) principles of organization and functioning of health system; (iv) principles of organization and functioning of health financing system; (v) legal and governance framework.

The horizontal and vertical pooling of health services and funds at the UHC Program level is a necessary precondition for achieving these goals. The pooling of funds is also necessary to improve the equity of the system because it allows health care resources to be allocated/distributed according to the health care needs of the population. Risks are pooled to increase the predictability of the loss in the UHC Program and, consequently, to redistribute the costs of unexpected losses. The risk pool size is critical. The larger the risk pool, the more predictable the risks and the greater the probability of correctly assessing the probability of a loss occurring in Universal Healthcare Program and other state health programs. A small risk pool, such as cases of UHC sub-programs (Emergency inpatient, Inpatient Care) or separate programs for the same type of care (Primary health care from UHC Program and Rural Doctor Program) is not be able to generate sufficient resources to cover even their predicted losses. Further, all universal healthcare mechanisms improve equity by redistributing the costs, but small and fragmented risk pools are a barrier to redistribution. Therefore, health financing and delivery systems that pool resources at the sub-program level weaken the financing function of a publicly financed health system because they create small risk pools that do not adequately predict or redistribute the costs of losses associated with health problems.

The second reason that pooling health care funds is necessary is due to the fact that it allows a seamless health delivery system to be established. Currently, separate health delivery (i.e. primary health care, etc.) exist at different level of administration (i.e. primary health care in Tbilisi municipality) and different health programs (UHC Program and Rural Doctor); and each system is financed and operated by different governance units – local public authorities, UHC Program, etc. Having parallel health delivery systems creates tremendous duplication within the health sector.

Program code	Name of program	Component	Financing	UHC subprogram which is proposed to include the component of the vertical program	Funds reallocated to UHC subprogram
35 03 02 06	**Infectious diseases and parasitology**	Inpatient treatment of infectious diseases	9,885,000.00	Subprogram for inpatient care	9,885,000.00
35 03 02 09	**Children and mothers' health**	Antenatal services	2,630,000.00	Subprogram for primary healthcare	2,630,000.00
		Hospitalization at high risk (mothers, laboring mothers and pregnant women)	1,960,500.00	Subprogram for inpatient care	1,960,500.00
		Diagnosis of genetic diseases	371,700.00	Subprogram for inpatient care	371,700.00
		Testing and confirmation of hepatitis B, C, HIV/AIDS and syphilis	350,000.00	Subprogram for specialized medical care	350,000.00
		Screening of newborns for genetic diseases	791,700.00	Subprogram for specialized medical care	791,700.00
		Screening for hearing loss in newborns	50,400.00	Subprogram for specialized medical care	50,400.00
		Drugs for mothers	10,000.00	Subprogram for reimbursement of drugs	10,000.00
			36,000.00	Subprogram for reimbursement of drugs	36,000.00
		TOTAL	**16,085,300.00**		**16,085,300.00**
35 03 03 01	**Mental health**	Outpatient	2,865,300.00	Subprogram for specialized medical care	2,865,300.00
		Psycho-social rehabilitation	70,100.00	--	--
		Mental outpatient diagnosis for children	151,000.00	Subprogram for specialized medical care	151,000.00

		Crisis services	662,300.00	Subprogram for specialized medical care	662,300.00
		Outpatient community mobile group	96,800.00	Subprogram for specialized medical care	96,800.00
		Psychiatric hospital services for adults and children	10,778,700.00	Subprogram for inpatient healthcare	10,778,700.00
		Hospital services for individuals with mental and behavioral disorder	540,000.00	Subprogram for inpatient healthcare	540,000.00
		Hospital services for alcohol intoxication	481,200.00	Subprogram for inpatient healthcare	481,200.00
		Shelter for persons with mental disorder		--	--
		TOTAL	**15,645,400.00**		**15,575,300.00**
35 03 03 02	**Diabetes**	Healthcare services for children	786,100.00	Subprogram for specialized medical care	786,100.00
		Outpatient	781,700.00	Subprogram for specialized medical care	781,700.00
		Diabetes and diabetes insipidus	5,120,400.00	Subprogram for reimbursement of drugs	5,120,400.00
			550,000.00	Subprogram for reimbursement of drugs	550,000.00
			213,900.00	Subprogram for reimbursement of drugs	213,900.00
		Logistics	204,000.00	Subprogram for reimbursement of drugs	204,000.00
		TOTAL	**7,656,100.00**		**7,656,100.00**
35 03 03 03	**Children Oncohematology**	Outpatient and inpatient treatment	**1,274,000.00**	Subprogram for specialized medical care	318,500.00
				Subprogram for inpatient care	955,500.00
35 03 03 04		Hemodialysis	11,928,400.00	Subprogram for inpatient care	11,928,400.00

	Dialysis and kidney transplantation	Peritoneal dialysis	145,000.00	Subprogram for inpatient care	145,000.00
		Purchase of consumables for dialysis		--	--
		Transplantation	600,000.00	Subprogram for inpatient care	600,000.00
		Purchase of immunosuppressants	585,000.00	--	--
		Provision of patients on hemodialysis with consumables	110,000.00	--	--
		Logistics of immunosuppressants	36,000.00	--	--
		TOTAL	**13,404,400.00**		**12,673,400.00**
35 03 03 05	**Palliative care**	Outpatient	260,000.00	Subprogram for specialized medical care	260,000.00
		Inpatient	240,000.00	Rehabilitation, long-term and palliative care	240,000.00
		Procurement of pain medication (morphine)	732,000.00	--	--
		Logistics	284,000.00	--	--
		TOTAL	**1,516,000.00**		**500,000.00**
35 03 03 06	**Rare diseases**	Outpatient	70,000.00	Subprogram for specialized medical care	70,000.00
		Inpatient	200,000.00	Subprogram for inpatient care	200,000.00
		Hemophilia in children and adults	180,000.00	Subprogram for specialized medical care	180,000.00
		Provision of children and adults with hemophilia with drugs	3,523,600.00	--	--
		Provision of children with phenylketonuria with drugs	367,000.00	Subprogram for reimbursement of drugs	367,000.00
		Provision of patients with cystic fibrosis with drugs	65,300.00	Subprogram for reimbursement of drugs	65,300.00

		Provision of patients with X-linked a-gamma globulinemia with drugs	48,200.00	Subprogram for reimbursement of drugs	48,200.00
		Provision with drugs of patients with growth hormone deficiency, children and adults with Turner syndrome	437,800.00	Subprogram for reimbursement of drugs	437,800.00
		Provision of patients with juvenile rheumatoid arthritis with drugs	568,000.00	Subprogram for reimbursement of drugs	568,000.00
		Provision of patients with thalassemia with drugs	348,600.00	Subprogram for reimbursement of drugs	348,600.00
		Logistics	153,000.00	--	--
		TOTAL	**5,961,500.00**		**2,284,900.00**
35 03 03 08	**Rural doctor**	Rural doctor	19,194,500.000	Subprogram for primary healthcare	19,194,500.00
		Rayonal center that services the doctors from villages	213,500.00	Subprogram for primary healthcare	213,500.00
		Special funding for cross-border and mountain regions	3,585,000.00	Subprogram for primary healthcare	--
		Special funding for medical institutions/individuals	2,340,000.00	Subprogram for primary healthcare	--
		TOTAL	**25,333,000.00**		**19,408,000.00**
35 03 03 10	**Recruits' medical examination**	Medical examination of recruits	820,000.00	Subprogram for specialized medical care	820,000.00
		Additional examination of recruits	180,000.00	Subprogram for inpatient care	180,000.00
		TOTAL	**1,000,000.00**		**1,000,000.00**

Fragmented health care budgets are a barrier for planning in the health sector. It is difficult for health policymakers to accurately assess the level of resources available, which is essential information to set health sector priorities and plan capital investments.

Also, there is no incentive to consolidate health delivery systems under the current fragmented budgeting process. This is not the case if the health funds are pooled. While the current budgeting and reimbursement processes contains an incentive not to rationalize health programs and health providers, creating a pool of funds removes this perverse incentive, and it becomes easier and more advantageous to rationalize and contain the health sector.

The issue of reallocation of savings from rationalizing the health sector is critical in the current system. Therefore, pooling of funds is critical to allow any health sector savings that are obtained through rationalization to be retained in the health sector.

The wide usage of market mechanisms in the health care system, namely increased patient choice of providers, allowing greater competition between providers, and relying on more private services, etc. are generating opposite effects in Georgia in terms of costs reductions, improving the efficiency of the health care system. The inefficiencies in spending in many UHC sub-programs conclude there is much space to contain cost increases without compromising health by type of care.

Expenditures targets with central oversight are a powerful tool for restraining expenditures. Setting expenditures targets by types of care based on reasonable and objective expenditure projections, as opposed to simply reimbursing all spending, determine contain spending growth.

Because the relative benefit of public expenditure on an open-ended program such as Universal Health Care is higher than the relative benefit of public spending on other vertical health programs, there are considerable incentive to devote more of their budgets to UHC Program than they would otherwise and to shift measures that had been funded entirely by the vertical programs to UHC Program.

Targeting expenditures for UHC sub-programs could have several advantages. It could generate rationalization, through reallocating of resources to primary and specialized ambulatory care, and stabilization for the national budget. Expenditures targets that were significantly lower than current projections/ expenditures could produce large savings, i.e. hospital care. Setting an

upper limit on spending (i.e. primary care including drug reimbursement) would also make costs for UHC Program more predictable. In addition, UHC sub-program expenditures targets would reduce Government' current ability to increase UHC Program funds - an ability created by the open-ended nature of state financing for the UHC program and by the relatively high share of costs paid by the public budget, comparative to co-payments covered direct by consumers.

UHC Sub-programs		Share	Co-payment
1.	Primary health care	30%	No
1.1	*Drug Reimbursement Program*	*12%*	*Yes*
2.	Specialized ambulatory care	10%	Yes
3.	Specialized hospital care	41%	Yes
4.	Rehabilitation, long-term and palliative care	7%	Yes
5.	Other types of care	-	Yes

Targeting UHC Program spending could also have several disadvantages, if the limits on sub-programs payments were set low enough, they would shift additional costs, perhaps substantial costs and cause UHC budgets to become less predictable. In response, the Government would have to commit more of resources to UHC Program or reduce services, restrict eligibility or enrollment, cut payment rates for health care providers and increase co-payments or, to the extent feasible, develop ways to deliver services more efficiently. Therefore, such targets are most effective when applied broadly: establishing budget targets on inpatient care should be complemented with increasing expenditures on outpatient care and rehabilitation and long-term care, as well as regulations regarding patient's pathways in the health system.

The proposed policy intervention include two principal ways to limit public UHC spending through targets that cap overall public expenditure for the sub-programs and spending per enrollee – co-payment mechanism. In general, overall expenditure targets would consist of a maximum amount of funding that the public budget would allocate to each UHC sub-program to operate. Once established, those targets would generally not change in response to changes in enrollment or (depending on how the targets were set to increase over time) in response to changes in the cost of providing medical services.

UHC Sub-programs		Share (according to the draft budget for 2016 on the UHC, within the budget ceiling, GEL)	Co-payment	Allocated funding (according to the draft budget for 2016 on the UHC, within the budget ceiling, GEL)	Allocated funding (funds from vertical programs transferred to UHC, according to the Governmental Decree No. 308 from 06.30.2015, GEL)	Total
1.	Primary health care	30%	No	186.000.000	27.963.000	213.963.000
1.1	*Drug Reimbursement Program*	*12%*	*Yes*	*74.400.000*	*7.969.200*	*82.369.200*
2.	Specialized ambulatory care	10%	Yes	62.000.000	8.105.300	70.105.300
3.	Specialized hospital care	41%	Yes	248.000.000	37.844.500	285.844.500
4.	Rehabilitation, long-term and palliative care	7%	Yes	49.600.000	500.000	50.100.000
5.	Other types of care	-	Yes	-	-	-
TOTAL				**620.000.000**	**82.382.000**	**702.382.000**

Policy options to UHC expenditure target are directed to intervene not on all of that spending, but on spending for types of care. In UHC Program, most public spending covers inpatient services (82.3% for eight-months in 2015), namely emergency hospital (166 million Lari in 2014), planned interventions (120 million Lari in 2014), deliveries (27 million Lari in 2014), oncology (13 million Lari in 2014), etc. all of which could be merged into one sub-program. In general, the more "spending" categories of services are included under the targets and reallocated to less "spending" categories, the greater the potential for containment to the public budget.

Establishing UHC Program expenditures targets would generally begin with selecting a year of UHC spending and calculating that year's total spending for the service categories and eligibility groups to be included in the targets. Those expenditures totals would then be adjusted based on the shifting to outpatient care (primary care, including drug reimbursement, and specialized outpatient care) to calculate the expenditures targets in future years. Thus, for both sub-programs and per-enrollee expenditures targets, the selection of the base year is important because the level of public expenditures in that year would help determine future spending targets: A higher base-year amount would lead to higher targets (and lower public budget savings) than a lower base-year amount would.

Further, another criterion in selecting a base year is whether to use a past or future year. Most targets proposals that include base years use a past year for which UHC Program expenditures are known. The main reason for using the past year is that MoLHSA cannot raise tariffs for health providers, make additional one-time supplemental payments or budget allocations, or move payments for claims from different periods into the base year to maximize UHC Program expenditures and thereby boost their future spending limits.

However, **the Consultancy Mission recommends choosing a future base year (2016)** due to the fact that the past years would not adequately reflect an upcoming program change, such as the implementation of the sub-programs approach, shifting to outpatient-base care, etc.

Another argument is that using a prior base year would essentially lock in MoLHSA past choices about UHC Program and perpetuate those policy interventions. Once expenditures targets were set on the basis of Government' prior choices, it would be increasingly difficult over time for MoLHSA to raise/reduce the payment rates or add covered services because,

unlike under current normative framework, such policy measures would not lead to higher/lower public spending.

The annual rate of growth that would be applied to base-year expenditure to determine the targets on (and rate of increase for) UHC Program spending in future years, based on macroeconomics indicators, might be equivalent to the rate of national budget growth.

In designing the normative interventions on UHC Program expenditure targets, for both the overall UHC sub-programs and per-enrollee spending targets (co-payments), MoLHSA should have to establish new mechanisms to ensure compliance with the spending limits. The nature of those enforcement mechanisms would depend on the way in which authorizing legislation directed to establish the expenditures targets.

Targeting UHC sub-program expenditures would fundamentally change the financial relationship in the program. A targeted expenditure commitment would mean that the MoLHSA should design measures to mitigate effects of any growth in the program's costs that exceeded the national budget growth through developing a National Reference Tariffs Payment System.

The ways in which UHC Program expenditure targets would affect enrollees would depend greatly on the beneficiary status established in accordance to the Government Decrees and the declared priorities (primary health care, etc.). Primary health care is declared to be at the cornerstone of the Georgian healthcare system. Given the high burden of non-communicable diseases and related morbidity and mortality, a robust preventative and ambulatory-oriented care system is essential for improving health outcomes, lowering costs and increasing health equity. In UHC subprograms focused on managing the patient in outpatient settings, beneficiaries would experience little or no co-payment. By contrast, in UHC sub-programs covering provision of care in inpatient settings enrollees would pay more out-of-pocket.

There is a high convergence of equity and health systems agendas as demonstrated by the reports of the Commission on Social Determinants of Health and the WHO reports on health financing and on health systems, among others.' These underline the need for the development of a health systems regulated framework bringing together the basic elements of organizing care towards a people-centered primary care system, which acts as a hub for coordination and is supported by hospitals. This approach sees hospitals as an important part of the wider health

system, providing a highly valued "rescue" function for life-threatening conditions, and that can improve treatment outcomes by focusing technology/expertise where necessary.

At the core of this framework are primary care providers who hold the responsibility for the health of a defined population and act as the primary entry point to the health system while hospitals form part of health care networks to fill the availability gap of complementary referral care.

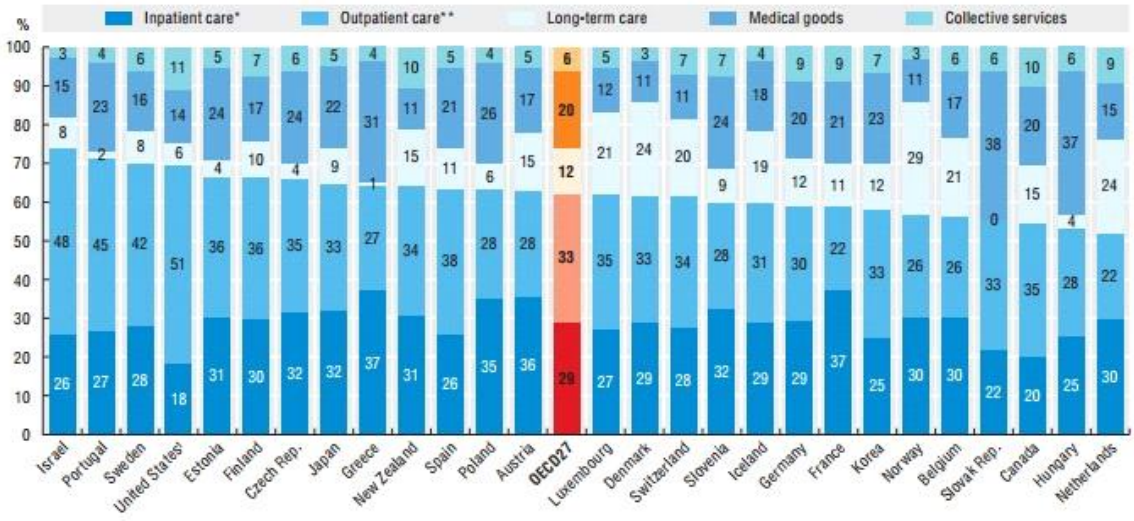
The need to refocus health system strengthening on health gain is determined by the new paradigm shift from "disease oriented" care to "goal oriented" care. **The current disease-oriented focus in the UHC Program (reimbursed services – oncology, elective surgery, inpatient emergency, deliveries, C-sections, etc.) led to a form of inequity that is determined by the nature of the condition, so potentially creating "inequity by disease".** Such reorientation requires better integration within and between types of care (governance dimensions) and UHC sub-programs (financial dimension) with a new model of resource allocation (illustrated above). Such funding pattern will face challenges, in particular regarding the required reallocation of resources from hospital to ambulatory secondary and primary health care, implying a need to involve responsible governmental agencies and health care providers in this process.

The agenda for quality of care has now been firmly embedded in Georgian health care system. At the same time, MoLHSA can make further gains in patient safety, thereby contain the costs. Health care quality can also be improved by strengthening primary care systems to better manage complex conditions.

As Georgia works to develop an effective PHC under UHC Program, it must do so in a financially sustainable manner that ensures Georgian patients have access to needed medicines and maintains incentives for human resources and development. Recognizing that well-targeted health care spending is an investment in public health and individual well-being, MoLHSA should increase the share of allocated resources to primary health care, including reimbursed medicines, and specialized ambulatory-based care.

There is no a "gold standard" for financing the primary health care. Analysis of the international practices concludes about an "acceptable" level of 30% of health expenditures for the primary health care.

Fig. 3. Health expenditures by function of health care, 2011, OECD



In Australia, the second largest component of health spending (2011-2012) was for primary health care services ($50.6 billion, or 36.1% of total health expenditure). Primary health care includes a range of front-line health services delivered in the community, such as GP services, community and public health initiatives and the cost of medications not provided through hospital funding. A comparative assessment concludes that primary health care services received $50.6 billion in funding, slightly less than hospital services. The Australian Government was the main funder, providing $23.1 billion (45.7% of total primary health care funding), followed by the non-government sector ($20.4 billion, or 40.3%), and the state and territory governments ($7.1 billion, or 14.0%).

INTERVENTION 3: Case Integral financing for inpatient services

The intervention consists in replacing the funding for certain parts of the disease treatment (hospital emergency, planned surgeries, etc.) with the full financing of the case to which the

co-payment is applied depending on the category of beneficiaries. The effect of cost containment is achieved by reducing the cost of the treated case. At the same time, access to services - pillar of universal coverage - is ensured. This mechanism of cost containment has a high degree of sustainability and flexibility compared to the segregated funding of the case to be treated, by applying co-payment as a percentage to the whole tariff (regulatory tool owned by MoLHSA) and not as a difference between the tariff set by the healthcare facility and the average tariff set by MoLHSA.

Based on arguments presented in the previous chapter, the intervention lies on the fact that the financing of hospital care has an incomplete or fake case payment mechanism, determined by the segregation of the case, which leads to bundling fee-for-service for the given component of the treatment case.

Case payment mechanism creates, at the same time, the incentives to increase the number of cases and to minimize the inputs allocated on each case. Both the Social Service Agency and the inpatient care providers have more control over resource use per case than the total number of treated cases, the latter incentive is typically stronger, and case payment represents a mechanism to costs containment in the hospital sector.

Practically, in a case payment the costs reimbursed to the inpatient facility reflects the average cost of producing a unit of output in an average hospital, which is adjusted to account for specific country economic conditions. Pricing based on the average cost is also administratively desirable, because the variety of patient requirements is so vast and, as health systems develop, the technology for the production of health care changes so quickly that any attempt to match payment with the treatment provided to each patient would be counterproductive.

The DRGs – as a form of case payment - should the initiated as quick as possible; therefore SSA began to use them based on a Prospective Payment System (PPS) that pays a fixed amount for each patient that receives care. The Prospective Payment System, in condition of private sector provision of inpatient services, will determine the distribution of the financial risk and create the framework for incentives (pay for performance, etc.) for the offered services. In PPS the provider takes the risk of the variation in costs, thus increasing the incentives to operate efficiently.

The road map for DRG implementation is presented in the reports provided by Consultancy Missions on DRG.

However, shifting to the case payment mechanism should be mandatorily complemented with the costing exercise to establish the tariffs of health care services.

The risks associated to this process are the avoidance by the hospitals of the most costly cases and splitting expensive cases into multiple stays, as all cases in a group are reimbursed at the same rate in a case payment system. In this case the co-payment system in place plays the role of the counteracting tool.

The payment strategies described above were designed to determine an institutional and professional behavior that would contain the costs of the UHC Program. At the same time, these also can encourage under- or over-provision of services (consumer demand forcing), in turn increasing UHC Program costs and threatening harm to beneficiaries. Under DRG-PPS, for example, hospitals that can discharge UHC patients in fewer days than the average length of stay on which the DRG rate is predicated, or provide fewer or less costly services to hospitalized UHC beneficiaries, can keep the difference between the DRG payment and their cost. Conversely, hospitals that retain patients for longer than average lengths of stay, or provide more or costlier services to their patients than the norm, will rarely be able to recover their excess costs from UHC Program. Thus, efficient and waste-avoiding behavior and policy interventions are encouraged and mandatorily needed. These should be focused on:

- National Reference Tariffs Payment System
- Clinical Protocols.

As compared to cost-based reimbursement in place ***(bundling fee-for service mechanism)***, which rewarded the hospital for using more resources, DRG-PPS rewards the hospital for using less.

DRG-PPS as a cost containment measure should be implementing within a broader context (reference tariffs, clinical protocols, integral financing of the case, etc.) due to the fact that nothing in the DRG system itself, however, guarantees that cost cutting by hospitals will stop at the point where the patient is provided the optimal amount of services for economical, yet effective, care. Indeed, absent constraints external to the DRG payment system, the incentives it creates would determine a hospital to use fewer and fewer resources per-admission to permit a greater and greater profit. Thus, possible products of DRG-PPS reimbursement include premature discharges of patients, provision of insufficient medical care to patients while hospitalized, and “dumping” of patients who are likely to require extraordinary amounts of

resources on other hospitals. In addition to under-service, DRG-PPS reimbursement creates incentives for perverse behaviors that could likewise increase costs and threaten patients. For example, in case hospitals will be continued to be paid under DRG-PPS on a per-admission basis – inpatient emergency services, they could cause a patient with multiple complaints to undergo multiple admissions, as it was analyzed in the chapters above. Alternatively, the hospital could create multiple admissions by transferring patients among hospitals or distinct parts of hospitals (to emergency inpatient department, ITC unit for example). Hospitals might also attempt to "up-code" patients to a more lucrative DRG, or to "un-bundle" charges by, for example, requiring transferring from emergency inpatient department or ITC unit to other department and back, to increase reimbursement.

Therefore, a number of considerations are essential for establishing an agenda for implementing cost containment measures effectively. First, the development of practice protocols or similar guidelines of optimal processes for medical care is essential. Such guidelines would assist the task of utilization and quality review in several respects. **Guidelines or protocols could in many instances eliminate the need for regulatory intervention.** As the shift of cataract surgery from the inpatient to outpatient settings illustrates, articulation of standards may in itself be sufficient to change practice. **Articulation of standards may largely eliminate the need for extensive case-by-case claim management before approval reimbursement**. The vast majority of cases could, given viable guidelines, simply be disposed of with minimal review by reference to the standards, with individual consideration focused on marginal cases. Where appeals are brought for denials of non-standard care, evidentiary issues would be greatly simplified. The recent commitment of MoLHSA to develop of practice guidelines and extend their usage is thus a very positive development to improve utilization and quality review.

Another step in this direction is the imminent implementation of the National Reference Tariffs Payment System, which will permit the purchasing authority – SSA to apply a uniform set of tariffs to a more complete clinical data set, enabling more objective and systematic procurement decisions.

In summary to Intervention 1, 2 and 3 one of the main goals of health reform is to improve allocation of scarce health care resources to improve the effectiveness and quality of the system. This requires rationalization of the delivery system and the implementation of new payment systems that reward providers for providing more cost-effective, higher quality

services and attracting more patients. Vertical and horizontal pooling of health funds allows the allocation of health resources to be disengaged from historical budgeting patterns and to be allocated by new payment systems according to activity and the population's health needs.

INTERVENTION 4: National Reference Tariffs Payment System

The development of a National Reference Tariffs Payment System through the application of the same methodological elements which are currently underlying the calculation of the tariff reimbursed by SS has an extremely low degree of feasibility. The main feature of the given policy is the lack of transparency in establishing the cost and, subsequently, the tariff of the health service by healthcare providers, in the context in which MoLHSA uses as a basis for calculating the reimbursed tariff the price calculated and required by the provider [Reimbursed tariff = (Maximum tariff - Minimum tariff)/4 + Minimum tariff].

The implication of such methodology consists in a shortfall in efficiency improvement combined with finances not deteriorating correspondingly and providers are taking additional actions other than improving efficiency to protect or improve providers' financial positions. These actions are referred to as leakage. A lower tariff applied by healthcare providers concludes on a hypo-selection in establishing the cost of the health service (cheap and low quality drugs, low remuneration of healthcare staff, limited range of investigations, etc.), and a higher tariff - on a hyper-selection, which is mostly often in the interest of the provider, because it mainly includes expenses that are related to the non-clinical dimension of the health service.

Shifting to new patterns of care provision and allocations of funds represents a priority if the sector is to achieve a long-term balance between growth in patient expectations and largely effective budgets. The Consultancy Mission recognize this as a significant challenge, but, at the same time, implementation of recommended policy interventions will raise levels of care quality and patient safety, with more patients receiving the right care, in the right setting, at the right time.

The payment system design needs to adapt to this changing framework. First, changes to the patterns of care provision will be reflected in funding flows, with focus on reducing the need

for acute services by investing in primary care interventions, including drug reimbursement, and specialized ambulatory care. The Consultancy Mission anticipates that the financial impact of these changes will be different for each service; however, the payment system must enable such changes to funding flows. Second, the payment system itself can be a catalyst for service transformation (DRG-PPS, new formula for capitation in primary care, pay for performance system, etc.).

The Consultancy Mission task over the longer term is to propose, at the current stage, the design of the reference tariffs payment system that includes the right blend of tools and incentives to work best for patients.

In contrast to the current tariff system there is need, from the 2016, to design a national reference tariff system to contain policies that will underpin shifting to new patterns of care, including strengthening the "building blocks" of the payment system – through using better data; transparent assumptions, detailed impact analysis, etc.

The need to reform the tariff system is urgent, but so is the need to do this in a considered and systematic way. In developing the policy interventions summarized in this document the Consultancy Mission have been mindful of the need to promote stability in difficult circumstances while continuing to incentivize efficient provision of services. For 2016 is needed to be planned and created the framework to provide the health sector with opportunities to adopt new reference tariff system, which will be evaluated with a view to possible wider roll-out in future years.

The national reference tariff system should include not only a set of specific currencies and associated prices, but also a set of principles, rules and methods, and which would:

- specify a set of healthcare services provided for the purposes of the UHC and other vertical health programs which are to have national prices (referred to as currencies).
- specify the method used for determining the national prices of those specified services.
- specify the national price of each of those specified services (whether as an individual service, or as a bundle of services, or as part of a group of services).

- provide the rules under which providers and policy-makers agree to vary the currency or the national price of services specifies variations to the national price for a service by reference to the circumstances in which the services are provided or other factors relevant to the provision of that service.

The Consultancy Mission recommends that national prices should reflect the efficient costs of care and send appropriate signals. Therefore, the process of establishing of the National Reference Tariff System should include the following phases:

Health Services Costing Phases	Timeframe
Step 1. Select the Costing Methodology	by September 30, 2016
Including Institutional Arrangements for Data Management	
Step 2. Design National Currencies*	by February 28, 2017
Step 3. Determine the cost components for the national currencies **	by August 31, 2017
Step 4. Calculate average tariff prices from reference costs	
Step 5. Adjust the cost base from Reference Cost	by October 31, 2017
Step 6. Ensure tariff price relativities reflect the reference costs relativities	
Step 7. Reconcile expenditure to pre-manual adjustment levels	
Step 8. Adjust prices to correct for illogical or inappropriate outcomes/relativities	
Step 9. Ensure total tariff quantum reflects the target cost base (scaling factor)	
Step 10. Account for substantial changes in the tariff through smoothing of price changes (smoothing factor)	
Step 11. Apply cost uplifts and the efficiency factor to adjust prices	

*Note: * Currencies are specifications of health services, used as the basis for payment for UHC Program and other state health programs' services. For inpatient care, the currencies used*

are Diagnostic Related Groups (DRGs), which group together diagnoses, treatments and care that may typically occur during a spell of care and use similar levels of resource.
*** The usage of cleaned data (i.e. raw reference cost data with a number of implausible records removed) will, over time, reduce the number of illogical cost inputs (for example, fewer very-low-cost recordings for a particular service and less illogical relativity). This, in turn, should reduce the number of modeled prices that require manual adjustment and should therefore increase the reliability of the tariff. This benefit outweighs the disadvantage of losing a number of data points as a result of the data cleaning process.*

One of the functions of the National Reference Tariffs is to set the national prices for certain healthcare services provided under UHC and other state vertical programs (categorized as currencies for pricing purposes). However, for services without a national price (only provider-based price), MoLHSA and health providers should have regard to the cost uplift factors and efficiency requirements for national prices.
This health care costing exercise should set unit prices that encourage better patient care within the existing healthcare budget. Therefore, in setting prices the costing exercise need to balance, among other things, the need for prices to reflect efficient costs with the need for prices to be set in a way that is reasonably simple and transparent. A highly complex system, with many prices for different types of services and patients, may reflect underlying costs more accurately than a system with fewer prices. However, such a system is likely to be hard to understand and costly to administer. A simpler approach to setting prices, reimbursing the total costs of all services, would be easier to understand and operate, and more cost effective to administer.

The prices should provide appropriate signals to all actors of the health system. When prices reflect efficient costs they signal to consumers, providers and other market participants what it costs to produce a health service. In the National Reference Tariff System, prices signal to MoLHSA/SSA the average costs of each service they procure from providers. They also signal the cost of providing UHC services more generally. National Reference Tariffs and the payment system in general, should indicate resource costs to SSA, providers and other interested stakeholders (e.g. MoLHSA) to inform crucial decisions about UHC services. In the framework of the UHC Program, the national reference tariffs would enable better patient care for a given budget, based on two mechanisms:

- The payment system encourages purchasing authority (SSA) to make the most effective use of available budgets (that is, it enables authority to make the best decisions about the mix of services likely to offer the highest value to their local population).

- The payment system incentivizes providers to reduce their unit costs by finding ways of working more efficiently.

At the same time, the health service costing exercise should cover both short-term and long-term considerations. Thus, setting prices too high may disadvantage patients by reducing the volume of services that SSA can purchase within a fixed budget. High prices could also reduce the incentive for providers to find cost savings, which would negatively affect patients in the longer term. On the other side, setting prices too low can be just as detrimental to patient interests, particularly in the long term, because: (i) providers may not be fully compensated for the services they provide, potentially leading to withdrawal of services, compromise on service quality, and/or underinvestment in the future delivery of services; (ii) SSA may "over purchase" low-priced services, at the expense of other services, because they may perceive the value for money of those services to be better than it actually is. The relationship between cost and quality is complex; however, it is plausible that some health providers are able to provide both higher quality and lower cost services.

INTERVENTION 5: Reformulate Payment Rates for Primary Care Services

The mechanism for new payment rates for primary health care services is presented in the Primary Health Care Development Program.

INTERVENTION 6: Increase access to affordable medicines through re-designing the Drug Reimbursement Program

The drug reimbursement methodology and volumes are presented in the Drug Reimbursement Program.

INTERVENTION 7: Design and implement a National Integrated eHealth System

The road map for National Integrated eHealth System is presented in the reports provided by Consultancy Missions on eHealth, including feasibility study.

INTERVENTION 8: Volume Thresholds for Funding Eligibility

Reduced regulations on access of medical institutions in providing health services, as well as short-term political, social and economic constraints in implementing policies in the field determine the need for interventions that would ensure control on the eligibility of healthcare providers regarding UHC Program services. Volume thresholds are an effective measure in this regard, with direct implications in ensuring quality of health services.

At the international level there is an increased interest in terms of quality of health services and the implementation of quality control instruments aimed at directing patients to healthcare providers that deliver high-quality and cost-effective health services.

Over the past 20 years, studies in the field have brought to the forefront of public debate and have proved a significant relationship between the high volume of surgical interventions performed in hospital and the reduced number of complications (hospital/postoperative mortality, mortality at 30 days, readmission rate, postoperative/postpartum complication rate, etc.).

Many of these studies, based on specific diagnoses and procedures, demonstrated that patients hospitalized with a low volume of interventions or treated by surgeons who perform a small number of interventions register a higher rate of complications compared with patients hospitalized with a high volume of interventions or treated by surgeons that perform a greater number of interventions.

Based on these facts at the international level, policy makers in different health systems initiated a process of reevaluation of policies in the field of surgical and obstetrical hospital care. In 2005 the Ministry of Health and Solidarity of the French Republic established as a priority measure the ensurance of security, quality and continuity of the surgical hospital care, based on the fact that it represents a central element in the organization of health service delivery. The report commissioned by the Ministry of Health and Solidarity established that

113 public hospitals have a volume of surgical interventions < 2,000 interventions, 112 public hospitals have 3 specialists in surgery, 32% of public hospitals perform 10 interventions of colectomy per year, and 43% of public hospitals - 10 prostatectomies per year. At the same time, the report established that these hospitals cannot ensure and guarantee standards of quality and safety for patients and recommended that a threshold be established for surgical activity and the closure of health institutions that do not meet these requirements.

These recommendations were reflected in the process of public policies on surgical hospital healthcare. Thus, the French National Board of Surgery established general criteria for authorizing surgical practice in public hospitals, namely: the minimum threshold of annual activity of a hospital operating theater must be 2,000 interventions; coverage of a pool of population of at least 50,000 people.

The French National Cancer Institute developed the criteria for authorizing oncological activity in hospital facilities and established minimum standards of interventions. Based on these regulations, in 2007 the Ministry of Health and Solidarity approved annual minimum standards of activity applicable to oncological healthcare (Table 9).

Similarly, in the case of cardiac surgery, the Regional Agency of Hospitals developed and approved in 2006 minimum annual activity standards of 400 major cardiosurgical interventions for adult patients and 150 cardiosurgical interventions for pediatric patients.

The implementation of minimum standards of volume as a policy measure in the hospital assistance has had as an impact the reorganization of surgical service delivery in France, especially through the centralization of certain types of surgical interventions.

Table 11. Minimum annual activity threshold in the oncological service, France

Therapeutic practice	Health condition	Number of interventions or patients per facility
Surgical oncology	Breasts pathology	Interventions: 30
	Digestive tract pathology	Interventions: 30
	Urologic pathology	Interventions: 30
	Chest pathology	Interventions: 30
	Gynaecological pathology	Interventions: 20

	Otolaryngology and maxillofacial pathology	Interventions: 20
Radiotherapy	External radiotherapy	Patients: 600
Chemotherapy	Chemotherapy	Patients: 80
	Outpatient chemotherapy with day hospitalization	50

In the United Kingdom of Great Britain and Northern Ireland, the Association of Upper Gastrointestinal Surgeons, at the request of the Department of Health, developed in 2009 recommendations on the minimum volume of interventions per surgeon. Thus, the minimum threshold of esophageal resections per surgeon was established at 15-20 interventions/year, the minimum threshold of pancreatic resections per surgeon - 12-16 interventions/year, and the minimum threshold of hepatic resections per surgeon - 15-25 interventions/year.

In the USA, in 2007, Leapfrog Group established annual minimum volume standards per surgeon for 7 procedures that were selected as evidence-based admission criteria (Table 10).

Other evidence is provided by the Medicare system, which implemented in the 90' annual minimum volume standards in the transplant service (12 transplant surgeries/year) for contracting these types of services.

Table 12. Annual minimum volume standards, USA (*according to Leapfrog Group*)

Procedure	**Annual minimum number of interventions per hospital**	**Annual minimum number of interventions per surgeon**
Coronary artery bypass	450	100
Percutaneous coronary interventions	400	75
Aortic valve prosthesis	120	22
Aortic abdominal aneurysm repair	50	8
Esophagectomy	13	2
Pancreatic resection	11	2
Bariatric surgery	125	50
Birth with high risk (<1500g, <32 weeks gestation, prenatal diagnosis of major congenital anomaly)	50	-

Considering the potential of minimum volume standards to improve the quality of hospital services, Germany decided in 2002 to introduce in the regulatory framework provisions related to mandatory implementation of annual minimum volume standards as a measure to ensure quality in the hospital sector. Mandatory health insurance companies proposed in 2003 a list of 10 procedures that would fall under the minimum volume standards. The Joint Federal Committee established a list of 5 procedures to meet annual minimum volume standards as of 2004. Under this provision, hospitals that didn't meet in 2003 the annual minimum volume requirement for surgical interventions did not have the permission to perform the given surgeries in 2004. Moreover, in 2004-2005 the regulation on the annual minimum number of 5 major interventions (interventions on the esophagus and pancreas) per surgeon was also in force. In 2006, the Joint Federal Committee extended the list of interventions and reevaluated the minimum volume standards (Table 10).

The Joint Federal Committee did not stipulate penalties for not reaching the minimum activity threshold, but insurance companies use these standards in negotiating the annual contraction with hospital institutions, assuming the right to refuse the reimbursement of costs for non-compliance.

According to InEK, 18,404 of hospital cases (approx. 1.1%) were affected by regulations adopted in 2004. After the implementation of the minimum threshold for TRK in 2006, their value has increased to 146,000 cases, i.e. approx. 8.5% of all hospital cases.

Table 13. Annual minimum value standards per hospital, Germany

Surgical procedure	Minimum value proposed by insurance companies (2003)	Minimum value (2004)	Minimum value (2006)
Liver transplant	25	10	20
Kidney transplant	40	20	25
Stem cell transplant	20	10 – 14	25
Major interventions on pancreas	10	5	10
Major interventions on esophagus	10	5	10
Major interventions on the mammary gland	150	-	-
Heart transplant	9	-	-

Coronary interventions	100	-	-
Carotid endarterectomy	20	-	-
Percutaneous coronary interventions	150	-	-
Total knee replacement (TKR)	-	-	50

The focus of the Consultancy Mission is on regulating the volume, as an internal UHC regulation, of either inputs into or outputs from the UHC and other state health programs.

In consequence, the recommendation of the Consultancy Mission concerns implementation from 2016 the Minimum Volume Standards for the annual number of procedures as a main criteria for funding eligibility in UHC Program, as follows *(estimated based on historical patterns)*:

Health condition/Procedure		**Minimal Volume Threshold per facility/year** (cases or interventions)
Obstetrics and Gynecology	Spontaneous vaginal delivery	500
	Births with high risk (<1500g, <32 weeks gestation, prenatal diagnosis of major congenital anomaly)	50
	Cesarean delivery	150
	Abdominal hysterectomy	35
	Vaginal hysterectomy	15
	Laparoscopic hysterectomy	20
General Surgery	General surgical pathology	2000
Neurosurgery	Vascular	35
	Pediatric	20
	Spine	250
	Trauma	50
Cardio surgery	Coronary interventions	150
Surgical oncology	Breasts pathology	30
	Digestive tract pathology	30
	Urologic pathology	30
	Chest pathology	30
	Gynecological pathology	25

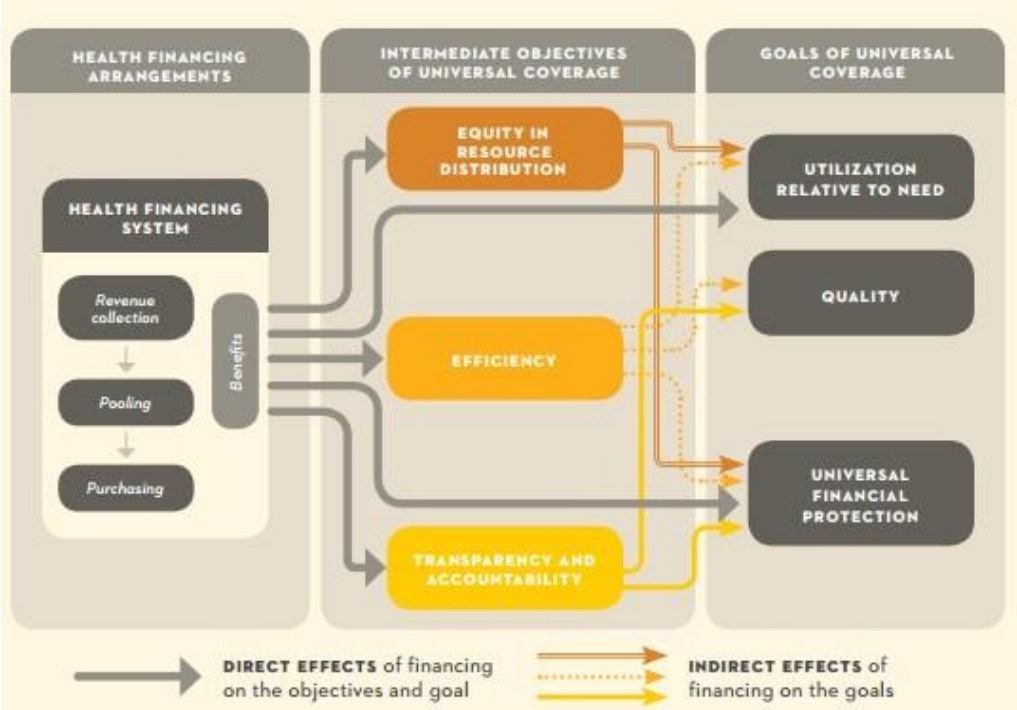
	Otolaryngology and maxillofacial pathology	20
	Neuro pathology	50
Radiotherapy	External radiotherapy	Patients: 300
Chemotherapy	Chemotherapy	Patients: 75
	Outpatient chemotherapy with day hospitalization	Patients: 50

INTERVENTION 9: NO NEED FOR EXTENSIVE CASE-BY-CASE CLAIM MANAGEMENT BEFORE REIMBURSEMENT APPROVAL

The extensive case-by-case claim management was mentioned by the health authorities, during the meetings and working groups, as a potential cost containment measure for UHC Program.

The Consultancy Mission concludes on a very low effectiveness and efficiency of this measure to contain the cost in the specific context of Georgia. Arguments in this regard will be based on a broader insight into the case-by-case claim management in relation to the universal health coverage.

To achieve and sustain UHC program, Georgian Government is alocating resources from national budget and is acting to distribute the resources equitably, and use them efficiently to achieve the most benefit in terms of meeting health care needs, ensuring quality of care, and protecting users from financial hardship due to out-of-pocket expenses. In our view, it is necessary to point out three peculiarities of the UHC program from Georgia. First, the principle of solidarity in financing health care, which is inherent in establishing contributions in relation to income, is applied. Second, the person is benefiting from a volume of health care services depending on his health needs and depending on a cost ceiling. It is critical to be mentioned that the applied ceiling is not related to health risks presented by the consumer.



Source: Kutzin, 2013

Third, within the UHC system, the allocations of financial resources are made on community-rated estimations (general population health profile) and not on actuarial estimations based on the individual health risks.

Such a context creates all the premises to eliminate the express need for a regulatory intervention in terms of case-by-case claim management. The argumentation is based on the condition that the policies of the MoLHSA are intended for the pre-authorization of the health care providers and setting "filters" for automatic exclusion of leakages and abuses on a regular basis. The policies designed should not cover evaluation of all claims, or the large majority of them, but should carefully establish which is permitted and which is not; therefore managing the reimbursement request based on a technical validation with "standard" audit capacities of the SSA.

With this option purchasing authority (SSA) do not need to run a case-by-case claim management. Instead, purchasing authority (SSA) automatically excludes any pre-existing conditions for leakage or fraud from the health care provider side through applying measures regarding:

- Access control of the providers in the UHC Program (clinical volume thresholds, etc.)
- Integral financing of the case based on DRG-PPS
- National Reference Tariffs Payment System
- Clinical Protocols
- Expenditures Targeting.

The way providers are reimbursed is one of the most important factors impacting the micro-level efficiency of health spending. By combining the purchasing powers of the Universal Healthcare Program and other state health programs and adopting common contracting standards, Georgia could drive down the rates it pays, reduce waste, and improve quality.

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