UTILIZATION AND AFFORDABILITY OF HEALTH SERVICES IN DIFFERENT HEALTH SERVICE PROVISION MODELS

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EAST · WEST MANAGEMENT INSTITUTE

Policy, Advocacy, and Civil Society Development in Georgia (G-PAC)

საჯარო პოლიტიკის, ადვოკატირებისა და სამოქალაქო საზოგადოების განვითარება საქართველოში

Partnership for Social Initiatives

პარტნიორობა სოციალური ინიციატივებისათვის

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Definition

An integrated delivery system (IDS) is a network of health care providers and organizations which provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the clinical outcomes and health status of the population served. An IDS may own or could be closely aligned with an insurance product.

The IDS represents a vertically integrated structure, that is, it brings together healthcare organizations such as hospitals, medical groups and other service providers, uses aligned incentives and is frequently linked to insurance plans.

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OBJECTIVES OF INTEGRATED DELIVERY SYSTEM

Main objectives of the IDS are quality improvement and cost reduction. Namely:

- Reducing administrative/overhead costs
- Sharing risk
- Eliminating cost-shifting
- Outcomes management and continuous quality improvement
- Reducing inappropriate and unnecessary resource use
- Efficient use of capital and technology

Consumer Responsiveness:

- Seamless continuum of care
- Focus on the health of enrollees

Community Benefit:

- Improvement of community health status
- Addressing the prevention of social issues which affect community health

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STATUS OF INTEGRATION AND EXPENDITURES

INTEGRATION OF FUNCTIONS	MODEL A	MODEL B	MODEL C
Organization	PI	FR	FR
Management	I	FR	FR
Finance	PI	FR	FR
Medical Management	PI	FR	FR
Clinical Management	PI	FR	FR
STATUS OF INTEGRATION	PI	FR	FR

TOTAL HEALTH EXPENDITURE	NI	IN	NI	IN	NI	IN
THE	H	L	L	H	L	H
OP	H	L	L	H	L	H
Pharmaceutical	H	L	L	H	L	H
Hospital	H	L	L	H	L	H

THE - Total Health expenditure;
OP- Out-patient;
PI – partial Integration;
FR – Fragmentation
NI – non-insured;
IN – insured,
H – high;
L- low

In order to justify reliability of above shown findings in the second phase of research the decision was made to study in addition two “Model A” districts operated by **different** Health Operators (Insurance Companies). The comparison of results can reveal whether degree of integration affordability and access to services.

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Degree Of Integration

CHARACTERISTICS	DISTRICT 1	DISTRICT 2	DISTRICT 3
FINANCE			
Integration of financial streams on each level	Yes	Yes	Yes
Capitation Funding	Yes	No(Yes)	No
Other Methods of reimbursement	No	No	No
Incentives	No	No	No
MEDICAL MANAGEMENT			
Case Management	Yes	Yes	Yes
Disease Management	No (Yes For Certain Diseases)	No	No
Discharge Management	Yes	Yes	Yes
Referral Management	Yes	Yes	Yes
Pharmaceutical Management	Yes	Yes	No
Utilization Management	Yes	Yes	Yes
QUALITY MANAGEMENT			
Quality Assurance Teams available	Yes	Yes	Yes
QA team members trained (specific training)	No	No	No
QA strategy and plan available	No (Yes)	No	No
QA methodological guidelines available	No	No	No
QA performance metrics maintained	No	No	No
CLINICAL MANAGEMENT			
Guidelines and Protocols	Yes	Yes	Yes
Performance Management	Yes	Yes	Yes
Team approach to coordination of care	No	No	No
SUMMARY	**Partially Integrated**	**Partially Integrated**	**Partially Integrated**

Assessment of the main functions of the model in all studied districts revealed that Model A is partially integrated and integrates all financial resources, receives funding on the capitated basis, practices elements of medical management such as case management, discharge management, utilization and pharmaceutical management.

Moreover, the model has established service quality assurance mechanism, though not yet fully implemented, uses clinical guidelines and protocols as well as monitors compliance and measures performance.

The level of integration achieved at present in the Model A positions it to be more efficient and effective in delivering services to population

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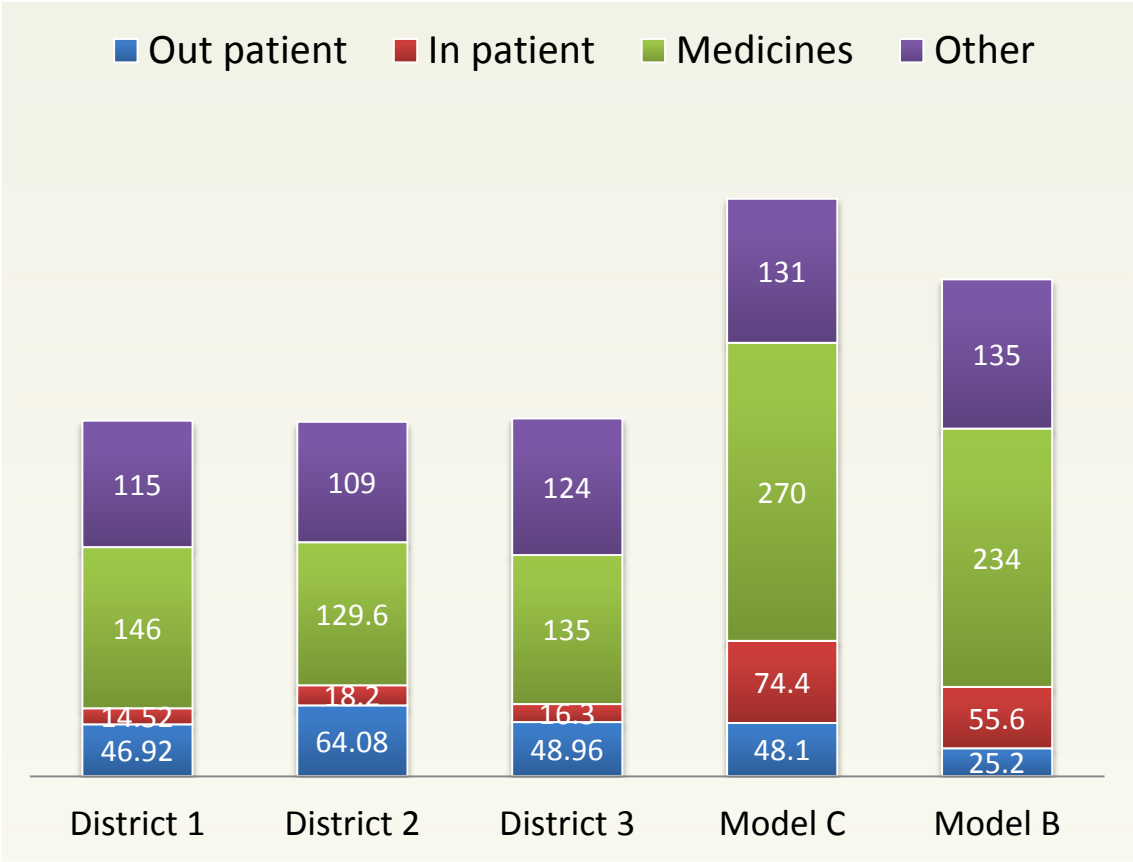
ANALYSIS OF TOTAL HEALTH EXPENDITURE

Per capita THE per year (GEL)



The difference in total per capita health expenditure by districts with Model A represents only 1-2 GEL per capita per year. It is notable that about 15% - 20% is spent on outpatient services. Though still low it is higher compared to other two models.

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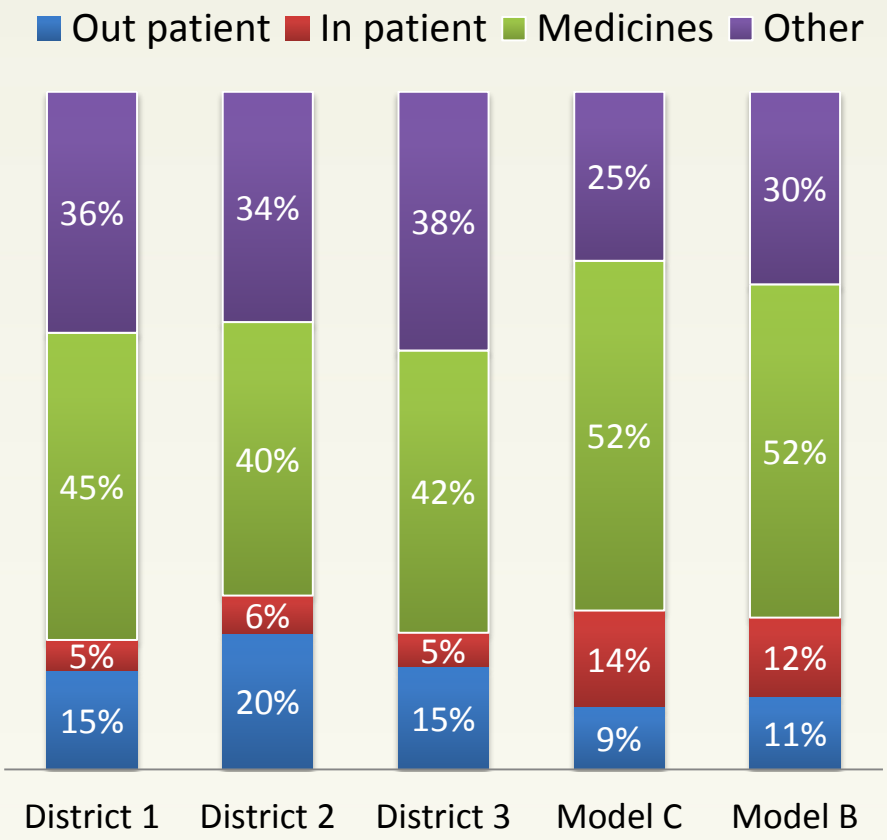
ANALYSIS OF TOTAL HEALTH EXPENDITURE

Share of per capita THE per year per service type



The share of expenditures on medicines remains to be the higher cost center in all three models, however “Model A” demonstrates lower expenditures (40% - 45%) in comparison to Model B and Model C (54% and 52% respectively).

Another comparative advantage of the Model A is proved by lower share of in-patient expenditures (5%-6%) in contrast to other two models where the share of total hospital expenditure represents 14%.

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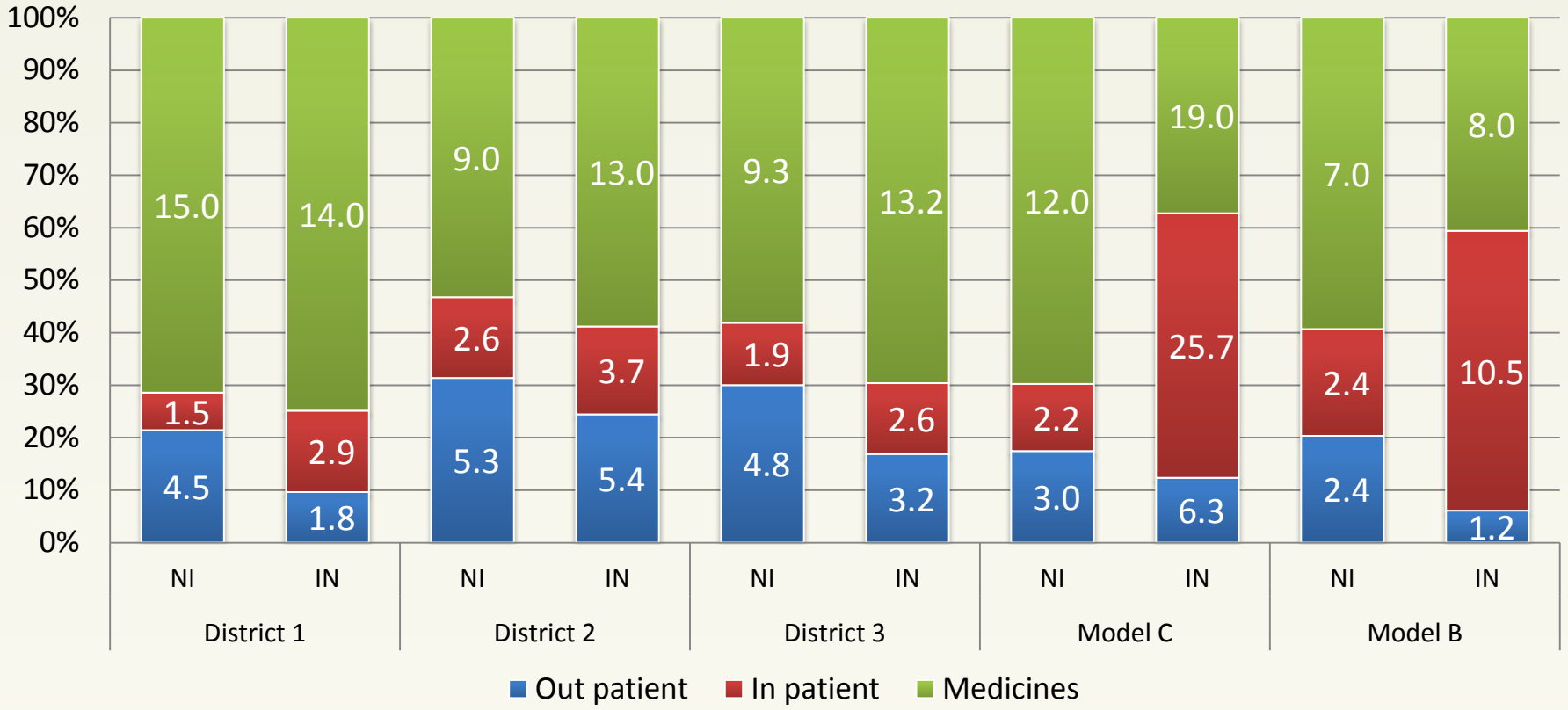
ANALYSIS OF TOTAL HEALTH EXPENDITURE

Per Capita expenditures per month per insurance status



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ANALYSIS OF TOTAL HEALTH EXPENDITURE

The lowest average per case expenditure on total outpatient services including the diagnostic services has been recorded in all three districts operating under Model A for insured patients. Though it is notable that for non- insured average outpatient expenditure per case is almost 1.3 times higher than for insured, possibly due to hyper-diagnostics as referrals for the secondary consultations are 1.5 times higher for non-insured than for insured. The Model A utilizes different price lists for insured and non-insured and is selective in applying case management practices for outpatient services.

	District 1		District 2		District 3		Model C		Model B	
	NI	IN	NI	IN	NI	IN	NI	IN	NI	IN
Out patient (total)	79,0	56,0	97,7	78,0	82,3	67,5	62,1	121,0	54,0	84,0
Consultations	18,0	18,0	44,2	44,4	22,4	22,5	17,2	21,7	20,0	26,3
Diagnostics	61,4	38,0	53,3	48,0	66,2	42,7	45,1	99,8	35,0	47,0
In patient	334,0	109,2	350,8	289,8	346,7	234,6	774,4	3 050,5	509,5	1 469,2

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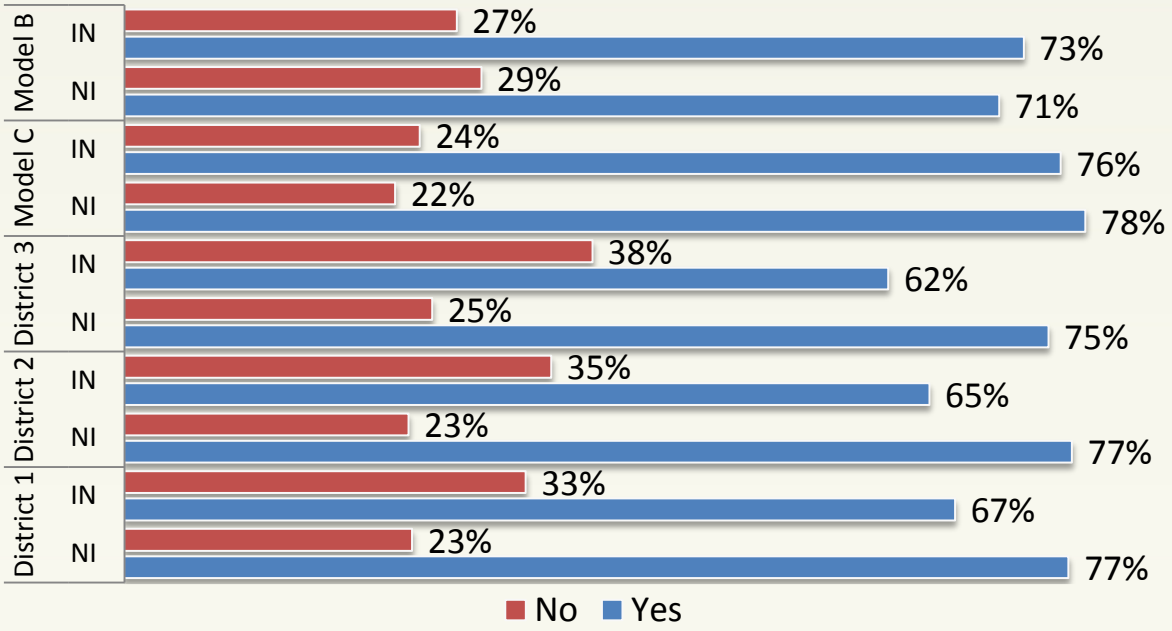
ANALYSIS OF TOTAL HEALTH EXPENDITURE

The utilization of pharmaceuticals is over 62% in all three models regardless of insurance status. Out of those who did not purchase medicines over 63% names cost to be a major barrier. Non-Insured mainly enjoy self- prescription practices while physician prescriptions are practiced for insured. On the one hand, the highest rate of physician prescribed utilization of medicines is recorded in Model A for insured and on the other hand insured in Model A enjoys fewer expenses on medicines compared to other models.



These findings echoes qualitative study findings about **Model A practicing a higher level of medical management. The worrisome is the fact that non-insured are not treated equally as insured in none of the assessed models resulting in high expenditures and low access to medicines.**

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SUMMARY OF TOTAL HEALH EXENDITURES BY MODELS

For better visualization of expenditures per model all types of health expenditures were summarized for all three models. According to the level of total health expenditure Model C is prevailing other two models. However analysis of expenditures within the model per insurance status characterizes the Model A as the best model able to manage expenditures of insured.

In summary Model A demonstrates better access and affordability of services for both insured and non-insured individuals compared to other two models, however there is still a significant room for further research and improvements.

Expenditure	MODEL A		MODEL B		MODEL C	
	NI	IN	NI	IN	NI	IN
Total health expenditure	H	L	L	H	L	H
Out-patient	H	L	L	H	L	H
Pharmaceutical	H	L	L	H	L	H
Hospital	H	L	L	H	L	H

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THANK YOU

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