**Graduating from GAVI Support:**

**Georgia’s Financial Projections and Analysis**

**Excerpts the GAVI Georgia Country Report**

1. **Health Expenditures**

Total health spending in Georgia is reported to account for a relatively high share of gross domestic product – over 8% and possibly as high as 10%. At the same time, public spending only makes up around a quarter of total health expenditure, with the rest composed of mostly out of pocket payments and a small but growing private voluntary health insurance sector which covers over 400,000 persons or about a tenth of the Georgian population. Government expenditures for health in the mid-1990s constituted a modest 6-8% of all public spending (see Table 7), but it appears that the current government has started raising this share and that they are committed to further rapid growth in the health budget, mainly to finance a universally-available package of services to be implemented by private insurance intermediaries. Roughly half of the population (around 2 million persons) will benefit from this government-financed package by September 2012, and there is widespread talk of progressively extending the package over the next few years until it reaches all Georgian citizens.

According to data received during the GAVI/WHO/UNICEF visit to the country, the ministry of health budget is projected to increase by 14% a year between 2012 and 2015.

Table 1: Georgia: Health expenditures (in million GEL)

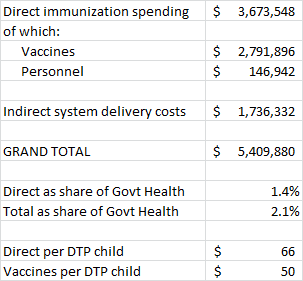
|  | 2006 | 2007 | 2008 | 2009 |
| --- | --- | --- | --- | --- |
| Public expenditure on health (current million Gel) | *255* | *256* | 343 | 419 |
| Public expenditure on health as Per Cent of General Government Expenditure | *6.6%* | *5.1%* | 5.9% | 8.0% |
| Total Health Expenditure (current million Gel) | 1,160 | 1,387 | 1,661 | 1,819 |

1. **Past expenditures on immunization**

According to the data compiled for the 2011 country multi-year plan (cMYP) for immunization, the government of Georgia, spent around $5.4 million on immunization in 2010 (see Table 8). This included $3.7 million (68%) in direct costs and the balance of $1.7 million (32%) in so called “joint system” (shared costs?) costs for health workers to deliver the vaccines to children and adults in the population. Just over three-quarters of the direct immunization costs ($2.8 million) were for the vaccines themselves, according to the cMYP.

Total public spending for immunization was equivalent to 2.1% of government health expenditure in 2010?. The direct public outlays represented 1.4% of the health budget in 2010. The cMYP further calculated vaccine spending per child immunized with all three doses of DPT vaccine at $50, but this figure is possibly a bit misleading, as vaccine spending included purchases of rabies vaccine which appears to be a major item in the government’s vaccine procurement, amounting to around $0.5 million annually (price per dose of rabies vaccine?).

**Table 2: Georgia: Public sector immunization expenditures, 2010 (definition of direct and indirect?)**



1. **Sources of financing for immunization**

While in the early years following the establishment of the Republic of Georgia in the 1990s, the country was heavily dependent on external assistance to pay for its immunization program, in recent years the country has been assuming the majority of costs and appears to be well on the road to financial self-sufficiency. According to the cMYP, the government covered approximately 77% of the direct immunization costs mentioned earlier (about $2.8 million), with donors assuming the remaining 23%, comprising GAVI (16%), WHO (5%), the Rostropovich-Vishnevskaya Foundation (2%), to pay for immunoglobulin for babies born to mothers testing positive for Hepatitis B antibodies), and UNICEF (1%). If the indirect joint system costs are included, then the government’s share in the immunization program costs in 2010 was even larger, at 84% of the total.

1. **Estimated future financing of immunization**

As part of the joint WHO/UNICEF/GAVI visit, the team discussed with their Georgian counterparts the future prospects for financing the national immunization program. The financing of the vaccines themselves was closely examined, to answer the questions: How much will Georgia have to pay for its vaccines? Will the country be able to afford these vaccines, especially as external assistance to the country declines and Georgia becomes self-sufficient? To answer these questions, the GAVI vaccine “fiscal space” model was used.

In running the baseline scenario under the GAVI model, the following was assumed:

* The country will introduce two new vaccines, rotavirus (2012) and pneumococcal (2013) with GAVI co-financing support.
* This GAVI co-financing support will decline from 80% to zero over four years following vaccine introduction, at which point Georgia will cover the full cost of the vaccine
* Georgia will procure all of its vaccines except for rabies and immunoglobulin using UNICEF SD procurement services, thereby benefitting from UNICEF’s combination of good prices and high quality products (situation in the past?). UNICEF prices were therefore applied not only for the GAVI co-financed vaccines (pentavalent, rotavirus, and pneumo), but also for “traditional” vaccines (BCG, polio, DTP and tetanus/diptheria) and for other basic vaccines in the Georgia immunization schedule (measles/mumps/rubella).
* For rabies and immunoglobulin, Georgia will self-procure quality vaccines at the prices levels obtained in 2011 for these two products.
* The Georgian economy will grow at the rates published by the International Monetary Fund: 6.1% in 2012 and 5.5% from 2013 to 2020; and the government’s health budget will increase annually at the same rate as overall GDP growth

Using these basic assumptions, the model suggests that government vaccine expenditures will nearly double over the next five years, from $1.62 million in 2012 to $3.22 million in 2017, the year in which Georgia will become fully self-sufficient as GAVI co-financing support ends. As the graph below shows, only a very small fraction of the costs (in orange) – around $100,000 per year – will be needed for the traditional vaccines, which are very inexpensive on a per dose basis. During 2012-17, with the introduction of rotavirus and pneumococcal vaccines and transitioning of financial responsibility for pentavalent vaccine, co-financing by the Georgia government represents a significant share of the total, peaking at $1.14 million in 2015 and amounting to $3.16 million over the five years. The remaining costs to the government are largely due to the purchase of MMR and rabies vaccines and immunoglobulin, which absorb about $1.35 million a year over the next five years.

As a proportion of government health expenditures, Georgia’s financial outlays for vaccines rise gradually from just under 0.5% to about 0.7% in 2016-17, before falling again to around 0.5% at the end of the decade as absolute vaccine spending levels off while the economy and government budget continue to expand.

The key takeaways from this modeling analysis are that:

* Public spending on vaccines can be expected to increase sharply over the next few years, with the amount of expenditure incurred by the government doubling in five years;
* At the same time, Georgia should have the fiscal capacity to handle this increase without unduly straining its overall public budget for health, based on current economic forecasts, provided that the government continues to give a high priority to immunization
* A small number of vaccines – especially pentavalent, pneumococcal, MMR, and rabies – will account for the majority of expenditures over the coming years. These are the vaccines that need to be procured efficiently, while maintaining high quality in product selection.

**Figure 1: Georgia: Projected government vaccine costs, 2012-20**

1. **Financial planning and budgeting for immunization**

The process and roles and responsibilities for public sector planning and budgeting for Georgia’s national immunization plan have undergone a series of rapid changes in recent years, in line with larger institutional changes in the health sector – notably the expansion of the National Center for Disease Control (NCDC) and the recent incorporation of public funds to cover the cost of vaccination delivery by private sector providers throughout the country inside the larger insurance benefit package for all children aged 0 to 6.

In 2011, the budget for procuring all vaccines was held by the Social Services Agency (SSA), a legal-constituted public body under the Ministry of Labor, Social Services, and Health which had financial responsibility both for purchasing vaccines for the “vertical” public immunization program and for paying providers a small fee of GEL 1 (the “one Lari” scheme) for each vaccination delivered. NCDC executed the procurement of the vaccines on behalf of the SSA, and performed other technical functions such as distributing vaccines down to the level of public health centers; maintaining the cold chain to that level; and monitoring and reporting to the Ministry on the physical movement and consumption of the vaccines.

But starting with 2012, financial responsibility for the national immunization program was transferred to the NCDC and its Immunization Unit. Thus for the current year, the head of the Unit was given a “program budget of GEL 4,085 (US$ 2.48 million), divided into five areas that are listed in Table 9 below.

This program budget for immunization is part of NCDC’s larger program allocation of roughly GEL 16 million for 2012, divided among a series of vertical activities including AIDS and tuberculosis control, management of communicable diseases, and maternal and child health.

**Table 3: Georgia: NCDC Immunization Programme budget, 2012**

|  |  |
| --- | --- |
| **Activity** | **Budget (GEL ‘000)** |
| Procurement of vaccines and supplies | 1,650 |
| Procurement of specific sera and vaccines | 201 |
| Procurement of rabies vaccine and immunoglobulin | 1,614 |
| Logistics (transport, storage) | 120 |
| Vaccination services | 500 |
| **TOTAL** | **4,085** |

In addition, the Immunization Unit of CNDC has a notional budget to cover its “administrative” costs – personnel, per-diems, building space and utilities – within the larger NCDC budget of approximately GEL 4 million a year.

The GAVI/WHO/UNICEF joint team was informed that the annual program budget of the NCDC’s immunization unit had been earmarked GEL 5,200 million in the medium term expenditure estimates of the Ministry for 2013, an increase of 27% more than in 2012. This is even more generous if it turns out that the 2013 allocation for the immunization unit does not have to cover payments to providers of immunization services, which are in theory to be included in the government’s capitation for the insurance package to be delivered by private providers starting in September.

The process and timetable for financial planning and budgeting for immunization appear to be along the following lines:

* March-April: Immunization Unit (IU) develops its administrative budget which is consolidated with the full NCDC admin budget, plus its program budget for all other items – and sends this to NDCD management for negotiation and approval
* May: NCDC sends both its administration and program budgets, including the latter for immunization, to the Ministry of Labor, Social Services, and Health (MoLHSA)
* June-August: The Health section of MoLHSA reviews the NCDC budget and passes it on to the Financial section of MoLHSA; regarding the immunization program budget, there may be some discussions back and forth involving the Health section, Finance section, and NCDC’s IU
* September: MoLHSA sends its final budget to the Ministry of Finance
* October: Ministry of Finance sends full “state budget” to the Parliament
* November: Parliament approves the “state budget”

In the case of the immunization program, once the state budget is formally approved, the IU within NCDC receives a nominal budget with a breakdown along the lines of the five areas shown above for 2012. But there is a major caveat in all of this – it is only in November that the IU begins the process of developing its detailed estimates of the quantities and prices of the vaccines that it has to procure for the following year. Procurement, either through UNICEF or self-procurement in the case of a few vaccines like rabies, takes place during the first half of the following year. It is only at this time that the exact cost of the vaccines under several of the lines in the IU budget is known with precision.

The GAVI/WHO/UNICEF joint team was informed that the MoLHSA and the MoF understand that the amounts allocated for vaccine purchase in the budget are only approximations, and that the IU may have to come back to the MoLHSA to requests upward or downward adjustments during the year. So far, this process does not appear to have led to significant problems.

The IU’s program budget is then made available to the Unit on a quarterly basis. This seems to be happening in a timely way for purposes of actual expenditure by the IU. The MoLHSA is also willing to adjust the amount of the quarterly budget releases upward or downward to meet the actual needs of the IU, for example “frontloading” funds so that e.g., UNICEF or local vaccine suppliers can be paid in a timely manner.

While this financial planning, budgeting, and execution process appears to have a number of positive features, highlighted above, it also seems to have experienced some problems that need to be addressed:

* The exact calendar for each step and the roles and responsibilities of each party (IU manager, NCDC director, heads of the MoLHSA health section and finance section) have not been explicitly spelled out in an operational protocol. With all of the organizational change in the Georgian public sector, plus turnover of individual personnel, there seems to be some loss of institutional memory in this area, which could cause avoidable confusion and delays
* The administrative budget and program budgets of the IU, while loosely connected, are not fully integrated. There is a chance that the administrative budget could turn out to be too large or too small to support the effective implementation of the national immunization program, especially if the IU is assigned different responsibilities in the run-up to a new financial year
* The current IU budget does not contain funds for essential and catalytic activities, including immunization training, supervision of lower level facilities outside of the capital, monitoring, and communications. Given the many changes occurring along with the introduction of new vaccines and significant lingering doubts among parents and medical professionals about the quality and safety of government-procured vaccines in Georgia, a more robust budget for these essential and catalytic “supporting” activities would seem to be well justified. In earlier years, donor paid for these activities, but the prospects for this continuing in the future are low.