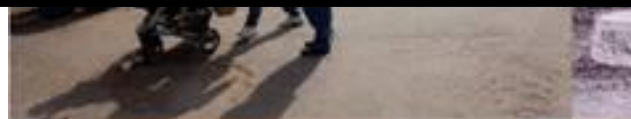


HEALTH INSURANCE FOR THE POOR IN GEORGIA

Content, Process and Actors



ALLIANCE FOR HEALTH POLICY AND SYSTEMS
RESEARCH ASSESSING EFFORTS TOWARDS
UNIVERSAL FINANCIAL RISK PROTECTION IN
LOW AND MIDDLE INCOME COUNTRIES



“...MAKING THE FINANCING OF THE UNIVERSAL STATE PROGRAM FOR URGENT CARE REALISTIC AND IN PAR WITH MARKET PRICES FOR HEALTH SERVICES WOULD HAVE MEANT EITHER SUBSTANTIAL INCREASE IN THE FUNDING LEVELS - WHICH WAS NOT AFFORDABLE, OR INCREASE IN THE LEVEL OF PATIENT CO-PAYMENT FROM 25 PER CENT TO 75-80 PER CENT – WHICH WAS NOT POLITICALLY ACCEPTABLE. FOCUSING THE AVAILABLE LIMITED FUNDING TO FULLY FINANCING THE ACCEPTABLE BENEFIT PACKAGE FOR PRIORITY GROUPS WAS CONSIDERED AS ONLY VIABLE ALTERNATIVE POLICY OPTION”

Key Informant

CONTEXT

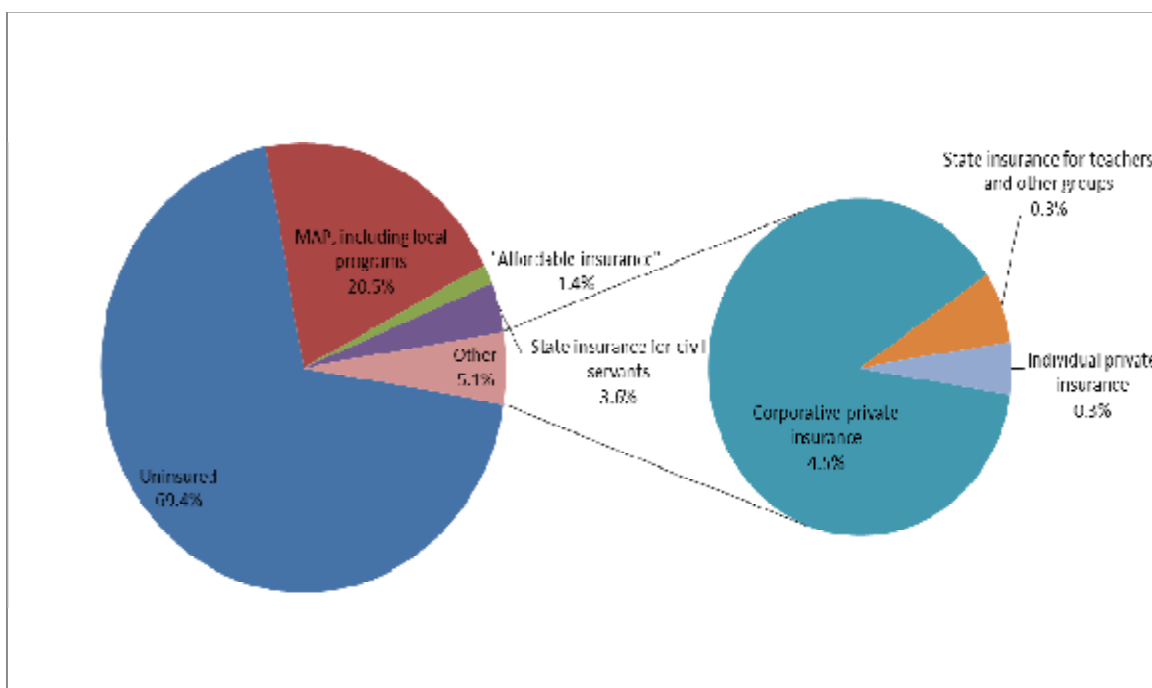
During the last two decades Government of Georgia initiated series of reforms introducing major changes in health financing policy and restructuring the health system to reverse the negative trends observed in equity, affordability and quality of essential health service for significant part of the country

population and particularly for the poor.

Addressing problems in equity and financial protection against health care costs through re-attainment of universal coverage for essential health care services for the entire population was one of the longstanding and explicitly stated national health policy goals. However, first practical steps towards achievement of this goal were made only in the recent years, when more public funds became available to the health sector. Paradoxically, this happened in the situation when the overarching goal of achievement of the universal coverage for the entire population through public funds has been removed from formal public agenda in favor of the “selective” approach targeting the priority groups. According to the key informants – the universal approach in defining *acceptable* and *realistic* benefit package for all was not possible due to the limited public funding available (no more than 25 per cent of total health expenditures).

Back from the year 2001, the government operated national health program that offered higher health care benefits to poor. However, the administrative system used to deliver subsidies to the poor was inherited from the Soviet Union and was based on social categorical groups (e.g. internally displaced, war veterans, etc.). This system significantly limited the effectiveness of the state health subsidies. In 2005, the government started developing a proxy-means-tested system for the detection of poor households and for delivery of the state subsidies (cash and in-kind). By mid-2006, this new administrative system became functional throughout the country that allowed delivering targeted health care benefits to poor households in addition to poverty cash benefits through then existing single public purchaser for health care services. In the years 2006-07, the

government has launched ambitious health financing reform program with an overall goal to improve equity and financial access to essential health services with a special focus on the poor. The state assumed responsibility for purchasing coverage for essential health services for the poor population and for a selected cadre of public servants (e.g. teachers, law enforcement, and military) through private insurance companies. Since the beginning of the year 2009, this Private Public Partnership (PPP) in health financing was widened through the new GoG initiative under which the state subsidized private voluntary insurance for defined essential health services for the rest of the population. The State subsidization of private voluntary insurance covering a basic package of services (emergency care, urgent care and basic PHC) was expected to further promote affordable health insurance against catastrophic health care expenditures. Finally, after several important adjustments MIP, in March 2012, the Government of Georgia has announced major initiative for MIP expansion that will result in insurance coverage for one out of two citizens of Georgia.



Source:
Georgia
Insurance
Association

CONTENT
ELIGIBILITY
CRITERIA
AND

TARGETING
MECHANISM
Beneficiaries of MIP are chosen based on welfare scores

		Private insurance companies International Organizations Providers Parallel health systems	health) for Hospitals Premiums for private health insurance Fee for service (FFS)
007-2011	State budget Local government Budgets Private insurance companies International Organizations Users	Ministry – for administrative programs HESPA and then SSA– for personal services and preventive care (HESPA abolished in 2010) NCDCPH (former PHD)– for epidemiological surveillance Local Health entities Private Insurance companies – for voluntary insurance or state insurance scheme for poor International Organizations Providers Parallel health systems	Output based Contracts Capitation for PHC Case based (Global Budget for mental health/TB) – for Hospitals Premiums for health by state insurance schemes Premiums for private health insurance

derived from a proxy means test. This proxy means test system is managed by the Social Services Agency (SSA) subordinated to the MoLHSA. The test includes over 100 variables to estimate a household's welfare standing. The system was launched in July 2006, after 1.5 years of careful preparation, including developing and testing a proxy means targeting mechanism, designing implementation procedures, developing institutional and human resource capacity and piloting. The proxy means testing mechanism was considered adequate for Georgia because of high level of informal economy, which makes declared income from formal sources an inaccurate indicator of household welfare. All Georgian households are entitled to apply to be included in the poverty database. By January 2012, there were about 500 thousand households (45 per cent of the households) with individuals (35 per population) SSA database. The identification of the degree of certainty. exclusion errors threshold (eligible to are estimated at no cent [38], which is in international targeting. The proxy means test increase in score. The amount to 25-30 per 100,000 and will levels above this.

THE PROXY MEANS TESTING SYSTEM AND CERTAIN INDICATORS USED FOR DEFINING THE WELFARE STATUS HAS RECEIVED AN INCREASED ATTENTION FROM MASS MEDIA AND CRITICISM FROM THE POLITICAL OPPOSITION. THE TARGETING MECHANISM WAS CONSIDERED TOO NARROW EXCLUDING MANY IN REAL NEED.

more than 1.6 million cent of the registered with the system allows poor with sufficient Both inclusion and under 54,000 score social cash assistance) more than 20 per par with best experience in sensitivity of the decreases with the inclusion error may cent at a threshold of reach unacceptable Initially, households

with scores below 100,000 were allowed to obtain health insurance coverage under MIP. In the early 2007, due to budget limitations, the government changed the inclusion threshold, requiring a score of 70,000 or below to be qualified for MIP. However, Tbilisi municipality and the government of the Autonomous Republic of Adjara (one of the Georgia regions) continued to purchase coverage for up to 100,000 individuals having welfare scores between 70,000 and 100,000 residing in Tbilisi and Adjara through supplemental local government programs. The proxy means testing system and certain indicators used for defining the welfare status has received an increased attention from mass media and criticism from the political opposition. The targeting mechanism was considered too narrow excluding many in real need. For instance, ownership of an old Soviet TV set or refrigerator by the household was enough to alleviate a household's welfare score to the levels exceeding the eligibility threshold for the targeted social assistance or MIP. Responding to the criticism, the GoG introduced changes into the proxy means testing methodology decreasing its

sensitivity to such variables in 2010. This decision was widely advertised by the political leadership as an example of the GoG's responsiveness to the needs of the poor people. Yet, stories criticizing the targeting mechanism still appear in the media, one story broadcasted by the independent channel "Kavkasia" claiming that almost 25,000 individuals were excluded as a result of the change in methodology.

By the beginning of the 2011, the national MIP program along with Tbilisi municipality program were covering up to 910,000 beneficiaries which represent over 50 percent of the estimated number of the poor population or up to 20% of the total population.

BENEFIT PACKAGE DESIGN

MIP benefit package covers the following: 1) Urgent out-patient and in-patient treatment, including necessary diagnostic-laboratory tests for determining need for hospitalization; 2) Planned in-patient services, excluding expenses for cosmetic treatment, aesthetic surgery, resort treatment, sexual disorder, infertility, treatment abroad, sexually transmitted infections, HIV, and hepatitis C, outpatient pharmaceuticals with the annual insurance limit of 15,000 GEL; 3) Chemotherapy and radiation therapy within 12,000 GEL annual insurance limit; 4) Out-patient care and limited diagnostic and lab tests prescribed by the family physician or general practitioner; 5) Compensation of delivery costs (up to 400 GEL); 5) Outpatient prescription drugs from predefined essential drugs list and with the annual limit of 50 GEL and with 50 per cent copayment (was added in 2010). Beyond this, up until recently, the benefit package did not undergo any other major changes. As noted above, the President and GoG have announced the plans to revise the benefit package in September 2012 by including significantly increased outpatient drug benefit. Details of this change are not yet known at the time of writing this paper.

INSTITUTIONAL AND PURCHASING ARRANGEMENTS

Institutional and purchasing arrangements for MIP have changed drastically since its introduction in 2006. MIP was an outcome of several policy processes, including reevaluation of the country's social protection model on the subject of a fundamental choice about whether the core principle behind social provisioning will be "universalism", or selectivity through "targeting" and subsequent abolishment of social insurance; the GoG's attempts to find most effective and at the same time politically most acceptable ways of spending scarce public resources available for health; and finally, political business cycle prior to local elections in 2006. Initially implemented through a public single payer, in September 2007, the government has contracted out the delivery of MIP benefits to Private Insurance Companies (PICs). This move was most likely triggered by the Post Rose Revolution strive of the Georgian leadership towards libertarian ideals and "small government" as a main tool in fighting corruption has also influenced transfer of the purchasing function for MIP from the State purchaser to the Private Insurance Companies. All 14 private insurance companies operating in Georgia by the year 2007 had the right to participate. The

participating insurance companies are mandated to provide the benefit package defined by the state and were not able to refuse membership to any beneficiary with publicly provided vouchers. The insurance companies contract health services from a network of predominantly private providers, or provide through their own clinics and hospitals. The average annual insurance premium per beneficiary paid to the insurance companies at the initial phase was 84 GEL. Important changes were introduced since mid-2010. The country was divided into 26 medical regions and three-year contracts for each region were awarded to PICs identified through the competitive tendering procedure. Because of the tendering procedure, the annual insurance premiums were brought down from 180 GEL in 2009 to 116-132 GEL (depending on the region). MIP voucher holders are obliged to enter into insurance contracts with PICs according to their place of residence. However, beneficiaries still have the right to change the insurance carrier once a year, in case if they are not satisfied with provided services. As an important addition, the PICs that won tenders for MIP implementation were mandated to construct/upgrade hospitals and medical centers in respective medical regions to ensure the access to quality health services for

By the beginning of the year 2012, seventy five medical centers/hospitals were constructed throughout Georgia. Another 75 will be completed by the beginning of the year 2013. Total of 150 million GEL investments were made in health infrastructure by the PICs

MIP beneficiaries insured by them.

Since 2011 - reacting on allegation regarding the pervasive delays in distribution of the insurance contracts ("policy") to the beneficiaries[51] - the GoG mandated the PICs to organize this process through the SSA employed social agents and pay a fixed amount of 3 GEL per contract distributed to the SSA. These arrangements will be in place up until the year 2013. The PICs that won tenders for MIP implementation were mandated to construct/upgrade hospitals and medical centers in respective medical regions to ensure the access to quality health services for MIP beneficiaries insured by them. By the beginning of the year 2012, seventy five medical centers/hospitals were constructed throughout Georgia. Another 75 will be completed by the beginning of the year 2013 (see the Error! Reference source not found.). The Chamber of Control of Georgia (CCG) audit also claimed that the insurance premium rate paid to the PICs was inadequately high, as the direct loss ratio¹ for MIP beneficiaries reported by the PICs in the period from the beginning of the 2008 through the end of 2010 did not exceed app. 53 per cent of the 311.3 million GEL paid by the State

¹Loss ratio is the ratio of total losses paid out in claims plus adjustment expenses divided by the total earned premiums

to the PICs in the same period. The remaining 146.8 million GEL, according to the CCG, were “unjustified earnings” for the PICs and hence can be considered as “misappropriated public money”. On the other hand, according to the GIA and PIC representatives, not only the CCG assessment of the direct loss ratio was inaccurate, but also that direct loss ratio is an inappropriate measure for MIP efficiency, as it does not take into account the significant acquisition, administrative and investment costs (including capital investments in hospital infrastructure) required for suitable implementation of MIP. When all the costs are taken into account, the combined loss ratio will be app. 93 per cent in average for all PICs, leaving “only” 7% of the average net profit margin, which is within the range observed internationally. Moreover, even this “moderate” profit has to be reinvested in health infrastructure for MIP beneficiaries as mandated by the conditionality of the three years contracts with PICs. For instance, “GPI Holding” - one of the participating PICs, plans to invest all the profits received and top up this with additional capital, which considerably exceeds the total profit received by the company from more than three years of participation in MIP. In addition, as a result of the competitive tender, the premium rate for the years 2011-2013 has been reduced by 27 per cent. This will also diminish future earnings, even to the level that -according to the PIC FGD participants - may jeopardize future financial viability of the program. In any case, the CCG audit report was one of the main reasons for changing MIP content in 2010 in terms of institutional arrangements. It was assumed that shifting to longer term - three year contracts will remove the need for substantial expenses related to beneficiary acquisition and motivate the PICs to invest more money in keeping insured healthier through expanded prevention services and free up some funds for investments in infrastructure to improve the quality of services. As noted above, the latter has been made as a key conditionality for the extended contract.

PROCESS

Agenda Setting	
1. Preliminary situation analysis (H)	+/-
2. Vision, ownership and leadership (C)	Yes
3. Clear policy objectives (I)	+/-
Policy Formulation	
4. International national scientific evidence used (H)	No
5. Contextualized scientific evidence and local knowledge used (C)	+/-
6. Different policy options assessed (H)	-/+
7. Thorough assessment of the selected option (I)	No
8. Early identification of accompanying measures (I)	No
9. Key implementation stakeholders are involved in the formulation stage (C)	+/-
10. The content of the reform meets preferences of key stakeholders (C)	Yes
Programming & implementing	
11. Sequencing reform elements (H)	+/-
12. Planning implementation steps (C)	-/+
13. Broad communication strategies (C)	
14. Medium-term commitment to budgetary balance (C)	
15. Clear rules for contracting and beneficiary enrollment (C)	
16. Clear rules for interpretation of the benefit (C)	
17. Technical leadership by the Ministry of Health (C)	
18. Capacity building (H)	
19. Empowered co-ordination unit (C)	

Our overall assessment of the “good practices” in MIP formulation and implementation process is presented in the table below:

AGENDA SETTING

Agenda setting stage for MIP has been closely linked

“The MIP design was determined by the main perceived purpose of MIP: to protect socially vulnerable from catastrophic risks and to manage their out-of-pocket expenditures”

Key informant

with overall policy and economic reform context and was driven by strong national ownership, vision and leadership. The need for health financing reform was emphasized by the President of Georgia who created a special commission on health reforms under the Prime Minister in 2006. After four months of work, the special commission came up with medium term health policy objectives “Main Directions in Health 2007-2009” which embodied some key principles characteristic for reforms in post-revolutionary Georgia: “marketization”, PPP, private provision, private purchasing, liberal regulation and minimum supervision [41]. MIP became an integral part of this policy once the option of private purchasing through the PPPs with PICs has been selected as a preferred mode for the program implementation. Time devoted to preliminary situation analysis was limited due to the electoral considerations. Overall understanding of the problems related to financial barriers to health services existed but specific and detailed situation analysis was not performed [49]. The idea of MIP as a precise targeting instrument for delivering health benefit along other social cash benefits to the poor - was “...floating since 2005, when the development of the proxy means testing system started, and certain preparatory work was done during the November-December of 2005, however

this work then stopped and suddenly, without any further preparation MIP introduction started just prior the local elections in summer of 2006 through the MoLHSA issued vouchers". MIP was considered as a key instrument for achieving one out of four main policy objectives defined in the 2007-2009 medium term health strategy – "to ensure the overall affordability of basic health services and protect the general population from catastrophic financial health risks". However, the concrete policy objectives for the program were never formulated explicitly in any legal or policy document. Two main objectives were implied: (1) "creation of a targeting system for public financing of health services for the socially vulnerable" and (2) "redirection of the public funds to support the development of private insurance". The development of the private pre-paid schemes was also sought to decrease both informal and formal out-of-pocket expenditures, increase the share of the prepaid resources and enhance risk pooling. The increased risk pooling in the national health system, in turn, was anticipated to make the health coverage more affordable to the majority of population. Vouchers distributed to MIP beneficiaries were considered as preferred method for individual targeting and as the means for delegating them the right of "free choice" of insurance companies. This was an investment in free choice and "an informed citizen". Another objective was related to legalization of financial flows in the health sector by decreasing informal payments. Same policy objectives with similar wordings were mentioned by all interviewed policy makers among key stakeholders.. No specific final and/or intermediary targets for improved financial protection, access and utilization of health services were set. Moreover, as one of the key informants stated: "increased utilization observed and reported during the initial phase of MIP implementation and implied as a key objective by the international experts, was a positive externality, rather than a predefined objective" [54]. Three explicit objectives and targets for MIP were defined only after three years of implementation in 2011. The Law on the State Budget of Georgia 2012 adopted in September 2011 defines three MIP objectives: (1) to increase financial access to health services for the targeted groups of the population; (2) to mitigate the financial burden induced by the health expenditures for the targeted groups of the population; (3) to reduce the OOP expenditures in health sector. Respectively, three targets and indicators for the year 2012 are determined: (1) number of insured under MIP (1 million 700 thousand for the year 2012); (2) Reduction of the share of OOPs in total health expenditures by 10 per cent; (3) Increased utilization of outpatient and inpatient services by 2-3 per cent for the population insured under MIP in 2010. It is noteworthy that in this document the increased utilization is specified as an explicit policy objective for MIP.

FORMULATION AND IMPLEMENTATION

Overall political and policy contextual factors have been the key determining factors for the introduction of MAP in Georgia.

MAP was an outcome of several policy processes, including reevaluation of the country's social protection model on the subject of a fundamental choice about whether the core principle behind social provisioning will be "universalism", or selectivity through "targeting" and subsequent abolishment of social insurance; the GoG's attempts to fund most effective and at the same time politically most acceptable ways of spending scarce public resources available for health; and finally, political business cycle prior to local elections in 2006, which significantly "expedited" MAP introduction, even without proper technical preparation. Post Rose Revolution strive of the Georgian leadership towards libertarian ideals and "small government" as main tool in fighting corruption has also influenced transfer of the purchasing function for MAP from the State purchaser to the Private Insurance Companies. This agrees with similar experience internationally, as political factors were decisive in adopting decisions on similar policy issues, like user fee removal policies in Africa [96], or the insurance for the poor in Latin America [12].

Presence of functional means testing system and targeting mechanism was a key to acceptance and introduction of MAP and appear to be effective in reaching the neediest; however there are still equity problems in MAP eligibility that need to be addressed

Transformation of category based social assistance system (inherited from the Soviet Union) into "means tested" social assistance system with functional targeting mechanism for the poor in 2004-2005 was one of the key determining factors and was a unique window of opportunity for MAP introduction in Georgia. Despite concerns on accuracy and precision of the means testing targeting mechanism both in terms of inclusion and exclusion errors, this targeted mechanism allowed MAP to reach up to 40 per cent of the nation's poor. This achievement is in par with international best practice in effectiveness of individual targeting. Yet, the current targeting mechanism is far from being equitable, as it discriminates the population by a place of residence: people with test scores over 70,000 and not residing in Tbilisi or Adjara are not eligible receiving MAP benefits, while they may, in fact, be very poor.

Surprisingly, up until recently, an explicit definition of MAP goals, objectives and targets was absent, thus complicating MAP impact assessment

Up until 2011, MAP goals, objectives and targets were not defined in any of the legal or policy documents. This has left an ample room for various stakeholders to imply and often speculate on intended goals of the program and made it difficult to assess the success and/or failure in achieving MAP impact against predefined policy objectives.

Wide circle of national and international partners and experts were consulted, however no due deliberation time was given for reflection of their recommendations in the initial MAP design and subsequent changes introduced that led to numerous major deficiencies at the early stages of the program implementation.

Despite the formal involvement of a number of national and international technical experts in the discussions regarding the new MAP design, short time period between the adoption of a political decision on transferring purchasing arrangements for MAP to the Private Insurance Companies (PIC) and actual implementation of the program (6 months) did not allow sufficient time for preparation and reflection of qualified research and technical advice into the initial MAP design. Thorough assessment of MAP policy options (public vs. private) was never conducted with final decision on implementation modalities based on political and ideological preferences and not on policy or technical soundness of the selected alternative. This in turn led to significant deficiencies during the initial (pilot phase and beyond) of MAP implementation – inadequate premium rate per insured paid by the State and high acquisition costs per beneficiary for PIC resulting in high loss ratios (140-150%), misinterpretation of MAP benefit package, absence of coverage for services provided by the providers not yet contracted by the PICs, etc.

The entire process of MAP implementation was artificially accelerated by the considerations of political “urgency” which resulted in some shortcomings during the implementation

Initial piloting of new purchasing arrangements for MAP in two regions of Georgia: Tbilisi and Imereti during the year 2007 has been performed without rigorous monitoring and evaluation framework, thus decreasing the opportunity to learn from pilot testing. Moreover, these pilots did not have clearly articulated objectives, or “what” to pilot, beyond perhaps the premium rate per insured. The latter has been adjusted from 7 GEL to 11 GEL as a result of the pilot. Any other significant adjustments to the initial design of MAP have occurred in 2008-2010, or long after the pilot implementation. More generally, not enough time was allowed between different phases to ensure appropriate planning and smooth implementation. Most common violations of rules during MAP implementation identified by our research were related to: the beneficiary inclusion, timely issuance of insurance contracts to the beneficiaries, interpretation of MAP benefits and insurance terms, illegitimate denial of services included in the benefit package to the beneficiaries and creation of additional bureaucratic barriers for users to defer them from services.

High level political actors have dominated the process of MAP formulation and implementation

High level policy actors, such as the President, Prime Ministers and State Minister for Reforms Coordination played a defining role in MAP inception and implementation. The Ministers of Health played little role in MAP inception but has assumed more influence in the last two years MAP implementation. Private Insurance Companies and Georgian Insurance Association also had active role throughout the policy process. MAP received substantial media coverage. Other interest groups such as individual citizens, health providers and technical experts having limited influence over the policy decisions associated with MAP.

Development of insurance and generating widespread demand for insurance still faces significant challenges in the country.

Despite the articulated objective for MAP to support the development of the private insurance and “insurance mentality” and impressive increase in overall insurance coverage in the country, the specifics of the insurance mechanism are yet to be understood not only by the insured, but also by all relevant governmental stakeholders, as evidenced by the recent accusations voiced by the Chamber of Control and the Prosecutor General of Georgia in misappropriation of the public money allocated for MAP. According to the Chamber of Control, the direct loss ratio of app. 45%² for MAP beneficiaries reported by the PICs in the period from 2008-2010 shows that PICs have enjoyed unjustified earnings and that premium rate paid by the public is artificially inflated. When arriving to this conclusion, the Chamber of Control inspection has neglected very significant acquisition costs that PICs have incurred for attraction and enrolment of MAP beneficiaries and investments costs in health provider infrastructure and information systems to serve these beneficiaries. These accusations were widely discussed and in most often cases misinterpreted in the mass media triggering unnecessary damage to the reputation and credibility of the MPA program and health insurance in general.

Creation of an independent mediator between the PICs and MAP beneficiaries is considered as a beneficial addition to the mechanism of MAP implementation

Establishment of “Insurance Mediation Service” (IMS) initially sponsored by the PICs participating in MAP has been assessed as very positive development in improving the observance of the rights and entitlements of MAP beneficiaries. However, the financial dependence of the IMS on PICs has been negatively regarded by the new MoLHSA leadership and as a result the IMS has been transformed into publicly supported body. IMS services and its hotline number are currently widely advertised to MAP beneficiaries by the MoLHSA through mass media.

²Loss ratio is the ratio of total losses paid out in claims plus adjustment expenses divided by the total earned premiums

The government has been moderately successful in raising the awareness regarding MAP and communicating the rights and benefits provided by MAP. Further efforts are needed to improve communication, particularly targeted to national minorities.

According to the HUES 2010 Knowledge of MAP is widespread in the population, with 93% of respondents saying that they knew it, although only 65% said they knew what benefits it provided. Both surveys (HUES 2007 -2010) suggest that there are concerns around both under-coverage of the poorest households and inclusion of better-off households in MAP. These findings need to be considered in the light of some limitations to the data, including that the Social Services Agency program includes a cash transfer which may itself lift some households into a higher quintile.

The recent governmental decision on major expansion of MAP coverage and inclusion of additional drug benefit are expected to significantly enhance the overall MAP impact and its potential as a viable policy instrument for achieving universal coverage. However, it appears that there is no clear consensus yet among policy makers in which direction to proceed in future for further improving the financial protection of the population, which presents a window of opportunity for the researchers and advocacy groups to provide evidence and influence the decision making process.

Additional 1 million individuals under 6 years of age and elderlies are expected to be insured by MAP by the end of the years 2012, extending coverage to almost half of the total population. However, longer term plans regarding MAP expansion are not yet determined. According to the key informant interviews - two prevailing ideas are contemplated by the policy makers currently. "Universalists" support the idea to further expand MAP coverage using the same "means testing" system by elevating MAP eligibility criteria from 70,000 to 100,000 and hence further increase MAP coverage by about 600,000 individuals self-declared and registered as poor in the MoLHSA's Social






















Services Agency (SSA) with respective scores, which will also eliminate existing discrimination in MAP coverage between the residents of Tbilisi and Adjara and the rest of the country. In this case, MAP coverage will be extended to almost half of the population. Those in favor of “selectivity” in social policy are against further expansion of the coverage beyond the poorest; however support the increase in the scope and depth of coverage by including far more generous outpatient coverage. There are arguments in favor of both approaches which need to be carefully deliberated and costs and benefits analyzed. This clearly presents the window of opportunity for researchers and advocacy groups to participate in this process and generate and communicate sound evidence that may influence the decision making. The research team believes that findings and results of the current study may also help to inform policy makers to determine the future path of the planned health financing reform, while the research findings dissemination activities planned following the Study (policy briefs, workshop and dissemination through the websites of the advocacy groups) will be timely and contribute to the policy uptake process.

ACTORS

The list of key policy actors in MIP formulation and implementation, their influence, nature of interest and perceived position on possible future MIP expansion (beyond the one planned for 2012) are presented in Table 1.

TABLE 1 POLICY ACTORS BY CATEGORIES, POWER, NATURE OF THEIR INTERESTS AND POSITION REGARDING MIP EXPANSION

Player name	Nature of the interest in MIP Expansion	Category	Position	Power
Academic/Technical experts	Public/Professional – addresses the public issue of professional concern	Interest group – civil society	Medium Support	Low
Citizens, insured	Solidarity – their fellow citizens receive equal benefits in health	Individual	Non-Mobilized	Low
Citizens, insured and uninsured, better off	Solidarity – their fellow citizens receive equal benefits in health	Individual	Non-Mobilized	Low
Citizens, uninsured	Beneficial – access to basic health insurance, financial protection	Individual	Non-Mobilized	Low
Georgian Insurance Association	Public/Professional – will reduce the individual responsibility for one’s own health, constrain the development of the private insurance in long term	Interest group - commercial	High Opposition	Medium
Gilauri, Nikoloz (Prime Minister)	Political/Personal – winning move for his political team, may be regarded as one of the major accomplishments of his term	Appointed officials	Medium Support	High
Health Providers (not owned by PICs)	Financial – both harmful and beneficial – expanding insurance may increase utilization and provide increased revenue however expanding insurance may drive down prices the services they provide	Interest group - Commercial	Non-Mobilized	Low
International Development Partners and NGOs	Global/Public – the way towards universal coverage in health care, financial protection of the population	Interest group - international	High Support	Low

Local Governments	Political/financial – may increase the satisfaction of their constituents, will save funds for those (Tbilisi and Adjara) currently financing coverage above the national eligibility threshold for MIP	Elected/ appointed	 High Support	 Medium
Ministry of Finance	Financial/harmful – will require major additional public outlays	Appointed officials	 Medium Opposition	 High
MoLHSA	Policy – ensuring access to health services as a necessary precondition for successful health policy	Appointed officials	 Medium Support	 Medium
National NGOs	Public – addresses the issues of public concern, equity, rights of disadvantaged	Interest group – civil society	 Medium Support	 Low
Opposition Minority in the Parliament	Political/Symbolic – provides winning issue for public statements and debates in the parliament; may strengthen their political position and popularity both for national and local elections	Elected officials	 High Support	 Low
Pharmaceutical Companies	Financial – both harmful and beneficial – more insured will provide more premium revenue for those owning PICs, however expanding insurance may drive down prices both for drugs and services	Interest group - commercial	 Medium Opposition	 High
Political Parties outside the Parliament	Political – may strengthen their political position and popularity both for national and local elections	Interest Group – Political	 High Support	 Low
Press and Media	Public/Financial – addressing the issue of high public concern that may increase sales	Interest group – media	 Medium Support	 Medium
Private Insurance Companies	Financial/moderately beneficial -		 Medium Support	
Ruling Party Majority in the Parliament	Political - Electoral considerations for the local elections in 2014	Elected officials	 Non-Mobilized	 Medium
Saakashvili, Michael (President)	Political and Personal - will demonstrate his concern with well-being of the population, can be winning move for next elections, may be regarded as one of the major accomplishments of his presidency	Elected	 Medium Support	 Huge

Source: Key informant interviews, interviews with key stakeholders, focus group discussions, media monitoring.

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