



Medical Insurance for the Poor: impact on access and affordability of health services in Georgia

FOCUSING ON THE POOR

Policy Brief

“The health care in Georgia is currently affordable for very rich and very poor”

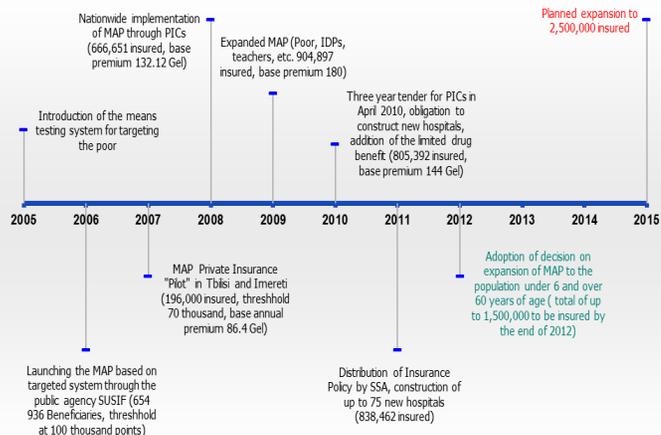
Key informant

Key Messages:

- Number of notable achievements and shortcomings may be attributed to the Private Public Partnership in realization of MIP. Yet, development of private health insurance and generating widespread demand for it still faces significant challenges in the country
- The government was only moderately successful in raising the awareness regarding MIP and communicating the rights and benefits provided by MIP. Further efforts are needed to improve communication, particularly targeted to national minorities
- MIP was instrumental in improving all three dimensions - breadth, scope and depth of the population coverage; was successful in enhancing financial access for the insured poor; and contributed to geographical access enhancement for everyone. However, MIP has limited effect on overall financial protection of the population due to lack of adequate outpatient drug benefits.
- Inclusion of very limited outpatient drug benefit in MIP provided insurance negatively affected the potential impact of MIP on financial protection of the population
- If implemented properly, the recent governmental decision on major expansion of MIP coverage & inclusion of additional drug benefit are expected to significantly enhance the overall MIP impact

Medical Insurance for the Poor: impact on access and financial protection of the Georgian population

MAP Timeline



Introduction

Affordability of health care services is among top five most important national issues for a large part of the Georgian population. Medical Insurance for the Poor (MIP), a public program initiated in 2007, provides private insurance coverage to one fifth of the Georgian population and is aimed to protect its beneficiaries from financial hardship and impoverishment that may be caused by health care expenditures.

This policy brief presents key findings, and conclusions of the study that assessed the impact of MIP on equity in access to essential health care services and financial protection against health care costs for the poor and general population. It briefly describes identified accomplishments and shortcoming of the public private partnership in realization of MIP and discusses emerging policy options and policy recommendations on the future of MIP.

What are Major Achievements?

- ✓ MIP has managed to reach 40 per cent of the nation's poor, which is in par with international best practice
- ✓ The government has been reasonably successful in raising the awareness regarding MIP and communicating the rights and benefits the program provides. Over 90% are aware of MIP, but from 1/3 to 2/3 of the poor families have incorrect knowledge about covered benefits
- ✓ Overall responsiveness of insurance carriers and health providers appears to be acceptable and beneficiary satisfaction levels are high (77% of beneficiaries).
- ✓ MIP has been instrumental in increasing breadth, scope and depth of the population coverage. As a result, the share of the population covered with comprehensive health benefit package has reached slightly over 30 per cent of the population, or about 1.5 million individuals (see figure) within limited time.
- ✓ Creation of an independent mediator - Health Insurance Mediation Service (HIMS) - between the private insurance companies and MIP beneficiaries is considered as a beneficial addition to the mechanism of MIP implementation
- ✓ MIP has managed to improve financial protection of the beneficiaries against expenditures related to the inpatient care, which in turn had positive impact on financial access indicators for the general population. MIP insured were three times more likely to receive completely free outpatient care and seven times more likely to obtain free inpatient treatment. An increasing proportion of patients (from 17% to 25%) report receiving inpatient care that is free at the time of service.

Breadth of coverage - who is covered, or the definition and share of the population entitled to receive benefits

Scope of coverage – what services are covered, or range of services within the benefits package

Depth of coverage - to what extent services are covered, or the level of patient cost sharing

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International Best Practice and Georgia Experience

Achievement of **universal health coverage** for the population - to enable everyone to access health care services and not be subject of financial hardships in doing so – is one of the key global health policy objectives promoted by the World Health Assembly Resolution 58.33 from 2005. There is common set of actions recommended by the World Health Organization (WHO) for accomplishing this objective by raising sufficient resources, reducing the reliance on direct payments for health services and improving efficiency and equity. Yet, country level approaches may differ. Many low and middle-income countries are engaged in diverse health financing reforms in order to move closer to the universal coverage. Content of these reforms differ depending on the decisions that each country makes regarding the available alternatives. Nonetheless, the Georgian experience may be considered somewhat unique for two reasons. Firstly, it provides more generous benefits to the poor than to other groups of the population, which is not a common practice globally. In most cases the wider welfare entitlements - including those in health - are directed towards the most organized or politically the most powerful and the poor people are least likely to be covered who have high health care requirements and need financial protection. Secondly, the coverage for the poor is purchased through competing private insurance companies. Only 11 countries out of 154 LMIC channel at least 10 per cent of total health expenditures through private insurance and for most of these countries private for-profit schemes are generally limited to the wealthy minority.

Catastrophic health expenditures are defined as occurring once out of pocket payments cross some threshold share of household expenditure, at which the household is forced to sacrifice other basic needs, sell assets, incur debt or be impoverished. The health expenditure is determined as being catastrophic if a household's financial contributions to the health care system equals and/or exceed 40% of household's nonfood expenditure or Capacity to Pay

A non-poor household is considered **impoverished** by health payments when it becomes poor after paying for health services - when its expenditure is equal to or higher than subsistence spending, but is lower than subsistence spending net of out-of-pocket health payments

What are Major Problems?

- ✓ The entire process of MAP implementation was accelerated by the considerations of political "urgency", which resulted in some shortcomings during the implementation;
- ✓ There are still problems in awareness regarding the MIP and its benefits, particularly among ethnic minorities, possibly contributing to lower MIP coverage among Azerbaijani and Armenian population. Respectively 32% and 16% compared to 55% of Georgians;
- ✓ Current MIP targeting discriminates the households with welfare scores between 70,000 and 100,000 not residing in Tbilisi or Adjara;
- ✓ In the existing "soft" regulatory environment, possible risks of consolidation of the insurance carrier, health provider and pharmaceutical company under single "roof" may be detrimental for financial protection of MIP beneficiaries. Consolidations bear risk of perpetuating irrational prescription practices fueling pharmaceutical consumption and sales, and further escalating the pharmaceutical prices. Yet risk mitigation strategies are lacking.
- ✓ Various cases of violation of insured's and patients' rights are continued to be reported, which include the beneficiary inclusion, timely issuance of insurance contracts to the beneficiaries, interpretation of MIP benefits and insurance terms, illegitimate denial of services included in the benefit package and creation of additional bureaucratic barriers for users to defer them from services
- ✓ Very narrow (up to 25 GEL) outpatient drug benefit seriously constrains the MIP potential to improve the financial protection of the insured population. In the context when 40% of Georgian households use drugs on a daily basis and their mean expenditure on drugs has increased by almost 90% from 105 GEL in 2007 to 197 GEL in 2010 and reached 60% of household's total expenditures on health, drug benefits become essential for financial risk protection.
- ✓ MIP has not delivered benefits beyond poor, fueling demand for insurance among the general population. The share of families with catastrophic health expenditures has increased from around 11% in 2006 to over 13% in 2010. Similarly, the share of those who were impoverished due to high expenditures on health also increased from 1.8 per cent in 2006 to 2.6 percent in 2010, which points towards need of insurance expansion beyond poor.

MIP experience in Private Public Partnership (PPP) between the State and the Private Insurance Companies

PPP Accomplishments:

- + Budgetary planning became more predictable and risk of the budgetary deficit was alleviated;
- + Mobilized more than 150 million GEL in capital investments for health care infrastructure and achieved a breakthrough in nationwide health care delivery system restructuring;
- + Partially curbed the health care inflation, although only for services and only for insured;
- + Supported the legalization of informal financial flows within the health system;
- + Made health care insurance more affordable to the general population and contributed to diversification of health insurance products;
- + Increased demand for private health insurance;
- + Supported development of the private insurance industry, with private health insurance accounting for more than 2/3 of the total mobilized insurance premium;
- + Contributed to creation of empowered and informed health care consumer



PPP Shortcomings:

- Contributed to fragmentation of the national risk pool;
- Has added high administrative costs;
- Concerns regarding protection of the MIP beneficiary rights and securing access to health service entitlements remain to be resolved.

LACK OF INFORMATION AND BUREAUCRATIC BARRIERS MAY AFFECT QUALITY OF HEALTH CARE

“We did not have information on health facilities to go in case of need of medical attention. My family member had emergency and ambulance service had to spent two hours to clarify where to take the patient” (*MIP beneficiary*)

“To get needed referral to a specialist, I had to travel three times from my village to the rayon center, which cost me a lot of money and time” (*MIP beneficiary*)

PPP DRIVES DOWN PRICES FOR HEALTH CARE

“We managed to drive down the prices for medical services. For instance, for Cardiac Bypass Surgery the price was negotiated down by 30%”, (*Insurance Company Representative*)

Insurance industry manages to maintain lower annualized growth rate (11%) of pharmaceutical spending in comparison to overall pharmaceutical expenditure growth rate (26%). (*Insurance Association*)

INSURANCE COMPANIES ARE SOMETIMES DENYING SERVICES AND INTERFERE WITH CLINICAL DECISION MAKING

“Referrals to specialists and diagnostic services, particularly more expensive ones like computer tomography are refused even when these referrals are backed by the second opinion and approved by the administration of the health facility. Sometimes this leads to worsening in a patient’s health status - we already had plenty of such cases” (*Health Provider*)

“Often case managers from PICs are interfering with clinical decision making, even if they are not physicians; sometimes they are even attending surgeries to make sure that the diagnosis we supplied is accurate” (*Health Provider*)

Medical Insurance for the Poor: Future Prospects and Policy Recommendations



Future Prospects

- ✓ The recent governmental decision on major expansion of MIP coverage to up to 2 million Georgians by including the children under-6 years of age and senior citizens and inclusion of additional drug benefit will significantly enhance the overall MIP impact and its potential as a viable policy instrument for achieving universal coverage for entire population.
- ✓ There is broad consensus among all stakeholders, including high level decision makers, on the need to further improve affordability of health services in Georgia. However, the politicians and policy makers yet have not spelled out clear vision about concrete steps, which presents a window of opportunity for experts and advocacy groups to provide evidence and influence the policy development process.

Policy Recommendations

- ✓ Careful preparation and elaboration of the technical details of the planned MIP expansion in September 2012 should be performed to avoid the same implementation problems that have been observed during the initiation of MIP in 2008;
- ✓ Required drugs for the treatment of the leading causes of chronic illnesses, such as hypertension, arthritis, bronchial asthma, gastro duodenal ulcers, should be included in the extended drug benefit. Special attention should be devoted to its costing and appropriate organizational arrangements;
- ✓ Wide scale and targeted communication efforts should be organized to increase awareness about MIP benefits; about procedures for obtaining these benefits and to whom to apply in case of disputes with insurance company;
- ✓ Health Insurance Mediation Service needs to be strengthened and its scope of services in protecting the rights of insured should be broadened beyond MIP and/or state insured individuals;
- ✓ Further expansion of the breadth of MIP coverage should be considered in the years 2013-2014 by using and refining the current targeting system of the MIP. For instance, by elevating MIP eligibility criteria for the families registered in the poverty data base, from below the welfare score 70,000 to below 100,000, the MIP coverage will be increased by about 120,000 families self-declared and registered as poor in the MoLHSA's Social Services Agency with respective scores. This will also eliminate existing discrimination in MIP coverage between the residents of Tbilisi and Adjara and the rest of the country.

Further Reading:

1. "Health Insurance for the Poor: Georgia's Path to Universal Coverage?" CIF. 2012
2. "World Health Report 2010," WHO, Geneva. Available: <http://www.who.int/whr/2010/en/index.html>
3. "Results from two rounds of a household survey on the use of health services and expenditure on health. Final Report," MoLHSA, GeoStat, OPM, CIF Tbilisi, 2011.
4. UNICEF, USAID HSSP, "Survey of Barriers to Access to Social Services in Georgia in 2010. November 2011. [Online]. Available: www.unicef.org/georgia/BASS_final-eng.pdf

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