The GEL 5 Health Insurance Scheme: An Appraisal

Introduction

On February 12, 2008, President Saakashvili announced in his annual state of the nation address the introduction of a new co-financed health insurance scheme[1]. The scheme potentially covers the one million people not covered by other free government backed schemes. The package on offer covers basic risks and includes three parts: accidental, urgent and ambulatory services. The premium is GEL 5 a month, of which the state pays GEL 3.35.

This paper seeks to examine the new health insurance scheme, to ascertain whether it fulfills the needs of the Georgian population and whether it meets commitments made by Georgia in the UN Declaration of Human Rights[2], which guarantees equitable health care for all. Fundamentally – given the nature of the scheme – we will also explore its feasibility.

Background

Although not expected to have been rolled out for another year[3], the so-called GEL 5 insurance scheme is, in fact, keeping with a long term health reform strategy. In what the World Bank terms a "major reform of the health sector"[4] in 2006, "channeling public health financing through private health insurance companies"[5] is identified as one of four priorities. An anonymous Aldagi Insurance employee we spoke with, although critical of the current scheme, also admitted that "the idea was circulating"[6] in December 2006.

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1 Insurance Firms, Government Sign Deal on New Plan, Civil Georgia, Tbilisi, 18 Feb 2009, http://www.civil.ge/eng/article.php?id=20443&search=insurance

2 The UN Declaration of Human Rights, article 25, http://www.un.org/en/documents/udhr/#atop

3 Told to TI Georgia by Dr Devi Khechinashvili, Chairman of the Board, Georgian Insurance Association, in interview with author, April 5, 2009.

4 World Bank Primary Health Care Development Project, http://www.wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2009/03/20/000334955_20090320042742/Rendered/PDF/478160PJPR0P04101Official0Use0Only1.pdf

5 *Ibid*

6 Anonymous employee of Aldagi insurance company, in interview with author, April 2, 2009.

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The Need

The Georgian health care system has been plagued by endemic problems, and reform is consequently long overdue.

Lack of funding has been the primary problem. Spending on healthcare per person in 1985 stood at USD 95.5, but had plummeted to USD 0.90 by 1994[7]. Although since the Rose Revolution there has been considerable reinvestment in the system[8], government spending on health is still abysmal in comparison to OECD countries.

Government expenditure on health as % of total expenditure on health.[9]	
Georgia	23.9
USA	44.6
France	76.3
Germany	78.2
Denmark	83.0

Financial shortfalls in the health sector have been mostly met by individuals themselves in the form of so-called Out of Pocket (OOP) payments – cash payments or the doctor's favorite cognac, or as the World Bank deftly says "ranging from the ex post gift to the ex ante cash payment."[10] OOP payments, although down from 80 percent in 2002, still represented 72 percent of total healthcare expenditure in Georgia in 2006.[11]

Corruption of this sort, however, is just the tip of the iceberg. Given "the specific mix of uncertainty, asymmetric information and large numbers of dispersed actors that characterise the health sector"[12] the limited state funding available has not always gone on patient care. The problem lies with what one insurance company described as "the medical mafia[13]." Overpriced and unnecessary drugs are often prescribed by many doctors, who are only "concerned with taking

7 Development of State Health Insurance System in Georgia, Temur Kalandadze, Ioseb Bregvadze, Revaz Takaishvili, Ann Archvadze, Nino Moroshkina, Croatian Medical Journal, http://www.cmj.hr/1999/40/2/10234065.htm

8 In 2003, state spending on healthcare constituted 1.3% of GDP; by 2006 it had risen to 1.8%. Cited in Georgia Human Development Report 2008, UNDP, P. 48, http://www.undp.org.ge/new/files/24_278_524979_NHDR-08-ENG.pdf

9 http://www.investmentguide.ge/files/161_159_209762_HealthcareStats.doc

10 Health Systems in Transition: Learning from Experience, Eds. Josep Figueras, Martin McKee, Jennifer Cain, http://www.euro.who.int/document/e83108.pdf

11 Household catastrophic health expenditure: evidence from Georgia and its policy implications, George Gotsadze et al, Tbilisi, April 2009, http://www.biomedcentral.com/content/pdf/1472-6963-9-69.pdf

12 The Causes of corruption in the health sector: a focus on health care systems, chapter 1, Why are health systems prone to corruption? William D. Savedoff and Karen Hussmann, www.transparency.org/content/download/4816/28503/file/Part%201_1_causes%20of%20corruption.pdf

13 Alexander Lordkipanadze, General Director, Imedi International Insurance Company, in interview with author, April 13, 2009.

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money."[14] The money in question comes from what one report described as "a sophisticated industry."[15] No figures exist for Georgia, but one can reasonably assume that Georgia is not immune from what is an international phenomenon. For example, "in recent years, the pharmaceutical, device and biotechnology industries have spent some US $ 16 billion annually in the United States on marketing to physicians; US $13, 000 a year per doctor."[16] Ultimately the patient or the state pays for such largesse, and although the corruption it represents is "not very tangible [in Georgia], it is real."[17] As the Ministry of Health itself acknowledged there were "some problems,"[18] made worse by a pharmacy cartel on the ground, which is "always ready to agree on prices."[19] [20]
Exacerbating these problems in Georgia are the inefficiencies associated with the system itself. Other countries have introduced "cost-effective purchasing of services through the separation of purchaser and provider functions"[21] but Georgia still retains the old system of resource allocation. At the heart of the problem is the fact that the Georgian health care sector has not "shifted from structures, standards and norms to outcomes and processes linked to outcomes by scientific evidence"[22] – a symptom of a Soviet legacy.

The Soviet legacy also rears its head in the form of limited patient choice and inadequate responses to patient needs. What the World Health Organisation (WHO) describes as "provider pluralism"[23] is almost non-existent in the old Georgian health realm, leaving patients with little choice but to accept what they are given.

Choices

Clearly then something needed to be done. The question was what.

The European social insurance model – wherein employees pay a fixed percentage of their salaries – was an option, but ultimately deemed unfeasible for what WHO calls "labour market features:"[24]

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14 *Ibid*

15 Pharmaceutical policy challenges in Central and Eastern Europe Andreas Seiter, http://www.lse.ac.uk/collections/LSEHealth/pdf/eurohealth/VOL14No1/Seiter.pdf

16 Summary sheet: Corruption in the pharmaceutical sector, http://www.transparency.org/publications/gcr/gcr_2006#download

17 Sophie Gasitashvili, Medical Insurance Director, GPI Vienna Insurance Group, in interview with author, April 27, 2009.

18 Sofia Lebanidze, Head of Health Department, Ministry of Labour, Health and Social Affairs, in interview with author, April 20, 2009.

19 Alexander Lordkipanadze, General Director, Imedi International Insurance Company, in interview with author, April 13, 2009.

20 Drug and pharmaceutical imports into Georgia were worth USD 31 million for the first ten months of 2007, making the country's consumption rate the highest in the Caucasus. Georgia Investment Guide, Health, http://www.investmentguide.ge/index.php?lang_id=ENG&sec_id=161

21 Health Systems in Transition: Learning from Experience, Eds. Josep Figueras, Martin McKee, Jennifer Cain, http://www.euro.who.int/document/e83108.pdf

22 *Ibid*

23 Funding health care: options for Europe, edited by Elias Mossialos, Anna Dixon,Josep Figueras and Joe Kutzin, http://www.euro.who.int/document/e74485.pdf

24 Health Systems in Transition: Learning from Experience, Eds. Josep Figueras, Martin McKee, Jennifer Cain, http://www.euro.who.int/document/e83108.pdf

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> High levels of unemployment mean that the proportion of the population in formal employment is low, thus creating a very narrow revenue base from which to draw contributions. The numbers of people in formal employment are low, and therefore few employers are required to contribute. Many of those in formal employment are public employees, thus the employer share has to be made by government out of tax revenues. In addition, there are large numbers of self-employed and a large agricultural labour force, for whom contribution rates are lower and only levied when a profit is declared (which is not usual).[25]

Despite gains in terms of state consolidation over the past five years, the Georgian state is essentially too weak – and the economy too fragile – to support such a system. Lack of funding – and consequent OOP payments – and corruption in procurement in the current system testify to this.[26]

Having already provided for other social groups, the government therefore effectively had only one option in terms of providing for the one million, relatively affluent citizens still without cover, what one commentator described as the "only way to solve health issues in transition countries"[27] – health insurance.

Financial Feasibility

Having made that choice, a number of issues arise, among them financial ones.

On the negative side are rising health costs[28], which according to Magda Anikashvili of the Christian-Democratic parliamentary faction, "jeopardize[s] the project's implementation."[29] Although inflation applies no matter what the system, international experience suggests private health insurance has been particularly prone to it. One report in the U.S. found that "private health insurers' average annual spending per enrollee grew 29 percent faster than Medicare spending between 1983 and 2006."[30]

That said, the proposed insurance scheme offers many pluses from a financial point of view.

Its main attraction is that it "ascrib[es] purchasing functions to insurance funds and employ[s] contracts as the main tool for resource allocation."[31] Another innovation seen as critical for cost

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25 *Ibid*

26 "Maybe 10 or 20 percent [of the healthcare budget] is going to corruption," according to Alexander Lordkipanadze, General Director, Imedi International Insurance Company; in interview with author, July 10, 2009

27 Sophie Gasitashvili, Medical Insurance Director, GPI Vienna Insurance Group, in interview with author, April 27, 2009.

28 Twenty to 25 percent price hikes, according to one source: Affordable Insurance for Everyone, Nino Japaridze, Georgia Business Week, http://www.gbw.ge/news.aspx?sid=6e152ba6-af0a-4995-b680-ef1aad72acbd

29 Affordable Insurance for Everyone, Nino Japaridze, Georgia Business Week, http://www.gbw.ge/news.aspx?sid=6e152ba6-af0a-4995-b680-ef1aad72acbd

30 A Public Health Insurance Plan: Reducing Costs and Improving Quality, http://www.ourfuture.org/files/IAF_A_Public_Health_Insurance_Plan_FINAL.pdf

31 Health Systems in Transition: Learning from Experience, Eds. Josep Figueras, Martin McKee, Jennifer Cain, http://www.euro.who.int/document/e83108.pdf

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effectiveness has been the introduction of performance-related payment systems for providers with outputs linked to payment. Importantly, insurance companies are profit seekers, with one insurance company in Tbilisi actually saying it was in the "direct interest of insurance companies not to spend money."[32] Private sector involvement can of course expect to yield considerable cost savings as opposed to the current state procurement system, which involves higher risks of corruption. Already some evidence of this exists. By-pass operations – previously costing GEL 13,000 – now cost GEL 9,500, simply because insurance companies shopped around until they were able to find a clinic willing to undercut others demanding more. Other providers are set to follow.[33]

In terms of containing drug costs, the involvement of the insurance companies is particularly important. Given that "commercial interests of well resourced market participants give them an advantage in blocking or defusing attempts to control drug expenditure…implementing cost containment successfully will require political backing from the most senior political level."[34] The government has in the past year demonstrated some willingness to reduce costs[35] but it is its decision to cede control to the insurance companies that will ultimately see steep decreases in costs. Introducing another commercial element – insurance companies – will counter the commercial rent seeking instincts of the drugs suppliers.

Commercial interests also apply to combating corruption. "With insurance companies," one insider told TI Georgia, "every case is checked."[36] If "corruption is bad for your health"[37] as one report found, then this can only be good news for patients.

While cost savings and less corruption can be expected, ultimately the GEL 5 insurance scheme will only be a success if it acts as a springboard for the wider population to involve themselves in health insurance. Currently only 150,000 people have health insurance[38] and so there is huge potential for market development. Indeed the insurance industry itself sees little commercial gain from this particular scheme, seeing in it instead a way of broadening the market by attracting interest and subsequently new clients. It is as one insurance representative told us, "our investment."[39] Given limited government resources, this financial reservoir must be tapped if the health sector is to be properly funded.

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32 Sophie Gasitashvili, Medical Insurance Director, GPI Vienna Insurance Group, in interview with author, April 27, 2009.

33 *Ibid.*

34 Pharmaceutical policy challenges in Central and Eastern Europe Andreas Seiter, http://www.lse.ac.uk/collections/LSEHealth/pdf/eurohealth/VOL14No1/Seiter.pdf

35 Recent legislation has, for example, allowed for the importation of EU-made drugs without a license, thereby opening the market to smaller players who previously found the licensing system burdensome and opaque. Another change introduced this year allows hospitals to buy drugs directly from producers, cutting out middlemen and reducing prices.

36 Sophie Gasitashvili, Medical Insurance Director, GPI Vienna Insurance Group, in interview with author, April 27, 2009.

37 Corruption is bad for your health: findings from Central and Eastern Europe Richard Rose, www.transparency.org/content/download/4815/28500/file/Part%201_2_scale%20of%20problem.pdf

38 Georgia Investment Guide, Health, http://www.investmentguide.ge/index.php?lang_id=ENG&sec_id=161

39 Alexander Lordkipanadze, General Director, Imedi International Insurance Company, in interview with author, April 13, 2009

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Implementation Problems

As of May 2009, however, little interest has been shown in the scheme with only 12,000 people signed up.[40,41]

This disinterest and low take-up to some extent reflect a "traditional Georgian mentality"[42] wherein "people [in Georgia] don't want to consider bad possibilities."[43] There has also been a problem in motivating agents to aggressively sell the package. Agents ordinarily get GEL 5 to sell an insurance package, but with this particular one they stand to gain only GEL 3. With diminishing choices as other product lines run dry, this is, however, expected to change. The agents may be "ready to sell in May, but not in March."[44]

More likely though low take-up is symptomatic of the fact that the product on offer is not particularly good. Despite suggestions from the Georgian Insurance Association that a more comprehensive package, and consequently a more expensive one, be offered, the government opted for a slimmer less expensive one. "It is very important for us that each person has an opportunity to receive insurance at a minimal price,"[45] current Prime Minister Nika Gilauri said at the launch of the scheme. While this may be a laudable priority it has meant sacrificing quality. The cost of a standard annual health insurance package is GEL 150-200,[46] suggesting that the GEL 5 package is less than adequate. Indeed, it essentially offers only minimal cover against accident and emergency. Given Georgian ingenuity, policy-holders – in collusion with doctors – have of course found a way around this, and incidentally left themselves open to charges of fraud, by claiming that what would ordinarily be considered routine procedures are medical emergencies. In Georgia, 60 percent of in-patient procedures are deemed emergencies, while the comparative international figure is a mere 10 percent.[47] One insurance insider dryly noted that medical emergencies always seem to conveniently happen during weekday working hours. "No emergencies," he noted, "occur at weekends or Christmas."[48] His lament is suggestive that the product itself is inadequate.

Low take-up on the GEL 5 scheme is more than just disappointing; it threatens – much more than inflation for instance – the entire viability of the scheme. Insurance, by definition, is about pooling or spreading risk. It entails attracting large numbers of people – most of whom are healthy – so that

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40 Figure supplied by Sofia Lebanidze, Head of Health Department, Ministry of Labour, Health and Social Affairs, in interview with author, April 20, 2009

41 Latest figures, provided by Alexander Lordkipandze of Imedi insurance company on July 10, 2009, show that 68,000 people have bought the GEL 5 insurance policy, a figure that goes some way towards undermining adverse selection – an important factor in reducing costs.

42 Sofia Lebanidze, Head of Health Department, Ministry of Labour, Health and Social Affairs, in interview with author, April 20, 2009.

43 Alexander Lordkipanadze, General Director, Imedi International Insurance Company, in interview with author, April 13, 2009.

44 *Ibid*

45 Insurance Firms, Government Sign Deal on New Plan, Civil Georgia, Tbilisi, 18 Feb.2009, http://www.civil.ge/eng/article.php?id=20443&search=insurance

46 Brief overview of development trends of Insurance sector in Georgia, http://www.osgf.ge/data/file_db/Biblioteka/Irina-English%20version%201_cMHMlrElE.pdf

47 Sophie Gasitashvili, Medical Insurance Director, GPI Vienna Insurance Group, in interview with author, April 27, 2009.

48 Alexander Lordkipanadze, General Director, Imedi International Insurance Company, in interview with author, April 13, 2009.

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the few who subsequently get sick can have their expenses covered by a common pool. Because the GEL 5 health insurance scheme is so limited – or perhaps because many Georgians use insurance to insure against today's reality rather than tomorrow's possibility – most people buying the package, according to one source[49] TI Georgia spoke to, are already sick. This makes insurance unworkable.

There are also other concerns. The insurance industry in Georgia is particularly fragile, being one of the worst affected by last year's Russo-Georgian war. Since then "demand for insurance packages shortened by 25-30%"[50] with mortgage and credit insurance cover in particular suffering as a result of the collapse in the construction and housing sectors, registering a whopping 90 percent drop on pre-war demand.[51]

Underlying the sector's weakness is its ownership structure. Most Georgian insurance companies are owned by commercial banks[52] who treat the insurance companies they own as "additional services departments,"[53] offering cheap health insurance cover to the banks' corporate clients as an additional sweetener to stay with the bank. The profitability and viability of the insurance company itself is secondary.

With the banking sector itself under immense pressure, consolidation and buy-outs cannot be ruled out. If this scenario plays out, the implications for the insurance sector will be significant if past experience is anything to go by. When France's Société Générale wanted to buy a 60 percent share of Bank Republic in 2006, one of its preconditions for the purchase was that the Georgian bank divest itself of Aldagi insurance company which it then owned. The French rationale was simple: seeking indemnity from one's own resources is "stupid."[54] Of course this is exactly what many Georgian banks still do, insisting for instance that customers taking out car loans buy credit insurance from the banks' own insurance companies. New investors will not tolerate this practice and insurance companies can expect to go against the wall.

As in Kazakhstan in the mid 1990s, where "several companies selling private health insurance went out of business owing to lack of regulation or oversight of their solvency,"[55] Georgia – a free-marketeer's dreamland – will soon witness insurance company closures, too.

If insurance companies offering health insurance go bust, where does this leave policy holders?

In addition, questions remain about the Georgian insurance industry's maturity, in particular its capacity to extract maximum cost savings. Although the GIF told TI Georgia that all systems would be in place within a few years, the sector currently lacks the technical and administrative instruments.

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49 Dr. Devi Khechinashvili, Chairman of the Board, Georgian Insurance Association, in interview with author, April 5, 2009.

50 Aldagi BCI - 15 Years of Generating an Insurance Culture amongst Georgians, Madona Gasanova, The Financial, Tbilisi, Feb 23, 2009, http://www.finchannel.com/index.php?option=com_content&task=view&id=32601&Itemid=52

51 Alexander Lordkipanadze, General Director, Imedi International Insurance Company, in interview with author, April 13, 2009.

52 Aldagi Insurance is owned by Bank of Georgia, GPI by TBC, Tao Insurance by Tao Bank, etc.

53 Alexander Lordkipanadze, General Director, Imedi International Insurance Company, in interview with author, April 13, 2009.

54 *Ibid*

55 Health Systems in Transition: Learning from Experience, Eds. Josep Figueras, Martin McKee, Jennifer Cain, http://www.euro.who.int/document/e83108.pdf

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Its information and monitoring systems are unable to deliver timely and accurate data, and its staff is incapable of using such systems in any case.

Human resources and systems problems also plague the Ministry of Health, whose role is to monitor and oversee the health providers and insurance companies.

A further complicating factor is the political environment in Georgia. The scheme has become associated in the public's mind with the current administration, making its future closely tied to that of the government's. That the president himself unveiled the package in a high profile event means that it is less associated with on-going administrative reforms and somehow seen as a political maneuvre – however untrue this may be – among the general public. One employee of a prominent insurance company said she "can't say if next year this programme will exist."[56]

Changes

In principle, the GEL 5 insurance package is to be welcomed, given its potential to introduce greater financial resources into the health sector. For it to work in practice, however, changes need to be made.

Firstly the package itself needs to be expanded, especially in terms of non-emergency in-patient care, and primary care services. As well as giving beneficiaries a better deal, the latter would maximize cost efficiencies as primary care serves as a gatekeeper, ensuring "equity by judiciously matching healthcare services, including specialty referrals, to healthcare needs."[57] The need for the former is quite obvious with one survey finding that "only 6% of Tbilisi's population (90,000 people) could cover the cost of inpatient care without borrowing or devastating family finances."[58]

Doing so of course requires more money on the state's side or from policy holders themselves or both. The scheme – structured as it is now – discourages this. Policy holders who opt to purchase a more comprehensive policy worth more than GEL 15 a month automatically lose the subsidy on offer from the state. "The State," commented one newspaper report, "declines to share the costs whatsoever."[59]

This would also serve to increase take-up, as, according to one source we spoke with,[60] many people initially interested in buying the GEL 5 package, reconsidered when they realized what was on offer. A better package would therefore not only result in better cover, but also greater numbers of people buying into the scheme.

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56 Sophie Gasitashvili, Medical Insurance Director, GPI Vienna Insurance Group, in interview with author, April 27, 2009.

57 Primary care gatekeeping and referrals: effective filter or failed experiment?, Christopher B Forrest, http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=152368

58 Report on State of Health Care in Georgia, Konstantinos Karavasilis, Mediclub Georgia, http://www.investmentguide.ge/files/161_159_209762_HealthcareStats.doc

59 Saakashvili Meets Insurance Companies on New Plan, Civil Georgia, Tbilisi, Feb 16, 2009, http://www.civil.ge/eng/article.php?id=20431

60 Anonymous Aldagi insurance company employee in interview with author, April 2, 2009.

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This is fundamentally important as only large numbers can prevent what the industry calls adverse selection, whereby those with a greater potential to file claims disproportionately buy policies. With greater numbers come what is known as anti-selection, which in turn means that an even better product can be offered for less. Greater take-up would effectively allow the insurance companies to offer the same kind of product at similar prices that corporate clients currently enjoy.

Encouraging people to opt for more comprehensive and more expensive packages also serves another important function, indeed given the state's inability to finance health care adequately, possibly the most important one – the injection of money into the system.

For this to happen, incentives need to be built in to encourage people to buy better products. These could include increased state contributions as a percentage of the premium or, as in other countries, tax relief.

In addition, what WHO describes as the MoH's "stewardship functions"[61] need to be looked at, something that is "vital in ensuring that purchasers act in the best interests of the population."[62] Similarly the capacities of the insurance companies need to be improved and technical and information management skills upgraded. Routine information systems need to be put in place.

Conclusion

Anyone having had the pleasure of experiencing the Georgian health care system would certainly agree that change was required. The so-called GEL 5 health insurance scheme – while perhaps not quite "our new great social initiative"[63] – is nonetheless a fundamentally important step in the right direction. Given the financial restraints, this scheme, if tweaked, could prove to be the solution to health care issues facing the Georgian population.

This scheme addresses problems of corruption in the procurement system, provides for patient choice, introduces competition, reduces drug costs, and switches to a model allowing for cost effectiveness through the introduction of performance-related payment systems for providers with outputs linked to payment. Most importantly, the new scheme has the potential to attract greater funding for the healthcare sector by encouraging ordinary Georgians to buy insurance cover.

However, because the package on offer – basically emergency cover – is so limited, the population has been slow to come on board. Low take-up – as well as reflecting badly on the product on offer – fundamentally threatens the scheme itself.

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61 Health System Functions: Stewardship - monitoring stewardship in order to strengthen it, P Travis; D Egger; P Davies; A Mechbal, November 2001, http://gis.emro.who.int/HealthSystemObservatory/Workshops/WorkshopDocuments/Reference%20reading%20material/Literature%20on%20Governance/Stewardship14-formatted.doc

62 Health Systems in Transition: Learning from Experience, Eds. Josep Figueras, Martin McKee, Jennifer Cain, http://www.euro.who.int/document/e83108.pdf

63 Saakashvili Meets Insurance Companies on New Plan, Civil Georgia, Tbilisi, Feb 16, 2009, http://www.civil.ge/eng/article.php?id=20431

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For insurance to work, large numbers of people are required as risk must be spread as thinly as possible to avoid what is know as adverse selection.

If the scheme were beefed up so that more people would be encouraged to participate, if incentives were put in place to encourage individuals to purchase better policies, and if better oversight were in place, both within the insurance sector and relevant regulatory authorities – then, this GEL 5 Insurance Scheme could indeed be a possible solution to the healthcare demands of the Georgian people.

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