WORKING TOWARDS UNIVERSAL HEALTH COVERAGE: LESSONS FROM GEORGIA

By: Erica Richardson and Nino Berdzuli

Summary: In 2012, the newly elected government in Georgia sought to make good on their promises of improving access to health care by making clear political commitments to achieving universal health coverage (UHC). Progress has been made in improving access to health care, protecting the population from financial risks of inpatient care and reducing inequalities. Consolidating and developing these gains will require further government investment in population health and broadening coverage for outpatient pharmaceuticals.

Keywords: *Universal Health Coverage; Georgia (Republic); Benefits Package Design, Single Payer*

Introduction

Since 2013, Georgia has been striving to provide UHC through a tightly defined package of publicly funded benefits. Reforms have fundamentally altered health system financing through the introduction of a single purchaser for the government's package of benefits. This replaced the previous system where competing private insurance companies provided a state-funded package of benefits to a tightly defined group of recipients who lived below the poverty line. Under the old system, although the lowest income households were covered, most of the population remained uninsured. However, the introduction of the Universal Health Care Programme extended the breadth of coverage to almost the whole population.[1]

What is the Universal Health Care Programme?

The government that came to power in 2012 was committed to higher social spending. The state budget for health in 2013 increased dramatically (from 388 million to 662 million GEL (US$235 million to US$401 million), steadily growing to over 1bn GEL (US$416 million) in 2017) as the new government sought to refocus on spending in the social sphere. All citizens were to receive a universal basic package of high-quality health services, protection from financial risks, prevention of diseases and coverage of emergency care using globally approved mechanisms. The ultimate aim is to increase the population's life expectancy and improve its overall health.

Package of benefits

The first phase of reforms introduced the Basic Package of Benefits in February 2013 and the whole uninsured population were eligible. Over 90% of the resident population became entitled to a tightly defined package of state-funded benefits in 2013. The package of benefits covered primary care services

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(including many basic diagnostic tests) and emergency medical care – both inpatient and outpatient services. This was then expanded in July 2013, when the Universal Health Care Programme was implemented, to include elective surgery, oncology and childbirth (all with variable limits and co-payments). All those uninsured in July 2013 could apply for cover.

> the depth of coverage is greater for lower income households

Within the package of benefits under the Universal Health Care Programme, the depth of coverage is greater for lower income households. More comprehensive cover is provided to pensioners, children aged five years and under, and households registered as living below the poverty line. Basic primary care and some diagnostic services, as well as urgent outpatient and inpatient care (with a cost ceiling), elective surgery (with 10–30% co-payments), oncological services and obstetric care, are available for those above the poverty line but earning less than the highest income bracket.

In March 2017, the next wave of health care reforms was announced and this brought further differentiated packages for those covered under the Universal Health Care Programme. The highest income group of around 43, 000 people was excluded from the Universal Health Care Programme from July 2017, as they are expected to purchase voluntary health insurance. The savings accrued from no longer covering this group are intended to be used to cover an expanded package of pharmaceutical benefits for the lowest income 'target' group. The impact of this policy on solidarity and risk pooling in health financing is yet to be seen.

Single payer

The Social Services Agency (SSA), which conducts means testing and access to social assistance programmes, is now the single payer in the health system for different levels of government-funded cover under the Universal Health Care Programme. The purchasing function was consolidated to the SSA and moved from the private health insurance industry in order to improve efficiency and reduce the high administrative costs of the previous model. The vertical programme covering high-risk maternal and newborn care was integrated into the Universal Health Care Programme to be purchased by the SSA and the Ministry of Labour, Health and Social Affairs (MoLHSA) is working on the integration of the diabetes programme. The gradual incorporation of vertical programmes should help to reduce fragmentation in the system and consolidate funding flows.

Why was it introduced?

The nature of the health system in place in 2012 has fundamentally shaped the Universal Health Care Programme, as it was put in place to address the shortcomings the previous Medical Assistance for the Poor (MAP) programme. MAP was part of an approach to the health system driven by the aim of complete marketisation of the health sector: private provision, private purchasing, liberal regulation and minimum supervision. From 2008 to 2012, most government spending on health was channelled through private health insurance companies, which were paid to provide a standard package of benefits for households living below the poverty line – MAP.

Studies have shown that the targeting of MAP was robust in that it did cover the most vulnerable population with very little 'leakage' to higher-income groups. MAP also improved access to inpatient services. However, although access to and utilisation of acute care improved for those covered by MAP, there was no improvement in access and utilisation for those with chronic conditions. This is important because chronic conditions dominate the disease burden in Georgia. This also highlighted a very significant gap in the scope of coverage even for the lowest income households – outpatient pharmaceuticals.[1]

The limitations of the MAP programme meant that out-of-pocket (OOP) payments were almost three-quarters of total health expenditure in 2010. The narrow targeting of MAP also meant that the leading causes of household impoverishment in Georgia were related to health care costs.[2] In 2010, only 27% of the population had health insurance, and households on the cusp of eligibility for MAP were at most risk of being pushed into poverty by catastrophic health spending.[3]

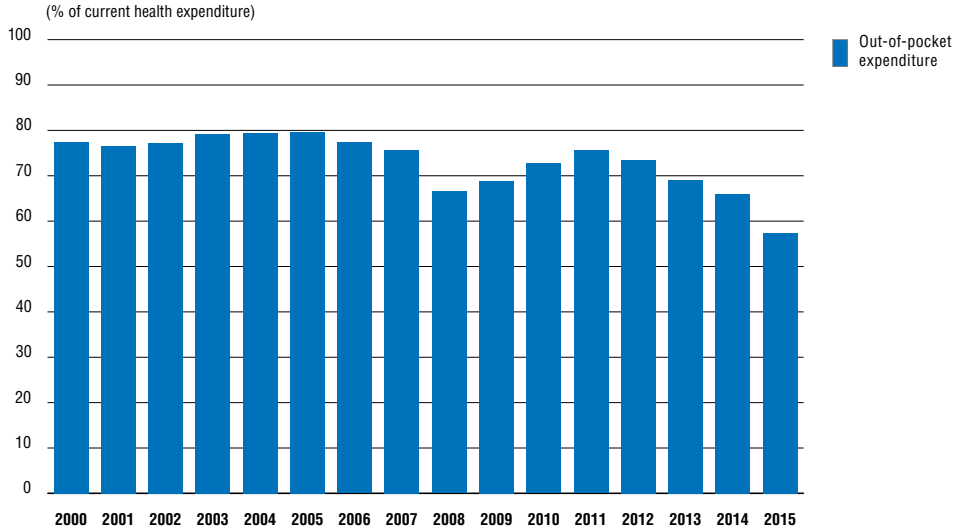
As elections approached in 2012, access to health care became an increasingly important political issue and the government of the time committed to quite radical expansions of the MAP programme in September 2012 to cover all broader population categories, not just those below the poverty line, but also pensioners, people with disabilities, children aged six years of age and under, and students. With these changes, coverage was extended to about 45% of the population, but the elections in October 2012 ushered in the new government which was committed to much higher social spending and universal health care.

What has been the outcome?

Financial protection

Since independence in 1991, one of the key financing issues faced by the Georgian health system has been the lack of political will to prioritise health for national development and fund the health sector accordingly. The expansion of coverage under the Universal Health Care Programme was made possible by a substantial increase in budgetary funding for health, although government health expenditure remains low in international comparisons. Current government per capita spending on health in Georgia was $278 (PPP) in 2015, which was below the average for the Europe and Central Asia Region as a whole ($1 997 PPP) and well below the average for EU28 countries ($2 942 PPP); even in an EU Member State such as Latvia, which has a relatively low

Figure 1: Out-of-pocket expenditure in Georgia



Source: Ref.[2]

share of government spending in current health expenditure (CHE), government per capita health expenditure was $821 (PPP).[2]

> The role of the SSA as a single purchaser has significantly improved efficiency

An increase in government health expenditure is consistent with the experience of other countries when they have moved towards universal coverage from less equitable systems, as it goes hand-in-hand with reducing the financial barriers to care. Since 2014, the Universal Health Care Programme has consistently overspent its budgeted amount. This was largely due to the rapidly growing demand for health services among those who were previously uninsured or lacked coverage for certain treatments.

Georgia still has some of the lowest utilisation rates for outpatient care in Europe, but utilisation of outpatient and inpatient care has more than doubled since the introduction of the Universal Health Care Programme. Utilisation of inpatient care is relatively high, but this is indicative of a strong preference in the system for care-seeking and treatment at more specialised levels of the system. Despite primary care being made free at the point of use for all, most of the Universal Health Care Programme budget is spent on inpatient services.

Increased government expenditure has also reduced levels of OOP spending, although OOP expenditure still dominates health system financing in Georgia. Although they remain among the highest in the European Region, OOP payments fell from 73% of CHE in 2012 to 57% in 2015.[2] Outpatient pharmaceuticals are the largest driver of OOP spending on health as they represent one of the biggest gaps in coverage and pharmaceutical costs can be impoverishing for low-income households. This has serious implications for overall equity and financial protection in the system. Formal co-payments are also an important component of OOP spending. Although co-payments are fixed at 10–30% of the official price of an elective procedure, the benefits are capped at this price and hospitals often charge more, with patients covering these extra bills themselves. An increase in public spending on health is needed to help further lower OOP spending on health.

Efficiency

The role of the SSA as a single purchaser has significantly reduced fragmentation in the system and improved efficiency. In 2016, the Universal Health Care Programme was spending less per person than the MAP programme – approximately 166 Georgian lari (GEL) ($72) compared with 180 GEL ($78), even though the benefits offered were more extensive. This demonstrates a big decline in spending on administration; prior to 2013, Georgia's public spending on health administration was considerably higher than most high income countries, including Switzerland.[1]

Nevertheless, incentives in the system for patients and providers still strongly favour emergency and inpatient care. Even though the per capita cost of coverage has fallen with the implementation of the Universal Health Care Programme, more than half of the funding went on emergency inpatient care. It has been difficult for the SSA to control costs with the reformed payment system, and incentives in place encourage providers to treat patients as urgent cases. As a result, the SSA introduced standardisation of tariff-rule setting, which has already led to cost savings at the system level. However, any savings in health expenditure are accrued to the central government budget rather than the health system.

Satisfaction

Overall satisfaction with the health system has increased and grown since the introduction of the Universal Health Care Programme in 2013. Survey data show that patients appreciate the level of choice in the system and the improved access to specialist services, but dislike making co-payments and the restrictions on the services covered – particularly for pharmaceuticals and dental care.[4]

Future reform directions

Ongoing reform plans focus on strengthening governance and the role of the SSA as a strategic purchaser, ensuring the quality of medical services, improving the training and regulation of the health workforce, strengthening primary care and public health services, and increasing financial protection – particularly around

outpatient medicines, which account for around two-thirds of OOP spending in Georgia. This is recognised as being one of the main barriers to UHC in Georgia as medicines are expensive and generally not covered if prescribed in primary care.

> expansion of coverage was made possible by a substantial increase in funding

In July 2017, the government introduced essential medicines coverage for four common types of chronic disease – cardiovascular (including hypertension), chronic obstructive pulmonary disease, type 2 diabetes and thyroid conditions – for households below the poverty line. From September 2018, this was expanded to all pensioners and people with disabilities to reduce financial hardship among these groups as they tend to be at higher risk of living in poverty and have greater health needs. The goal is to provide coverage for up to 40 essential medicines required for evidence-based management of chronic conditions. Further reforms are needed to encourage physicians, pharmacists and patients to prescribe, dispense and use generic and cheapest alternative medicines.

The challenges faced as part of expanding coverage in Georgia are common to many countries around the globe and policy lessons could be particularly valuable for other middle-income countries in Europe. The Georgian experience also highlights how moving towards universal health care requires increased public spending and improved health system performance.

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Copenhagen: World Health Organization, 2017 (on behalf of the Observatory)

Number of pages: 90; **ISSN:** 1817-6127

Freely available for download: http://www.euro.who.int/__data/assets/pdf_file/0008/374615/hit-georgia-eng.pdf?ua=1

Since 2012, political commitment to improving access to health care, to protecting the population from the financial risks of health-care costs and to reducing inequalities has led to the introduction of reforms to provide universal health coverage. Considerable progress has been made such that over 90% of the resident population became entitled to a tightly defined package of state-funded benefits in 2013; previously, only 45% of the population had been eligible. To finance this broader coverage, the government increased health spending significantly, although it remains low in international comparisons.

Out-of-pocket (OOP) payments have fallen as public spending has increased. Nevertheless, current health expenditure is still dominated by OOP payments (57% in 2015), two-thirds of which are for outpatient pharmaceuticals. For this reason, in July 2017, the package of benefits was expanded for the most vulnerable households to cover essential medicines for four common chronic conditions. The system has retained extensive infrastructure with strong geographical coverage. Incentives in the system for patients and providers favour emergency and inpatient care over primary care. Also, financial incentives to improve the quality of care are limited and disincentives are lacking to inhibit poor quality of care. Future reform plans focus on ensuring universal access to high-quality medical services, strengthening primary care and public health services, and increasing financial protection.