საქართველოს მეცნიერებათა ეროვნული აკადემიის მოამბე, ტ. 16, №1, 2022
BULLETIN OF THE GEORGIAN NATIONAL ACADEMY OF SCIENCES, vol. 16, no. 1, 2022

Economics

Development of Social Health Insurance in Georgia: Challenges and Lessons

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The social health insurance system, unlike general tax financing system, is more focused on market mechanisms. Despite certain achievements, the introduction of social health insurance in Georgia turned out to be quite difficult. Due to ongoing economic crisis, the state failed to finance its promised commitments, resulting in a chronic shortage of funding for the healthcare system. The new government abandoned the idea of building a social insurance system and switched to the general tax financing model, where the state takes a dominant lead, and the healthcare is financed from the state budget. Given that the social insurance system is the best way of mobilizing additional funds and therefore providing sustainable funding for health sector, it is advisable to promote social insurance development. The healthcare sector needs consistent, continued and successive reforms. Despite the change of governments, the strategic course should not change drastically in the long run and the achievement should not be denied due to the political climate change. *© 2022 Bull. Georg. Natl. Acad. Sci.*

Social Insurance system, healthcare reforms, general tax-financed healthcare model

Since the early 1990s, the former communist countries of Central and Eastern Europe have implemented extensive reforms in the financing, organization, and delivery of healthcare. One of the hallmarks of the health systems is funding. There are two main models of the health system financing: the health insurance (Bismarck) model and the general tax-funded (Beveridge) health insurance model. Under the Bismarck model, the citizens are required to pay pre-determined insurance premiums to the insurance funds. The national (Beveridge) model of healthcare is completely financed from the state budget and tax revenues. Under the Beveridge model, the state takes a dominant lead, compared to the Bismarck model, because healthcare organizations are more dependent on the state.

When creating a new financing system, 22 out of 28 countries in the region have introduced the social health insurance system. The adoption of the social health insurance (Bismarck) model in Eastern Europe and former Soviet Union countries was conditioned by many factors. One of the main reasons is usually related to politics, in particular,

to the political desire of distancing oneself from the Soviet system [1].

Thus, as the Beveridge model was more associated with the centralized state structures of the Soviet period (the Ministry of Health), while the Bismarck model was associated with non-state, public institutions (Social Insurance Funds), the preference was given to the development of the latter.

Also, a big role was played by the desire of sharingthe Bismarck model which proved to be successful in developed European countries [2].

Other factors included the search for and mobilization of additional funds for health sector and cost containment, demand for transparency increase, search for sustainable funding, and limiting the policymakers' ability to divert the healthcare to other areas, as well as creating services that meet the patients' needs, and desire of introducing market-mechanisms, related to the privatization of medical services. The World Health Organization and the World Bank have recommended an insurance-based healthcare system in many countries [3]. The goal of the research is to study the peculiarities of the development of social health insurance in Georgia.

The article is based on a documentary analysis, which included both official and non-official documents. The official papers included legislative and othergovernmental documents. All health policy documents that could be obtained from WHO/EURO, the Ministry of Health of Georgia and regional health departments were included in the study. In total, 11 official papers were analyzed.

Non-official documents were the journal publications from major health databases (SCOPUS, MEDLINE, PubMed). The articles published from 1990 to 2021 were also used.

Results

The Georgian context of healthcare reorientation. In December of 1991, after the collapse of the Soviet Union, Georgia became an independent country. For the first four years of independence, Georgia had a hard period of severe economic crisis, emerging as a result of the civil war [4, 5]. Between 1990-1994, gross domestic product per capita amounted approximately from $8,000 to $2,200, i.e., was reduced by 70%; In 1994, and industrial production was decreased by more than half [6, 7].

The acute economic crisis in the country led to the demolition of the healthcare system. State budgetary funding of medical field was also sharply reduced. At the beginning of the 1990s, the share of healthcare in the state budget decreased from 13.2% (1991) to 0.54%. In 1985-1994, the state healthcare expenditure per capita decreased from $95,5 to$0,81 [8]. The state share in total healthcare spending diminished to 4.9% in 1995. In 1985, healthcare expenses per capita were 95,5 USD, in 1990 – 13 USD, and by 1994, it dropped to 0.90 USD [9]. The funds allocated by the state for healthcare financing were significantly lower than the minimum essential need for medical services. Following the economic crisis, the wages of the medical staff were so symbolic that the annual incomes have been less than the monthly subsistence level. Due to low wages and unstable economic situation, many prominent specialists have been encouraged to quit their jobs and leave the country [10].

As a result of meager state spending on healthcare, people had to pay medical bills out of their own pockets. Informal out-of-pocket payments were common. The helpless population could not receive vital medical care due to the lack of funds. The demographic picture was poor: the morbidity rate increased, the birth rate decreased, and the proportion of socially dangerous diseases (tuberculosis, venous diseases) increased. Average life expectancy decreased by 3 years. Maternal and child health had deteriorated significantly since the early 1990s.

The healthcare system disruption, deterioration of sanitary-epidemiological situation and insuffi-

cient implementation of preventive measures contributed to a significant increase of infectious diseases. The situation was further complicated by delays in vaccination dates for children and adolescents, which led to an outbreak of diphtheria and other dangerous infections. The disruption of routine vaccination in 1991-1992 due to lack of vaccine material led to a diphtheria epidemic. There were 23 cases of diphtheria registered in 1993, 312 in 1994 and 425 in 1995. 42 patients died. Tuberculosis morbidity and mortality rose sharply. The main reason for the spread of tuberculosis was the low detection rate of cases. Cases of diseases considered eradicated have increased, including malaria, visceral leishmaniasis and rabies.

The hard socio-economic situation in the country brought the healthcare system to the brink of collapse, making it almost impossible for medical institutions to function. The state could no longer fulfill its duty of providing medical services to the population. Georgian medicine was essentially in a state of collapse.

Introduction of the Health Insurance System in Georgia

In searching for a solution to the acute crisis developed in the healthcare sector, an issue of applying a principally new model for fundamental reorganization of a self-functioning field, being on the verge of destruction, had been on the agenda since the mid-1990s.

The beginning of fundamental reforms was preceded by the first public statement on reforms made in the Parliament of Georgia on March 3, 1994. The Parliament was represented by the largest number of political figures in the history of independent Georgia – 24 parties. Despite such a diversified composition of the Parliament, the Minister of Health was unanimously approved, thus supporting the launch of radical reforms in healthcare sector.

The process of structural and qualitative reform in the health sector was supported by the World Health Organization, the World Bank, and the governments of Japan, Germany, Sweden, and the United Kingdom.

The concept of the healthcare system reorganization recognized the need of healthcare system reform, defined political, economic and legal components of the state policy strategy.The main goal of health system reorientation was to prepare and implement a healthcare organization and management model when switching to market-economic relations, which would be in line with the requirements of the country's political and economic development. The country's scarce financial resources in fact made the comprehensive medical care imposisble, making it necessary to balance the state obligations in the public health sector with its capacities. Under the new Constitution of Georgia, the state, for the first time, declared, that the burden of healthcare responsibility was distributed among various entities of the state and that the medical care was no longer free. The responsibility of the state was no longer comprehensive and the obligations were defined by the state healthcare programs, as well as by field (regulation) management mechanisms. The public had the right to have access to medical services provided by state health programs.

The difficult, painful and multi-stage process of healthcare system reorientation began on August 10, 1995. Healthcare reform was one of the first state reforms implemented in the recent history of Georgia, with the key goal to restore thecollapse, self-sustaining healthcare system, establishing qualitatively new relationships in the system that would be in line with the country's political and economic development requirements [11]. In 1999, the National Health Policy of Georgia and the Strategic Health Plan 2000-2009 were developed. The reform was aimed at improving equality and access to healthcare services for the population.

When creating a new financing system in Georgia, the choice was made in favor of the social insurance model. Implementation of the social

health insurance model was driven by many factors: the introduction of market mechanisms in the country; equal and fair distribution of health responsibilities between the state, employer and employee; the desire to raise additional funds for the health sector; the search for sustainable financing; cost containment; the demand for increased transparency; the successful emulation of the Bismarck model in developed European countries; distrust of a tightly centralized state system and interventions. It is important that by opting for a social health insurance model, Georgia followed the processes taking place in Eastern European countries.

In 1995, the State Health Insurance Company consisting of 12 regional branches was established. The company enjoyed financial, managerial and contractual independence; under the law, the highest advisory body of the company was the Supervisory Board. As in Georgia, single social insurance funds were established in Croatia, Hungary, Estonia, Poland, Latvia, Lithuania, Slovenia and Bulgaria.

The source of income for the state health insurance company was a social health insurance contribution of 3%, of which 2% was paid by the employer and 1% by the employee. By legalizing a health "tax" and then an "insurance premium", the so-called “insurance risk” was created. The insurance premiums were accumulated in the state health insurance fund.

In addition to health insurance premiums, the source of income for the state health insurance fund was a transfer from the central budget. The central budget was drawn from general government revenues. The central budget transfer was mainly intended to finance state programs for those who were not employed (the unemployed, part of the disabled, the helpless, pensioners, children, and IDPs).

In order to decentralize the health care system, the burden of public funding was redistributed between central and local governments by establishing local health funds that receive revenues from municipal budgets. Contributions to health funds were averaged per capita, based on the number of people living in the municipalities. The Law of Georgia "On State Budget for 1997" stipulated that local governments were to receive at least GEL 2.5 per capita from the local budget and at least 10% of municipal budget expenditures to finance municipal health programs. Municipalities had the right to increase this amount if their budget allowed doing so. The optimal model of municipal health programs and their effective implementation largely determined the maintenance and improvement of public health in the country.

Problems of Development Social Health Insurance in Georgia

As a result of the healthcare reforms, the number and scope of compulsory state health insurance programs, i.e. state obligations to the population in the health field, increased on a yearly basis, and covered a wider range of population. By 1999, the number of insurance policy holders had increased to 700,000. Despite certain achievements, the introduction of social health insurance turned out to be more difficult than expected. It was associated with a large share of informal economy in Georgia, high unemployment and severe macroeconomic constraints. It took Georgia more than two decades to achieve a level of independence of GDP per capita. As a result, the basis for revenue increase was negligible.

The healthcare system suffered from chronic funding shortage as the state often failed to finance its promised commitments. As a result, in 1999 the State Medical Insurance Company received only 64.2% of its approved budget. Lack of public funding had a negative impact on the funding of specific health programs. The low level of funding means that the policyholders under the state health insurance program will not be able to receive the guaranteed medical service. Due to low state funding of healthcare system, the share of out-of-

pocket direct taxes in Georgia accounted for most healthcare expenditures.

In the initial period of the reform, the continuous deficit of state funding contributed to the spread of informal so-called “under the table” taxes, which has become a major source of income for many healthcare professionals. Out-of-pocket direct payments prevent equal access to healthcare, creating negative incentives for physicians, posing a problem to system transparency, and acting as a serious obstacle to reform [12]. The high proportion of out-of-pocket payments by patients in total health care expenditure runs counter to the goals of health care financing, as this time access depends more on ability to pay than on medical need.

An effective mechanism for regulating or formalizing informal payments is the introduction of legal co-payments that can be used by physicians and hospitals for service improvement [13]. As a result of reforms introduced in 1995, taxes on certain health services not covered by the state program were legalized. Tax legalization has reduced informal payments by patients. However, due to the scarcity of state funding, informal out-of-pocket payments still took place, often leading to catastrophic financial consequences for families.

Due to constant economic crisis, the government was unable to maintain the -balance between revenues and expenditures, leading to state funding reduction, the accumulation of large debts towards medical organizations, and an increase of out-of-pocket private payments. Revenues from compulsory medical insurance contributions increased from GEL 21 million in 2001 to GEL 36.3 million in 2003. However, they accounted for only 5% of total health expenditures. the state budget had a deficit of $150 million in 1999 and $90 million in 2003, with a domestic debt of $120 million. The main causes were a flawed tax code, failure to collect non-tax revenues, failure to receive grants and loans from international donors, and the territories of Georgia out of control of the national government. In fact, the newly formed state failed to ensure the efficiency of public finances and to collect taxes. The share of the state budget in GDP was negligible (12% of GDP in 2004), one of the lowest in the entire post-Soviet space.

The state intended to implement further reforms in the direction of social insurance. It aimed at the integration of financial resources, in particular the pooling of funding streams into a single “channel”, i.e. the pooling of health insurance contributions from central and local budgets. The aim was to merge municipal emergency care programs and national health insurance plans into a public health insurance fund. Combining the municipal and insurance plans increased the number of people covered by the insurance system, which in turn made it easier for workers to register with the health insurance fund.

In addition to merging health funds, the reform included: a) integrating the registration and reimbursement mechanisms into insurance plans to create a universal guarantee; b) stabilizing the resources needed to finance the insurance plans; c) managing information systems and developing a communication network; d) structural development, increasing the role of regional offices of the state health insurance company, in particular entrusting them with information management and premium collection in addition to supervisory functions.

The main goal of the strategy of the further reformation of the social insurance system was to reduce the central budget expenditure required for public health care, to shift the main financial burden of medical expenses to the employer and the employee and to optimize the health care system of Georgia. The implementation of the strategic plan would make the health system more manageable and efficient.

Following the “Rose Revolution” in November 2003, Georgia underwent a change of political leadership. Reforms implemented by the new government led to fast and stable economic growth. Most importantly, the tax system was streamlined.

There was an expectation that the adjustment of the tax system by the new government would improve the collection of obligatory health insurance premiums by the insurance fund. In order to completely overtake the previous government, the new government sacrificed the initial germ of developing a social insurance system in Georgia. In 2004, Georgia refused to build a social insurance system (Bismarck model) and switched to the general tax financing (Beveridge) model. The same continued in 2012, when a new political party, "Georgian Dream – Democratic Georgia", came to power. Although the new government introduced the principles of universal health care and the state universal health care programme came into force, the general tax financing (Beveridge) model did not change and health care funding from the state budget generated from general tax revenues continued with inertia.

A comparison of the healthcare system reforms in Georgia and in Eastern European countries evidences that the decision-making regarding reforms in Georgia is mainly related to the change of governments in the country. In many Eastern European countries, unlike Georgia, the social insurance system has not been replaced by a general tax system despite the change of government. These countries have not yet abandoned the principles of insurance financing. They have remained committed to a strategic plan for health reform, which rejected a more state-dominated health financing system.

Conclusion

Given that the social insurance system is the best way to mobilize additional funds and hence to ensure sustainable financing of the health sector, it is advisable to promote social insurance.

The study shows that the health sector, which is meant to ensure human health security, needs a consistent, continuous, successive, and systematic approach to reform and cannot be subject to endless constant fluctuations. A country should have long-term strategic objectives and a vision for health system reform that promote effective and coherent health system development. A broad range of stakeholders should be involved in the strategy development process. Formulating a long-term health policy is a topic and consensus of higher-level stakeholders. Despite the changes in governments, the strategic direction should not change dramatically in the long term, and achievements should not be denied by changes in the political situation.

ეკონომიკა

სოციალური ჯანმრთელობის დაზღვევის განვითარება საქართველოში: გამოწვევები და გაკვეთილები

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საქართველოს ჯანდაცვის სისტემის რეფორმის პერიოდში, რომელიც დაიწყო 1995 წელს, დაფინანსების ახალი სისტემის შექმნისას არჩევანი შეჩერდა სოციალური დაზღვევის მოდელზე. ნაშრომის მიზანია საქართველოში ჯანმრთელობის სოციალური დაზღვევის განვითარებასთან დაკავშირებული გამოწვევების შესწავლა. სოციალური დაზღვევის სისტემა უფრო მეტად არის ორიენტირებული საბაზრო მექანიზმების დანერგვაზე, სადაც პასუხისმგებლობა ჯანმრთელობაზე თანაბრად და სამართლიანად გადანაწილდება სახელმწიფოზე, დამქირავებელსა და დაქირავებულზე. მიუხედავად მიღწევებისა, ჯანმრთელობის სოციალური დაზღვევის დანერგვა მოსალოდნელზე რთული აღმოჩნდა. ჯანდაცვის სისტემა განიცდიდა დაფინანსების ქრონიკულ დეფიციტს. 2004 წლიდან სოციალური დაზღვევის სისტემა შეიცვალა ზოგადი გადასახადებით დაფინანსების მოდელით, სადაც სახელმწიფო დომინანტურ როლს ასრულებს და ჯანდაცვა უმთავრესად ფინანსდება სახელმწიფო ბიუჯეტიდან. იმის გათვალისწინებით, რომ სოციალური დაზღვევის სისტემა ყველაზე უკეთ ახდენს ჯანდაცვის სექტორისათვის დამატებითი სახსრების მობილიზებას და, შესაბამისად, მდგრად დაფინანსებას, მიზანშეწონილია ქვეყანაში სოციალური დაზღვევის განვითარების ხელშეწყობა. ჯანდაცვის სფერო საჭიროებს რეფორმირების თანმიმდევრულობას, უწყვეტობას და მემკვიდრეობითობას.

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Received January, 2022