

# HEALTHCARE REFORM IN GEORGIA

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## I Introduction

*The inherent vice of capitalism is the unequal sharing of blessings;*

*the inherent virtue of socialism is the equal sharing of miseries.*

- **Winston Churchill**

*Reform – change that removes or puts right faults, errors, etc.*

- **Oxford Advanced Learner's Dictionary**

The word "reform" could be the most popular word in Georgia's recent history. Since the restoration of independence, Georgia has initiated quite a number of reforms. Some have been quite successful. The majority, though, have created an additional burden on the population. There are a number of conditions that determine the success of these reforms. The most important could be the desire to change. Both the government and the population must feel the need for change. The complexity of reform is such that it cannot be successful without joint input from both. Alone, neither can effect any change, no matter how strong the desire.

Reforming Georgia's healthcare system was vital. The system Georgia inherited from the Soviet Union was too costly to maintain. Moreover, the sheer plethora of other reforms made it impossible to ignore the healthcare crisis. Unfortunately, Georgia still awaits joint input from both sides. While the key players involved in the reform (the Ministry of Health and policy makers) consider the reorganisation of the healthcare system a success, the consumers (the general population) consider it disastrous.

## **II The Georgian Healthcare System—Background**

### **A. Before 1991**

Before 1991, the Georgian healthcare system—its financial and administrative structure—represented only a small part of the entire Soviet healthcare system. This system, following the "Basic Law on Health in the USSR and Soviet Republics" enacted in 1964, provided a unified framework for legislation and regulations in each republic. Though the law covered all the Soviet republics, it still provided for some variation in operations and performance in order to allow for the economic, cultural and social diversity of each Soviet region.

The Soviet system was based on the "Semashko model"—a totally centralized, command-and-control healthcare system, 100% publicly owned and financed. Its main focus was primary care. Central (Moscow) and local (in this case, Georgian) healthcare authorities administrated the system. The central authority (the USSR Ministry of Health) was in charge of planning, organizing, controlling and allocating almost all resources. Consequently, the few tasks and/or responsibilities delegated to the local authorities were limited to providing performance evaluations and reports to the central authorities. Formally, the Ministries of Health of both the Soviet Union and Georgian Soviet Republic carried out strategic decision-making. In actuality, the central authority made all key decisions.

The Semashko model—its financial structure, organisation and philosophy—could be compared with the National Health Services system of the United Kingdom. Having a well-developed infrastructure, particularly in the area of primary care, the Semashko model guarantees urban and rural populations to basic healthcare services. Secondary and tertiary care is concentrated in district and regional centres (depending on the administrative division of a country). The Soviet (or socialist) model of healthcare has certain positive features that many countries want to achieve. However, as with other socialist models, this one has also faced serious problems when put into practice.

Soviet healthcare services were free. The primary source of healthcare funding was the central budget. Pharmaceuticals were provided on a subsidised basis to out-patients and free of charge to in-patients. Healthcare professionals received a salary. Private practice was quite rare although not forbidden. Private, out-of-pocket payments to healthcare professionals, however, were illegal but very common, especially in the southern republics of the USSR.

The primary care system, consisting of preventive medicine and out-patient care, was staffed by district doctors, general practitioners (more specifically, internists) and a wide range of specialists (mostly in clinics). Primary care institutions performed nearly all routine lab work and tests. There was no choice of district doctor. Each person was assigned to a district doctor based on his or her residence.

The district doctor played the role of gatekeeper, referring a patient to specialists, lab technicians and to secondary and tertiary healthcare institutions as necessary. For admission into a hospital, a patient was required to have a referral from his or her district doctor, except in emergency situations when arrival in an ambulance provided automatic admission.

A well-developed network of district, regional, municipal and republic hospitals provided secondary care mostly on an in-patient basis. Like all healthcare, secondary care was free of charge. The central budget paid doctors and medical staff their salaries and provided hospitals an operational allowance based on the number of beds in each facility. Hospital management was also guided by an established ratio: the number of beds per population. In many cases, decisions to establish new or to expand existing hospitals were based on political rather than economic conditions. Hence, the number of hospitals or hospital beds often turned out to be much higher than needed. Before 1991, though, the average bed occupancy rate was very high, creating an illusory justification for hospital bed inflation.

There were no implicit incentives to improve hospital performance or cost-effectiveness. The former was measured by a set of indicators, such as the number of admissions and discharges, deaths per admission, average length of hospital stay, bed occupancy rate, etc. If a hospital had poor results, usually administrative measures were applied by the healthcare authorities (i.e., replacement of the head doctor), which did not really address the true reasons for poor performance.

Traditionally, secondary care institutions were overstaffed with medical personnel, particularly in the urban areas. Usually the best doctors were practising in the hospitals either as attendant physicians or as faculty members.

According to 1990 health data, the health status of the population in Georgia was relatively poor compared to the rest of Europe. Life expectancy was 68.1 years for men, 75.7 for women (compared to 71 years for men and 78 for women in Western Europe). The infant mortality rate (IMR) declined by 50% over the previous 30 years, yet remained twice as high as in Western European countries. Poor prenatal and neonatal care was the reason for one-third of all infant deaths occurring in the first three days of life. The maternal mortality rate (MMR) was estimated to be more than four times that in Western Europe. Another serious health problem was adult male mortality mainly caused by cardiovascular diseases.

## **B. After 1991**

The Soviet healthcare system was considered by the Soviet authorities as one the Soviet Union's highest achievements and superior to all other systems in the world. Thus, until 1991, no improvements were sought in the USSR nor consequently in Georgia.

While discussing Georgia's pre-reform years, 1991-1995, it is important to

mention the general situation of the country. This was a period of great political, social and economic upheaval. A civil war and separatist wars in the regions of Abkhazia and South Ossetia (delineated along ethnic lines) negatively affected development in the economically and politically immature country. There is no data that could accurately track the loss of the healthcare system's capital assets or the decline of its staff's morale. Deterioration of the healthcare system was rapid and impossible to stop.

In addition to all of these problems, a lack of funding resulted in the total collapse of the state-owned and utilised Semashko model of healthcare in Georgia. The same trend was noticeable in other Soviet countries. The Soviet-based healthcare system was falling apart in every republic.

The likely major factors affecting the collapse of the Soviet healthcare model were:

- inherent weakness of the Soviet politically driven economy;
- overall economic and political crisis in the former USSR;
- constant cuts of funding for healthcare in the central budget;
- weak and/or incorrect administration of the healthcare system at all levels; and
- distorted and/or irregular patterns of utilisation of the medical services.

After 1991, the health status of the country continued to deteriorate. The IMR had risen by 13%, reaching an estimated 21.4 deaths per 1,000 births in 1993. Severe outbreaks of measles and diphtheria occurred in 1994 and tuberculosis turned into a serious threat among the population. The MMR likewise increased, due to an increasing number of home deliveries. Death caused by cardiovascular diseases increased by 35% and the overall age-adjusted mortality rate rose by 18%.

The table below shows the situation of Georgia's healthcare in 1995.

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Like all post-communist countries, Georgia suffered from both allocative and technical inefficiencies in its healthcare system. Georgia had over-invested its resources in in-patient care at the expense of primary care and preventative medicine. Healthcare facilities were in critical condition and continued to deteriorate. Over half of the healthcare facilities had been built before 1940. Instead of upgrading or even maintaining these facilities, the government allocated funds towards the construction of new facilities. In 1988, 115 facilities were under construction; most remain unfinished today.

The lack of necessary medical equipment became an acute problem in the pre-reform years. Misuse of human resources also contributed. Georgia had over 120,000 persons employed in the health sector. The density of doctors was one of the highest in the world: 1 physician per 197 inhabitants. Under-trained, under-utilised and inadequately managed healthcare professionals greatly inhibited the efficiency and effectiveness of Georgia's healthcare services.

All of these factors brought Georgia to the point where its healthcare system

had to be reformed.

## III Georgia's Healthcare Reform

### A. Preparatory stage

The Georgian Healthcare Reform package (GHR) launched in 1995 was actually designed in 1993. It took almost two years to complete the conceptual framework and draft the implementation plan. The principles of the GHR were designed in close co-operation with World Bank experts, who held a number of conferences and workshops.

It is important to mention the main players involved in the overall design and implementation of the GHR.

**Ministry of Health** (MOH) is the overall administrator of the GHR. It has the authority to define and design policy issues and monitor the implementation processes. All major decisions are made by the MOH with a little input from non-governmental organisations (NGOs). The reason for the small input from the NGOs has more to do with their lack of capacity than anything else.

*Ministry Departments.* The departments within the Ministry of Health are responsible for developing policy frameworks within their sectors, presenting them to the Ministry and Georgian government for approval, and then implementing all decisions.

*National Health Management Centre (NHMC).* The NHMC is one of the most important players. Although an independent public body, the NHMC falls under the Ministry's supervision. The NHMC is actively involved in policy design and implementation through its affiliates in the regions.

*State Medical Insurance Company (SMIC).* The SMIC is a separate government entity established according to the laws on medical insurance. It collects the mandatory healthcare premiums and finances state programmes. It is an independent governmental agency but with close connection to the MOH.

*Academic and Research Institutions* affiliated with the MOH carry out various tasks assigned and financed by the MOH.

**World Bank** has the co-ordinating role in the whole reform process. It funded the initial preparatory stage of the reform and continues to provide technical assistance throughout the implementation period. Recently, the World Bank initiated the design of the second stage of reform. The World Bank also provides direct financial and technical assistance to various medical facilities and institutions in the country.

**WHO** mainly provides technical assistance to the MOH. Its financial support is minimal compared to other donors. WHO, in co-operation with MOH and the Georgian government, is currently working on designing the National Healthcare Policy, which is expected to be out by 1999.

**UNICEF** is an active advocate for the improvement of maternal and child healthcare. It operates under its Country Programme for Co-operation 1996-

2000, along with the MOH and Georgian government, by providing technical and financial assistance to the MOH.

**Other UN Agencies.** UNFPA finances and implements a reproductive healthcare programme with its local counterpart, Jordania Research Institute of Human Reproduction. UNAIDS provides support to the AIDS Centre. UNDP provides assistance within the context of its mandate. By addressing issues of vulnerable groups, UNDP indirectly assists the implementation of the GHR.

**Other Bilateral Donors.**

## **B. Legal base**

Another main facilitator in launching the GHR was the legislative base. Legislation passed in June 1995 laid the ground work for the GHR by adjusting several components connected to the healthcare organisation within the country. The legislation created the justification for:

the improvement of programmes focusing on preventive medicine, a reduced need for state financing of clinics and a focus on strategic planning, monitoring and policy adjustment by the MOH;

the separation of budgets and funding by creating a State Health Fund and regional agencies financed by the government, municipal contributions and a wage-based social security tax;

the self-management of hospitals with all costs covered by self-generated revenues;

the allocation of municipal funds based on population size; and

the legitimisation of direct, out-of-pocket payments from consumers to providers, enabling the privatisation of healthcare and the regulation of importation and distribution of pharmaceuticals.

There were a number of decrees issued prior to launching the GHR.

Decree 400, issued by the president and later ratified by parliament in 1994, was the first step towards reforming the healthcare system in Georgia. It shifted Georgian healthcare from a centrally controlled system, financed entirely by state revenues, to a decentralised system, financed at the municipal level. The decree established 12 healthcare regions and created new regional hospitals, providing tertiary level in-patient care, and regional healthcare funds, responsible for ensuring adequate service to the public and for processing and auditing insurance payments from providers.

Six decrees from the cabinet of ministers on the implementation of the GHR were issued in June 1995.

Decree 390 on the composition and implementation of state healthcare programmes included five components: a) public healthcare programmes financed by the state: namely, immunisation, healthy children and safe motherhood, prevention of communicable diseases, in-patient treatment and health awareness programmes; b) a State Health Fund budget plan for 1995; c) a basic municipal healthcare package; d) the reorganisation of the



regional and municipal healthcare administrations; and e) the organisation of regional and municipal healthcare funds.

Decree 399 defined the role of the MOH in the reorganisation of the healthcare system.

Decree 389 called for the dismantling of the MOH's Sanitary Epidemiological Department. The Department of Public Health would be created to take over the healthcare services formerly provided by the SanEpid Department.

Decree 392 called for the privatisation of healthcare institutions by either letting employees buy a share in the institution or by auctioning the institution off to the highest bidder. The institutions were grouped into three categories: a) those that would keep the in-patient profile during the next 10 years and would carry out state policies; b) those that would maintain an out-patient profile for not less than 10 years; and c) those that would be privatised without any limitation.

Decree 388 on the future development of the pharmaceutical sector established mandatory licensing for importing, distributing and selling pharmaceuticals. It also created registration and quality assurance mechanisms for all pharmaceutical products and pharmaceutical-related activities.

Decree 391 on the financing of the State Health Fund included a supplement describing the rules for the collection of a 3% payroll tax from employers and 1% from employees, which would be one of the main sources of funding for the basic healthcare package.

Decree 269, issued by the president in July 1995, established another set of policies to improve the healthcare system in a market economy. This decree included some key changes.

All the healthcare institutions would become administratively and financially autonomous from the state budget. The Ministry of Finance would cover all debts of former public institutions. Every institution would have to be registered with the MOH.

The basic healthcare package, sponsored by the state (through municipal budgets and the State Health Fund) would include: maternal and child healthcare including every type of delivery, emergency care for children 1-15 years, care for veterans and the population under the poverty line, prevention of communicable diseases, including AIDS and STDs, critical and urgent care, in-patient and out-patient care for tuberculosis and mental health problems, insulin for insulin-dependent patients, pain relieving drugs for oncological patients, and medical care for victims of disasters and epidemics.

The MOH would select the healthcare institutions to provide free healthcare to the poor according to the poverty line and vulnerability scale designed by the Ministry of Labour and Social Protection.

The MOH would guarantee the quality of medical care through licensing and accreditation programmes for staff and institutions, including quality control, registration and licensing of drugs and medical supplies.

Decree 351, issued by the president on 13 September 1995, provided for the creation of a State Social Insurance Company for medical personnel. It also instituted the municipal obligation to pay 90% of the cost for such services to the healthcare facilities in their areas.

The Law on Medical Insurance enacted by parliament and signed by the president on 18 April 1997, provided the legal basis for the transformation from state coverage of healthcare to medical insurance coverage. The law defined a legal, economic and organisational basis for medical insurance in two forms, compulsory and voluntary.

Compulsory medical insurance collects payroll taxes and receives revenues through budget transfers, which are defined by the Law on the State Budget. The SMIC is responsible for funding state programmes, including insurance programmes, and for implementing the compulsory medical insurance. Tax contribution is mandatory for all citizens and residents of Georgia. The SMIC only covers the cost of medical services that are provided by state programmes and that are guaranteed to the public.

Any insurance company, private or public, can carry out voluntary medical insurance that is:

- registered in the country of Georgia in accordance with the Entrepreneurial Law;
- is allowed to carry out insurance activities in the country; and
- has a registered medical insurance programme with the MOH.

### **C. The concept of reform**

The list below describes the main characteristics of the GHR.

#### **NEW CRITERIA FOR GEORGIA'S HEALTHCARE SYSTEM**

- Must be in accordance with the strategic direction of the economical development of the country.
- The volume of work must be balanced with required facilities and human resources.
- The system must be well controlled and aimed towards the rational utilisation of resources.

#### **MAJOR DIRECTIONS OF THE REFORM**

- The creation of a legal basis for the new healthcare system.
- The decentralisation of healthcare management.
- The innovation of new financial and economic foundations for the healthcare system, including instituting programme-based funding.
- The precedence of primary care.
- The dismantling of the Sanitary-Epidemiological Department.
- The transition from state-funded healthcare to the principles

of medical insurance coverage.

- The creation of a medical insurance programme for healthcare employees.
- Reform of the drug policy.
- Support for the privatisation process.
- Regulations for accreditation and licensing of all medical institutions and personnel.
- Reform of medical education.
- Reform of medical science.
- Reform of the healthcare information service.

## IV Implementation of Reform

### A. Existing environment

It is important to describe the social, economic and political settings in which the GHR was introduced. Having a clear picture of the socio-economic and political trends in 1991-1995 will enable a better understanding of the GHR in general.

1994, just one year prior to introducing the GHR, could be considered a turning point in Georgia's recent history. In early 1994, the country focused on rebuilding its economy, restoring macroeconomic stability and fostering the resumption of growth. The World Bank and IMF assisted this process. As a result, the first signs of macroeconomic stabilisation became noticeable. The country had made important advances: the monthly inflation rates in April and May of 1995 were below 1% and the exchange rate of the newly introduced currency, the Lari, to the US dollar was stable.

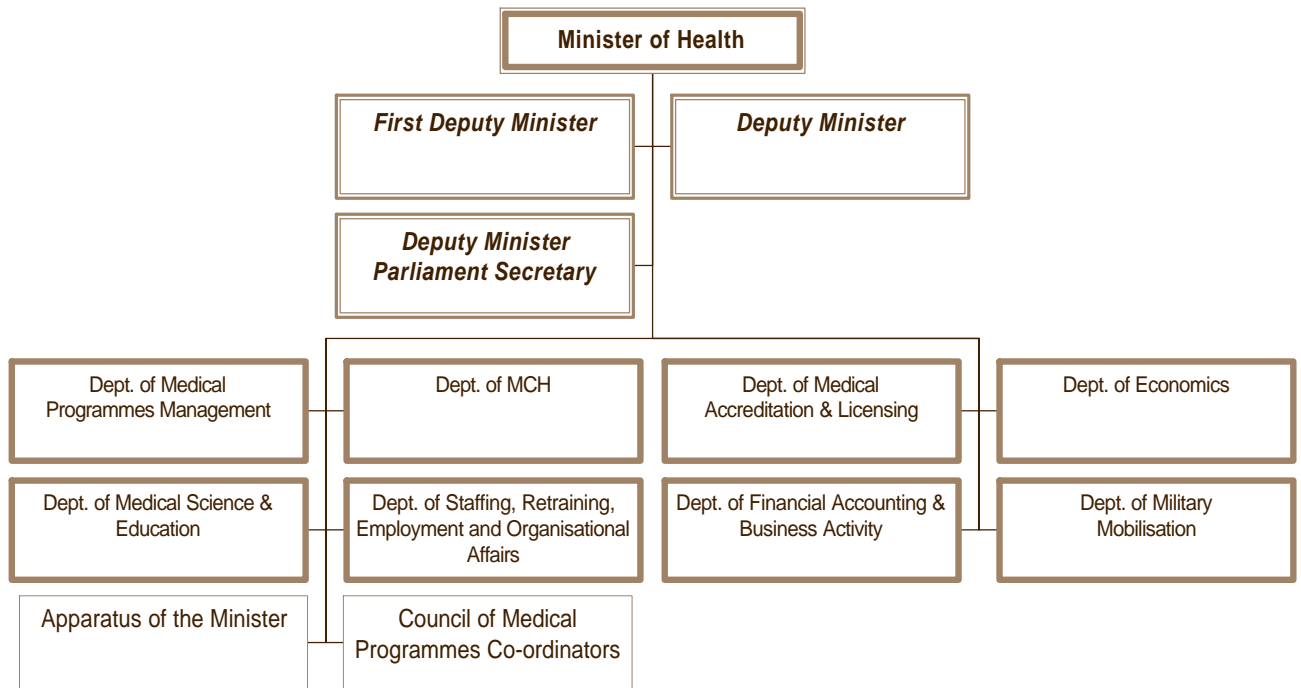
A new constitution was enacted in 1995 followed by parliamentary and presidential elections. The constitution established a form of asymmetric federalism in the country. The Georgian constitution, similar in many respects to that of the United States, was based on a strong presidency elected every five years by popular vote. The constitution also established a strong judicial branch. The Constitutional Court consisting of nine judges—three appointed by the president, three by parliament and three by the court itself—had broad powers as adjudicator between state bodies and reviewer of legislation.

In addition, the post of public defender was created. The public defender, elected by parliament for a five-year term, was mandated "to defend human rights and freedoms".

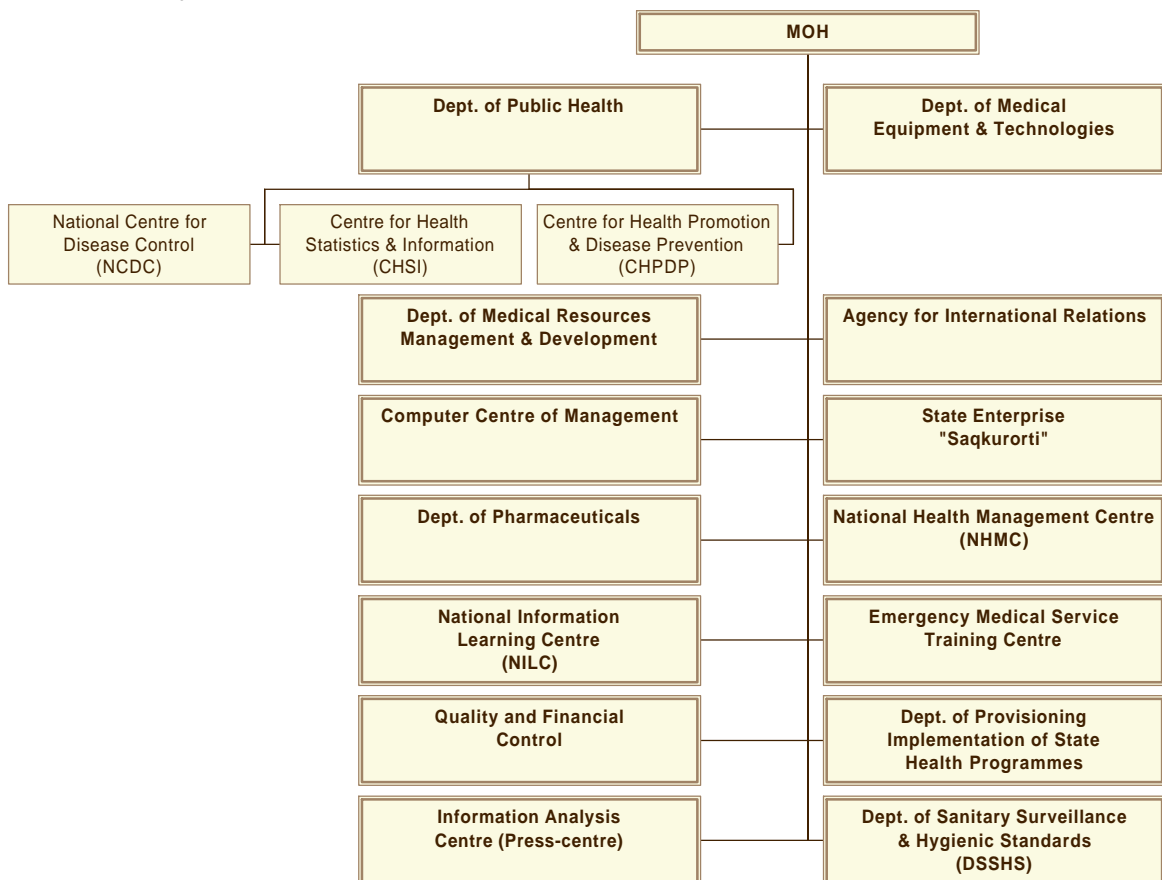
The central government exercises greater power than the local authorities. The debates and hopes on the decentralisation of power and democratisation of local governance came to an end after parliament passed the Law on Local Governance that enabled the president to appoint governors and mayors.

### B. Healthcare Decentralisation

The first step in reform was the decentralisation of the administrative body of healthcare system. All the policy documents produced since launching the GHR established the precedence of decentralisation. As shown below, the newly established structure of the Ministry, in essence, concentrates most of the strategic tasks under the purview of the MOH.



The figure below reflects the healthcare administration at the central level of the Ministry.

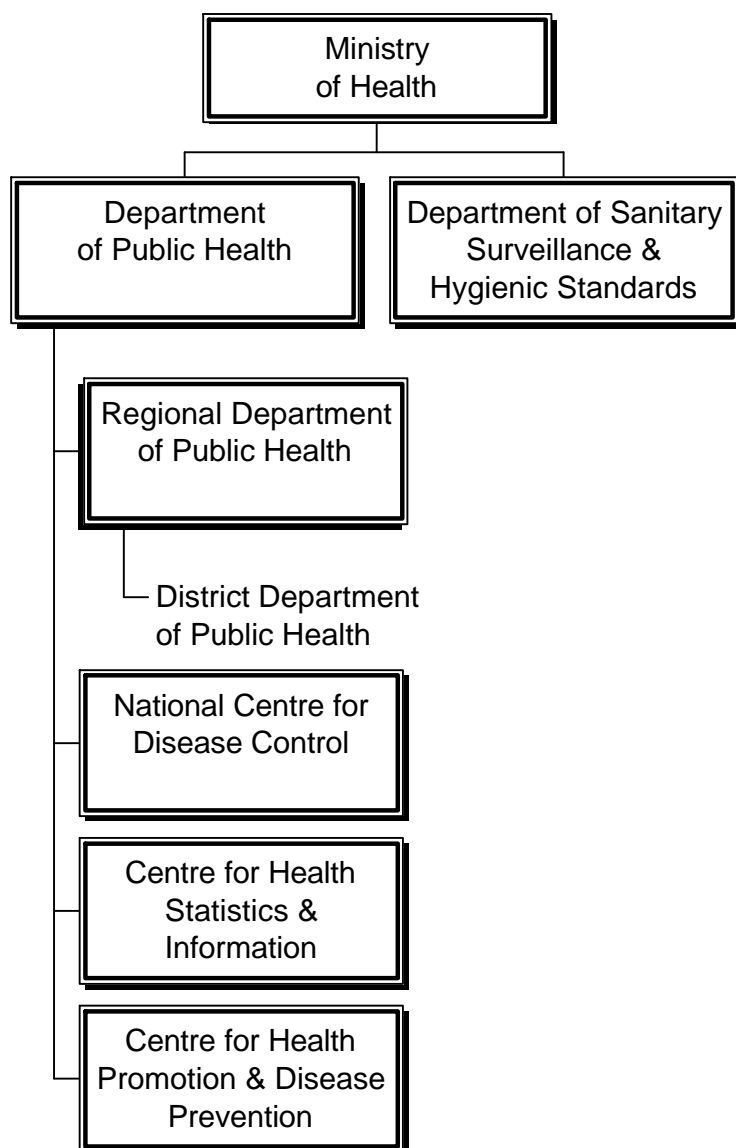


At the central level of the Ministry, the trend towards specialisation of functions is obvious. The Ministry is slowly assuming all the regulatory and policy-making roles, while few other agencies are performing equally specialised tasks.

There are several achievements that should be mentioned, though. Decentralisation of the Ministry's functions allowed for the creation of one of the most important bodies towards the implementation of the GHR. Since the structure of any organisation should be designed in response to a given strategy, one way of evaluating the current structure is to assess how well it responds to the needs created by reform. It quickly became apparent during the reorganisation of Georgia's healthcare system that the functions of the former SanEpid Department would have to be divided between two new departments, the Department of Sanitary Surveillance and Hygienic Standards (DSSHS) and the Department of Public Health.

The Department of Public Health (DPH) is supervised by the Deputy Minister of Health and has three sub-departments: a) the National Centre for Disease Control, b) the Centre for Health Promotion and Disease Prevention, and c) the Centre for Health Statistics and Information. The DPH, which has branches in all 12 healthcare regions and provides some services at the

**Figure IV-10 Organisational Structure of DPH**



district level, is responsible for the analysis and management of the epidemiological situation in the country, for organising, co-ordinating and implementing public healthcare measures for the prevention of diseases, for reducing disability and premature mortality, and for promoting healthy lifestyles. The DPH has also been granted the authority to supervise the healthcare information system, to guarantee the epidemiological surveillance, to organise state, regional and municipal programmes for health promotion and disease prevention, and to ensure international co-operation in these areas.

The DPH implements its activities through its sub-departments. The National Centre for Disease control is responsible for the implementation of anti-epidemic measures, preventive healthcare

measures, and curative care in the case of extremely dangerous infectious diseases. The Centre for Health Statistics and Information is in charge of collecting, compiling and analysing health statistics to be used in the formulation and evaluation of healthcare policies throughout the country. The Centre of Health Promotion and Disease Prevention has been established recently and exists only in theory.

The flowchart (see Figure IV-1 above) reflects the structure of DPH.

Another step in the right direction was the creation of the Department of Sanitary Surveillance and Hygienic Standards. The DSSHS was established in 1996 and assumed the majority of responsibilities from the former SanEpid Department. The DSSHS is an independent public agency. The central unit, called Central Inspection, is in charge of communal hygiene (potable water, soil, sewage, refuse collection), nutritional hygiene (food, food production and restaurants), child and adult hygiene (children's education and recreation), and occupational hygiene (occupational health and work safety). The DSSHS also consists of the Unit for Certification of Enterprises which is in charge of certifying public and private organisations, corporations and enterprises in compliance with sanitary regulations, defining public health regulations and standards and enforcing them (inspection), and controlling the international spread of infectious diseases (quarantine).

The National Health Management Centre (NHMC) is another major player in Georgia's healthcare system. Established in March 1995, the NHMC was mandated to co-ordinate medical and nursing education, create a system for licensing and accreditation for healthcare professionals and training institutions, and to develop post-graduate medical and nursing curricula. The NHMC is also the think-tank on further healthcare reform.

As mentioned above, the very first step made during the reform was the restructuring of the administrative body of the healthcare system. The new structure of the Ministry is modern and seems to be more mobile and responsive towards the country's healthcare needs than its predecessor.

Nevertheless, though the current structure has combined strategic and operational tasks, during recent years it has become obvious that there has been a noticeable lack in the management of either task. To some extent, the decentralisation of the MOH could be a threat to successful implementation of the GHR. Instead of a technically strong and unified Ministry, there is a union of various autonomous departments, each with separate funding and broad authority. This threat becomes obvious when it is observed in the context of available human resources. Facing major changes in the health sector, while maintaining (or trying to maintain old command and control) mechanisms of management old functioners threaten the success of the reform. Training-retraining of managerial human resources, was/is partially addressed under the World Bank supported project, but reality proves that this need still remains and should receive more attention.

The lack of public healthcare professionals could be another threat to the

reform. The healthcare administrators at the ministerial level in the Soviet republics never had any decision-making authority. Complex training in public healthcare administration is necessary among the current Ministry staff to ensure the successful continuity of the reform process.

## **C. Healthcare Organisation and Financing in Georgia**

### **IV.C.1 Organization of the Health Care System**

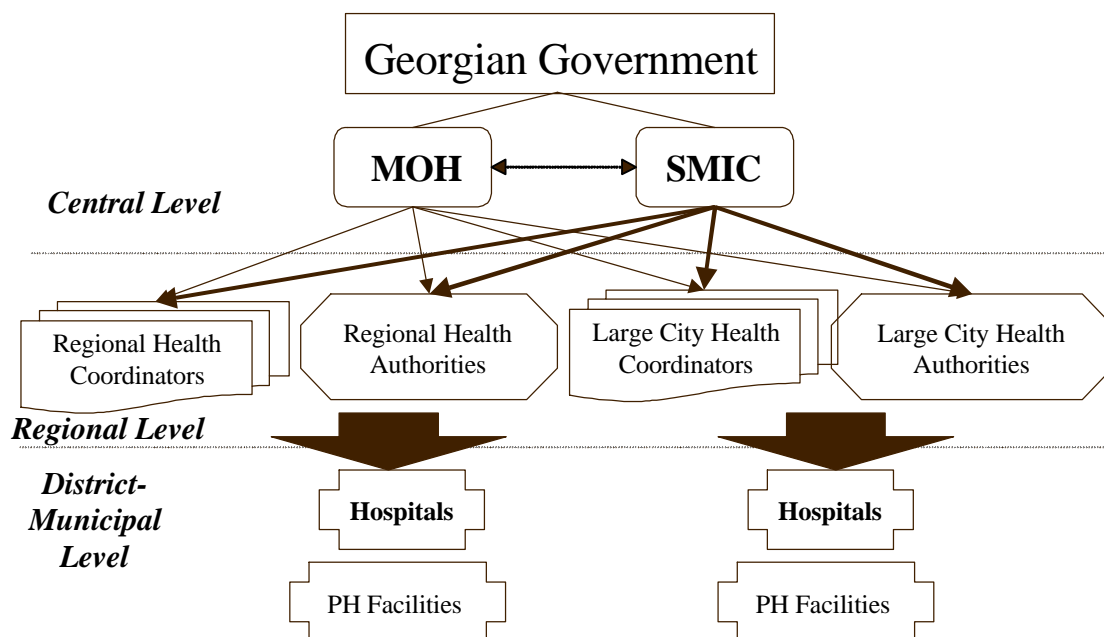
Reorganisation of the MOH was an expected outcome of the GHR according to the terms of the Georgia Health Project. It can be considered both as a means to and a result of the reform process.

Despite recent decentralisation of the healthcare administration, the MOH still maintains control over lower levels of the administrative structure by means of legislative and financial mechanisms. Also *de Facto* command-control style of management still has power under existing circumstances and is still widely applied by healthcare officials. This helps the MOH avoid unexpected and undesired initiatives from the regions. The most prominent drawback of such centralisation, though, is that the periphery has no incentives or means to drive reforms. They must follow directives and accept regulations, seemingly arbitrary at times, imposed by the central government.

The MOH tries to delegate almost all administrative and financial as well as certain decision-making responsibilities to the lower levels of the administrative structure. The MOH is probably among the few agencies within the government that really wants to retain its policy-making function and get relief from its administrative function. But surprisingly, recipients are reluctant to take on additional responsibility. Thus, the delegated responsibilities halt somewhere along the administrative axis. Perhaps low-level administrators suppose that the delegated duties are not congruent, or they feel they don't have enough capacity at present to handle the reorganisation of authority. The figure below shows the current healthcare administrative structure of Georgia.



Figure IV-2. Administrative Structure of Georgia's Health Care System



At the regional level, the policy framework proposes the transfer of state (central) responsibilities to the regions, following the current political organisation of Georgia. This transfer does not amount to much, since there is very little communication or co-operation between the municipal-regional healthcare facilities and the municipal-regional governments. It is notable that under the budget law (and based on the reform policy) local (municipal) governments should assume certain financial responsibilities for their populations health care. However, reports prove that municipalities are not willingly contributing to health budget of their cities. Local healthcare Authorities having no legal power or responsibility to demand the health dollars from municipalities can not resolve mounting problems in their designated areas. The Ministry of Health has begun to address this problem by creating regional healthcare co-ordinating bodies, these bodies should be responsible to collect health money from municipalities, allocate resources available to the region based on the needs and finance and monitor health service delivery. Even though the latter seems the solution to the existing problem, it is doubtful that under existing local governance in Georgia, regional health-care co-ordinating bodies could be effective. Nor only they lack the legal power to fulfil their tasks, but also they need skills and technical assistance from the center, which is doubtful to come.

The influence of the MOH is most strongly felt in the capital. Consequently, the city health department formally in charge of the administration of public healthcare programmes stays in the shadow of the central authorities. The MOH makes most decisions and conveys them to the city authorities. The city health department finds itself more preoccupied with implementation than policy-making.

A kind of constructive competition is present between Tbilisi's healthcare authorities and the regional healthcare authorities. In distinction from their colleagues in the capital, the regional healthcare authorities in western Georgia, particularly in the Imereti region, are more proactive and

demonstrate a more creative approach to the realisation of municipal and state programmes.

### **IV.C.2 Health Care Financing**

The role of the central government is even stronger when it comes to financing healthcare. The established tool for funding healthcare is the State Medical Insurance Company, the independent body that collects healthcare payments and funds state healthcare programmes.

To have a better understanding of the changes in healthcare funding, it is necessary to review the former financing schemes. The Georgian healthcare system was totally financed by the central (Soviet) budget. A certain portion of the budget was devoted to healthcare needs; and only in 1980, at the first signs of the Soviet recession, the budget for healthcare started to decrease. During the communist rule, healthcare funding resembled general taxation. There were no special taxes (corporate or payroll) dedicated to healthcare.

The well-known "Medical Insurance and Social State Fund" caused a lot of misunderstanding. The fund collected (and still does) a significant portion of payroll taxes—up to 37%. The accumulated resources were dedicated to pensions and other social benefits and to the healthcare of special groups inasmuch as a healthcare component was included in their social benefit packages. (The fund caused even more confusion when the State Health Fund was created in 1995. Despite the fact that the SHF was an independent body, it was always associated with the MOH.)

Employer and employee contributions were collected by the trade unions, contributing to the overall healthcare budget. Allocations from various ministries and enterprises were another form of contribution to the healthcare budget. Some big factories such as the steel industry, or state departments like the Railway, possessed their own healthcare infrastructure formally separated from the MOH. All of these entities, however, were funded from the central budget. Thus, their contributions to the healthcare budget should not really be considered as alternative sources of funding.

The expenditure structure and reimbursement schemes were very simple. All expenses were covered by the approved budget. Healthcare authorities carried out the budgeting of costs. The budget depended on the fixed capacity of the institution: the number of beds in the case of a hospital, or the number of population served in the case of an out-patient clinic.

The GHR was the means for a new way of healthcare funding in Georgia. There was a transformation from centrally budgeted healthcare to a more flexible, performance-oriented and efficient financing system, allowing for more practical allocations of public resources.

According to the concept of the GHR, the state will strive to balance the existing healthcare demands and the available public healthcare resources during the transition period. In other words, the state will try to meet the public's demand as much as given funding allows. What kind of strategy and implementation mechanisms the State selects to achieve the highest efficiency is subject for future discussions. But yet Georgia had chosen the

social insurance scheme for health care financing. This scheme has been known as Bismark Model and has been chosen by many Eastern European and CIS countries. However, in Georgia it has major specificity: Social Insurance and Health care in Georgian context are viewed separately by almost everybody in the country. Georgia has separate ministries for social welfare and health care, they both have funds, which are formed with payroll tax and on top of everything they bear almost same names. Their separate existence is further complicated by the lack of co-ordination and co-operation which is observed in all levels of executive branch of the government.

The flowchart below presents the new healthcare financing system in Georgia.

**Error! Objects cannot be created from editing field codes.** The population should cover the price of medical services that fall outside of state-guaranteed healthcare programmes. This can be achieved by either out-of-pocket payments or third-party payers.

The state considers several sources for public healthcare funding: special healthcare taxes (3%+1%), budget subsidies, humanitarian aid and revenues from the privatisation of healthcare institutions.

The role of the government is very important to the financing of healthcare. Not fulfilling its responsibilities, which has been the case in past years when the state was unable to cover the costs incurred, is negatively affecting the reform process.

The government possesses three major functions:

- Regulatory—setting up the rules for collecting, accumulating and allocating public healthcare funds.
- Financial—setting up the mechanisms for reimbursements and the rates for medical services.
- Beneficiary—delivering state-guaranteed healthcare through state-owned and self-managed healthcare institutions.

The local government acts in accordance to the mechanisms set by the central authorities.

The other problematic side of the healthcare finances could be the growing healthcare expenditures on the national level. The preliminary national health expenditures show national spending of 313 million GEL in 1997, out of which 87% percent is out-of-pocket spending. The apparent extent of catastrophic expenses associated with the lack of pooling mechanisms is substantially noticeable. Based on the UNICEF 1997 survey, the most expensive 2.5% of all households on average spent over 2800 GEL, representing 40% of total out-of-pocket expenses. Reducing the large expense burden by pooling based on some form of public program would require substantial increase in the proportion of national health spending through the government channels. The state yet is not in a position to address this problem. The current national government system works through the State Medical Insurance Company (SMIC) to provide curative

#### **IV Implementation of Reform**

treatment for vulnerable groups and children of 0-2 years of age, as well as obstetrics treatment for specific diseases. The emergency cases are addressed by the municipalities through their health programs.

However, both federal and municipal programs are seriously underfunded due to the low tax revenues and lack of emphasis placed upon the health care in the governmental finance system. In 1997, SMIC received only 60% of expected revenues.

The main “trick” of the proposed health care financing and reimbursement scheme is the so called cost-sharing on end users (consumers). The point is that even if state programs (either federal or municipal) were fully funded from the budget, end users have to cover significant portion of health care costs at the point of receiving services. Thus, the fact that 87% of national health care expenditures are out of pocket payments is due to the implicit and explicit cost-sharing elements of the health care reform.

Explicit cost-sharing mechanism shifts a half of financial burden of municipal programs on consumers. That is, when a citizen receives medical services under municipal program, he/she has to pay 50% of hospital fees while another half is covered by municipalities. I.e., if the cost of municipal health programs for hospital care was estimated to be 15 million GEL, the population is automatically exposed to the same volume of out of pocket expenditures.

However, the major portion of out of pocket expenses come from implicit cost-sharing element of the reform. The state's approach in benefit package design is based on the selection and coverage of justified (rational) medical services for essential health problems. The list of the approved medical interventions (procedures) are reflected in state medical standards. However, as a matter of fact, the medical practice is not organized and regulated by medical or professional bodies. As a result, a citizen with health problems covered by state programs usually is exposed to the medical services above the state standards. Consequently, those (above the standard) service costs are paid by the patient which is not in a position to judge, whether those services were needed or not.

Another contributing factor to implicit cost-sharing is under-rating of medical procedures/services within the state standards. The prices set by the government in most cases do not reflect the real/actual costs of services. As a result, the money paid by the state to health care institution for a single case can hardly cover the real costs even in when the management is appropriate in the institution. The only way the institution can compensate the difference between the actual costs and preliminary “agreed” rate is to inquire direct payment from the patient/consumer. Usually, those out of pocket payments are not registered.

The rate setting practice for the state standards is asymmetric and unfair: it only reflects the interests of payer, not of the provider. The payer (federal or municipal) is interested in getting more (of acceptable quality) for less price in order to fulfill the obligations proposed by the state. Health care providers have no means to negotiate rates and their natural reaction to restore “the

justice” is to charge patients. It is obvious that patients/population suffer the most out of this chain payer – provider – consumer. They are not able to shift those hidden costs to anybody.

The difference between actual costs and service rates is furthermore aggravated by several “illnesses” inherited by the majority of state owned health care institutions. Excess capacity, both in terms of capital assets and human resources, makes impossible the cost-efficient operation of health care institutions. Lack of experience of the management at any level of administration within the medical organization couldn't assure that the medical institution meets their total financial requirements.

On the other hand, the number of medical institutions “competing” for the state money (and patients) is so high, that none of them (except of specialized institutions) are loaded adequately (especially in the big cities). Because of the low level of operation the portion of fixed costs allocated per unit of service (either admissions or hospital day) is incredibly high and is not addressed by any governmental payment. Deterioration of capital assets owned by the state will have the logical long term negative consequence if not addressed promptly on a macro level. Replacement cost of those devastated assets after certain period will be unaffordable for the owner. Depreciation costs are not accumulated somewhere: either at the state or institutional level.

The lack of risk pooling and the high level of out-of-pocket expenses makes impossible for the government to exercise control over the system. Until more government and private third party financing develops, it will be hard to implement efficiency improvements and illegal payment reductions.

The government is exploring new policy options to improve the sustainability and fiscal soundness of the healthcare financing system, while addressing both risk pooling and control. The reforms made in recent years have not yet fully worked their way through. The financial and organizational difficulties of past years are declining and overall government spending is increasing. Beyond efforts to improve efficiency in the health care delivery system, there is a strong interest in exploring the implications of broader restructurings, especially with respect to stronger coordination of public financing of health care with much larger private channels of payment.

#### **D. Privatization Issues**

In 1998, the Ministry of Health launched the study to assess the medical facilities in Georgia in order to proceed with the privatization process in health system. The goal of the mentioned project is to move from a centrally administered and budgeted health care to socially oriented health care system with more optimal collection and collation of resources. To improve quality, efficiency and effectiveness of the health services. To increase the cost-efficiency of non-public spending on health through the introduction of complementary or supplemental risk pooling mechanisms. The work has started to assess in total of 274 in-patient clinics that are under the jurisdiction of the Ministry of Health. This number does not include the specialized facilities that are under various ministries (Railroad, Ministry of

#### **IV Implementation of Reform**

##### D Privatization Issues

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Defense, State Security, etc.)

The objective is to develop a hospital sector restructuring plan in order to reduce excess capacity in secondary and tertiary level of care and optimize the national network of health facilities. The outcome will be the to determine the category of the health facilities that would: 1) remain in public ownership (under MoH); 2) be liquidated as a health facility; 3) consolidated with other facilities; 4) privatized.

This effort will result in reducing the number of medical facilities and staff. Even at the very first stage the ministry is facing the obstruction from the head doctors. The staff is concerned about the future reductions and it will be very difficult for the Ministry to undertake the privatization process.

## V Health Care Reforms – customer’s perspective

### A. Introduction

The ultimate goal of any health reform is to improve the nation's health. Population has to benefit in short and long run from proposed changes. However, that is not always the case, especially in developing countries. Long term success of health care reforms often requests the short term benefits to be scarified. If those short term losses are inevitable, the overall success of health care reforms should be measured by the extent to minimized or made less painful immediate drawbacks of reforms for population, especially for vulnerable groups.

Opponents often refer to adverse effects imposed by health care reforms. However, blaming the team of reformers only in the occurrence of unavoidable adverse effects makes no sense. Unfortunately opponents do not suggest practical scenarios which could minimize those adverse effects if incorporated in the implementation of health reforms.

In this chapter we try to highlight several omissions of the implementation in regard with social impact as well as certain contingencies specific for the country.

### B. Customers of Health Care Services in Georgia

It would be noteworthy to characterize in brief Georgian customers before we describe Georgian customers’ perspective on health care and health care reform.

Georgian customers are similar to the customers of health care services in any part of the world. They face same problems or disadvantages, like asymmetry of information between a health care provider and a consumer. Consumption of health care services is determined by provider-driven demand as well as several cultural factors.

On the other hand health care consumers in Georgia are different from other nations, especially of developed countries. Because of its past - the absence of any form of market relationships – Georgia inherited generations which are far from standard definition of a customer in the Western countries.

Customers in Georgian do not know their rights. In any sector of the market they are more passive consumers of services and goods, then active players on the market.

The term “quality of care” or “proper medical care” which is vague for consumers even in Western countries is absolutely abstract in Georgia. It is substituted by traditional believes and consumption patterns, which contradicts with any rational scheme of utilization of health care resources. The unjustified usage of antibiotics can serve as good example. Several studies revealed incredibly high usage of antibiotics – up to 90% for such a common health problems like acute respiratory infections. Despite of coordinated efforts of the government, donor community (UNICEF, USAID,

etc.) and NGOs (IFRC, UMCOR, etc.) targeting both providers (physicians in outpatient and inpatient clinics) and consumers (parents, households) this indicator was decreased only to 65% in certain cases. The resistance of population was recognized as a main obstacle toward rational usage of antibiotics after the education/training of physicians.

In a country with scarce resources as Georgia, irrational consumption pattern of health care services becomes critical factor in the efficient distribution of national health care resources (both public and private).

### **C. Public attitude to health care and health care reforms**

Everybody agrees, that public attitude toward health care reforms in negative.

However, the worth of this negative opinion becomes questionable considering the level of public awareness of health care reforms.

Several independent social studies revealed, that the great majority of population which used medical services has no idea, what is provided by state health programs. So the part of the population who was supposed to benefit from state programs didn’t realize the existence of those benefits although all of them received them. One can argue that this happens because the benefits are not tangible or valuable. But it is unlikely not to recognize the benefit when one pays 100 GEL for hospital care knowing that another 100 GEL is covered by the state. Unfortunately, most of beneficiaries are not aware of this “invisible” contribution from the State. They are exposed to direct out-of-pocket payments: partially legal, partially informal at the point of service. The overall impression often is that the customer is left face-to-face to all health care costs. And regardless of the fee volume the citizen doesn’t feel state’s support: neither financial, nor organizational or legal. After this kind of experience why one should expect positive attitude of the population toward changes in health care?

Why customers are not informed about the basic principles of health reforms? Because of the lack of experience to do so or because of the ignorance of its importance?

Are health care professionals or organizations interested to deal with informed patients/customers?

Those and many other similar questions are not properly addressed yet. The fact is that the Ministry of Health recognized the importance of social marketing: to help people to get maximum benefit out of what is proposed by state; to escape the unfavorable (and unfair) position of the target of all sort of blames regarding the problems in health care, to make the process of health reforms more transparent and understandable not only for population, but for health care professionals too.

### **D. Customers’ Rights**

Reviewing the achievements and failures of health care reforms it is impossible not to ignore crucial moment: enactment of the Law of Georgian



on Health Care. The Law covers almost all aspects of health care creating good basement for legislative activities in specific directions.

The biggest innovation the Law proposes is reflected in Chapter II. Citizens’ Rights in Health Care.

Never before citizens of Georgia have such rights consistent with the best traditions of Western countries. But only a few patients use these rights. The simple explanation is that neither population nor health care professionals are aware about them!

As a matter of fact, the Law doesn’t work yet. And, unfortunately that’s true regarding other basic laws enacted recently. To build up a civic society needs time and multiple efforts of the government, community organizations and individuals. There is enormous room for non-governmental organizations, donor community and mass media to foster this process.

Patient’s advocacy doesn’t exist: there are no third-party payers (insurance carriers) or non-governmental agencies actively involved or interested in this field. As a result, despite of obvious violations and unfair treatment of citizens in health care system it would be very hard to recall a precedent of law suet.

## ***E. Conclusion***

Health care reform in Georgia implicates the establishment and development of health care market.

Each player in the health care market: the government, health care providers and community has its ultimate role.

The only effort of the government to develop the health care market is insufficient without active involvement of the community (as a consumers and payers) and health care providers.

The major omission of the implementation scenario of health care reforms is that the importance of coherent participation of the community and health care providers has been ignored.

Taking into account the experience of developing countries the government and the team of reformers should be more proactive in the involvement of population and health care professionals in health reforms transforming them from passive observers/beneficiaries into active assistants or constructors.

## VI Summary

### A. Conclusions

In 1995, Georgia made another step towards building a democratic state with a market economy by launching aggressive healthcare reform even though it did not yet have a coherent economic or political structure. Analysis of the reform, after three years of implementation, gives one definite answer: it was necessary and unavoidable. The inherited Soviet system was too costly and almost impossible for a newly emerging country to maintain. The healthcare system on the verge of collapse, it was important that the country realise change was necessary and that the steps being made by the government were extremely important, including the launching of the GHR.

One of the most important steps was to create the legal basis for the GHR. The strategy for the health sector was supported with decrees, resolutions and laws issued by the office of the president, cabinet of ministers, MOH and parliament.

The government also greatly supported the development of a medical insurance market by enacting the Law on Medical Insurance and General Insurance Law. The existing regulatory framework clearly defines the functions and responsibilities of different governmental bodies in charge of the country's healthcare system.

The restructuring of the entire healthcare system, including the reorganisation within the MOH, was also a very important step. New means of financing the whole system were introduced.

It is too early to evaluate the overall success or failure of the GHR; the country has seen both negative and positive trends. The reorganisation has not yet been completely realised nor have the reform policies been fully implemented.

Recently, the MOH, with the support of the World Bank, announced the launching of the second phase of reform called the Georgia Health Project II. The second phase will include analysis of the already implemented reforms and the launching of new ones. The team of experts, including national and international staff, is working on the project document.

### B. Recommendations

When a recommendation has no concrete addressee then it is rather a wish than a practical suggestion. Particularly when one has to target both the conceptual framework and the implementation strategy of the health care reform.

In order to organize "wishes", let put them in order of importance.

On a top level it would be better, if health care reform becomes real priority on a political agenda across and down of government branches: from executive to juridical branch, from central to local (district) authorities.

Without fair distribution of responsibilities for and authority on the implementation of health care reform between the central government and municipalities, between the executive and legislative branches of the government, only efforts of the Ministry of Health are not sufficient to achieve the success.

A team work needs not only clear assignment of roles, but also clear vision of the overall goal and the context. Health care reform needs ideological support. It should be part of the ideological context explaining why and where society moves. The recent draft of the National Policy on Health Care aims at filling this ideological gap, but its unlikely to be effective without overall ideological context.

When the vision of health care reform is formulated, it should be disseminated among all stakeholders: from population to government officials. Somebody can argue that the vision of health care reform exists, at least on a paper like the draft National Policy on Health Care. But it would be very hard to recall any measure or event for its sustainable publicity. So the most critical (and simple!) recommendation is to design and implement public relations programs integrated with social marketing campaign.

If there is an ideological and political consensus, then it makes sense to modernize the conceptual framework. In this regard we could wish the health care reform to equally intervene in public and private sector, setting clear “protection zones” within the public sector, while giving to the rest of public and private health care providers equal opportunity to survive and develop due to efficient operation.

The first requirement to create this kind of environment is a political will. This sort of steps entail certain unpopular measures, particularly among health care professionals. Health care reformers do not lack courage, but need to demonstrate political will making painful, but necessary decisions.

Political will could not originate without public support and activity. Particularly that is true at a regional and municipal level, where electorate and authorities, or consumers and providers of health care at the same time are close to each other. But again, community participation in health care reform will not arise without public relations campaign. That’s another argument in favor of recommending public relations/social marketing as a critical element for successful implementation of health care reforms.

The right social marketing based on proper vision or ideology, setting clear goals and proposing simple implementation strategy can help to overcome many obstacles and drawbacks of the health care reform.

Going back to the revision of conceptual framework, one more general recommendation can be given regarding the financing and reimbursement of health care services. As it was described in corresponding chapters above, the design of health care financing in Georgia reassembles a mixture of general tax based and social insurance based models. In both alternatives there is a long route from the money source and destination point. This route needs to be simplified considering specifics of Georgian tax payers, consumers or purchasers of health care services. In other words, the

process of paying for health care, or purchasing health care services should as short and transparent, as possible. Direct group purchase of health services (or health care coverage through public or private insurance programs) doesn't mean to sacrifice such an important value like solidarity. In contrary, it will make more clear what is paid for personal benefit (through direct purchase of coverage) and what is contributed for solidarity to common public pool (either through social insurance or via special taxes). A group purchase mean when certain number of citizens, either employees or community in a village collect and allocate funds to different insurance carriers (indemnity insurance, managed care plans, preferred provider organizations, health care providers, etc.) getting access to the certain volume of medical care. There are thousands of modifications of direct purchase schemes in the Western countries. The present review does not intend to conduct comparative analysis assessing their relevance to Georgian realities. Many local and international experts are ready to design and propose specific options. For example, six scenarios now are the subject of intensive discussions and studies: 1) Employer Mandate; 2) Catastrophic Insurance; 3) Voluntary Insurance with Expanded Private Insurance and Consolidated Management of Government Funds; 4) Competitive Optional Insurance; 5) SMIC Optional Insurance and 6) Publicly Administered Mandatory Employee Insurance with Voluntary Insurance and Consolidated Management of Government Funds.<sup>1</sup>

Again, the main point is to implement more simple, straightforward and transparent financing and reimbursement schemes, at least until Georgia achieves sufficient institutional development to support more sophisticated European models of solidarity.

The list of recommendations and wishes can be continued with more specific issues covering all aspects of health care reforms, e.g. what should be done on supply-induced and consumer-induced demand, bringing them to more rational and efficient point; what kind of legislative activities are desired to create conducive environment for health insurance and private market; what is necessary to improve quality of care and medical outcomes at institutional or sectoral levels, how to overcome the deficit of proper management at all levels of health care administration, etc. Each of these recommendations deserve more detailed and accurate review. As deep we go down to technical issues, as easier to make wrong judgements and provide less useful recommendations considering constraints and specifics of the current review.

Finally, we believe that full potential of Georgian health care reform is not realized yet. One is clear – doors are open for everybody, for health care professionals, community organizations, professional associations, non-governmental organizations, governmental and international agencies to participate actively and promote health care reforms contributing their unique experience, knowledge and resources.

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<sup>1</sup> The detailed description of those options could be found in “Preliminary Analysis of Risk Pooling Potential in the Health Care Financing System of Georgia, Actuarial Research Corporation, July, 1998”

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