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Georgia

Health system review

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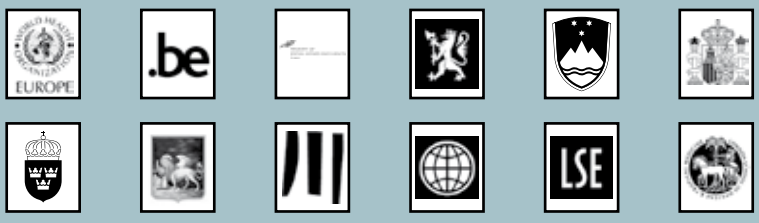

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Preface

The Health Systems in Transition (HiT) profiles are country-based reports that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a specific country. Each profile is produced by country experts in collaboration with the Observatory's staff. In order to facilitate comparisons between countries, the profiles are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a profile.

HiT profiles seek to provide relevant information to support policy-makers and analysts in the development of health systems in Europe. They are building blocks that can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems;
- to describe the institutional framework, the process, content and implementation of health care reform programmes;
- to highlight challenges and areas that require more in-depth analysis;
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries;
- to assist other researchers in more in-depth comparative health policy analysis.

Compiling the profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different

sources, including the World Health Organization (WHO) Regional Office for Europe Health for All database, national statistical offices, Eurostat, the Organisation for Economic Co-operation and Development (OECD) Health Data, the International Monetary Fund (IMF), the World Bank, and any other relevant sources considered useful by the authors. Data collection methods and definitions sometimes vary, but typically are consistent within each separate series.

A standardized profile has certain disadvantages because the financing and delivery of health care differs across countries. However, it also offers advantages, because it raises similar issues and questions. The HiT profiles can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analysis of health systems. This series is an ongoing initiative and material is updated at regular intervals.

Comments and suggestions for the further development and improvement of the HiT series are most welcome and can be sent to info@obs.euro.who.int.

HiT profiles and HiT summaries are available on the Observatory's web site at www.euro.who.int/observatory. A glossary of terms used in the profiles can be found at the following web site: www.euro.who.int/observatory/glossary/toppage.

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The current series of HiT profiles has been prepared by the research directors and staff of the European Observatory on Health Systems and Policies. The European Observatory on Health Systems and Policies is a partnership between the WHO Regional Office for Europe, the Governments of Belgium, Finland, Greece, Norway, Slovenia, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

The Observatory team is led by Josep Figueras, Director, and Elias Mossialos, Co-director, and by Martin McKee, Richard Saltman and Reinhard Busse, heads of the research hubs. Jonathan North managed the production and copyediting, with help from Sophie Richmond and with the support of Steve Still (design and layout). Administrative support for preparing the HiT profile on Georgia was undertaken by Caroline White. Special thanks are extended to the WHO European Health for All database, from which data on health services were extracted; to the Organisation for Economic Co-operation and Development (OECD) for the data on health services in western Europe; and to the World Bank for the data on health expenditure in central and eastern European countries. Thanks are also due to national statistical offices which have provided national data.

The HiT reflects data available in September 2009.

List of abbreviations

ADRs	adverse drug reactions
BBP	basic benefit package
CME	continuing medical education
CoE	Council of Europe
DfID	Department for International Development (United Kingdom)
EC	European Commission
EDPRP	Economic Development and Poverty Reduction Programme
ENP	European Neighbourhood Policy
EU	European Union
GAVI	Global Alliance for Vaccines and Immunization
GDP	gross domestic product
GIS	Geographical Information System
HeSPA	Health and Social Programmes Agency
HSPIC	Health and Social Programme Implementation Centre
HTA	health technology assessment
IDPs	internally displaced persons
MoE	Ministry of Education
MoED	Ministry of Economic Development
MoF	Ministry of Finance
MoH	Ministry of Health
MoLHSA	Ministry of Labour, Health and Social Affairs
MSRA	Medical Service Regulation Agency
NATO	North Atlantic Treaties Organization
NCDCPH	National Centre for Disease Control and Public Health
OECD	Organisation for Economic Co-operation and Development
OPM	Oxford Policy Management
PGCMEB	Postgraduate and Continuing Medical Education Board
PHC	primary health care
PPP	purchasing power parity

SHF	state health fund
SMIC	State Medical Insurance Company
SUSIF	State United Social Insurance Fund
TB	tuberculosis
UNFPA	United Nations Population Fund
USCE	Unified State Certification Exam
VHI	voluntary health insurance
VRF	Vishnevskaya-Rostropovich Foundation
WHO	World Health Organization
WTO	World Trade Organization

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Abstract

The Health Systems in Transition (HiT) profiles are country-based reports that provide a detailed description of a health system and of policy initiatives in progress or under development. HiTs examine different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems; describe the institutional framework, process, content and implementation of health and health care policies; and highlight challenges and areas that require more in-depth analysis.

This report chiefly focuses on developments after the Rose Revolution in 2003, which brought fundamental change to the role of government in providing, financing and managing public services, including health care. Nearly all health care providers are private actors, independent of the state. Much hospital stock has been sold to private investors for redevelopment as modern hospitals. Mandatory social health insurance, introduced in the 1990s, has been abandoned and private health insurance is being promoted as the main mechanism for the pre-payment of health services in Georgia. Private insurance coverage for households living below the poverty line is paid from public funds but all other individuals are expected to purchase cover on their own initiative. Out-of-pocket payments remain the main source of funding for the health system in Georgia, which reduces access to services for much of the population, particularly in access to pharmaceuticals. Overall, health system regulation is rather weak, particularly when compared with the challenges it faces.

Executive summary

Introduction

Georgia has undergone a profound demographic transformation since independence. According to official figures, the population has shrunk by nearly a fifth to 4.4 million, but the United Nations Population Fund (UNFPA) estimates the *de facto* resident population to be 3.9 million due to intense out-migration. There is also a large number of internally displaced persons (IDPs) following conflicts in Abkhazia and South Ossetia. These two regions are now *de facto* beyond the jurisdiction of the central Georgian authorities.

Civil war, rapid marketization and hyperinflation following independence left Georgia in a state of economic collapse, but from 1994 the economic situation improved rapidly; gross domestic product (GDP) growth averaged 9.7% during the period 2003 to 2007, falling to 2.0% in 2008. Nevertheless, a large proportion of the population (officially 21.3% in 2007) is still living in poverty despite the GINI index falling to 36.3 in 2007 from 40.8 in 2005. The Rose Revolution in 2003 occurred, in part, as a response to the shortcomings of the previous government, which had allowed social inequalities to widen. The new government has embarked on a radical reform strategy to reduce bureaucracy and the role of the government in regulating financial transactions in order to combat corruption. Deregulation and trust in market mechanisms are therefore the hallmarks of the new economic policy.

While data must be interpreted with considerable caution, overall health status in Georgia following independence fell and only began to recover at the beginning of the 21st century. While still high in international comparison, maternal and infant mortality rates have been falling as socioeconomic conditions in the country improve. However, infectious diseases, particularly multiple drug resistant tuberculosis, are very significant public health problems.

Organizational structure

In 1991 Georgia inherited an extensive and highly centralized Semashko system, which governments struggled to maintain following independence. Subsequent reform efforts have separated policy-making, purchasing, service delivery and regulation functions in the current system. While the Ministry of Labour, Health and Social Affairs (MoLHSA) formally takes the lead in developing health policy, implementation is constrained as service providers are either wholly private or under the Ministry of Economic Development (MoED) and there has been a considerable deconcentration of regulatory powers from the central MoLHSA to a number of subordinated executive agencies. MoLHSA also manages publicly funded health services provided through the state health programmes, but this accounts for a relatively small share of the health system as services are predominantly financed through out-of-pocket payments at the point of delivery.

Financing

While health expenditure as a proportion of GDP in Georgia has been growing since independence (reaching 8.2% in 2007), health expenditure from public sources as a proportion of total health expenditure was just 18.4%, which is extremely low by European standards. In the same year, 70.9% of total health expenditure was in the form of direct out-of-pocket payments for services at the point of delivery. Since 2008, households registered as being below the poverty line have been entitled to vouchers with which they can purchase private health insurance policies. Georgians not living below the poverty line are expected to purchase their own private health insurance cover voluntarily or pay out of pocket for services.

Given the pre-eminence of direct payments at the point of service, access to services is limited most by an individual's ability to pay rather than their entitlement under different pre-paid services. There is no mandatory social health insurance scheme, nor a Semashko-style national health service with universal access for citizens. Up until 2008 certain groups, had access to a limited range of services through state health programmes, which were sometimes part funded by co-payments. Historically, allocations to these programmes have not always been disbursed and the amounts allocated did not cover the full costs of services provided. This was reinforced by the chronic underfunding of services provided through the state health programmes.

Changes in 2008 have sought to address this issue by drastically reducing entitlements through state health programmes, trying to target public funds to the most vulnerable households and changing the way services are purchased.

The pooling of funds is not a significant feature of the health system in Georgia as the majority of health spending is made out of pocket rather than through pre-paid schemes. For the state health programmes, the organizational relationship has been shifting from one based on an integrated model to one based on a contracting model. Since 1996, health care personnel have been employed directly by health facilities, all of which have the status of independent actors except in rural areas where individual primary care teams of one doctor with one nurse are now budget holders. Payment mechanisms for the state health programmes differ according to the nature of the services to be purchased.

Regulation and planning

Since the Rose Revolution, in the context of economic reforms aimed at significant liberalization to promote economic growth, the regulatory role of MoLHSA has been diminished and the approach to regulation in the health sector has been to allow market mechanisms to regulate relations between users, purchasers, providers and public authorities. This withdrawal of the state has taken place in the belief that regulations would evolve through the needs of the health care market. In general, most health care reform initiatives have been planned with little emphasis on the necessary regulatory tools and arrangements. Similarly, MoLHSA's planning role in a system dominated by private actors and market relations is constrained, and the characteristic high proportion of out-of-pocket payments in total health expenditure has also complicated the planning function. It is hoped that MoLHSA will be better able to fulfil its regulatory role through its position as the main purchaser of private health insurance.

Physical and human resources

Georgia inherited an extensive health care infrastructure which had excess hospital capacity. The number of hospital beds has fallen significantly since independence (from 10 per 1000 population in 1992 to 3.3 per 1000 in 2007), but the contraction was mostly an ad hoc response to severe resource constraints rather than a concerted effort to rationalize the hospital sector. Different

approaches to rationalization have been used since 1999, but at the end of 2006, the Hospital Development Master Plan was launched, which envisaged divesting the state's remaining stake in the country's hospital stock, with the exception of six facilities in Tbilisi.

Georgia has an extremely high number of doctors per capita (4.7 per 1000 in 2006) compared with the rest of the World Health Organization (WHO) European Region, but particularly when compared with countries in the European Union (EU) (see Fig. 5.2). Furthermore, there are three times as many doctors in Tbilisi than there are in other regions, and recruiting and retaining staff to work in rural areas is a significant challenge. There are also problems with the recruitment of nurses, who are considerably outnumbered by doctors working in the system.

Provision of services

Primary health care (PHC) service providers are differently configured in each region depending on how they were incorporated under commercial law in 1997. A few were registered as limited liability or joint stock companies as separate entities, but most grouped together to create one legal entity (e.g. polyclinic-ambulatory unions, hospital-polyclinic unions, etc.) covering the population of the district. As a result there is a variety of PHC service providers across the country. Family medicine was introduced as a specialty in 1997 and many of the PHC services are staffed by general practitioners offering a broader range of services, but some are staffed by generalist physicians, general paediatricians and narrow specialists. Primary care doctors only act as gatekeepers for patients covered under relevant private health insurance schemes, because patients mostly pay out of pocket for services and are free to self-refer to inpatient services. For many patients, this is the preferred option, as the quality of PHC services is still perceived to be low.

Inpatient care in Georgia is provided by secondary and tertiary care institutions, general multi-profile and referral hospitals, scientific-research institutes, specialized hospitals and dispensaries. Although higher than its nadir in 2001 at 4.6 per 100 population, Georgia still has one of the lowest annual inpatient admission rates in the WHO European Region (6.5 per 100 capita in 2007). The number of outpatient contacts per person per year was just 1.95 in 2007, which is also among the lowest in the WHO European Region (see Fig. 6.1); it was at its lowest at 1.4 in 2000. Both low utilization rates can be taken as evidence of patients encountering problems in accessing care.

Health care reforms

The main principles of health care reform since 2006 were to make the transition towards complete marketization of the health sector: private provision, private purchasing, liberal regulation and minimum supervision. The basis for these decisions was rooted in the country's economic policy, which was to ensure economic growth based on liberalization and private sector development. Mandatory social health insurance, which was introduced in the 1990s, was abolished and private health insurance has been promoted as its replacement. The population living below the poverty line is issued with vouchers for the private insurers of their choice and the state then contracts with the insurer, purchasing a cover package with public funds. The population living above the poverty line is expected to purchase its own cover voluntarily or pay out of pocket for services. With a view to boosting pre-payment for this population, the government developed some limited private insurance packages which were subsidized by the state and promoted as affordable cover.

Assessment of the health system

The stated aim of the Georgian health system is to improve the health status of the population. In meeting this overall goal, the strategy is to ensure access to affordable, good quality health care with protection from catastrophic financial health risks. However, although there is no shortage of health facilities across the country, utilization is low and financial barriers in accessing care remain significant. All the evidence indicates that charges have a strong deterrent effect on low-income households accessing necessary services, even where such services should in theory be provided free of charge. The cost of pharmaceuticals in particular remains prohibitive.

Total health expenditure in Georgia is relatively high, but 70.9% of expenditure is in the form of direct out-of-pocket payments for services at the point of use. Currently, the system seems to heavily favour more expensive outpatient services provided by secondary and tertiary care hospitals rather than more cost-effective primary care level services. The extensive capacity of the system, combined with low utilization rates, also shows the system has low productivity. The weak regulatory environment means there is no way to measure (and ensure) quality of care.

Changes in the health status of the Georgian population, such as improvements in infant and maternal mortality rates, provide ample evidence of the importance of wider social and economic factors for the health status of populations, but key indicators highlight continuing weaknesses in the health system which need to be addressed if Georgia is to meet its health-related Millennium Development Goals.

1. Introduction

1.1 Geography and sociodemography

Georgia is situated in the South Caucasus, on the southern foothills of the Greater Caucasus mountain range. There is a short border with Turkey to the south-west and a western coastline on the Black Sea. The northern border with the Russian Federation follows the axis of the Greater Caucasus. To the south lies Armenia and, to the south-east, Azerbaijan.

Fig. 1.1
Map of Georgia

Source: United Nations, Department of Peacekeeping Operations Cartographic Section, Map No. 3780, Rev. 5, August 2004.

Georgia has an area of 69 700 km^2. The country is divided by the Surami mountain range, which runs from north to south between the Lesser and Greater Caucasus mountains. To the west of Surami lie the Rion plains and the Black Sea littoral; to the east lies the more mountainous Kura basin. The west part has a warm, humid, subtropical climate, with over 2000 mm of rain annually and temperatures of 6 °C in January and 25 °C in July. Eastern Georgia has a more continental climate, with cold winters and hot, dry summers.

The size of the Georgian population is disputed; official statistics estimate that the population is 4.4 million people with an average population density of 61 inhabitants per square kilometre (State Department of Statistics 2007). However, UNFPA has estimated the *de jure* population to be 4.3 million and the *de facto* population to be 3.9 million (Tsuladze, Maglaperidze and Vadachkoria 2005). From 1993 the civil registration system failed to capture the scale of migration flows since independence and the introduction of a fee for the issuance of death certificates from 1991 to 1999, meant that potentially 20% of deaths in Georgian hospitals were also not captured (Badurashvili et al. 2001). However, recent official statistics show an increase in the number of registered deaths after the Ministry of Justice introduced a new rule on the registration of vital events, which stated that each inpatient and outpatient clinic has to send copies of all medical death certificates issued to the local territorial agencies of the Georgian Civil Registry, irrespective of whether the families apply for a civil death certificate. This has been a significant step forward in harmonizing official statistics with international standards (Badurashvili et al. 2009).

Two administrative-territorial units (Abkhazia and South Ossetia/Tskhinvali region) are beyond the jurisdiction of the Georgian authorities, and are currently under the control of a Commonwealth of Independent States (CIS) peacekeeping force consisting of Russian troops. As a result of conflicts in Abkhazia and South Ossetia there were 300 000 IDPs before the conflicts escalated once more in August 2008, creating an estimated 128 000 more IDPs in Georgia (Redmond and Sunjic 2008). After the conflict both territories reasserted their independence, but their independence has only been recognised by four United Nations Member States (the Russian Federation, Nicaragua, Venezuela and Nauru).

Georgia has undergone a profound demographic transformation (see Table 1.1). According to World Bank estimates, population growth has been negative since independence, and the overall population has shrunk by a fifth between 1990 and 2008 (see Table 1.1). It has been estimated that by 2025 the population of Georgia will shrink by a further 0.8 million (Chawla, Betcherman

and Banerji 2007). The age profile of the population has shifted, with the proportion of children declining from 24.6% in 1990 to 17.1% in 2008; while the proportion of the population aged 65 years and over has increased from 9.3% in 1990 to 14.5% in 2008. By 2050 it is estimated that 24.2% of Georgia's population will be over 65 years old (Badurashvili et al. 2001). This pattern has been reinforced by significant out-migration of the working-age population, which is reflected in the significance of remittances in the economy, which account for an estimated 5–10% of GDP (Chawla, Betcherman and Banerji 2007).

Table 1.1

Population/demographic indicators, selected years

	1990	1995	2000	2004	2005	2006	2007	2008
Total population (millions)	5.5	5.0	4.7	4.5	4.5	4.4	4.4	4.4
Population, female (% of total)	52.5	52.2	52.7	52.7	52.8	52.8	52.9	52.9
Population ages 0–14 (% of total)	24.6	24.2	22.0	19.1	18.4	17.9	17.4	17.1
Population ages 65 and above (% of total)	9.3	11.3	12.4	14.2	14.4	14.6	14.6	14.5
Population growth (average annual growth rate)	-0.2	-1.8	-1.1	-1.0	-1.0	-0.9	-0.8	-0.8
Population density (people per km^2)	78.6	72.4	67.9	65.0	64.4	63.8	63.3	62.8
Fertility rate, total (births per woman)	2.1	1.7	1.5	–	1.4	1.4	1.4	–
Birth rate, crude (per 1000 people)	15.9	13.0	11.4	–	10.9	10.9	10.8	–
Death rate, crude (per 1000 people)	9.3	10.0	10.7	–	11.5	11.7	11.8	–
Age dependency ratio (% working population)	51.4	54.9	52.4	49.8	49.0	48.0	47.0	46.1
Urban population (% total population)	55.1	53.9	52.7	52.5	52.5	52.6	52.7	52.7
Literacy rate (% in population aged 15+)*	99	99	99.6 (1999)	100 (2003)	–	–	–	–

Sources: *World Bank 2009a; WHO Regional Office for Europe 2009.

1.2 Economic context

Prior to independence, Georgia enjoyed one of the highest standards of living in the Soviet Union, and the economy was traditionally based on Black Sea tourism, viticulture, agriculture and some mining (mainly manganese and copper). However, decoupling from the Soviet economic system, combined with the rapid introduction of a market economy and civil war, left the country in a state of economic collapse which severely reduced resources for the health sector (Gamkrelidze et al. 2002). From 1990 to 1994 GDP fell by 68% and in 1993 inflation was over 1500% (World Bank 2009a). However, after 1994, the

economic situation improved rapidly, with an average growth rate of 8% per year, and inflation has remained stable (see Table 1.2). As with many other former Soviet republics, Georgia is dependent on Russian energy imports, although the country has increased its hydroelectric capacity.

Table 1.2
Macroeconomic indicators

	2000	2001	2002	2003	2004	2005	2006	2007	2008
GDP (current US$, millions)	3 057	3 219	3 396	3 991	5 126	6 411	7 762	10 175	12 793
GDP, PPP (current int'l $, millions)	9 782	10 499	11 268	12 780	13 918	15 747	17 767	20 506	21 370
GDP per capita (current US$)	648	690	736	875	1 135	1 433	1 751	2 313	2 931
GDP per capita, PPP (current int'l $)	2 072	2 250	2 442	2 800	3 081	3 520	4 008	4 662	4 896
GDP growth (annual %)	1.8	4.8	5.5	11.1	5.9	9.6	9.4	12.4	2.0
Income or wealth inequality* (GINI Index)	–	–	40.3	–	–	40.8	–	36.3	–
Value added in industry (% GDP)	22.4	22.0	24.4	25.6	26.4	26.8	24.9	24.1	23.7
Value added in agriculture (% GDP)	21.9	22.4	20.6	20.6	17.9	16.7	12.8	10.9	10.4
Value added in services (% GDP)	55.7	55.6	55.0	53.8	55.7	56.5	62.3	65.0	65.9
Labour force (total, millions)	2.3	2.4	2.3	2.4	2.3	2.3	2.3	2.3	–
Unemployment, total (% labour force)	10.8	11.2	12.6	11.5	12.6	13.8	–	13.3	–
Official exchange rate (lari per US$)	2.0	2.1	2.2	2.1	1.9	1.8	1.8	1.7	1.5
Real interest rate (%)	26.8	20.8	24.5	27.9	21.1	12.7	9.5	9.8	10.2
Poverty headcount ratio at national poverty line* (% population)	–	–	52.1	54.5	–	–	–	23.6	–

Sources: World Bank 2009a; *World Bank 2009b.

The Georgian economy has not been immune to external shocks such as the 1998 rouble crash or the contentious Russian ban on key Georgian exports, but in 2006, GDP growth was 9.5% and reached 12.3% in 2007 (Government of Georgia 2009). However, economic growth has not benefited all sectors of the population equally, as shown in the country's GINI index, (see Table 1.2). Poverty has been a pervasive problem for Georgia and its reduction has been a key target for both national governments and international partners. The government has started to implement the Economic Development and Poverty Reduction Programme (EDPRP), approved in April 2003 and developed in collaboration with the World Bank.

Following the Rose Revolution in 2003 (see Section 1.3 *Political context*), the new government introduced radical economic reforms focused on deregulation, privatization, the fight against corruption and transformation of social sectors, including health and education (Government of Georgia 2007a). For Georgia's long-term economic development, the government is hoping to build on the country's role as a key transit state for oil and gas pipelines and to attract foreign investment. Foreign investments constituted about 25% of Georgian GDP in 2007 (National Bank of Georgia 2007). Nevertheless, the significant percentage of the population living below the poverty line remains the major economic challenge.

From 2000 to 2004 the State Department of Statistics and all other sources indicated that the poverty level varied between 51% and 54.5%. In 2005, the Government of Georgia did not publish poverty level indicators. In 2006, the Department of Statistics under the MoED with support from the World Bank revised the process of calculating the official poverty line (or subsistence minimum) and corresponding poverty indicators based on the cost of an Official Minimal Food Basket. The basket is based on the actual food consumption patterns and the minimum calorie intake level of 2300 kcal/day per equivalent adult. The Department of Statistics recalculated the poverty level for 2004 and 2005 vis-à-vis the adjusted subsistence minimum. According to official figures, the incidence of poverty at 60% of median consumption has fallen from 24.6% in 2004 to 21.3% in 2007 (State Department of Statistics 2008). Poverty indicators based on the consumption patterns of households are central to the proxy-means testing approach to awarding social and health benefits that the government introduced in 2006.

1.3 Political context

Until independence in 1991, Georgia was a constituent part of the Soviet Union and was subject to centralized rule from Moscow. The Republic of Georgia is now a presidential democracy. The head of state is the president, who is popularly elected for a five-year term. The executive branch comprises the president supported by a cabinet of ministers who are appointed by, and directly accountable to, the president. The legislative branch consists of a unicameral parliament with 150 seats (from 2008). Members of parliament are elected for a five-year term either by proportional representation from party lists, or through

the 75 single-seat constituencies. The judicial branch consists of the Supreme Court, the judges for which are elected by the parliament on the recommendation of the Supreme Court chair or the president, and the Constitutional Court.

Georgia's independence from the Soviet Union encouraged independence movements in the "autonomous republics" within Georgia, and this legacy of the Soviet Constitution has had serious consequences for maintaining the integrity of Georgia's borders as conflicts in two autonomous republics (Abkhazia and South Ossetia) are unresolved after escalation in August 2008 and the situation remains tense. In 1995, Eduard Shevardnadze, who had been an influential politician in the Soviet Union, was elected president and presided over a programme of reform which brought stability and some economic growth to the country, but also saw increasing levels of poverty, crime and corruption. The current president is Mikheil Saakashvili, who was elected in January 2004, following the "Rose Revolution", and subsequently re-elected in January 2008. The Rose Revolution was a series of popular protests challenging the official results of elections held at the end of 2003 and pushing for fresh elections to be held. Saakashvili is the leader of National Movement-Democratic Front, which won 59.2% of the vote in the parliamentary elections in May 2008. The second biggest party bloc was National Council-New Rights (17.7%) with a number of smaller parties and coalitions accounting for the remaining 23.1% of the vote (CIA 2009).

Georgia is sub-divided into 67 electoral districts (*rayons*), including those within the two autonomous regions of Abkhazia and Adjara and five independent cities. In addition, Georgia is divided into administrative territorial units, called regions. There are nine regions in Georgia: Samegrelo-Zemosvaneti, Racha Lechkhumi, Imereti, Guria, Samtskhe-Javakheti, Shida Kartli, Kvemo Kartli, Kakheti, Mtskheta-Mtianeti. Governance at the local level is defined by the Law on Local Self-government, adopted by the parliament in December 2005, which introduced a one-level system of local self-government (*rayon sakrebulo*) at the *rayon* level. The parliament has also enacted the Law on the Property of the Self-governing Unit and the Law on the Budget of the Self-governing Unit. According to these laws, larger self-governing units at the *rayon* level are economically viable and could potentially have a greater capacity to balance the power of the national government. There are also several self-governing towns, including Tbilisi, the capital, with a municipal government independent from the national authorities.

Important laws related to health care are enacted mainly by primary legislation. The Parliamentary Committee on Health and Social Issues develops recommendations and proposals for amendments to the existed laws or initiates the process of drafting the new laws. After successfully passing the committee hearings (a maximum of three), draft laws or amendments become subject to parliamentary discussions and final approval. The government can also initiate laws or amendments and if they are approved at a cabinet meeting the proposals are put before parliament.

Georgia is a full member of several international organizations relevant for health including the United Nations, the Council of Europe, the World Trade Organization (WTO) and the CIS until 2009. A significant direction in foreign policy since the Rose Revolution has been the desire to join both the European Union (EU) and the North Atlantic Treaties Organization (NATO), and to start proceedings to withdraw from the CIS following armed conflict with Russian Federation forces in August 2008 in Abkhazia and South Ossetia. The Individual Partnership Action Plan, which regulates Georgia's adjustment to NATO standards, was agreed in October 2004. In the same year, Georgia was included in the European Neighbourhood Policy (ENP). In November 2006, the EU-Georgia ENP Action Plan was approved in Brussels. However, moves towards joining NATO and the EU and resolving the previously "frozen" conflicts in Abkhazia and South Ossetia have resulted in a significant deterioration in relations with the Russian Federation.

Georgia has ratified most major international treaties/documents which have a direct or indirect impact on health, including the European Convention on Human Rights and Fundamental Freedoms (Council of Europe [CoE]), International Covenant on Civil and Political Rights (United Nations), International Covenant on Social, Economic and Cultural Rights (United Nations), Convention Against Torture, Convention for Elimination of all Forms of Discrimination Against Women (United Nations), European Convention Against Torture (CoE), as well as General Agreement on Tariffs and Trade (GATS). Georgia has also ratified the Convention on the Rights of the Child (United Nations), but significant concerns have been raised about some legislative changes, which have lowered the age for criminal responsibility from 14 to 12 years of age, as of 1 July 2008, particularly in the absence of specialist juvenile courts (Committee on the Rights of the Child 2008). Other human rights concerns include prison overcrowding, police abuse (particularly during the arrest of suspects), and use of torture and the ill-treatment of detainees by police (Amnesty International 2005). Many specific reports of police using

excessive force relate to the breaking up of street protests and the calling of a state of emergency in November 2007, which precipitated the presidential elections in January 2008 (Amnesty International 2007).

In the 2009 Global Corruption Report (Christensen and Karosanidze 2008), Georgia scored 3.9 on the Corruption Perception Index, where 10 would be a country without any perceived corruption. It is one of the best scores for countries of the former Soviet Union and it represents a significant improvement from a score of 1.8 before the Rose Revolution (Transparency International 2009). The score is also above the threshold level of 3.0, below which countries are deemed to have a rampant corruption problem. Nevertheless, there are still concerns about the protection of property rights and the blurring of government and party boundaries, with the resulting potential for the misuse of state resources.

1.4 Health status

Socioeconomic crises, civil war, significant numbers of IDPs, increased unemployment and intensive migration observed since the 1990s in Georgia have all had a negative impact on the population's health status, but have also made it challenging to accurately determine basic mortality and morbidity statistics, particularly as the basic denominator (population size) is disputed (see Section 1.1 *Geography and sociodemography*). The collection of data for health indicators is dependent on the accuracy of medical records and the goodwill of the providers to submit accurate statistics to the government (it is obligatory, but not enforced), civil registry records and calculations of aggregated official reports. However, since independence challenging socioeconomic conditions have made it very difficult to maintain reporting structures which are not computerized. Medical records in hard copy are initially analysed at facility level, from where the data are forwarded (usually in hard copy) to *rayon* then to regional level, and finally aggregated at the central level. Consequently, there are often significant discrepancies between different national data sources, for example, in 2007 the Department of Statistics reported the number of stillbirths as 632 (12.7 per 1000 births) based on civil registry data, while the National Centre for Disease Control and Public Health (NCDCPH), under MoLHSA, reported 738 (14.7 per 1000 births) based on records from medical facilities (NCDCPH 2009). This implies that the barriers to registering births and deaths in the civil registry system remain, despite changes to the legislation in 1999 and 2006 removing official charges.

Trend data showing the health status of the Georgian population is hard to assess due to difficulties associated with data collection for basic health indicators; the social, economic and political upheaval of the early 1990s and civil war had a significant impact on the quality of data collection in Georgia (Badurashvili et al. 2001). While the data must be interpreted with considerable caution, it seems that the overall health status of the country only began to recover at the beginning of the 21st century.

Average life expectancy in Georgia in 2005 was 73.1 years (69.3 years for men, 76.7 years for women) (see Table 1.3). This was below the WHO European Region average life expectancy of 74.6 years and the EU average of 78.5 years, but it was considerably higher than the CIS average of 67.0 years (61.6 years for men, 72.9 years for women) in 2005 (WHO Regional Office for Europe 2009). However, the magnitude of the reported increase in 2004–2005 is implausible and is therefore a reminder of the need for caution in interpreting Georgian data. National data gave the three most common causes of death in Georgia in 2007 as: diseases of the circulatory system (66.9%), malignant neoplasm (10.9%) and external causes, injuries and poisoning (3.2%); symptoms, signs and abnormal findings not classified elsewhere accounted for 8.2% of deaths. As the burden of disease is now largely noncommunicable, lifestyle factors play an important role in population health. According to a survey conducted in 2005, 27–39% of the population are tobacco consumers and about 50–65% of men and about 22% of women are smokers (Policy Department of MoLHSA 2005).

Table 1.3

Mortality and health indicators 1990, 1995, 2000, 2004, 2005

	1990	1995	2000	2004	2005
Life expectancy at birth, female (years)	76.6	74.2	75	74.9	76.7
Life expectancy at birth, male (years)	69	66.3	67.5	67.8	69.3
Life expectancy at birth, total (years)	73	70.3	71.3	71.4	73.1
Mortality rate, adult, female (per 1000 female adults)	752.0	867.3	767.9	–	–
Under 65 mortality rate, adult female (per 1000 adult females aged under 65)	245.5	302.2	192.8	–	–
Mortality rate, adult, male (per 1000 male adults)	1 234.8	1 473.3	1 035.2	–	–
Under 65 mortality rate, adult male (per 1000 adult males aged under 65)	549.4	738.4	452.9	–	–
Mortality rate, infant (per 1000 live births)	20.7	28.2	22.6	23.8	19.7

Source: WHO Regional Office for Europe 2009.

According to the NCDCPH, the maternal mortality rate increased by almost 20% between 1990 and 2000, from 41 to 49 maternal deaths per 100 000 live births. The peak rate occurred in 1997, when 70.6 maternal deaths per 100 000 live births were recorded. Using a three-year rolling average (as is standard for smaller populations), the maternal mortality rate fell from 51.5 in 2000–2002 to 40.3 in 2003–2005 (Chkhatarashvili et al. 2006). There were concerted policy efforts to improve access to maternity services at this time, but the improvement also coincided with a general improvement in socioeconomic circumstances in the country (see Section 1.2 *Economic context*).

There are some concerns relating to discrepancies between the findings of different surveys and national statistics reporting under-5 and infant mortality rates (MoLHSA 2009a). Nevertheless comparison of the 1999 and 2005 Georgia Reproductive Health Survey results shows a dramatic decline in the infant and child under-5 mortality rates: infant mortality declined from a rate of 40.7 per 1000 live births in 1990–1999 to 21.1 per 1000 live births in 2000–2004 (Serbanescu et al. 2007). The neonatal mortality rate fell from 25.0 to 16.8 per 1000 live births but the post-neonatal mortality showed the most significant drop falling from 15.7 to 4.3 per 1000 live births over the same period (Serbanescu et al. 2007). The survey also found that the child under-5 mortality rate declined from 45 per 1000 live births to 25 per 1000 live births between 2000 and 2004 (Serbanescu et al. 2007). However, improvements in the overall child survival rate should be attributed mainly to the reductions in post-neonatal mortality, which is more amenable to care by the family and broad public health approaches, rather than improvements in health service delivery. As with maternal mortality rates, improvements coincided with a general improvement in socioeconomic circumstances in the country.

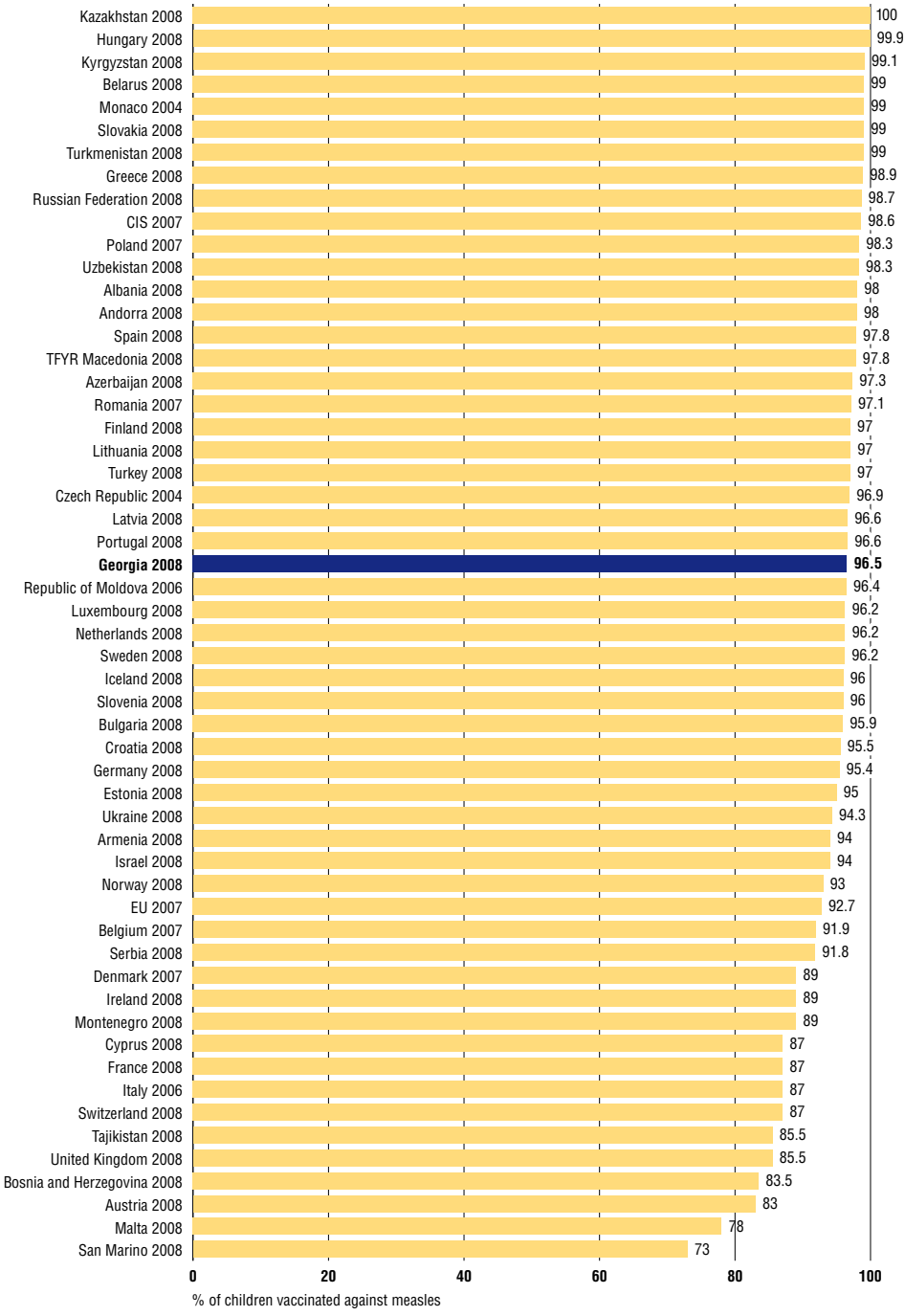
Infectious diseases are still significant public health problems in Georgia, particularly tuberculosis (TB), as both incidence and prevalence remain high. In 2006, TB prevalence for pulmonary and extra-pulmonary types was 112.9 per 100 000, incidence 68.9 per 100 000 population; overall TB rates have been growing since 1990, reaching a peak in 1995 with a prevalence of 166.9 per 100 000 and an incidence of 86.6 per 100 000 population (Centre for Medical Information and Statistics 2007). TB incidence is particularly high in some regions, namely Ajara (163.8) Samegrelo (111.4) Guria (110.9) and Tbilisi (101.7). Recent increases in the incidence rate of TB can be largely attributed to improvements in laboratory services and enhancement of the TB surveillance system countrywide in 2003–2004, as the national TB programme has received significant financial support from the Global Fund. TB rates in Georgia remain

high, but while the new case notification rate remains stable, the prevalence of multi-drug resistant strains has become a serious public health concern and requires timely attention (Mdivani et al. 2008).

The immunization level was very high in Soviet Georgia. It dropped dramatically from around 95% to just 30–50% in 1990–1995 for major vaccine preventable diseases (TB, diphtheria, pertussis, tetanus, polio, measles), and only started to improve after 1995 to around 70–90% coverage in the 2000s (WHO Regional Office for Europe 2009). Hepatitis B vaccine coverage remains modest as it was only introduced in 2001. Although the surveillance data for vaccine preventable diseases has improved in recent years (see Section 6.1 *Public health*), vaccination coverage rates call for careful interpretation given the uncertainty over the basic denominator. In 2003, the WHO reported 86% immunization coverage for measles, down from 97% in 2000; this indicator was back to 97% in 2008 (see Fig. 1.2).

Fig. 1.2

Levels of immunization for measles in the WHO European Region, percentages, latest available year



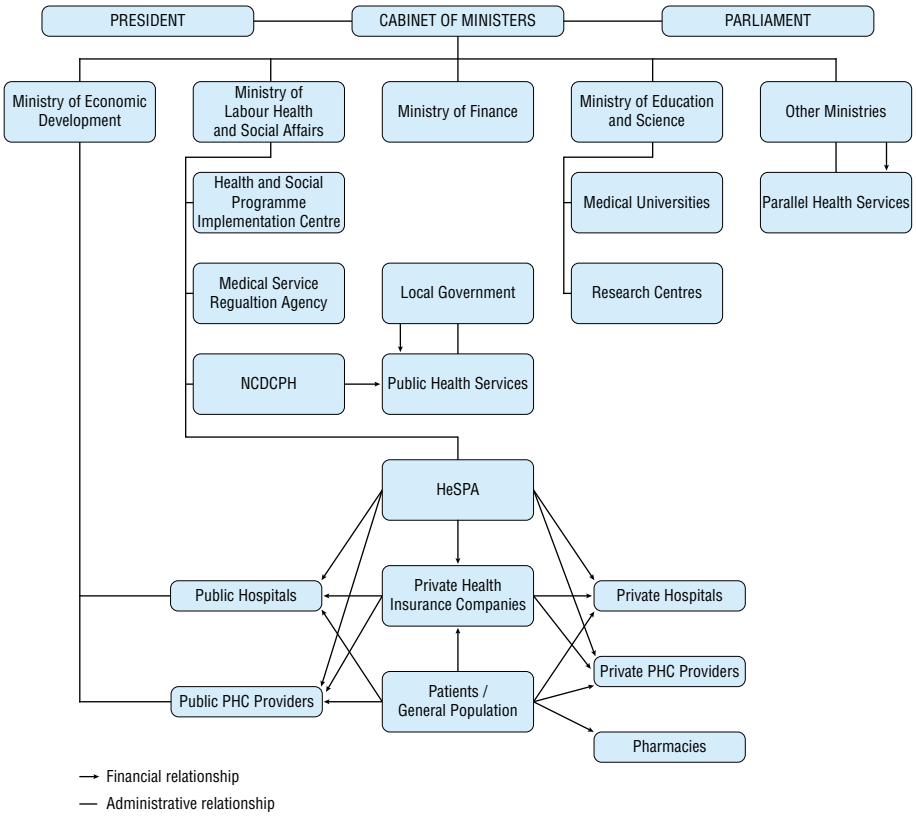
Source: WHO Regional Office for Europe 2009.

2. Organizational structure

2.1 Overview of the health system

In contrast to the Soviet Semashko model, policy-making, purchasing, service delivery and regulation functions are separated in the current system. The key actors in Georgian health care are presented in the Fig. 2.1 and described in Section 2.3 *Organizational overview.*

Fig. 2.1
Overview of the organizational structure of the Georgian health care system



2.2 Historical background

The Soviet legacy

The Semashko system set the original context for the health system in Georgia as from 1921 to 1991 it was a constituent part of the Soviet health care system. The Soviet Semashko system was organized around the guiding principle of universal access to health care free at the point of use. It was a tax-based system with highly centralized planning of resources and personnel based on a hierarchy of facilities at the district, regional, republican and all-union levels. All health care workers were employed by the state and only very limited private practice was allowed – although illegal out-of-pocket payments and the giving of gratuities to health personnel were also common. Care was focused on inpatient treatment and, consequently, primary care was very weak. There was an emphasis on the continuous expansion of staff and facilities and an extensive system of parallel health services which were attached to large industrial enterprises, certain ministries (e.g. the Transport Ministry, the Ministry of Internal Affairs, etc.), and the Communist Party elite.

The extensive coverage and universal access to free care meant that the Semashko system was equitable, despite qualitative differences in provision between geographical regions and mainstream and parallel health services. However, it was also inefficient and resource intensive – particularly in the reliance on inpatient care. Also, while the Semashko system proved effective initially in the control of communicable diseases, with the epidemiological shift towards a noncommunicable disease burden, the system was insufficiently flexible and primary health care and health promotion too weak to enable the control of noncommunicable diseases, which predominated towards the end of the Soviet era (Figueras et al. 2004). Until independence in 1991, the Ministry of Health (MoH) in Georgia simply administered policies that had been made in Moscow, as part of a centrally planned system managed through a hierarchical structure. Some micro-management but no policy-making responsibilities were delegated to Georgian authorities, whose role was limited to reporting to authorities in Moscow on the performance of the republican system against predetermined plans.

Soviet norms and standards were set to maintain micro-management within a highly centralized system. When regulations were violated, the sanctions were administrative (a warning or dismissal) for local health authorities or health institution managers. More serious violations were considered a criminal matter. Soviet regulations lasted much longer than the Semashko system in

Georgia. Until 2005, some standards and normative acts which referred to the Soviet health standards set in Moscow for medical facilities, and sanitary and hygienic services were still in place.

During the Soviet period there was no recognition of the Western European notion of patient rights. Under the Semashko model, people's health and social well-being were centrally planned by the state and there was no recognized institutional development of civil rights. There were no patient organizations, and individuals' rights were prescribed by the state. The state also controlled public information and awareness of health issues (Oxford Policy Management [OPM] 2004).

Independence

In the first years of independence, severe political and economic crisis suspended the centralized mechanisms of management in all spheres. The real challenge faced by the government after 1991 was a sharp reduction of resources for all sectors, including health care, forcing the government to renege on inherited obligations for universal service provision. Following the collapse of the Soviet system, public financing fell from around US$ 149 per capita in 1990 to just US$ 0.45 per capita in 1991–1993. In parallel, national health authorities were faced with the urgent need to develop new health care policies and independently administer the system, while having neither the capacity for conceptual policy development nor experience of independent public management.

Following independence, meaningful regulation of service providers was also greatly weakened so that while regulations include strict requirements for hygienic standards, sanitary conditions in the medical facilities were extremely poor: most of the buildings were built before 1940, safety testing of equipment was not present, and the environment was polluted. Moreover, in many hospitals there was no laboratory and diagnostic capacity, let alone proper surgery and intensive care functions.

In 1993, there were plans to begin reform of the health sector in Georgia. The first changes took place in 1994–1995 in line with macroeconomic stabilization, with assistance from various international organizations. The reforms introduced new concepts, including social health insurance, official user fees and new provider payment mechanisms (Gamkrelidze et al. 2002). In 1995, the Comprehensive Health Reform Package was prepared and launched, including governmental decrees for the reorganization of the health care system (October 1994, December 1994), composition and implementation of state

medical programmes (June 1995), future development of the pharmaceutical sector (June 1995), privatization of health care facilities (June 1995), and the introduction of social health insurance (April 1997). The right to health insurance and free medical aid was also incorporated into Article 37 of the Constitution of the Republic of Georgia (adopted 24 August 1995). The goal of the reform package was to maintain the provision of a basic package of services to the entire population. Four main objectives of the reform were outlined: (1) to clearly define the package of services to be paid for by the government in the form of vertical state programmes substituting for the unlimited promise of the previous authorities to finance everything; (2) to decentralize the management of the health care system, giving greater power to the regional authorities; (3) to introduce privatization for certain types of health service providers; and (4) to introduce social health insurance as an earmarked source of financing in addition to the state budget. The reform package was truly ambitious but it was held back by a weak implementation process, with political expediency repeatedly overriding sound health policy. Crucially, throughout this period the health sector continued to be inadequately funded.

In 1999, the Georgian National Health Policy was developed and adopted by the government. The declared main objectives of the policy were to improve the equity, accessibility and affordability of health care services for the population of Georgia. Thirty-eight objectives were outlined in the policy paper. The vision for the future health care system was that it should be (1) financed by the state as well as through social insurance, while maintaining the principles of solidarity and equity, and (2) led by primary health care, with a major emphasis on health promotion and disease prevention. The document was followed by the Strategic Health Plan for Georgia 2000–2009, which attempted to set the framework for utilization of public resources, indicating the areas of intervention through additional funding. Over the years, these strategies remained nice statements, pleasant to communicate to international society, the government and the public, but they brought only minor changes to the system. Most of the transformations in this period were reflected in the inflation of the state health programmes to address the needs of particular groups of society not necessarily based on population needs; and the introduction of complex bureaucratic regulations for medical personnel and facilities.

Introduction of social health insurance

From 1995 to 2004, a social health insurance system operated in Georgia. In theory, basic health care was paid for by an independent state body with additional funding for certain services coming through municipal health funds

and for preventive activities through MoLHSA. The State Health Fund (the State Medical Insurance Company [SMIC] from 1996) was created in 1995 to pool payroll contributions from employers (at 3%) and employees (at 1%), together with central budget transfers for the non-working population (pensioners, unemployed, children, etc.). municipal health funds received their funding from municipal budgets at a flat per capita rate. In 1997–1999, to address economic disparities between municipalities and promote risk pooling, the 65 municipal health funds channelled resources into 12 regional health funds which then redistributed it back to the municipalities to fund that part of the basic benefit package (BBP) for which they were responsible.

The BBP was initially made up of nine state health programmes and five compulsory municipal health programmes, it subsequently expanded for political reasons (rather than as the result of needs assessments or economic analysis), but the expansion was not accompanied by a corresponding increase in funding (Gamkrelidze et al. 2002). The health system continued to be chronically underfunded, and universal coverage was not achieved as shortfalls in funding were covered by out-of-pocket payments. The target groups for different state programmes were dissimilar, varying from the victims of political repression or IDPs, to people with disabilities, or different age and gender categories, and social groups; each receiving a different portion from state funding for undefined reasons.

The payroll tax was pooled with general budget resources to finance the government-promised BBP for the whole population, but the entitlements of contributors were not linked to contributions. Partly because of successive economic crises, the government was unable to meet its revenue and expenditure targets, which led to (1) across-the-board expenditure cuts in the 1998, 1999 and 2000 budgets; (2) the continued accumulation of large arrears in reimbursements for health facilities, wages and pensions; and (3) increasing reliance on private out-of-pocket payments to finance health care. Revenues generated from mandatory payroll contributions went from 21 million Lari in 2001 to 36.3 million lari in 2003, accounting for about 5% of total health expenditure.

The shortcomings of the Georgian social health insurance system led to it being abandoned in 2004. The BBP was extremely complex in terms of which services were free, which required co-payments (and how much) and which were full cost. Few patients were informed as to their rights under the BBP and the overall lack of transparency facilitated the perpetuation of informal

payments in the system. Overall, the introduction of social health insurance was not successful in delivering a basic package of services to be made accessible to the population in the light of scarce resources.

Decentralization

The first wave of decentralization happened in 1995, with the establishment of 12 regional health authorities subordinate to regional governments. The regional health authorities were given the task of identifying local health needs and developing strategies to meet them (Gamkrelidze et al. 2002). The Law on Local Self-governance (1997) then granted municipal authorities almost full independence from central government with respect to their functions, including the allocation of resources to health care, negotiating contracts with health care providers, deciding on the target population groups, monitoring quality and amending local budgets. The law set the responsibility for funding health care facilities, as well as planning and implementing local health care programmes at the municipal level.

From the beginning, the implementation process for the decentralization of health system management was not optimal. Whether regional authorities were ready, and capable of taking on the greater power and responsibilities designated to them was not properly considered. Strategic planning, management and administration remained solely functions of the core ministry. At best, regional representation appeared to be an arm of the ministry in executing decisions in the districts and regions. At worst, they existed without a significant function and were ignored by the local service providers, who communicated directly with the central ministry and purchaser. The overall approach to decentralization weakened the administrative links both vertically, that is, between the MoLHSA and regional governments, and horizontally, namely between health care facilities at different levels of care and types of provider. In addition, the separation of functional accountability and the scope of responsibilities, especially at the community level, remained vague.

Privatization

Privatization brought enormous changes to the health sector. The process was based on the rationale that the government should give away the burden of maintaining excessive infrastructure, as well as bowing to strong lobbying from the influential provider side to get ownership and management for private service provision. In 1995–1996, almost all pharmacies and dental clinics were privatized. In 1997 all other health facilities were made autonomous:

hospitals and polyclinics became managerially independent, taking over the responsibility for budgeting and contracting. From 1995, all medical personnel, previously employed as state salaried workers, became independent providers or employees of the facilities where they worked.

Hospitals, polyclinics and ambulatories, although gaining managerial independence by being incorporated under corporate law, still remained in public ownership through 100% government shareholding. The manager was limited in maximizing the facility's effectiveness and profitability since a lack of freedom to effectively use property rights meant s/he had no right to rent or sell property without the permission of the MoED. This situation meant that much of the health system was at least formally managed by the MoED rather than MoLHSA and weak governance arrangements complicated the development and implementation of health policy. Also, weak corporate governance arrangements for the publicly owned health care providers created an environment where informal payments in the health sector could flourish. This had important implications for the full divestment of hospital stock from state ownership after 2007.

Rationalization

Georgia inherited considerable excess capacity, and attempts to rationalize and modernize the system have been ongoing since 1995. Granting the vast majority of health facilities autonomy in 1999 reduced excess staffing levels, but they still remained high. Similarly, this move had little impact on the levels of excess infrastructure given that, although they were autonomous "enterprises", the limited freedom of facility managers to dispose of excess property/infrastructure without MoED participation on the one hand, and the weak performance of the MoED on the other, prevented effective downsizing. In order to rationalize hospital stock, an assessment of the quantity and capacity of hospitals throughout the country was conducted in 1999, and a Hospital Master Plan was developed in which hospitals were classified into three groups:

- hospitals that were best left in the public domain;
- hospitals to be privatized and maintain a health service delivery function;
- hospitals to be sold as real estate without obligation to maintain a health care delivery function.

The Hospital Restructuring Fund was set up and designated to accumulate investments from privatization, and lead the process of hospital sector optimization and the development of all related aspects, such as legal aspects,

staffing levels, etc. However, full implementation of the master plan did not take place due to the change of leadership at the MoH following the Rose Revolution. Instead, a number of hospitals were merged, some hospital buildings were sold off and some medical personnel were made redundant, but there was still considerable excess institutional and human resources capacity in the system when the process was stopped in 2004 (see Chapter 7 *Principal health care reforms*).

2.3 Organizational overview

An overview of the organizational structure of the Georgian health care system as of December 2008 is shown in Fig. 2.1. The formal roles of the various actors in the system are presented below.

Ministry of Labour, Health and Social Affairs

The Charter of the MoLHSA, portrays the ministry as a central actor with regard to health and social issues, accountable for the health of the population, oversight of the system, the quality of health services and equity in relation to access to health care throughout the country. In reality, its responsibilities have been substantially reduced since Soviet times, especially concerning direct service provision, direct purchasing, and, in some respects, regulation. Following extensive reorganization (see Chapter 7 *Principal health care reforms*), the MoLHSA formally has the following functions:

- planning and determining health priorities;
- developing and implementing national health care policy;
- drafting health care laws and enacting regulations subsequent to primary legislation;
- ensuring supervision of health-related law enforcement;
- developing and overseeing the implementation of public health programmes, including epidemiological monitoring and infectious disease control to protect the population's health;
- collecting and reporting health statistics;
- advocating for adequate resource allocation for health care programmes from the state budget;
- issuing licences and permits to health care facilities and pharmaceutical entities;

- regulating health care professions;
- regulating the pharmaceuticals market.

Ministry of Economic Development

The MoED has been a very important player in the health system as, formally, the management of all public health care facilities has been under the competence of MoED, rather than MoLHSA, since health facilities were made autonomous units in 1997 (see Section 2.2 *Historical background*). This role has also meant that since 2006 the MoED has been at the centre of the hospital divestiture process, with responsibility for the preparation of facilities for tendering and conducting auctions.

Ministry of Finance

The Ministry of Finance (MoF) fulfils two main functions: routine oversight of the spending processes of all ministries to ensure compliance with the predefined plan; and leading the annual budget preparation process. The volume of public health financing, as well as the composition of the benefit package, is a matter for approval by the MoF, the highest levels of government and parliament.

The Health and Social Programmes Agency

The Health and Social Programmes Agency (HeSPA) was created in 2007, and its role is as defined by budget law. According to its Charter, HeSPA is an institution subordinated to the state under the administration of MoLHSA. HeSPA administers service purchasing in accordance with the state health programmes by contracting suppliers and paying for services according to a fixed price list. However, HeSPA does not hold the funds in its bank account for purchasing as this goes direct from the Treasury to contracted suppliers as per HeSPA's invoice. HeSPA is obliged to provide MoLHSA with annual reports on the procurements for state health programmes. HeSPA must approach MoLHSA, MoF and the Ministry of Justice for legal permission to make any changes to service purchasing in terms of service volume or type, as this would require a change to budget law.

Medical Service Regulation Agency

The Medical Service Regulation Agency (MSRA) is mainly responsible for issuing the licences and permits for health care facilities, and certification of medical professionals. Another function of this agency is investigation of patients' complaints regarding the quality of medical services (see Section 4.1.2 *Regulation and governance of providers*).

In 2008, the Drug Agency was incorporated into the MSRA and it is now the Drug Agency Department that is responsible for the implementation of state drug policy. The main task is ensuring that pharmaceutical products registered in Georgia meet the criteria for quality, safety and efficacy. It is also responsible for ensuring that the market is free of counterfeit pharmaceutical products and that the physical conditions in manufacturing facilities and retail pharmacies are in conformity with established standards (see Section 4.1 *Regulation* and 5.1.5 *Pharmaceuticals*).

National Centre for Disease Control and Public Health

The NCDCPH was created in spring 2007, after a merger of the Public Health Department and the Centre for National Disease Control and Medical Statistics. NCDCPH is responsible for the public health of the entire population, including immunization, surveillance, disease prevention, health promotion and the laboratory system for health and veterinary services.

Health and Social Programme Implementation Centre

The Health and Social Programme Implementation Centre (HSPIC) conducts two completely different types of activities: it administers loans from international financial institutions and donor-supported projects (World Bank, European Commission (EC), Global Fund), and also runs the State Programme for Rehabilitation of Health Infrastructure. Following the selling off of many public health facilities in 2007–2008 (see Chapter 7 *Principal health care reforms*), the scale of this programme has shrunk. The nature of donor-supported projects has also changed. Initially, the HSPIC was functioning as a project implementation unit for the World Bank- and Global Fund-supported projects. However, since 2007 the EC has given PHC investment funding to the government for administration, and this function has been carried out by the HSPIC.

Local authorities

According to the Law on Local Self-governance, enacted in December 2005, local governments acquired limited responsibilities for health promotion, healthy lifestyle formation, and some measures for disease prevention.

Professional representation

The development of professional medical associations in Georgia is still at an early stage although there are many of them in existence (OPM 2004). Since 2005, the major activity of professional associations has been supporting the MoLHSA in its endeavour to elaborate national clinical practice guidelines and protocols. The MoLHSA brings together funds for this initiative from budget sources and various international partners, and invites professional associations to work on specific areas of their expertise. There are also a number of specialty-related associations (for endocrinologists, oncologists, cardiologists, neurologists, etc.), which encourage best practice, innovation and development in their specific areas of work in the medical community in Georgia.

International partners

Numerous international partners strongly support the health sector in Georgia. The Open Society Institute, International Committee of the Red Cross, Kreditansalf für Wiederaufbau, the United Kingdom Department for International Development (DfID), EC, the United States Agency for International Development (USAID), the World Bank, the WHO, United Nations Children's Fund (UNICEF) and the United Nations Development Programme (UNDP) have permanent offices in the country, largely supporting developments in the health and social sectors. In addition, a number of projects are implemented by foreign and national development organizations, and consultancy firms contracted by donors.

2.4 Decentralization and centralization

The decentralization process has been ongoing in Georgia since independence (see Section 2.2 *Historical background*). All types of decentralization except delegation have been employed in Georgia to some extent since the 1990s. MoLHSA is now envisaged as an overseeing body rather than a service provider and agent for policy implementation, as it was during the Soviet era. Since

2003, there has been a considerable de-concentration of power from the central MoLHSA to subordinate executive agencies such as HeSPA, NCDCPH and MSRA.

As indicated, service providers are independent of the state. Most health facilities have been autonomous state-owned joint-stock companies or limited liability companies since 1997, rather than being the responsibility of local government or the MoLHSA; the MoED is formally responsible for the management of these facilities until the full divestiture of health care facilities has been achieved as part of the current privatization programme (see Chapter 7 *Principal health care reforms*).

2.5 Patient empowerment

Patients receive information about the costs and quality of health care services mainly through informal mechanisms such as social networks. Although the MoLHSA and HeSPA have a hotline service providing information to the general public about state health programmes, sometimes even medical providers are not clear what is paid for by the state and what is not. There is no quality measurement system collecting information on the quality of either primary or secondary care. Consequently, there is no source to apply to in order to access information before selecting a medical provider. It is hoped that the introduction of the voucher scheme for individuals identified as living below the poverty line will act as an instrument for empowerment by encouraging patient choice and forcing an improvement in patient information systems. However, there is evidence to suggest that most beneficiaries of the state programme purchasing medical insurance for those living below the poverty line are unaware of the specific services included in the benefit package (MoLHSA 2009a).

In 2003, the Georgian government tried to ensure a sound legal basis for protecting patient rights, which formally complies with the principles established in western Europe and the United States. The basic tenets of patient rights in the health care system in Georgia have been given as (Nunes 2003):

- respect for persons and the need for free, informed consent
- protection of incompetent persons (children and psychiatric patients)
- the ethical imperative to maximize benefits and minimize harms (beneficence and non-malfeasance)
- privacy rights and confidentiality for the patient

- justice in access to health care (equity)
- accountability of health care professionals
- responsibilities of ethical review committees.

However, despite the extensive rights granted by legislators, there is little evidence that patients are effectively protected in everyday life. The system is mostly legal (as opposed to administrative) and there is ample evidence of a top-down supply-side mechanism for institutional arrangements, rather than arrangements developing "bottom-up" in response to patient needs.

The MSRA considers retrospectively the cases of serious malpractice on the basis of patient claims. To review the patient's history, and service provider activities regulated under the Law on Entrepreneurship, the MSRA needs permission from the court. The results of the MSRA's investigation are submitted to the state certification board chaired by the minister. The board makes decisions about adequate administrative measures, which could be the withdrawal or revocation of the physician's certificate or organization's licence for different periods of time.

Unless they are insured, the only recourse open to an individual who believes their rights as a patient have been infringed is through direct litigation in the Georgian court system, and only in extreme cases, when patients end up with very serious outcomes. Having this single sanctioning system is, in practical terms, unworkable because: it is too costly for individuals; the legal system in Georgia cannot cope with a large number of individual claims; patients do not yet regard themselves as having individual rights as consumers of health services; there is no informal power among patients due to the lack of development of patient rights organizations; the court procedures are very lengthy and unresponsive to individuals; access to the legal system for individuals living in rural areas is much harder; and information on patient rights is not well publicized, especially outside Tbilisi. There are no means for impartial arbitration of questionable cases other than a court hearing, which cannot be generally effective due to the high cost of the procedure, and the lack of experience of the professionals involved in the process. However, as part of the government move towards promoting private health insurance cover for the population, a new ombudsman for mediating in disputes between patients and health insurance providers was established in 2008. The Health Insurance Mediation Service in Georgia is a private NGO affiliated to the Georgian Insurance Association that emerged in response to the government's decision to provide insurance coverage for health through private insurance

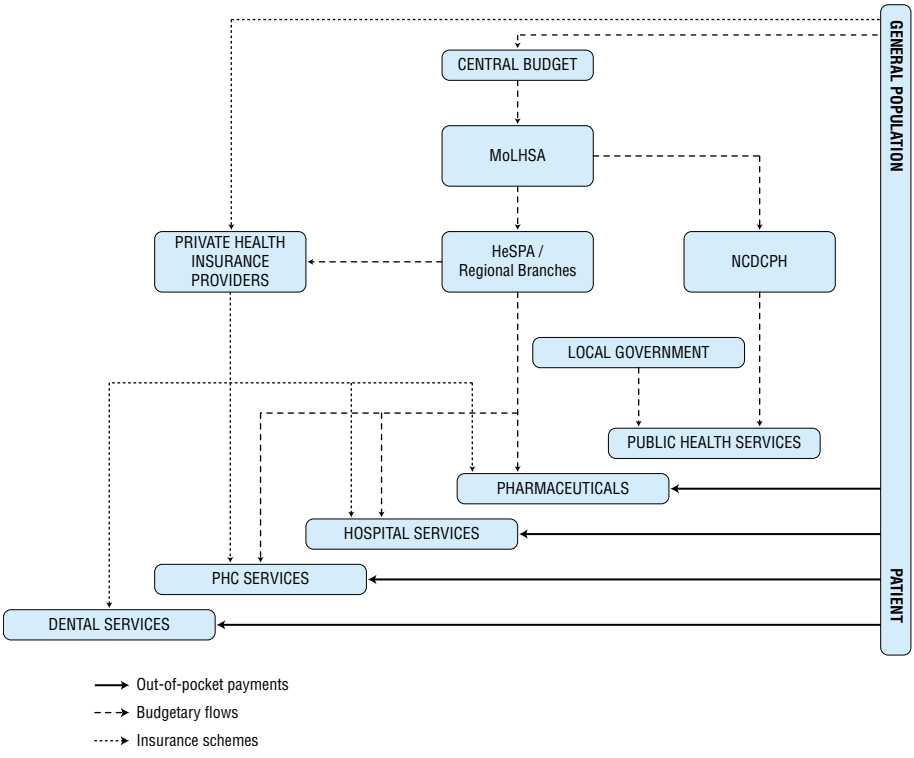
companies. This NGO mediates disputes between insurance companies and insured individuals. In its first year, the NGO mediated several thousand disputes, and in a significant proportion of them the ombudsman ruled in favour of the insured.

In Georgia there has been very little development on the demand side of institutional development in patient rights. To date, little attention has been paid to this issue through community mobilization of patient rights organizations or the development of independent institutions lobbying for patient needs on a local basis. Overall, patient rights remain a theoretical concept, developed centrally and enshrined in legal decrees but as yet lacking effective implementation mechanisms (OPM 2004). Nevertheless, initial developments are taking place and several leading national NGOs have formed a coalition called Human Rights in Healthcare. This coalition is supported by the Open Society Georgian Foundation (Human Rights in Healthcare 2009).

3. Financing

As shown in Fig. 3.1, the health system in Georgia is dominated by direct out-of-pocket payments for health services and pharmaceuticals, with budgetary revenues funding the state health programmes (including the purchase of private health insurance for households living below the poverty line) and a small percentage of the general population purchasing private health insurance cover for themselves.

Fig. 3.1
Financial flows within the Georgian health system



3.1 Health expenditure

The data used for reporting health expenditure are generated through the National Health Accounts, which are produced following a standard methodology (World Bank et al. 2003). To improve the accuracy of the data gathered, MoLHSA initiated an assessment of household health expenditures in 2007 (MoLHSA 2007c). Currently, the National Health Accounts give an overview of the share of different finance sources in expenditure on health care in Georgia from 2003 to 2007. This includes non-pooled out-of-pocket expenditure.

Although health expenditure has been increasing since 2001 in monetary terms, data from the National Health Accounts show that total health expenditure is dominated by private expenditure, with government spending accounting for less than one-fifth of total health expenditure (see Table 3.1). Total health expenditure as a percentage of GDP fell back to 8.2% in 2007, but public health expenditure on health was only 1.5% of GDP and 4.7% of general government expenditures in 2007 (MoLHSA 2009a). According to WHO estimates, total health expenditure as a percentage of GDP in Georgia reached 8.6% in 2005, which is relatively high in international comparisons, the EU average being 8.9% while the CIS average was 5.5% for the same year (see Fig. 3.2). Total health expenditure has been rising in Georgia since the late 1990s, which is in marked contrast to total health expenditure in other countries of the CIS, but most notably Georgia's neighbours (see Fig. 3.3).

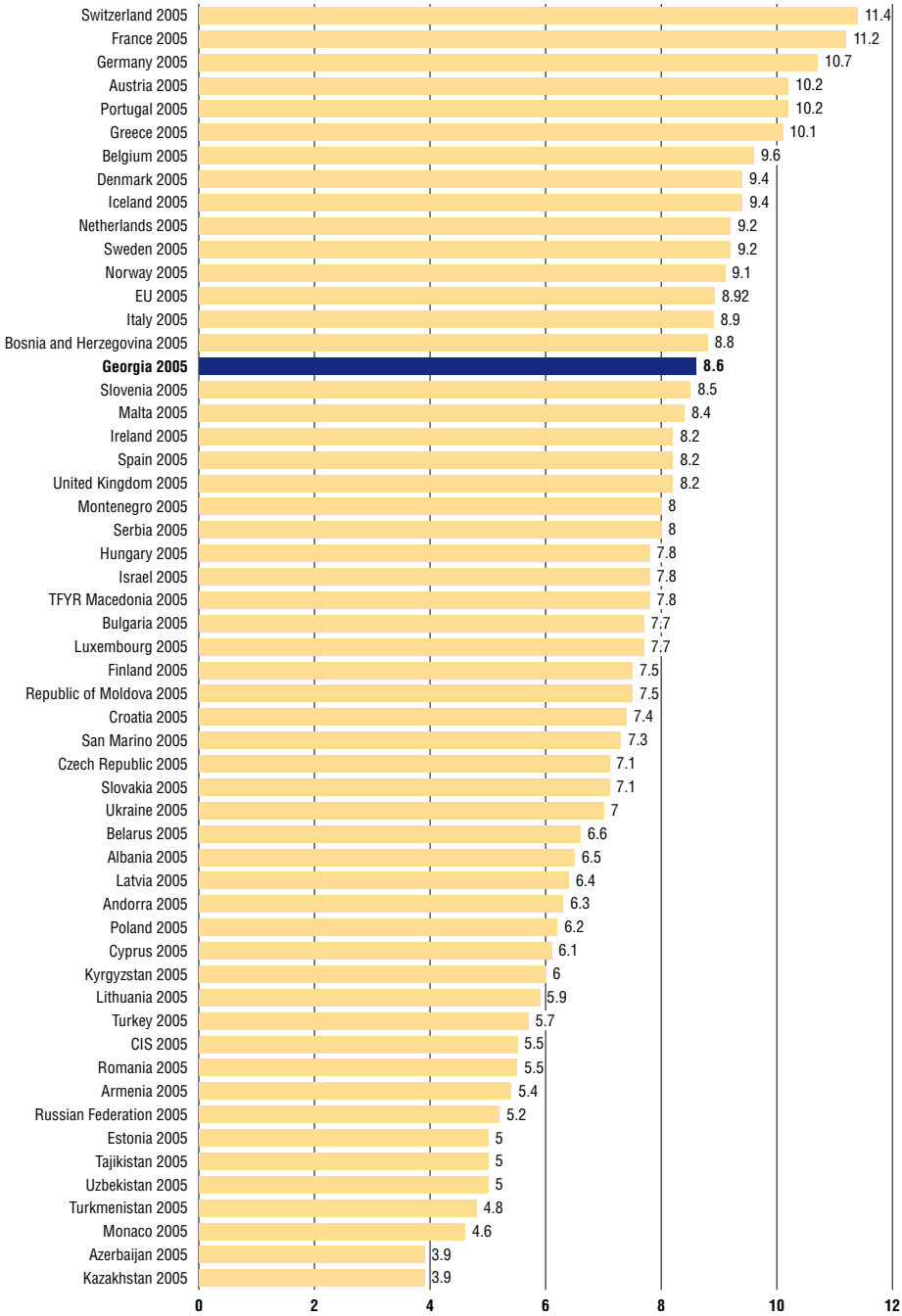
Table 3.1
Trends in health expenditure in Georgia, 2003–2007

	2003	2004	2005	2006	2007
GDP (current prices, US$, millions)	3 991.5	5 124.7	6 411.0	7 761.7	10 171.9
Total health expenditure (US$, millions)	337.8	436.2	550.7	651.3	830.0
Public health expenditure (US$, millions)	50.6	67.8	107.9	142.9	152.9
Private health expenditure (US$, millions)	262.2	341.9	427.7	475.3	600.7
Donor aid (US$, millions)	25.1	26.5	15.1	33.0	76.4
Total expenditure on health (THE) % GDP	8.5	8.5	8.6	8.4	8.2
General government expenditure on health (GGHE) % THE	15.0	15.5	19.6	21.9	18.4
Private expenditure on health (PvtHE) % THE	77.6	78.4	77.7	73.0	72.4
GGHE % General government expenditure	6.7	5.4	6.0	5.7	4.2
SUSIF/HeSPA* expenditure on health % GGHE	64	62	45	51	58
Out-of-pocket spending on health % PvtHE	99.5	99.0	99.0	98.8	97.9
Private pre-paid plans expenditure on health % PvtHE	0.5	1.0	1.0	1.2	2.1
Externally funded expenditure on health % THE	7.4	6.1	2.7	5.1	9.2

Source: MoLHSA 2009b. *State United Social Insurance Fund (SUSIF) is the predecessor of HeSPA.

Fig. 3.2

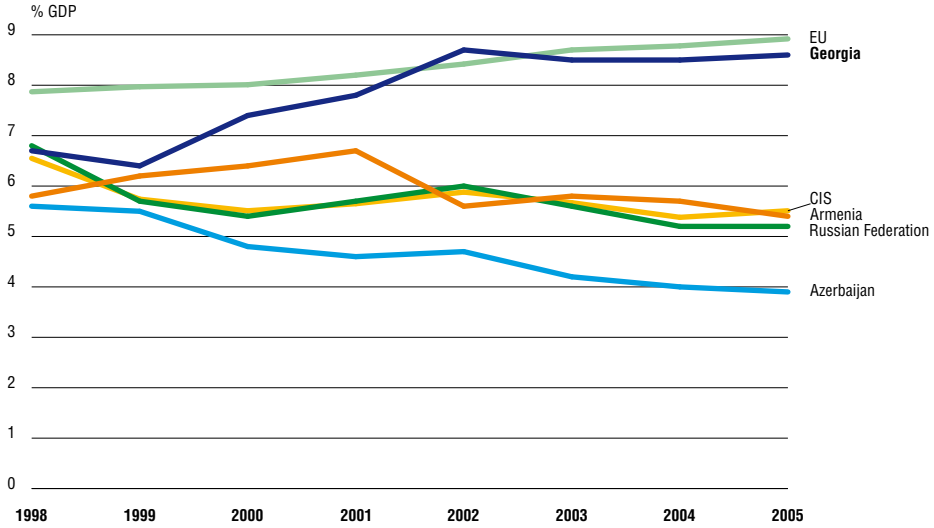
Health expenditure as a share (%) of GDP in the WHO European Region, latest available year (WHO estimates)



Source: WHO Regional Office for Europe 2009.

Fig. 3.3

Trends in health expenditure as a share (%) of GDP in Georgia and other selected countries and averages, 1998 to latest available year (WHO estimates)



Source: WHO Regional Office for Europe 2009.

However, in terms of purchasing power parity (PPP), according to WHO estimates for 2005, total health expenditure in Georgia was relatively low for countries of the WHO European Region at US$ 318 per capita, which was below the CIS average of US$ 448 and the EU average of US$ 2468 in 2005 (see Fig. 3.4). Table 3.2 shows the contribution of public funds and out-of-pocket payments to total health expenditure (US$ PPP) using data from the National Health Accounts. Georgia has the lowest proportion of public expenditure in total health expenditure in the WHO European Region, at just 19.5% in 2005, according to WHO estimates (see Fig. 3.5).

Table 3.2

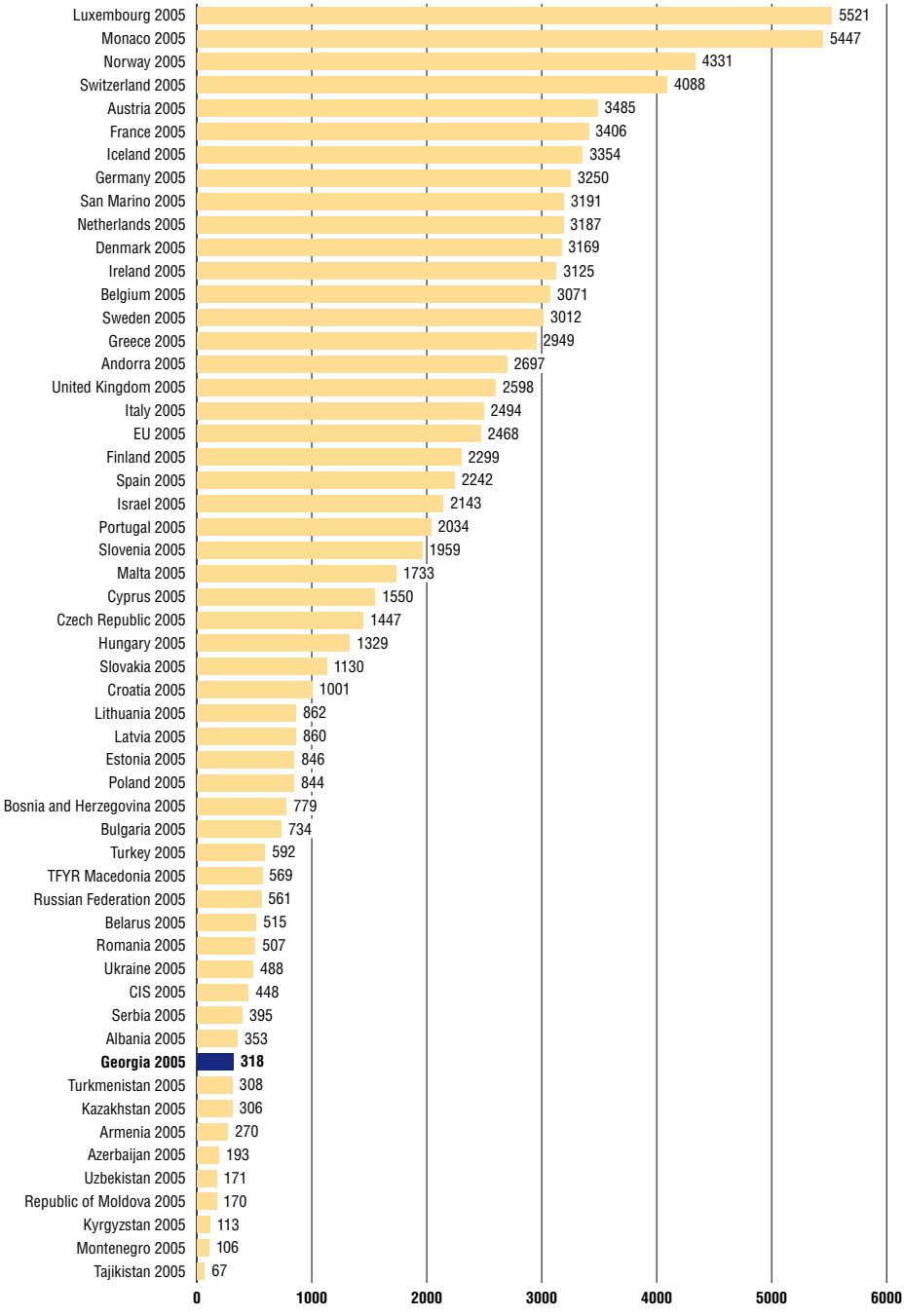
Trends in health care expenditure in US$ PPP per capita in Georgia, 2001–2007

	2001	2002	2003	2004	2005	2006	2007
Total expenditure on health, US$ PPP per capita	181	225	251	275	310	340	381
Public expenditure on health, US$ PPP per capita	26	31	38	43	61	75	70
Out-of-pocket payments, US$ PPP per capita	139	168	195	215	241	248	276

Source: MoLHSA 2009b.

Fig. 3.4

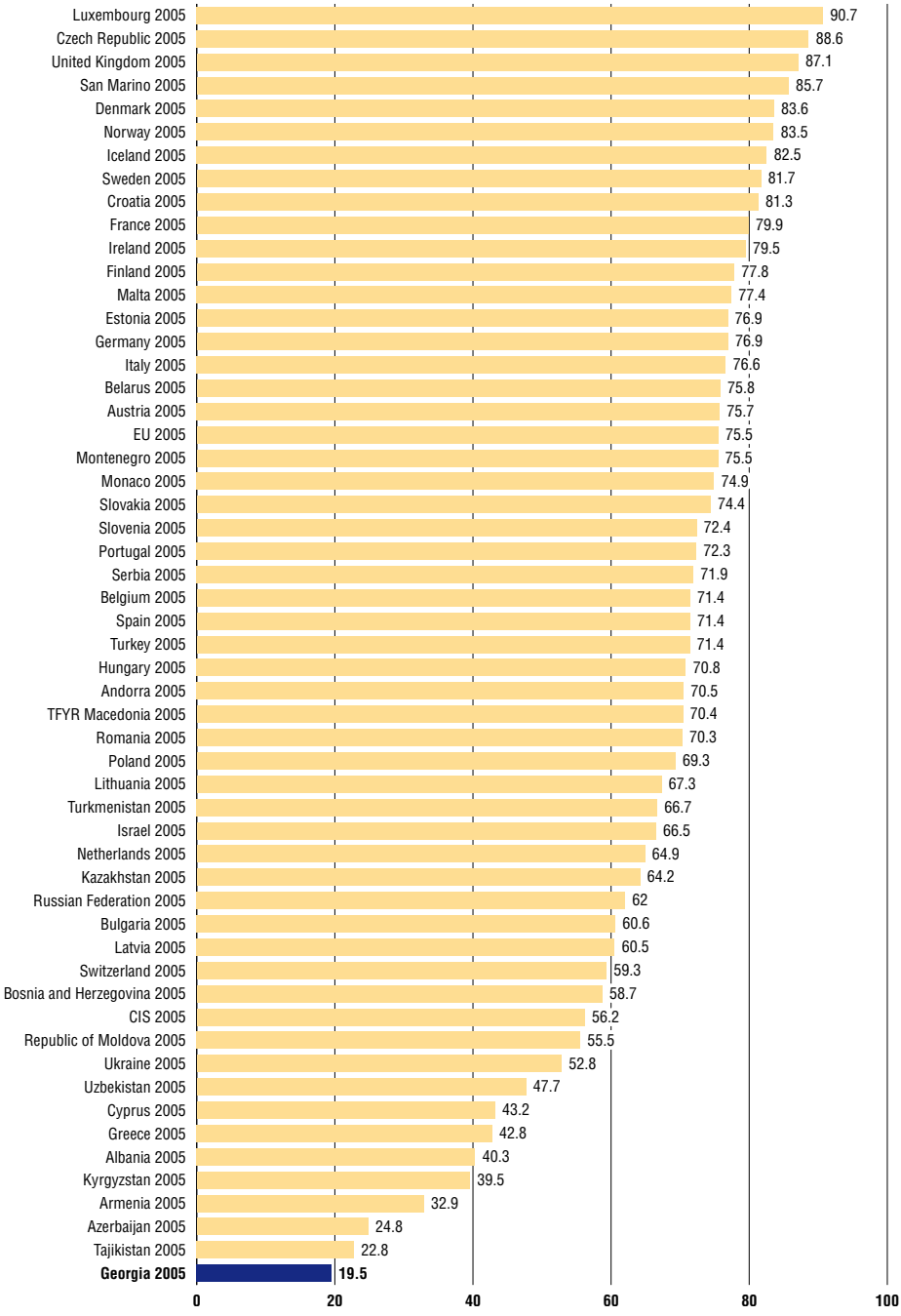
Health expenditure in US$ PPP per capita in the WHO European Region, latest available year (WHO estimates)



Source: WHO Regional Office for Europe 2009.

Fig. 3.5

Health expenditure from public sources as a percentage of total health expenditure in the WHO European Region, latest available year (WHO estimates)



Source: WHO Regional Office for Europe 2009.

Table 3.3 presents data on total health expenditure distribution among financial agents in the years 2003–2007. These data show that out-of-pocket payments as a proportion of total private health expenditure have fallen, but remain high. Central government administered 6.2% of total health expenditure in 2007, which is 2.4 times more than in 2004, but this is still extremely low in international comparison. The significant increase in public funding from 2005 is related to increased state allocations for health services, as well as health infrastructure rehabilitation, which were funded through the hospital restructuring fund. In this bigger picture, the MoLHSA budget only financed the administration of the MoLHSA system, comprised of the core ministry and its affiliated agencies in the regions. Municipal governments received 1.5% of total health expenditure in 2006, down from 4.1% in 2005. This is linked to the revised law on local governance, which limited the number of exclusive health functions of local government (see Table 3.3).

Table 3.3

Distribution of total health expenditure among financial agents 2003–2007 (%)

	2003	2004	2005	2006	2007
Total central government	**2.6**	**2.5**	**6.5**	**8.9**	**6.2**
MoLHSA	0.9	1.0	0.9	0.5	0.5
Public Health Department	0.5	0.4	0.3	0.3	0.1
HSPIC	0.5	0.4	1.8	1.8	4.2
NCDCPH	0.0	0.0	0.1	0.0	0.1
Hospital restructuring fund	–	–	2.7	4.1	–
Other ministries	0.1	0.0	0.1	0.1	0.4
Other government institutions and departments	0.6	0.7	0.6	2.1	0.9
Total municipal governments	**2.8**	**3.2**	**4.1**	**1.5**	**1.1**
Tbilisi health department	1.2	1.9	2.0	0.3	0.5
Adjara MoLHSA	0.8	0.3	0.8	0.6	0.3
Abkhazia MoLHSA	0.1	0.1	0.1	0.1	0.0
Other municipality health department	0.7	1.0	1.2	0.6	0.3
SMIC/SUSIF/HeSPA	**9.6**	**9.7**	**8.9**	**11.1**	**10.6**
Private insurance	0.4	0.8	0.8	1.1	2.0
Households' out-of-pocket payments	77.2	77.6	76.9	72.1	70.9
Total private	**77.6**	**78.4**	**77.7**	**73.2**	**72.9**
International aid outside state budget	**7.4**	**6.2**	**2.8**	**5.3**	**9.2**
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Source: MoLHSA 2009b.

In terms of services, the data presented in Table 3.4 show that the hospital service providers received 24% of total health expenditure, and outpatient care providers received 16% in 2007. Health administration and health insurance administration costs amounted to 1% in 2003 and 3% in 2006–2007 of total health expenditure.

Table 3.4

Trends in health expenditure by service categories (percentage of total public health expenditure), 2003–2007

	2003	2004	2005	2006	2007
Inpatient care	24	25	24	24	24
Outpatient care	16	17	17	17	16
Home care	0.3	0.4	0.3	0.4	0.4
Rehabilitation care	0.4	0.1	0.2	0.2	0.0
Ancillary services	8	8	10	11	11
Pharmaceuticals and medical supplies	44	43	40	37	37
Total expenditure on personal care	**93**	**93**	**91**	**89**	**89**
Prevention and public health services	2	3	2	2	2
Health administration and health insurance	1	1	1	3	3
Other	6	9	4	2	4

Source: MoLHSA 2009b.

National figures disguise wide variations in health expenditure between regions in both public and private expenditure. Tbilisi receives the highest relative public spending by far, but significant volumes of services for residents from different parts of Georgia are provided by specialist health facilities in the capital (see Table 3.5). However, it is more difficult to justify why Racha-Lechkhumi received the second largest government allocation, when the poorest regions are the Kvemo Kartli and Kakheti regions. It is possible that the allocations to different regions are higher if the region is rolling over debts from the previous year, while other regions receive commensurately less funding as a consequence. Private expenditure differences between the regions are also significant, ranging from the lowest in Samtskhe-Javakheti to the highest in Tbilisi and Imereti. The lowest health expenditures in the Samtskhe-Javakheti region could be explained by the lower geographic and financial accessibility of medical services in this very difficult, mountainous region, whereas higher private health expenditures in Imereti and Tbilisi could be linked with the relative prosperity of residents in these regions, as well as the presence of a number of multi-profile and tertiary care hospitals. Imereti-Kurtaisi is the

referral centre for western Georgia and Tbilisi is the referral centre for the eastern part of the country. Therefore these two locations accumulate most of the cases that require services that are being offered on tertiary level.

Table 3.5

Geographic distribution of health care financing (lari per capita in current prices), 2007

Region	Public	Private
Adjara	34	180
Tbilisi	106	294
Kakheti	16	188
Imereti	26	284
Samegrelo-Zemosvaneti	16	173
Shida Kartli	17	171
Kvemo Kartli	13	186
Guria	18	254
Samtskhe-Javakheti	19	131
Mtskheta-Mtianeti	18	214
Racha-Lechkhumi	36	262
Total average	58	229

Source: MoLHSA 2009b.

3.2 Population coverage and basis for entitlement

Article 37 of the Constitution of the Republic of Georgia (1997, amended 2004) states that everyone shall have the right to enjoy health insurance as a means of accessible medical aid, and that in some cases as prescribed by law, free medical aid shall be provided. Currently, only the population deemed to be living below the poverty line (approximately 751 000 people in 2008) and some state employees such as teachers and their families have comprehensive cover for most medical care at the primary, secondary and tertiary levels. A further 122 000 have purchased government-subsidized cover for a limited package of services under the "5 Lari" scheme. A limited number of people are covered by private health insurance which is not state purchased or subsidized, often as an employment benefit. In 2008, approximately a third of the Georgian population were covered by some form of health insurance (MoLHSA 2009a). State health programmes fund primary care for children aged 0–5 years (with no co-payment) and hospital care for children aged 0–3 years with a 20% co-payment. For those aged over 60 years, state health programmes also fund emergency and hospital care (with a 20% co-payment), with cardiosurgery and cancer treatment funded with a 30% co-payment from the patient. State health

programmes also fund some specific services, such as primary care for the rural population, psychiatric services, TB care, HIV/AIDS care, kidney dialysis, and diabetes care with no co-payments (see Table 3.6). All those without insurance aged 6–59 years pay for services not covered under any of the state health programmes in full out of pocket.

Since 2008, especially vulnerable households living below the poverty line as defined by the government (see Section 1.2 *Economic context*), have been entitled to vouchers with which they can purchase private health insurance coverage. Especially vulnerable households are defined by their poverty score which is devised according to information on the country's poorest households held on the targeted social assistance programme database. In effect, it is the extension of proxy-means testing from social assistance programmes to health service benefits, as these are considered part of the social welfare package. The State Health Programme on Medical Insurance for the Population below the Poverty Line was piloted in Tbilisi and Imereti region in 2006 when it covered about 200 000 people, and expanded nationwide in 2007–2008 to cover approximately 18% of the total population (according to official figures, 21.3% of the population was living below the poverty line, see Section 1.2 *Economic context*). Consequently there was an increase in the budget allocation to this programme from 37.2 million lari in 2007 to 74.9 million lari in 2008, which would equate to approximately 150 lari/US$ 83 per capita (Government of Georgia 2007b). The package provided comprehensive cover with no co-payments, although elective hospitalizations were rationed through waiting lists of two to three months. There was no payment ceiling for acute care and a 50 000 lari per person per year ceiling for planned inpatient treatment, with a 12 000 lari per person per year ceiling for cancer treatments such as chemotherapy and radiotherapy. In 2009, the annual premium was 180 lari, with a 12 000 lari limit for cancer treatment and 15 000 lari limit for heart surgery and unlimited acute care. State health programmes cover some specific services for those with specific medical needs (such as those needing kidney dialysis). However, there is also a long negative list of services not covered under these state health programmes, which adds to the complexity of the system (see Table 3.6).

Table 3.6

State health programmes in Georgia (with entitlement and co-payment details), 2009

State health programmes (SHP)	Total budget (lari, estimates)
SHP on medical insurance for the population living below the poverty line (with no co-payments)	129 511 700
SHP on supporting voluntary health insurance (population aged 4–59 yrs, limited package covering ambulatory and some emergency care – "5 Lari" scheme)	–
SHP on medical insurance for national artists and Rustaveli Prize laureates (no co-payments)	50 000
SHP on psychiatric services (whole population, no co-payments)	9 794 800
SHP on TB services (whole population, no co-payments)	7 823 000
SHP on health services for children (neonatology and 0–18 yrs cancer treatment, no co-payment; 0–3 yrs inpatient care, 20% co-payment)	14 962 500
SHP on treatment of infectious diseases (0–18 yrs, 20% co-payment; 60+ yrs, 30% co-payment; 19–59 yrs, 50% co-payment)	2 121 000
SHP on obstetrics care (4 antenatal check-ups and complex deliveries with co-payment of 200 lari)	4 257 000
SHP on organ/tissues transplantation and kidney dialysis (whole population, no co-payments)	15 748 500
SHP on diagnostics and treatment of oncology diseases (60+ yrs, with co-payments of 30% or 50%	3 883 400
SHP on referral services (whole population, no co-payment)	19 684 000
SHP on emergency care (60+ yrs, free or with 25% co-payment for hospital care)	9 275 100
SHP on heart surgery (60+ yrs, with 30% or 50% co-payment; for genetic conditions no co-payments up to 18 yrs, 30% thereafter)	8 659 500
SHP on treatment for adults and children with haemophilia (whole population, no co-payments)	130 000
SHP on primary health care (whole rural population and urban population aged 0–5 and 60+ yrs, no co-payment)	24 916 600
SHP on early detection and treatment of HIV/AIDS patients (whole population, no co-payments)	2 000 000
SHP on ambulance services (whole population, no co-payment)	18 740 500
SHP on supplying the population with specific medicines (whole population, no co-payments)	11 792 748
SHP on disease prevention (whole population)	6 616 700
SHP on medical services for veterans	800 000
SHP on medical examinations for individuals called to serve in Army	1 200 000

Source: MoLHSA 2009c.

In 2009, the government attempted to further boost population coverage through private health insurance, particularly for those living near the poverty line, through a widely publicized "5 Lari" scheme, which was open to most Georgian citizens who did not already have comprehensive private insurance cover. The scheme subsidized a specific limited package of care, which was sold by private health insurance companies for a limited time only (1 March – 21 July 2009); 19.80 lari was paid per person and the balance was paid by the government for one year's cover. It was calculated that if 200 000 people signed up for the scheme then the total monthly premium would cost 5 lari,

or 60 lari for the year. Individuals buying the package could also spend more (up to 180 lari per person annually) to broaden the package of services on offer. However, the popularity of the scheme was considerably overestimated by the insurance industry, and the government and the scheme now covers approximately 122 000 people (61% of the planned amount, and 3% of the population). The "5 Lari" package covers unlimited visits to a primary care physician plus eight diagnostic tests per year; urgent care delivered outside hospitals up to 300 lari with no co-payments; acute hospitalizations (such as appendicitis) up to a limit of 200 lari with 10% co-payments; and accident and emergency cover up to 5000 lari with no co-payment are also included. Planned inpatient care and pharmaceuticals were not covered as a part of the standard package of benefits.

A great deal of the complexity in the old financing system used to stem from chronic underfunding. Almost all of the state programmes used to operate with deficits as budget estimations did not reflect true costs. The service volume to be provided to the population through the programme would therefore cost more than the budget approved by the Government of Georgia, perpetuating chronic underfunding in the system and the high proportion of out-of-pocket payments in total health expenditure. Due to state laws governing public finance management, HeSPA would establish ceilings on monthly transfers to health care providers, by dividing the entire value of the contract by 12 months. When the monthly amount was used up, providers would have to ask patients to pay for services which were nominally subsidized by the government. To overcome the mismatch between *de facto* and *de jure* benefits and to redirect government spending towards covering the most vulnerable groups, there has been a significant rationalization of state health programmes, which now only cover a very limited number of procedures for patients with specific conditions. Since 2009, HeSPA has also moved to a more patient-oriented purchasing system through the distribution of vouchers to purchase services provided by the government (see Section 3.5 *Purchasing and purchaser-provider relations*). In addition to the state health programmes listed in Table 3.6, which are financed entirely from the national health budget, there are other programmes which are funded by international partners. However, with the exception of the Global Fund, international partners primarily fund investment and technical assistance.

Despite recent moves to promote pre-paid schemes, the Georgian health system is still financed primarily through out-of-pocket payments (see Section 3.1 *Health expenditure*); consequently access to health care is most limited by an individual's ability to pay rather than their entitlement to access different pre-paid services. Recent initiatives in health care financing have

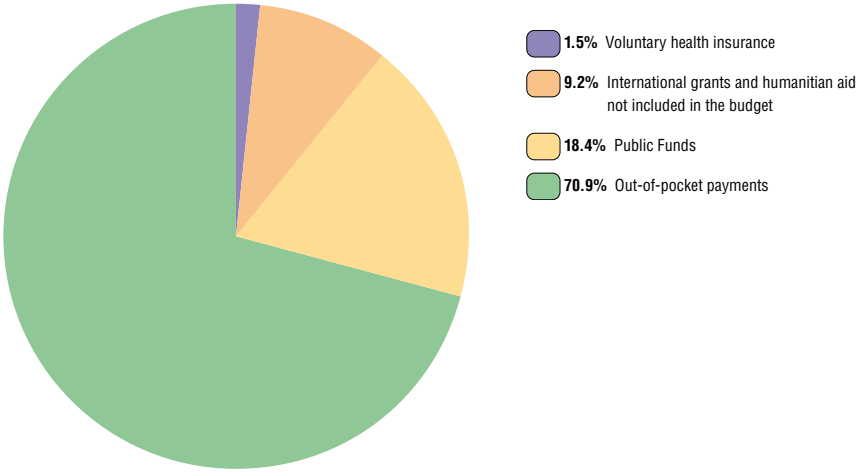
aimed to move a significant portion of out-of-pocket payments into pre-paid pool(s) by using state subsidies to trigger such developments. One-third of the population has been enrolled into private health insurance schemes; a small number of citizens have private (voluntary) health insurance and certain conditions and groups are directly covered from the state budget (see Table 3.6). Outpatient pharmaceuticals are not covered under any government-backed scheme and the purchase of pharmaceuticals accounts for more than a third of out-of-pocket expenditure.

3.3 Revenue collection/sources of funds

The largest portion of health revenues remain out-of-pocket payments (see Fig. 3.6). The most important sources of funds for pooled health finance in Georgia are still taxpayers' contributions (individuals, employees, businesses) and donors. Individuals contribute mainly through value added tax (VAT), excise duties and direct income taxes. Complementary sources of revenues include other direct and indirect taxes, non-tax fees, and grants and loans, but they are quantitatively less important. Table 3.7 describes all sources of health funds in the country during the period 2003–2007.

Fig. 3.6

Percentage of total expenditure on health by source of revenue, 2007



Source: MoLHSA 2009b.

The share of public sources increased from 14.4% in 2003 to 18.4% of total health expenditure in 2007, and private sources decreased from 76.7% to 72.4% (see Table 3.6). Reducing the high levels of out-of-pocket payments for health

services remains the key challenge for the Georgian government. Therefore, as of 2007, the government vision for health financing in Georgia is for out-of pocket payments to be formalized and a sizable portion to be transferred to pre-paid private schemes, thereby reducing the share of out-of-pocket payments in total health expenditure and improving cover against catastrophic health care costs. Providing catastrophic cover through private health insurance is a challenge, as private insurers seek to reduce their exposure to such risks, so the government would need to pay high premiums and strictly regulate the industry to ensure that private insurers deliver what is expected. The volume of funds mobilized by private insurance companies was negligible: less than 1% of total health expenditure in 2001–2003, increasing to 2.1% in 2007 (see Table 3.7).

3.3.1 Out-of-pocket payments

Out-of-pocket payments in Georgia include: official co-payments, direct formal payments to health facilities and informal payments to health care providers.

Direct payments numbers for headings

Medical institutions – PHC centres, outpatient clinics, polyclinics, diagnostic centres and hospitals – have established rates for services which are not covered by state health programmes. The price list for services is called the "internal standards". Prices for additional services differ from provider to provider and are mainly based on the perceived purchasing ability of the population served. Direct payments also include payments to private medical professionals providing services out of medical facilities owned by another legal subject. However, direct payments are most significant in relation to the cost of pharmaceuticals, particularly in outpatient care, as these are most often not covered under insurance schemes or state health programmes so must be purchased at full price by the patient.

Co-payments

The system of co-payments has been considerably simplified in order to promote greater transparency, as it used to be hard for patients to know precisely which services were included, or the level of legal co-payments for these services. The range of services provided to the whole population through state health programmes has been drastically reduced and in 2009 a new payment mechanism, using vouchers, was introduced to promote transparency. The level and amount of co-payment is printed on the voucher which patients can take to the hospital of their choice for treatment. The levels of co-payment under the state-subsidized private insurance schemes are detailed above (in Section 3.2 *Population coverage and basis for entitlement*).

Table 3.7
Sources of funds 2003–2007 (% and lari [millions] in current prices)

	2003	2004	2005	2006	2007
Total sources mobilized on health in lari (mill)	725	836	998	1 160	1 387
Public funds	**108.5 (15.0%)**	**129.9 (15.5%)**	**195.7 (19.6%)**	**254.5 (21.9%)**	**255.5 (18.4%)**
Central government revenue	40.7%	64.7%	66.8%	84.3%	85.9%
Donor aid to government via state budget	2.5%	2.9%	12.1%	7.6%	7.4%
Municipal and regional government revenue	23.4%	32.4%	21.1%	8.2%	6.7%
Private funds	**562.5 (77.6%)**	**655.3 (78.4%)**	**775.2 (77.7%)**	**846.3 (73%)**	**1 003.4 (72.4%)**
Out-of-pocket payments	93.0%	99.0%	99.0%	98.8%	97.9%
Mandatory funds	6.5%	–	–	–	–
Voluntary insurance contributions	0.5%	1.0%	1.0%	1.2%	2.1%
International aid not included in the budget	**54.0 (7.4%)**	**50.7 (6.1%)**	**27.4 (2.7%)**	**58.8 (5.1%)**	**127.7 (9.2%)**

Source: MoLHSA 2009b.

Informal payments

Informal payments can be defined as direct payments to individual or institutional health care providers, in kind or in cash, that are made outside official payment channels, or purchases of goods or services that are meant to be covered by the health care system, but in practice informal charges are levied (Lewis 2000). In Georgia, fees for services which are not covered by the state should be paid to the health institutions according to the "internal standards" established by the organization. Although direct payments, as detailed above, occur through formal transactions according to advertised prices, cases of "direct transactions" with physicians are still encountered. However, they are not as common as they once were because there is less space in the system for them to occur since benefits under the state health programmes have been reduced.

Historically, in hospital settings, physicians who treated the patient asked for direct payments in exchange for higher-quality care. The traditional lament of those levying informal payments was that they only received a very small amount (7–8%) if anything of formal payments paid at the cashier (Belli, Gotsadze and Shahriari 2002). Patients also often believed they would be charged less by paying informally; and providers endorsed this through reducing the price charged to patients either by not reporting the service to the

administration or by manipulating the diagnosis so that the service would be covered by a pre-paid scheme. For example, most emergencies covered under a state health programme occur in office hours Monday to Friday while few occur at weekends. Evidence suggests that insured patients are less inclined to make informal payments (Hou and Chao 2008). However, the issue of informal payments is one which requires further investigation given the changed environment.

3.3.2 Compulsory sources of finance

In late 2004, a new Tax Code was passed by the parliament to initiate tax reforms promoted by the government. The new Code eliminated a large number of small taxes which were by their nature more nuisance taxes than major revenue raising instruments. One of the main objectives of the Tax Code reform was to simplify the tax system, making it easier to administer and enforce. From a total number of 21 taxes, Georgia now has only five taxes: income tax (personal and corporate); VAT; excise duty; property tax and tax on gambling business. The social tax, was withdrawn in January 2009. Another theme in the tax reforms was to try to encourage voluntary compliance by distributing the tax burden more equitably. Previously, high payroll taxes and social contributions, collectively amounting to almost 53% of the payroll, had driven employment into the shadow economy. Employers typically showed a smaller number of "official" employees on their books than they had working in reality, and showed employees working for minimum wages when they would often actually be working for competitive market wages, the supplementary component being paid in cash. Personal income tax was reduced from a top marginal rate of 20% to a flat rate of 12% without an income threshold. Total social tax contributions to several different funds (with the employer paying 31% and the employee paying 2%) were merged into a single social tax of 20%, and from 1 January 2009 personal income and social taxes were merged into a single 20% income tax. In an effort to encourage voluntary compliance with VAT and reduce undisclosed sales in the shadow economy, the VAT single rate has been reduced from 20% to 18%.

Although VAT, income tax and social tax rates have also been reduced, a substantial compensatory increase has been made in the rates of excise duties on alcohol, petroleum products, tobacco and automobiles. Excise duty on petroleum and automobiles had previously been low by international standards. Corporate income tax has been reduced to a 15% rate. Most changes

in corporate income tax have been made to: limit the number of exemptions; streamline depreciation allowance; remove ambiguity in some provisions; and introduce certain restrictions on thin capitalization.

The State Tax Department of the MoF is responsible for collecting all taxes, which are brought together in the accounts of the State Treasury. The MoF redistributes resources between *rayons* and municipalities (see Section 3.4 *Pooling of funds*). The Law on Local Self-government Budgets (2005) and the Law on Budgetary Distribution of Tax, Non-tax and Capital Revenues (2007) regulate the distribution of collected funds to the central and municipal budgets.

3.3.3 Voluntary health insurance

Private health insurance in Georgia is subject to the Law on Insurance (1997) and is largely regulated by the Civil Code. A supervisory body – the Insurance State Supervision Service of Georgia was created in 1997 to implement state objectives in the insurance sphere and to provide state regulation of insurance activities. Although initially an independent legal entity, in 2007 the ISSS became part of the National Bank of Georgia. The financial means for the service is provided by a 1% levy on the insurance premiums paid by insurers and funders of non-state pension schemes.

Since Georgia joined the WTO in 1998, any foreign legal entity or body, or insurance and reinsurance company, has had the right to hold a 100% share in Georgian insurance companies. Foreign insurance organizations have been allowed to act as a principal insurer in Georgia since December 2004. Currently, foreign insurance and reinsurance companies, registered and licensed by the relevant authorities in Organisation for Economic Co-operation and Development (OECD) member countries, are granted the right to pursue insurance activities. From 2005, branches established by foreign insurance companies registered in OECD countries have been permitted to function without needing a licence from Georgian authorities.

When a free choice of health provider is allowed, the insured person pays the provider out of pocket and the amount is reimbursed by the insurer; third-party payment is applied when insurance members seek health care from providers accredited by the private health insurers, in which case the provider is directly paid by the insurer for the services provided to their members.

Since September 2007, private insurance companies have administered public health funds to provide health insurance to the population living below the poverty line (and some government employees such as teachers) in the

scope of a state health programme. This has significantly boosted the health insurance industry and private health insurers are in the process of extending their reach to the regions by opening up a number of branches. Although regional expansion is ongoing, the private insurers currently only cover some of the more important regional centres. To some degree, private insurers currently tailor their health insurance products to the financial capacity and preferences of corporate clients. This gives rise to a large number of different coverage packages at different premiums. Therefore the market is difficult for the individual consumer to navigate. Private insurers compete on products, prices, provider choice (accredited and/or free choice of provider), services and geographic distribution.

3.3.4 Parallel health systems

Other ministries, such as the Ministry of Defence, Ministry of Interior, etc also contribute to health spending, albeit less than 1% of total health expenditure. Spending on parallel health services is included in public health expenditure figures. These other ministries provide some services to their current and retired staff but these services are no longer as extensive as they were before independence under the Semashko model.

3.3.5 External sources of funds

A further source of health care funds is the international donor community. It contributes in the form of grants and loans, either directly to the MoF in the form of budgetary aid, to the MoH to support specific health sector programmes or via extra-budget programmes and projects. During the last decade a significant amount of international aid has been given to the country, mainly targeting the development of human capacity, infrastructure and technical work for the development of the health system, although the level has been falling more recently. The coordination of external aid provided from many different organizations remains a challenge.

3.4 Pooling of funds

3.4.1 Pooling agencies and allocation

Public funding for personal health services is pooled via HeSPA. Funding for public health services (health surveillance, immunization, etc.) is pooled by MoLHSA. Out-of-pocket payments, which accounted for 71% of health

expenditure in 2007, are by definition not pooled. There is multiple pooling through private health insurance companies involved in the State Health Programme on Medical Insurance for the Population below the Poverty Line.

3.4.2 Mechanisms for allocating funds among pooling/ purchasing agencies

Revenues from general taxation are brought together in accounts of the State Treasury of Georgia. The distribution of collected funds to the central and municipal budgets is regulated by the Law on Local Self-government Budgets (2005) and the Law on Budgetary Distribution of Tax, Non-tax and Capital Revenues (2007). The MoLHSA prepares the budget on an annual basis for publicly funded health services, which is to be spent through the state health programmes. As there are no earmarked funds for health, the entire budget has to be negotiated between the MoF and the MoLHSA. The final decision on the budgetary allocation to the MoLHSA lies with the parliament.

Priorities for the state health programmes are decided by the government in consultation with the MoLHSA, and each programme has its own budget. Budgets are set annually. Historically there was a problem with ensuring that all the resources allocated to the state health programmes were actually disbursed, although this is no longer the case. Setting priorities for state health programmes has also lacked transparency, but it is clear that academics and clinicians working in specialist care have been highly influential in lobbying for certain high technology services to be included in the state health programmes (such as transplant surgery). Reallocation of resources between the sectors almost never happens within the budget year. If the government changes its priorities, for example favouring PHC, it would be reflected in the next year's budget. For the state-funded private health insurance programme, funds are allocated based on an estimated annual premium per insured person included in the relevant database, which is weighted for those aged over 65 years.

3.5 Purchasing and purchaser-provider relations

The organizational relationship between purchasers and providers has been shifting from one based on an integrated model to a contracting model. Individual health care providers are not employed by the state but by the health facilities where they work, and all health facilities are independent actors, but payment mechanisms for the state health programmes differ according to the nature of the services to be purchased. Private health insurance companies

purchase the health care benefit package for the vulnerable population and some government employees through the relevant state health programme. Private insurance companies also purchase services for those with voluntary health insurance. Any services outside the state benefit package are purchased by the population from the service provider of their choice in an open market, in most cases through formal and informal out-of-pocket payments, and through private insurance for those who have it.

Rayon branches of the HeSPA purchase health care services from contracted service providers; neither legal status, nor the form of ownership matters in the process of contracting, so that private and public institutions are considered on an equal basis. Since 2009, in order to improve transparency in purchaser-provider relations, the system has moved towards more patient-led services. HeSPA provides a list of prices for hospital services based on nosological groups and per capita rates for primary care services covered under state health programmes outside the private insurance programmes. Prices are often close to those reimbursed by private insurance companies. Any provider can agree to contract with HeSPA to provide services under these state health programmes, to be reimbursed at the fixed price. For hospital services, on referral, patients are provided with vouchers and they are free to choose any facility which provides the given procedure (e.g. bypass surgery) and which has contracted with HeSPA (in practice, nearly all facilities do) in order to benefit from the relevant state health programme.

MoLHSA issues normative acts to define technical regulation for the implementation of particular state health programmes. MoLHSA defines a set of necessary medical interventions and the prices for reimbursement by HeSPA to service providers within the boundaries of the state health programmes. HeSPA is not a true health service purchaser using selective contracting, but more an administrator of budgetary funds. Either there is no meaningful choice of service provider, or the patient makes the selection, although it is not clear by what criteria (see Section 2.5 *Patient empowerment*).

3.6 Payment mechanisms

3.6.1 Paying for health services

Formal charges for medical services outside the state health programmes are set by the providers through the "internal standards" in hospitals and fees for outpatient services. For services covered under the government-sponsored

insurance package, payments are made retrospectively according to the contracts agreed between the private insurers and specific facilities. Insurance companies "shop around" to find the best prices for different procedures and contract with facilities according to agreed prices for specific procedures. Payments are then made retrospectively, except where particular private insurance companies are known to be unreliable; in such cases facilities expect payment "upfront". Insured patients can go for treatment at a hospital not covered under their insurance, but if the procedure costs more, the patient must pay the difference in price. Under other state health programmes which cover some hospital services, patients are given vouchers on referral so they can choose their provider. TB services are paid for using a mix of capitation, global budgets and other mechanisms.

Those primary care services funded by the state are prospective at a fixed annual per capita rate, and the providers contract with HeSPA and private insurance companies to provide services. The contracting means that patients covered under the insurance for especially vulnerable groups or the "5 Lari" package do not have a choice of PHC provider; unless they pay out of pocket, they need to go to the PHC provider that contracts with their private insurance provider and this may not be their usual polyclinic. Where the patient is covered under the private insurance scheme for especially vulnerable households as well as qualifying under a different state health programme (such as that providing PHC for rural populations) the cost is borne by the private insurers with no co-payment and not by HeSPA.

Since 1996, with the exception of TB and psychiatric hospitals, the provider payment mechanism for hospitals was also mainly case-based. The hospitals were paid retrospectively based on their monthly activity reports. However, the total budget could not exceed quarterly provisions (the ceiling), which in practice capped the provider's budget so that debts could not accrue in the system. If the provider delivered more services than could be refunded within one quarter, the provider did not receive payment for any services provided in excess but could keep any savings made. In practice, the budget received by the hospitals often did not cover the full cost of services delivered, which led to rationing and unofficial invoicing strategies by health providers. These included double invoicing (to both the MoLHSA and the patient), price-setting in relation to a patient's ability to pay, loosely assessed by the health care provider, and informal under-the-counter payments.

The scaling down of benefits available under the state health programmes has simplified the system and reduced opportunities for such informal practices as the patient is expected to pay full price out of pocket for treatment more often. For planned hospitalization and primary care visits the patient pays upfront for the services to be provided according to the price list which is fixed at the facility level. For emergency care, hospitals treat first and then invoice patients. Hospital staff are available to meet with the families of patients to explore payment options, such as applying for hardship funds, and major banks have branches in hospitals to process payments. Officially, patients should pay their bills before discharge, but this is not always possible. Individual hospitals are responsible for any budgetary deficits accrued.

3.6.2 Paying health care personnel

Salaries for health care personnel are not determined by the government or MoLHSA but by their employers – the managers of the health care facilities where they work. Payment is negotiated on an individual basis between health care personnel and facility managers, and can be based on workload or an agreed salary, or have elements of both. State health programmes define the price of the service to be paid to the medical facility, which includes hourly remuneration rates for surgical staff and monthly rates for primary care staff which are low, and these rates can be used by facility managers to justify paying their staff low salaries. However, managers are now finding it necessary to pay higher wages to retain high-quality, motivated personnel in the marketplace and the government has been exploring ways of remunerating rural primary care doctors to encourage them to stay in rural practice. Previously they were employed by the district polyclinic, whereas now they have all been made individual budget holders and thus have more flexibility in deciding their own pay by economizing in other areas.

4. Regulation and planning

4.1 Regulation

Since late 2003, the main drive has been to deregulate the health system in Georgia, in the same way that deregulation has been introduced in other sectors. The approach to regulation has been to allow market mechanisms to regulate relations between users, purchasers, providers and public authorities, and to downsize an excessive public sector which was empowered with regulations and characterized by corruption. From autumn 2006, greater emphasis has been given to the development of new laws, or the modification of existing laws, as a vehicle for enacting health policy decisions. The Law on Public Health was elaborated and approved in 2007. The draft Law on Pharmaceuticals was prepared in 2007 and approved in 2009 (see Chapter 7 *Principal health care reforms*). The draft law on service provision has been prepared, but not finalized by the MoLHSA. It was decided to concentrate less on the regulation of service purchasing (beyond existing regulation) in the first stage of the reforms. The regulation of purchaser-provider relationships has not been updated and this is a significant gap in current health legislation.

In most cases laws have not been accompanied by adequate norms and standards, and it is not clear whether this has happened by design or by default. Most of the health care reform initiatives were planned without elaborating necessary regulatory tools and arrangements. It was hoped that new contractual and accountability arrangements between the government and the private sector, and adequate health management information systems and purchasing instruments would evolve. Consequently, there are significant holes in the regulatory environment, which are theoretically to be filled through market self-regulation; however, where there is no profit, the market has no incentive to develop the necessary regulatory mechanisms, so it cannot be relied on to fill all the gaps (Dunn 2008).

4.1.1 Regulation and governance of third-party payers

Prior to the 2007 reforms, private insurance companies were of little importance for the state regulators, as they collected less than 1% of total health expenditure. In addition, private insurance companies were concentrating on the high-income segment of population. The formal body for the regulation of the private health insurance industry was the "Insurance Supervisory Agency", which regulated all types of insurance, including health. Therefore, before the end of 2007, this agency possessed inadequate instruments for supervision of an expanded private health insurance market. The organizational structure and leadership of the agency was changed at the end of 2007. At the time of writing, the implications of this change had not been assessed.

4.1.2 Regulation and governance of providers

From 2000 to date, the government has used mainly ex ante regulation through the licensing of medical facilities and mandatory certification of medical personnel (see Section 5.2.3 *Registration/licensing*). The licensing of medical facilities is formally conducted by the MSRA, under the MoLHSA, according to norms and standards approved by the government. The Law on Permits and Licences, adopted in 2005, has reduced the number of activity licences from 302 to 42 types of general licences, embracing 72 special subtypes of licences. Currently the MoLHSA is working on a further reduction in the number of licences and substituting licences with permits for hospitals and PHC facilities. In response to the development of a new Hospital Master Plan (see Section 5.1.1 *Infrastructure*), and the government plans to replace all existing hospitals with new or refurbished ones, licensing standards were updated in 2007.

A certification process for medical professionals is conducted by the MSRA in 21 specialties. A further reduction of certified specialties and the substitution of certification for the licensing of medical personnel have been discussed in 2007–2008. Some medical professions are not regulated at all. For example, there is no process for the certification or licensing of nurses and nursing specialties are not defined. This leaves the profession in an ambiguous position and widely hinders the development of specialized nursing competences and best practice.

4.1.3 Regulation and governance of purchasing process

If the provider, regardless of ownership and legal status, participates in providing services under state health programmes, it has to follow administrative norms defined by MoLHSA for the particular state programme. HeSPA incorporates

these requirements into the contract accordingly. HeSPA acts more as a claims administrator for the state health programmes, rather than an active purchaser, because the patients choose the providers themselves in the open market and limitations on the choice of providers are set by the private insurance companies. Purchasing for the majority of services happens at the time and place of service provision, through out-of-pocket payments from patients (see Section 3.3 *Revenue collection/sources of funds*)

Regional HeSPA agencies transmit a report on services delivered and forecasted to the central HeSPA office before the 15th of each month. Reports from central HeSPA go to the MoLHSA Department of Financing. HeSPA (regional as well as central branches) focuses its efforts on essential functions only; few resources are devoted to periodic financial auditing or quality control of the information delivered by the providers. Quality-of-care management is also virtually absent in this process. The periodic activity reports for MoLHSA provided by the service providers theoretically provide information for the MoLHSA so it can adapt its budgetary provisions for the coming year, but in practice they do not play a major role in budget planning.

4.1.4 Regulating quality of care

Due to the independent status of the provider organizations, the MoLHSA is not allowed to fully monitor service provision. The only entry point for the MoLHSA is the inspection of staff certificates and facility licences. MoLHSA can only undertake an investigation/assessment of a facility's activities that fall under the regulation of the Law on Entrepreneurship with the court's permission. However, the judge will only grant permission on the basis of reasonable evidence – that is, customers' complaints or evidence of malpractice. At the same time, due to contractual arrangements between the service purchaser and service delivery organization, the purchaser (nominally HeSPA) is the only agency eligible to assess the performance of service providers and report on the quality of care provided. In reality, performance assessment does not take place and the purchaser focuses on the assessment of financial resource utilization.

Since 2006, the government, in close cooperation with professional associations, has been actively supporting the elaboration of clinical practice guidelines and protocols. MoLHSA has already approved National Practice Guidelines in a many specialties which are recommended (not mandatory) and these set the standard of care against which patient complaints would be judged. However, there is a mismatch between the elaborated guidelines and the "practice standards" of the state health programmes, and the clinical practice

requirements of new investors and private insurance companies for health service providers. Because of imbalance between the MoLHSA's supervisory power and investors' influence on service providers, it is more likely that investors are better placed to promote their own standards for medical practice. In this case, the relevance of national protocols and guidelines becomes questionable.

In conclusion, the quality of services in terms of their ability to satisfy the stated or implied needs of the users is not monitored; and there is no system in place to monitor the compliance of interventions with established standards. There is also no full articulation of the work, in terms of well-defined roles and functions, which would allow services to "generate" quality.

4.2 Planning and health information management

4.2.1 Health technology assessment

Health technology assessment (HTA) has been defined as "a form of policy research that systematically examines the short- and long-term consequences, in terms of health and resource use, of the application of a health technology, a set of related technologies or a technology related issue" (Henshall et al. 1997). HTA should allow the introduction of only those new technologies that have been proved to be effective and efficient in improving treatment. As such, HTA has not been practised in Georgia. Only assessments of the safety and efficacy of pharmaceuticals and some medical devices and technologies have been introduced and implemented with varying degrees of success. The state agency responsible for monitoring and assessment is the MSRA (see Section 2.3 *Organizational overview*). The MSRA develops and supervises compliance with minimal requirements for medical equipment, as part of the licensing requirements for medical facilities. The efficacy of medical devices, procedures and prostheses is not assessed at the national level. Potentially, outdated technologies, for example X-ray machines from Soviet times, present a significant threat to the health of patients and medical providers working with them. The use of HTA from other countries is being considered.

4.2.2 Information systems

Details on the collection of basic health indicators are given in Section 1.4 *Health status* and details of the National Health Accounts are given in Section 3.1 *Health expenditure*. A core issue for the development of health information systems in Georgia, as in other countries of the former Soviet Union, is the need to break away from Soviet models of health information systems as tools for data creation to move towards more dynamic models, which provide not only timely, high-quality data, but also link it to key performance indicators, so that information systems can underpin evidence-based policy-making and be used to improve health management at all levels. In Georgia specifically, the moves towards deregulation and marketization of service provision have seriously hampered data collection from service providers (MoLHSA 2009a). Recent efforts to improve information systems have included moves towards the full implementation of ICD-10, and the Financial Monitoring Service of Georgia, in collaboration with the insurance industry and MoLHSA, has developed and issued new regulations to govern information exchange between insurance providers and the state, to monitor losses and revenues as well as financial solvency requirements of private insurers. Information transparency and disclosure requirements are imposed through state-sponsored private health insurance schemes. Efforts are being made to improve the information flow, its quality and transparency and accessibility for the public, which is expected to form solid ground for improved regulation at a future date.

5. Physical and human resources

5.1 Physical resources

5.1.1 Infrastructure

There were 265 inpatient facilities with 14 565 beds in Georgia in 2007 and 331.9 hospital beds for every 100 000 population (WHO Regional Office for Europe 2009) (see Table 5.1). In hospitals there were 7892 posts for physicians and 11 514 for middle-level medical staff. On average there were 2.2 hospital beds per physician and 1.5 hospital beds per nurse (Imnadze et al. 2006). However, following the comprehensive privatization of the former Semashko system, and the subsequent management decentralization, there are currently no effective mechanisms for enforcing the mandatory reporting of health information and statistics from health service providers, which means that the data on utilization and capacity are unreliable (MoLHSA 2009a).

Table 5.1

Number of beds per 100 000 people in acute care hospitals, psychiatric hospitals and long-term institutions, selected years

Years	Acute care hospital beds per 100 000	Psychiatric hospital beds per 100 000	Nursing and elderly home beds per 100 000
1980	879.9	95.9	–
1985	865.6	93.6	–
1990	857.5	84.9	–
1995	679.7	54.6	–
2000	434.2	26.9	6.8 (1999)
2005	384.3	29.1	–
2006	343.6	35.0	–
2007	291.5	28.1	–

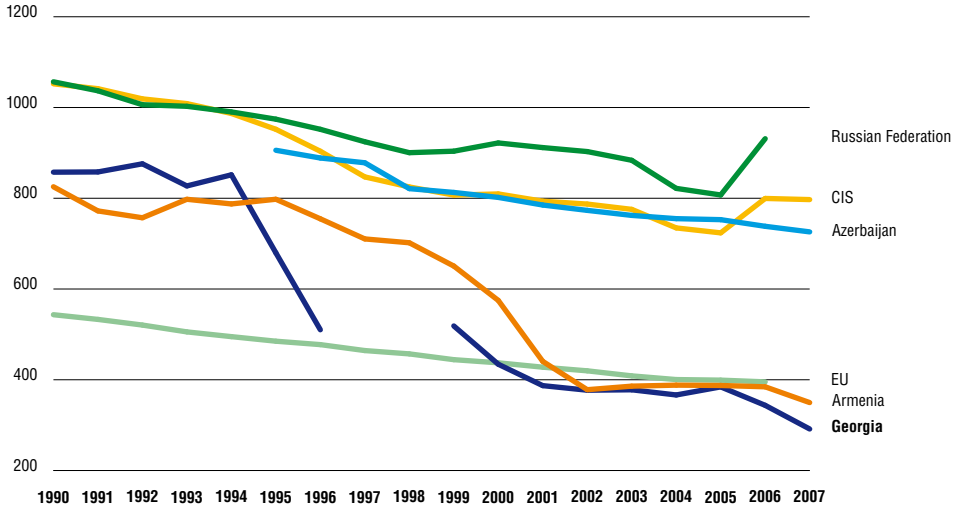
Source: WHO Regional Office for Europe 2009.

The number of acute hospital beds has declined substantially since 1990 (see Fig. 5.1) as acute beds are used less for patients requiring social or chronic care. The decline has not, however, been accompanied by an increase in the number of beds in care institutions for elderly or chronic diseases patients. Severe consequences of this change have been partially mitigated by the tradition of Georgian families caring for their elderly or disabled members, but high rates of unemployment and poverty makes it very difficult for many families to uphold this tradition.

Following the change of government in 2003, the Hospital Master Plan that was in place was abandoned (see Section 2.2 *Historical background*). A new attempt at optimization began in 2004 which articulated geographical accessibility as the optimization criteria. The aim was to guarantee access to basic hospital care within 45 minutes driving distance for 90% of the population. The plan suggested the establishment of 26 multi-profile and general hospitals countrywide, with two tertiary hospitals for east and west Georgia, and emergency care centres for the coverage of populations living in remote places. The total hospital capacity envisioned was 11 000 beds nationwide. However, before the proposed model was trialled, it was replaced by the Hospital Development Master Plan, announced at the end of 2006. This latest plan aimed for rapid changes, divesting the state of its stake in the hospital stock and the building of "100 new hospitals for Georgia". The concept for the latest master plan was that private provision of services would lead to increased capital investment, competition, patient choice and higher-quality hospital services. Consequently, most hospitals were put on a privatization list, with the exception of six hospitals in Tbilisi – two multi-profile, one paediatric, one TB hospital and two psychiatric hospitals. The listed six hospitals had to continue to be in state ownership, while all others will be in private ownership.

The Hospital Development Master Plan was passed by government resolution in January 2007 and the MoLHSA and the MoED were charged with ensuring its implementation. Private investors were to build 100 new hospitals with 7800 beds (4185 in Tbilisi and 3615 in the regions) within three years. The content and implications of this new plan are elaborated in Section 7.1 *Analysis of recent reforms*, but it is hard to comment on its impact as there were no data available at the time of writing on the number of hospitals put up for sale or the number of hospitals sold under the programme.

Fig. 5.1
Acute care hospital beds per 100 000 in Georgia and selected countries, 1990 to latest available year



Source: WHO Regional Office for Europe 2009.

In 2005, 674 primary health care facilities were reporting to the National Centre for Disease Control and Health Care. These included 180 independent polyclinics, 51 medical centres, 100 independent dental clinics, 19 women's consultation centres, 77 dispensaries and 247 independent ambulatories. There were 437 dependent ambulatories and 385 dependent nurse-midwife points in the form of ambulatory-polyclinic associations (for details on the provision of primary care, see Section 6.2 *Primary/ambulatory care*). From the total number of 81 ambulance stations (in charge of providing emergency care on call), only 72 were independent, and 9 were dependent, functioning together with other health providers. However, since 2005, when the mandatory licensing of most health services was abolished, MoLHSA has not been able to monitor the number of functioning health services providers (MoLHSA 2009a).

5.1.2 Capital stock and investments

After the collapse of the Soviet Union, there was no investment in the rehabilitation of health facilities until the implementation of the first hospital restructuring plan, which resulted in the rehabilitation of a relatively small number of hospitals. As detailed above, the Hospital Restructuring Fund reinvested in health care infrastructure and equipment the accumulated

finances from the privatization of a defined number of hospital facilities. Some unplanned renovations also happened, that is, individual initiatives of providers and managers, investing their own money in the reconstruction of state-owned facilities, with the hope of attracting more patients. Since the service providers in Georgia are allowed to generate income through the provision of private services from public facilities, they had the financial motivation to invest in renovations. Since the Rose Revolution, the size of the state rehabilitation programme has been modified several times, reaching 42 million lari in 2005 and 54 million lari in 2006, to be spent on the rehabilitation of hospitals and PHC facilities countrywide. However, this budget shrank significantly in 2008 following the substantial change of policy direction in 2007, shifting to private provision and private investments for health infrastructure development.

5.1.3 Medical equipment, devices and aids

By law, the purchase of medical equipment and machinery, as well as pharmaceuticals and medical items by the public sector is conducted using tendering, regulated according to the Law on State Purchases (2005). This law defines the type of tender according to the amount of a service to be purchased; it could involve negotiations with one person, a price quotation, open international or closed (one- or two-step) tender. The tendering documentation should cover the technological specification of the product to be bought (concrete technical parameters, quality standards, warrantee terms and demands on staff training).

The purchasing decision itself is made by managers and policy-makers and is not regulated. The decision is mostly linked to the availability of finances. There is no scheme to ensure equal distribution of medical equipment to different geographic zones, nor statistics on the distribution of equipment.

Medical technologies are not regulated in the private sector, because the relevant changes to the Health Care Law in 2003 have not been implemented. There is no system of registration for medical equipment; there is no system for its further metrology or approval of the measuring parameters (see Section 4.2.1 *Health technology assessment*). The quality control of medical technologies is done by self-regulation, which means, that the equipment supplier and/or service provider is responsible for ensuring that international standards are met.

5.1.4 Information technology

In 2007, there were 8.2 Internet users per 100 population in Georgia, which is low in international comparison – the average for Europe and Central Asia was 25.8/100 in 2007 (World Bank 2008). Also, the utilization of information technology is lower in the health sector than the average country rate. Computer use is confined mainly to Tbilisi. There is no exact information on the utilization of information technology at different levels of health care. The purchase of information technologies is carried out according to the provisions of the Law on State Purchases (2005), but there is no information technology planning or national IT strategy in Georgia.

5.1.5 Pharmaceuticals

According to a household survey conducted in Tbilisi in 2000, ill respondents reported that they spent more on drugs (about 55%) than on the medical service itself (Gamkrelidze et al. 2002). Most of these respondents indicated that they were not able to purchase all the necessary medicines, because the medicines were too expensive for them. The Georgian health utilization and expenditure survey found that 18% of people who reported that they were sick in the previous 30 days said that they did not have a consultation because they could not afford it, and for around 12% of all consultations it was reported that prescribed medicines were unaffordable (this constitutes 14% of consultations where medicines were prescribed) (MoLHSA 2007c).The proportion reporting that they could not afford medicines was highest among the poor. However, even among the richest quintile, 9% felt that medications were too expensive, suggesting that some medicines may be expensive to purchase, or judged not worth purchasing, even for the wealthiest part of the population. Cost remains the key barrier to accessing pharmaceuticals in Georgia. Available data on pharmaceutical consumption are very limited. There are no routine processes for drug utilization review; no country statistics by defined daily dose of drug per 1000 population; no records of adverse drug reactions (ADRs) or of medication error reporting available. Georgian National Health Accounts estimates put retail pharmaceutical expenditure at 488.6 million lari or 35.3% of total health expenditure in 2007, and private expenditure on retail pharmaceuticals was 44.7% of private health expenditure in 2007 (MoLHSA 2009b).

The state provides a limited amount of free and/or subsidized medicines to patients through preventive and curative programmes as designated by the MoLHSA. All medical facilities eligible to implement the state health programmes are obliged to maintain stocks of medicines that are listed in

the state standards. In order to fulfil this requirement, the facility managers identify pharmaceutical suppliers through tenders. Due to the shortages and discontinuity of public funding, hospitals have not always been able to keep all the essential drugs mandated by the MoLHSA, and patients supposed to receive free and/or subsidized medicines have been asked to purchase medications out of pocket from private pharmacies and bring them to the hospital.

There are currently no import taxes or VAT applied to pharmaceuticals, in order to counteract incentives for developing an illegal market in pharmaceuticals. Indeed, the Georgian pharmaceutical market is now one of the fastest-growing markets in the country. The commercial retail pharmaceutical market has grown dramatically from US$ 9 million in 1996 to approximately US$ 305 million in 2007. The number of pharmaceutical importers has decreased considerably from 187 officially registered wholesale companies in 1996. The Georgian pharmaceutical market in 2004 was supplied by 13 wholesale companies. The import share of other small companies totalled only 10% (MoLHSA 2006). In 2005, of the 124 distributors, 12 companies controlled 90% of all pharmaceutical imports, with three of them controlling around 70% (Drug Agency 2005).

In principle, all routinely required pharmaceuticals are available in Georgia. However, some variability can be observed in the distribution of pharmaceuticals throughout the country, and while all routine medicines can be found in Tbilisi, in rural and in remote mountainous regions with a smaller population and lower per capita income, the full range of medicines may not be available. Generally, people living in remote villages do not have access to medicines within their community or nearby. In 2007, there were 2017 retail and 95 wholesale pharmacies in Georgia, but of these, 823 retail pharmacies were in Tbilisi and 325 were in Imereti, while Mtskheta-Mtianeti has only 28 for a region of 6800 km^2 and population of approximately 124 000 (Curatio International Foundation 2007).

The Georgian Law on Drugs and Pharmaceutical Activities (1997) is the primary legislation in pharmaceutical sector. However, some drawbacks of the law and its implementation have been observed (Bailey 2005), for example, the law forbids a financial relationship between doctors and pharmaceutical enterprises, but such activity is said to be a common occurrence in Georgia, particularly since the large-scale hospital privatization process began (Transparency International Georgia 2007). Similarly, the law refers to the monitoring of side-effects of medication but there is no evidence that such a process is in operation. The purchase of medicines without prescription

makes routine ADR monitoring impossible (Bailey 2005). Quality control of pharmaceuticals available on the market is also minimal; the number of drugs being tested has fallen from 10% in 2005 to 2.6% in 2007. Due to extensive deregulation of the pharmaceuticals market and the absence of organized regulatory activity, the data available on false, substandard or expired drugs on the market identified through quality control procedures does not provide an adequate picture of the quality of drugs available in the health system (MoLHSA 2009a).

Although a National Drug Policy exists (as part of the National Health Policy of 1999), full implementation of the drug policy was not feasible. The existing policy calls for the further development of the pharmaceutical industry of Georgia. However, at the present time, the Georgian pharmaceutical industry has approximately 2% of the pharmaceutical market share, and the country is reliant on imported pharmaceuticals. Overall, state influence and control in the pharmaceutical sector has been weak, although there have been recent moves to simplify the licensing procedures (particularly by accepting EU Standards) and to open up the market so it is not concentrated in the hands of just three key actors.

5.2 Human resources

5.2.1 Trends in health care personnel

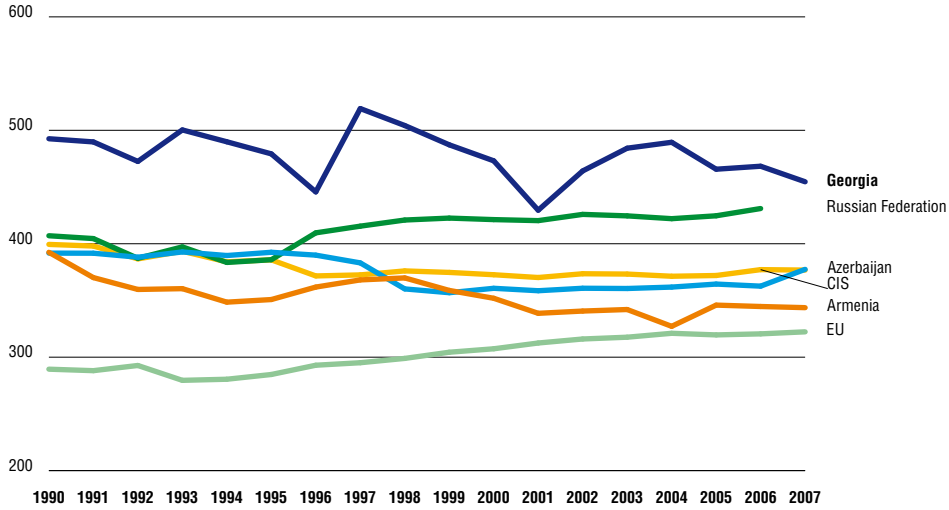
According to the MoLHSA Statistical Department, in 2005, 20 311 doctors (in total, regardless of their professional activity) were certified to carry out independent medical activity, which equated to 4.7 qualified doctors per 1000 inhabitants. Georgia traditionally had high levels of medical staffing, particularly doctors, even compared with other states of the former Soviet Union, a trend that has continued since independence (see Fig. 5.2). However, although there are a large number of trained doctors in the country, they are very unevenly distributed. There is a concentration of doctors in Tbilisi where there are approximately three times as many doctors as there are in other regions. Remote and rural areas find it particularly difficult to recruit and retain doctors and, while differences in distribution are to be expected and exist in all health systems, the concern is one of access and equity for those populations who are underserved (OPM 2005). For this reason, changes were made recently to the funding mechanisms for rural primary care doctor and nurse teams.

The number of middle medical staff has decreased dramatically since independence; there were 9.8 nurses per 1000 in 1990 and 3.6 in 2007 (see Fig. 5.3). In Georgia, the number of nurses is the lowest among the post-Soviet countries. In comparison with West European countries, the balance between the number of doctors and nurses is reversed and, overall, the number of nurses in the country is low, reflecting the very low status of nurses (see Fig. 5.4). Similarly, although historically Georgia has had a very high number of dentists per capita, since 1991 the number of dentists has been falling and it is now at the CIS average despite being considerably higher at independence (see Fig. 5.5). The number of pharmacists has also decreased dramatically (see Fig. 5.6).

5.2.2 Planning of health care personnel

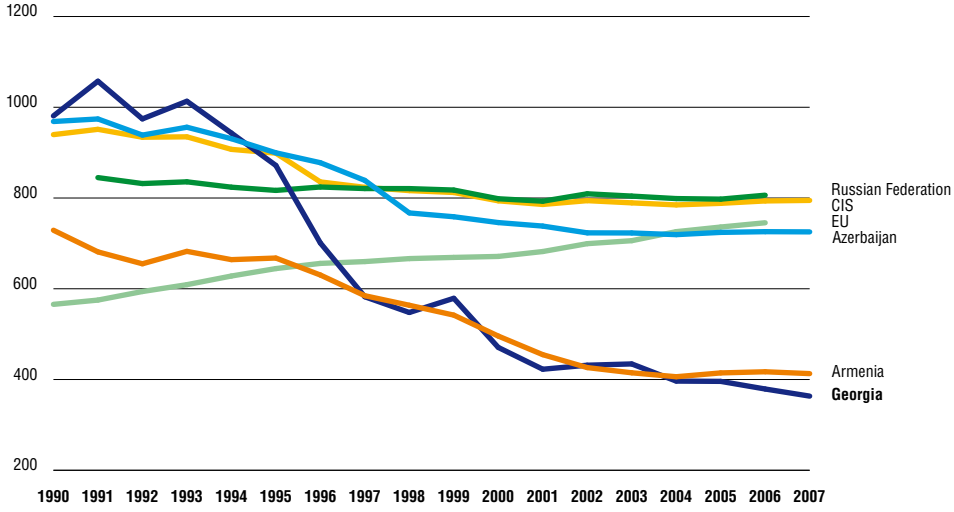
There was only one higher education medical institution before 1991 in Georgia – the Tbilisi State Medical Institute – and about 600–800 students were enrolled each year during the Soviet period. Radical changes to the constitution and regulatory acts covering the state education system in 1991, meant that in 2004 undergraduate medical education in Georgia was provided by four state and 69 private higher education institutions (with approximately 15 000 students), 22 of which were located in Tbilisi. This has led to massive increases in the number of doctors being trained in Georgia (OPM 2007b).

Fig. 5.2
Physicians per 100 000 population in Georgia and other selected countries from 1990 to latest available year



Source: WHO Regional Office for Europe 2009.

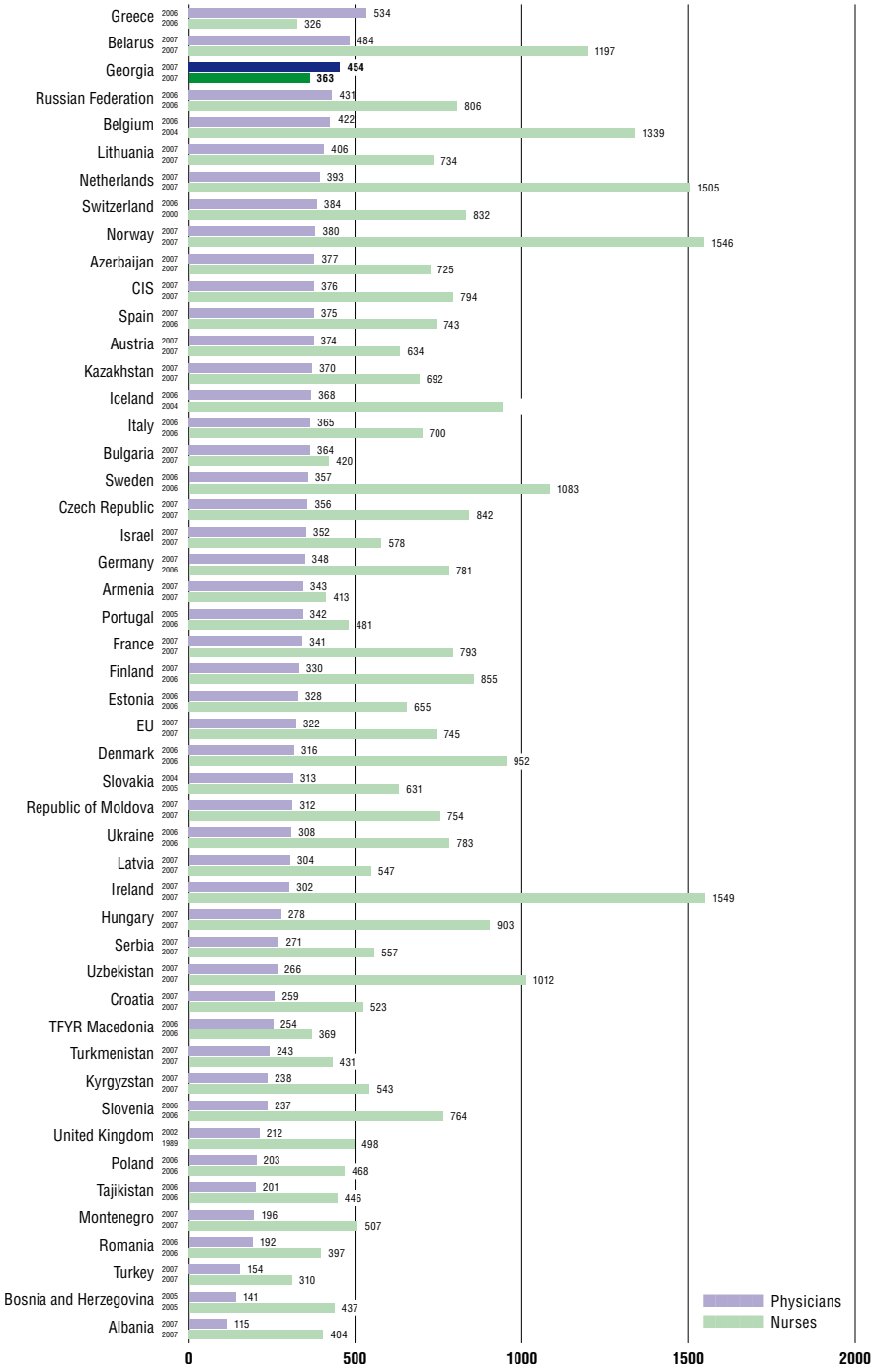
Fig. 5.3
Nurses per 100 000 population in Georgia and other selected countries from 1990 to latest available year



Source: WHO Regional Office for Europe 2009.

Fig. 5.4

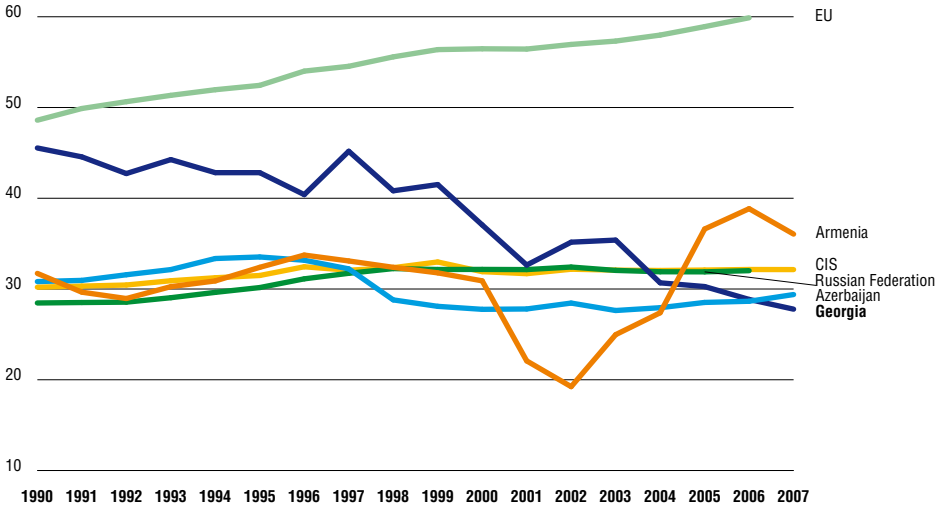
Number of physicians and nurses per 100 000 population in Georgia and selected other countries in WHO European region, latest available year



Source: WHO Regional Office for Europe 2009.

Fig. 5.5

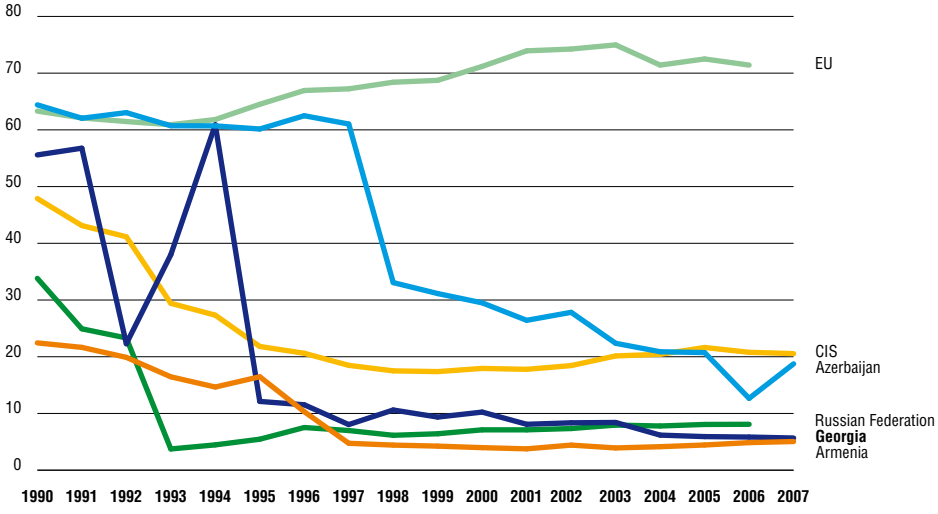
Dentists per 100 000 population in Georgia and other selected countries from 1990 to latest available year



Source: WHO Regional Office for Europe 2009.

Fig. 5.6

Pharmacists per 100 000 population in Georgia and other selected countries from 1990 to latest available year



Source: WHO Regional Office for Europe 2009.

The rapid increase in the number of higher education institutions teaching medicine is a response to the demand for places, but it has meant that Georgia continues to have an extremely large number of doctors. However, the MoLHSA had little control over their supply in terms of numbers or specialization. Responsibility for the regulation of higher education medical institutions was given to the Ministry of Education (MoE) in 2004. In the first cycle of the accreditation process the focus was on the institution itself and its management and resources, as well as focusing on programme-specific issues. In the next cycle (2006 onwards) the focus was on quality improvement and enhancement in specific subject areas. Following this process, the number of higher education medical institutions decreased to 34 in 2006.

From 2006, the MoE has held unified national university entry exams. The successful candidates are granted higher education vouchers. Depending on examination results, the state covers 100%, 75% or 50% of the cost of study. The number of places at a particular institution depends on the physical and human resources capacity available, assessed and defined by the State Accreditation Board. The number of fully or partially financed places depends on the availability of budget funds and it varies from year to year, with a tendency for it to increase. There is no evidence of any manpower planning process in terms of defining the future numbers of graduate doctors needed (as cohort output numbers), and then planning the required cohort input numbers to be funded by the state.

There were several attempts from the MoLHSA to undertake workforce planning and institutional mapping (OPM 2004; OPM 2007a; OPM 2007b). However, the work has neither been completed nor implemented. Assessments show that despite the overall excess of physicians, there are a number of specialties where there is a personnel shortfall already or will be in the near future (notably pharmacists, gynaecologists, geriatricians). There is a gap in planning medium- and long-term care provision capacity, as well as a lack of education/training programmes for nurses and long-term care personnel.

5.2.3 Training of health care personnel

The normal mechanism for supplying appropriately trained doctors in Georgia is through the higher medical education system which has three levels: undergraduate, postgraduate and continuing medical education. Under current legislation, the MoE is responsible for the regulation of undergraduate medical

education institutions, whereas MoLHSA is responsible for the management and coordination of the process of postgraduate education (residency training) and continuing medical education (CME).

Undergraduate education involves studying general medicine as a foundation for further, more specialized, study. The period of study is 4–6 years depending on the faculty chosen. In 2006, the following faculties were available at the State Medical University: faculty of curative medicine (focusing on adult health), faculty of paediatrics (focusing on child health), faculty of dentistry, faculty of public health and health care management, faculty of pharmacy, faculty of medical biology, faculty of psychotherapy, and faculty of medical physical training and rehabilitation. In 2007, some steps were taken towards the Bologna process, so the faculties above have been merged into four faculties: faculty of medicine, faculty of dentistry, faculty of public health and health care management and faculty of pharmacy. The higher medical education institutions other than the State Medical University integrated a different number of faculties from those listed, usually just one or two specialties.

After successfully passing the state exam to obtain the undergraduate diploma, students follow a postgraduate residency programme for 2–4 years in a particular specialty. This builds on their previous theoretical training but has greater clinical input. From June 2001, in order to have the right to practice independently, according to the Law on Health Care, graduates have to sit the state certification exams. Based on the examination results – according to the letter of the law – graduates obtain state certificates for independent medical practice. The state certificate for independent medical practice is granted in 16 medical specialties, as listed in the Ministerial Decree on the "List of medical specialties, related specialties and sub-specialties" of June 2007. The exam is unified across Georgia. New regulations on postgraduate training including continuing medical education within the framework of ongoing health care reforms are expected.

Nurses in Georgia are trained in vocational schools; there are 13 nursing schools across the country. After independence, the number of nursing schools increased to 112 (12 public and 100 private) in 2004. Entry to these programmes can be from class 9 (age 15) when students would follow a three-year programme (the initial year being a condensed version of secondary school years 10 and 11), or from class 11 (age 17) in which case the programme is two years. The nursing faculties are: nursing, midwifery, orthopaedic-dentistry, laboratory and pharmacy. In 2006, a nursing higher education school was established at the Tbilisi State Medical University.

Compared with the substantial legal basis behind all other forms of Georgian medical institutions there is remarkably little legislation underpinning nursing. Consequently, the status of nursing is very low and it is not regarded as a profession in the Georgian context. The educational system for nurses consists only of vocational education level schools (Nishiyama, Wold and Partskhaladze 2008). There is no specialization, licensing or continuing medical education. In order to fill the nursing educational gap a number of NGOs offer training courses for nurses and issue certificates. Some employers, heads of medical establishments, etc. are beginning to make attendance at such training compulsory.

Specialized medical training

As outlined above, upon completion of theoretical and clinical undergraduate medical education, graduates can then follow a number of possible routes to develop their clinical knowledge and acquire the necessary clinical skills:

- Proceed to a state-administered postgraduate programme in their chosen specialty, including family medicine. Doctors already practising and certified in general therapy and paediatrics, or in other medical specialties related to family medicine (gastroenterology, nephrology, pulmonology, cardiology and rheumatology), can undertake a mini-residency (six-month re-training course) to gain a second specialty in family medicine;
- Undertake further research and teaching activity in the theoretical fields of medicine or in other fields of health care in research or education institutes. However this cannot involve independent clinical practice;
- Seek an appointment as a junior doctor, usually in a hospital, working as an assistant and under the direct supervision of a clinical specialist. The Law on Medical Activities regulates junior doctors as well. If the junior doctor wishes to become qualified then it is mandatory for their employer to inform the Postgraduate and Continuing Medical Education Board (PGCMEB). Junior doctors can be approved to practise independently if they fulfil the following criteria:
  1. The work duration in their chosen specialty is not less than the residency course duration in the same specialty and that the work performed complies with the requirements considered in the residency programme of this specialty;
  2. It is certified that s/he was working under the supervision of an appropriately skilled and trained specialist throughout this period;
  3. S/he has successfully passed the state certification exam.

A junior doctor who meets the above criteria would become a fully fledged specialist with the same rights and responsibilities as one who came through the state residency programme.

Specialized medical training in Georgia is primarily organized through residency programmes for each of the specialties. The state has not provided financial support for residency education since 2005. The number of residency places is determined by the MoLHSA. There is no restriction placed by the MoLHSA on the number of junior doctor placements or appointments (OPM 2004). One of the main requirements for entry to a particular residency course is that the chosen specialty should correspond to the faculty enrolment in the higher medical institution during undergraduate training. The selection of candidates for residency programmes is undertaken competitively through an entrance examination.

Training of health care managers

In theory, only qualified doctors can become managers of clinical institutions in Georgia, and from 2001 the supply of managers was restricted to doctors who have passed the state certificate exam in public health and health care management. Since 2006, those appointed as managers are not required to show specific health care management qualifications and the number of non-medical staff becoming managers has been increasing. However, in 2006–2007, with the initiatives of aid partners, the MoLHSA recognized the need to re-train health care managers. One hundred and sixty health system, PHC and hospital managers have been re-trained under the DfID PHC reform support programme through the six-month modular training course. In 2007, 200 managers were trained through the same training programme, supported by the state budget. It is expected that the demand for qualified health managers will increase as a result of recent health reforms privatizing health facilities.

5.2.4 Registration/licensing

There is no register of doctors or other health professionals in Georgia. On satisfactory completion of the residency programme or the registered junior doctor programme, the law stipulates that doctors have to pass the Unified State Certification Exam (USCE) in order to become certified. The USCE is administered by the State Regulatory Agency of Medical Activities – a state enterprise functioning under the MoLHSA. The Agency is also formally responsible for the institutional accreditation of postgraduate programmes. The Agency is supported by two boards: the State Certificate Granting Board and the PGCMEB.

The State Certificate Granting Board issues doctors with an individual certificate that effectively allows them to undertake independent medical practice within specialist boundaries defined by the residency programme for a defined period of time (as already indicated, five years). Certification exams are held twice a year (in spring and in autumn). An applicant who fails the exam can take it again at the next sitting. There is no limit on the number of times a candidate may sit the examination. There are no numerical entry restrictions or quotas for this exam, which is very much a memory test rather than a test of whether a doctors' competence or skills are fit for purpose (OPM 2004).

The PGCMEB implements the necessary measures for the state certificate validity extension (recertification) for a new period. According to its charter, the PGCMEB is in charge of preparing and carrying out measures needed for CME. Also any institution willing to offer a residency programme submits an application to the PGCMEB, which is part of the MoLHSA. Its members are appointed by MOHLSA in accordance with MoLHSA Decree No. 332/n (21 November 2002). The PGCMEB is composed of 33 members and members should be changed once every three years, but the principle of composition remains the same: six representatives from professional associations, six from higher education medical institutions, six from the State Medical Academy, six from scientific research institutions, five from medical facilities, and four from MoLHSA. The residency programme project teams are approved by ministerial decree upon the recommendation of the PGCMEB. This body assesses the applications and recommends approval to the PGCMEB. The PGCMEB discusses the residency programme and list of institutions that will be supporting the delivery of the residency programme, for example, clinics, hospitals and medical institutes, etc. that are proposed as appropriate for that particular programme by the programme team; the PGCMEB then decides whether the applicant institution has sufficient competence to deliver a such a residency programme and, if so, the PGCMEB recommends it to the MoLHSA.

The accreditation processes for the residency programmes are weak, based only on a written application prior to commencement of the programme. There is no ongoing monitoring of the residency programmes to verify that residents actually follow the programme specified in the application. There is also no evaluation procedure in place to assess the success of these programmes in terms of achieving their original objectives (OPM 2004). The competition for resources has led to a proliferation of CME programmes which are rather disjointed and difficult to assess/accredit. The PGCMEB has been overwhelmed with accreditation requests and there are too many programmes for effective accreditation; about 400 accredited programmes have already been offered for

CME by different institutions. Also, some PGCMEB members responsible for accrediting CME programmes have had a conflict of interest in this process since they also represent the CME programme delivery organizations. There is also no system in place for the public authorities to credibly verify attendance or satisfactory completion of any CME programme.

5.2.5 Doctors' career paths

A graduate of a medical institution can go through the following steps in their career:

- work as a junior doctor under the responsibility of an independent doctor;
- conduct research or teaching in theoretical subjects, which do not involve independent medical practice;
- begin to work as a family doctor and specialize in family medicine;
- continue studies into postgraduate or take an alternative course after successfully passing the entrance exams;
- after successfully passing the certification exams, s/he can work in a medical institution and practise independently;
- become associate professor after successfully securing a position (in a higher education medical institution);
- work at central and local administrative offices after successfully securing a position as a civil servant;
- work in the pharmaceutical sector and become a representative for pharmaceutical firms;
- continue postgraduate education in a European or American university.

6. Provision of services

6.1 Public health

The Law on Public Health (2007) defines public health services as the assembly of disease prevention and control measures aimed at improving population health, and in practice a relatively narrow definition of public health is used in Georgia. The vast majority of public health services focus on activities associated with the prevention, control and surveillance of communicable diseases. Public health services are implemented through the state health programmes. State programmes on public health accounted for just 2.1% of the state health budget in 2007. The State Programme for Disease Prevention, with an overall budget of 1.3 million lari in 2008, finances the reimbursement of health care providers and the purchase of vaccines but also includes components to support the fortification of foodstuffs, the prevention of STIs and HIV/AIDS, cancer registration, prevention of drug abuse, screening the hearing of neonates, prevention and monitoring of occupational diseases, early diagnostics and treatment of genetic disorders, and the prevention and treatment of epilepsy. The State Programme for Epidemiological Safety Assurance finances the logistics of immunization services and surveillance at the regional level. In addition, 3.3 million lari is budgeted for the NCDCPH for public health activities, including staff salaries and administrative costs.

A key focus for public health services has been strengthening immunization services in Georgia which almost ceased entirely in the early 1990s (Gamkrelidze et al. 2002). From 1994 to 2001 UNICEF (through USAID and UK Natcom financial assistance) was the major donor for vaccine and injection safety device procurement. In 2002, the Government of Georgia ensured procurement of a 20% share of the routine immunization supplies, followed by increased contribution to the Vaccine Independent Initiative (VII), and this increased to a 30% share in 2003. The government phased out donor agency support for routine immunization supplies from 2006. In 2006 a memorandum of understanding signed between the Government of Georgia and UNICEF

allowed SUSIF (now HeSPA) to purchase childhood vaccines through the UNICEF Supply Division. The channel was successfully tested for the first time in 2006 with a cost saving of US$ 400 000 for the state budget. From 2002, with the approval of the Global Alliance for Vaccines and Immunization (GAVI), the country has been receiving supplies of hepatitis B vaccine and from 2004 Vishnevskaya-Rostropovich Foundation (VRF) has been providing the MMR vaccine. VRF and GAVI financial support for the procurement of MMR and hepatitis B vaccines and safe injection supplies has been secured until 2009. In 2009, MMR vaccines (75%) will still be provided by VRF, but from 2010 onwards all types of vaccines will be procured by the government alone.

In parallel with strengthening the immunization programme, there have been considerable efforts to improve the surveillance system for communicable diseases through the Disease Surveillance and Health Information System Reform (2002–2006). The primary instrument for disease surveillance is now the national guidelines, which outline how to identify and register, confirm and classify, notify and report communicable diseases; how to analyse data; how to investigate outbreaks; and how to utilize available information for making decisions to prevent and control infectious diseases. Individual health care facilities are formally responsible for notifying public health centres of any clinically diagnosed or laboratory-confirmed cases. The NCDCPH determines and updates the list of notifiable diseases annually on the basis of the current epidemiological situation. Better-quality immunization and disease surveillance data are now available, and since 2003 the reformed immunization health information system has been rolled out countrywide. Nevertheless, there are still considerable barriers to strengthening the surveillance system, including the lack of availability of telephones and electricity in some health facilities and public health centres, and the lack of data of sufficiently good quality from subordinate health facilities and private providers (Hotchkiss et al. 2006). However, data analysis is also insufficient, and apparently there is insufficient motivation to do it. The performance of the surveillance system depends not only on the quality and availability of health information, but on the demand for such information by policy-makers (Hotchkiss et al. 2006).

6.2 Primary/ambulatory care

From 1997, all health service providers were incorporated under commercial law, including primary care facilities. A few registered as limited liability or joint stock companies as separate entities, but most grouped together to create one legal entity (e.g. polyclinic-ambulatory unions, hospital-polyclinic unions,

etc.). As a result there is a variety of PHC service providers across the country. For example, in the Kakheti region, as in many other regions, the village ambulatories within *rayons* were grouped around the *rayon* polyclinic, forming polyclinic-ambulatory unions, or sometimes ambulatories were grouped around the *rayon* hospital, forming a hospital-polyclinic-ambulatory union. By contrast, in the Imereti region even the small village ambulatories were registered as independent legal entities.

In 2007–2008 only a small fraction of PHC services were publicly funded and these were determined by the State PHC Programme, which identified as its executors ambulatories as well as polyclinics, women's consultation centres and specialized dispensaries. From 2009, public funding for PHC services for the uninsured population has been limited to care for children aged 0–5, adults aged over 60 years and rural populations. A change was also made in the funding of primary care services in rural regions as individual doctors became budget holders and HeSPA started contracting with them directly rather than working through the *rayon* polyclinic.

Family medicine was recognized as a specialty in 1998 and an exam for primary care specialists was introduced in 1999. This also explains why the staffing of PHC facilities is diverse, with a mixture of family doctors, generalist physicians and narrow specialists. Most facilities with family doctors are in various pilot regions for international aid programmes and these are the new facilities which are most recently refurbished. Apart from these centres with upgraded facilities, the rest of Georgia has services provided by the old PHC ambulatories. The state-financed package of PHC services offered by old centres comprised consultations, home visits, some essential medicines, rapid laboratory tests and referral to contracted specialists (without a doctor's referral the patient is charged formally). The specialists are divided into two groups, those participating in the specialized ambulatory programme (TB specialists, psychiatrists, obstetrician-gynaecologists for pregnant women) and others: neurologists, endocrinologists, orthopaedic surgeons (for children), oncologists, radiologists, ENT specialists and ophthalmologists. The package offered by new centres differed due to the expanded roles and functions of family doctors. In addition to the above activities, family doctors provided antenatal care within their competence (in addition to four antenatal visits covered by the state), family planning services, otoscopy and ophthalmoscopy. Until 2008, the distinction between old and new PHC ambulatories was significant in terms of financing mechanisms, but this is no longer the case.

Services which fall outside the state-guaranteed package or insurance cover are provided by the same staff in the same institutional settings on a fee-for-service basis. Managers are free to charge uninsured patients for non-state-funded services according to an internally defined price list. The out-of-pocket cost of seeking care to individuals has led to a serious decrease in the uptake of all kinds of medical services, and even the uptake of services which, by definition, should be provided for free has declined. PHC utilization rates in Georgia are among the very lowest in the WHO European Region (see Fig. 6.1). There has been a sharp decline in the number of PHC consultations per patient per year; outpatient contacts fell from between 7–8 visits per person per year in 1990 to 1.4 visits per year in 2000, and, although increasing since, it had reached only 1.95 per person per year in 2007 (see Fig. 6.1).

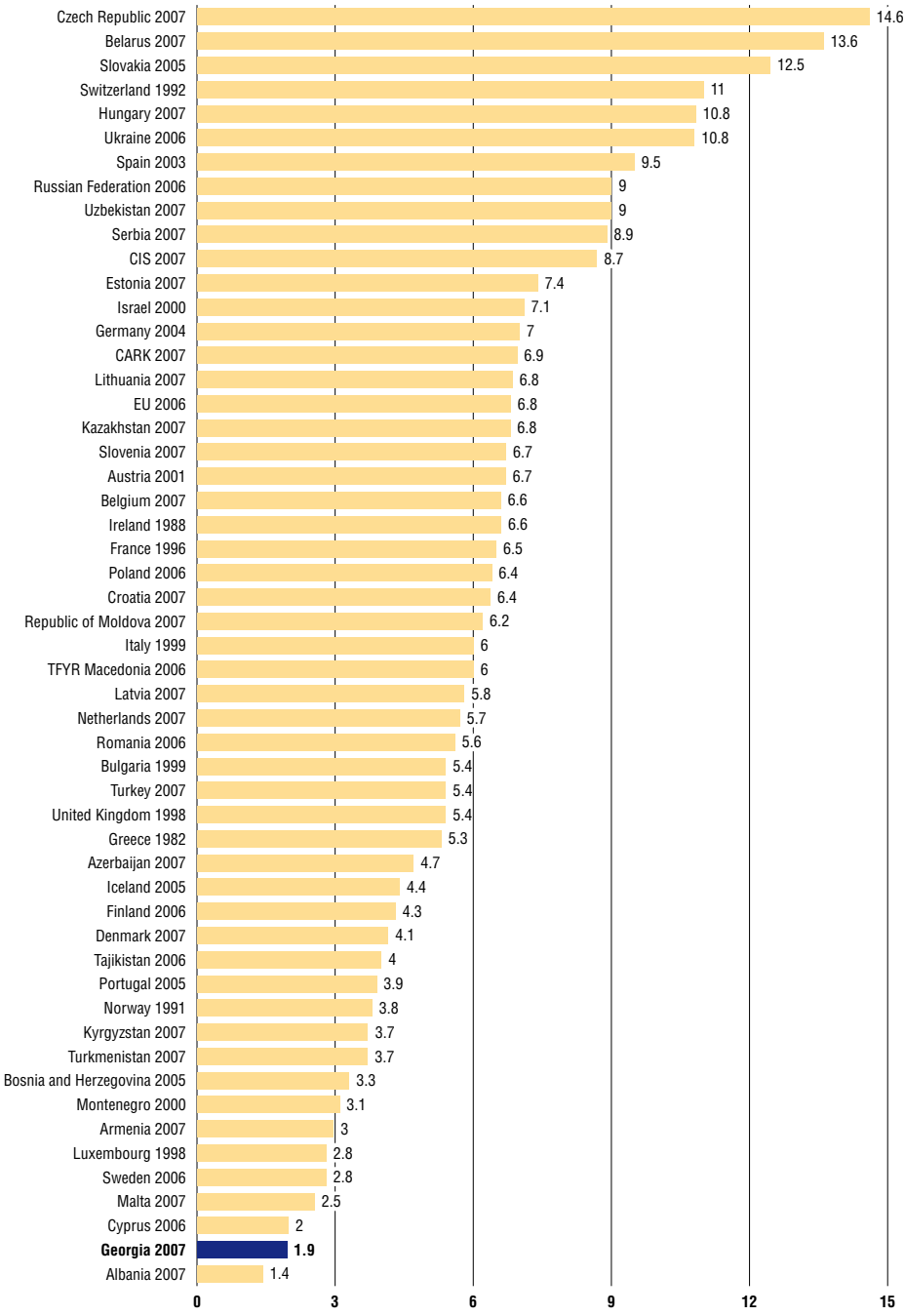
In addition to affordability, the quality of services provided at the PHC level is perceived to be low and there are concerns about perverse incentives with regard to referrals and prescriptions by PHC service providers (MoLHSA 2007c). These perceptions mean that primary care doctors have severely limited gatekeeping capacity. The *Household survey on health utilization and expenditure* (MoLHSA 2007c) found that 28.8% of respondents went to hospital as an outpatient as the first point of consultation when ill, 52.7% of first consultations being at the PHC level. Generally, respondents also went to see a specialist – in a hospital or PHC setting (68.5%, urban = 69.8 %, rural = 67%) – most often, rather than a generalist or family doctor (average = 18.4%, urban = 15.5%, rural = 21.8%) (MoLHSA 2007c).

6.3 Inpatient care

Inpatient care in Georgia is provided by secondary and tertiary care institutions, namely by general multi-profile and referral hospitals, scientific research institutes, specialized hospitals and dispensaries. Hospital admission rates declined sharply from 13.6 per 100 inhabitants in 1990 to 4.43 in 2001. In 2007 Georgia had one of the lowest acute care hospital admission rates in the WHO European Region, at just 6.3 per 100 population, when the average for the EU was 17 per 100 (2006) and the CIS was 20.7 per 100 (WHO Regional Office for Europe 2009). The average length of stay in acute care hospitals in Georgia was 5.7 days in 2007, which is below the 2006 EU average of 6.5 days and considerably lower than the 2007 CIS average of 11 days (WHO Regional Office for Europe 2009). However, as there has not been a parallel improvement in technologies such as key-hole surgery, it is likely that

Fig. 6.1

Outpatient contacts per person per year in the WHO European Region, latest available year



Source: WHO Regional Office for Europe 2009.

providers are discharging patients without regard for medical indications in an attempt to reduce cost per case (MoLHSA 2009a). A substantial reduction in excess hospital capacity started in the early 1990s. Despite this, the number of beds throughout the country was 16 600 in 2005 and increased to 17 500 in 2006 (Imnadze et al. 2006). In Tbilisi, the number of beds per hospital varies from 3 to 600. In 2007, there were seven hospitals with more than 200 beds; around 15 hospitals in which the number of beds varies from 100 to 200 and the remainder range from 3 to 100 beds (MoLHSA 2007c). Hospitals with fewer beds (less than 50) are mainly private hospitals. Before 2007, 142 hospitals were located outside Tbilisi, 130 of them were state owned and only 12 of them were private.

Following independence, there has also been a sharp decline in the hospital bed occupancy rate, largely linked to a lack of affordability combined with excess capacity in the hospital sector. The acute care hospital bed occupancy rate is now among the lowest in the WHO European region, at just 34.4% in 2007, when the average for countries of the CIS was 85%. The average for countries of the EU was 76.3% in 2006 (WHO Regional Office for Europe 2009). The average length of stay has been falling since 2003, and was 5.7 days in 2007 in acute care hospitals (WHO Regional Office for Europe 2009). As in Soviet times, the highest bed occupancy rate and average length of stay in Georgia in 2005 were registered for patients with tuberculosis and mental health problems (see Table 6.1).

Table 6.1

Hospital beds by profiles and their utilization data, 2005

Profiles	Number of beds	Average length of stay	Rotation
General medicine	2879	6.3	11.8
Paediatrics	1866	9.4	16.5
Surgery	4256	6.2	13.7
Oncology and radiology	418	19.2	9.7
Infectious diseases	1083	7.3	13.6
TB	547	57.5	5.2
Obstetrics and gynaecology	3303	4.7	22.8
Neurology	589	9.6	10.9
Psychiatry and narcology	1271	73.5	3.3
Ear, nose, throat	214	1.5	24.8
Ophthalmology	215	4.1	19.9
Dermatology/STDs	20	5.8	2.5

Source: (Imnadze et al. 2006)

6.4 Pharmaceutical care

All pharmaceuticals prescribed as part of outpatient care are purchased by patients at full cost. State-financed pharmaceutical care envisages two components: medicines provided for the poorest population of Georgia, under the State Programme for Purchasing Health Insurance for those Living Below the Poverty Line; and the State Programme on the Provision of Specific Medicines. The latter relates to the financing of specific medicines for defined groups of patients and it has a number of sub-components, namely:

- adults with diabetes mellitus (insulin provision);
- children and young adults with diabetes mellitus (insulin and glucagon);
- children and adults with haemophilia (antihaemophilic factor concentrates);
- terminal oncology patients (painkillers);
- organ transplant patients (immunosuppressants);
- patients with diabetes insipidus;
- anti-rabies vaccine for children aged 0–15 and vulnerable populations;
- immunization (vaccine procurement, storage and cold chain maintenance);
- food supplements for children with phenylketoneuria;
- patients with the cystic fibrosis;
- substitution therapy for dependent drug users (methadone programmes).

Any pharmaceuticals not covered under these state programmes need to be purchased at full cost by patients. The high cost of pharmaceuticals is one of the major issues with regard to accessing care in Georgia and they constitute a significant share of out-of-pocket payments.

6.5 Long-term care

There is no standard definition of long-term and social care in Georgia. The Department for the Protection of Invalids was established under the Ministry of Social Affairs in 1994 to develop a national policy to address the needs of the disabled population. In 1999, the MoH was merged with the Ministry of Social Affairs, and consequently the department was transformed into the Department for Disabled People. Currently, the Department of Social Policy is addressing the social issues of people with disabilities.

For adults with intellectual disabilities, there is one special ward in the Tbilisi psychiatric hospital with 70 beds, and only one separate institution, the House for People with Intellectual and Physical Disabilities, for 55 people in Dzevri village in western Georgia. In 2007, the state ensured coverage for 125 adult patients with intellectual and intellectual plus physical disabilities, and the corresponding finances come from the State Social Care Programme. Some adults with intellectual disabilities stay in institutions for years because they have nowhere else to go: there is no community-based supported housing in the country; there are no employment programmes for people with intellectual disabilities; and nor is there a system of rehabilitation or vocational training targeting this group of people.

There are no specialized medical institutions (children's departments in psychiatric or general hospitals) that provide services to children with developmental problems or to children with intellectual disabilities. There are limited numbers of day-care centres, but the number of places available does not satisfy demand. Until 1993, there were departments for children with intellectual disabilities at the Institute of Psychiatry (Tbilisi) and at Batumi Psychiatric Hospital (in western Georgia). After the severe economic crisis following independence, which seriously affected the quality of care, these children were taken out of these institutions by their parents, and the departments were closed.

There are 44 social care institutions for children in Georgia (orphanages, boarding schools, special education schools, rehabilitation centres, and specialized nursery schools) which serve about 4800 children nationwide. Of these, 31 institutions serve children with disabilities. Children with intellectual disabilities can be found in all 44 institutions, as standard admittance procedures are not followed. It is not possible to specify the exact number of children with intellectual disabilities in these institutions due to poor record keeping. In 2007, there were eight institutions in the country, specifically for children with intellectual disabilities: seven supplementary boarding schools and one supplementary special school in Tbilisi. Two homes (Senaki and Kaspi) served children with severe intellectual and physical disabilities, and there were two homes for infants with intellectual disabilities. There is great variation in the quality of service provision in these facilities, which to a large extent, depends on the management team of a facility, rather than being the result of state regulation. There is a recognized need for child protection reforms that should promote placing children in family-type institutions, but also improving

physical conditions at child care institutions, upgrading the competences of staff, introducing innovative approaches to child education, and improving the supply of food and medicines (O'Brien and Chanturidze 2009).

The MoLHSA is responsible for funding institutions for people with intellectual disabilities, while financing for supplementary special schools for children with intellectual disabilities as well as for orphanages is administered by the MoE. Long-term/social care services for the disabled are delivered through the State Social Programme, defined by MoLHSA.

6.6 Palliative care

Palliative care is developing in Georgia. The government's decision to include both inpatient and outpatient (home care) modes of palliative services in the health benefit package, will accelerate development, which has so far relied on international support. Nevertheless, very limited public resources are committed to palliative care, covering services only for terminal oncology patients at the Tbilisi Cancer Prevention Centre. For home palliative services provided by the mobile groups in Tbilisi, there are both state- and donor-financed schemes. Both schemes are implemented by the Tbilisi Cancer Prevention Centre. The state scheme envisages a 30% co-payment from patients, and the Centre is allowed to include up to 20% non-oncology cases. Cordaid (a Dutch non-governmental organization) provided palliative care services free of charge until its withdrawal from Georgia at the end of 2007. This scheme covered around 50 patients.

The key issues and challenges facing the development of palliative care in Georgia are:

- the state policy on drug availability is still being elaborated;
- lack of highly qualified professional staff in palliative care;
- lack of public awareness about palliative care issues;
- limited choice of opiates in Georgia;
- the limited scale of services available.

6.7 Mental health care

Following the socioeconomic turmoil and due to the prevailing shortage of resources, the number of psychiatric hospital beds has been reduced by over 70% since 1991 and currently Georgia has the one of the lowest numbers of psychiatric beds (28 beds per 100 000 population in 2007) in the European Region (WHO Regional Office for Europe 2009).

Mental health services at both primary and secondary levels of care are financed through state health programmes. In 2007, psychiatric hospital services were classified as short-, medium- and long-term hospital care services. Short-term care was envisaged for acute patients and included patients' isolation, intensive supervision and intensive treatment for up to 15 days; medium-term care was applicable to sub-acute cases with up to 45 days intensive treatment and rehabilitation; long-term care (more than 45 days) was for chronic patients and included supportive therapy and rehabilitation activities. It is more than 10 years since the launch of the State Psychiatric Programme in 1996, but still no data are available on the quality, effectiveness and accessibility of the services provided (Sharashidze et al. 2005). Current expenditure on psychiatry in Georgia is just US$ 1.1 per capita.

The Law on Psychiatric Care (1995) envisages two forms of involuntary hospitalization: emergency hospitalization and compulsory treatment. In both cases, the patient has the same constitutional rights as other citizens unless s/he is found to be incapacitated. Decisions about emergency hospitalization are made by a medical commission, which examines the patient within 48 hours of initial hospitalization and makes a decision as to whether hospitalization is warranted (Sharashidze et al. 2005). The decision about whether a patient is legally incapacitated is made by the courts. Either the patient's relatives or the hospital administration (if the patient is hospitalized) must submit a written statement to the court, asking the court to recognize the person as legally incapacitated. The court convenes a forensic psychiatric examination to advise on the patient's capacity and makes its decision based on the conclusions of the examination. There is no separate law on social integration and rehabilitation, nor is there separate legislation regarding people with mental health problems and people with intellectual disabilities (Sharashidze et al. 2005).

7. Principal health care reforms

7.1 Analysis of recent reforms

Major health care reforms since independence are summarized in Box 7.1; however, this section reviews the major transformations occurring since the Rose Revolution in 2003. Analyses of reform efforts through the 1990s are available elsewhere (see Section 2.2 *Historical background*; see also Gamkrelidze et al. 2002; Schaapveld and Rhodes 2004). The government which came to power after the Rose Revolution was faced with addressing the problems which grew out of the weak implementation of previous reforms, but especially the growth in out-of-pocket payments, the excessive and obsolete health infrastructure, and inequity in access to health services. Initially, the new government refrained from making changes in the health sector. A lot of international technical assistance had been provided to the MoLHSA to work out separate segments of the health care reform programme, including the transformation of PHC, health financing, pharmaceutical policy, and the hospital sector, but almost no significant decisions were endorsed to modify the system in the years 2003–2005. The only exception was the cancellation of social health insurance and, subsequently, the abolition of social health insurance, which was very much related to the overall government policy of reducing taxation for the sake of economic growth, rather than it being a decision of the MoLHSA to improve efficiency.

By contrast, in 2004–2006, a major emphasis was placed on the transformation of the social sector, and the targeted social assistance programme was introduced, defining a single group of beneficiaries by socioeconomic status, based on proxy-means testing. A database of the poorest households was created within the framework of the programme, identifying those in most economic need for receiving cash social benefits. Previous forms of social assistance to different target groups were substituted by this programme, and it was extended to the health sector.

Box 7.1

Major health care reforms and policy measures

Before 1991	Semashko model, completely state-funded health services.
1991	Fully tax-funded health care for all in theory, but severe lack of service financing in practice.
1994	Presidential Decree No. 400 on reorganization of health care system in Georgia adopted, introducing different types of health service financing.
1995	Resolution No. 390 of the cabinet of ministers of Georgia on the composition and implementation of the state medical programmes adopted.
1995	Splitting of the Sanitary-Epidemiological Services into two parts: the Department of Public Health and the Department of Sanitary Surveillance and Hygienic Standards at the MoH.
1995	Resolution of the cabinet of ministers of Georgia on the future development of the pharmaceutical sector, defining compulsory registration, licensing and inspection procedures for the pharmaceutical sector.
1995–1996	Introduction of social health insurance, mandatory payroll taxes for health and creation of the state health fund (SHF).
1996	Creation of municipal health funds.
1996–1997	Substitution of the SHF with the SMIC.
1996–1997	Introduction of certification and accreditation for higher medical education institutions.
1997	The Law on Medical Insurance adopted, providing the legislative basis for compulsory and voluntary health insurance systems.
1998	Introduction of postgraduate education through long-term residency training.
1998	Introduction of compulsory certification of medical
1999	National Health Policy developed.
1999	The MoH and Ministry of Social Affairs merged into the MoLHSA.
2000	Strategic Health Plan for Georgia 2000–2009 published.
2002	Introduction of compulsory continuing medical education
2003–2004	PHC pilots start in four regions of Georgia.
2003	SMIC becomes the State United Social Insurance Fund (SUSIF).
2004	Abolition of social health insurance.
2005–2006	Abolition of numerous public health institutions.
2006	Establishment of the State Agency for Social Assistance.
2007	Strategic paper: “Main directions in health 2007–2009” developed.
2007	State Hospital Development Master Plan, envisioning a complete change of course in the hospital sector based on privatization approved by the government.
2007–2008	Almost 80% of hospitals sold to the private sector.
2007	SUSIF splits into HeSPA and the State Social Subsidies Agency.
2007	Public Health Law adopted by the parliament.
2007	Public funds given to private insurance companies in Tbilisi and Imereti region for the administration of the state health programme for the poorest.
2008	Pilots using private insurance companies to administer the state health programme for the most vulnerable populations are rolled out nationwide.

In January 2006, the MoLHSA was requested by the prime minister to develop a health reform concept in a transparent and participatory way, with the involvement of all key stakeholders. The elaboration process took four months, and the first draft of the Health Reform Concept was presented to the government in May 2006. The document highlighted three major aspects: health system organizational design, service provision and financing, mainly outlining a publicly owned system with improved capacity, management and administration. However, the document was not approved by the government, which instead sought to consider a transition to private provision, liberalization of the role of government, modification of health financing and stimulating the role of private insurance.

In October 2006, the president called on the government to change the health policy-making process. The prime minister and the State Minister of Public Reforms were asked to take responsibility for health care reform. The Governmental Commission for Health and Social Reforms was created as a decision-making body for health care reforms, headed by the prime minister, with members of line ministries and the State Minister of Public Reforms. The Secretariat for the Governmental Committee was created at the level of the State Minister of Public Reforms, with only a secondary role for the high representatives of the MoLHSA.

The first policy elaborated in 2006 by the MoLHSA together with the state minister's office was Main Directions in Health 2007–2009. The document outlined four main objectives for the government to develop over three years to transform the health sector: (1) to ensure the overall affordability of basic health services and protect the general population from catastrophic financial health risks; (2) to ensure the quality of medical services by creating and enforcing the necessary regulatory environment; (3) to ensure the accessibility of quality medical service by the continuing development of medical infrastructure and competent human resources; and (4) to increase health system efficiency by capacity-building of the MoLHSA and its subordinate institutions, and the introduction of sound managerial principles.

This time the reform objectives were over-ambitious, intending to transform almost all components of the system from service provision to financing, purchasing, regulation and supervision. The main principles were to transition towards complete marketization of the health sector: private provision, private purchasing, liberal regulation and minimum supervision.

As explained elsewhere, the basis for these decisions was rooted in the country's economic policy, which was to ensure economic growth based on liberalization and private sector development. To this end, the government has taken a number of important steps, such as: (1) reducing tax rates (in 2005 a new Tax Code was enacted, where the number of taxes was reduced three-fold and tax rates were decreased considerably); (2) introducing fewer licences and permits for doing business (the number of business activities subject to licensing and permit regimes was reduced by 84%); (3) less regulation by the state; (4) aggressive privatization policy; (5) customs reform, significantly simplifying customs administration procedures; and (6) reducing import duties in 2006 and abolishing import duties in 2008. These changes resulted in sharp economic growth until the global recession in 2008/9.

The new government strongly believed that the overall development directions chosen had to be undertaken in all sectors to be consistent with the country's overall development. Thus, health care reform was considered a continuation of changes already undertaken in other sectors as part of the national development policy, rather than separate or specific reforms, calling for particular planning and considering of specific characteristics of health care and health care markets. This time the reform was not designed to be left on paper. The government started implementation immediately, starting with the definition and organization of services and infrastructure development initiatives, including the 100 New Hospitals programme.

Reform of the hospital sector

The Hospital Development Master Plan was developed and enforced by the government from January 2007. The master plan called for the complete replacement of existing hospital infrastructure within a three-year period (2007–2009) by transferring full ownership rights from the state to the private sector through a tendering process. The master plan determined total hospital sector capacity; optimal location of inpatient facilities based on the principle of 45-minute geographic accessibility; the optimal number of hospital beds per facility based on population health needs (see Table 7.1); the types of hospital services; and, finally, conditions for the operation of hospitals (e.g. minimum standards for physical infrastructure and equipment). A few more directives for secondary/tertiary care provision came out of the master plan: the concentration of multi-profile hospitals in the regions; very few tertiary/referral hospitals countrywide (equidistant for both east and west Georgia); small district hospitals in almost all *rayons*; the integration of psychiatric, narcology,

oncology, obstetric and gynaecology, paediatric, infectious diseases, TB and other mono-profile services into multi-profile hospitals; the development of medium- and long-term care, including institutions for psychiatric and TB services, and hospices (see Section 5.1.1 *Infrastructure*). It was envisaged that hospitals would differ by size, with 15 and 25 beds in *rayons*, and 50–100 beds in regional centres and big cities. The minimum requirements imposed were 50 m^2 per bed in small hospitals and 75 m^2 per bed in the larger hospitals and were those used for hospital planning. However, there was an inherent tension between this prescriptive planning approach and the requirement to implement it through competitive private sector tendering; particularly in such a weak regulatory environment.

Table 7.1
Ideal hospital service capacities in Georgia (according to the master plan)

	Number of beds
Short-term services	
Gynaecology and obstetrics	1036
General medicine, including:	
Internal medicine	1097
Infectious diseases	308
Paediatrics	676
Intensive care	343
Surgery	2458
Psychiatry and long-term care	1465
Tuberculosis	417
Total	**7800**

The basis for implementation of the Hospital Development Master Plan was the Investment Programme. It had no fiscal implications, so that the state received no financial dividends from the sale of hospital sector assets. Investors took over existing hospitals with the attached land in Tbilisi or the regional centres and were required to create a minimum number of beds according to the master plan and tender conditions. Investors would then own the hospitals built by them, and were obliged to keep the same health profile, but only for seven years. Investors paid nothing for the existing hospitals on the understanding that the provision of hospital services would be profitable and cover their costs. Also, after meeting the obligations indicated in the tender documents, investors could utilize any excess territory and the buildings of the old hospital for commercial purposes. Initially this scheme proved extremely popular with investors, who sought to impress with their bids by aiming to provide much bigger facilities

than the tender required. Therefore, according to the original estimates, about 17 investment projects were needed to supply the entire hospital capacity for the country, but after eight project tenders were completed all 7800 beds were already supplied, as investors were proposing to create two to three times more beds than the government expected. The quality of these beds was not assured, nor was the efficiency of having more beds than necessary (Transparency International Georgia 2007).

The State Minister's Office and the MoLHSA had plans to establish a joint commission to monitor the quality of new facilities' construction and investor procurement of hospital beds and other new equipment. However, as one monitoring organization noted:

> A key concern among the stakeholders regarding this initiative is the tendency of the privatization programme to reward investor focus on numbers – quantity of new facilities and hospital beds, speed of completion of new construction, etc. – at the expense of guarantees of quality. A second major concern is the sustainability of the new hospitals and investors' commitment to providing health care services in the long-term future. (Transparency International Georgia 2007)

The government has placed more emphasis on the creation of master plan implementation supervision capacity within the MoLHSA, in collaboration with the MoED (as most of the construction supervision matters were the competences of MoED). It also envisaged the development of accountability and contractual mechanisms for hospital/MoLHSA/state or private purchaser relationships. These intentions were not fleshed out as implementation plans with defined dates and responsible bodies, despite the pace of the tendering process. Less emphasis was placed on the elaboration of a human resources development programme for medical personnel in hospitals. It was assumed that private owners and hospital managers will introduce adequate schemes for meritocratic selection, promotion and the competence development of their staff, but there was no policy in place to ensure that this happens.

The Hospital Development Master Plan sought to ensure geographic accessibility to high-quality secondary and tertiary care services, but, for this to happen, a number of significant aspects of the new private purchaser-provider relationships needed to be resolved. According to the master plan, all types of investors were allowed to participate in hospital privatization, including pharmaceutical companies. As a result, pharmaceutical company owners are trying to impose their own protocols for health service delivery in the institutions which they own. This includes developing their own clinical practice

guidelines and promoting their own pharmaceutical products, even though there are national clinical practice guidelines in place (Transparency International Georgia 2007). The other key investors in the programme were property developers, often working at the international level. However, these companies have faced serious liquidity problems with the global economic downturn, which has had serious consequences with regard to fulfilling their contractual obligations under this programme. As a consequence, implementation of the 100 New Hospitals programme has stalled and data on the number of hospitals sold under the scheme and their profiles were unavailable at the time of writing.

Reform of PHC services

The original idea for the PHC Master Plan was to create a territorially based publicly owned network, ensuring accessibility to PHC centres within 15 minutes for the entire population of Georgia. Development of the PHC Master Plan started in 2003, with support from the international donor community, recognizing that the existing network of facilities needs to be rationalized, refurbished and reconfigured in the way services are delivered. The updated facilities were to be configured and built as PHC facility types that accommodate solo family medical practices, group medical practices and health posts. A computer-based Geographical Information System (GIS), capable of conducting an optimization analysis of existing facilities, was selected as the research tool.

The GIS optimization analysis examined the configuration of villages with existing PHC facilities and calculated how much of the population was covered within a specified travel time interval (15 minutes). In those *rayons* where mountainous conditions make the 15-minute access time unrealistic without retaining so many facilities that it would have limited service delivery viability, the access standard was extended to 20 minutes (RMC Resources Management Consultants Ltd 2006). A decision was taken to consolidate PHC practices in cities into a single facility to serve 30 000 people. From the existing 750 PHC facilities (excluding centres in Tbilisi), the optimization plan suggested removing 217 facilities and adding 16 facilities where there were none. The net result of the optimization plan was a reduction of 201 facilities. However, the implementation of this required strong government regulation as PHC providers are private entities and as such the state had much less flexibility in closing providers that were surplus to requirement or in moving providers to underserved regions.

The government reconsidered this plan in March 2007, regarding it as unrealistic in resource terms for mountainous regions, and unnecessary for urban areas. Thus, the PHC Master Plan was revised so that urban and rural models of PHC provision were differentiated, with about 900 PHC facilities in rural areas, and an unlimited number of PHC facilities in the cities and regional/district centres, which were all to be privatized. The government intended to give away PHC facility buildings in villages at a nominal price to medical personnel currently practising or willing to provide PHC services for not less then seven years in the indicated territories. It planned to sell PHC facilities in urban areas by auction to investors, giving preference to local medical personnel. Privatization should have started in 2008, but has been postponed as it became clear that there was a lack of interest among potential investors, particularly in rural areas. It was also problematic for international partners working in PHC development as the refurbishment of primary care premises was often a core component of their strategies. The vision of having one PHC facility in every village was packaged as a component of the "50 days programme towards elimination of poverty in Georgia", which was articulated prior to the parliamentary elections in May 2008.

According to the revised PHC Master Plan, ideally the state was to fund the full package of PHC services for the population of Georgia living below the poverty line, as well as for people older than 65. The package would have been determined by the MoLHSA and would have covered: (a) medical consultation, (b) functional-laboratory examinations, (c) minor surgery at the ambulatory level, (d) essential pharmaceuticals, (e) public health preventive activities. In theory, the current target group (the vulnerable population) would have been broadened gradually to completely cover the indicated target groups by the end of 2009. PHC would also be financed for the rest of the population in the transition period (2008–2009). After this, it was envisaged that those living above the poverty line should purchase primary care services through out-of-pocket payments or advance payment via private insurance schemes (MoLHSA 2007a).

In 2008, the government implemented a part of the revised PHC Master Plan (although it had not been officially approved) – that is, MoLHSA distributed the PHC toolkit to rural PHC providers (in about 900 villages). Individual primary care doctors working in some rural regions were given grants to renovate their practices and all primary care doctors working in rural areas became budget holders rather than being paid through the *rayon* polyclinic (see Section 3.6.2 *Paying health care personnel*). From 2009, PHC services for only certain

segments of the population have been funded directly from public sources, namely the rural population, and the urban population aged over 60 and under 6 years of age (see Section 3.2 *Population coverage and basis for entitlement*).

Health care financing

According to the National Health Accounts, total health expenditure was equivalent to US$ 830 million, or 8.2% of GDP in 2007. Public health expenditure accounted for 18.4% of total health expenditure, international aid 9.2%, and the rest (72.4%) was private funding, out of which 70.9% was paid by the population out of pocket (see Section 3.3 *Revenue collection/sources of funds*). The government deemed it necessary to initiate profound reform of health care financing, with the aim of ensuring financial accessibility to medical services for the entire population, protection from catastrophic financial health risks, enhancing equity in financing contributions, and introducing financial protection for the socially vulnerable. The substitution of direct out-of-pocket payments with pre-paid schemes was considered necessary to achieve this goal. In this context, one solution would have been the re-introduction of mandatory social health insurance, but, as described above, this had been perceived by the government to be incompatible with overall economic development policy (the introduction of payroll contributions being incompatible with previous tax cuts). Therefore, the government decided to create an environment where private health insurance providers could fill the gap. Thus, the private health insurance industry has been asked by the state to participate in service purchasing for state programmes, initially receiving public money with 15% of administrative expenses paid, but with this figure rising to 25% in 2008.

An early experiment with using public funds to purchase private health insurance cover was conducted by the Mayor of Tbilisi prior to local elections. The initiative in Tbilisi was implemented in 2006, giving 4 million lari to a single insurance company through a tender to purchase services for the poorest residents of the capital. The programme ran for six months, but has not been fully evaluated. The only evaluation report was prepared by the insurance company itself, stating that 32 000 individuals were served out of 50 000 beneficiaries in the scope of the programme, and almost 90% of those who received the service were satisfied. However, it is unclear why the remainder of the target group did not apply for coverage, especially if the programme covered full costs not only for treatment, but also medicines, and if most of the beneficiaries were the poorest pensioners with multiple chronic diseases.

The government prepared a more solid foundation for pilots in 2007, modifying the Law on Health Insurance, introducing vouchers – an instrument for funding services for identified beneficiaries – and issuing a governmental decree on the implementation of the state health programme for the poorest in Tbilisi and Imereti region from September 2007 for a full year. The main difference was that the private insurance companies were not selected for participation in the process through tendering. Instead, the government gave vouchers to the beneficiaries – defined as an individual (household) who is registered and who scored below 70 000 points in the database of the most socially vulnerable. The individual has the right to choose the private insurance company by which s/he wants to be covered. After the private insurance company signs the contract with the beneficiaries, it submits a copy to the state health purchaser – HeSPA – which is in charge of the administration of the vouchers and automatically pays the insurance premium for the beneficiary on a monthly basis. The rules are defined in the voucher conditions approved by the government in August 2007. Officially, the state purchaser can sanction the private insurance company in cases of underperformance, but this has not been tested yet. The entire budget for the 2007/2008 pilots was 15 million lari. The government extended the scale of the programme ahead of schedule in 2008, rolling it out nationwide.

In 2008, voluntary health insurance (VHI) was purchased for 808 501 people living below the poverty line in Georgia, while 235 969 were insured through their public and private employers and 28 296 had voluntary insurance. This means that 1 072 766 individuals, approximately one-quarter of the population had insurance coverage of any type (MoLHSA 2009a). The remainder of the population relies on out-of-pocket payments for care and the limited benefits package as defined by the state health programmes (see Section 3.2 *Population coverage and basis for entitlement*). The state health programmes have still not been fully refined so that problems arising since 1995 from the lack of meaningful needs assessments and economic analysis, which allowed programmes such as kidney dialysis treatment, secondary and tertiary services for cancer, and cardio-surgery to be included in the benefits package have been perpetuated, with less emphasis being given to prevention and primary care. Nevertheless, in the absence of universal cover, it is impossible, both politically and socially, to refuse the financing of services to groups of beneficiaries confronting illness or death, and who were accustomed to getting government funding for a decade.

One of the key financing issues faced by the Georgian health system since independence has been the lack of political will to prioritize health for national development and fund the health sector accordingly. Though the sharp

increase of public health expenditure in 2005–2009 has to be acknowledged, it did not bring state funding anywhere near the required level in international comparison (see Section 3.1 *Health expenditure*). Health systems are not cheap, but a healthy population is central to economic development (Suhrcke, Rocco and McKee 2007).

Regulatory environment

The current features of the regulatory system have been formulated through the influence of different political directions. In 1995–2003 the MoH was tempted to concentrate regulatory power in its own hands to increase control over medical providers that were becoming increasingly independent. From 2003, and especially 2006, the new wave of deregulation has forced the simplification of both licensing and certification procedures. In fact, the MoLHSA has gone to the opposite extreme, relying largely on self-regulation of both service providers and purchasers, delegating most regulatory functions to independent entities, and refusing to develop accreditation standards or undertake accreditation in the belief that supply-side regulation should be as liberal as possible. This has severely weakened the capacity of the MoLHSA to fulfil its regulatory role, as evidenced by the weak quality control over drugs and the absence of mechanisms to report adverse drug effects or to ensure patient safety (MoLHSA 2009a).

Health system administration

In theory the reform approach in Georgia follows the new public management model, being mission-driven, decentralized and entrepreneurial. Ideally, the structural characteristics of this model, compared with the traditional government bureaucracy, should be a smaller policy core, less hierarchical, with a more fragmented implementing periphery. Such organizational arrangements typically mean that a ministry should identify a specific set of objectives for a certain period; appoint a leader on a competitive basis; set out the strategic plan; annually set out in a business plan with key financial, service and quality targets; and establish a performance measurement and management system.

Thus far, the government focus has been mainly on one part of the model – the devolving of functions that were not in its domain, but the second part, strengthening what is left, still requires a lot of development. Although the central ministry has become smaller, core capacities for policy-making and supervision of policy implementation have not been developed in parallel. Although decentralization happened formally, in fact regional representations of

the MoLHSA became weaker and some have been abolished. The state system is far from being entrepreneurial because of low capacity, as public structures lack incentives to attract the best professionals. To date, chief executives are still appointed by high-level officials, without any competition, rather than the appointment being based on merit. There are also blurred lines of accountability between the government and myriad affiliated organizations and independent legal entities, due to the reduction of formal political control and the increase in managerial autonomy; at the same time, day-to-day ministerial interventions restrict granted independence. Finally, there is also a big gap in relation to the contractual arrangements and accountability mechanisms in public-private partnerships. This has become pressingly urgent since the pilot programme of using public funds to purchase private health insurance for especially vulnerable people has been rolled out nationwide.

There has been little consistency in the health care reforms introduced over the last 20 years. Different health authorities, representing the will of the governments in power, were operating in different contexts – economic collapse in 1990–1994, some stabilization from 1995, and slight economic improvements until 2003, and liberal government after 2003 directed towards rapid economic growth through the market orientation (see Section 1.3 *Political context*). They were driven by diverse political values, and had varying commitment and capacity to implement the reforms outlined. These differences lay behind the strategic twists over the years, forcing governments to come up with new policies instead of building on existing strategies and best practices, and adding value to achievements of previous actions.

Largely because of their short lifespan and alterations to commitments to the declared strategic decisions, almost all reform initiatives were implemented as activities, but produced very few outputs and outcomes. But the technical inadequacy of those in charge combined with incorrectly defined processes, the inefficiency of resource allocation and the lack of capacity at an implementation level, also played a significant role.

7.2 Future developments

Steps undertaken under the current programme of health care reform might have different implications in future if placed in different regulatory and political environments. Turning back on initiatives undertaken in the health sector in the last few years by the renewed government would not be good, as constant changes of direction in reform has a detrimental effect by itself.

Another potentially negative scenario would be if the government considered the health care reform programme to be successful already and so did little to strengthen stewardship, regulation and supervision functions. In the best-case scenario, enthusiasm and efforts should be maintained in order to complete the reform with professionalism and genuine commitment, while resolving some of the pending issues: weak financial protection of the population, poor accessibility to effective health care, etc.

Stewardship function

In health care policy and administrative documents, it is stated that the government adheres to an understanding that the state should guarantee the quality, efficiency and effectiveness of care, access to care and the financial protection of population against catastrophic health expenses, as well as fighting health inequalities. To turn these objectives into reality, the stewardship function of MoLHSA needs to be strengthened substantially. A good steward is expected to decide on the scope and direction of the system, to provide regulation and ensure in a transparent way the necessary intelligence for stakeholders to act. Therefore stewardship entails not only setting the goals but also having control of the means to reach them in practice, to influence other actors and to gain support for health care, etc. MoLHSA needs the capacity to provide leadership in each of the three components of the stewardship function (policy-making, regulation, intelligence creation) and to be held accountable accordingly.

Although the Georgian government has chosen private health services provision and purchasing, this does not mean that the system and private-public relationships do not need to be structured, organized, regulated and supervised. Consequently, MoLHSA needs to provide adequate mechanisms and processes to lead the sector – for example, additional capacity in its planning institutions, to elaborate the strategies and instruments for interacting with the private sector and with other public actors. Developing the monitoring and evaluation of state health programmes so that their effectiveness can be measured has also been highlighted as an area for further development (MoLHSA 2009a).

Information system

There is a consensus in the government that a unified information system should be established to allow the identification of citizens and the registration of the population based on a single identification number. A unified database would enable the population to be classified, or scored according to socioeconomic status, and would register what state social and health benefits people are

entitled to, as well as services provided to them. The Health Management Information System should be based on this identification number system. The database could be shared with HeSPA, for collecting and analysing information on health service purchasing and provision. The Centre for Medical Information and Statistics, as part of the NCDCPH, would also be involved in the analysis of collected data. The information should be available to all stakeholders, including the government, parliament, the insurance industry, health care providers and the public.

Health financing reform initiatives

As mentioned above, the government considers mandatory social health insurance to be counter to overall economic development policy. Nevertheless, the introduction of mandatory medical insurance for specific categories of people, that is, public servants, is being discussed. Health insurance for all the population living below the poverty line is financed from public funds by the government as part of a social package. The non-poor population have been encouraged to purchase private insurance through the "5 Lari" scheme. For this purpose, the government will create a supportive environment for the enlargement and strengthening of the private insurance sector. However, it is not yet clear how issues around risk pooling or the affordability of premiums for people with chronic conditions will be resolved and such concerns are not currently being discussed. There are also no explicit plans to increase the share of public expenditure in total health expenditure. Taking away all benefits from the non-poor runs counter to the principles of solidarity upheld by many European institutions and as a result the non-poor may take no interest in the development of social services.

Pharmaceutical policy

In autumn 2007, the government ordered the MoLHSA to prepare a new Pharmaceutical Policy and Law on Pharmaceuticals to guarantee the availability of good-quality pharmaceuticals to all inhabitants of Georgia at an acceptable price, and to decrease the share of total health expenditure spent on pharmaceuticals. Rules for market entry for small companies have been simplified in order to increase market competition. A draft law was presented to the government in early 2008, incorporating the following major changes in pharmaceutical regulation:

- simplifying existing complex and overly bureaucratic registration procedures for pharmaceuticals by introducing (a) automatic registration for products recognized by the European Medicines Agency, the United States Food and Drugs Administration, and other internationally recognized pharmaceutical quality control agencies; (b) making registration simple for internationally recognized products from developed countries; (c) applying thorough registration procedures for unknown products from developing countries;
- creating a system of product tracking after import and distribution;
- introducing GMP standards for local production within a 10-year period;
- creating a supportive environment for small-scale importers;
- promoting the use of generic medicines through national protocols and guidelines;
- investing in the training of doctors in the rational use of medicines, including the promotion of generics.

The government approved the presented draft law and it was adopted in spring 2009. However, a significant remaining gap after the adoption of the new law on pharmaceuticals, besides issues of affordability (explained in Section 5.1.5 *Pharmaceuticals*), relates to the promotion of medical prescriptions, and access to information on medicines of both local and foreign production.

Human resource development

Despite the sharp decline in the number of private academic medical institutions, there is still a surplus of medical doctors already in the health system as well as new graduates. The attractiveness of the medical profession is gradually decreasing in the country, which in the long run will balance the excess production of medical personnel. There is also a significant problem with the geographical distribution of health personnel as rural communities remain underserved despite recent efforts to encourage family doctors in rural practice. In line with the privatization of service delivery, private providers should invest in the continuing medical education and professional training of their staff. However, it is not clear how this will be achieved without strong supervision from outside agencies and there are no current CME plans in place.

Medium- and long-term care

As part of the Hospital Development Master Plan, it is envisaged that medium- and long-term care providers will emerge in Georgia. In fact, as a characteristic of the old Semashko system, these types of services were provided in hospitals. This was a particular problem for patients with psychiatric disorders and TB, and the elderly, who were placed in hospitals instead of nursing or care homes. In future, a more holistic vision for the development of a long-term care system, including types of care, capacity needed and payment mechanisms for services would be required, which would also need to be reflected in appropriate legislation.

8. Assessment of the health system

8.1 The stated objectives of the health system

The aim of the Georgian health system, as given in Main Directions in Health 2007–2009, is to improve the health status of the population. On paper, outlined policy objectives are very much in line with WHO recommendations on health policy and capture key aspects of population health needs. The main strategies to meet the overall goal of improved health included the following:

- to ensure the overall affordability of basic health services and protect the general population from catastrophic financial health risks;
- to ensure the quality of medical services by creating and enforcing the necessary regulatory environment;
- to ensure the accessibility of quality medical service by the continuous development of medical infrastructure and competent human resources;
- to increase health system efficiency by capacity-building of the MoLHSA and its subordinate institutions, and the introduction of good managerial principles.

These stated objectives therefore form the benchmark by which the health system may be assessed in terms of equity, efficiency, quality and efficacy.

8.2 The distribution of the health system's costs and benefits across the population (equity in finance as well as in the distribution of services and resources for the population)

According to the Georgian Health Utilization and Expenditure Survey, 2007, most people have access to health facilities within 30 minutes, even in rural areas (MoLHSA 2007c). The survey also found that most service users

reported that tests and medicines prescribed could be obtained at the places they were prescribed – around 85% in each case (MoLHSA 2007c). Therefore, geographical access to care is relatively even across the country, however, an appreciable portion of the population (18%) reported that they did not seek a consultation when sick because services were unaffordable. Financial barriers in accessing care remain important, particularly for the poor, even if those living in extreme poverty have cover (Hauschild and Berkhout 2009). Other surveys have found charges to have a strong deterrent effect on low-income households to access necessary services, even where such services should in theory be provided free of charge (Balabanova et al. 2009).

Current health care financing policies posit that state funding should be targeted only to those in greatest need. Consequently, there is a medium-term plan to modify the state health budget so that about 65–70% of state health resources are allocated to the purchasing of health insurance for the poor. In 2006, 12.3% of the state health budget was allocated to this target group (MoLHSA 2006). For 2007, allocations to the poor increased to 21.8% (MoLHSA 2007c); but in real terms achieved 26.9% (MoLHSA 2007b). However, the targeting exercise does not cover population groups who may become poor as a result of paying for health services, for example those with chronic diseases (Balabanova et al. 2009). Evidence shows that the threat of catastrophic health care expenditure is cause for serious concern in Georgia across all income brackets, but particularly for the poor (Gotsadze, Zoidze and Rukhadze 2009; MoLHSA 2009a). Private health expenditure increased from 82 lari to 224 lari per capita between 2001 and 2007; a rate of increase (270%) which considerably exceeds the rate of inflation over the same period (190%). This shows that there has been a considerable growth in out-of-pocket expenditures on health, which has been driven mainly by increased expenditure on pharmaceuticals (MoLHSA 2009a). Pharmaceuticals are not covered under the state-sponsored private health insurance packages and have only limited cover under state health programmes.

8.3 Efficiency of resource allocation in health care (across services, across inputs)

There is also very low level of public expenditure on public health and prevention, falling from 8.1% of total government allocation for health in 2001 to 2.3% in 2007, which is low for the European region (MoLHSA 2009a). There are no national screening programmes such as regular pap smears for cervical

cancer or mammography for breast cancer. As most health expenditure is in the form of out-of-pocket payments, patient preference for hospital services rather than PHC services is a significant factor in the balance of resource allocation to primary, secondary and tertiary levels of care. The data obtained from the Georgian Health Utilization and Expenditure Survey, 2007 (MoLHSA 2007c) show that utilization of PHC services for initial consultation and diagnostics is low. Consultations with specialists and hospital doctors account for two-thirds or more of first consultations, even in the rural areas. Village ambulatory centres still play quite a limited role, with around 20% of consultations by rural households being undertaken there; a similar proportion to polyclinics and less in hospitals (MoLHSA 2007c). It is not clear how the promotion of private health insurance will impact on patient preference for specialist care.

8.4 Technical efficiency in the production of health care

The health system performance assessment (MoLHSA 2009a) of 2009 found that, despite a steady reduction in the number of hospital beds, numbers are well above the target figures for all bed profiles and all regions in the Hospital Development Master Plan with the exception of long-term hospital beds in psychiatry and tuberculosis. While outpatient contacts have been increasing since 2001, utilization of services has remained low at 1.95 outpatient visits per person per year in 2007 (one of the lowest in the WHO European Region) despite having one of the highest ratios of doctors per capita in the WHO European Region at 4.7 doctors per 1000 population in 2006 (WHO Regional Office for Europe 2009). The government hopes that the introduction of market mechanisms will improve technical efficiency in the production of health care because health care facilities will be private, and so run for profit. However, in international experience there is little evidence that this will indeed be effective and data limitations (detailed in Section 5.1.1 *Infrastructure*) mean that it is difficult to assess technical efficiency in the production of health care in the Georgian context.

8.5 Quality of care

There is abundant evidence that every government since 1995 has had ambitions to improve the quality of health care services through strict regulation and control (Gamkrelidze et al. 2002). However, most of these efforts have been

partially or completely unsuccessful. Overall quality of medical care in Georgia has remained low. The state of medical facilities and equipment deteriorated because of insufficient investment in renovation and maintenance. The comparative prestige of Georgian doctors in former Soviet countries is related to the reputation of exceptional individual professionals.

The government which came to power in 2003 radically changed the vision of health system regulation, giving a dominant share to private health providers and purchasers. The creation of a competitive environment in the health sector was encouraged, including liberalization of regulations and the development of minimum standards for health service provision (unlike the Soviet system, where the standards defined the maximum attainable level). The government initiated a simplification of existing regulations, and significant changes in the licensing of medical facilities and certification of medical personnel. However, the government has recently decided not to develop an accreditation process for health care facilities in the medium term, arguing that the very low quality of facilities means that priority should be given to ensuring minimum standards rather than focusing on quality measures.

The new Hospital Development Master Plan requires the complete substitution of existing hospitals with new capacity, including infrastructure, equipment and operation procedures. The government hopes that the hospital development programme will radically improve the quality of care, especially as the new owners of the hospitals should be highly motivated to attain maximum hospital care quality within the short term, investing in not only the infrastructure but also the re-training of personnel. However, many fear that the MoLHSA currently lacks sufficient regulatory capacity to ensure that even minimum quality standards are met and there is no policy on the quality of medical services to be provided, such as requirements for clinical performance, operational performance, patient safety or patient satisfaction. In addition, there is also a lack of reliable data with which to benchmark or assess the quality of care (MoLHSA 2009a). The weak regulatory environment can only be interpreted as a refusal explicitly to measure (and ensure) quality of care. This contrasts with other countries (such as Switzerland and the Netherlands), where a clear pro-market orientation is supplemented by strong regulation by public authorities.

8.6 The contribution of the health system to health improvement

Life expectancy for both men and women in Georgia fell significantly after 1990 and only started to improve from 1999, returning to previous levels in 2005 (see Section 1.4 *Health status*). Georgian health statistics are subject to serious limitations and need to be used with caution, but it would appear that only recently has there been a declining trend in both the maternal mortality rate and the infant mortality rate. Indicators such as improvements in overall life expectancy and falls in the infant and maternal mortality rates show important improvements in the population's health status but also demonstrate the challenges facing the Georgian health care system.

While there have been improvements, maternal and infant mortality rates, for example, are still very high in comparison with rates in other countries of Europe. There is evidence that improvements in the infant survival rate should be attributed mainly to the reductions in post-neonatal mortality, which is more amenable to care by the family and broad public health approaches, rather than improvements in health service delivery, as there have been no discernible improvements in access to or quality of care since 2000 and the early neonatal death rate has remained stable (see Section 1.4 *Health status*). The high rates of multi-drug resistant TB can also be read as a marker for weaknesses in health system functioning, as it is an iatrogenic development (McKee and Falkingham 2008).

In summary, changes in the health status of the Georgian population provide ample evidence of the importance of wider social and economic factors for the health status of populations, but key indicators highlight continuing weaknesses in the health system which need to be addressed if Georgia is to meet its health-related Millennium Development Goals.

9. Conclusions

Since independence there have been many health reform efforts in Georgia, but out-of-pocket payments as a proportion of total health expenditure have remained stubbornly high, thus limiting access. Overcapacity in urban areas with severe undercapacity in rural districts is also still a feature of the system, despite many schemes to improve efficiency. Challenging vested interests in the medical establishment by rationalizing provision has thus far proved impossible. The constant flux of reform efforts has therefore served to weaken the health system.

The most recent marketization reforms in the Georgian health system have bold objectives, have achieved some successes and should only be measured in the fullness of time. Nevertheless, experience shows that any bold privatization of service purchasing has many associated risks. First, international experience shows that the administrative costs of private insurance largely exceed the costs when public expenditures are administered by a public purchaser, and these administrative costs have risen significantly since the scheme was introduced in Georgia. Second, the regulation, reporting and accountability instruments to supervise the private insurance function in the framework of the state health programmes remain weak. This is a very complex reform package that is difficult to understand, has many different actors and relies heavily on relatively small private insurers to purchase health services and inexperienced state agencies to regulate the purchasing process. The strategy has raised serious concerns about the equity and sustainability of the health system, as well as issues relating to quality and efficiency.

Georgia has made progress in significantly increasing absolute spending on health since 2004, which is clearly related with improvements in, for example, vaccination coverage and other areas. Targeting the poorest households has achieved a considerable shift in the proportion of public spending allocated to those most in need (in 2006, 12.3% of the state health budget was allocated

to services for the poorest households, in 2007, allocations increased to 26.9% and in 2008 this doubled). However, the burden imposed by high levels of out-of-pocket payments remains a serious concern, particularly the high cost of pharmaceuticals which are not covered under any state-sponsored health insurance schemes. It is hoped that the new pharmaceutical law will have an impact on the cost of pharmaceuticals by promoting greater competition in the market, but cost sharing is lower down the agenda.

Regulation and oversight of the system probably remains the biggest single challenge as it affects all aspects of health care in Georgia, including the production of human resources for health and the quality of care. Actively building the regulatory environment will involve more stringent and transparent enforcement of laws and regulations. Transparency is an essential prerequisite for increasing accountability in the system and building public trust, indeed, transparency in decision-making is a part of the stewardship function. Greater transparency and accountability are necessary to avoid conflicts of interest, particularly in a marketized system. Developments in the regulation and oversight of the system could support improvements in the rightsizing of service provision; improvements in quality and efficiency; speeding up the fulfilling of investors' obligations to the public and the government; and increasing the accountability of insurance companies.

Georgia still has a relatively low resource base and the challenge must be to pool these resources in as simple a way as possible in order to purchase services for the population. New policies aimed at reducing out-of-pocket payments by promoting broad participation in private health insurance schemes have to be thoroughly monitored and evaluated. The main risk now is that if new policies fail to deliver adequate population coverage, barriers to access and the potential for catastrophic health care costs will push households into poverty, even if currently they are not officially registered as such.

10. Appendices

10.1 References

Amnesty International (2005). Georgia: torture and ill-treatment two years after the Rose Revolution. 23 November (http://www.amnesty.org.uk/news_details.asp?NewsID=16622, accessed 3 October 2008).

Amnesty International (2007). Georgia: authorities must promptly investigate police actions in dispersing demonstrators. 9 November (http://www.amnesty.org.uk/news_details.asp?NewsID=17519, accessed 3 October 2008).

Badurashvili I et al. (2009). *Harmonization of Georgian demographic statistics with European Standards*. Tbilisi, Georgian Centre of Population Research.

Badurashvili I et al. (2001). Where there are no data: what has happened to life expectancy in Georgia since 1990? *Public Health*, 115(6):394–400.

Bailey M (2005). *Development of recommendations for pharmaceutical policy and regulation*. *Tbilisi*, World Bank.

Balabanova D et al. (2009). Navigating the health system: diabetes care in Georgia. *Health Policy and Planning*, 24(1):46–54.

Belli P, Gotsadze G, Shahriari H (2002). *Qualitative study for informal payments for health services in Georgia*. Tbilisi, Curatio International.

CIA (2009) [web site]. World factbook: Georgia. Washington, DC, Central Intelligence Agency (https://www.cia.gov/library/publications/the-world-factbook/geos/gg.html, accessed 8 October 2009).

Centre for Medical Information and Statistics (2007). *Health care statistical report*. Tbilisi, NCDCPH and MoLHSA.

Chawla M, Betcherman G, Banerji A (2007). *From red to grey: the 'third transition' of aging populations in eastern Europe and the former Soviet Union*. Washington, DC, World Bank.

Chkhatarashvili K et al. (2006). *Assessment of perinatal care in Georgia*. Tbilisi, Curatio International.

Christensen C, Karosanidze T (2008). Georgia. In: *Global corruption report 2008: corruption in the water sector*. Cambridge, Cambridge University Press:236–243.

Committee on the Rights of the Child (2008). Summary record of the 1317th meeting. Geneva, United Nations Committee on the Rights of the Child.

Curatio International Foundation (2007). *Pharmaceutical market analysis*. Tbilisi, Curatio International.

Drug Agency (2005). *Drug Agency database market analyses* (in Georgian). Tbilisi, Drug Agency.

Dunn E (2008). Postsocialist spores: disease, bodies, and the state in the Republic of Georgia. *American Ethnologist* 35(2):243–258.

Figueras J et al. (2004). Overview. In: Figueras J et al. *Health systems in transition: learning from experience*. Copenhagen, European Observatory on Health Systems and Policy.

Gamkrelidze A et al. (2002). Health Care Systems in Transition: Georgia. Copenhagen, European Observatory on Health Care Systems.

Gotsadze G, Zoidze A, Rukhadze N (2009). Household catastrophic health expenditure: evidence from Georgia and its policy implications. *BMC Health Services Research* 9:69.

Government of Georgia (2007a). *Basic data and directions for 2007–2010*. Tbilisi, State Chancellery.

Government of Georgia (2007b). State law on "The State budget of Georgia 2008". *Legislative Bulletin*, 50.

Government of Georgia (2009). *2009 budget adopted*. Tbilisi, Ministry of Finance, Government of Georgia.

Hauschild T, Berkhout E (2009). *Health-care reform in Georgia: a civil-society perspective: country case study*. Oxfam International Research Report. Oxford, Oxfam International

Henshall C et al. (1997). Priority setting for health technology assessment: theoretical considerations and practical approaches. *International Journal of Technology Assessment in Health Care*, 13(2):144–185.

Hotchkiss D et al. (2006). Health system barriers to strengthening vaccine-preventable disease surveillance and response in the context of decentralization: evidence from Georgia. *BMC Public Health* 6(175):175.

Hou X, Chao S (2008). *An evaluation of the initial impact of the medical assistance program for the poor in Georgia*. Policy Research Working Paper No. 4588. Washington, DC, World Bank.

Human Rights in Healthcare (2009). The coalition – human rights in healthcare. (http://www.hrh.ge/portal/alias__HRH/lang__en/tabid__1774/default.aspx, accessed 16 November 2009).

Imnadze P et al. (2006). *Statistical bulletin, health care, Georgia 2005*. Tbilisi, MoLHSA, National Centre for Disease Control and Medical Statistics.

Lewis M (2000). *Who is paying for health care in Eastern Europe and Central Asia?* Washington, DC, World Bank.

McKee M, Falkingham J (2008). The changing face of transitional societies. In: Coker R, Atun R, McKee M, eds. *Health systems and the challenge of communicable diseases: experiences from Europe and Latin America*. Maidenhead, Open University Press.

Mdivani N et al. (2008). High prevalence of multidrug-resistant tuberculosis in Georgia. *International Journal of Infectious Diseases*, 12(6):635–644.

MoLHSA (2006). *State health budget*. Tbilisi, Government of Georgia.

MoLHSA (2007a). *Draft report on rural PHC development*. Tbilisi, MoLHSA.

MoLHSA (2007b). *Executed budget*. Tbilisi, MoLHSA.

MoLHSA (2007bc). *Household survey on health service utilization and expenditure report*. Tbilisi, MoLHSA, Department of Statistics, MoED, Oxford Policy Management, Curatio International Foundation.

MoLHSA (2009a). *Georgia health system performance assessment*. Tbilisi, MoLHSA.

MoLHSA (2009b). Official National Health Accounts data from the MoLHSA, Tbilisi, requested by the authors October 2009.

MoLHSA (2009c). Unpublished data from the Health Care Department, MoLHSA, Tbilisi requested by the authors September 2009. Tbilisi.

National Bank of Georgia. (2007). Statistics. (http://www.nbg.gov.ge/index.php?m=304, accessed 1 November 2007).

NCDCPH (2009). *Health and health care in Georgia, statistical yearbook 2007.* Tbilisi, National Centre for Disease Control and Public Health.

Nishiyama M, Wold JL, Partskhaladze N (2008). Building competencies for nurse administrators in the Republic of Georgia. *International Nursing Review* 55(2):179–186.

Nunes R (2003). Speech at the Bilateral Conference on Research and Medical Ethics of the Council of Europe and MoLHSA, 15 July.

O'Brien C, Chanturidze T (2009). *Assessment of child welfare reform in Georgia*. Tbilisi, UNICEF.

OPM (2004). Institutional map of agencies involved in human resources and service delivery in Georgia. OPM-DFID PHC Reform Support Programme: Discussion Paper. Oxford, Oxford Policy Management.

OPM (2005). Planning human resources for health in Georgia. OPM-DFID PHC Reform Support Programme: Discussion Paper. Oxford, Oxford Policy Management.

OPM (2007a). *Health policy systems*. Georgia: Health Sector Reform Programme. Oxford, Oxford Policy Management.

OPM (2007b). *Introduction to primary health care in Georgia*. Georgia: Health Sector Reform Programme. Oxford, Oxford Policy Management.

Policy Department of MoLHSA (2005). *National health report*. Tbilisi, MoLHSA.

Redmond R, Sunjic M (2008). UNHCR chief visits South Ossetia. 22 August (http://www.unhcr.org/news/NEWS/48aef0dc4.html, accessed 15 January 2009).

RMC Resources Management Consultants Ltd (2006). National master plan for primary health care facilities: draft final report. Tbilisi, Georgia Health and Social Projects Implementation Centre, Ministry of Health.

Schaapveld K, Rhodes G (2004). Observations on health financing reform in the Republic of Georgia, 1996–2002. *Applied Health Economics and Health Policy*, 3(3):127–132.

Serbanescu F et al. (2007). *Reproductive health survey Georgia, 2005: final report*. Atlanta, GA, United States Department of Health and Human Services.

Sharashidze M et al. (2005). *The situation of people with mental health problems and people with intellectual disabilities: Georgia: needs assessment report*. Tbilisi, Georgian Association for Mental Health.

State Department of Statistics (2007). *Statistics yearbook of Georgia: 2006*. Tbilisi, Ministry of Economic Development of Georgia.

State Department of Statistics (2008). *Statistics yearbook of Georgia: 2007.* Tbilisi, Ministry of Economic Development of Georgia.

Suhrcke M, Rocco L, McKee M (2007). *Health: a vital investment for economic development in eastern Europe and central Asia*. Copenhagen, World Health Organization on behalf of the European Observatory on Health Systems and Policies.

Transparency International (2009). *Global corruption report 2009: corruption and the private sector*. Cambridge, Cambridge University Press.

Transparency International Georgia. (2007). "One Hundred New Hospitals" for Georgia: how long will they last? (http://www.transparency.ge/files/50600_314_428808_OneHundredNewHospitalsforGeorgia_E.pdf, accessed 26 September 2008).

Tsuladze G, Maglaperidze N, Vadachkoria A (2005). *2004 demographic yearbook of Georgia*. Tbilisi, Georgia: UNPF.

World Bank (2008). World Development Indicators [online database] (http://go.worldbank.org/IW6ZUUHUZ0, accessed 8 July 2008).

World Bank (2009a). World Development Indicators [online database] (http://go.worldbank.org/IW6ZUUHUZ0, accessed 8 October 2009).

World Bank (2009b). *Georgia poverty assessment*. Tbilisi, World Bank.

World Bank et al. (2003). *Guide to producing national health accounts: with special applications for low-income and middle-income countries*. Geneva, WHO.

WHO Regional Office for Europe (2009). European Health for All Database (HFA-DB) (offline version, August), Copenhagen, WHO Regional Office for Europe.

10.2 HiT methodology and production process

The Health Systems in Transition (HiT) profiles are produced by country experts in collaboration with the Observatory's research directors and staff. The profiles are based on a template that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources, and examples needed to compile HiTs. While the template offers a comprehensive set of questions, it is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context. The most recent template is available online at: http://www.euro.who.int/observatory/Hits/20020525_1.

Authors draw on multiple data sources for the compilation of HiT profiles, ranging from national statistics, national and regional policy documents, and published literature. Furthermore, international data sources may be incorporated, such as those of the OECD and the World Bank. OECD Health Data contain over 1200 indicators for the 30 OECD countries. Data are drawn from information collected by national statistical bureaux and health ministries. The World Bank provides World Development Indicators, which also rely on official sources.

In addition to the information and data provided by the country experts, the Observatory supplies quantitative data in the form of a set of standard comparative figures for each country, drawing on the European HFA database. The HFA database contains more than 600 indicators defined by the World Health Organization (WHO) Regional Office for Europe for the purpose of

monitoring Health for All policies in Europe. It is updated for distribution twice a year from various sources, relying largely upon official figures provided by governments, as well as health statistics collected by the technical units of the WHO Regional Office for Europe. The standard HFA data have been officially approved by national governments. With its summer 2004 edition, the HFA database started to take account of the enlarged European Union (EU) of 27 Member States.

HiT authors are encouraged to discuss the data in the text in detail, including the standard figures prepared by the Observatory staff, especially if there are concerns about discrepancies between the data available from different sources.

A typical HiT profile consists of 10 chapters.

1 Introduction: outlines the broader context of the health system, including geography and sociodemography, economic and political context, and population health.
2 Organizational structure: provides an overview of how the health system in the country is organized and outlines the main actors and their decisionmaking powers; discusses the historical background for the system; and describes the level of patient empowerment in the areas of information, rights, choice, complaints procedures, safety and involvement.
3 Financing: provides information on the level of expenditure, who is covered, what benefits are covered, the sources of health care finance, how resources are pooled and allocated, the main areas of expenditure, and how providers are paid.
4 Regulation and planning: addresses the process of policy development, establishing goals and priorities; deals with questions about relationships between institutional actors, with specific emphasis on their role in regulation and what aspects are subject to regulation; and describes the process of HTA and research and development.
5 Physical and human resources: deals with the planning and distribution of infrastructure and capital stock; the context in which IT systems operate; and human resource input into the health system, including information on registration, training, trends and career paths.
6 Provision of services: concentrates on patient flows, organization and delivery of services, addressing public health, primary and secondary health care, emergency and day care, rehabilitation, pharmaceutical care,

long-term care, services for informal carers, palliative care, mental health care, dental care, complementary and alternative medicine, and health care for specific populations.

7 Principal health care reforms: reviews reforms, policies and organizational changes that have had a substantial impact on health care.

8 Assessment of the health system: provides an assessment based on the stated objectives of the health system, the distribution of costs and benefits across the population, efficiency of resource allocation, technical efficiency in health care production, quality of care, and contribution of health care to health improvement.

9 Conclusions: highlights the lessons learned from health system changes; summarizes remaining challenges and future prospects.

10 Appendices: includes references, useful web sites, legislation.

The quality of HiTs is of real importance since they inform policy-making and meta-analysis. HiTs are the subject of wide consultation throughout the writing and editing process, which involves multiple iterations. They are then subject to:

- A rigorous review process (see the following section).
- There are further efforts to ensure quality while the profile is finalized that focus on copy editing and proof reading.
- HiTs are disseminated (hard copies, electronic publication, translations and launches). The editor supports the authors throughout the production process and in close consultation with the authors ensures that all stages of the process are taken forward as effectively as possible.
- One of the authors is also a member of the Observatory staff team and they are responsible for supporting the other authors throughout the writing and production process. They consult closely to ensure that all stages of the process are as effective as possible and that the HiTs meet the series standard and can support both national decision making and comparisons across countries.

10.3 The review process

This consists of three stages. Initially the text of the HiT is checked, reviewed and approved by the research directors of the European Observatory. The HiT is then sent for review to two independent academic experts and their comments and amendments are incorporated into the text, and modifications are made accordingly. The text is then submitted to the relevant ministry of health, or appropriate authority, and policy-makers within those bodies are restricted to checking for factual errors within the HiT.

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Armenia (2001[g], 2006)
Australia (2002, 2006)
Austria (2001[e], 2006[e])
Azerbaijan (2004[g])
Belarus (2008[g])
Belgium (2000, 2007)
Bosnia and Herzegovina (2002[g])
Bulgaria (1999, 2003[b], 2007[g])
Canada (2005)
Croatia (1999, 2007)
Cyprus (2004)
Czech Republic (2000, 2005[g], 2009)
Denmark (2001, 2007[g])
Estonia (2000, 2004[gj], 2008)
Finland (2002, 2008)
France (2004[cg])
Georgia (2002[dg])
Germany (2000[e], 2004[eg])
Hungary (1999, 2004)
Iceland (2003)
Ireland (2009)
Israel (2003, 2009)
Italy (2001, 2009)
Japan (2009)
Kazakhstan (1999[g], 2007[g])
Kyrgyzstan (2000[g], 2005[g])
Latvia (2001, 2008)
Lithuania (2000)
Luxembourg (1999)
Malta (1999)
Mongolia (2007)
Netherlands (2004[g])
New Zealand (2001)
Norway (2000, 2006)
Poland (1999, 2005[k])
Portugal (1999, 2004, 2007)
Republic of Korea (2008)
Republic of Moldova (2002[g], 2008[g])
Romania (2000[f], 2008)
Russian Federation (2003[g])
Slovakia (2000, 2004)
Slovenia (2002, 2009)
Spain (2000[h], 2006)
Sweden (2001, 2005)
Switzerland (2000)
Tajikistan (2000)
The former Yugoslav Republic of Macedonia (2000)
Turkey (2002[gi])
Turkmenistan (2000)
Ukraine (2004[g])
United Kingdom of Great Britain and Northern Ireland (1999[g])
Uzbekistan (2001[g], 2007[g])

Key
All HiTs are available in English. When noted, they are also available in other languages:
[a] Albanian
[b] Bulgarian
[c] French
[d] Georgian
[e] German
[f] Romanian
[g] Russian
[h] Spanish
[i] Turkish
[j] Estonian
[k] Polish

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HiTs are in-depth profiles of health systems and policies, produced using a standardized approach that allows comparison across countries. They provide facts, figures and analysis and highlight reform initiatives in progress.

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