HiT summary

Georgia

Introduction

Government and recent political history

Georgia became an independent republic in 1991 following the collapse of the Soviet Union. Georgia suffered civil unrest following independence, resulting in the secession of the Abkhazian region. The country has a democratically elected government headed by President Eduard Shevardnadze. Administratively, Georgia is divided into 12 regions and 65 districts.

Population

The population is estimated at between 4.1 and 5.4 million. The last census was undertaken in 1989 but due to difficulties in data collection, population movements and casualties related to the civil unrest, emigration and uncertainties about the population growth rate, the population estimates vary. This major variation means that caution must be used when interpreting other statistics using a population denominator.

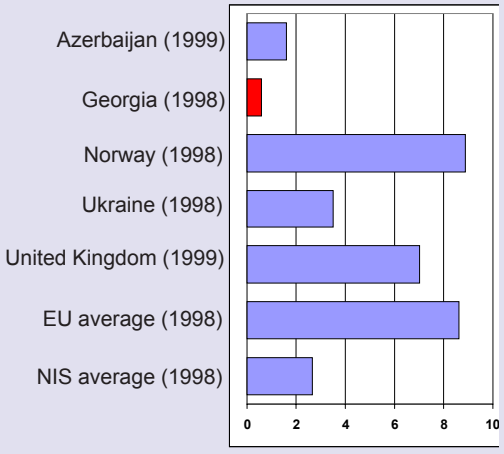
Average life expectancy

In 1995 average life expectancy was 72 years. Leading causes of death are circulatory system diseases, ischaemic heart disease and cerebrovascular diseases. Widespread smoking is likely to be a key contributing factor to this mortality burden.

Recent history of the health care system

At independence Georgia inherited a large and costly health system based on the centrally run Semashko model. Although the system was generally well regarded, it proved to be too expensive to maintain post-independence. It was also felt to be less well suited to meeting the primary care needs of the population. The system was staffed by very high numbers of specialist health staff and there was provision of a very large number of secondary and tertiary care beds. In the years immediately following independence the health system suffered severe financial shortages. These resulted in delayed or non-payment of staff salaries, informal user fees being levied on patients, a virtual cessation of investment in equipment or buildings for

Fig. 1. Total health care expenditure as % of GDP, comparing Georgia, selected countries and EU and



Source: WHO Regional Office for Europe health for all database

European Observatory on Health Care Systems
WHO Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen
Denmark
Telephone: +45 39 17 14 30
Telefax: +45 39 17 18 70
E-mail: observatory@who.dk

http://www.observatory.dk

health facilities, the development of a black market in pharmaceuticals and a near collapse in the national preventive programmes, including the national immunization programme. As a result, in 1993 the government began to plan health reforms to address these issues and in 1995, implementation of the new changes began.

Reform trends

The government has introduced wide-scale changes. These include: the introduction of a health insurance system, introducing a basic free or co-payment health benefits package and ending the provision of free health care for measures outside the health package and the establishment of new provider payment mechanisms.

Health expenditure and GDP

Health expenditure decreased dramatically from pre-independence to current levels. The low level of funds available for health reflect both a decreased provision for health as part of the national budget and the decreasing national budget due to economic difficulties post-independence. In 1998 Georgia allocated 0.6% of GDP to health. Total health expenditure on health by the population and state is estimated at US$20 per person per year for the same year.

Overview

Georgia became an independent republic in 1991. Following independence the country suffered both civil unrest and economic difficulties. Today the country has an elected government but the breakaway Abkhazian region does not participate in this. The health care system inherited at independence proved too costly for the available resources and it was also felt that it no longer met the primary care needs of the population. In the years following independence many systems of regulation became weakened, informal payments increased and the provision of basic care to the population drastically diminished. Thus, planning for health reform began in 1993 and the first reforms were introduced in 1995. The government has taken a broad and bold set of reforms and these include: development of a limited free or subsidized "Basic Benefits Package" of health services and the introduction of user fees for other services, development of a health insurance system, a new form of contracting health care facilities and staff, strengthened regulation of pharmaceutical supply and the development of an Essential Drugs List, and pilot projects for enhanced primary care services and new training programmes for family medicine. Although the health reforms have been large-scale there are concerns that the population has not yet felt the benefits of such change. The longer-term outcomes of the reforms remain to be seen.

Organizational structure of the health care system

The Ministry of Health, Labour and Social Welfare is the lead agency for the health system. As part of the reforms, its role has changed from being a provider of health care services to one of regulation and accreditation and also implementation of some national health promotion and prevention programmes (such as the national immunization programme). The State Medical Insurance Company (SMIC) runs the health insurance programme and is responsible for contracting providers (health care facilities) to supply health services covered by the programme. Regional health administrations have been established to develop and manage programmes at the regional level. Municipal authorities also play a role through their administration of the municipal health funds.

At the national level a State Commission for the Regulation of Social Policy has been created to assist with health reform implementation and it is intended that regional level committees on health reform report back to this committee. The National Health Management Centre (NHMC), established in 1994, provides technical support to the health reform process. Health care facilities are now generally managerially and financially independent of the MoHLSA. Most pharmacies now operate on a private basis. Although a small number of private health insurance companies have been established, few people have taken up this form of insurance. A number of parallel health services are provided by other Ministries (such as the Ministry of Defence). Non-governmental organizations have played a role in health care services since independence, undertaking activities such as drugs provision and care for vulnerable groups.

Planning, regulation and management

Health care planning for the reform process has been based around three key documents: "Georgian Health System Reorientation: Major Directions" (1996, NHMC), the 1999 National Health Policy and the Strategic Health Plan for Georgia 2000–2009 (MoHLSA 1999). The MoHLSA is the agency responsible for the overall management and regulation of the health system. It develops and sets guidelines for health care provision. The NHMC provides technical guidance for the planning of the health reform process.

Decentralization of the health care system

Decentralization has been an important theme and is central to most reform activities. Key decentralization activities undertaken to date include: the establishment of the 12 regional health administrations, the privatization of much health care provision (pharmacies and some health care facilities) and the separation of service planning and provision.

Health care financing and expenditure

Georgia entered the 1990s with a wholly tax-funded health care system. In 1995 this was replaced with a social insurance system which is run through the SMIC. As part of the reforms a Basic Benefits Package (BPP) of health care was developed available under the social insurance programme (together with a number of programmes provided through the MoHLSA and the municipalities). At the same time, user fees were introduced for health services not covered under the BPP.

The details of entitlements of the BPP and which agency provides them are shown below. Services covered by the BPP are free or require a form of co-payment. All non-BPP health services must be paid for directly by the patient. Employees and employers must contribute 1% and 3%, respectively, of employee salaries to SMIC for health care entitlements. The state must make payments to SMIC for the unemployed and vulnerable groups (such as the elderly). Although the BPP lists entitlements for SMIC participants, due to the low level of financing provided to the health system, there have been difficulties in meeting these obligations.

Preventive health programmes under the BPP are financed by Central Budget Transfers and implemented by the Department of Public Health (MoHLSA). They include immunization, prevention of infectious diseases, health promotion, prevention of STDs, prevention of AIDS, epidemiological surveillance and quarantine, prevention of micronutrient deficiencies, prevention and treatment of trauma, blood safety, and screening.

The health insurance programme and Central Budget Transfers finance services

implemented by health care facilities contracted to the SMIC. These programmes, also under the BPP include: psychiatric patients care, TB care, prenatal care and delivery, health care for children under 3 years and orphans, health care for "vulnerable population", cancer treatment, infectious disease treatment, renal dialysis, paediatric cardiac surgery, ischaemic heart disease surgery and organ transplantation (limited numbers), and pharmaceuticals for some chronic conditions.

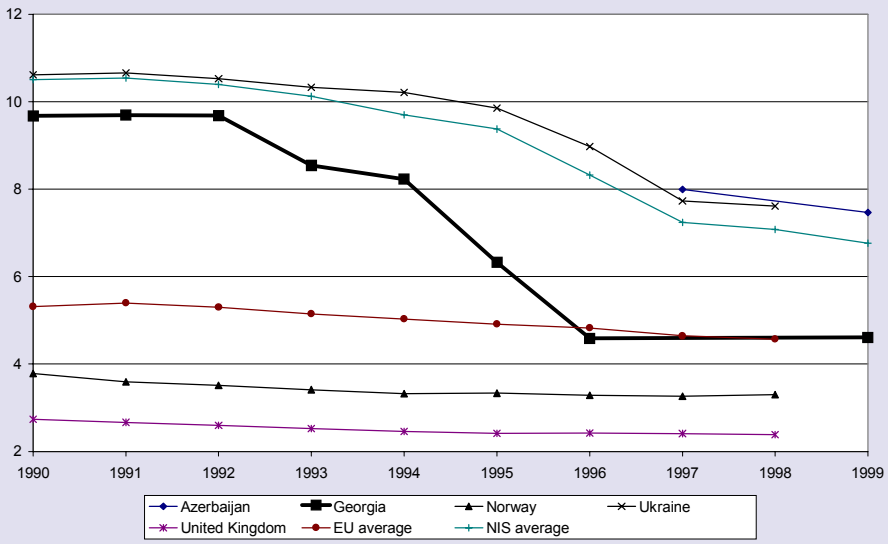
Municipal health funds fund services provided at municipal level including emergency care and ambulance service, provision of forensic expertise, outpatient care, critical care, palliative care for oncology patients and medical services for adolescents (4–14 years). These services are also part of the BPP.

Complementary sources of finance

These include direct formal payments by patients for health services not covered by the BPP or those services under the BPP which require a co-payment. Informal charges for health care also make up a large part of the complementary sources of finance. In 1997 formal and informal payments to health providers were estimated to account for as much as 87% of expenditure on health in the country. It was hoped that by formalising payments for certain health services under the health reforms that the high level of informal payments taking place in the first years of independence would be reduced. However, it appears that informal payments continue to be requested of many patients. In 2000 it was estimated that the formal and informal payments were deterring as much as 30% of the population from seeking health care services. A 1999 World Bank report identified the illness of a family member as one of the main causes of impoverishment in Georgia.

Seven private health insurance companies were operating in Georgia in 2001. However, the private insurance market is relatively undeveloped and few people have taken out

Fig. 2. Hospital beds in acute hospitals per 1000 population in Georgia, selected countries and EU and NIS averages



Source: WHO Regional Office for Europe health for all database

policies due to the relatively high price of the premiums and the low purchasing power of the population.

Not only is health expenditure in Georgia extremely low, the amount of money pledged to the health sector in the annual budgeting process for the national budget is not always received by the health sector.

Health care delivery system

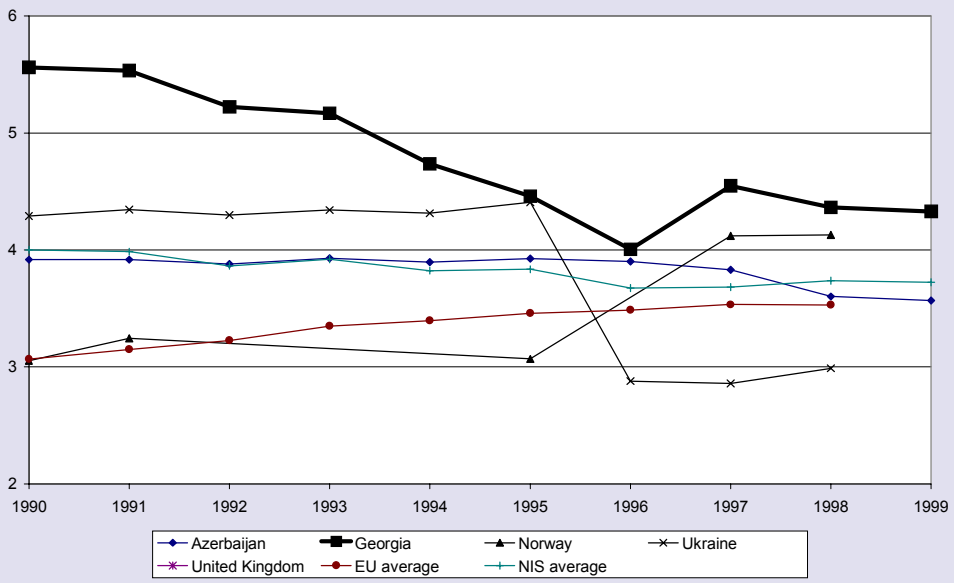
Primary health care, the patient's first contact

The primary care structure in place is essentially that inherited from the Soviet era. Thus, there is a large and widespread network of primary care units in rural and urban areas. However, under the Soviet system these were generally staffed by sub-specialists and an integrated model of family medicine did not exist. Post-independence many of these units suffered from a lack of economic resources for salaries, equipment and basic pharmaceuticals. With the general breakdown in referral procedures, many patients by-passed the primary system altogether preferring to consult directly with a specialist. Under the new health reform arrangements, primary care facilities which are now free-standing legal entities, provide the BPP in addition to providing services which require full payment.

The main facilities currently offering primary care services are: ambulatories, children's polyclinics, women's consultation clinics, adult polyclinics, private PHC centres, private obstetric clinics and independent dental polyclinics.

Under the new national health strategy, primary care is to be given additional emphasis in the Georgian health system. A number of

Fig. 3. Physicians per 100 population in Georgia, selected countries and EU and NIS averages



Source: WHO Regional Office for Europe health for all database

primary health care pilot projects are underway to develop models for strengthened primary care. A Society of General Practitioners and Family Medicine was set up in 1995. In 1998 Georgia was also one of the first countries of the former Soviet Union to recognize family medicine as a speciality. It is hoped that by 2003 there will be national and regional centres in place for family medicine, full financing mechanisms in place by 2005 and the completion of a national network of primary care centres with trained primary care teams by 2008.

Public health services

Georgia inherited the "San-Epid" network of the former Soviet Union. The San-Epid system was designed to undertake both environmental health activities and epidemiological surveillance and disease control work. Under the health reforms this system was divided into two new departments of the MoHLSA: the Department of Public Health (DPH) and the Department of Sanitary Surveillance and Hygienic Standards (DSSHS). The role of the DPH is to monitor and assess the epidemiological situation of the population, to promote good health through education and to manage preventive health services. The DSSHS is responsible for environmental health services such as inspection of water quality, food hygiene and occupational health and safety. Both centres face an increasing workload and suffer from inadequate resources.

Secondary and tertiary care

At independence Georgia had one of the highest levels of staffing and bed provision in the secondary and tertiary care sectors of the former Soviet states. In 1991 there were around 53 000 beds in 390 hospitals in the country. Secondary and tertiary health care facilities take the form of polyclinics, municipal or "gamgeoba" hospitals, specialised hospitals and research institutes, dispensaries and spa resorts. Many hospitals had very low occupancy rates post-independence – due mainly to over-capacity in the system but also an inability of many patients to pay for health services. The government has tried to reduce the excess capacity in hospital provision through the new system of payment for health services (health care facilities must win contracts with the SMIC to provide services covered under the BPP).

To some extent the reform strategies have gone some way to achieve their intended effects in this area: provision in 1999 had been reduced to 246 hospitals and 22 500 beds. However, compared to other countries, bed numbers remain high and occupancy rates low (488.5 beds per 100 000 population on average and 740 and 798 per 100 000 in the two main cities of Tbilisi and Poti respectively). It was envisaged that the reforms would lead to the closure of inefficient hospitals and that staff numbers would also be reduced by this mechanism. However, some hospitals have been reluctant to lose staff (resulting in low salaries as resources are shared widely). The government has thus developed a hospital rationalization plan which has identified which hospitals will remain open, which will be closed and which fully privatised.

Social care

Social care is defined here as the non-medical care of dependent people (such as the elderly or disabled). In 1999, the Ministry of Social Welfare, responsible for social care activities, merged with the Ministry of Health to become the Ministry of Health, Labour and Social Affairs (MoHLSA) and this new ministry is now responsible for most social care programmes. At the local level services are provided through the health sector (hospitals and ambulatories) and the social sector (through day-care and residential sectors). Social welfare in Georgia under the Soviet era was relatively under-developed. Elderly people and some categories of psychiatric patients were often placed in long-term medical beds although they

did not need medical supervision. These gaps in service provision continue today.

Basic social welfare programmes are intended to be free of charge to specific categories of people needing assistance. However, with 198 000 people classified as "disabled" (using the broad Soviet era definition) available resources are stretched and entitlements, in reality, are very limited. Concerns have been raised about the quality of some social care provision, particularly for some aspects of mental health care provision. A number of non-governmental organisations have begun assisting in a limited number of areas with social welfare provision.

Human resources and training

The Georgian health sector employs the greatest number of staff after the education sector despite large-scale reductions in staff numbers post-independence. In 1990 the country had 4.9 physicians per 1000 population compared to 3.1 in the EU. In 1999 this had been reduced to 4.3 per 1000. The country has relatively few nursing staff compared to some western European countries and in the capital, Tbilisi, doctors are thought to outnumber nurses.

Up until the health reforms, staff were employed by the state and were salaried employees. Under the reforms this was changed and they are now employed by the independent health facilities. Between August and December 1995,120 000 health personnel were removed from the government pay roll in this way.

Prior to independence, medical training was carried out in one main medical school. Since 1995 more than 50 private "medical schools" have opened leading to concerns about the quality and numbers of graduates from these new institutes.

Health care personnel have faced great difficulties over the last decade due to low, delayed or absent payment. According to official data, they now form the lowest paid professional sector in the country with official incomes falling below the "extreme poverty line". However, income is often supplemented by informal payments leading to difficulties for patients seeking care.

Pharmaceuticals

One of the first activities of the health reforms was the privatization of the formerly state pharmacies. Local pharmaceutical production is small-scale and most drugs are imported. In 1995 the government created an Essential Drugs List to encourage better prescribing. All pharmaceuticals, with the exception of those supplied free or with some co-payment under the BPP must be purchased directly by patients. In some cases, due to resource shortages, pharmaceutical entitlements under the BPP may not be available. Because of the financial problems faced by much of the population in purchasing pharmaceuticals, a pilot project was undertaken in Kutaisi between 1997 and 2000 to investigate ways of sharing and lowering drugs costs. It also trialed the return to a prescription based system (which has generally been abandoned in most parts of the country). The lessons from this project will be looked at for possible replication elsewhere.

Financial resource allocation

National budget setting takes place on an annual basis and, within this, the MoHLSA leads the health care budget setting process. The MoHLSA develops its budget based on submissions from the regions, SMIC, municipalities and departments of the ministry. Available resources determine the overall national budget and the budget received is often less than that approved in the budget setting process. The health allocation in the national budget is very low. In 1999 the total central budget contributions to the health bill of the

country amounted to 8% of total health expenditure (around US $3.35 per person). With the exception of certain preventive programmes (such as national vaccination activities – for which health facilities receive a fee from the MoHLSA) hospitals are contracted and paid by SMIC and the municipalities and/ or by patients directly.

Health care reforms

Health care reforms were initiated following planning which started in 1993. The reforms were felt to be necessary because firstly, the health system in place required financing beyond the resources available to maintain it and secondly, because it was felt that the system was no longer meeting the basic needs of the population (particularly for primary care).

The main aims of the reform process were spelled out in the 1996 document "Georgian Health System Reorientation: Major Directions". The key features of the reform plan included decentralisation of the health care management system; a move to programme based financing and prioritisation of primary health care. Other important aspects were reforming the San-Epid system, introducing health insurance, reforming pharmaceutical policy and the health information system. Ensuring medical education standards continued to be high was also a priority and the plan included the aims of reforming medical education and medical science and also accrediting and licensing medical institutions and personnel.

The 2000–2009 strategic health document expands on the concepts outlined in the 1996 document. Most of the plans outlined in the 1996 document have been undertaken or initiated. The Government has been bold in undertaking the reforms, introducing both a new financing mechanism, defining a BPP and also introducing user fees, and privatizing the pharmaceutical sector while also developing an essential drugs list.

Conclusions

Although the reforms have been introduced to strengthen the provision of basic care for all, the benefits have not yet been widely felt by the population. Access to care continues to be limited by the widespread payments demanded by the health providers and the BPP. The health insurance system faces difficulties by the sometimes inadequate financing it receives through the central government and is unable to provide all parts of the basic package to those who both need it and are entitled to it. As the economy improves, it is hoped that the new reforms will bring benefits and a basic level of care to all. The outcome remains to be seen.

Table 1. Inpatient utilization and performance in acute hospitals in the WHO European Region, 1999 or latest available year

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Azerbaijan	7.5	4.7	14.9	30.0
Georgia	4.6	4.7	8.3	83.0
Norway	3.3[a]	14.7[c]	6.5[c]	81.1[c]
Ukraine	7.6[a]	18.3[a]	13.4[a]	88.1[a]
United Kingdom	2.4[a]	21.4[a]	5.0[c]	80.8[a]
EU average	4.6[a]	18.75	8.32[a]	77.1[b]
NIS average	6.8	18.6	13.3	84.8

Source: WHO Regional Office for Europe health for all database.
Note: [a] 1998, [b] 1997, [c] 1996, [d] 1995, [e] 1994, [f] 1993, [g] 1992.

HiT summary

Georgia

The Health Care Systems in Transition profile on Georgia was written by Amiran Gamkrelidze, Rifat Atun, George Gotsadze and Laura MacLehose. It was edited by Laura MacLehose and Martin McKee.

The European Observatory on Health Care Systems is grateful to the WHO Tbilisi office, Dr Otari Vasadze, Dr Ioseb Bregvadze, Dr Levan Jugeli, Dr Valery Tchernjavskii, Dr Paata Imnadze, Dr Giorgi Tsuladze, Dr Marina Shakhnazarova, Dr Irina Karosanidze, Dr Tamar Gotsadze, Mr Alexander Vadachkoria, Mr David Gzirishvili, Ms Sarbani Chakraborty and Mr Levan Metreveli. The full text of the HiT can be found in www.observatory.dk.

The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Care Systems.

The Observatory is a unique undertaking that brings together WHO Regional Office for Europe, the Governments of Greece, Norway and Spain, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe.