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Health Care Systems in Transition

Georgia

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Written by
Amiran Gamkrelidze, Rifat Atun,
George Gotsadze and
Laura MacLehose

Edited by
Laura MacLehose and
Martin McKee

Georgia 2002

The European Observatory on Health Care Systems is a partnership between the World Health Organization Regional Office for Europe, the Government of Greece, the Government of Norway, the Government of 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.

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Foreword

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.

The aim of the HiT initiative is to provide relevant comparative information to support policy-makers and analysts in the development of health care systems and reforms in the countries of Europe and beyond. The HiT profiles are building blocks that can be used to:

- learn in detail about different approaches to the financing, organization and delivery of health care services;
- describe accurately the process and content of health care reform programmes and their implementation;
- highlight common challenges and areas that require more in-depth analysis;
- 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 the different countries of the European Region.

The HiT profiles are produced by country experts in collaboration with the research directors and staff of the European Observatory on Health Care Systems. In order to maximize comparability between countries, a standard template and questionnaire have been used. These provide detailed guidelines

and specific questions, definitions and examples to assist in the process of developing a HiT. Quantitative data on health services are based on a number of different sources in particular the WHO Regional Office for Europe health for all database, Organisation for Economic Cooperation and Development (OECD) Health Data and the World Bank.

Compiling the HiT profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health care system and the impact of reforms. Most of the information in the HiTs is based on material submitted by individual experts in the respective countries, which is externally reviewed by experts in the field. Nonetheless, some statements and judgements may be coloured by personal interpretation. In addition, the absence of a single agreed terminology to cover the wide diversity of systems in the European Region means that variations in understanding and interpretation may occur. A set of common definitions has been developed in an attempt to overcome this, but some discrepancies may persist. These problems are inherent in any attempt to study health care systems on a comparative basis.

The HiT profiles provide a source of descriptive, up-to-date and comparative information on health care systems, which it is hoped will enable policy-makers to learn from key experiences relevant to their own national situation. They also constitute a comprehensive information source on which to base more in-depth comparative analysis of reforms. This series is an ongoing initiative. It is being extended to cover all the countries of Europe and material will be updated at regular intervals, allowing reforms to be monitored in the longer term. HiTs are also available on the Observatory's website at http://www.observatory.dk.

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The current series of Health Care Systems in Transition profiles has been prepared by the research directors and staff of the European Observatory on Health Care Systems.

The European Observatory on Health Care Systems is a partnership between the 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.

The Observatory team working on the HiT profiles is led by Josep Figueras, Head of the Secretariat and the research directors Martin McKee, Elias Mossialos and Richard Saltman. Technical coordination is by Suszy Lessof.

Administrative support, design and production of the HiTs has been undertaken by a team led by Myriam Andersen, and comprising Anna Maresso, Caroline White, Wendy Wisbaum and Shirley and Johannes Frederiksen.

Special thanks are extended to the Regional Office for Europe health for all database from which data on health services were extracted; to the 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 (CEE) countries. Thanks are also due to national statistical offices which have provided national data.

Introduction and historical background

Georgia is an independent country situated in the southern Caucasus, bounded by Armenia, Azerbaijan, the Black Sea, Russia and Turkey. It covers an area of 69 700 km². Mountains and rivers dominate the Georgian landscape. The climate varies from humid and subtropical conditions in the Kolkhida Lowland to drier conditions in the eastern uplands. The official population estimate is 5.4 million *(1)*, but other estimates vary considerably *(2)*, and there has been extensive migration in recent years.

On account of its position at a crossroad between Europe and Asia, Georgia has a long history of trade, and its climate provides a fertile agricultural base. Although it was absorbed into the Russian Empire in the early nineteenth century

Table 1. Basic data on Georgia and the WHO European Region

	Georgia 1999	European Region 1998
Population (millions)	5.1	–
Population aged		
0–14 years, %	20.0	20.1
15–64 years, %	66.7	66.3
65 years and over, %	13.3	13.6
Area km²	69 700	–
Population density per km²	73.2	31
Urban population, %	57.7	72.7
Births per 1000 population	11.5	11.1
Deaths per 1000 population	9.9	10.9
Natural growth rate per 1000 population	1.6	0.2
Gros domestic product (GDP) per person in US$ PPP[a]	3 353[b]	12 500

[a] PPP = purchasing power parity; [b] 1998

Fig. 1. Map of Georgia[1]

and was one of the original republics of the USSR, it has cultural links with the Mediterranean and the Middle East. The country has a rich history thanks to its strategic location. Ionian Greeks colonized this area in the sixth century BC. At this time the western region of what is now Georgia was known as Kolkhida and the eastern region as Iberia. In the fourth century BC Georgia was united into a single kingdom, with Mtskheta as its capital. Christianity was introduced in the fourth century AD. The Persian and Byzantine empires dominated the area until the Arab conquest in the seventh century. The region then came under control of the Seljuk Turks in the eleventh century before their foray into Anatolia. A period of unification and independence in the twelfth century, under King David IV, was swept aside by the Turco-Mongol invasion in the thirteenth century led by Tamurlane. Between the return of Timur's army to central Asia and the eighteenth century, control of Georgia oscillated between

[1] The maps presented in this document do not imply the expression of any opinion whatsoever on the part of the Secretariat of the European Observatory on Health Care Systems or its partners concerning the legal status of any country, territory, city or area or of its authorities or concerning the delimitations of its frontiers or boundaries.

the Persian and Ottoman empires. A short-lived Georgian kingdom was proclaimed in the mid-eighteenth century, followed soon after by annexation by the Russian Empire. Initially, in 1783, this took the form of control of the kingdom's foreign affairs. In 1801, with the abdication of the last Georgian king, Georgia was fully incorporated into the Russian Empire. After the Russian Revolution, in 1917, Georgia briefly became an independent republic. This independence was short-lived, lasting only until 1921, when it was incorporated into the Union of Soviet Socialist Republics (USSR), where it remained for the following 70 years.

During the Soviet era, Georgia was a relatively prosperous republic, supplying USSR with produce and services and exerting considerable influence over internal exchange and cultural networks. The country declared its independence from the USSR in April 1991. In December 1991, the USSR broke apart, and soon after a military coup brought Eduard Shevardnadze to power in Georgia. The volatile political climate of the early 1990s only stabilized in late 1995, although sporadic violence still persists with continuing secessionist movements in South Ossetia and Abkhazia *(3)*. Parliamentary and presidential elections were held in November 1995, in which Eduard Shevardnadze was elected president. He was re-elected for a further five-year term in April 2000.

The break-up that followed intense civil conflict in the Soviet Union and the Georgian declaration of independence in 1991 led to separatist pressures in autonomous regions and to the displacement of some 270 000 people in 1993. There was also a profound economic collapse, in part due to the civil disturbances and in part due to the unravelling of what had been a centrally planned economy directed from Moscow. The Soviet system did not encourage diversification within republican economies, leaving them vulnerable after independence. There was a large decline in output, a collapse of the system of payments, and thus trade between republics, and consequently a series of dramatic economic declines after 1992, which resulted in a sharp fall in the standard of living.

The health care system was also severely damaged as a result of the war and the economic collapse. Many refugees were housed in hospital facilities, occupying between 80% and 90% of the existing hospital capacity at the height of the civil war, even though fuel shortages meant that hospitals were without electricity for the winters of 1994 to 1996. Collectively, these disruptions led to a breakdown in the health system. Post independence, another major factor in the decline of health services was the drastic reduction in public monies to fund a system that was largely dependent on public resources. For example, between 1990–1994, real per capita public expenditures on health declined

from about US $13.00 to less than a dollar in 1994. People had to pay out-of-pocket for the majority of health services, which affected demand. The physical condition of facilities severely deteriorated, as did medical technology and equipment.

Today the economy is improving and governmental structures are being reformed, with the support of large-scale international assistance. However, the return of internally displaced people and the status of the autonomous regions remain unresolved. As a consequence there are, de facto, two governments and thus two ministries of health: one in Tbilisi for Georgia as a whole and one in the Abkhazia region.

Demographic and health indicators

Estimates of the current population of Georgia vary between 4.07 million *(2)* and around 5.4 million people *(1)* (not including the Abkhazia and Tzkhinvali regions). Georgians make up around 70% of the population, with Armenians (8.1%), Russians (6.3%), Azeris (5.7%), Ossetians (3%) and Abkhazians (1.8%) and others (5%) forming the remainder *(4)*. The last census was undertaken in 1989, and the next round may take place in 2002. Population estimates vary due to difficulties in accounting for large-scale population movements, as a result of the internal secessionist movements (and related breakdown in data collection in these areas), the probable non-recording of many deaths due to civil conflict and out-migration to the Russian Federation and other countries following independence (Table 2). In addition, these figures are also distorted by under-reporting, due to the introduction of an administrative charge that has been levied for birth registration *(5)* since 1996/1997. Because evidence of registration is, typically, only required at school entry, many births will either be missed or only recorded some years later. Taken as a whole, the available demographic estimates portray a decreasing total fertility rate over the past 30 years, with a more pronounced drop from around 1994 *(6)*. It is estimated

Table 2. Population data

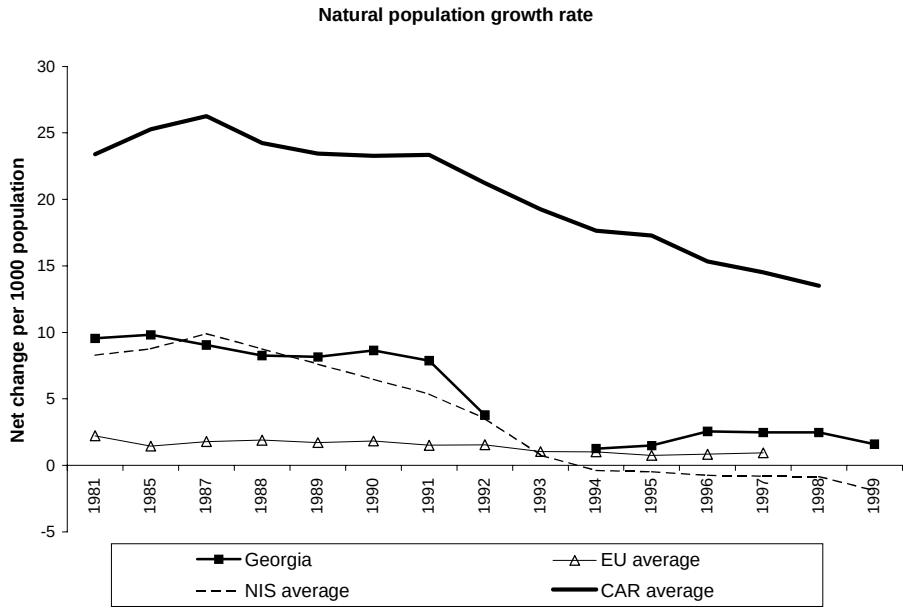
	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Population (millions)[a]	5.44	5.41	5.4	5.4	5.45	5.43	5.42	5.42	5.42	5.44	5.44
Population (millions)[b]	–	5.42	5.44	5.41	5.16	4.69	4.50	4.34	4.21	4.15	4.10
% population under 15 years[c]	24.7	24.6	24.5	24.4	24.1	23.6	22.46	21.72	20.91	20.91	–
Crude death rate per 1000[c]	8.71	9.57	9.69	9.76	–	9.24	–	–	–	–	–
Total fertility rate[c]	2.14	–	2.1	2.1	2.1	2.0	2.0	–	1.4	1.3	1.07
No. live births per 1000[c]	16.86	19.34	18.57	15.19	12.92	12.06	11.86	11.28	10.9	9.81	10.17

Source: [a] Demography Division of the State Department for Statistics of Georgia; [b] *(2)*; [c] *(6)*.

that the total fertility rate in Georgia declined from a figure of 2.14 births in 1989 to 1.4 births in 1997 *(6)*. The proportion of births to unmarried mothers has more than doubled from 17.7% in 1989 to 35.4% in 1998 *(7)*.

The age structure of the population is also changing, because of the growing number of elderly people. The proportion of the population under 15 years of age decreased to 20.4 % (from 24.7% between 1989 and 1998) and is expected to further decrease with the falling birth rate (see Table 2).

Fig. 2. Natural population growth rate



Given the uncertainty about the population size, statistics derived from it must be treated with considerable caution. On the basis of official data, the health status of the Georgian population, as assessed by life expectancy at birth, approximated closely that of the European region average in the early 1980s. However, by the end of the 1980s it dipped slightly until the mid-1990s, when it began to improve again *(2,6)*.

Table 3. Infant mortality rate

Source	1995	1996	1997	1998	1999
State Statistical Department	14.4	17.4	15.3	15.2	17.5
Centre for Medical Statistics and Information	24.6	27.8	24.0	21.3	23.4

For the reasons stated earlier, figures for the infant mortality rate (IMR) must also be treated with caution. Official data shows that the rate has remained fairly steady over the second half of the 1990s. However, there is some discrepancy between different official sources. In 1999, IMR was recorded as 23.4 and 17.5 by the Centre for Medical Statistics and Information (CMSI) and the State Statistics Department (SSD), respectively. The CMSI data are likely to be more accurate as they include figures from both the Civil Registry and information collected directly from hospitals (unlike the State Statistics Department, which relies solely on the Civil Registry). A recent survey found that, in 1998, approximately 20% of all deaths (up to 26.7% of infant deaths) registered at hospitals were not registered by the Civil Registry Bureau. Of six maternal deaths registered by hospitals, the Civil Registry Bureau recorded none. Also, birth certificates were not issued for 22% of live births in Delivery Houses *(8)*. However, neither source covers the regions of South Ossetia or Abkhazia, which provide no data to the National Statistical Office. It is likely that inclusion of these regions, which have been subject to major civil disturbance, would produce a worse picture.

The three main causes of infant mortality are conditions originating in the perinatal period (58.0%), followed by infectious and parasitic diseases (14.1%) and diseases of the respiratory system (10.8%). There are large regional differences in IMR, with the highest rates in 1999 being recorded in Tbilisi (42.9). Other regions showed figures such as 23.4 in Ajara, and implausibly low figures of 12.2 in Guria, and 7.4 in Racha-Lechkhumi *(9)*.

Recorded maternal deaths have increased substantially since the 1980s, according to data from both the SSD and the CMSI. From a figure of 35.9 deaths per 100 000 births in 1984, the rate had doubled to 71.1 in 1997 (or 48.5 according to the SSD). In a 1996 study on maternal mortality covering the period from 1984 to 1995, the main recorded causes of maternal death were haemorrhage (45%), embolism (18%), sepsis (13%) and preeclampsia (11%). Just over 3% of maternal deaths were classified as being related to abortion *(10)*, although this seems likely to be an underestimate. In 1999, haemorrhage (37.5%) continued to be the main cause of death, but was followed in second place by preeclampsia (20.8%), embolism (16.7%) and sepsis (8.3). Three abortion-related deaths were recorded that year accounting for 12.5% of deaths.

Table 4. Health indicators

Indicators	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999[a]
Life expectancy at birth, in years[c]	71.8	72.0	71.9	72.2	71.5	71.5	71.6	–	72.0	–	–	–	–	–
SDR ischaemic heart disease (0–64 per 100 000)[c]	78.4	86.7	98.6	96.9	109.4	118.9	129.2	–	119.2	–	–	–	–	–
TB incidence per 100 000 (all forms)[c]	34.6	33.9	29.7	29.8	32.0	31.9	44.6	57.5	60.1	94.1	145.0	113.7	93.7	97.3
Infant mortality rate (per 1000 live births)[c]	25.5	24.5	22.0	19.6	15.8	13.8	12.6	–	16.9	–	–	–	–	–
Under 5 mortality rate (per 1000 age group)[c, b, a]	32.0[c]	30.0[c]	28.0[c]	24.6[c]	20.6[c]	18.5[c]	16.7[c]	–[c]	21.8[c]	–[c]	–[c]	–[c]	–[c]	–
									27.0[b]	–	16.5[b]	18.7[b]	17.1[b]	–
										28.1[a]	31.9[a]	26.0	25.3[a]	–
Maternal mortality per 100 000 live births[c, d]	20.4[c]	16.9[c]	22.9[c]	54.9[c]	20.5[c]	10.1[c]	4.3[c]	–	1.74[c]	–	–	–	–	–
								32.4[d]	39.6[d]	55.0[d]	59.9[d]	70.1[d]	68.6[d]	51.3[d]
														49.2[d] (2000)
Abortions per 100 live births[c]					61.3[c]	55.7[c]	55.8[c]	59.6[c]	62.1[c]	56.8[c]	55.9[c]	40[f]	40[f]	40[f]
												210[e]	200[e]	220[e]

Source: [a] Centre for Medical Statistics and Information ; [b] Central Statistical Department (SDS)[1]; [c] WHO health for all database 2001; [d] MoLHSA [e] Reproductive Health Survey, Georgia 1999; [f] Ministry of Health unpublished data quoted in the Reproductive Health Survey, Georgia 1999.

Table 5.

Average income/month	Morbidity level/10 000	Mortality level/10 000
Up to 30 GeL (Georgian lari)	82	36
30-50 GeL (Georgian lari)	27	27
Higher than 50 GeL (Georgian lari)	8	2

Source: *(5).*

Table 6. Macroeconomic indicators

Indicators	1990	1991	1992	1993	1994	1995	1996	1997	1998
GDP real growth rate 1989 base year=100[b]	84.9	67.4	37.2	27.8	24.6	25.2	27.8	30.9	31.8
GDP US$ per person[c]	–	–	862	554	–	–	–	913	736
GDP US$ PPP per person[c]	4 572	3 670	2 300	1 750	1 585	1 389	–	838	3 353
Annual average inflation rate (%)[a]	–	79	887	3 125	15 606	163	39	8	3.6
Real growth of average wages (base year 1989=100[b])	111	77	51	24	34	28	42	57	717
Registered unemployment rate (%)[b]	–	0.2	2.3	6.6	3.6	2.6	2.4	5.0	5.0

Source: [a] World Bank Online Database; [b] UNICEF TransMONEE database 3.0. [c] WHO Regional Office for Europe health for all database.

Abortion is believed to be the most widespread form of contraception. The ratio of induced abortions to live births was two to one for the period from 1996 to 1999. Forty-three per cent (43%) of women of reproductive age reported having had at least one induced abortion in the 1999–2000 Reproductive Health Survey of Georgia *(11)*.

Available evidence suggests large disparities in health in relation to income, although, as in all post-Soviet societies, assessment of income is highly problematic due to the increasing non-monetarization of transactions (see Table 5 below).

The pattern of mortality is similar to that in other former Soviet republics, with high levels of adult (especially male) mortality, although Georgia has never experienced the extremely high levels of alcohol-related mortality seen in the Russian Federation. Neither did it experience the fluctuations in mortality seen at the time of the 1985 anti-alcohol campaign. This may reflect a pattern of consumption based on wine and brandy, rather than vodka. The high adult mortality is driven by noncommunicable diseases, although levels of heart disease are lower than in some neighbouring countries – in part reflecting the strong agricultural base, with ready access to fruit and vegetables. As in the rest of the former Soviet Union, especially among men, tobacco makes a major contribution to the burden of disease. The expenditure on tobacco exceeds that on health care *(12)*. In the past, societal pressure mitigated against women smoking. However, since the 1980s, according to data from the Georgian Institute on Addiction, smoking is increasingly common among women and female rates are now thought to be close to that of men, with an estimated 40% of women and 40–50% of men smoking *(13)*. Also reflecting the common post-Soviet pattern, injuries are an important cause of premature death and disability.

The difficult economic conditions and the problem of internal displacement are thought to be key factors in the threefold increase in the number of suicides in the decade following independence *(5)*.

Although overall mortality is driven by noncommunicable disease, there have been increases in several notifiable infectious diseases, including sexually transmitted infections. The reported incidence of syphilis increased from 14.5 cases per 100 000 in 1990 to 27.45 per 100 000 in 1999 *(6)*, but this is likely to underestimate the rise because of under-recording. A cumulative total of 124 cases of HIV/AIDS had been recorded at the end of 1999, with a rapid increase in incidence after 1994 *(14)*. Over 70% of these cases were associated with intravenous drug use in 1999. Knowledge about the range of measures available to reduce the risk of transmission of HIV is low, according to a 1997 study *(15)*.

The incidence of tuberculosis has risen both in children and adults since the start of the 1990s, from 29.7 per 100 000 in 1988 to 145 per 100 000 in 1997. In 1998, the reported incidence had fallen (implausibly) to 93.7 (6). As in the rest of the former Soviet Union, tuberculosis is reported to be a particularly severe problem within the prison system, although it has not been possible to obtain valid data from this sector

After earlier increases due to a breakdown in immunization programmes in 1992–1993, vaccine preventable diseases are falling again, reflecting a strengthening of national immunization efforts *(16)*. A diphtheria outbreak took place in Georgia in 1993, with a peak in 1995. Improved vaccination coverage has decreased the annual number of cases of diphtheria to around 25 in 2000. The latest multi-cluster survey conducted by UNICEF indicates that 67% of Georgian children between 15–23 months are immunized, and there are regional variations.

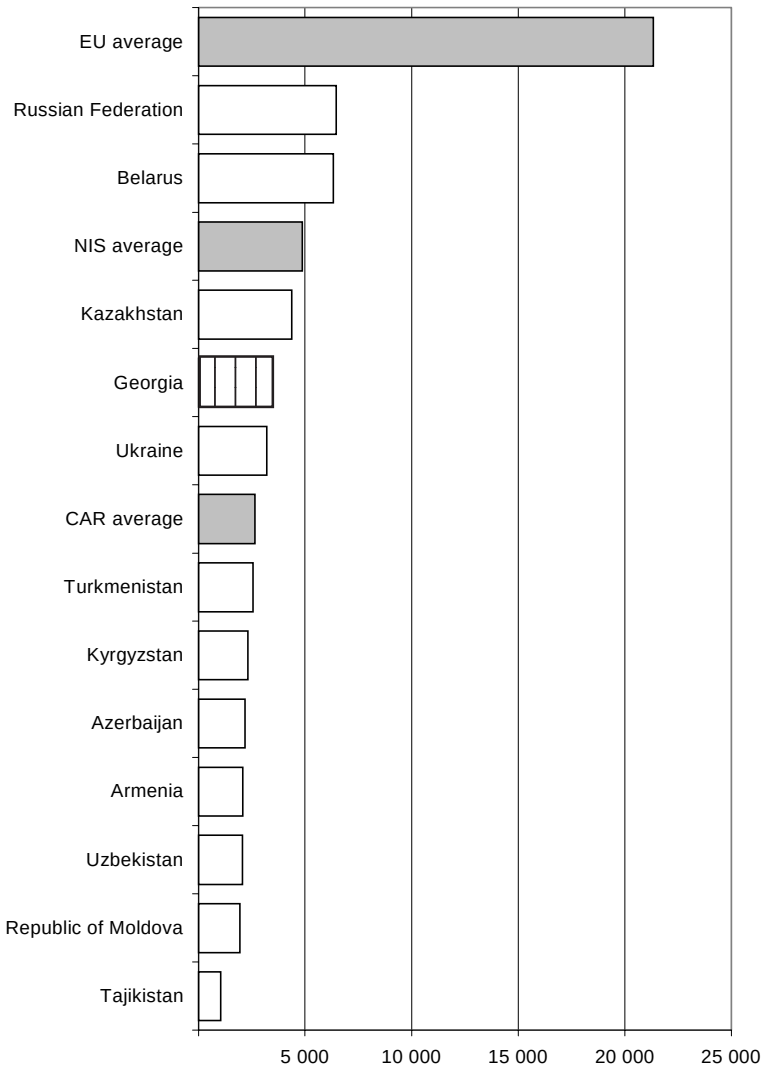
Socioeconomic indicators

Prior to independence, Georgia enjoyed one of the highest living standards in the Soviet Union, although this reflected a low cost of living as official per person income was lower than in many other Soviet republics *(17)*. The economy has traditionally been based around Black Sea tourism, cultivation of citrus fruits, tea and grapes, mining of manganese and copper, and the output of industrial sectors (wine, metals, machinery, chemicals and textiles). Decoupling from the Soviet economic system, combined with a rapid transition to a market economy and civil war, left Georgia in a state of economic collapse, with reduced resources for the health sector. Official estimates indicate a fall in gross domestic product (GDP) by 1994 to about 30% of the 1990 level. In 1993, inflation was over 1200% (6). After 1994, however, the economy improved rapidly and in the years from 1995 to 1999 it has been growing at an average rate of 8% per annum *(18)*. A new Georgian currency, the Georgian lari (GeL), was introduced in 1995 replacing the Russian rouble, US dollars and Georgian coupons, all of which had been circulating. It has been stable since 1998, the year of post-devaluation, and there are approximately 1.7 lari to the euro (or around 2 to the US dollar). Since 1997, inflation has remained stable at around 3.6 %.

Georgia imports most of its energy requirements from the Russian Federation, but has some of its own hydroelectric power capacity *(19)*. Large-scale energy shortages were experienced following independence and some shortages continue as Georgia faces problems in meeting deadlines for payments for energy *(20)*. The lack of power has obvious implications for health facilities and population health, particularly in the winter.

Economic improvement has not benefited all sectors of the population. Income inequality is very high and a recent World Bank household budget survey found substantial poverty *(18)*, with only 11% of the population above the newly-defined poverty line of 52 GeL (around US $26/€32) per adult

Fig. 3. Real gross domestic product per person in US $PPP, 1998



Source: WHO Regional Office for Europe health for all database.

equivalent per month and with 8.9% under the "extreme poverty" line (40 GeL or US $20/€24 per adult equivalent per month). The authors concluded that a major improvement in the efficiency of tax collection, with a redistribution of resources, as well as economic growth, would be necessary to reduce poverty levels.

Table 7. Poverty in fourth quarter of 1997

Poverty measures	Official PL	New PL	Extreme PL
Poverty incidence (Headcount Index) in %	42.7	11.1	8.9
Poverty depth	14.9	33.0	2.7
Average shortfall of the poor[a]	35.0	29.9	30.5
Severity of poverty[b]	7.4	1.5	1.2

Source: Case Study for the Debate: Poverty Definition and Indicators. Alliance for Business Environment and Development, Tbilisi, November 2001.

[a] Average shortfall of poverty "is a distance between the average consumption of the poor and the poverty line (as percent of the poverty)". It is the same as Income-Gap Index (IGI), which when multiplied by Headcount Index equals Poverty Gap Index PGI.

[b] Severity of poverty "gives relatively greater weight to poverty shortfalls that are way below the line (e.g. it captures the degree of inequality among the poor)".

In these adverse circumstances, the Georgian Government sought external assistance. A Programme of Stabilization and Structural Reforms, characterized by free market policies, was designed to stabilize the economy, with assistance from the International Monetary Fund (IMF) and the World Bank (WB). The elaboration of the Poverty Reduction and Economic Growth Programme supported by the international donor community and financial institutions is being lead by the Government of Georgia through a participatory process. (http://poverty.worldbank.org/files/georgia%20IPRSP2.pdf).

Government administration

Until independence in 1991, Georgia was part of the Soviet Union and was subject to centralized rule from Moscow. Independence brought democratic reforms, including establishment of a unicameral Parliament. A new constitution was enacted in 1995. There is a president as executive, with Eduard Shevardnadze currently head of state and of government.

The executive branch of government comprises the President, supported by a Cabinet of Ministers. Ministers are appointed by, and are directly accountable to the president. Presidential elections are by popular vote. The legislative branch of government, the single chamber Parliament, contains 150 members elected by proportional system from party lists and 85 by popular vote for

a 4-year term. The judicial branch is headed by the Supreme Court, which comprises judges elected by the Parliament on the President's recommendation. The ultimate constitutional arbiter is the Constitutional Court. The "Public Defender", elected by the parliament has to uphold human rights and freedom *(21)*. The new constitution is not recognized in Abkhazia, which has instituted its own government and set up parallel ministries. The Abkhazian structures are not recognized internationally, and the region has faced an economic blockade since its secession. Trade does, however, take place across its frontier with the Russian Federation, although, in the mid-1990s, the Russian Federation also imposed an official economic blockade. There is considerable concern in Georgia about the scope for smuggling along the border with the rest of Georgia. The Abkhaz area currently remits no tax to the central Georgian government.

Georgia is divided into 12 administrative regions and 65 districts. Elections for the local-elected bodies are held every 3 years but the Law on Self-governance and Local Governance, passed in 1997, enables the President to appoint local governors and mayors. As will be discussed later, local government plays a role in collecting and distributing health care funds

Historical background

Georgia has a long, well-documented medical tradition, with artefacts bearing the international symbol of medicine (a snake twined around a staff) dating from the fourth century. Major medical treatises were produced from at least the tenth century. Western medical traditions were introduced to Georgia in the seventeenth and eighteenth centuries, and in the latter half of the eighteenth century young Georgians were sent by King Vakhtang to study medical sciences in Moscow and St Petersburg. By the time of Georgia's unification with Russia in 1801, western medical traditions had been widely adopted in Georgia *(22)*.

In the brief period of Georgia's independence from Russia, between 1918 and 1921, the State University of Georgia, including a medical faculty, was established. It was not until 1921, however, when the Soviet medical system was introduced in Georgia that a unified system of health protection was established *(22)*.

From 1921 to 1991, the Georgian health system was part of the Soviet system. The "Basic Law on Health in the USSR and Soviet Republics", enacted in 1964, provided the framework for each republic. The system, known as the Semashko model, was centrally run. It was characterized by almost complete public ownership, with financing from general government revenues. Planning, organization, control and allocation of nearly all resources were undertaken in

Moscow. Few responsibilities were delegated to the Georgian health authorities, whose role was limited to reporting performance against predetermined plans to the authorities in Moscow *(23)*.

Health care was meant to be free at the point of delivery, and health professionals received a salary. Although some private practice was allowed, illegal out-of-pocket payments to health professionals were also common *(24)*.

The system was curative in orientation, reliant on inpatient care and, to a lesser extent, on outpatient care delivered by specialists in polyclinics or dispensaries *(25)*. Hospitals dominated the delivery system. Parallel systems existed beside the Ministry of Health facilities, in particular those for the Ministry of Defence, the Ministry of Internal Affairs and the Department of Railways. There was also a special system for high-ranking officials, dignitaries and others that provided high quality health care and was not accessible by the general population. The centralized Soviet health system was very resource intensive, based upon high bed numbers and very large numbers of medical personnel. The health-care budget was generally allocated on what was left after other higher priority sectors (such as defence) had been funded. Already meagre resources started to decrease after about 1980, reflecting the growing financial plight affecting the Soviet Union *(21)*.

In 1993, there were plans to begin to reform the health care sector. Presidential Decree #400, ratified in 1994, provided the basis for the reorganization. The first changes took place in 1995, with assistance from the World Bank, the United Nations Children's Fund (UNICEF), WHO and the American International Health Alliance (AIHA). The reforms introduced new concepts, including social insurance, official user fees and new provider payment mechanisms.

Organizational structure and management

Organizational structure of the health care system

The Ministry of Labour, Health and Social Affairs (MoLHSA) is the lead agency for the health care system. Its main responsibility is implementation of government policy on health care and coordinating all activities.

In order to implement the strategic health plan and manage and coordinate the national health system the State Commission for Regulating Social Policy, was established under the President and is granted with superior power. In the implementation process of the strategic health plan the Commission is intended to identify the roles of the different sectors that influence health and to monitor how they carry out their responsibilities. However, it is not yet fully functional in this role, and the MoLHSA remains the key strategic health decision maker.

The National Health Management Centre, which reports to the MoLHSA, provides scientific and technical advice to the MoLHSA for the health reform process. Also at the national level are Republican hospitals, research centres and medical schools. Much decision-making power and responsibility for funding at the local level have been handed to twelve new Regional Health Departments (RHDs). Each region is also meant to have an intersectoral "Regional Committee" that communicates with both the Regional Health Departments and the State Committee; in practice, however, these are not yet fully functional. Reporting, in turn, to the RHDs are the municipal health authorities which have responsibility for the hospitals, polyclinics and primary health care (PHC) services in the local area. A number of health services are also provided as parallel services through other ministries (such as the Ministry of Railways).

The State Medical Insurance Company (SMIC) and the Ministry of Finance are the key financial players in the health care system. The SMIC is in charge

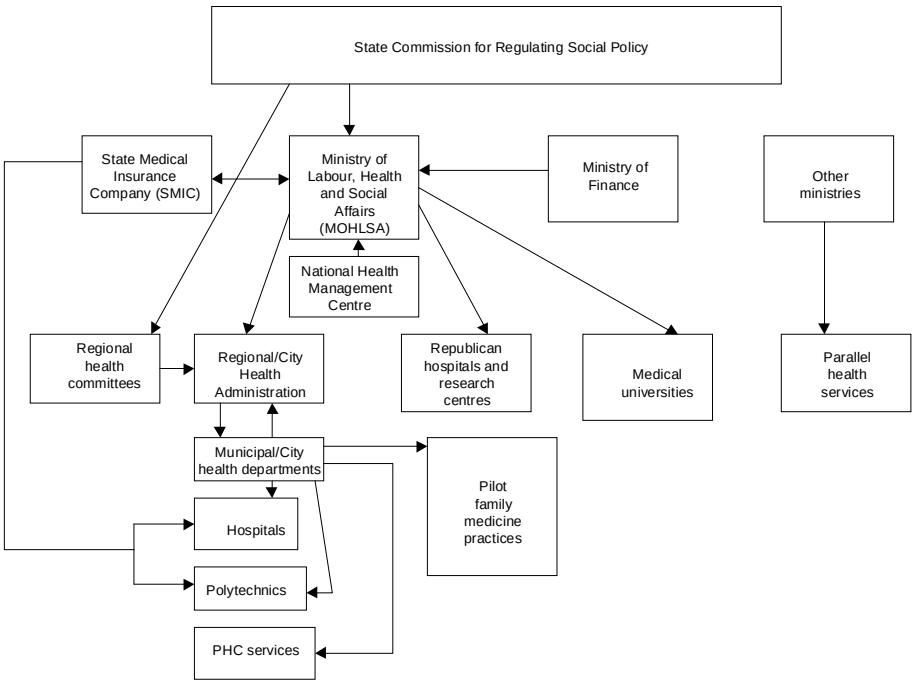
of the national health insurance fund and contracts health facilities at the local level directly. The details of the structure are given in Fig. 4.

Further details about each of the key players in the health structure are given below.

State Commission for Regulating Social Policy: The Committee, set up as part of the 2000–2009 Strategic Health Plan of Georgia, is intended to play a role in coordination at the highest level of national health activities. The committee, which is supposed to be made up of representatives from different sectors of government and business, was designed to look at the roles of different sectors that influence health issues and activities and to monitor how the responsibilities of these sectors are carried out. The Committee should report directly to the President and provide guidance to the MoLHSA, the National Health Management Centre, Regional Committees and other health-related sectors. However, although the committee was designed to have a key role in the health policy process, it is not yet functioning.

Ministry of Labour, Health, and Social Affairs (MoLHSA): In 1999, the Ministry of Health joined with the Ministry of Social Welfare to become what

Fig. 4. Organization of the health care system



has been named, from 2000, the Ministry of Labour, Health and Social Affairs. It is responsible for the development and implementation of government policy on health care and medical research. Its social welfare responsibilities include distribution of pensions and provision of care for the disabled, elderly and other vulnerable groups. Under the 1995 reforms, restated in the 2000–2009 health programme, the Ministry has changed its emphasis from implementation of health care to support for preventive activities, as well as regulation and accreditation of health services and training. It directly funds a range of preventive health services, such as the national vaccination programme *(26).*

The roles of the ministry can be summarized as follows:

- developing the strategic policy for social–economic and scientific–technical priorities based on the long-term prognosis and indicative plans;
- state health care and medical programme development and implementation and development of strategic preventive priorities;
- in the area of maternal–child health and social protection design of priority interventions and their implementation;
- development of state medical standards and their implementation;
- ensuring health care providers adhere to state medical standards;
- development of state medical insurance and municipal programmes according to the regulations in the country;
- coordination of the work of the regional health care departments;
- registration, expertise and coordination of voluntary health insurance programmes;
- through development of sanitary and hygienic norms and implementation of anti-epidemic measures, assurance of a safe environment for the population;
- guaranteeing that priority health needs of population are met with accessible services;
- support of local pharmaceutical production and its integration into the local and international market;
- within the limits of Georgian legislation, solving the issues related to medical education and medical science;
- identification and support for the priority directions in producing pharmaceuticals, medical equipment and other medical items;
- quality control of imported drugs;
- support to the continuous medical education and development of medical staff.

The Ministry is made up of the following departments: Labour and Employment; Health Policy; Social Issues; Standardization, Norms Development and Licensing; Programme Management; Drug and Pharmaceutical Affairs; Medical

Equipment and Technology; Financing-Budgeting; Parliamentary relations and legal issues; Social Protection of Disabled; Labour Relations.

The Ministry also supervises the efforts of the following departments and organizations: Public Health Department; Military-Mobilization Department; Medical and Social Expertise Department; Non-military Alternative Service Department; Sanitary Surveillance and Hygienic Norms Inspection; At-border crossing points sanitary inspections; Inspection for Pharmaceutical Market and Legal Control of Narcotic Substances; Labour Inspection; Demography; Traditional Medicine.

The state agencies under ministerial supervision are: United Social Protection Fund; State Medical Insurance Company; Hospital restructuring Fund; State Employment Service; Centre for Medical and Social Project Implementation; Forensic Expertise Centre; Centre for Pharmacopoeia; Pharmacology Committee; Academy for Postgraduate Education; Labour Institute; Human Development Centre; Centre for Experimental Neurology; Centre for Audiology and Hearing Rehabilitation; Medical History Museum.

National Health Management Centre (NHMC): The NHMC was established in 1994. It reports to the MoLHSA, and its role is to provide scientific and technical input into the process of health sector reform. Although subordinate to the MoLHSA, it functions as an independent body and it works directly with international and local nongovernmental organizations (NGOs) *(27)*. The NHMC has contributed to drafting the new Georgian health legislation and to preparing health reform plans.

Regional health departments (RHDs): Reporting to the MoLHSA are the 12 regional health departments that were set up in 1995 by Resolution 390 of the Cabinet of Ministers. These departments were developed as part of the process to decentralize the health system. Each administers a regional health fund to which municipalities in the region contribute. In the 10-year period beginning in 2000, their responsibility will be to develop regional health plans in line with the national health plan and to monitor local activities. The role of the RHDs is, however, currently somewhat limited by the MoLHSA.

Regional health committees: The concept of regional health committees was established under the Strategic Health Plan for Georgia for 2000–2009. These committees are intended to be made up of people from the region who represent different sectors that influence health. They should report directly to the State Commission for the Regulation of Social Policy, as well as to the regional health administration in their area, and are also intended to communicate with other health related sectors. However, as noted earlier in relation to the State level health committee, this structure is not yet functioning adequately.

Regional Commission for Regulating Social Processes: The concept of the creation of regional commissions was based on the strategic health plan. The commissions are to be formed with the representatives of the region and should represent various sectors linked to health sector. They report directly to the State Commission for Regulating Social Policy and local administration. As it has been mentioned above, the State Commission for Regulating Social Policy yet has not been functioning fully.

Municipalities: There are 65 municipalities in Georgia. Each municipality administers a municipal health fund (MHF). Money from the fund is channelled to the regional health fund on a per person basis. The municipalities must support five compulsory municipal health programmes.

Health care providers: The decentralization contained in the 1995 reform programme and subsequent developments made most health care providers financially and managerially autonomous from MoLHSA control. Now nominally independent from the state, they are responsible for administering their own affairs under contract with the SMIC or the municipalities. Contracts are made with municipalities for the municipal programmes, with the MoLHSA for the state health and prevention programmes, or with SMIC for programmes covered under the national health insurance programme. In addition, a large number of polyclinics and hospitals have recently been privatized, as have nearly all dental clinics and pharmacies.

There were two options for health care institutions for privatization: to be transformed into a 'Society of Limited Liability' (Ltd) or to become a 'Joint Stock Company' (JSC). The majority of institutions were transformed into Societies of Limited Liability rather than into JSCs. The Society of Limited Liability status gives less rights to institution staff to participate in decision-making. According to privatization legislation, if an institution becomes a Society of Limited Liability, the institution belongs to the state and it is owned by the Ministry of State Property. In many cases, especially in the more rural parts of the country, the privatization process was announced to staff members after it had been completed.

Parallel health services: The parallel systems run by the Ministry of Defence, Ministry of Internal Affairs and the Department of Railways have continued since independence, although with significant changes. Now, formally, only the Ministry of Defence maintains its own health facilities, and the others have officially been integrated with the national health system. However, they remain, administratively, within the original ministries.

Health care training institutes: Prior to independence the Tbilisi State Medical University was the only institution in Georgia providing higher medical education. The current day Medical Academy, which today provides part of

the Georgian postgraduate residency programmes, was previously the Institute of Retraining. As the Institute of Retraining under the former Soviet system, it provided periodic retraining of physicians as required by the law at that time. Since independence, however, over 50 new medical training institutions have opened. Unsurprisingly, this vast expansion of training facilities contains many of dubious quality, creating a major challenge for policy-makers.

Ministry of Finance: The Ministry of Finance is responsible for formulating state fiscal policy under the budget law and managing the expenditures from the state budget. It plays a key role in the annual health budgeting process, working together with the MoLHSA (see the section on *Financial resource allocation*).

State Medical Insurance Company (SMIC): The SMIC is responsible for running the state health insurance programme. The national headquarters of SMIC is in Tbilisi, but it also has twelve regional branches *(26)*. It was established in 1997 and is based on the Law on Medical Insurance (18 April 1997). Despite having the word "company" in its title, SMIC is neither a state-owned enterprise nor a corporation under private corporate law. It is rather a special type of state organization, designed to administer the financing of the state compulsory medical insurance programmes *(28)*. It is fully publicly owned, has no shares and is a non-profit venture. It collects mandatory health premiums from the population and employers and finances the Basic Benefits Package through contracts with health care providers. In 2000, there were 39 programmes funded by SMIC. In 1999, nearly 700 health care providers carried out work on 1300 contracts.

Private health insurance companies: Seven private health insurance companies exist in Georgia in 2001, in response to new legislation permitting their establishment. The market is relatively undeveloped, and few people have taken out policies due to the relatively high price of the premiums and low purchasing power of the population. Private insurance is supplemental to the compulsory state health insurance contributions made through the SMIC. Despite the low uptake of private health insurance, insurers continue to offer health care cover policies through two main methods: offering the health policy in parallel with other (more profitable) types of insurance such as car, accident or property insurance or through being contracted by municipalities for managing municipal health care programmes. The latter has only been used so far once, in the capital city, where one insurance company was contracted. It is still unclear whether this practice of delegating state healthcare obligations and financial resources to private sector is economically and socially effective.

Trade unions and professional associations: Since independence, a Nurses Association has been founded (the Georgian Nursing Association established

in 1996), which focuses on nursing education and professional standards. The Georgian Medical Association was formed in 1989. The Georgian Health Law and Bioethics Society, formed in 1997, focuses on advocacy of patients rights. An association of General Practitioners and Family Doctors was established on 8 December 1995. The role of the professional groups in influencing policy-making is somewhat limited, but continues to develop.

Voluntary organizations: Since independence, several voluntary organizations in the area of health have been established – a new concept for Georgia that had no such tradition during the Soviet era. These include organizations that support children with neurological diseases (Children's Neurological Disease Rehabilitation organization), children with diabetics (Children's Diabetic Association), children with disabilities (First Step), the Alzheimer's Disease Research Society and a group providing support to haemophiliacs among other groups. The role of nongovernmental organizations in taking part in consultations in national health policy formulation and decision making is unclear although this sector has expressed wishes to be more involved *(29)*.

International donors: International donors and banks have provided Georgia with technical advice, grants and loans in the health sector since the early 1990s. They continue to play an important part in both providing essential supplies (such as for immunization programmes) and supporting innovative primary care and other pilot projects.

Planning, regulation and management

Since independence, Georgia has looked to new models for the health sector. The MoLHSA has been active in developing new long-term plans for reform, drawing on international advice. A 10-year strategic health plan, developed by the MoLHSA, began in 2000. This followed the 1995 reform plan, developed by the Ministry of Health in conjunction with the World Bank and with support from other external contributors, and the 1999 National Health Policy Document, which was prepared with the assistance of the WHO. While input from the international community was extensive, there have been concerns about the limited contribution by citizens, consumer organizations and non-governmental organizations, so that some concerns of the population were not fully addressed *(21)*. Besides long-term strategic planning, the MoLHSA leads the annual health-planning cycle, which coincides with the fiscal year. Each annual plan must be approved by the parliament. A variety of other bodies contribute to this process, including the National Health Management Centre, the National Communicable Disease Centre and the State Medical Insurance

Company. The annual plans create a framework within which regional health authorities can develop their own plans.

Regulation of the health sector is the responsibility of government, with the MoLHSA taking the lead role. The MoLHSA has been working with other institutions, such as the NHMC, to develop accreditation and licensing procedures, as well as issuing clinical guidance (the Soviet era Prikaz system).

Although a number of key financing functions have now been transferred to the SMIC and the regional and municipal health funds, the MoLHSA maintains a supervisory role over these agencies. Additionally, the MoLHSA directly manages the State pharmaceutical firms in Tbilisi, Zugdidi and Kutaisi.

Decentralization of the health care system

Prior to independence, the health system was extremely centralized, with financing, provision of materials and staffing decided in Moscow. This centralization inevitably led to unresponsiveness and widespread inefficiencies. Decentralization was thus a key early element of the reform process. Managerial decentralization was also a major component of the 1995 health reforms *(30)* and was reiterated in the 2000–2009 strategic health plan *(5)*. As already noted, the management of the health system has been decentralized, with 12 regional health authorities established in 1995 *(30)*. This was enacted by Presidential Decree #400 (1994) *(21)*. These regional health administrations are subordinate to regional governments and have been given the task of identifying local health needs and developing strategies to meet them. The MoLHSA has been given the lead role in implementing these changes.

Decentralization has also taken place through the privatization of much of the provision of health care. The 1995 reform plan envisaged separating service planning and implementation. From 1999, all health service providers (with the exception of those in a few remote and mountainous areas) ceased to be managed by the MoLHSA and were incorporated under commercial law. Some of the new corporations were privatized, while others remain under public ownership. Two processes occurred under Decree 392, which set out the basis for privatization. Some facilities were privatized outright, while others were required to provide their current service package, subject to state direction, for a minimum of ten years *(30)*. From 1996, nearly all pharmacies and most dentists have been privatized.

Health care financing and expenditure

Main system of finance and coverage

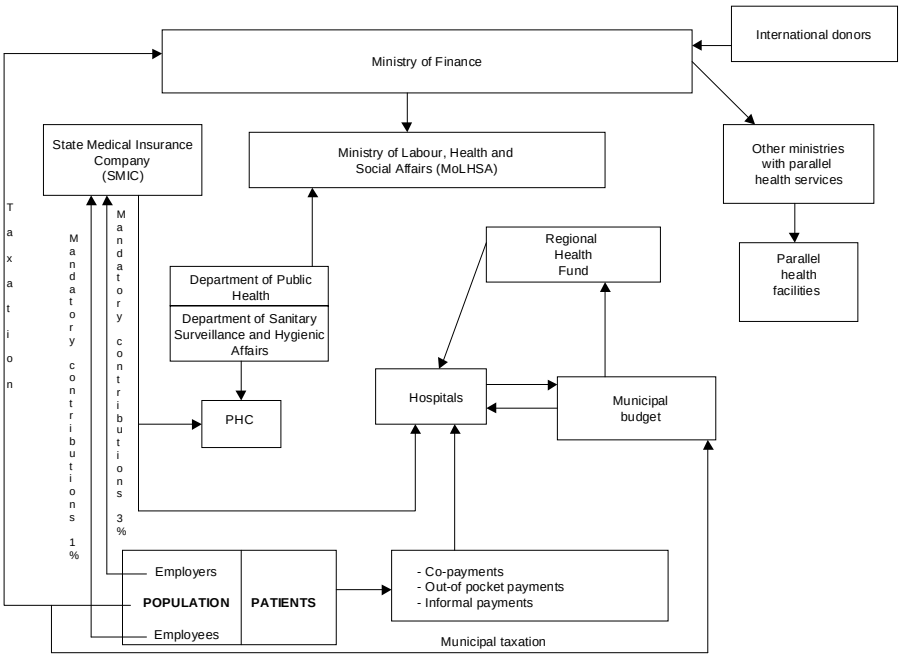
Georgia entered the 1990s with, in theory, a wholly tax-funded health care system. The 1995 reform process replaced this system with a social insurance model run through the specially-created State Medical Insurance Company (SMIC). In theory, basic health care is paid for by the SMIC, with additional funding for certain services from Municipal Health Funds and with preventive health activities through the MoLHSA. In addition, many services are subject to official fees, although informal payments are also very widespread. The SMIC and Municipal funds cover a Basic Benefits Package (BBP) (see later).

To run the social insurance programme, a State Health Fund, was created in 1995. Its sources of revenue were a mandatory payroll tax together with central budget transfers. In 1996, it was replaced by the State Medical Insurance Company (SMIC). The SMIC funds are collected from employees and employers, with employers contributing 3% and employees 1% of salary. Contributions for the unemployed, pensioners, and children are covered by transfers from general government revenues.

The municipal health funds receive revenues from municipal budgets. Contributions to the health funds are a flat rate per person, depending on the number of people living in the municipality, but they must be at least 2.5 GeL (in 2000). The municipalities are, however, permitted to increase this sum if their budgets allow. In 1997, because of the variations in the economic situations of the municipalities, it was decided to pool municipal funds to create regional funds that permit risk sharing between them. The regional health funds became effective in 1999. The funds gathered at the regional level in the regional health funds are then redistributed back to the municipalities for funding the portion of the basic benefit package (BBP) that falls under municipal responsibility. The expected results of spreading the risk through the regional health funds

through pooling, increasing local contributions and increasing local level input into programme design have, however, not yet been seen. For all health care services not provided under the BBP, direct fees-for-service must be paid. Under the health reforms, payments for services not in the BBP were legalized and co-payments for some BBP services formalized. Today, both legal and informal fees-for-service make up a large part of the health system financing.

Fig 5. Financial flows



Health care benefits and rationing

Until 1995, the Soviet model of health care that guaranteed free treatment to all was, in theory, in place in Georgia (although a system of "unofficial" payments had accompanied the "free" system, even in the Soviet era). However, in reality, funding for health care providers all but ceased in the economic downturn and civil strife that followed independence, and patients were obliged to pay full costs for many services (alongside deteriorating salaries and environmental conditions). Preventive services also broke down, including the virtual collapse in the national immunization programme in the early 1990s. One of the related results of this was the large-scale diphtheria outbreak in 1993. In the development of the 1995 health reforms, an assessment was made

of what essential basic services could be covered by the funds available to the SMIC, the MoLHSA and the municipalities. Following much debate on the content, taking account of the cost–benefit ratio of possible services, a BBP was designed to provide a minimum health package. Initially the BBP consisted of nine federal (state) and five compulsory municipal health programmes. Since then, this package has gradually expanded to 28 federal and 8 municipal programmes. The expansion was, however, not accompanied by a corresponding increase in funding.

The BBP is administered by the three different administrations of the MoLHSA, the SMIC and the municipal health funds. The MoLHSA, administers a number of public health programmes, such as immunization, while others, such as treatment of cancer patients, are administered through the SMIC. The SMIC has taken on an increasing number of programmes from the MoLHSA throughout the reform process. The municipal health funds cover health services, such as emergency health service provision. Box 1 shows the programmes included in the package in 2000 and also shows which agency administers the programme.

Under the BBP concept, all services included in the BPP list are either free or partially subsidized. In general, programmes under the BPP that are financed and run by the municipal health authorities require some form of co-payment, while those funded through the central government budget do not. For any services not included in the BPP, patients must pay the hospital or doctor directly (or through private insurance, if they possess it). People paying into the insurance programme receive an insurance card that must be shown to access services to which they are entitled.

While the programmes outlined under the BBP appear to be wide-ranging, what is covered in programmes is fairly limited. Condition, socioeconomic status or age determines eligibility for treatment. For example, free prenatal care covers only four antenatal visits after the third month of pregnancy and delivery, with two possible additional visits requiring some co-payment *(11)*. Any additional visits needed must be paid for by the patient. For provision of services to adolescents, the municipal funds fully cover costs of care, but for a limited number of services only. Similarly, ambulance service costs are borne by the municipality only where the condition is one from a specified list.

The way the somewhat complex BBP is designed in Georgia requires an understanding by the patient of which services are free, which require co-payment and how much, and which require full costs to be paid. At least one survey has highlighted that the population is inadequately informed about their rights to certain free or subsidized services *(32)*. In such circumstances, there is room for providers to manipulate the cost of treatments and for the patient,

Box 1. The state programmes for 2001

Programmes	Financed by	Executed by
I		
Health promotion Epidemiological surveillance & quarantine Immunization Prevention of Drug addiction Iodine and micro-nutritient deficiency Trauma Malaria CVD Active disease detection Safe blood, AIDS & STD prevention Detection of cancer diseases Medical evaluation of young military reserve Additional medical care of rural population Additional medical care for population of high mountainous regions	Central budget transfers	Department of Public Health
II		
Treatment of psychiatric patients Treatment of TB patients Prenatal care and delivery Treatment of children under 3 years and orphans Pediatric cardiac surgery Treatment for children that require continuous substitute treatment Programme for vulnerable population Treatment of infectious diseases Diagnosis and treatment of oncology patients Haemodialisis Treatment of ischemic heart disease patients Tissue and organ transplantation Provision of specific patients with drugs Additional medical care of population in Tskhinvali region Additional medical care of IDPs settled in Samegrelo-Zemo Svaneti region	Obligatory medical insurance premium (3% employer and 1% employee contributions) that contribute up to 60% and 40% from central budget	State Medical Insurance Company (SMIC)
III		
Programme for catastrophic events and natural disasters State sanitary surveillance Support to medical science and education Management of health reforms Monitoring of state programmes Unexpected expenses Medical statistics and health information	Central budget	MoLHSA
IV		
Emergency care and ambulance service Medical services for 4–14 year olds Outpatient care for the population 15+ Drug supply for terminal oncology patients Provision of forensic expertise	Local municipal budgets	Municipal funds

unclear as to which services are free, to miss out on benefits to which he or she is entitled. Clear information, through public information campaigns, has been largely absent.

Complementary sources of financing

Complementary sources of finance in Georgia include direct formal payments by patients for health services not covered by the BBP or for those services under the BBP which include a co-payment. Informal charges for health care also make up a large part of the complementary source of finance. Formal and informal payments to health providers and purchase of drugs were estimated to account for as much as 87% of all expenditure on health in the country in 1997 (although the study did not take into account international donor contributions) *(33)*.

Out-of-pocket payments

Out-of-pocket payment to physicians was an established tradition in Georgia, as in other former Soviet republics, under the former Soviet system of medical care. However, these payments were informal. With the collapse of the economy in the early 1990s, out-of-pocket payments became the main source of income for many health staff and charges were high and unregulated. Under the 1995 reforms, payments for certain health services not covered under the BBP were legalized and charges defined for different types of services. It was expected that formalizing charges would reduce informal payments and stop excessive charging of patients. However, out-of-pocket payments have continued to flourish alongside formal charging, often with catastrophic financial consequences for affected households.

A large number of people (estimated at up to 30% of the population) are deterred from seeking medical services at all due to the high level of out-of-pocket payments charged *(12)*. Others delay their visits to health care providers *(34)*. Nearly 22% of individuals with health problems surveyed in the recent World Bank Poverty Assessment did not see a health provider because of inability to pay *(18)*. A similar finding was reported in a survey in western Georgia, where 50.7% of the poor in the population surveyed did not seek medical care mainly due to economic reasons *(35)*. A single case of hospitalization can consume a full month's earnings of a poor family. Nearly half of the poorest fifth of the population report borrowing or selling property to pay for health services *(36)*. A 1999 World Bank report identified the illness of a family member as one of the most prevalent causes of impoverishment in Georgia *(18)*.

Voluntary health insurance

Under current Georgian legislation, any registered insurance company can sell medical insurance, providing the company is registered with the MoLHSA in accordance with the Law on Entrepreneurship *(21)*. The Law on Medical Insurance, which came into force in 1997, provided the basis for the move to a national health system based on social insurance and provided the legal and regulatory basis for the provision of private insurance. Private insurance is supplemental to the compulsory state medical insurance.

Few people have, however, purchased voluntary medical insurance. In 1999, approximately 468 000 GeL (or US $0.04 per person) was spent on voluntary insurance *(37)*, largely by the well-off.

External sources of funding

Georgia receives a variety of external funding for health care activities. Total official development assistance through the United Nations system for all sectors including health in 1999 was over US $150 million *(38)*. In addition to this Georgia received bilateral aid for health activities from a range of governments including Germany, Japan, USA and the United Kingdom together with assistance from several nongovernmental organizations (NGO's).

Georgia has received substantial health financing from the World Bank. In 1993, the government sought assistance from it for its health sector reform project. The Hospital Restructuring support is through a project approved in 1999 (Structural Reform Support) – the total amount for the loan is US $16 million of which 10 million is for hospital restructuring. A second round of financing was agreed in principle in 1999 for restructuring and strengthening the hospital sector in Tbilisi and a further 5-year project, covering the period 2002 to 2007, is expected to follow the current projects. This project will focus on primary health care development.

Table 8. Health care resources and their utilization in Georgia compared with European averages

	Georgia 1999	Europe 1997
Hospital beds per 1000 population	5.695	6.120
Physicians per 1000 population	4.872	3.434
Hospital admissions per 100 population	5.4	18.7
Average hospital stay in days	10.6	12.7
Health care expenditure as a percentage of GDP	0.6[a]	6.0

Source: UNDP Office in Georgia, 1999.

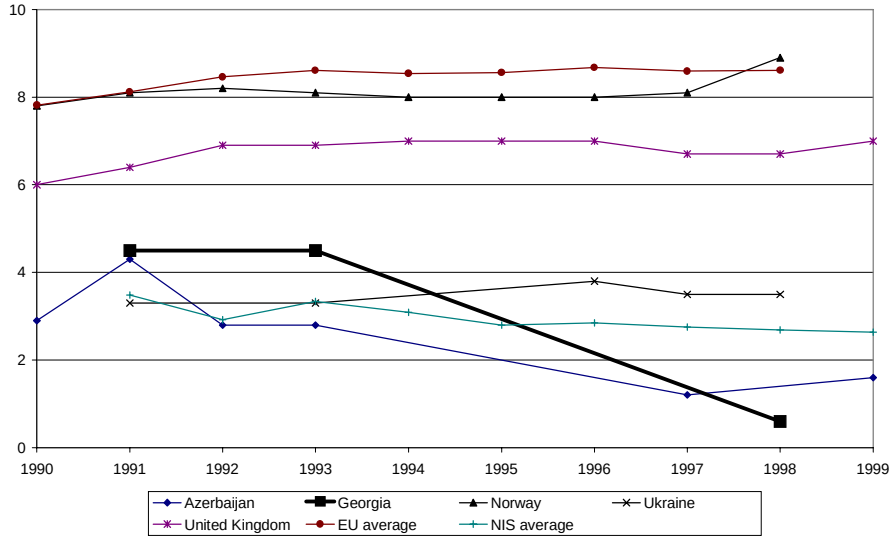
[a] 1998 state expenditure.

Health care expenditure

Since Georgia gained its independence, health care expenditure by the state has been severely reduced, both in absolute terms and as a part of the national budget. Levels of financing are below those required to provide basic care to the population and also to maintain the health care facilities themselves. Because the poor have financial difficulties in accessing health services, much of the health expenditure by the state and the state medical insurance company benefits only those with higher incomes.

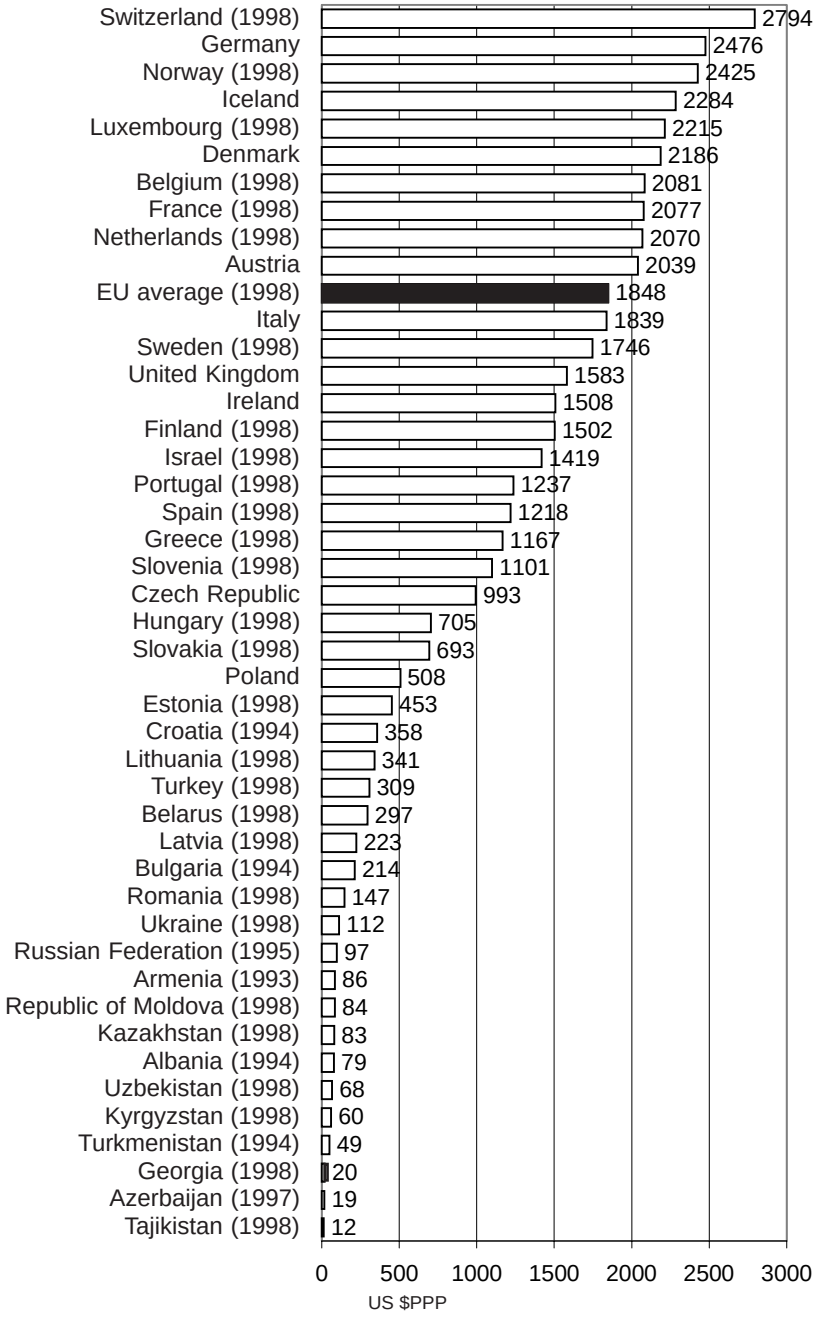
Government expenditure on health as a percentage of GDP has dropped substantially from just over 4% in 1991 to 0.70 % in 1998 and further down to 0.59% in 1999 *(12)*. In fact, a small increase for health spending to 1.3% had been planned in the 1999 budget, but these additional funds were not received by the federal programmes. As a consequence, in 1999, preventive programmes received only 23% of their planned budget *(39)* and the SMIC received only 64.2% of its approved budget *(40)*. There were similarly low real allocations to the health budget in 1995, 1997 and 1998 *(33)*. In 2000, approximately US $11 per person was budgeted for annual state spending on health, although much less was received than was pledged. The low allocations to the health

Fig. 6. Trends in total expenditure on health as a % of GDP in Georgia and selected countries, 1970–1997



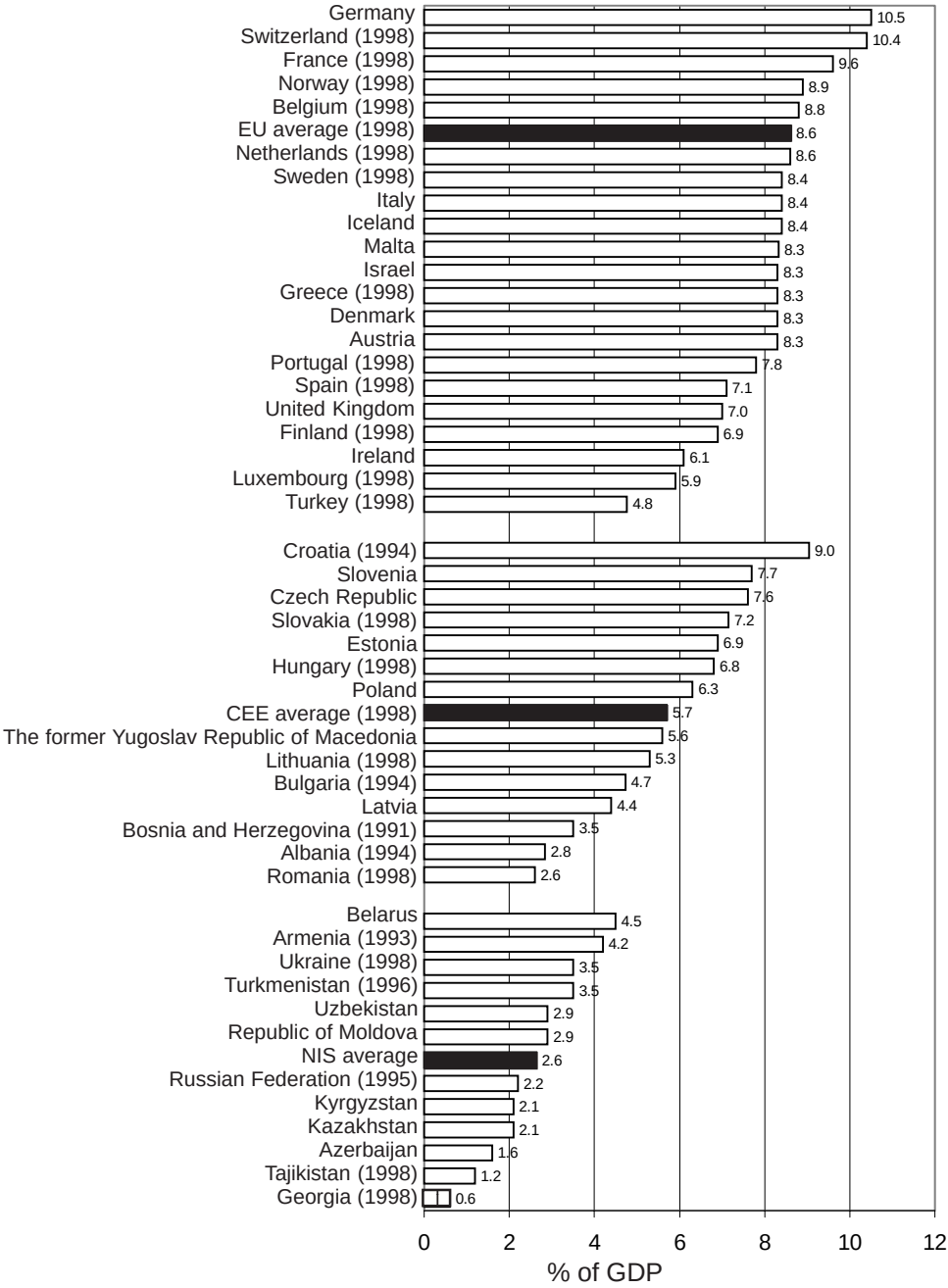
Source: WHO Regional Office for Europe health for all database.

Fig. 7. Health care expenditure in US $PPP per capita in the WHO European Region, 1999 (or latest available year)



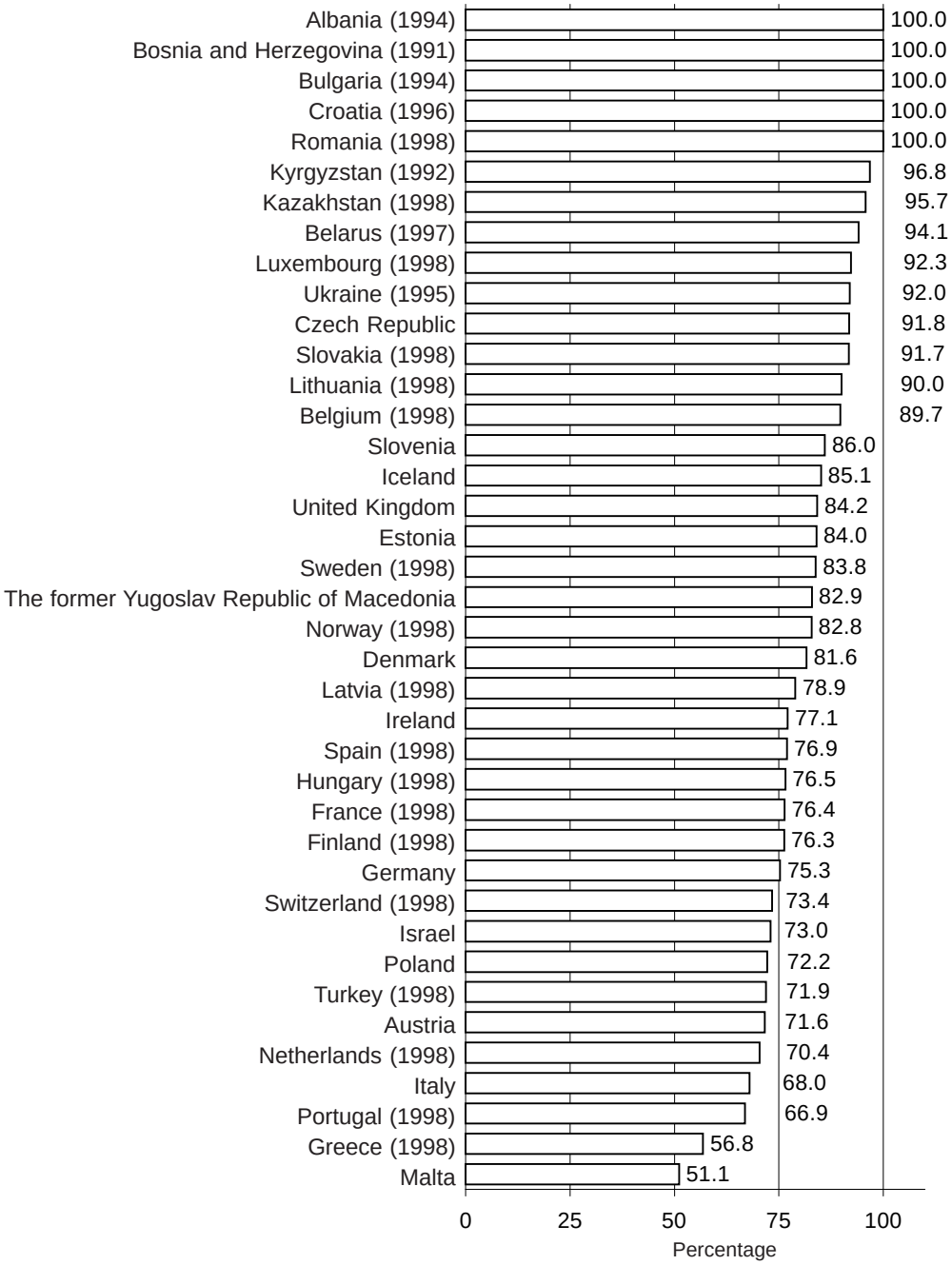
Source: WHO Regional Office for Europe health for all database.

Fig. 8. Total expenditure on health as a % of GDP in the WHO European Region, 1999 (or latest available year)



Source: WHO Regional Office for Europe health for all database.

Fig. 9. Health care expenditure from public sources as a percentage of total health care expenditure in countries in the WHO European Region, 1999 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database.

budget have implications for the financing of specific health programmes covered under the BBP. Within the SMIC budget in 1999 only 23.6% of funds were received for the state programme of dispensary treatment of the rural population and only 55.6% of that planned for medical aid to children *(12)*. The low level of funding means that many of those insured under the SMIC programme will not be able to receive services intended to be guaranteed under it. For example, the funds allocated to oncological services for 1999 will cover only about 700 patients, while around 2100 patients are expected to require such services *(12)*.

As a result of the low state funding of the health system, direct out-of-pocket payments now account for most health expenditure in Georgia. According to the World Bank, in 1999 only about 22% of all health care expenditure came from state or municipal budgets or insurance funds. In 1997, households spent an average 9.4% of total cash expenditure on health care, with the poorest households spending the least of all households *(36)*.

Health care expenditure through the government and the health insurance programme continues to be weighted towards hospital care. Over 50% of all MoLHSA and SMIC funding is made on inpatient care. However, the different income groups do not access these services equally. Less than 10% of all hospital users are from the poorest 20% of the population *(18)*.

However, a 1999 United Nations Development Programme (UNDP) report states that access to health care for 30% of the population is almost out of reach, and for 50% it is very limited *(34)*. Thus the limited expenditure on health tends to go to those with a high enough income to obtain access to the health services. In 2000, it was estimated that around 40% of all health care spending in Georgia was for only 2.5% of the whole population *(12)*.

Structure of health care expenditure

Table 9. Health care expenditure by categories as a percentage of total expenditure on health care, 1970–1997

Total expenditure on each category, as share of total expenditure on health care	1980	1985	1990	1991	1992	1993	1997
Public (%)							13.0
Inpatient care (%)							39.8
Outpatient care (%)							30.9
Pharmaceuticals (%)							27.0
Public health care (%)							0.9
Administrative costs (%)							0.9
Investment (%)							–

Source: *(6)*; *(32)*.

Health care delivery system

Primary health care and public health services

The primary health care (PHC) structure currently in place in Georgia is essentially that inherited from the Soviet era. Although it was generally hospital-oriented, it did create a large network of primary care units in rural and urban areas. However, these units were generally staffed by sub-specialists, and an integrated model of family medicine did not exist. The primary care system currently faces financial constraints and is poorly attended. As part of the health reforms, the MoLHSA is trying to strengthen primary care provision. A number of pilot programmes to develop family medicine has been started recently with the support of international organizations.

In 1998, PHC facilities comprised 951 independent outpatient facilities, 114 outpatient hospital departments, 53 medical posts and 512 midwife posts. In 1999, there were 977 independent outpatient facilities and 94 outpatient hospital departments. In addition to this, 683 rural ambulatories worked under polyclinic supervision. For certain medical conditions (for example, tuberculosis), 79 dispensaries provided specialist services.

Although there is a plethora of structures, the PHC system is currently poorly utilized. Many facilities see few patients each day. As the referral process has nearly ceased to function in many areas, many patients bypass the primary care level altogether and see specialists at higher levels directly. There are low expectations among the public and also an inability to afford out-of-pocket payments that are often requested. The related under-financing of the facilities also contributes to the under-use. Many facilities are short of very basic equipment such as thermometers and sterilizers. A study in western Georgia in 2000 found that only 61% of polyclinics and 5% of ambulatories had sufficient basic equipment *(35)*. Additionally, many providers rely on humanitarian support for pharmaceuticals *(35)*.

Table 10. Outpatient facilities according to the regions, 2000

	Outpatient facilities	Outpatient facilities per 100 000 population	Number of outpatient contacts per person
Tbilisi	120	10.1	1.7
Ajara	64	17.5	1.5
Guria	66	45.8	1.3
Zemo Svaneti	14	93.3	1.3
Shida Kartli	79	23.6	1.2
Poti	6	11.6	1.2
Imereti	157	21.2	1.1
Kakheti	136	33.9	1.0
Samegrelo	131	30.8	1.0
Mtskheta-Mtianeti	43	34.1	0.8
Racha-Lechkhumi	33	64.9	0.7
Kvemo Kartli	85	15.5	0.7
Samtskhe-Javakheti	48	22.4	0.6
Georgia	1015	22.1	1.3

Source: Statistical Bulletin "Health Care, Georgia, 2000" of MoLHSA and CMSI, Tbilisi, 2001.

Primary health care facilities are now free-standing independent legal entities. They provide state, SMIC and municipality health programmes (which should be free or with a co-payment requirement), in addition to providing fee-for-service activities. Polyclinics are generally paid on a capitation basis by the public purchasers (SMIC, MoLHSA) for the care covered by the state and municipal programmes. Staff in primary care facilities in sparsely populated remote or mountainous regions receive a higher reimbursement from the SMIC and the municipalities for services performed. A portion of any profits generated from official fees paid by patients should be transferred to the state budget. However, such transfers are rare and, more often, the state is in debt to the providers due to late payment for health-care activities undertaken

Family Medicine: A Society of General Practitioners and Family Medicine was established in December 1995. Georgia was one of the first countries in the former Soviet Union to recognize family medicine as a specialty in 1998, and a licensing exam for primary care specialists was introduced in 1999. A department of primary care was established within the MoLHSA in 2000. In 2001, this was merged with Public Health Department. Under the new national health strategy, it is intended that primary health care be given additional emphasis, and it is planned that resources will be shifted from the hospital sector. The strategy sets targets to establish national and regional centres for family medicine by 2003, financing mechanisms by 2005 and completion of a national network of primary care centres staffed by trained primary care teams

by 2008. Since 1996, a number of pilot projects that focus on strengthening primary care have begun, and expansion of successful initiatives is envisioned. Sixteen family medicine trainers and 48 family medicine specialists have been trained under the Family Physicians Training programme since it began in 1997, funded by the United Kingdom Department for InternationalDevelopment (DFID). Under a second DFID Project, a further cohort of family medicine specialist trainers, as well as specialist trainers of primary care nursing and management, are being trained. The establishment of five family medicine demonstration sites, including a National Family Medicine Training Centre, is also being funded under the initiative. A rural primary care development is funded by United States Agency for International Development (USAID) and implemented by the American International Health Alliance (AIHA) and International Medical Corps (IMC) programme. A second AIHA programme is training health system managers. The British nongovernmental organization, OXFAM, is also supporting a pilot primary health care project in both urban and rural areas. The next round of World Bank financing, scheduled for 2002–2007, is planned to support further reform of the primary sector, although the final model that will be used is not yet finalized. Further training and refurbishment of PHC facilities is planned. Policies on rational and cost-effective drug prescription are being established with support of DFID and WHO as part of strengthening primary care.

In the Soviet era, "Ministerial Orders" outlined precisely what type, and how many staff should work in each type of facility. Today these orders are no longer adhered to and staffing varies, depending on the population needs and also the resources available to the facility. The following types of facilities make up the core of the PHC structure in place:

*Ambulatories***:** These are the frontline of PHC in the rural areas and usually serve a catchment of about 1000 people. They provide only outpatient care and have been traditionally staffed by around four to five part or full-time medical staff. The staff are usually "generalists", paediatricians, gynaecologists, surgeons and dentists. In 1999, there were 683 such centres in Georgia.

Polyclinics: The adult polyclinic provides outpatient care and was originally designed to cover 10 000 adults (defined as those over 15 years old). They are staffed by both generalist physicians and usually at least 10 part-time specialists, typically employing between 30 and 60 staff overall. The clinics thus provide both primary care and specialty care under one roof. During the Soviet era, the polyclinics acted as referral points to specialist care, whether in hospital or to specialists within the polyclinic, although now, in reality, patients have direct access to specialists. The adult polyclinics are generally found in urban areas.

*Children's polyclinics***:** Children's polyclinics provide basic and some specialized services to children up to the age of 15 years. They are located in both rural and urban areas and have outpatient facilities. Services include immunization and home visiting of new-borns. When the clinics were built, they were intended to cover a catchment of 10 000 children under 15 years of age. The clinics mainly employ paediatricians but, depending on the size of the catchment and funds available, may also have a minimum of nine part- or full-time specialists.

Women's consultation clinics: Women's consultation clinics provide ante-natal, gynaecological and obstetric care to women on an outpatient basis. Abortions are also undertaken at the clinics. The clinics are usually staffed by at least five staff, including obstetricians, gynaecologists and nurses. The clinics are located in urban areas, though clinic staff should carry outreach programmes into the communities using ambulatory facilities.

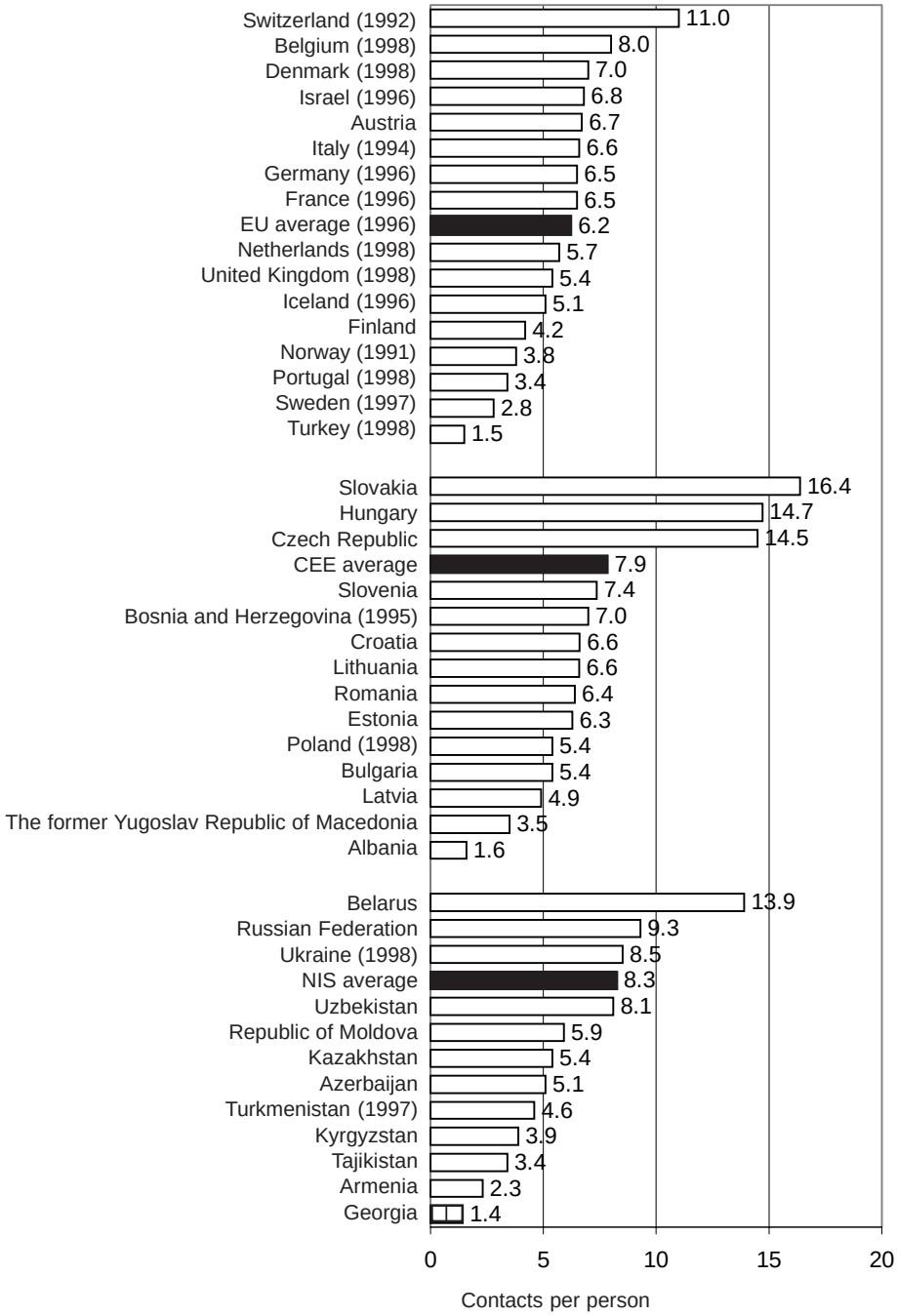
Private PHC centres: These centres, based mainly in the urban areas, are staffed by family doctors and offer fee-for-service primary care. Diagnostic and emergency services are provided in some. Several private clinics/companies (four organizations) have been providing pre-paid health plans (similar to staff and/or group model HMOs) combining integrated delivery of medical service and medical insurance since 1992. They pioneered family doctor practices and case management in Georgia.

Private obstetric clinics: These centres mainly started after 1995 in urban areas. They provide obstetric and diagnostic services that are paid for directly. They are mainly found in Tbilisi.

Independent dental polyclinics: There were 62 independent dental polyclinics registered in Georgia in 1999.

Family planning services: These are provided mainly by the hospitals (obstetric/gynaecological wards), women's consultation clinics and maternity wards. However, not all women's primary care facilities offer family planning services. A 2000 study in western Georgia found that only 8.4% of primary care facilities offered family planning services and only 6% could provide contraceptives *(35)*. Pharmacies also play an important role in supplying contraceptives. However, abortion remains the main method of family planning in Georgia *(11)*. Overall contraceptive use is low, while there is also a substantial "unmet need" for family planning services, particularly in rural areas *(11)*.

Fig.10. Outpatient contacts per person in the WHO European Region, 1999 (or latest available year)



Source: WHO Regional Office for Europe health for all database.

Public health services

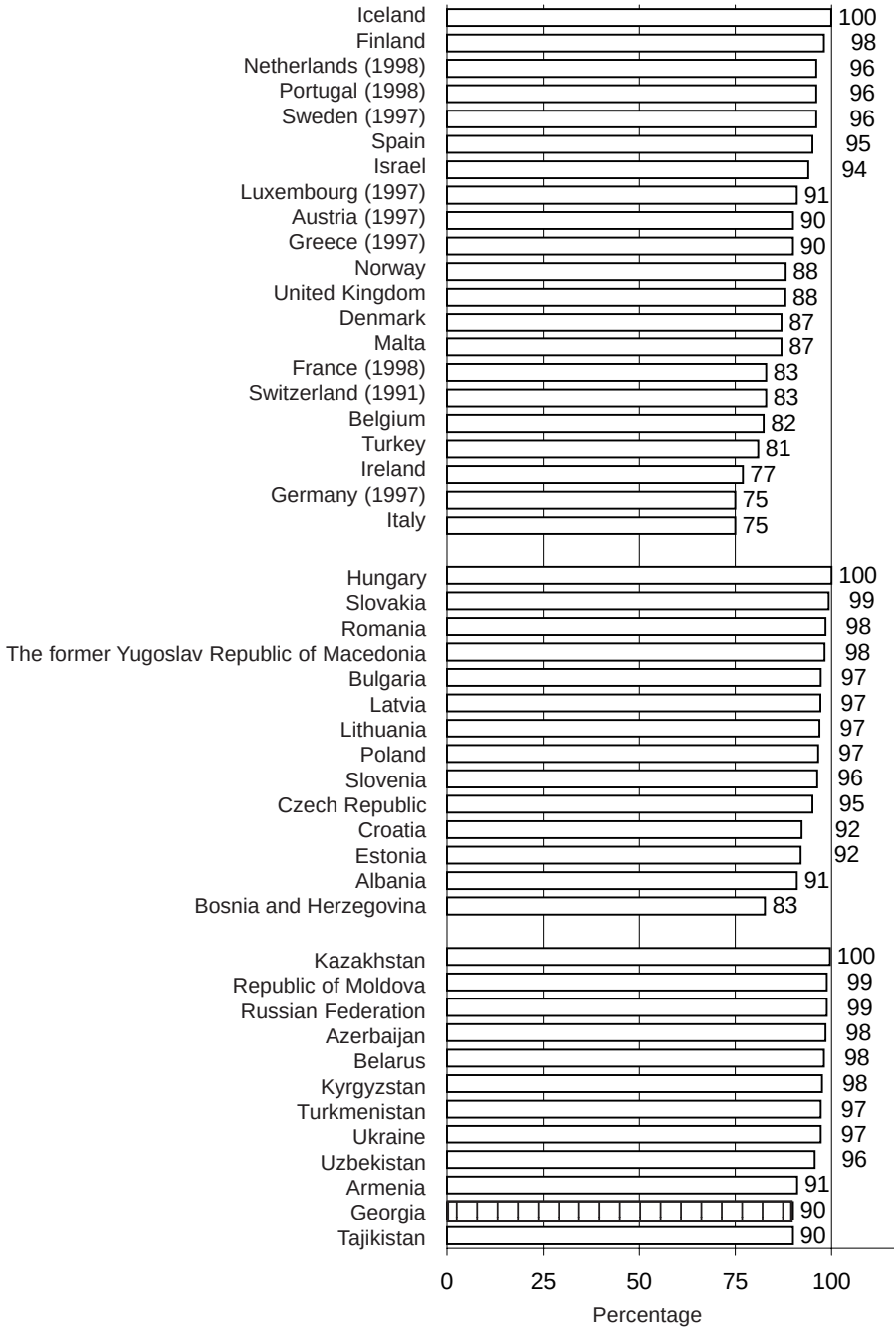
During the Soviet era, an environmental and epidemiological health system was established, known as the "San-Epid" (or San-epid) network. The role of the San-epid network was to undertake epidemiological surveillance, investigate communicable disease outbreaks, conduct immunization programmes and carry out environmental health functions. In the post-independence health reforms, the system was divided into two separate organizations. According to the decree of Cabinet of Ministers No. 389 from 1995, the Department of Public Health (DPH) and the Department of Sanitary Surveillance and Hygienic Standards (DSSHS) were created. The functions of DPH were as following: monitoring of communicable and noncommunicable diseases, analysis and prognosis of future trends in morbidity, promotion of healthy life. The DSSHS was charged with the responsibility to develop sanitary-hygienic norms and standards, monitor the compliance to these norms and standards in the country and prevent the territory of Georgian from importation and spread of various infectious diseases.

The role of the DPH is to monitor and assess the epidemiological situation of the population and to promote good health through education, as well as management of preventive health services. The DSSHS is responsible for environmental health services, such as inspection of water quality, refuse collection activities, food hygiene, occupational health, work safety and certification of facilities in relation to environmental health.

DPH: The DPH has three divisions: the National Centre for Disease Control, the Centre for Health Information and the Centre for Health Promotion and Disease Prevention. The National Centre for Disease Control (NCDC) coordinates epidemiological surveillance and communicable disease control and prevention activities. It was established in 1996, with laboratory facilities based in Tbilisi and a network of regional branches. It produces quarterly epidemiological bulletins. It coordinates the national immunization programme and also collaborates with other donors and disease control centres, such as the US Centers for Disease Control and Prevention, for educational programmes on a range of communicable diseases. The Centre for Health Information is responsible for collecting health statistics within the MoLHSA. This data complements data collected by the National Statistics Office. The Centre for Health Promotion and Disease Prevention is responsible for health education and health promotion.

DSSHS: The DSSHS has its headquarters in Tbilisi and one office in each municipality (formerly the "San-epid stations"). It carries out inspection and certification activities related to environmental health issues. Inspection of water

Fig. 11. Levels of immunization for measles in the WHO European Region, 1999 (or latest available year)



Source: WHO Regional Office for Europe health for all database.

quality, food safety, school and recreational facilities and workplaces is carried out by DSSHS employees under the auspices of the "Central Inspection Unit". Under the "Unit for Certification", such activities as certification and enforcement of implementation of public health regulations in private enterprises and quarantine procedures at the Georgian borders are performed. The municipal offices are staffed by doctors and environmental health experts ("hygienists"). Municipal offices have laboratories and other facilities. However, a lack of investment in these centres is hindering work.

Secondary and tertiary care

The Soviet health system left Georgia with massive over-capacity in the hospital sector. Provision was high even compared with Soviet norms of the time. Through the health reform programme, the government has tried to reduce excess capacity; however, while bed numbers have dropped substantially, they remain unaffordable for most people, and occupancy rates remain low. The referral system to secondary and tertiary care has effectively ceased for most conditions, and many of those who can afford it bypass primary care altogether. Low incomes of health staff are compounded by the lack of financing, poorly maintained hospital buildings and inadequate funds for new investment.

In 1999, there were 246 hospitals in Georgia (or 287 specialized, including specialized institutes). In 1999, these facilities provided 22 491 hospital beds. This is a substantial decrease in bed provision from 1991 when there were 53 122 beds in 390 hospitals. However, despite these reductions, numbers remain high compared to other countries and, in 1999, there were approximately 488.5 beds per 100 000 population. In Tbilisi and Poti, the bed complement is particularly high with around 740 and 798 beds per 100 000 population. However, occupancy is low, having earlier decreased dramatically since the mid-1980s to around one third of their earlier level *(6)*. The fall in bed occupancy is due largely to a dramatic drop in the admission rate. From a rate of 15.8 people hospitalized per 100 in 1988, the number fell to 4.8 per 100 in 1999. Occupancy rates dropped from 73% in 1980 to 28% in 1997. The ratio of doctors to beds in 1999 was 0.9 (or 0.4, considering hospital doctors only), but it was 3.2 (or 1.5 for hospital doctors only) for each occupied bed. In other words, each hospital doctor is, on average, responsible for less than one patient. Further details on hospital staffing are given in the section on personnel.

The recent reforms made hospitals responsible for generating all running costs through fee-for-service charges and through contracts with public purchasers. It was envisaged that unprofitable hospitals would go out of

business. However, it soon became clear that while capacity did fall with the closure of some hospitals and reductions in staffing, the reforms failed to reduce capacity at the expected rate. Moreover, professional incomes have fallen disproportionately as a result of the reforms, because facilities failed to reduce staff in line with falling income. For these reasons, Georgia developed a plan in 1999 to rationalize the hospital sector. This identified which hospitals should remain open and which should be closed down or privatized. The plan also identified the need to use funds so liberated from asset sales to be reinvested in the health sector.

The hospital sector, like the primary care sector, is facing problems in maintaining facilities and providing equipment. Health care facilities in Georgia are largely old, costly, and costly to maintain, due to high utility expenses, with over half the facilities being constructed before 1940 *(21)*. The building of many new facilities was begun in the 1980s, with 115 recorded as being under construction in 1988. However, insufficient funds were available to complete many of them, and most remained unfinished at the end of the 1990s *(21)*. Maintenance of existing buildings has been difficult, due in part to the system of municipal financing that covers only current and not capital expenses *(34)*. Ongoing problems with electricity supply also hamper work in the secondary and tertiary level, and deaths on operating tables have reportedly occurred during power cuts.

The types of secondary and tertiary facilities found in Georgia can be divided up as follows:

Municipal hospitals ("Gamgeoba Hospitals", formerly known as "rayon hospitals"): Each municipality has at least one municipal or gamgeoba hospital. The hospitals provide both inpatient and outpatient services. They generally employ emergency room physicians ("traumatologists"), gynaecologists, general surgeons, anaesthetists, intensive care specialists and sometimes cardiologists. Some of the larger municipal hospitals, found in the larger urban centres, also offer more specialized services, such as neurology and neurosurgery, oncological services, and some have specialist dispensaries attached. There were 52 municipal hospitals in Georgia in 1999.

Specialized hospitals and research institutes: Georgia has a large number of specialized hospitals, most of which are in Tbilisi. Attendance at these hospitals previously required a referral or admission through the emergency room, where one existed, but today many patients access the services directly. The specialized hospitals in Tbilisi are shown in Box 2.

Research institutes: The Georgian Academy of Sciences includes a range of research institutes. These include the Institute of Physiology, Biochemistry, the Research Institute of Morphology, the Research Institute of Molecular

Box 2. Specialized clinics and institutes in Tbilisi

Clinical and research institutes for:
Human reproductive health
Internal disease (therapeutic)
STD and dermatology
Cardiology
Resorts, physiotherapy and rehabilitation
Narcology
Neurology
Paediatrics
Perinatal medicine, obstetrics and gynaecology
Parasitology and tropical diseases
Sanitation and hygiene
Urology
TB and pulmonology
Psychiatry
Surgery
Occupational hygiene and occupational diseases
Oncology
Hematology and blood transfusion

Specialized clinics:
Centre for Cardiac and Vascular Surgery
Republican Antisepsis Centre
Republican Centre for Proctology
Joan Medical Centre of Cardiology

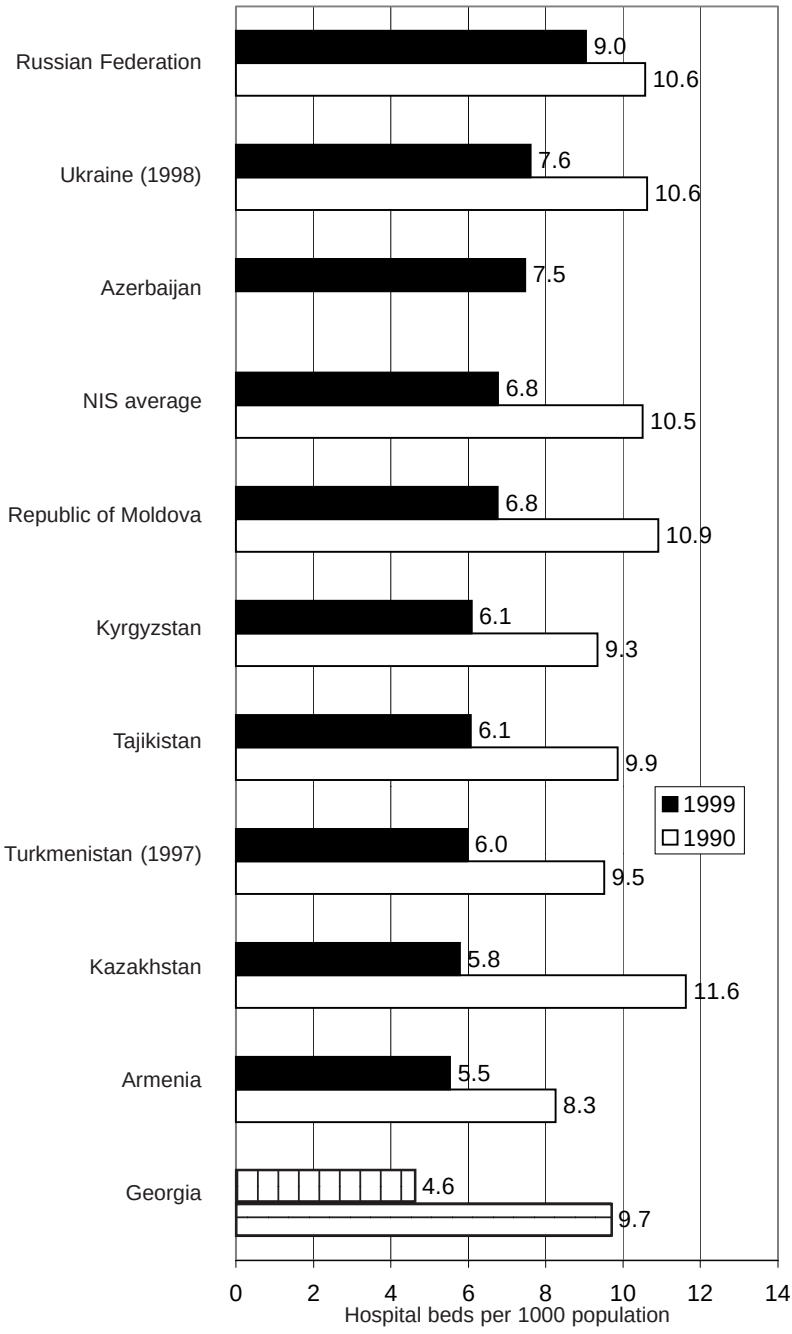
Specialized outpatient centres:
Rehabilitation
Mother and Child
Endocrinology
Plastic surgery and cosmetology centre
Rheumatic disease
Republican Diagnostic Centre
Republican Centre of Sports Medicine
Republican Centre of Proctology
Centre for Diabetes
Centre for AIDS and Clinical Immunology

Biology, the Institute of Biotechnology, and the Institute of Radiology and Intervention Medicine.

Dispensaries: Dispensaries are specialized outpatient clinics that provide services for endocrine conditions, tuberculosis, drug addiction ("narcological dispensary"), sexually transmitted diseases and dermatological, neuropsychiatric, rheumatological and cardiac problems. Some are attached to a hospital and are generally found only in the urban areas. There were 79 dispensaries in Georgia in 1999.

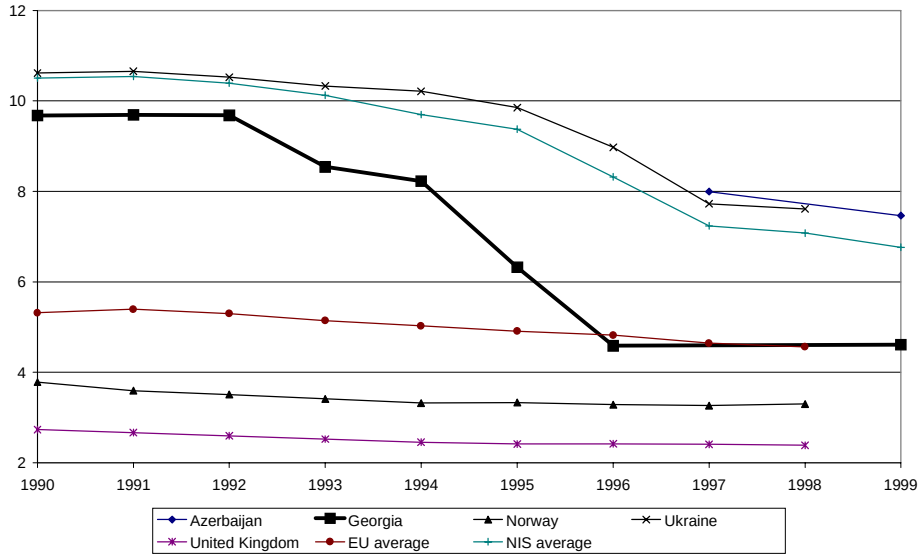
Spa resorts: Georgia has a long tradition of providing care for certain conditions through forms of physiotherapy spa or balneological treatment. Spa treatment is often prescribed for certain gastrointestinal diseases, respiratory illness (mainly in children), urological disease, rheumatological illness and others. People attend the spas both through referrals from polyclinics and directly. Treatment was free for some conditions in the Soviet era, but payment for services is now required. In the past, spas were owned by state ministries and used to provide treatment to their employees. Today most are privatized, although a number remain under government ownership. The clinics are mainly located in the mountain and Black Sea regions, in places such as Likani, Tskaltubo, Sairme, and Kobuleti.

Fig. 12. Hospital beds in acute hospitals per 1000 population in the newly independent states, 1990 and 1999 (or latest available year)



Source: WHO Regional Office for Europe health for all database.

Fig. 13. Number of hospital beds in acute care hospitals per 1000 population in Georgia and selected countries, 1990–1999



Source: WHO Regional Office for Europe health for all database.

Table 11. Inpatient facility utilization and performance, 1970–1997

	1980	1985	1990	1995	1996	1997
Admissions per 100 population	17.5	16.1	15.4	5.7	5.0	4.9
Average length of stay (in days)	15.5	15.5	14.8	13.4	10.7	10.5
Occupancy rate (%)	72.9	66.3	54.8	–	27.9	27.6

Source: *(6)*; CMSI-Georgia.

Social care

Social care is defined here as the nonmedical care of dependent people, such as the very elderly and disabled. Until 1999, when the Ministry of Social Welfare and the Ministry of Health were merged into the joint Ministry of Labour, Health and Social Affairs (MoLHSA), social care and health programmes were administered and funded separately. Social care programmes in Georgia are facing pressure on two fronts: large numbers of people requesting assistance and inadequate resources available to carry out programmes of care.

According to official data, 198 000 people are classified as disabled (using the wide-ranging definition developed in the Soviet era). Of these people, 81%

Table 12. Utilization and performance of inpatient services in acute hospitals in countries 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 (%)
Western Europe				
Austria	6.4[a]	25.8[a]	6.8[a]	75.4[a]
Belgium	5.2[b]	18.9[c]	8.8[b]	80.9[c]
Denmark	3.4[a]	18.7	5.7	78.3[a]
Finland	2.5	19.7	4.5	74.0[d]
France	4.3[a]	20.3[d]	5.6[a]	75.7[a]
Germany	7.0[a]	19.6[b]	11.0[a]	76.6[b]
Greece	3.9*g*	–	–	–
Iceland	3.8[d]	18.1[d]	6.8[d]	–
Ireland	3.2[a]	14.6[a]	6.8[a]	84.3[a]
Israel	2.3	17.9	4.3	94.0
Italy	4.5[a]	17.2[a]	7.1[a]	74.1[a]
Luxembourg	5.5[a]	18.4[e]	9.8[c]	74.3[e]
Malta	3.8	–	4.2	79.3
Netherlands	3.4[a]	9.2[a]	8.3[a]	61.3[a]
Norway	3.3[a]	14.7[c]	6.5[c]	81.1[c]
Portugal	3.1[a]	11.9[a]	7.3[a]	75.5[a]
Spain	3.2*c*	11.2[c]	8.0[c]	77.3[c]
Sweden	2.5	15.6[a]	5.1[c]	77.5[c]
Switzerland	4.0[a]	16.4[a]	10.0[a]	84.0[a]
Turkey	2.2	7.3	5.4	57.8
United Kingdom	2.4[a]	21.4[c]	5.0*c*	80.8[a]
Central and eastern Europe				
Albania	2.8[a]	–	–	–
Bosnia and Herzegovina	3.3[a]	7.2[a]	9.8[a]	62.8[d]
Bulgaria	7.6[c]	14.8[c]	10.7[c]	64.1[c]
Croatia	3.9	13.2	9.4	87.2
Czech Republic	6.3	18.2	8.7	67.7
Estonia	5.6	18.4	8.0	69.3
Hungary	5.7	21.8	7.0	73.5
Latvia	6.3	20.0	–	–
Lithuania	6.4	20.6	9.1	78.8
Poland	–	–	–	–
Romania	–	–	–	–
Slovakia	7.0	18.4	9.6	69.8
Slovenia	4.6	16.0	7.6	73.2
The former Yugoslav Republic of Macedonia	3.4	8.8	8.8	63.0
Newly independent states				
Armenia	5.5	5.6	10.4	29.8
Azerbaijan	7.5	4.7	14.9	30.0
Belarus	–	–	–	88.7[e]
Georgia	4.6	4.7	8.3	83.0
Kazakhstan	5.8	14.0	12.3	92.6
Kyrgyzstan	6.1	15.5	12.8	92.1
Republic of Moldova	6.8	14.4	14.0	71.0
Russian Federation	9.0	20.0	13.7	84.1
Tajikistan	6.1	9.4	13.0	64.2
Turkmenistan	6.0[b]	12.4[b]	11.1[b]	72.1[b]
Ukraine	7.6[a]	18.3[a]	13.4[a]	88.1[a]
Uzbekistan	–	–	–	–

Source: WHO Regional Office for Europe health for all database.

[a]1998; [b]1997; [c]1996; [d]1995; [e]1994; *f*1993; *g*1992.

depend entirely on state benefits, 17% have an irregular income in addition to the state benefits and only 2% are classified as having a sufficient income. Decreasing real benefits being paid out to this and other vulnerable populations covered by the state social care system is reducing many people to living in extremely difficult circumstances.

Despite the construction of a number of care homes and similar facilities, social care in Georgia in the Soviet era was underdeveloped. Elderly people and some categories of psychiatric patients were often placed in long-term medical beds although they did not require medical supervision. This situation still continues to a great extent today.

At the national level, social care is directed by the MoLHSA. The ministry sets the budget for social care programmes, coordinates services and is responsible for social care policy. At the local level, social welfare services are provided by both the health sector (hospitals and ambulatories) and by the social sector through day-care and residential centres ("pansionates"). There are no private for-profit organizations providing social care. Resource shortages limit the places available at the three day-care centres in the country, although generally these receive greater resources than the other sectors. Day-care centres provide rehabilitation services for physically or mentally disabled children aged from 3 to 18 years. Pansionates cater to individuals totally dependent on government care. There are two such pansionates for adults and a further two for children aged between 3 and 18 years. Pansionates suffer from severe underfunding, and less than satisfactory care and supervision of patients at these institutions has been reported. Orphaned or abandoned and physically or mentally disabled younger children (aged from birth to three years) are housed in special "infant houses". Two infant houses remain in Georgia with the third closing in 1997 *(42)*. Mentally ill patients are treated at 7 psychiatric hospitals and 17 ambulatories across Georgia. Access to psychiatric help is affordable and available to all who need it, but the standards in some areas are reported to be low. Six main programmes provided by the state are set out to provide assistance to specified vulnerable groups. These are given in Box 3.

A number of NGOs have begun to play a role in providing good quality social care to vulnerable sectors of the population. For example, the organization

Box 3. Social welfare programmes for vulnerable groups

- Social and medical rehabilitation of disabled people
- Social care for vulnerable disabled people
- Additional social and health care for blind people and individuals with weak sight
- Social rehabilitation of disabled IDPs
- Rehabilitation of most vulnerable population
- Health care for mentally ill patients
- Health care for orphaned children (0–3)

"Alliance for People Requiring Special Help" provides a day-care centre for handicapped children and adults and elderly people. Other organizations arrange home visits for elderly people living alone at home and provide food. The numbers catered for by such NGOs is, however, limited and has generally not yet expanded beyond Tbilisi.

Human resources and training

The Georgian health sector employs the greatest number of people after the education sector *(41)* despite large-scale reductions in health staff since independence. As in other former Soviet health systems, training medical specialists rather than general practitioners or family medicine staff was the priority prior to independence. Today Georgia is moving towards a greater focus on strengthening primary health care through training and a number of pilot projects. Health staff across Georgia face financial difficulties with official incomes now below the official poverty level. Despite the difficult conditions for medical staff and the decreasing number of medical positions available in hospitals, over 50 new medical schools, some with questionable training standards, have opened over the past decade.

Georgia had high levels of medical staffing, even for the region, under the Soviet era. In 1990, Georgia had 4.92 physicians per 1000 population compared to 3.9 in the former Soviet Union and 3.1 in the European Union *(42)*. Today, numbers have been reduced, and in 2000 there were 4.7 per 1000 population. Between August and December 1995, at the start of the new health reforms, 120 000 health care employees were removed from the government payroll *(30)*. However, despite the reductions in physician numbers, staffing levels remain high. In total, 21 000 full-time equivalent doctors staffed the health system in 1998, of which 9503 (around 45%) were working in the hospital sector. Thus, despite the large provision of hospital beds in Georgia, there is a high doctor-to-bed ratio. Georgia, however, has few nurses compared to doctors in comparison to western European countries. In 1999, there was just over one nurse for every doctor (1.33) in Georgia compared with over 7 nurses per doctor in the United Kingdom, 4.48 in Norway and 2.74 in Germany (WHA). In Tbilisi, where the major hospitals of Georgia are located, doctors actually outnumber nurses *(14)*.

The government recognizes that there is a clear over-provision of medical personnel, particularly at the secondary and tertiary care levels. However, a decision was made to leave market forces, subject to certain regulations, to reduce the over-supply of personnel. Payment of doctors on a fee-per-service

basis (rather than salaries), introduced under the health reforms, either under the BBP or for other services, was intended to reduce staff numbers.

The basic roles of nurse, "feldsher" (nurse practitioner with some midwifery skills) and doctor that characterized the Soviet era continue to dominate the structure of the health personnel in Georgia today. Under the Soviet model, nurses were relatively poorly qualified and acted mainly as doctors' assistants. Feldshers had more training than nurses and were allowed some clinical autonomy. In many cases they acted as the first point of contact for rural communities. Today the role of the nurse is being strengthened in a number of family medicine pilot projects. Nursing is also being strengthened through international alliances with schools of nursing outside the country, introducing new nursing procedures (for example, with nursing schools in Georgia in the United States). The profile of nursing was also raised through the appointment of a nursing director to serve as the Chief of Nursing of the MoLHSA. Additionally, the Georgian Nursing Association was established in May 1996 *(43)*. As part of the move towards family medicine practice, a number of doctors are being trained in family medicine skills. There is, however, some reluctance among medical specialists to retrain for more the more generalist role of family medicine.

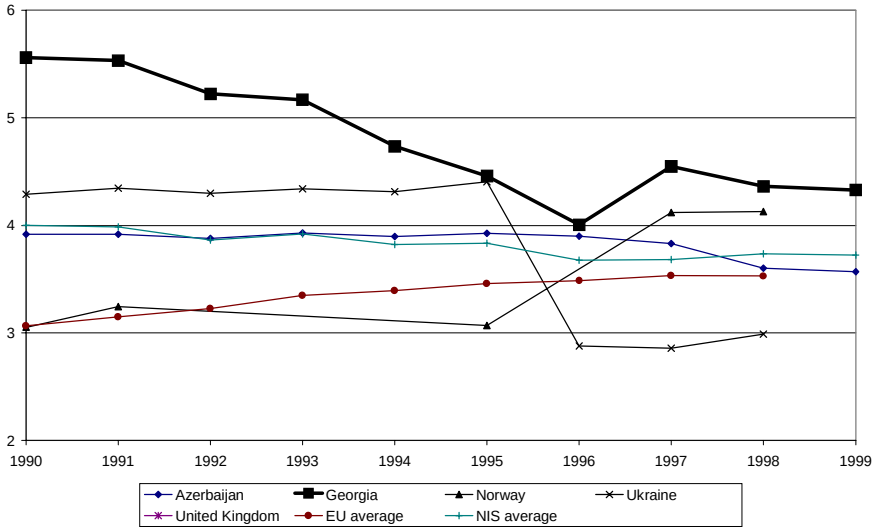
In the Soviet era, medical professionals were not highly paid but formed a respected profession which was characterized by full employment *(44)*. However, under the recent economic hardships, doctors' official incomes have been reduced to below official poverty levels. As detailed in the financing section, incomes are now calculated based on a number of factors, including case payments (as most staff are now not salaried employees of the MoLHSA). According to official data, health care staff as a group now form the lowest paid professional sector in Georgia *(41)*. The average pay of those employed in this sector was 30.4 GeL (approximately US $15) in 1999, a figure below the "extreme poverty line" (equivalent to the costs of a minimum survival food basket) of 40 GeL per month per equivalent adult *(18,41)*. However, income for health care providers is commonly supplemented by informal payments, with the result that, for some doctors, their formal remuneration forms only a small part of their income.

Table 13. Health care personnel (per 1000 population), 1970–1997

	1985	1988	1990	1993	1995	1998
Active physicians	461	487	556	517	446	436
Active dentists	–	–	–	–	–	35.3
Certified nurses	1009	1059	1107	1047	811	474
Active pharmacists	58.5	60.2	62.7	39.2	–	9.18

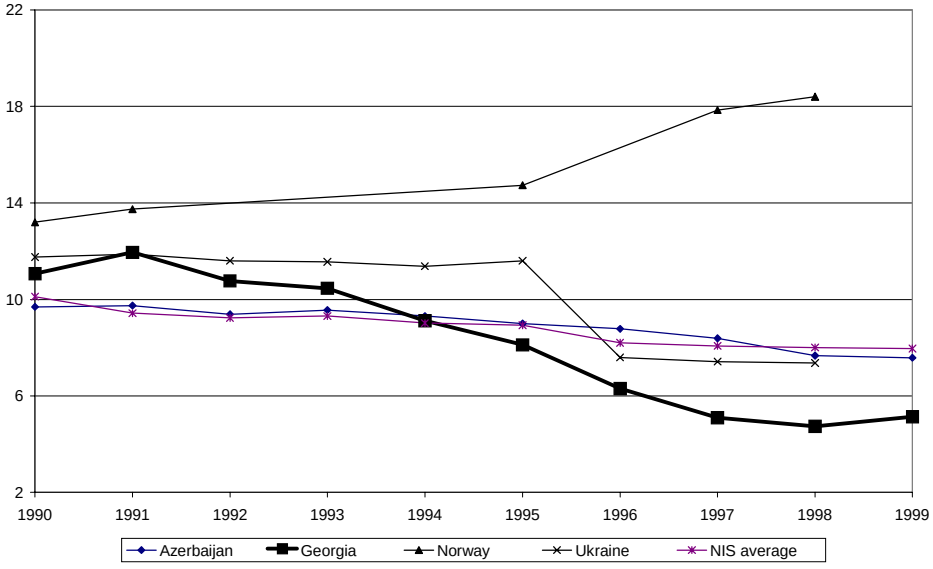
Source: *(6)*.

Fig. 14. Number of doctors per 1000 population in Georgia and selected countries, 1990–1999



Source: WHO Regional Office for Europe health for all database.

Fig. 15. Number of nurses per 1000 population in Georgia and selected countries, 1980–1995



Source: WHO Regional Office for Europe health for all database.

Table 14. Number of health care personnel entering the workforce in selected western European countries per 100 000 population for 1999 or latest available year

	Physicians	Dentists	Pharmacists	Nurses	Midwives
Azerbaijan	13.99	1.57	1.45	14.78	6.56
Bulgaria	14.56 (1989)	1.99 (1989)	1.18 (1989)	15.94 (1989)	2.49 (1989)
Georgia	41.86 (1992)	1.88 (1992)	3.12 (1992)	41.61 (1992)	–
Kazakhstan	17.16	1.84 (1990)	0.62	38.78	5.45
Norway	6.58 (1992)	1.94 (1992)	0.7 (1986)	47.64 (1992	–
Romania	14.22 (1996)	4.92	2.09	15.88	–
Turkmenistan	12.15 (1997)	0.99 (1997)	2.39 (1997)	23.07(1997)	7.6 (1997)
Ukraine	11.65 (1998)	2.55 (1998)	1.18 (1998)	37.17 (1998)	4.08 (1998)
United Kingdom	6.32 (1992)	1.27 (1992)	1.24 (1992)	48.69 (1989)	–

Source: WHO Regional Office for Europe health for all database.

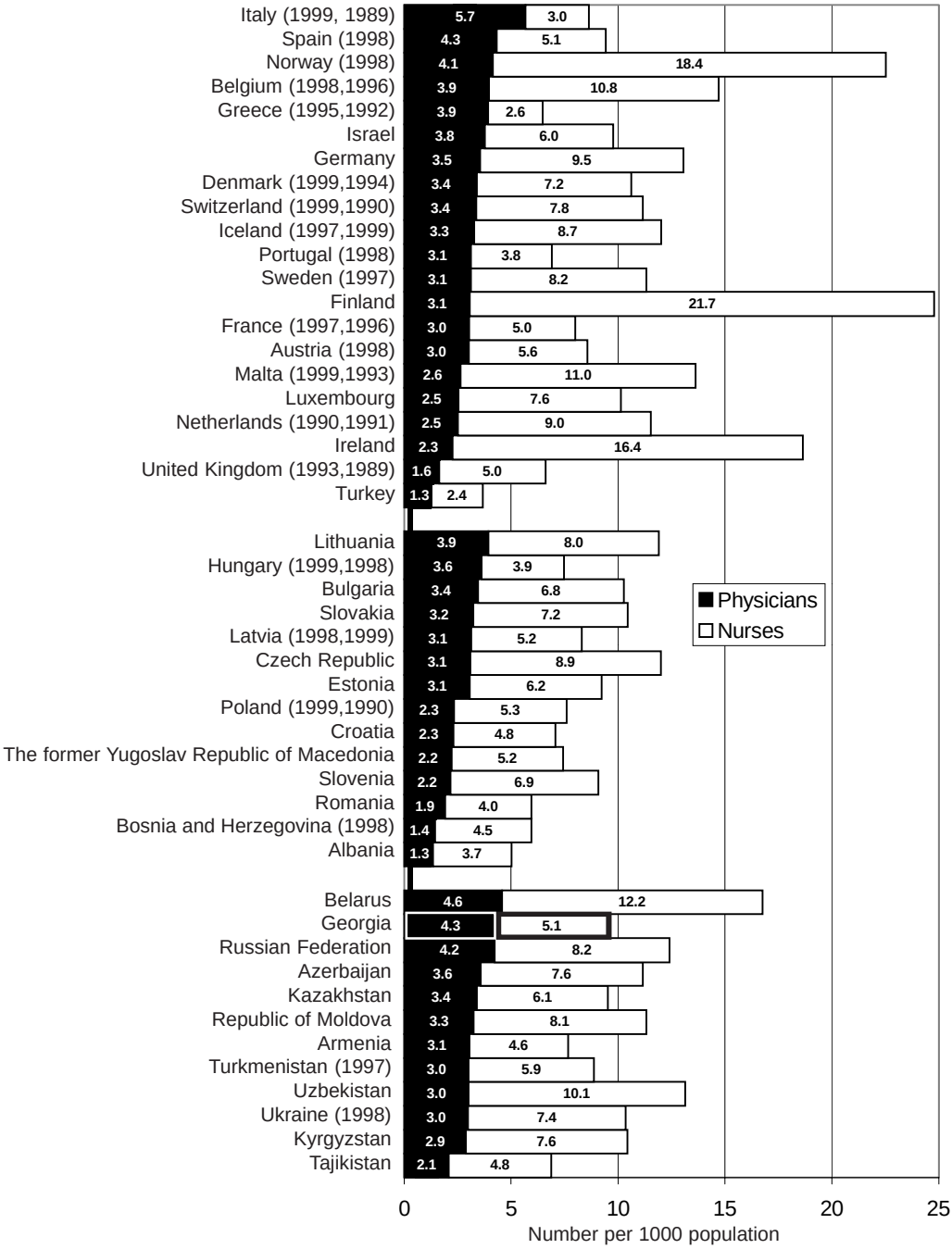
The opening of more than 50 private medical schools since 1995 has demonstrated the need for strengthened accreditation systems. Around 14 000 students are enrolled in these institutions, with around 3000 graduating yearly. The quality of these new schools is unknown, but is suspected to be low in many. Less than 5% of graduates from these schools took and passed the state final medical examination in 1998 *(45)*. In 1998, around 80% of medical graduates of these new colleges remained unemployed *(45)*. Under new legislation passed in 1998, responsibility for accreditation of medical education was passed from the MoLHSA to the Ministry of Education, and since this time the accreditation process has effectively ceased *(46)*. The need for strengthened accreditation is apparent, both to prevent students wasting time on an inadequate education and to ensure public safety.

Pharmaceuticals and health care technology assessment

During the Soviet era, there was one "wholesale" company importing and distributing pharmaceuticals for Georgia. Moscow controlled registration and licensing procedures *(45)*. Pharmacies belonged to the state. Drug distribution was tightly regulated and patients needed a prescription to access many products. Drugs were provided free to inpatients and on a subsidized basis to outpatients *(21)*. Since independence, the pharmaceutical sector has undergone many changes. The sector has undergone privatization for the development and distribution of drugs, and the role of the state has been changed from supplying drugs to accrediting and monitoring the sector.

At independence, one of the first activities in the reform of the health sector was the privatization of the pharmaceuticals importation and distribution sector

Fig. 16. Number of physicians and nurses per 1000 population in the WHO European Region, 1999 or (latest available year)



Source: WHO Regional Office for Europe health for all database.

through the Law on Privatization of Public Enterprises, which was passed in 1996. Today there are 12 wholesale pharmaceutical companies. In terms of local pharmaceutical distribution, there are around 600 registered, but now privatized, pharmacies and an estimated 80–100 non-registered and illegal pharmacies.

The drug production industry in Georgia is small, and nearly all pharmaceuticals are imported. According to official import license data, around US $50 million worth of drugs are imported annually into Georgia. Local production supplies only an estimated 2% of the domestic market. However, there are a number of projects under way to develop capacity in this area. For example, a joint venture with a Czech enterprise has resulted in the formation of the Lechiva company, which produces a number of pharmaceuticals. Large numbers of drugs are also brought in illegally, although the amount has decreased as the state role has been strengthened during the latter half of the 1990s. During the early 1990s, the medicines market was almost completely unregulated and much low-quality and outdated or, in other ways, dangerous products were being sold *(45)*. The black market trade is now estimated to form around 20% of total drug imports into Georgia. Black market drugs are fairly commonly traded in fairs and other informal locations *(47)*. In a large household survey carried out in 2000, 4.1% of those surveyed reported that they had bought drugs from unregulated sellers found in fairs and markets *(47)*. Drug registration, regulation and market research in Georgia is now carried out by the Department of Drugs and Pharmaceutical Affairs. This department, which is part of the MoLHSA, was created in 1996.

All pharmaceuticals, with the exception of those supplied free or with some co-payment required under the BBP, public health or municipal programmes, must be purchased directly by patients. In 1995, Georgia developed an Essential Drugs List (EDL). Under this, 253 generic drugs are listed. State treatment guidelines are based around drugs on this list. While the list is well considered in general, there have been some problems in persuading doctors to adhere to the practice of prescribing the recommended generic products. The prices for the EDL drugs are not regulated, with the exception of "restricted" drugs (for example, narcotic medications). Today patients can directly buy drugs from pharmacies without a prescription, although this is technically against the law. However, this law is not enforced at present, and patients wishing to avoid paying doctors consultation fees go directly to pharmacies or unregulated drug sellers.

Because of the financial problems faced by many people in accessing pharmaceuticals, a three-year pilot project, "Drug Polis: Drug Reimbursement Pilot System" was undertaken in Kutaisi, between 1997 and 2000 to investigate

ways of sharing and lowering drug costs and returning to a prescription based system. The project experimented with a voluntary insurance system for pharmaceutical provision *(48)*. The results and lessons of this project are planned to be included in the next expanded family medicine programmes in Georgia. In an effort to help some of the poorest of the population access pharmaceuticals over the last decade, humanitarian organizations have also played a key role, although this is now decreasing. In 1997, such organizations were supplying around 70% of all drugs to Georgia. In 2000, the figure was estimated to be around 17%. However, for low-income rural communities in some areas, this supply seems invaluable at the primary care level. According to a 1999 survey in western Georgia, 55% of ambulatories and 48% of polyclinics totally relied on drugs supplied by the humanitarian organizations *(49)*.

Financial resource allocation

Third-party budget setting and resource allocation

National level budget-setting for the health sector takes place on an annual basis. The process is led by the MoLHSA, which develops an annual budget. This is based on submissions detailing programmes and planned capital investments from the Departments of Public Health and State Sanitary Supervision and Hygienic Norms, SMIC, regional health authorities and the municipalities. This budget is then submitted to the Ministry of Economy, Industry and Trade to incorporate into the annual national "Indicative Plan" for the following year. Based on the indicative plan the Ministry of Finance develops a national budget for the next year and coordinates this process with every ministry or state agency, including MoLHSA. When the draft annual budget is developed it is discussed by the GoG and the President submits the draft law to the parliament. The parliament must approve the final budget in the "Law on the Annual Budget" which usually occurs in October or November of each year.

Available resources determine the final actual health budget, and the budget received is often less than that approved in the budget-setting process. In 1999, for example, 42 450 000 GeL was approved for the SMIC budget, but only 28 207 400 GeL or 66% was received from the state budget *(12)*. Municipalities complement the central budget funding for health through municipal health charges, although amounts provided from this level are also very low. In 1999, municipalities only contributed 2% of total health expenditure (around US $0.87 per person) (calculated from data in *(5)*). The central budget allocation to health care actually forms only a relatively small part of overall expenditure on health in Georgia. In 1999, the total central budget contributions to the health bill of the nation amounted to 8% of total health expenditure (around US $3.35 per person) (calculated from MoLHSA data in *(5)*). The bulk of the remainder of health expenditure is made directly through contributions to the SMIC and direct public expenditure for services.

In addition to the official health budget, other allocations are made for health care provision in Georgia through a number of different parts of the national budget. For example, there are allocations made to different ministries for health care provided through specific facilities run under the auspices of the Ministry of Defence, the Ministry of Internal Affairs, the Ministry of State Security, the State Border Defence Department and the Government Security Department *(49)*.

Payment of hospitals

Prior to independence, Georgian hospitals, like all facilities in the Soviet era, received funding based on their previous year's expenditure. Key features that were considered in allocating funding were numbers of staff and numbers of beds. High bed and staff numbers were rewarded. Consequently, high levels of patient admissions and long hospital stays were common. Under the 1995 health reforms, the funding of hospitals was changed from the Soviet formula to one based on reimbursement for services undertaken. This was undertaken as part of the move to the social insurance system in which provision of a limited number of services would be reimbursed under the state medical insurance programme. Hospitals are now reimbursed for the actual services they provide to the population. They must have a contract with the SMIC to provide services under the state medical insurance programme. In 2000, 1300 contracts were signed between the SMIC and 700 health care providers *(26)*.

Hospitals usually receive funding through case payments or global budgets.

Case payments were introduced in 1996 and form the main type of payment to hospitals. They are made by the SMIC, the MoLHSA and municipalities for certain specified services under the BBP or other programmes, as either full or partial reimbursement (the patient makes a co-payment) and directly as full out-of-pocket payment by patients for other services. Payments for the BBP services are structured through "Diagnosis Related Groups" (DRGs). Recommended lengths of stay (beyond which the patient must pay themselves) and other details are included in the guidelines. Although the pricing calculation method is considered by the MoLHSA to be accurate, there have been many complaints that the payments made by the SMIC do not reflect the actual cost of providing services and underestimate real costs *(21,31)*. Delays in payments to some providers from the municipal budgets have also lead to a number of complaints. For other services provided by the hospitals and paid for directly by patients, the hospitals themselves develop price lists that are monitored by the MoLHSA.

Global budgets are now used only for psychiatric hospitals and for long-stay tuberculosis treatment. Hospitals are reimbursed for the number of patients and length of stay for these specific types of treatments (per diem payments).

Payment of physicians

Under the Soviet era, physicians and other health staff held salaried positions and were employed by the Ministry of Health. Under the 1995 health reforms, employment of most staff was shifted to the health facilities themselves, and payment was changed to a fee-for-service basis for work undertaken by staff. "Performance Based Contracts" were signed by many health care employees under these new arrangements. Physicians are now expected to have a minimum workload as outlined by the MoLHSA.

Physician reimbursement is different in hospitals and polyclinics. In hospitals, physicians are mainly paid on a fee-for-service basis. In polyclinics, physicians are paid on both a fee-for-service basis for some services and a capitation basis for others. As noted earlier, physicians working in primary care facilities in sparely populated remote regions receive higher rates for services provided to the population.

A set of rates, "Internal Standards", sets the fees for treatments. Lengths of stay for different procedures and conditions are also included in the guidelines. Physicians are reimbursed at the standard rate for most services with the exception of programmes such as inpatient care for psychiatric and TB patients (which are reimbursed on a per diem method as outlined above in hospital payments).

The new payment formulas were expected to both reduce the number of staff and encourage more efficient prescribing and use of hospital resources. However, medical facilities have been hesitant to lay off staff and, thus, the official income generated by such facilities through fee-for-services has been spread thinly. The consequent low payments received by physicians and other medical staff have resulted in greater charging of patients with informal payments. According to the 1999 World Bank Poverty and Income Distribution study, health sector workers in Georgia have the highest informal income after hotel and restaurant employees *(18)*. A further criticism has been made of the payment structure that rewards productivity but not quality of work *(44)*.

Health care reforms

Aims and objectives

The health-care system inherited by Georgia at independence was costly to run, heavily weighted to secondary and tertiary care and contained large built-in inefficiencies. An enormous number of under-utilized health care workers staffed this system, with Georgia having one of the highest ratios of doctors to population in the world. Although the system was highly regarded in the Soviet era, maintaining the system post-independence in the face of the failing economy and civil unrest proved to be untenable. Deterioration in population health, including outbreaks of previously prevented diseases, such as diphtheria, alongside a collapsing health service where salaries, equipment and drugs were delayed or unavailable, helped drive the decision by the government to initiate a reform of the health-care system.

Content of reforms

Planning for the health reforms began in 1993, led by the Ministry of Health, with the assistance of the World Bank. The move to reform the health system was undertaken within the general post-independence shift towards a market economy. The first legislation which laid the ground for the health reform was in Decree No. 400 which legalized the change of funding health care from government revenues only to a decentralized system incorporating elements of payroll tax, government and municipal subsidies. Following two years of work, from 1993 on, the new framework for health reform, which involved a range of Georgian organizations and academic institutions, the first Georgian Health Care Reform package was launched in 1995 (see Appendix 1 for a list of key legislation introduced to support the health reform process). The overall aim

of the package was to deliver a basic package of services to the population in the light of scarce resources. The key features were the introduction of social insurance, user charges and co-payments. In addition, plans were made to ensure basic public health services continued to be supplied through the newly-independent health facilities. A vision of strengthening primary health care was outlined.

The main directions and objectives outlined in this first set of reforms are shown in Box 4, which are outlined in the strategic document "Georgian Health System Reorientation: Major Directions" (1996) *(30).*

Box 4. Georgian health system reorientation

Major directions (1996)

- create the legal basis for the new health care system
- decentralize the health care system management
- move to programme based financing
- prioritize primary health care
- reform the "sanitary-epidemiological service"
- move to a system based upon health insurance
- ensure social security for employees of the health care sector
- reform pharmaceutical policy
- support privatization
- accredit and licence medical institutions and personnel
- reform medical education
- reform medical science
- reform the health information system

After the first three years of the reform process, the Georgian National Health Policy was developed and published in 1999 *(52).* In this, the health priorities of the country, objectives, strategies and other factors were outlined. The objectives of the health policy are to improve equity, accessibility and affordability of health services for the population. The Policy forms an integral part of the reform process. A special committee, charged with overseeing the implementation, was established under the leadership of the President. The vision outlined for the reforms was a health system financed by semi-public social insurance, but maintaining the principles of solidarity and equity, led by a primary care system with an emphasis on health promotion and disease prevention. Thirty-eight objectives are outlined in the policy, with specific targets and monitoring mechanisms. In follow-up to the National Health Policy, the Strategic Health Plan for Georgia 2000–2009 was published *(5).* In this, more detailed strategies for implementing the National Health Policy were outlined. The Strategic Plan is partly an outline for use of available resources and partly an outline of the activities that would be undertaken should such additional funding become available.

Reform implementation

After the completion of the reform planning process in 1995, reforms were rapidly introduced in a number of areas, such as privatization, the establishment of social insurance and the introduction of new means of paying health care staff. Yet, despite some of the successes in undertaking these changes, the reforms have not yet, by and large, brought about the expected health benefits to the population. One of the main challenges has been the overall very low allocation of funds to the health budget and consequent high levels of individual direct payments by patients with inadequate risk sharing.

At the beginning of the reform process, one of the first steps was to decentralize the management of the health care system. Regional authorities were given greater powers and twelve regional health authorities were created to undertake some regional health administration tasks. Strategic planning and management remained the responsibility of the MoLHSA. Within the MoLHSA itself, the sanitary–epidemiological service was also split into the Department of Public Health and the Department of State Sanitary Supervision and Hygienic Norms, to more effectively deal with public health and environmental health concerns. Social care and health concerns were brought closer together through the joining of the Ministries of Health and Social Welfare in 1999. It is unclear to what extent management capacity at the new decentralized levels of health administration is able to undertake the new responsibilities designated to this level.

In terms of financial reforms, Georgia has completely changed the funding of the health system from an entirely state funded system to one of social insurance and some state and private funding. The SMIC was created in 1996 to administer the new national health insurance system. Fee-for-service was introduced as part of the health reforms in the hope that informal payments required of patients would decrease. However, as shown earlier, patients are still subjected to large demands for such illegal payments. Additionally, health facilities themselves were privatized, with a split between funders and providers of health systems being created as part of the reforms. Privatization of a range of health facilities began in 1995 with pharmacies and dental polyclinics. In 1999, the process began for other health facilities. Hospitals and polyclinics became managerially independent, taking on responsibilities for budgeting and staffing and contracting with the SMIC to provide services under social insurance and other programmes. The majority of the health care workers, once employed as state salaried workers, are now employees of the institutions in which they work. In 1995, 120 000 health care employees changed status in this way.

In terms of reorientation of the balance of health service provision from secondary and tertiary care to primary health care, a number of pilot PHC projects are now under way across Georgia with the support of a range of donors. Under the next round of World Bank funding, an expansion of one of the PHC models will be supported. An association of General Practitioners and Family Doctors was started in 1995. The first steps in more rational drug use were taken with the production of an Essential Drugs List for Georgia in 1995. Regulation of pharmaceutical distribution is being strengthened through a range of procedures. However, a substantial black market exists, together with possibilities for self-prescribing and direct purchase of drugs by patients.

Conclusions

The health system of Georgia faced substantial challenges at independence. The large and expensive system proved to be both unaffordable and less suited to the new health challenges arising in the 1990s. Georgia has developed and undertaken major steps to try and address the challenges to the health system at every level. The financing arrangements of the system have been changed, as have rights of patients, in terms of which services they may access free or at low cost. However, while the reforms have been bold, they have not yet succeeded in meeting their goals of providing a lower cost and basic health service to all who need it. For Georgia as a whole, the overall lack of investment in the health system is hindering provision of the most basic of services to the population. Many people are excluded from accessing health services in the face of both official and unofficial charges requested of them. Staff numbers, while reduced substantially, are still high. At the same time, staff are facing extreme difficulties in achieving adequate income. Training and accreditation procedures continue to need further strengthening to ensure public safety and to assist the new management structures brought about through the decentralization process. The reform process is beginning to strengthen primary health care and prevention activities. It is clear, however, that much work remains to be undertaken to address the causes of some of the noncommunicable diseases, such as smoking. The further development of primary care services, as is planned, should bring benefits to a large part of the population. The lack of data on the Abkhazian region makes it difficult to review the health system in this part of Georgia. However, it is clearly facing major challenges in providing services, and non-cooperation between the different parts of Georgia in health service provision have major implications for issues such as the control of communicable disease. The Georgian health system faced and continues to face very profound challenges to equity and solidarity in health and there are concerns that the reforms have both not made headway in improving the health situation and may even have contributed to further health inequalities. Radical solutions have been proposed and implemented. Georgia has now started a new phase of health system organization and financing. The outcome of these efforts remains to be seen.

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Appendix 1

Key legislation supporting the health reform process

Important legislation in the health reform process

- Decree of the Cabinet of Ministers "On the first stage of measures reorganization of the health-care system" (5 October 1994)
- Decree 400 of the Head of The State of Georgia "On activities at the first stage of reorganization of the health care system in Georgia" (outlines move from centralized to decentralized health system and separation of financing provision and management of services) (23 December 1994)
- Resolution 399 of the Cabinet of Ministers of the Republic of Georgia "On the role of the Ministry of Health in the reorganization of the health care system" (30 June 1995)
- Resolution No 390 of the Cabinet of Ministers "On the composition and implementation of the state medical programme" (outlines the organization and functions of the regional health administrations and regional health funds) (30 June 1995)
- Resolution No 392 of the Cabinet of Ministers "On the privatization of health care facilities" (enabled the process of privatization of health care facilities giving staff priority in purchasing the facilities) (30 June 1995)
- Resolution No 388 of the Cabinet of Ministers "On the future development of the pharmaceutical sector" (defines compulsory registration, licensing and inspection procedures for the pharmaceutical sector) (30 June 1995)
- Decree 269 "On additional measures for strengthening the health system under market economy conditions" (decreed that health facilities should independent from the Ministry of Health and also defined a basic package of health care) (5 July 1995)

- Decree 351 of the Head of State on "Additional measures on social security of staff of health institutions during the process of health care system reorganization" (outlined social insurance provision for health services for health staff who lost their jobs in the health system reorganization and provided the basis for the development of the national state medical insurance programme) (13 September 1995)·
- Decree of the Head of State of Georgia "On the extension of state assistance to the population at the first stage of reorganization" (4 November 1995)
- Decree 377 on the "Charter and Structure of the Ministry of Health of Georgia" (outlines a role based on policy-making and monitoring for the Ministry, rather than one of implementation of programmes) (11 June 1996)
- The Law on Medical Insurance (18 April 1997) provides the legislative arrangements for the creation of a health insurance system in the country. It allows both compulsory and voluntary insurance)
- Resolution No 389 of the Cabinet of Ministers "On the reorganization of the Sanitary–Epidemiological Department in the Ministry of Health" (preliminary legislation underpinning the transformation of the San–Epid system into the Departments of Health and Sanitary Surveillance and Hygienic Affairs).