

GEORGIA

HEALTH BRIEFING PAPER

A paper produced by IHSD, a Resource Centre for the Department for International Development



Georgia, a country in the Transcaucasus, has a population of 5.4 million people of which 56% is urban and 44% rural. It covers an area of 70,000 square kilometres¹.

Prior to her independence Georgia enjoyed one of the highest living standards and levels of per capita income in the FSU. However, her independence in 1991 was accompanied by a civil war in the regions of Abkhazia and Ossetia. This lasted until 1994, culminating in the formation of autonomous regions, and left Georgia with a disrupted economy, a declining economic

The economic plight was worsened by an influx of some 300,000 refugees to the capital city of Tbilisi and a further 200,000 displacement to other regions².

Very high inflation eroded the income levels. The estimated per capita income is now around US\$ 350. Pensioners' income can be as low as US \$ 80-100 per annum³.

Legislative and structural reform programmes in political, economic, welfare, taxation and the health sectors resulted in the resumption of macroeconomic stability but declining economic and living standards had an adverse affect on the health status of the population. Without financing and a clear direction for a health policy the health system reached a crisis. The Government of Georgia (GoG) sought financing from the World Bank for a Health Sector Reform Project to manage the crisis and to reform the health system. A US \$14 million financing was agreed and the Project commenced in 1995.

DFID is a partner in the comprehensive health reform project.

The four components of the World Bank Health Reform Project are: health systems reorientation; rehabilitation and maintenance of health facilities and equipment; development of health human resources, and modernisation of the health financing system^{4, 5}.

² Ibid.

³ Ibid.

⁴ Georgian Health Systems Reorientation: Major Decisions. 1996, NHMC. Tbilisi, Georgia

⁵ For a more detailed discussion of the World bank Health reform project please refer to the Report No 15069-GE:

¹.Human development report Georgia., 1995. Government of republic of Georgia and the United nations Development Programme. Tbilisi 1995

Within these health reforms the GoG will need to address the following issues:

- a) a deterioration in the health status of the population
- b) inefficient use of inadequate health service inputs: poor quality of health care services
- c) inadequate access and coverage of health services
- d) a collapse of government revenues.

Health Indicators

Since 1990 the IMR has worsened by 13%, reaching an estimated 21.4 per 1000 live births (adjusted WHO definition) in 1993. One third of infant deaths occur in the first three days of life. The MMR has increased to 39 per 100,000 deliveries and is expected to increase further due to an increased proportion of unassisted home deliveries.

Deaths due to cardiovascular diseases have increased by 35% since 1990. The overall age-adjusted mortality rate has risen by 18% in the period 1988-1994. The average life expectancy in 1992 was 72.6 (76 for women and 69 for men).

To compound the problems there is inadequate preventive activity that is reflected in the low immunisation uptake, which lead to outbreaks of measles and diphtheria in 1994 and increased the number of diphtheria cases from 28 in 1993 to 425 in 1995⁶. Tuberculosis is on the rise among children and adults. Newly diagnosed cases of active Tuberculosis increased from 28.7 per 100,000 inhabitants to 55.3 in the period 1988-1994⁷. Sexually transmitted illness is on the rise.

Health Sector Provision and Financing

The fiscal crisis hit the health sector particularly hard. In 1995 public expenditure on health was less than US\$1 per capita. In 1998 this level was US\$7, representing 6% of public spending⁸.

The majority of public financing for health comes from a 4% payroll tax and transfers from the central budget. But 87% of *total* health spending comes from patients themselves. This is an unprecedented level of out-of-pocket spending, and is a major factor that causes families to slip into poverty⁹. Additional public revenue is needed to allow risk pooling and targeting of services for those unable to pay.

The excess capacity in the health system is a remnant of the early Soviet Union model based on normative planning which at one point in the early 1980's required Georgia to have 60,000 hospital beds to serve its population¹⁰. Today, Georgia has 287 hospitals with nearly 25,000 hospital beds¹¹, with a ratio of 4.5 beds per 1000 population

⁶ Ibid. Georgian Health Systems.

⁷ Reorientation: Major Directions, 1996. NHMC, Tblisi, Georgia

⁸ Based on preliminary estimates of annual expenditures in 1998 of 48 million GEL, a total population of 5.4 million, and an average exchange rate of 1.3 GEL to the dollar. This is 63% of the budgeted amount for 1998. Expenditures for the Ministries of Defense and Interior (4 mil GEL) are not included. National health Policy, 1999 (draft).

⁹ These figures are supported in the background paper prepared by Nora Dudwick for the 1999 report: Georgia: Poverty and Income Distribution (March 1999).

¹⁰ Long term planning for a Network of medical Institutions, Ministry of Health of Georgia.

¹¹ This includes Republican, Municipal, Private hospitals, but not those of the ministries of Defense or Interior.

compared to 2.5 per 1000 population on average in OECD countries. As a result the occupancy rates are very low at 28% and average lengths of stay are high (ALOS of 10.5 days in 1997). More than 100 hospitals had occupancy rates less than 10% in 1998. The hospitals are in poor state of disrepair. A recent survey¹² (1999 WB hospital rationalisation PM preparations) found that 90% of hospitals in the country were unsafe. There is a corresponding surplus of physicians, with one physician per 245 population (compared with 1:400 in OECD).

There is a separation of financing and provision. A change in the legal status of hospitals and polyclinics has enabled the financial separation for health facilities from the national budget. A new case-based payment method for hospitals and a bipartite payment system for primary care from municipality and federal funds are introduced. Competition between providers was introduced, and reimbursement for services provided paid through a new intermediary agency, the State Health Agency. SHA receives its funding from two sources, namely the 3+1 payroll tax and the central budget funded by general taxation.

This enabled the Government to remove 130,000 health workers from the budget in 1995 although the practice of low official salaries paid to health care providers, supplemented with under the table payments from patients, creates little incentive for hospitals to remove staff. Today, the average annual salary of a typical physician practising in a hospital is 573 GEL (Approx US\$ 300), and for a primary care physician is about 150 GEL (Approx US\$ 100), while the minimal subsistence level of income in Georgia for one person is 1,080 GEL.

Primary care is characterised by fragmentation and over-capacity. The PC network includes polyclinics (Adult, Paediatric, Women), district/village clinics ("feldsher points", ambulatories), factory polyclinics (largely closed) and specialised outpatient clinics¹³ (dispensers for endocrinology, tuberculosis, psycho-neurology, rheumatology, cardiology and dermato-venereology).

Health Policies

The strategy for health sector reform was first published in the national health care policy document: "Georgian Health System Reorientation: Major Directions" (1996, MoH). The major directions are to:

- 1) create the legal basis for the new health care system
- 2) decentralise the health care system management
- 3) prioritise the importance of primary health care
- 4) reform the san-epid system
- 5) transition to the principles of health insurance
- 6) ensure the social security of employees of the health care sector
- 7) reform medical education
- 8) reform medical science
- 9) reform the health information system

The vision is a health system financed by semi-public social insurance but maintaining the principles of solidarity and equity, led by a primary care with an emphasis on health promotion and disease prevention.

¹² Report on Hospital Financing Study for Georgia, Curatio International foundation, (March 1999)

¹³ In urban areas

For the reforms to succeed, two sectoral issues must be addressed:

- 1) improving the tax collection system must raise additional resources
- 2) efficiency must be improved by reducing capacity.

A National Health Policy is being developed with assistance from WHO. This reiterates the need to consolidate services and to reduce capacity¹⁴.

Licensing and Accreditation

The Ministry of Health has assumed the role of licensing health facilities. This began in late 1998. So far 900 medical facilities, including 250 hospitals, have been licensed.

Graduating medical students are required to take a certification exam to progress to post graduate training. The first exam taken by 600 recent medical school graduates yielded a 60% failure rate. Practising physicians are required to take a licensing exam in their field prepared by expert groups under the National Health Management Centre (NHMC). The first exam failed 60% of obs/gynae specialists. The examination of paediatricians has just begun. That for family physicians will be in September 1999. Those unable to pass the licensure exams will not be allowed to practice, and all practising physicians will be licensed by December 31st 2000.

More than 50 private medical schools have opened since 1991, with an enrolment of 14,000 and expected annual graduating class of more than 3,000. A Commission of Accreditation was formed in 1996. New legislation in 1998, however, passed this responsibility over to the Ministry of Education and the accreditation process has stopped.

Privatisation

In 1996, the Law of Privatisation of Public Enterprises divided health facilities into three groups:

- 1) pharmacies and dentists' offices;
- 2) ambulatories and polyclinics;
- 3) hospitals.

In addition to the three groups, facilities are divided into three categories. Categories A and B create restrictions in the property right of purchasers, while category C gives unrestricted property rights.

Four hundred facilities were privatised during 1996-1997. Originally, the revenues from privatisation were earmarked to go to the State Health Fund, however, as part of the budget reforms, the money has been reassigned to the central budget.

DFID Activity

DFID is one of the donors participating in the World Bank-led Health Reform Project. The DFID Primary Care Project started in 1996 and has been a successful part of the

¹⁴ National health policy, 1999 (draft)

Reform Programme. It has developed a strong platform for primary care by establishing family medicine (FM) as a speciality in Georgia, training cohorts of FM trainers, FM specialists and developing the process for licensing and validation. A one-year family medicine training programme is established with a curriculum in Georgian language. The project has resulted in the introduction of a sustainable capacity to train family physicians.

The MoH and Tbilisi Municipal Health Department plan to roll out family medicine within Tbilisi and rural areas by utilising the family physicians trained under the DFID project. This involves committing significant resources. The GoG recognises the need for further structural reforms to create an environment in which the family doctors can practice.

The first World Bank Health project assisted in re-structuring the health system and a new WB Project, scheduled to start in 2002, will focus on primary care.

The Georgian government has asked DFID to play a critical role in health reform by supporting the reforms in primary care. A second DFID Project is planned to assist GoG in PHC development. The Project will focus on training of the PHC team, financing systems for PHC, development and implementation and evaluation of a new PHC model that will be rolled out nationally.

Donor activity:

World Bank – The first World Bank Health Project began in 1995 financed by a loan of \$14 million. DFID has supported the human resources component. A second Bank instrument is being used to fund hospital rationalisation and design novel methods of cost-recovery for hospital care. A third health sector project will be financed via a loan of US\$ 20 million to strengthen primary care based on the family medicine model. The Bank plans to include this project in the next 2001-2 World Bank project cycle.

The loan would finance the roll-out primary care demonstration sites developed by the second DFID Project.

The **World Health Organisation** (WHO) is providing technical assistance to develop a national health policy. The government at the end of July 1999 ratified a draft policy. WHO has scheduled a donor collaboration meeting for late September 1999.

The main programmatic activity of WHO in Georgia is the DFID-funded Drug Action Programme. This provides technical assistance for the development of the national drug law, a national essential drug list, and implementation of a drug reimbursement experiment in the city of Kutasi. This project now has over 10,000 members and is close to achieving full cost-recovery. It is the first fully functioning drug reimbursement pilot project, that exists in the FSU.

USAID has supported reform of the public health system from a Soviet model of disease control to a broader Western model of health promotion and disease prevention. The Sanitary Epidemiological Service (SES) has been transformed in public health departments with a much broader remit of public health. USAID also has a partnership program between hospitals, NHMC and universities and provides significant humanitarian aid in the Samegrelo region that has a high concentration of IDPs.

Other Donors

UMCOR is funding a primary care pilot project in two mountainous rural rayons in the Imereti region to provide equipment, drugs and renovation of the primary care facilities

and implement a community-based financing scheme. **UNICEF** is developing a pilot project in two rayons in Imereti similar to the UMCOR project.

Rifat Atun, September 1999



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