

OXFAM
RESEARCH
REPORT

Health-Care Reform in Georgia

A Civil-Society Perspective: Country Case Study

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BBP	basic benefit package
CIF	Curatio International Foundation
CIS	Commonwealth of Independent States
CPI	Corruption Perceptions Index (Transparency International)
CSO	civil-society organisation
DCD-DAC	Development Assistance Committee of the Organisation for Economic Co-operation and Development
DFID	Department for International Development (UK)
DO	Doctor of Obstetrics degree
EC	European Commission
ECA	European and Central Asian Countries
ENP	European Neighbourhood Policy
ER	European region (WHO)
EU	European Union
FDI	foreign direct investment
GCAP	Global Call to Action Against Poverty
GDP	gross domestic product
GEL	Georgian Lari
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GGHE	General Government Expenditure on Health
GNI	gross national income
HALE	healthy life expectancy
HDI	Human Development Index
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HSPA	Health and Social Programmes Agency (Georgia)
IDP	internally displaced person
IMF	International Monetary Fund
MBBS	Bachelor of Medicine and Bachelor of Surgery
MBCbB	Bachelor of Medicine and Bachelor of Surgery
MD	Medical Degree
MDG	Millennium Development Goal
MIS	Management Information System
MoE	Ministry of Economy
MoLHSA	Ministry of Labour, Health and Social Affairs

NATO	North Atlantic Treaty Organization
NCDCPH	National Center for Disease Control and Public Health (Georgia)
NGO	non-government organisation
NIS	Newly Independent States
ODA	Official Development Assistance
OPM	Oxford Policy Management
PHC	primary health care
PPP	purchasing power parity
PRSP	Poverty Reduction Strategy Paper
STI	sexually transmitted infection
SUSIF	State United Social Insurance Fund (Georgia)
TB	tuberculosis
UNDP	United Nations Development Programme
WHO	World Health Organization

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Glossary

Ambulatory care: Medical care, including diagnosis, observation, treatment and rehabilitation, that is provided on an outpatient basis.

Family medicine: The term 'family medicine' is used in many European countries instead of 'general medicine' or 'general practice'. Family medicine doctors may hold one of the following medical degrees: MD, MBBS, MBChB, or a DO degree.

Out-of-pocket payments: Payments made for services at the point of use. Out-of-pocket payments for health care include: direct payments, informal fees or cost-sharing/user fees.

Direct payment: Payment for goods or services bought from the private sector, and not covered by pre-payment or insurance schemes.

Cost-sharing: Where individuals are required to pay for part of the cost of care.

Informal payments: Unofficial payments for goods or services that are nominally free.

Polyclinic: Health facility providing a range of primary and other services.

Rayon: Territorial district or region.

Subsistence minimum: The recognised minimum level of income to avoid material poverty. It defines the amount of funds necessary for a household to provide for the essentials of life, at a very modest level. It is assessed by state agencies.

Utilisation rate: Number of visits per person to health facilities per year.

Georgia key facts: statistics and timeline

Demographic facts and figures

Population	4.43 million (2006) (capital Tbilisi: 1.3 million)
Population growth rate*	- 0.9% (2005–06)
% population rural (2004)***	48.8%
% population 0–14 years (2006)***	18.1% (2002: 21.0%)
% population above 65 (2006)***	14.5% (2002: 8.8%)
Fertility rate, total (births per woman, 2006)*	1.4 (WHO European region: 1.6)
Human Development Index rank of 177 countries (2007–08)****	96

Financial facts and figures

Total GDP and recent GDP growth/ inflation*	\$7.7bn (2006) (about GEL 13.6bn or € 5.9bn) 9.4% growth (2005–06) 8.4% inflation (2006)
Per capita income (2006)*	\$1,580 (about GEL 2,790 or € 1,200)
Revenue (% of GDP, 2005–06)*	22.5%
% Government expenditure health/education (2006)	Health: 5.6% (WHO European region average in 2005: 14.5%)
Total aid to government (2006)**	\$361m (about GEL 638 m or € 274m)
Biggest donors (top 5, 2005–06 average)**	1. USA (\$88m, about GEL 155m or € 67m) 2. World Bank (\$70m, about GEL 124m or € 53m) 3. Germany (\$50m, about GEL 88m or € 38m)

	<p>4.EC (\$45m, about GEL 79m or € 34m)</p> <p>5.IMF (\$41m, about GEL 72m or € 31m)</p> <p>Top 5 donors account for 80% of total aid</p>
Net ODA / GNI (2006)**	4.9%
Aid to health (2006)**	<p>\$21.2m (about GEL 37m or € 16m)</p> <p>Aid to health accounts for 6% of total aid</p>
Biggest donors to health (2006)**	<p>USA (\$9.1m, about GEL 16m or € 7m)</p> <p>EC (\$8.5m, about GEL 15m or € 6.5m)</p> <p>World Bank (\$2.3m, about GEL 4m or € 1.8m)</p>
Budget support (2006)**	<p>\$66.5m (about GEL 117.5m or € 50.5m)</p> <p>Budget support accounts for 18% of total aid</p>
Biggest budget support donors (2006)**	<p>EC (\$40.9m, about GEL 72m or € 31m)</p> <p>World Bank (\$19.5m, about GEL 34.5m or € 15m)</p> <p>Netherlands (\$6.1m, about GEL 11m or € 4.6m)</p>

*Source: World Bank, World Development Indicators database, April 2008, <http://web.worldbank.org/WBSITE/EXTERNAL/DATASTATISTICS/0,,contentMDK:20535285~menuPK:1192694~pagePK:64133150~piPK:64133175~theSitePK:239419,00.html>

** Source: OECD/DAC, Statistical Annex of the 2009 Development Co-operation Report, Paris, www.oecd.org/document/9/0,2340,en_2649_34485_1893129_1_1_1_1,00.html

*** Source: WHO Regional Office for Europe, European health for all database 2007, Copenhagen, www.euro.who.int/hfadb

**** Source: UNDP, 2008 Human Development Report HDI rankings, <http://hdr.undp.org/en/statistics/>

Executive summary

This report aims to identify key challenges arising from reform of the health-care system in Georgia, especially in primary health care, and to present some possible strategies to address them. It will be a useful reference document for Oxfam, our partners, and all those concerned with improving the provision of health care in Georgia.

Georgia in context

Georgia is one of the poorest countries of the former Soviet Union. According to official statistics, 31 per cent of the population live below the poverty line, but civil-society groups estimate that almost half of the population live below it. People living in rural areas, where unemployment is high, are much more likely to be poor and have little or no access to basic services such as health care. In theory, health care in Georgia is free for those living below the poverty line, but the reality is that patients often have to pay, especially for medicines.

Since gaining independence in 1991 after the collapse of the Soviet Union, Georgia has suffered a rapid and dramatic decline. There was a catastrophic drop in public health expenditures in the 1990s. Wealth and security quickly gave way to poverty, unemployment, and unrest. The transition to a free market economy meant that basic services such as health and education were no longer free, and rising unemployment pushed many families into poverty. The situation was exacerbated by civil war and unrest in the two separatist regions of Abkhazia and South Ossetia, which displaced more than 300,000 people who are still unable to return home. These people are particularly vulnerable to poverty and unemployment.

During this time, the Georgian government was weak and ineffective, and corruption was endemic. However, since 2004, the government (under President Saakashvili) has made some progress in tackling poverty and stabilising the economy. But political instability and unrest still threaten to undermine progress, and corruption and weak governance still represent major obstacles to development. Spending on health care and other key sectors remains hugely inadequate.

Political and economic relations with Moscow have been tense since Georgia gained independence in 1991. Russia's support for separatists in Abkhazia and South Ossetia is a key factor. In August 2008, these tensions flared up into full-scale conflict¹ involving Georgian, Russian, and South Ossetian soldiers, forcing thousands of people to flee their homes.

Key health issues

Poverty continues to be the main risk factor for ill-health in Georgia. Child, infant, and neonatal mortality rates have fallen in recent years but are still high, reflecting serious shortcomings in the maternal health-care system. Communicable diseases such as tuberculosis (TB) are increasing. The prevalence of hepatitis B and hepatitis C has dramatically increased, as has the number of sexually transmitted infections (STIs). This has come at a time when there have been substantial cuts in public funding for prevention and treatment of these diseases. A high neonatal mortality rate largely reveals the failure of the maternal health-care system, highlighting the need for urgent improvements in organisation, service use, and quality of maternity services.

Despite the fact that primary health care (PHC) services are supposed to be free for people living below the poverty line, many end up having to pay for treatment by a doctor. One of the main reasons for this is that medical staff are often low paid, so they depend on out-of-pocket payments to top up their salaries. Also, the state PHC programme does not cover complex diagnostic assessments and medicines. The result is that many people cannot afford treatment when they are ill.

There are a number of other barriers to health care. The quality of health services remains low, and facilities and equipment are substandard, lacking proper investment in renovation and maintenance. Access to services is an issue for the rural population, and availability and affordability of medicines is a significant factor.

The utilisation rate of health services has fallen dramatically in recent years, especially among the poorest groups. A state health programme for people living below the poverty line has gone some way to helping increase poor people's access to health care. But there is still huge inequality regarding access between rural and urban areas, and among different social groups.

Health policy, planning, and financing

In 2007, the government introduced a rapid and extensive programme of privatisation of public services, including health care. The rationale is that the free market will solve existing problems, including inefficiencies (in particular, issues around cost, access, availability, and equitable distribution, as well as quality, financial mismanagement and corruption). Reforms have been carried out with little or no consultation with civil-society groups or donors. The Ministry of Labour, Health, and Social Affairs itself has a limited policy space and limited capacity; other ministries (like the Ministry for Economic Reform Coordination) or key individuals have been driving health reforms.

Inadequate state financing of the health sector over the past 15 years has meant that large amounts of health financing (more than three-quarters) are private expenditures (mainly out-of-pocket payments). Although the Saakashvili government has increased health expenditure in recent years, in 2006 the state provided just 21.6 per cent of total health expenditure, compared with around 75 per cent in the World Health Organization (WHO) European region. Only 5.6 per cent of general government expenditure went on health in 2006, compared with 14.7 per cent in 2005 within the European region. Government funding levels are still far below those required to provide basic health care for people and maintain health facilities.

The biggest item of expenditure for households is medicines. Total pharmaceutical expenditure as a percentage of total health expenditure was 45.6 per cent in 2000 – by far the highest amount for any country in the European region. While up-to-date statistics are not available, it is reasonable to assume that this amount has not changed significantly in the last decade.

Major concerns about the privatisation of health care

The vision underlying privatisation of health care is to build up a system based on **private** provision and purchasing, which would work in a competitive environment. However, the health sector has certain characteristics that make it distinct from the conventional market approach based on supply and demand for goods and services. There are serious concerns that privatisation will result in even greater inequalities in access to health care. Currently, health-care reforms are being taken on a step-by-step basis, with no overall strategy and vision in place. There is an urgent need to ensure that adequate measures for supervision, regulation, and human resource development are adopted and implemented.

There are other major concerns, including how to extend coverage of private health insurance schemes, and how to help people who are poor but not officially living below the poverty line. Privatisation has also resulted in the creation of de facto monopolies (with pharmaceutical companies in particular). Finally, there has been a lack of consultation, transparency and information in relation to implementation of health-sector reforms.

The way forward

Based on our research, Oxfam has identified a number of possible strategies that might be used to influence the Georgian government and other stakeholders to bring about key improvements in the health-care system. These strategies have the broad aim of ensuring:

- universal access to services
- quality of care
- meaningful civil-society participation in decision-making.

The concluding chapter of this report presents some priorities for action on the part of civil-society organisations (CSOs) and the government, to ensure that these goals are met.

*At the time of writing, all information is correct and up to date. However, it should be noted that government initiatives and policy in Georgia can change very quickly, and so could potentially affect some of the information in this report.

1 Introduction

This report is intended as a reference document for Oxfam, our partners, and other organisations involved in the health sector in Georgia. It is hoped that by identifying key challenges and possible strategies to address them, it will inform health policy development, lobbying, and campaign work at local, national and international levels.

The case-study research was carried out in the first two weeks of April 2008.² The team comprised Oxfam staff from Georgia and the international policy team, together with staff from the Genesis Association and the Welfare Foundation,³ two of Oxfam's partners in Georgia. The team conducted interviews with key stakeholders in the health sector, including the government, private-sector representatives, and donors. Focus group discussions were held with communities, health providers and regional/local authorities in Adjara and Samegrelo. Finally, the team organised a one-day workshop in Tbilisi with representatives from civil-society organisations (CSOs) to discuss the research findings. Large parts of chapters 3, 4, 5 and 6 of this report are also based on desk research carried out by Tata Chanturidze, an expert in the Georgian health-care sector.

Oxfam's programme in Georgia

Oxfam's programme in Georgia is supported by two Oxfam affiliates: Oxfam GB and Oxfam Novib. Oxfam has been working in Georgia since the early 1990s. Oxfam focuses on improving people's access to health care, supporting refugees and internally displaced people, tackling domestic violence, helping civil society hold government to account, and supporting small farmers.

Oxfam works in rural areas of western Georgia (Zugdidi, Samegrelo, and Adjara), supporting health programmes run by the Genesis Association and the Welfare Foundation. These programmes improve vulnerable people's access to affordable health care. Oxfam is developing not-for-profit primary health care (PHC) centres, renovating health facilities or building new ones, and introducing innovative schemes such as community-based health financing.

Oxfam also provides technical support to local partners, including the Genesis Association, the Welfare Foundation, and the Future without Poverty coalition.⁴

Structure of the report

The next chapter looks at recent political and economic developments in Georgia that determine the context of poverty and access to basic services. Chapter 3 describes key health indicators and gives an introduction to PHC services. Chapter 4 identifies the main barriers to health care. Chapter 5 looks at the main issues in health-care financing and expenditure, and Chapter 6 describes key aspects of health policy and planning. Chapter 7 identifies major concerns about the privatisation of health care, and Chapter 8 concludes with the key challenges to be addressed.

2 Georgia in context

Socio-economic background

Georgia has a population of 4.4 million and a gross national income (GNI) per capita of \$4,770 (about 8,425 Georgian Lari (GEL) or € 3,240, 2007).⁵ The country is rich in natural resources, and is strategically located between Europe and Asia. In 2008, it was ranked 93rd out of 179 countries in the Human Development Index (HDI). According to World Bank statistics, Georgia is a lower middle-income country.

When Georgia emerged as an independent former Soviet state in 1991, it experienced economic collapse and civil war. During a rapid transition from a centralised, planned economy to a free market one, wealth and security quickly gave way to poverty, unemployment, and unrest. Almost overnight, Georgia lost its source of budget assistance, as well as preferential access to former Soviet Union markets, and the economy quickly collapsed.⁶ Soon after independence, output fell by 70 per cent and exports fell by 90 per cent.⁷ Poverty, corruption, crime, and natural disasters (including floods, landslides, and droughts) further weakened the economy. Basic services such as health and education were no longer free, and many families had no safety net to rely upon.

The situation was exacerbated by civil war and unrest in the two separatist regions of Abkhazia and South Ossetia, which displaced more than 300,000 people who are still unable to return home.

High poverty rate

Although some progress has been made in tackling poverty in recent years, the poverty rate is still high. In 2001, 54 per cent of the population lived below the national poverty line.⁸ According to official statistics, this figure had dropped to 31 per cent in 2006.⁹ However, civil-society groups have found out that this decrease happened primarily due to a revision of methodology and is not backed by a substantial improvement of poverty levels. They estimate that the real percentage is higher, and that by applying the formula that was previously used to define the poverty line, almost half of the population live below it.

There are huge inequalities between rural and urban areas. Paid employment is hard to find, and many people travel to other countries to find work. Although the economic situation has improved in recent years, the unemployment rate remains high, estimated at 13.6 per cent in 2006.¹⁰ There are also significant inequalities between social groups. For instance, the poorest 20 per cent of the population had just 5 per cent of national income in 2005.¹¹ Along with people in many other countries, the poorest groups in Georgia are struggling to meet rising costs of food and fuel, which are likely to comprise the bulk of household expenditure in future.

Most poor people live in rural or mountainous areas, where the labour market is dominated by agricultural employment, and farmers work on small plots (0.25–1.25 hectares per family). In 2006, 55.6 per cent of the Georgian population were employed in the agricultural sector.¹² In 2008, the agricultural sector accounted for 12.8 per cent of gross domestic product (GDP).¹³

The official subsistence minimum¹⁴ of an average consumer in 2007 was estimated to be GEL 103.4 (about €40 or \$60), which is totally insufficient. In 2007, the same figure for an average size family was GEL 195.9 (about €75 or \$110). *The average monthly salary* in the country in 2006 was GEL 277.9 (about €120 or \$155). In 2006, minimum salary was GEL

44.4 (about €21 or \$25). The average pension size was GEL 55 (about €25 or \$33). The number of pensioners (985,400 in 2008) is increasing, and many of them will be living below the poverty line, unless they belong to an extended household.¹⁵

Political and economic background

Georgia's recent political and economic history is characterised by civil unrest, political instability and economic collapse. Key events are detailed in the timeline below.

Figure 1: Timeline of key political and economic events

1991	Independence from the Soviet Union. Introduction of market economy sparks rapid decline from wealth and security to poverty and unemployment.
1992	Nationalist leader Zviad Gamsakhurdia overthrown. Replaced by Eduard Shevardnadze, former Soviet foreign minister. Shevardnadze ruled Georgia for 11 years. Poverty, corruption, and crime became rife.
1992–95	Civil war. Fighting between government troops and separatist forces in Abkhazia. Russian peacekeeping force deployed. More than 300,000 people displaced from their homes during the fighting.
1992	Abkhazia and South Ossetia form breakaway states.
2003 (summer)	Corruption and tax evasion prompt the International Monetary Fund (IMF) to suspend lending to Georgia.
2003 (Nov)	The 'rose revolution'. Mass peaceful demonstrations over the conduct of parliamentary elections lead to the downfall of President Shevardnadze.
2004 (Jan)	New leader, Mikhail Saakashvili, elected president and ushers in a new era of hope. Focus is on fighting corruption, stabilising the economy, and responsible use of public funds.
2007 (Nov)	Government imposes a state of emergency and announces elections in response to demonstrations against poverty and restrictions on civil rights. Many people disillusioned at government's failure to deliver on promises to tackle poverty, unemployment, and corruption.
2008 (Jan)	Presidential elections. Saakashvili re-confirmed as president.
2008 (May)	Parliamentary elections. President Saakashvili's United National Movement Party win with over 59 per cent of the votes. The party holds an absolute majority in Parliament (with 119 out of 150 seats).
2008 (Aug)	Heavy fighting between government troops, separatist forces and Russian soldiers in South Ossetia. Russia eventually withdraws its forces in response to international pressure.
2008 (26 Aug)	Russia recognises South Ossetia and Abkhazia as independent states. Georgia and Russia cut off diplomatic ties.
2008 (Sept)	A deal negotiated by French President Nicolas Sarkozy and Russian President Dmitry Medvedev sees Russian and Georgian troops withdraw to their original positions. EU sends observers to monitor enforcement of the plan.

External relations – forging closer ties with the West, while tensions with Russia intensify

Georgia's relations with its biggest neighbour, Russia, remain tense. There are two main factors underlying these tensions: President Saakashvili's Western-facing foreign policy; and Russia's support for the breakaway regions of Abkhazia and South Ossetia, which sparked an all-out war in August 2008.

The violent hostilities of the 1990s had already left about 200,000 refugees in various parts of core Georgia. A new wave of an estimated 133,000 refugees from the armed conflict with Russia (see below) were added in summer 2008. Of those, 22,000 (estimated) have not been able to return to their homes and are currently hosted in new settlements for internally displaced persons (IDPs).

Under President Saakashvili, Georgia's foreign policy has been based on developing stronger ties with the West. American troops are training the Georgian army, for instance, and the United States has invested heavily in an oil pipeline from Azerbaijan via Georgia to Turkey. But Georgia is still heavily dependent on Russia for its energy supply. In January 2006, gas supplied by the Russian energy giant Gazprom rose sharply in price and has doubled since.¹⁶ Georgia has therefore started to get some of its gas requirements from Azerbaijan.

In the short term, Georgia hopes to join the North Atlantic Treaty Organization (NATO) and in the longer term, to accede to the European Union (EU). Georgia's accession to the Council of Europe at the end of the 1990s and the advent of the EU's European Neighbourhood Policy (ENP) in 2004 have made the country an important European partner. An ENP action plan for intensified co-operation has been drawn up between Georgia and the European Commission. However, the NATO Summit in April 2008 dented Georgia's hopes of becoming a member; France and Germany were against Georgia's early accession, whereas the US government strongly supported it.

Recent progress – economic growth and reform

Under President Saakashvili, the government has made some progress on the economy, increasing tax revenues and overhauling the public sector.¹⁷ In recent years, stronger macro-economic management has been effective in safeguarding stability and growth, according to the World Bank.¹⁸ The government is now embarking on the second phase of its reform programme. This involves focusing on deeper institutional change, strengthening social protection, and delivering the infrastructure needed to create jobs and reduce poverty.¹⁹

However, political problems and the global economic downturn may yet hinder Georgia's economic progress. The war with Russia in 2008 has resulted in price increases for food, fuel, heating, and consumer goods.

Economic performance

The IMF has stated that economic performance in Georgia in 2007 was 'exceptionally strong',²⁰ with GDP growth of more than 12 per cent. This was mainly due to private capital inflows, which included a large element of foreign direct investment (FDI). There has also been significant growth in the construction, banking services, and mining sectors.²¹ Revenues of the central government increased, giving the government more space for political manoeuvre. Yet inflation remains high and there is a substantial trade deficit.

Farmers in poor rural areas still lack support

There are also few signs of economic development in rural areas, where poverty is much in evidence. Municipalities and districts lack the resources they need to play an active part in economic growth. The development of agriculture, the mainstay of Georgia's economy, is being hampered by inefficient land use, poor infrastructure, low processing quality, and poor training.

Counting the cost of war with Russia

The impact of the 2008 war with Russia on the Georgian economy will be substantial. In monetary terms, the damage is estimated to be around € 2bn (about \$2.9bn or GEL 4.1bn).²² In the wake of the conflict, the government had to revise the projected growth rate for 2008 down from 12 per cent to 5–6 per cent. In August 2008, Georgia's central bank sold almost 13 per cent of its foreign-currency reserves to preserve the value of the Lari. According to the Minister of Economy of Georgia, the country will have to absorb more than \$1.5bn (about GEL 2.1bn or €1bn) worth of direct and indirect losses.

Despite the large amounts of aid pledged by bilateral and multilateral donors – in the order of \$4.5bn (about GEL 6.3bn or €3bn) in the next three years – the economy will be seriously tested for its resilience to absorb the post-war recovery and rehabilitation costs.

Major challenges ahead – poverty and the fight against corruption

Although Georgia's economic situation had improved up to the summer of 2008, there are still major challenges. The government has to tackle the country's widespread poverty and to ensure that economic development benefits those who need it most. Key constraints are corruption, shortcomings in the rule of law, and the administrative weaknesses of the government.

There has been some progress in tackling corruption and tax evasion. Nevertheless, corruption continues to hamper development. In Transparency International's Corruption Perceptions Index (CPI) for 2007, Georgia was accorded only 3.4 points out of a possible 10.²³

Political and economic developments in the past couple of years have once more brought turmoil to Georgia. The ruling party and president now face an enormous challenge to maintain stability in the face of both external and internal threats.

3 The state of people's health

The political and economic crisis in Georgia in the 1990s resulted in a serious deterioration in people's health. Although there have been some positive trends recently, poverty is still the biggest risk factor for ill-health.

Key health indicators

Georgia's key health indicators are generally worse than the World Health Organization (WHO)'s European region (ER) average (see Table 1). Life expectancy in Georgia is 70 years (2007), compared with the ER average of 74.²⁴ It decreased in the 1990s but has been improving slowly since 1999. Healthy life expectancy (HALE) is close to the ER average (Georgia: 62 years for males and 67 years for females; ER average: 62 and 68 respectively).²⁵

The **maternal mortality ratio** increased in the 1990s, reaching 70 maternal deaths per 100,000 live births in 1997. In 2005, it was still high, with 66 deaths per 100,000 live births, compared with an ER average of 27. The **infant mortality rate** fell from 39 deaths per 1,000 live births in 1990 to 28 in 2006. The **under-five mortality rate** fell from 46 deaths per 1,000 live births in 1990 to 32 in 2006, but both rates are still significantly higher than the ER average (14 and 16 respectively). The **neonatal mortality rate** (babies who die within the first four weeks of life) was 25 per 1,000 live births in 2004, compared with an ER average of 10. Neonatal deaths account for 66 per cent of infant mortality and 58 per cent of under-five deaths in Georgia. Stillbirths also remain high, at 16 per 1,000 live births.²⁶

Table 1: Key health indicators for Georgia compared with WHO European region (ER) average

Indicator	1990	2000	2006	2006	
				Male	Female
Life expectancy: Georgia <i>(ER average)</i>	68 <i>(70)</i>	70 <i>(72)</i>	70 <i>(74)</i>	66 <i>(70)</i>	74 <i>(78)</i>
Infant mortality rate (0-1yr) per 1,000 live births <i>(ER average)</i>	39 <i>(27)</i>	32 <i>(19)</i>	28 <i>(14)</i>		
Child mortality rate (0-5 yrs) per 1,000 live births <i>(ER average)</i>	46 <i>(33)</i>	37 <i>(22)</i>	32 <i>(16)</i>		
TB incidence per 100,000 population <i>(ER average)</i>	89 <i>(37)</i>	82 <i>(51)</i>	84 <i>(49)</i>		

Source: WHO, World Health Statistics 2008, Geneva
www.who.int/whosis/whostat/2008/en/index.html

The disease burden

The main cause of mortality is non-communicable diseases. In 2003, diseases of the circulatory system caused 74 per cent of all deaths, and malignant tumours 11 per cent.²⁷

Communicable diseases were on the increase during the 1990s as a result of the deteriorating socio-economic conditions. For instance, tuberculosis (TB) morbidity increased during this decade from 29.7 per 100,000 people in 1988 to 145 per 100,000 in 1997, making it almost the highest level in the WHO European region. Although there has been a decline in TB morbidity rates, its incidence and prevalence are still unacceptably high – incidence is 84 per 100,000 people (2006), compared with an ER average of 49.²⁸

According to the Georgian Center for Medical Information and Statistics, the prevalence of hepatitis B and hepatitis C has also dramatically increased since 1995, from 10.3 and 6.0 per 100,000 people respectively in 2000 to 19.8 and 23.1 in 2006.²⁹ The number of sexually transmitted infections (STIs) has also increased. This can be linked to cuts in public funding to prevent and treat these diseases, as well as the discontinuation of mass preventive measures such as screenings and education campaigns.

HIV

Georgia has a relatively low HIV prevalence, at 154 per 100,000 people (adults aged 15 or over) compared with the ER average of 342.³⁰ But it is interesting to note that more than half (60 per cent) of the 1,156 registered HIV cases were reported in the last three years (2004–06), and the number of newly registered HIV infections has risen each year.³¹

PHC services – poor quality and free only in theory

Primary health care (PHC) services (including consultations, diagnostic tests and referrals, but excluding medicines) are supposed to be free for people living below the poverty line. The introduction of the state-funded private insurance scheme for the poorest groups, since 2007, has gone some way towards ensuring greater access to health care. But in practice, many people have to pay (in cash or in kind) for consultations or treatment.

There are a number of reasons for this (see Chapter 4, 'Main barriers to health care', for more detail). In the past, it was common for people to pay for consultations and treatment, as they often received a better service as a result. And doctors and other health workers are poorly paid, so informal fees are a way of topping up their salaries.

There is also a lack of transparency and information that can lead to abuse of the system of free health care for the poorest. A regional official in Samegrelo described the situation as follows: *'Many people living here do not even know what programmes exist. In a significant number of cases, the doctors misinform the patients so that they pay cash on the spot.'* (7 April 2008)

State health-care provision

The Georgian government provides PHC through a range of services:

- General health centre (in Georgia commonly referred to as ambulatory services)/outpatient network staffed by general practice doctors at village/rural level. On average, there is one doctor and one nurse per 2,000 people.
- Specialised health centres (created by regional dispensaries and polyclinics housing teams of specialists).

- Reformed PHC centres (known as family medicine centres) with family doctors who have received additional training (will cover not more than one-third of the outpatient service needs).
- An ambulance network.
- A public health network.

Utilisation rates have decreased dramatically

According to one of Oxfam's partners, the Genesis Association, service utilisation at PHC level has fallen drastically since the Soviet era. Between 1990 and 2005, the average utilisation rate fell from 7–8 visits per person per year to just 1.85 visits (this figure consisting mostly of regular check-ups and immunisation of children under 15). The utilisation rate in 2007 remained almost the same, at 1.9 visits per person per year. In 2006, a doctor working in an outpatient institution saw 946 patients a year on average (between two and three patients a day).³²

The utilisation rate for PHC services in rural areas is even lower, at just one visit per person per year on average. Several factors account for these low utilisation rates. For instance, there is evidence that the new free ambulance system is being used for minor complaints, and discouraging effective use of PHC centres when medical attention is required. But perhaps the main reason is that many pharmacies sell medicines without requiring a doctor's prescription. In fact, in rural areas, people often go to pharmacists with their health problems rather than pay to see a doctor.

Better access for the poorest, but still a long way to go

The population of Georgia faces huge inequality and injustice, as people with higher incomes are better able to access state-financed programmes. The state health programme for members of the population who live below the poverty level has been introduced in phases since June 2006. It has gone some way towards helping the poorest members of the population to increase their access to primary, secondary, and tertiary health care. The government has significantly increased its spending, especially for the poorest. However, there is still huge inequality regarding access to health services in rural and urban areas, as well as for the different social groups (see Chapter 4). Generally, the quality of services remains low, and the facilities and equipment available are poor due to a lack of proper investment in renovation and maintenance.

4 Main barriers to health care

As previously stated, poverty is one of the main barriers to accessing health care in Georgia, as poor people, especially those not covered by the state programme for people below the poverty line, cannot afford to pay informal charges or user fees demanded at the point of use (see Chapter 5, 'Health-care financing and expenditure', for more information on informal fees). But there are other factors: the health budget (despite being increased in 2009) is still very low; health professionals are underpaid; and facilities lack basic medicines and equipment. The cost of medicines is another important factor.

Access to services

Rural population have limited access

Nearly half of Georgia's 4.4 million population live in rural areas. Winters can be very harsh and in mountainous regions the roads are of poor quality, so people often cannot even get to the nearest health post or ambulatory. PHC facilities in rural areas are more likely to be of poor quality, with staff who have not benefited from retraining programmes.

From 1994 to 2000, largely as a result of inadequate public financing, many doctors and nurses left rural villages and moved to urban areas. The clinics they worked in either closed or were unable to provide even a basic service.³³

At present, the privatised health-care system means that patients may have to travel long distances to reach the closest health post, often depending on which providers their insurance company has a contract with. Another risk is that services may be centralised by commercial owners to save costs, further restricting access.

Access to medicines

Availability of medicines

While all routinely required medicines are available, there are differences in their distribution throughout the country. The full range of medicines are available in the capital, Tbilisi, but this is not always the case in rural and remote mountain regions, with a smaller population and lower per capita income. People living in remote villages often do not have access to medicines, either in their own community or nearby.

Cost of medicines

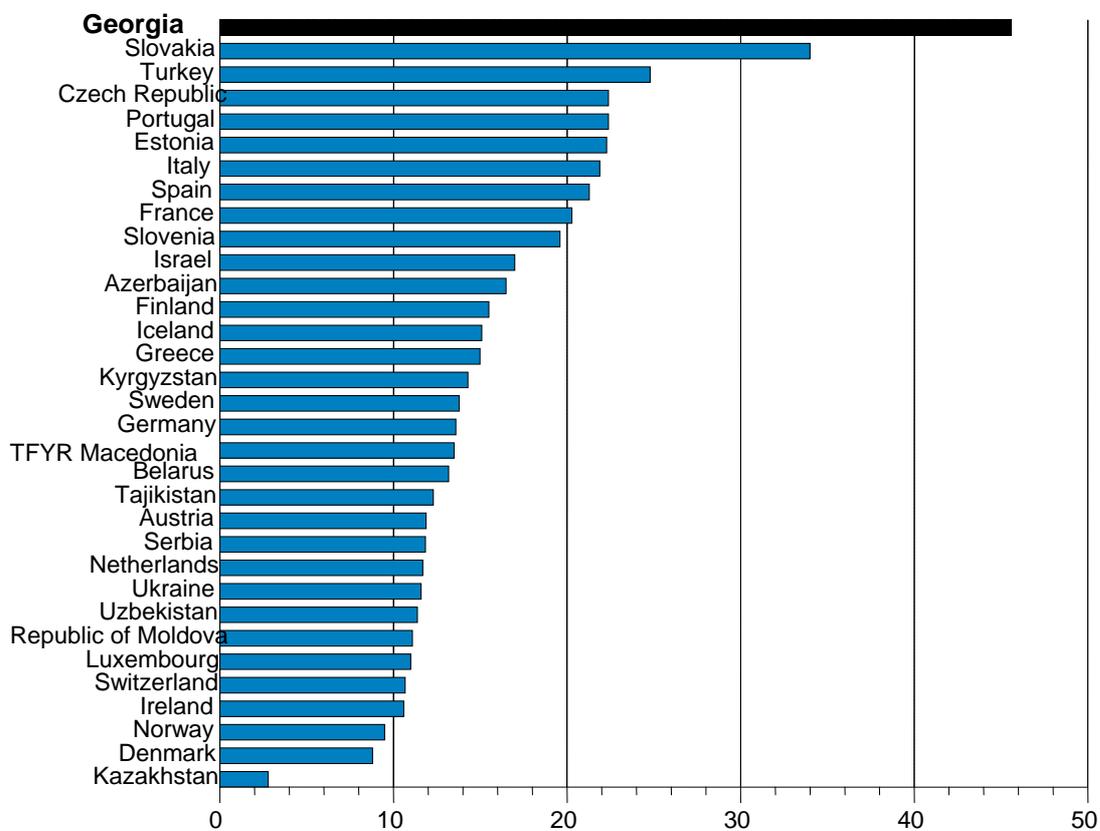
The cost of medicines is a big problem for most people. According to a household survey conducted in Tbilisi in 2000, ill respondents reported that they spent more on drugs (about 55 per cent) than on the medical service itself.³⁴ Most of these respondents indicated that they were not able to purchase all the medicines they needed because they were too expensive.

There is limited data available on medicine consumption, as drug utilisation reviews are not carried out at regular intervals. A National Drug Policy exists, but has not been fully implemented. According to the WHO, the total pharmaceutical expenditure for Georgia as a percentage of its total health expenditure was 45.6 per cent in 2000 (see Figure 2 below). This is by far the highest amount in the European region, and much more than is spent on medicines in other countries of the former Soviet Union. Data from the National Health Accounts (2006)³⁵ and the recent survey on Georgia Health Utilization and

Expenditure³⁶ show that household expenditure on medicines amounted to 49 per cent of total health expenditure.

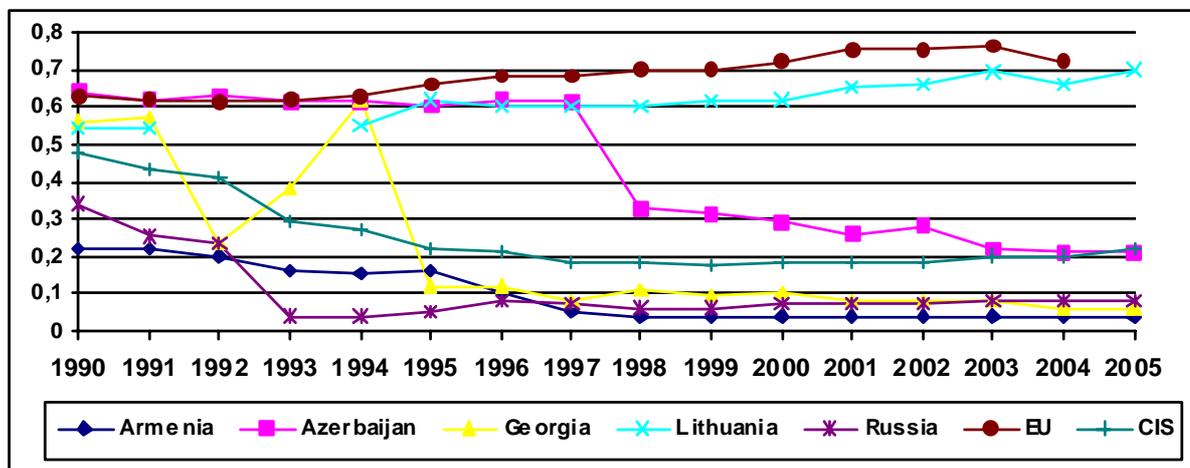
There are several reasons for high expenditures on medicines. One is self-prescribing, in the absence of a consultation with a doctor or nurse. Furthermore, the number of pharmacists decreased dramatically in post-Soviet years, and is now far below the density in other European and Asian countries (see Figure 3 below). As mentioned previously, people can buy most medicines from pharmacies without a prescription. Anecdotal reports indicate that this is common practice. People see this as a way of saving money through avoiding the possible costs involved in visiting a doctor. This leads to inevitable problems with irrational drug use.

Figure 2: Total pharmaceutical expenditure as a percentage of total health expenditure, 2000



Source: Health for All database (HFA-DB), Copenhagen, WHO Regional Office for Europe, www.euro.who.int/hfad

Figure 3: Number of pharmacists per 1,000 people



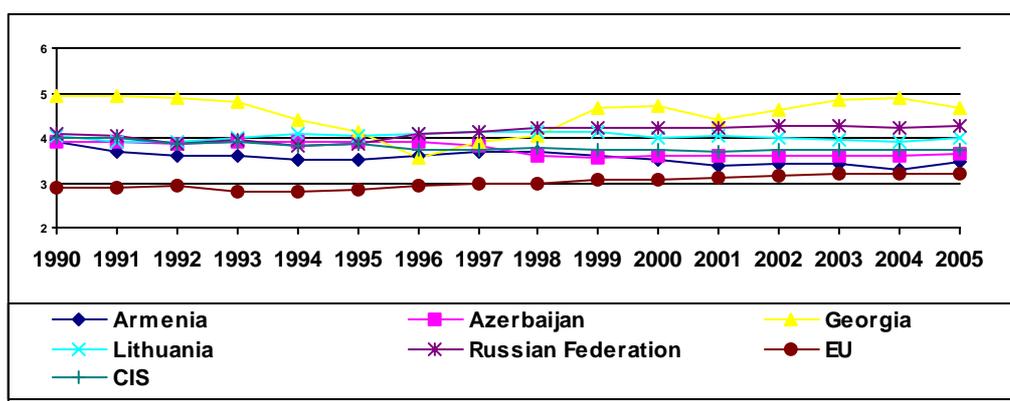
Source: Health for All database (HFA-DB), Copenhagen, WHO Regional Office for Europe, www.euro.who.int/hfad

Human resources

Health workforce

Unlike many developing countries, Georgia traditionally had high numbers of well-trained medical staff, particularly compared with European post-Soviet countries (see Figure 4 below). Even after the Soviet era, they remained high. According to the Department of Statistics of the Ministry of Economic Development of Georgia, in 2007 there were around 20,000 qualified doctors registered (4.65 per 1,000 people).³⁷ More than half of them are women.

Figure 4: Number of doctors per 1,000 people

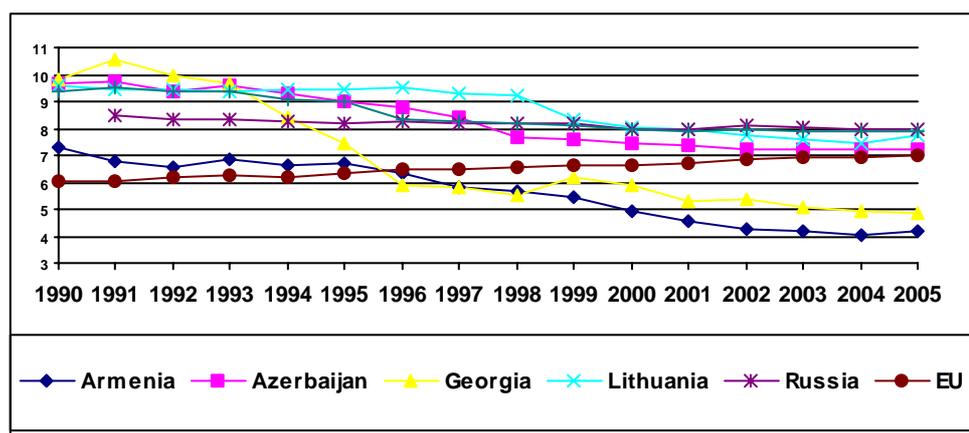


Source: Health for All database (HFA-DB), Copenhagen, WHO Regional Office for Europe, www.euro.who.int/hfad

But these statistics can mask inequalities in distribution of services. For example, there are approximately three times as many doctors in the capital, Tbilisi, as in other regions. In some of the poorest areas, particularly mountainous regions, there is a shortage of doctors and specialists, including emergency physicians, surgeons, and gynaecologists.

The number of other medical staff has decreased in the last 15 years (see Figure 5 below). There were 9.1 nurses per 1,000 people in 1990, but just 4.8 per 1,000 in 2005 (the European average is 7.8).³⁸ Georgia and Armenia have the lowest number of nurses of all the European post-Soviet countries. Almost 90 per cent of nurses are women. The balance between doctors and nurses is different to other European post-Soviet countries. In 2005, there were 1.04 nurses per doctor in Georgia, compared to 2.2 nurses per doctor in other EU states and the Newly Independent States (NIS).³⁹ The number of midwives per 1,000 people is 0.3, which is almost the same as in the EU.

Figure 5: Number of nurses per 1,000 people



Source: Health for All database (HFA-DB), Copenhagen, WHO Regional Office for Europe, www.euro.who.int/hfad

Training and re-training medical staff

Most medical staff received their training during the Soviet era. Because of the political and economic turmoil of the last 15–20 years, a skills gap has developed. The government has set up a programme to re-train general practitioners and nurses. About 1,000 PHC teams have already benefited from this training.

The Ministry of Labour, Health and Social Affairs (MoLHSA) has made several attempts to carry out workforce planning and institutional mapping. However, for a number of reasons, this work has not been completed. Assessments show that despite the high number of doctors, there are some specialties where shortages are or will soon be a problem (for instance, pharmacists, gynaecologists, and geriatricians).

Another problem is that some specialist doctors are allowed to practice without any obligation for continuing professional development, which may compromise the quality of the service they provide.

Health workers' salaries and informal payments

Another constraint is the reimbursement of medical personnel under state programmes. Up to 2004, doctors' fees were comparatively low; for instance, GEL 6 (about \$3 or € 2.50) per hour for surgery.⁴⁰ In recent years these rates have increased significantly, although they are still lower than private fees. In 2007, doctors working in health centres funded by the state received GEL 130 a month (about €60 or \$80).⁴¹ This is more than they were paid in 2003 (GEL 20 a month), but still only slightly above the official subsistence minimum of GEL 103 (about €40 or \$60). Doctors who have been re-trained and are contracted within the framework of reformed PHC centres (so-called family medicine centres) with re-trained family doctors are paid GEL 280 (about €135 or \$170) a month.⁴²

Currently, state programmes determine the cost of services to be reimbursed to medical facilities. However, managers of medical institutions still blame state programmes for

low health-worker salaries, and pay their own staff very little. Furthermore, state programmes do not provide any incentives for medical staff to update their skills or develop professional networks to share best practice. Several cases are reported where poor remuneration led to health workers demanding out-of-pocket payments from patients, which is a heavy burden for poor people.

5 Health-care financing and expenditure

According to WHO statistics,⁴³ total expenditure on health in Georgia as a percentage of GDP, at 8.6 per cent in 2005, is comparable to the European average. But the role of the state in the health sector has been severely weakened since the 1990s, and more than three-quarters of total expenditure on health in Georgia is now private expenditure (see Table 2 below).

A study by the Genesis Association revealed that in 2007, the MoLHSA's budget for health-care programmes was about GEL 167 million (about €65 million or \$95 million). This is only about GEL 39 (€14 or \$22) per person per year for all health-care services subsidised by the state, including in-hospital, outpatient, public health and other specialised services.⁴⁴

Government expenditure on health still too low

Health-care financing is not heavily dependent on donor funds; for example, in 2006, only 5.2 per cent of health funds came from donors. Compared with 2002, the importance of donor funds for health spending has decreased significantly (see Table 2).

Table 2: Trends in health expenditure in Georgia 2001–06 (\$ and %)

National Health Accounts (WHO 2007)	2001	2002	2003	2004	2005	2006
GDP (\$m)	3219,4	3395,7	3991,5	5125,9	6410,9	7747,1
Total health expenditure (\$m)	251,6	296,3	337,8	436,2	550,7	651,4
Public health expenditure (\$m)	45,3	48,5	40,5	67,2	107,5	140,5
Private health expenditure (\$m)	184	211,9	262,2	342	427,7	477,1
Donor aid (\$m)	22,4	36	25,2	27	15,6	33,8
Total expenditure on health (THE) % GDP	7,8	8,7	8,5	8,5	8,6	8,4
General government expenditure on health (GGHE) % THE	18	16,4	14,9	15,4	19,5	21,6
Private expenditure on health (PvtHE) % THE	73,1	71,5	77,6	78,4	77,7	73,2
GGHE % General government expenditure	7,6	7,6	7,7	5,3	5,9	5,6
State United Social Insurance Fund	43	46,2	64,3	62,8	45,5	51,4

(SUSIF) expenditure on health % GGHE						
Out-of-pocket spending on health (OOPs) % PvtHE	98,7	99,4	99,5	99	99	98,5
Private prepaid plans expenditure on health % PvtHE	1,3	0,6	0,5	1,0	1,0	1,5
Externally funded expenditure on health % THE	8,9	12,1	7,4	6,2	2,8	5,2

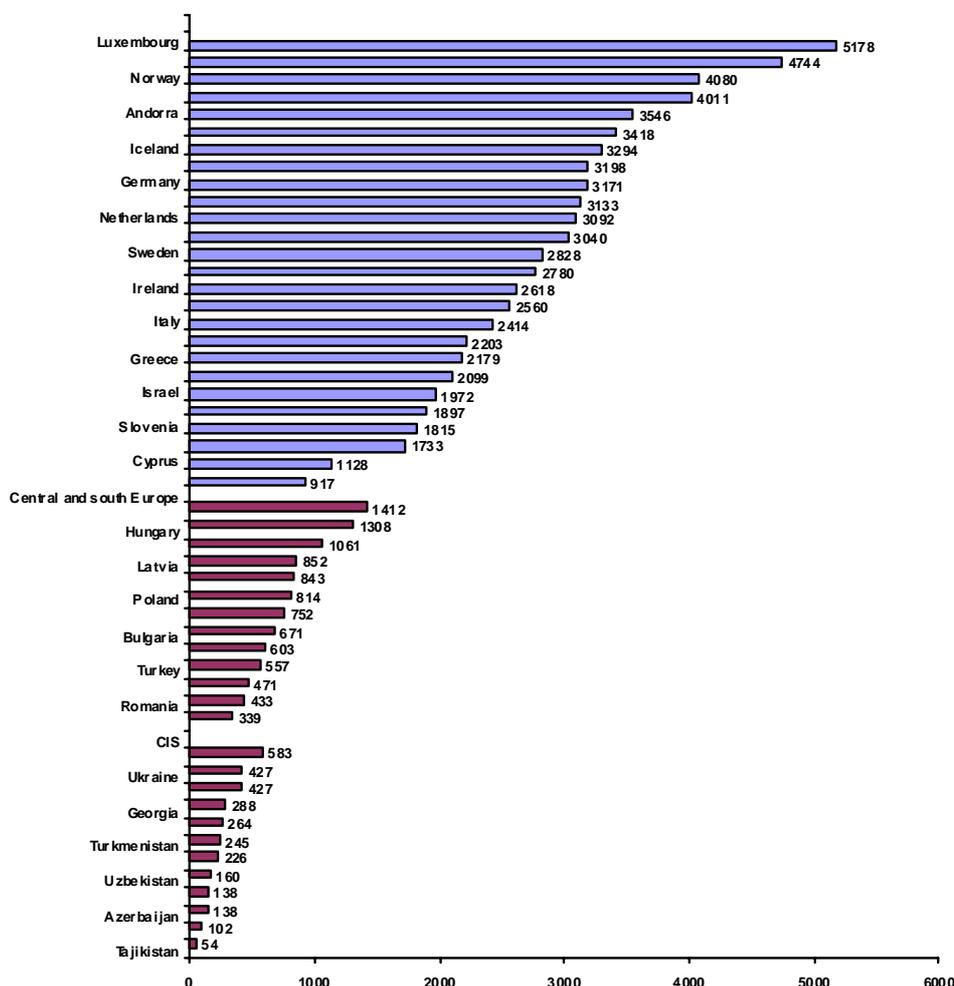
Source: WHO (2007), *National Health Accounts, Georgia*

During the economic crisis in the 1990s, Georgia saw a catastrophic fall in public health expenditures to less than \$1 per capita.⁴⁵ According to WHO National Health Accounts, **government expenditure on health** as a percentage of total health expenditure has increased recently, from 15.4 per cent in 2004 to 21.6 per cent in 2006 (see Table 2). However, this is still low when compared with the European region average, which stands at 74.3 per cent (for 2005).⁴⁶

Only 5.6 per cent of **general government expenditure** was going to the health sector in 2006 (see Table 2), compared with 14.7 per cent in 2005 within the WHO European region.⁴⁷ The result is that government levels of financing are still far below those required to provide basic health care to the people and maintain fully functioning health facilities.

Table 3 (later in this report) presents health-care expenditure in \$ purchasing power parity (PPP) per capita in the WHO European region in 2004. And Figure 6 shows that in Georgia, allocations for health are well below the average of countries of the former Soviet Union.

Figure 6: Health-care expenditure in \$ purchasing power parity (PPP) per capita in the WHO European region, 2004



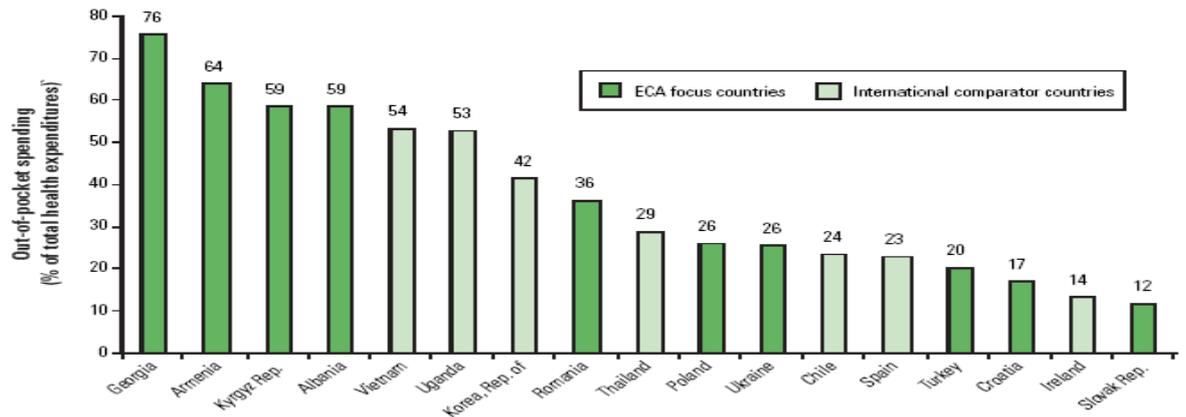
Source: Health for All database (HFA-DB), Copenhagen, WHO Regional Office for Europe, www.euro.who.int/hfad

Out-of-pocket payments

As already stated, the Georgian government's failure to allocate sufficient finances to the health sector has resulted in a dramatic increase in the role of private expenditures, which in 2006 accounted for 73.2 per cent of total health financing (see Table 2). These are represented mainly by out-of-pocket payments.⁴⁸ Though public health expenditures have nominally increased 60 times in the last 15 years, the share of out-of-pocket payments has only slightly changed and remains extremely high – from 1993 to 1995, they amounted to 84 per cent of total health expenditure, compared to 72 per cent in 2006. Figure 7 below shows the share of out-of-pocket payments as a percentage of total health spending in European and Central Asian countries and comparator countries in 2004.

Figure 7

Out-of-Pocket Spending as a Percentage of Total Health Expenditures, 2004 or Latest Year Available



Sources: World Health Organization European Health for All Database and World Health Statistics 2006.

Medicines, co-payments and informal user fees

The most important out-of-pocket expenditure burden for households is the cost of buying medicines. Resources spent on medicines and medical supplies amounted to 37 per cent of total health expenditure in 2006 (see Table 3 below). Other significant out-of-pocket expenditures are **co-payments** (or cost-sharing), **direct payments** to service providers, and **informal user fees** (payments in cash or in kind made direct to individual or institutional health-care providers that are outside official payment channels).

Government policy is to fund most health services to at least 75–80 per cent. This means that service users should co-pay 20–25 per cent of service costs at the point of use. Medical institutions – PHC centres, health centres, polyclinics, diagnostic centres, and hospitals – have set rates for services that are not covered by state funding. This priced list of services is called ‘internal standards’. Prices for additional services differ from provider to provider and are mainly based on the perceived purchasing ability of the population being served.

The State Programme for Inpatient Care is just one of the programmes that operates in great deficit. It covers only about 50–75 per cent of hospital emergency cases and referrals to tertiary care. Effectively, the state purchaser is reimbursing the claimed services up to the 15th–20th of each month. If people fall ill and require emergency treatment in the last 10–15 days of the month, they have to pay themselves.

Table 3: Trends in health expenditure by service categories as a percentage of total health expenditure, 2001–06⁴⁹

	2001	2002	2003	2004	2005	2006
Inpatient care	27%	23%	24%	25%	23%	23%
Daycare services	0,2%	0,2%	0,2%	0,2%	1%	1%
Outpatient care	19%	16%	16%	17%	17%	17%
Home care	0,4%	0,3%	0,3%	0,4%	0,3%	0,4%
Rehabilitation care	0,3%	0,2%	0,4%	0,1%	0,2%	0,2%
Ancillary services	8%	8%	8%	8%	10%	11%
Medical goods	37%	39%	44%	43%	40%	37%
Total expenditure on personal care	91%	87%	93%	93%	91%	89%
Prevention and public health services	2%	3%	2%	2%	2%	1%
Health administration and health insurance	1%	1%	1%	3%	3%	3%
Other	6%	9%	4%	2%	4%	7%

Source: WHO National Health Accounts 2007

6 Health policy and planning

Health-care policy

Since independence from the former Soviet Union in 1991, the health sector has been through a number of different policy directions. First, in the mid-1990s, came the move to decentralise health care and develop a health insurance system, funded by a \$14 million package from the World Bank.⁵⁰ This involved a state basic benefit package (BBP) providing limited services that were either free or subsidised. However, most people were unaware of their new rights, so continued to pay informal fees charged by medical staff at the point of use.

More recently, health policy has been almost completely overhauled, from a publicly owned system aiming to provide universal access to good-quality basic medical care, to one that has been brought into line with a national economic policy based on privatisation of public services. This represents one of the biggest problems with health policy: reforms initiated under different governments have been inconsistent, often contradictory, and not evidence-based.

Part of the problem is that the Ministry of Labour, Health and Social Affairs (MoLHSA) has had a limited impact on the overall direction of policy, which has recently been driven by other ministries (such as finance or economy) or individuals. (For instance, in autumn 2006, the Prime Minister of Georgia asked the State Minister in charge of public reforms to lead on developing a new health reform strategy.) The government believes that private solutions can deliver the improvements needed in the health-care system. As one official stated: *'The state-funded health system has failed for so many years. Now it is up to the market to resolve the problems.'* (1 April 2008)

Another issue is that privatisation of the health sector has been carried out without proper consultation with civil-society groups, donors, and other stakeholders. There are concerns that the new policy will mean that poor people in areas that are hard to reach will not have access to health care, either because services will not extend to their communities or because they cannot afford to pay.

MoLHSA's limited policy space

The MoLHSA and its implementing agencies are in charge of basic health legislation, oversight of the system, and quality and equity of health services. It is responsible for defining the benefit package, provided by the state health programmes, as well as human resource development. The health budget and composition of the benefit package has to be approved by the Ministry of Finance, the Cabinet and Parliament.

As previously mentioned, the MoLHSA's mandate is limited, particularly with regard to direct service provision, purchasing, and some aspects of regulation. Its limited role feeds public perceptions that it is unaccountable and unresponsive.

In December 2005, local/municipal governments acquired very limited responsibility and resources for health, mainly focusing on promoting healthy lifestyles, and prevention of disease. However, some regional governments, for example in Adjara, run programmes that provide financial support to the poor.

The Health and Social Programmes Agency (HSPA), affiliated to the Ministry, is responsible for purchasing. Up until now, the HSPA has acted more as a claim administrator rather than a purchaser. In practice, most services are purchased at the point of use – in many cases, through out-of-pocket payments from patients. Other organisations coming under the MoLHSA are:

- The Medical Service Provision Regulation Agency, responsible for issuing licences and permits for health-care facilities, and certification of medical professionals. It also investigates patients' complaints regarding quality of care.
- The Drug Agency, responsible for implementation of state drug policy. Its main task is ensuring that pharmaceutical products registered in Georgia meet the criteria for quality, safety and efficacy, and that all pharmacies comply with established standards.
- The National Center for Disease Control and Public Health (NCDCPH), responsible for public health, including immunisation, surveillance, disease prevention, health promotion, and the laboratory system for health and veterinary services.
- The Health and Social Programme Implementation Center, responsible for the implementation of the state programme for health infrastructure development, together with the administration of the projects funded by the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and the EU.

Reforming primary health care – PHC Master Plan I 2004–06

From 2004 to 2006, the PHC Master Plan I provided the framework for reform. Funded by the World Bank, the EU and the UK Department for International Development (DFID), and developed in consultation with key stakeholders, it aimed to provide universal access to quality basic medical care through a publicly owned and managed system. It was based on the principle that no one would be more than 15 minutes away from a PHC centre. It also included plans to re-train all medical staff delivering PHC, and to rehabilitate facilities.

It was assumed that financing for PHC would in the short term be covered through the state budget and by service fees, while slowly moving towards a fixed per-person tax system.

Shift towards privatisation in the health sector

However, in 2006, the government decided to reassess this plan, arguing that it was too expensive and ambitious – for instance, the promise of '15-minute access' was considered unrealistic, given that many people live in mountain regions where roads are poor.

The government decided to embark on a major privatisation programme for health services, bringing health policy in line with the broader national economic policy to promote greater private-sector involvement. Privatisation of some health services like pharmacies, dental clinics, hospitals and PHC centres had already begun in the 1990s, but despite this, the great majority of service providers were public entities until 2007. Even facilities that were privatised in the 1990s were independent legal entities without their own property, as the state owned all assets.

In fact, the government sees privatisation of public services as a necessary precondition for successful reform, and for overcoming the constraints of public financing: *'The government has its arguments for choosing this model. The main reason is that the government does not have sufficient funds to operate the public system well.'* (Statement by an official working in the Georgian health administration, 2 April 2008)

This dramatic policy change was implemented with minimal consultation with civil-society groups, donors, or other stakeholders. It prompted concerns from donors like the European Commission that their recent investments will be undermined. *'The European Commission to Georgia and Armenia has invested significantly in primary health care services in recent years, and is appropriately concerned about the fate of its newly trained medical personnel and renovated facilities. Ownership of the newly renovated facilities and management of primary healthcare services are of less concern to the European donors than the familiar question of*

*whether or not the new infrastructure will retain a healthcare-related function in the long-term future.*⁵¹

In January 2007, the MoLHSA, together with the State Minister's office, presented the new strategy, the *Main Directions in Health 2007–2009*.⁵² The new strategy set out four main objectives:

- to ensure overall affordability of basic health services and protect the population from catastrophic financial health risks
- to ensure quality of care by creating a sound regulatory environment
- to ensure greater access to quality medical care by continuous development of medical infrastructure and competent human resources
- to increase efficiency in the health system by building advanced management systems and capacity in the Ministry and institutions under its structure.

The aim of ensuring greater access is to be achieved through development of the hospital and PHC sectors. While privatisation measures were not explicitly mentioned in the strategy, the trend in health-care policy indicated that the private sector plays an important role in achieving these objectives.

PHC Master Plan II 2007–10

The government developed a new master plan, which aims to introduce a private PHC system, based on insurance. It is important to note that the plan has not been adopted. However, it provides a major guideline for reform. The plan proposes to strengthen the role of the Ministry as regulator and policy-maker, thereby improving efficiency, effectiveness and quality of the health system.⁵³ It differentiates between urban and rural models of PHC, with about 900 PHC facilities in rural areas and an unlimited number in cities and regional/district centres, all of which are to be privatised. It includes provision for state investment in rural/mountainous areas, where the private sector would be unlikely to provide adequate coverage.

The state aims to fund the full package of PHC services for the poorest people (all those living below the poverty line, as defined by the state). The government has started to do this in two geographical areas, and has said it wants to extend this gradually to completely cover all those living below the poverty line.

In 2007, a pilot programme began to be implemented, subsidising health insurance for people below the poverty level. It included all types of services, PHC as well as hospital, but did not cover expenses for pharmaceuticals. The plan envisaged that government stops financing PHC for the rest of the population at the end of a transition period, with private insurance companies replacing some of the core functions of the state's HSPA. In 2009, the government has introduced an insurance package for the whole population (so-called 'cheap insurance scheme'). It covers a certain package of outpatient services, which people are expected to buy.

Hospital-sector reform

Another important element of the privatisation process is the reform of the hospital sector through a Master Plan and Investment Programme. In January 2007, the Hospital Master Plan was enacted by the government, with the aim of providing high-quality and affordable hospital services. The government approved complete substitution of existing hospital infrastructure for new hospitals over a three-year period (2007–09) in which ownership would be transferred from the state to the private sector. The Master Plan determines total hospital-sector capacity (7,800 beds country-wide), location of inpatient facilities (based on the principle of 45-minute access), number of hospital beds per facility (based on the population's health needs), types of hospital services and, finally,

conditions for the operation of hospitals (e.g. minimum standards for physical infrastructure and equipment).⁵⁴

The Investment Programme has no fiscal implications – that is, the state receives no financial dividends from privatisation of hospital-sector assets, but all investments have to be poured in to the hospital sector. Investors get existing hospitals with attached land in the capital, Tbilisi, or regional centres, and provide a certain number of beds, according to the Master Plan and tender conditions. Investors own the hospitals they build and are obliged to keep the profile for at least seven years. The incentive for investors is the value of the development land on which existing hospitals are built, which is perceived to be greater than the cost of building new hospitals on greenfield sites on less valuable real estate.

However, some investors have remained behind schedule. There is growing evidence that the plan is failing.

The government's health priorities 2008–2012

In March 2008, the Georgian Health Minister announced the government's priorities until 2012, as part of the framework of the Programme of the Government of Georgia 2008–2012, 'United Georgia without Poverty'. There are three strategic objectives that aim to strengthen the health sector.⁵⁵

- **Objective 1:** Increase the well-being of the population through developing a more efficient social security network and improving the health of the nation.

As part of this objective, the government plans, among other things, to develop a Strategic Plan for Human Resource Development 2009–2020, addressing the needs of doctors, nurses, public health-care practitioners and health-care managers. In co-operation with the Ministry of Education and Science, there will be reforms to the undergraduate and postgraduate medical education sector.

- **Objective 2:** Ensure national security through minimising public health problems and threats and through creating a healthy environment for ensuring the well-being of the population.
- **Objective 3:** Strengthen the capacity of the Ministry (MoLHSA) and affiliated agencies to achieve better efficiency, effectiveness and responsiveness to the challenges related to access to quality health services by the Georgian population.

As part of this objective the government is planning, among other interventions, to:

- develop/modify national legislation to respond to the challenges and create an adequate legal environment for planned reforms
- strengthen the stewardship function of the MoLHSA to guide developments in the health and social sectors in order to serve the public interest, contributing to economic growth and promoting public-private partnership.

It is important to note, though, that these priorities and plans may not be fully implemented, as they are not legally underpinned.

7 Major concerns about the privatisation of health care

The private health insurance system

A big part of the government's privatisation plans involves the introduction of private health insurance schemes nationwide. Nowadays, health insurance companies are purchasing health care services for individuals below the poverty line. The estimated number of health insurance beneficiaries is 750,838 (January, 2009).⁵⁶

How to help those who are poor, but not poor enough

The private health insurance system is expected to exclude large numbers of people who are living in poverty. By April 2008, people classed as living below the poverty line (scoring less than 70,000 points on the poverty scale) received free health insurance within a state-funded programme. But a large part of the population score between 70,000 and 200,000 on this scale. This group is neither poor enough to receive free medical care, nor rich enough to afford out-of-pocket payments (in case of serious illness) or the premium of private health insurance (for less serious illnesses). An employee of a Georgian insurance company pointed out that: *'The decision to set up 70,000 points as the ceiling for receiving vouchers is a political decision. It is not based on the needs of the population. Many more people need subsidisation.'* (1 April 2008). One Georgian politician said: *'In the current situation, it is better to be a bit poorer.'* (4 April 2008)

Coverage

The government acknowledges that there is a problem with coverage of the scheme and is considering how to extend it. Options include complementary social insurance schemes for public employees such as teachers and government staff.

However, coverage does not automatically mean adequate access. A big limitation of the private insurance schemes on offer is that they only cover a limited range of costs, and medicines are excluded (although in-patient services do cover some medicines). The government realised, at the time of developing the benefits package, that it could not include medicines in the short term because of the substantial cost involved (representing over 40 per cent of total health expenditure). In fact, the problem of high out-of-pocket expenditures remains unresolved. Lack of (administrative) capacity/skills among insurance companies was also a factor.

It is unlikely that the current benefit package will be widened. The insurance companies are already dissatisfied with the premium provided by the government to insure the poorest group (those scoring less than 70,000 points), arguing that it is based on inaccurate statistics on health utilisation. It has been reported that since people have become insured through the state-funded insurance programme, the health service utilisation rate has increased significantly.

The costs of medical services are also expected to increase due to new technologies in the modernised hospitals. The insurance companies are worried that increasing costs will threaten the financial sustainability of the state-funded health insurance programme. Their concerns have proven to be well founded, as there have been cases where private insurance companies have failed to reimburse hospitals for services provided.

They are also concerned that administrative costs will increase under the new system (compared to when the HSPA administered the funds). An employee of a Georgian insurance company stated: *'If the prices will continue to increase, the state has two options. The*

first one is to stop the purchase of insurance, and the second one is to increase the insurance premium.' (2 April 2008). For the time being, many insurance companies view the current reforms as a danger for their business: *'The current reform is not effective. The government moves losses to the insurance companies. This could destroy the insurance industry, since business is not considered as profitable.'* (2 April 2008)

During our research, Oxfam interviewed representatives from insurance companies, donors and civil-society groups who were concerned that large groups of poor people would be excluded from the private health insurance schemes. Some of those interviewed expressed the view that it would be better to create (public) social health insurance for the whole population instead, as the current system clearly hinders universal access to health care.

Privatisation has created monopolies

One of the major concerns about privatisation is the issue of ownership of facilities. Because the regulatory environment was not shaped before the reforms took place, interested companies were able to establish monopolies in particular areas. Large, state-owned hospitals were mostly bought up by a limited number of private interests, including banks, pharmaceutical companies and insurance companies. The terms of the sales were not transparent and it remains unclear what investments these companies will make in the hospitals and what quality standards they are required to adhere to.

The role of pharmaceutical companies

Pharmaceutical companies are very powerful players in the health-care sector in Georgia, and they might become more powerful in the course of privatisation. Often, companies bought hospitals and later resold them to other investors, but in some regions, they now own all or most of the privatised facilities, effectively creating a monopoly. As well as selling medicines produced by international pharmaceutical companies, they have set up their own manufacturing facilities where they claim they produce high-quality medicines. It is expected that those pharmaceutical companies who own hospitals may limit competition and sell their own drugs to patients, whether or not these are appropriate to treat the patients' conditions. Pharmaceutical companies are also developing their own clinical guidelines, which the doctors working in hospitals they own will be required to follow. However, these guidelines do not necessarily comply with international clinical guidelines.

The main reason for high expenditure on medicines can be seen in the monopolisation of the pharmaceuticals market, which is one of the fastest-growing markets in Georgia. The import volume has grown dramatically from an industry valued at \$9m in 1996 to one valued at \$83m (about €60m) in 2004.⁵⁷ Branded drugs account for half of this increase. From 1997 to 2004, the number of commercial importers fell from 187 officially registered wholesale companies to just 13. Today, the pharmaceuticals market is controlled by three big companies. Government policy calls for further development of the pharmaceuticals industry. Currently, the industry has approximately 2 per cent of market share, with main reliance on imported pharmaceuticals.

There are concerns that a number of practices linked to privatisation will affect the quality of care. Cheaper or lower quality devices may be used, as private insurance companies and providers try to cut costs. There may also be a two-tier service, where those who receive subsidised care because they are poor end up receiving lower-quality care. One doctor reported a situation where, in a maternity home, people paying privately received a better service than people covered by a voucher from the state scheme (2 April 2008). Moreover, insurance companies fear the creation of a health facility monopoly owned by pharmaceutical companies, as this could dramatically reduce their bargaining power to set affordable prices.

An ad-hoc approach

Current reforms follow a step-by-step approach, with action first and planning later. As a result, adequate measures for supervision, regulation and human resource development have not been properly elaborated. This clearly constitutes a huge risk: *'Privatisation of PHC has to be accompanied by regulation as in general the private sector is income-oriented and will try to spend as little as possible for the greatest profit, whereas the interest of the government is to have a healthy population.'* (Statement by an official working in the Georgian health administration, 3 April 2008). A donor official said: *'The state has currently not the capacity to regulate effectively.'* (3 April 2008)

Lack of consultation, transparency and information

Many stakeholders (the general public, health professionals, health insurance companies, donors and non-government organisations (NGOs)) stated that they have not been properly consulted about proposed reforms; decision-making processes lack transparency; and stakeholders do not have access to reliable information (for instance, at the time of writing, there was still a lack of information about the number of hospitals and PHC facilities that have been privatised, and who now owns them). Civil-society organisations (CSOs) consider that the root cause of many problems with health reform in Georgia is the lack of a strategic vision – there is no clearly written strategic plan. And there is very limited involvement by CSOs, NGOs or other stakeholders in planning and decision-making.

Lack of transparency has other consequences too. Although there is a public tender process, agreements between private companies and the state only come into the public domain once contracts have been signed.

There are also concerns about adequate regulation and adherence to guidelines on clinical quality and other standards. Although the government is now putting in place some regulatory measures, many consider them to be too little, too late.

One further problem is that the objectives announced by the Minister of Health are not legally underpinned. The MoLHSA, as well as the Parliamentary Health Committee, have been inconsistent in their activities. They have taken decisions without any public consultation whatsoever, and many of these decisions have been reversed immediately following the start of their implementation.

NGOs and CSOs are beginning to get involved in advocacy work on health. The Future without Poverty coalition has set up a health focus group to monitor implementation of the reforms and their impact on the poorest sectors of society. Political instability and the shifting balance of power between ministries and key individuals has contributed to the problems, as they lead to frequent and major changes in the direction of health reform. It is also difficult for CSOs, NGOs and others to monitor the impact of reforms without having access to documentation that sets out their objectives and measurable indicators of achievement.

8 Conclusions and challenges

Our research revealed the following challenges facing health-care reform in Georgia:

1. How to ensure universal access to services within the private health insurance context.
2. How to ensure quality of care.
3. How to ensure meaningful civil-society participation.

Through our discussions with CSOs, NGOs and other stakeholders, Oxfam identified several strategies that should be prioritised to address these challenges.

1. How to ensure universal access to services within the private health insurance context

CSOs have a key role to play. They should:

- document cases of exclusion of the poorest people and present evidence about these to the government
- gather examples of good practice from the field with regard to access to services and to medicines specifically, and present these to the government
- get involved in monitoring the way beneficiaries for the state-funded insurance programme are selected, with the aim of ensuring that the process is fair and transparent.

The government of Georgia should:

- establish a plan (including a timeframe) to provide access to health care for people who cannot afford private insurance. This includes: people officially registered as being under the poverty line; those who are officially registered but not covered yet by the state-funded private insurance programme; and those who are not registered but cannot afford to buy private insurance
- develop comprehensive policies to assess and address the risks inherent in private health insurance systems. There must be adequate regulation of the insurance industry to prevent insurance companies taking on only healthier and low-risk clients
- invest adequately in preventive services (which the insurance companies are likely to be less interested in)
- ensure access for all to at least a basic benefit package, which should include essential medicines.

2. How to ensure quality of care in the privatised context

CSOs and NGOs should:

- provide the government with information from the field on the quality of care being provided and clearly express their concerns about the consequences of reforms
- collaborate with and promote the active role of professional associations, and request government to support them.

The government of Georgia should:

- establish quality standards for primary, secondary and tertiary care (including compliance with internationally and nationally accepted clinical guidelines and

protocols). These standards should apply to all medical facilities, irrespective of ownership. The government should enforce and monitor compliance with those guidelines

- ensure adequate and regular training of medical staff
- ensure regular monitoring of providers through an independent institute. Monitoring and evaluation data should be processed in a statistical database, which can serve to better compare and measure results and performance
- ensure that monitoring and evaluation data and reports are made available to the public and other stakeholders in order to promote greater accountability for the service being provided.

3. How to ensure meaningful civil-society participation in a situation of constant reform

We have already stated that there is a lack of information available to CSOs and others. But there is also insufficient communication from civil society to the government. So far, CSOs have not had enough power to engage with the government and have lacked the political space to do so. The media has shown little interest in voicing public opinion about the state of health care in the country and the government's reforms.

CSOs and NGOs should:

- develop an assertive strategy to communicate the information and knowledge they have to the government and to the public, building stronger links with the media.

The government of Georgia should:

- develop a clear and accessible strategy and mechanisms for meaningful civil-society engagement in planning and decision-making processes. This strategy should be developed in consultation with civil society
- enable meaningful engagement by CSOs by presenting drafts of policy proposals for public discussion in good time, so that proper discussions can take place.

The way forward – building the links for effective advocacy work

Since the reforms of the health sector are still in the early stages, there is an opportunity for CSOs, NGOs and other stakeholders to engage with the government on selected issues. The government has expressed willingness to work on a strategy towards broader access (acknowledging that current coverage is insufficient); less is known about the government's genuine willingness to work on regulation (recognising the need to improve quality of care, and mindful of some of the risks inherent in a privatised system). CSOs should find ways to actively and constructively engage with the government to improve the two-way flow of information and enable each other to work toward their common goal: access to quality, affordable health services for poor people.

Potential targets and allies

The main targets for future advocacy work on health include: the government, the Parliamentary Health Committee, the MoLHSA, the HSPA, pharmaceutical companies and insurance companies.

Potential allies include CSOs and NGOs (including the Future without Poverty coalition), medical associations, local health authorities and local communities. Some of the health insurance companies could also be allies, as many of them have identified the same problems with the current system.

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Notes

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This paper was written by Tobias Hauschild and Esmé Berkhout with contributions from Tata Chanturidze, David Dzebisashvili, Simon Gabrichidze, David Gogolishvili, Ketii Getiashvili, Irakli Katsitadze, Maia Magolishvili-Ryan, Nancy Holden, and Alessia Bertelli. The views expressed in the text and its conclusions are those of the authors only. The authors take responsibility for any errors herein.

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This paper was written by Tobias Hauschild (essential services policy advisor at Oxfam Germany) and Esmé Berkhout (health policy adviser at Oxfam Novib), with contributions from Tata Chanturidze, David Dzebisashvili, David Gogolishvili, Ketii Getiashvili, Irakli Katsitadze, Maia Magolishvili-Ryan, Nancy Holden, and Alessia Bertelli. This report is based on a fact-finding mission undertaken in April 2008 by Oxfam International in collaboration with the Genesis Association and the Welfare Foundation. Oxfam acknowledges the assistance of Tata Chanturidze in providing the desk research for the report. It is part of a series of research reports written to inform public debate on development and humanitarian policy issues.

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