

HEALTH CARE POLICY IN GEORGIA: REFORMS, PRIORITIES AND FUTURE DIRECTION

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Abstract

The majority of developed countries and several developing countries have created, and are regularly updating, their national health policies. This is especially important for social and economic development. In Georgia, as in other developing countries, the main objective of the health reform process is a comprehensive policy. It is based on the main priorities of the nation's health problems, and targets specific areas to be addressed and corrected over several years.

Key words: *health policy; health reform; Georgia; socioeconomic transition; market economy*

INTRODUCTION

Demographics and geography

The country of Georgia is located on the ancient Silk Road between Europe and Asia, between 40° and 47° longitude east and 41° and 44° latitude north, to the south of the Caucasus Mountains and along the southern slopes. The Georgian Republic occupies an area of 69,700 sq km (about 26,900 miles) in the middle of the Caucasian region. Georgia is surrounded by the high mountain ranges of Caucasus along its northern border with Russia, and Turkish highlands along its southern borders, Black Sea to the west and high plateaus to the east, along the border with Azerbaijan (Verulava and Kalandadze 2001).

Georgia's population is approximately 4.4 million and a gross national income (GNI) per capita of \$4,770. The country is strategically located between Europe and Asia and is rich in natural resources. 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 (Hauschild and Berkhout 2009).

Georgia is a democratic state with a republican form of government, under the rule of the President of Georgia, the Parliament of Georgia, and the courts of Georgia. The President of Georgia is the head of the state. Georgia is constitutionally composed of three branches of government: Executive, Judiciary and Legislative, all have separate powers from each other. The Parliament of Georgia is the country's highest representative body, executing the legislative power (Verulava and Kalandadze 2001).

History of healthcare in Georgia

In 1921, Georgia was incorporated into the Union of Soviet Socialist Republics (USSR), where it remained for 70 years. From 1921 to 1991, the Georgian health system was part of the Soviet system. The "Basic Law on Health in the USSR and Soviet Republics", also known as the Semashko model, provided the framework for each Soviet republic

and was characterized by almost complete public ownership of healthcare services (Gamkrelidze et al. 2002).

Planning, organization, control and allocation of nearly all resources were undertaken in Moscow, while few responsibilities were delegated to the Georgian health authorities. Healthcare was meant to be free at the point of delivery, but illegal out-of-pocket payments to health professionals were also common. Hospitals dominated the delivery system, with high bed numbers and very large numbers of medical personnel (Gamkrelidze et al. 2002).

The physical condition of facilities severely deteriorated, as did medical technology and equipment. That is why, since independence in 1991, the nation has had to reestablish itself and reform many of its governmental structures, including its health care system. Georgia has made a significant effort to adapt health policy and the health system to the new environment. A mandatory social health insurance was introduced after independence, but was abolished after the 2003–2004 Rose Revolution, which brought about fundamental change in the role of government in providing, financing, and managing public services like healthcare (Chanturidze et al. 2009). At present, healthcare and health insurance are privatized (Gamkrelidze et al. 2002).

Democracy and a market economy

Georgia is in a period of socioeconomic transition from a managed economy to the principles of a market economy. In most countries in such transition, the health indicators show a dramatic deterioration. According to the morbidity statistics, cardiovascular diseases, malignant neoplasms, and accidents are the primary health problems in Georgia, as in most post-socialist countries. At the same time, infectious diseases are widespread (WHO 2009).

Transition from a socialist system to a market economy was the cause of an economic recession and decline in real gross domestic product (GDP) throughout the Former Soviet Union (FSU) countries. Changes in the method of tax collection and a reduction in the size of the state sector have further diminished the tax base, which has resulted in significant reductions in public revenues (Georgia Article IV Consultation 2013).

In 1991, Georgia emerged as an independent former Soviet state and it experienced economic collapse and civil war. During this rapid transition from a centralized, planned economy to a free market one, economic security and wealth quickly gave way to poverty, unemployment and unrest. Almost instantly, Georgia lost any budget assistance and its preferential access to former Soviet Union markets, and the economy instantaneously collapsed.

Recently, Georgia has moved away from a state funded and input based financing model to a purchaser-provider split, incorporating a greater use of market mechanisms. Initially, the majority of health care expenses were to be funded through payroll taxes complemented by general and municipal budgets. However, due to a high unemployment rate, a large and growing informal sector, poor fiscal performance and low level of budget revenues undermined government intentions in this respect (Gotsadze et al. 2005c).

The period of 1992–1996 showed a sharp decline in Georgia's economy, which resulted in the deepest economic dive among all FSU countries. In 1995, in response to the economic crisis that brought public expenditures for health to a level of less than US\$ 1 per capita, the government launched an ambitious health sector reform program and introduced a new model for health care financing, combining social insurance, tax revenues and out of pocket payments. Health services are offered through a publicly financed primary care network and the state also finances "essential" hospital care (Jorbenadze et al. 1999). The constitutional guarantee to free health care was removed in 1995, and user fees were allowed formally either to co-finance services in the publicly financed benefit package or to pay for services not covered by public programs (Gotsadze et al. 2005a).

The main principles of health care reform since 2006 have been to make the transition towards complete capitalization of the health sector: private provision, private purchasing, liberal regulation and minimum supervision. The basis for these decisions was rooted in the country's economic policy, which was to ensure economic growth based on liberalization and private sector development. Mandatory social health insurance, which was introduced in the 1990s, was abolished and

private health insurance has been promoted as its replacement. The population living below the poverty line is issued health vouchers for the private insurers of their choice and the state then contracts with the insurer, purchasing a cover package with public funds. The population living above the poverty line is expected to purchase its own cover voluntarily or pay out of pocket for services. With a view to boosting pre-payment for this population, the government developed some limited private insurance packages which were subsidized by the state and promoted as affordable cover (Chanturidze et al. 2009).

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 conflict involving Georgian, Russian, and South Ossetian soldiers, forcing thousands of people to flee their homes (Hauschild and Berkhout 2009).

In 2007, the government introduced a rapid and extensive program of privatization of public services, including health care. The rationale was that the free market will solve existing problems, including inefficiencies in cost, access, availability, equitable distribution and quality of care. This newly established universal healthcare system will cover around 2.5 million previously uninsured individuals and it will cost around 1 percent of GDP. Since March 2013, emergency health care has been made free of charge for in-patient and out-patient services. From July onwards, individuals previously not covered by state insurance programs benefited from non-emergency services without having to contribute to the insurance scheme. A newly created Social Service Agency negotiates rates and procedures and reimburses medical providers. Most medical services have a substantial co-pay, which could leave a market for existing private insurance companies. Under the basic scheme, most drugs are not covered, but could be added in the future, together with additional medical procedures. From May 2014 onwards, the Social Service Agency will cover individuals previously covered by state programs whose insurance was operated by private companies. While substantial savings are expected from centralized purchases and negotiations, the

reform plans are estimated to add 1 percent of GDP per year to existing health costs, making health the largest reform area (Georgia Article IV Consultation 2013).

The Ministry of Labour, Health and Social Affairs (MoLHSA) remains the key strategic health decision-maker. The Georgian National Health Care Strategy for 2011–2015 was launched in November 2011. As the current Government has chosen a different approach of moving towards UHC, there has been a plan to elaborate a new National Health Sector Development Strategy and Operational Plan in the coming months (Country Cooperation Strategy 2013).

Healthcare reform

Healthcare reform is understood as planned changes toward the organization, financing, provision, and regulation of public/private mix for more accessible, efficient, cost effective, fair and quality healthcare goods and services. Clarity and certainty are key features for the success of this endeavor, and State policies should be unambiguous and explicit. Because the issues implicated are complex and many vested interests are involved, conceptual and practical frameworks aiming at renovated, more efficient and effective healthcare will guide the process of reform.

The reform of the Georgian health system was developed during the period from 2006 until today. It was an integral part of the reform process and proceeded from its goals and strategies including development of a democratic society and establishment of corresponding relations in the shortest period of time with minimal losses. These frameworks should consider the roles of the State at all levels, central, regional, and local (Dzhakeli et al. 2009).

It is hard to find a country where the government is not carrying out health reforms. The continuing increase in health costs due to the use of high technology has resulted in the failure of governments to fulfill their responsibilities in health. This is due to the fact that the governments try to balance between social responsibility and equal access to health services on one hand, and simultaneously try to decrease health expenditures. In this respect, Georgia is no exception. According to the WHO Global Health for All policy, disease prevention,

treatment, rehabilitation and care of people with disabilities are elements of a constantly developing strategy. The goal of improved health is to provide all citizens with protection of their right to be healthy, to live in a healthy environment, and to avoid disease and injury (WHO 2009).

Healthcare reforms are complex and multidimensional endeavors. Partial reforms have limited impact or influence on the whole and may create systemic distortions when not followed by simultaneous changes in reforming delivery and management, and the institutional and legal foundations of the healthcare system.

Concurrent changes should include amendments in the rule of law, governance, transparency and accountability; in organizational and institutional development; in corporate development; and in the availability and quality of credit. Partial financial reforms often result in deteriorating public healthcare, in the emergence of largely unregulated private healthcare, and on increasing formal and informal out-of-pocket payments (Belli et al. 2004).

While government health spending as a share of GDP is low in Georgia, total health spending is quite high. The agreed plan of health care reform could help reduce Georgia's very high private health costs and improve health outcomes. The proposed reforms would still leave sizeable co-payments for drugs and the future role for private insurers remains unclear. The speed of reform could create implementation risks, in particular at the outset, and the Georgia governments is working closely with the World Bank and WHO to minimize their risks. The government expected the Social Service Agency would achieve major cost savings through centralized procedures and better control of medical services (Georgia Article IV Consultation 2013).

Policy

Health policy is an agreement on the declared approaches and strategies between the State and different political forces concerning the basic directions of maintaining and strengthening the state of health of the nation for the next 10–15 years. As a rule, mechanisms of health reform are key factors for the implementation of changes in public

health, and consequently in health policy. Thus, a clearly and precisely developed national health policy becomes the basic driving force for future reforms (WHO 2009).

The problem with access to needed services and inadequate public financing is a problem well recognized by the previous government and attempts have been made to resolve these critical issue. Three major policy documents were developed during 1999–2003, which outlined planned improvements in state health policies. These major documents are Georgian National Health Policy (NHP), Strategic Health Plan for Georgia 2000–2009 (SHP) and Economic Development and Poverty Reduction Program of Georgia (EDPRP). All of these documents are outdated, but are continuously being revised and used by the current Georgian government as a starting point for future policy development (Gotsadze et al. 2005b).

As a democratic society develops in Georgia, the State has declared a socially oriented reform policy. It is necessary to understand the utmost importance of the role of health. The formulation of a national health policy oriented on health maintenance and accessibility of health services is essential (Garey and Lorber 2008).

Priorities

At the start of the health system reform, priorities were determined by the financial abilities of the country. As a result of the reorientation, institutional arrangements of the system have been completed. A considerable part of medical care is now based on insurance principles. Thus, the determination of priorities of national health has become one of the most important tasks of the national health policy program and insurance programs.

Determination of priorities means that financial, material and human resources must be directed to selected spheres, and the participation and responsibility of different sectors in solving problems related to the health of the population must be considered (Djibuti et al. 2008).

Selection of priorities and development of strategies in Georgia are based on the following fundamental values and principles:

- health as the main goal of social development;

- equity and solidarity in health issues;
- development of person-oriented health;
- scientific foundation, responsiveness and accounts as ethical bases of measures that should be developed and implemented in health sector;
- sustainability of health strategies.

Determination of priorities is one of the most important conditions for implementation of the national health policy. The criteria for selection of priorities are:

- main causes of morbidity and mortality;
- maximum coverage of population with priorities;
- economic impact of priorities.

Selection of priorities is based upon the following fundamental values and principles:

- health as the main aim of social development;
- human oriented health system;
- using scientific data, responsiveness and an ethical basis of health system accountability.

The main priorities for maintaining and improving the health of the population of Georgia until 2020 are as follows: improvement of maternal and child health; reduction for morbidity and mortality caused by cardiovascular diseases; improvement of prevention, detection and treatment of ontological diseases; reduction of traumatism; reduction of communicable and socially dangerous diseases; mental health; establishment of healthy lifestyle; and provision of an environment safe for human health (Kvizhinadze and Gerzmava 2013).

Caucasus region

The Caucasus is a region at the border of Europe and Asia, situated between the Black and the Caspian Seas. It is home to the Caucasus Mountains, which contain Europe's highest mountain, Mount Elbrus. Politically, the Caucasus region is separated between northern and southern parts. The southern parts consist of independent sovereign states. The northern parts are under the jurisdiction of Russia – Appendix 1 (Table 1–6).

Health care in the south Caucasus has suffered as a result of the socioeconomic decline that followed the collapse of the Soviet

Union and the ensuing – still unresolved – conflicts between Armenia and Azerbaijan over Nagorno-Kharabakh and between Georgia and its breakaway republics Abkhazia and South Ossetia. As in most parts of the former Soviet Union, these places have increasing cardiovascular mortality, a high burden of mental illness, and spreading infectious diseases such as tuberculosis, sexually transmitted infections, and HIV (Schoen-Angerer 2004).

Future directions

Varying aspects of development such as economic development, social development or health development are often considered separately, but they are all parts of the same whole. Economic growth does not always mean progress, while health improvement, as a necessary aspect of human development, always implies social progress. Health is not only considered as medical care. The most important indicators for the improvement of the health of the nation are the establishment of a safe environment, provision of safe food and drinking water, carrying out of reasonable demographic policy, the promotion of a healthy lifestyle, and the elimination of social stress factors (Gotsadze et al. 2010).

The level of the health system reflects the level of socioeconomic development of the country. Improving the health status of the nation is the process of improving the quality of human life and determination of its global goals and values. This is the focus of the entire nation, and is why state goals should:

- proceed from the cultural heritage of the country;
- be of importance for the major part of the population;
- correspond to the level of economic development of the country;
- reflect the ethnic specificity and experience of the nation;
- be free from ideological dogmas;
- reflect the direction of international socioeconomic development;
- be scientifically justified.

The new health model must be based on the principles of justice, accessibility and equity. It should concentrate not only on the reduction of morbidity, disability, and mortality, but also on the social, physical and

mental welfare of individuals, families and the community as a whole. Right from the beginning, four groups of objectives have been selected in Georgia (Gerzmava et al. 2011):

- lifestyle and health;
- risk factors affecting the health of the population;
- reformation of health systems;
- selection of political, administrative and technological forces, needed to accomplish change.

To develop an effective and quality health system in the near future, it is necessary to take the following four basic statements as a foundation to new efforts (Abdushelishvili et al. 2005):

- outcome-oriented treatment;
- population-oriented primary health care system;
- more effective and flexible hospital care;
- better quality and effectiveness of health.

CONCLUSION

It is a paradox of modern times that healthcare systems, created during a period of relative prosperity in the developed world, are facing financial ruin. Compared

with the past, the early 21st century is a time of scientific advancement, economic progress, and social stability in Georgia. Yet the financial foundations of the healthcare system are deteriorating, and could crumble unless policies are changed quickly. The basic problem is the spiraling cost of healthcare, which is expected to continue. The Georgian government and other players are trying to slow that upward spiral of cost and increasing access to care.

A key question is how healthcare systems can be redesigned without damaging the foundation upon which they were originally built. Underpinned by the principle of solidarity the healthcare system is paid for by the population at large, with the risks of medical expenditure essentially pooled. Most Georgian citizens agree with this shared-risk principle and would resist any efforts to change it and thereby remove the promise of universal healthcare coverage. However, the financial contributions required for healthcare have risen steadily, to the point where local and state governments realize that further increases are no longer possible or politically acceptable. Yet the rise in the cost of healthcare systems continues to outstrip economic growth and shows no sign of slowing down.

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APPENDIX 1

The following tables provide comparative data for the Caucasus region:

Table 1. Population comparison in Caucasian region (thousand)

Countries	1990	2000	2011
Armenia	3,351,600	3,226,899	3,268,468
Azerbaijan	7,020,366	8,048,600	9,309,301
Georgia	5,438,850	4,418,300	4,483,400

Note: Adapted from World Bank (2008a). Georgia Country Brief.

Table 2. Total fertility rate of the population in the Caucasian region

Countries	1990	2000	2011
Armenia	2.63	1.11	1.5
Azerbaijan	2.8	2	2.4
Georgia	2.15	1.5	1.7

Note: Adapted from WHO (2009). World Health Statistics. World Health Organization.

Table 3. Real gross domestic product, PPP\$ per capita of the countries in Caucasian region

Countries	1990	2000	2011
Armenia	2121.82	2036.3	5789.38
Azerbaijan	3433.41	2208.94	10061.5
Georgia	4433.15	2219.83	5465.08

Note: Adapted from World Bank (2008a). Georgia Country Brief.

Table 4. Total health expenditure as % of gross domestic product (GDP) of the countries in Caucasian region (WHO estimates)

Countries	1990	2000	2011
Armenia	–	6.28	4.34
Azerbaijan	–	4.68	5.24
Georgia	–	6.94	9.44

Note: Adapted from WHO (2009). World Health Statistics. World Health Organization.

Table 5. Total health expenditure, PPP\$ per capita of the countries in Caucasian region (WHO estimates)

Countries	1990	2000	2011
Armenia	–	127.72	249.54
Azerbaijan	–	102.38	523.14
Georgia	–	143.42	537.52

Note: Adapted from World Bank (2008a). Georgia Country Brief.

Table 6. Physicians per 100,000 population in Caucasian region

Countries	1990	2000	2011
Armenia	–	256.9	252.38
Azerbaijan	391.72	360.72	342.75
Georgia	–	378.83	409.64

Note: Adapted from World Bank (2008b). Georgia Country Brief.