

Hospital Sector Reform and Its Implications on HRD in Georgia

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Abstract

Georgia has excess hospital sector capacity inherited from the old Soviet era. Recent economic problems and decreased public health care expenditures down to 1 USD per capita forced the Georgian Government to embark on ambitious health sector reform since 1995. Reforming the hospital sector was an intrinsic part of the process.

This paper describes major directions of the reform thought by the MoH of Georgia to rationalize the hospital sector. It reviews the reform directions in the environmental context, and attempts to provide some quantitative and qualitative indicators to characterize the reform process and its impact.

The discussion addresses the issues of granting autonomy to hospitals, exposure of hospitals to the market, social functions of the hospitals, and improved accountability of hospital facilities.

The implications of the reform on HRD are analyzed. The final section of the paper summarizes the lessons learned from the Georgian experience.

Key words: Hospital Autonomy, Rationalization, Hospital Reform, Human Resources Management.

Background

Georgia has a population of 5.2 million in a geographical area of 70,000-sq. km., bounded by the Black Sea, Russia, Azerbaijan, Armenia and Turkey. Since the independence of the country on April 9th 1991, Georgia appeared to be a relatively well off republic with good potential for growth. However, the country has suffered from civil wars and ethnic conflicts that resulted in an influx of displaced persons. A burden of approximately 270,000 displaced people worsened the economic plight of the country. In addition, disruption in trade within the former Soviet Union (FSU), trade shocks^a, and general economic decline in the former socialist countries, further aggravated economic and social problems in Georgia. After 70 years of Soviet ruling, Georgia, a country with more than a 2000-year history, faced major political changes with similar scenarios as elsewhere in the Former Soviet Union. On August 24, 1995, under fierce political controversy, the Parliament of Georgia adopted the new Constitution. Based on the new Constitution, a new Parliament was elected in November 1995. The parliamentary elections were held together with presidential elections. Mr. Eduard

^a TRADE SHOCKS – right after the declaration of independence and separation from the Soviet Union Georgia was almost overnight separated from the Soviet market. While in the Soviet Union all financial settlements (wire transfers) took place through the Central Bank in Moscow. After independence Russians closed the bank channels and Georgia's banking system was totally isolated from the world and former soviet republics. This resulted in a major shock for Georgian trade relations with other republics and countries.

Shevardnadze (former Foreign Minister of the Soviet Union) was elected as the first president.

Before 1991, the Georgian healthcare system—its financial and administrative structure—represented only a small part of the entire Soviet healthcare system. This system followed the "Basic Law on Health in the USSR and Soviet Republics" which was enacted in 1964. This act provided a unified framework for legislation and regulations in each republic. Though the law covered all the Soviet republics, it still provided for some variation in operations and performance in order to allow for the economic, cultural and social diversity of each Soviet region. The Soviet system was based on the "Semashko model", a very centralized, publicly owned, command-and-control healthcare system. It was financed totally from the general budget. Its main focus was primary care. Central (Moscow) and local (in this case, Georgian) healthcare authorities administered the system. The central authority (the USSR Ministry of Health) was in charge of planning, organizing, controlling and allocating almost all resources. Consequently, the few tasks and/or responsibilities delegated to the local authorities were limited to providing performance evaluations and reports to the central authorities. Formally, the Ministries of Health of both the Soviet Union and Georgian Soviet Republic carried out strategic decision-making. In actuality, the central authority made all key decisions.

In the FSU, healthcare services were officially free for all to assure equity of access. Pharmaceuticals were provided on a subsidized basis to outpatients and free of charge to inpatients. Healthcare professionals were public servants and received fixed salaries. Private practice was quite rare *although not forbidden*. Private out-of-pocket payments to healthcare professionals were **illegal but very common**, especially in the southern republics of the FSU⁽¹⁾.

Georgia at the very end of the Soviet era in 1990 had 53,079 hospital beds. With an average length of stay of 14.8 days, the beds were only utilized by 53%. There were 5 physicians serving 1,000 population in the country. Budget allocation to the hospitals was retrospective, mainly based on their bed capacity. *Human Resource Development (HRD) in the health sector was governed, managed and financed solely by the State*. The role of the hospital management was limited to fulfillment of orders of the Ministry of Health and other central and regional health authorities. The budget management was carried out according to pre-approved line item budgets provided by the central authority.

However major political and economic hardships faced by Georgia after its independence, including inefficiencies of service delivery, forced the government to embark on ambitious reforms in the health sector. In 1995, in response to the economic crisis that brought public expenditures on health to a level of less than US\$1 per capita, the Government launched a "*Big-Bang*" reform program. The vision of the future health system was a social insurance model sustaining the principles of solidarity and equity.

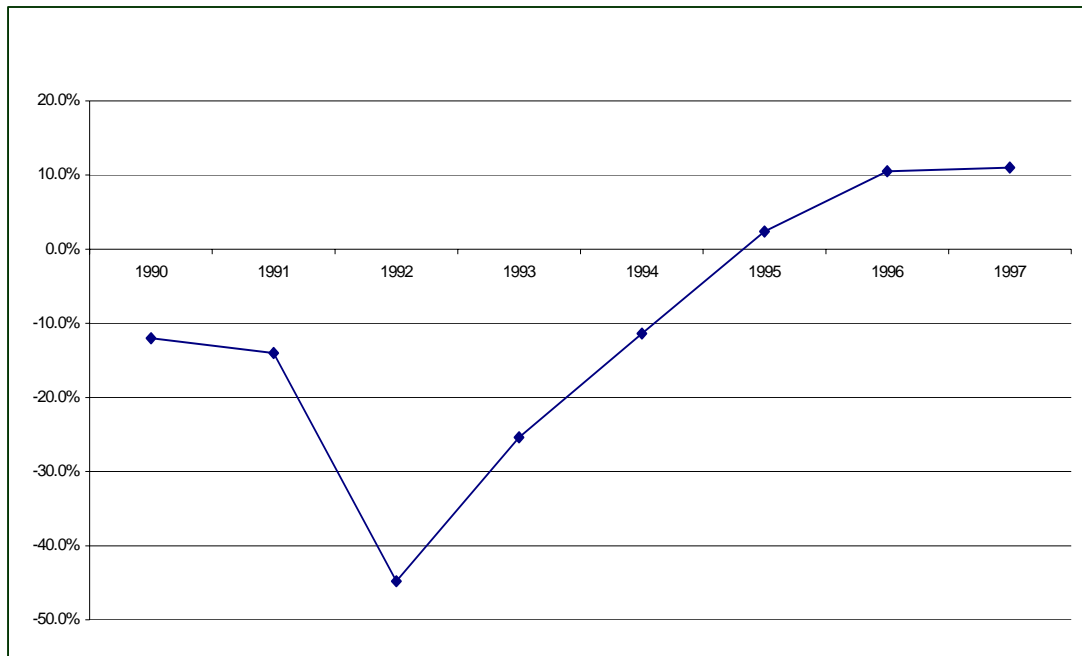
This paper aims at describing the context around the reform, major direction of the reform, its process and impact. A special focus on Human Resources Development was described.

Reform Context

It is well known that the reform process is influenced by political, ideological, social, historical, cultural and economic factors, all of which need to be taken into consideration in understanding the context of pressure for reform⁽²⁾. Georgia's economy after sharp decline in 1990-1994 (Figure 1) started recovering slowly. In 1997, GDP growth rate amounted to 11% and the country was considered as the fastest growing economy in the *Commonwealth of*

Independent States. However, the Russian economic crisis in August 1998 affected Georgia's economy with the GDP growth rate declining in 1998.

Figure 1 Annual percentage change in real GDP (1989=100) in Georgia 1990-1997.



Source: State Department of Statistics, Georgia.

Observed growth in the economy did not affect increases of resources allocated to health care. **Percent of GDP allocated for health** care grew from **0.7%** (1996) to **1.2%** (1998). Even though the volume of financial resources from public funds increased by 2.36 times over the course of 3 years, in real terms it only amounted to almost nine USD/per capita^b. Georgia's budget revenues only amount to **9% of GDP** and due to permanent budget shortfalls (which could be attributed to widespread corruption in the country) the health sector is permanently short of state financing. The State, having only a 13% share in National Health Expenditures, lacks the means to fully influence reform policies.

Georgia, being among the lower-middle income countries^c, has demographic characteristics that are very much comparable to those observed in OECD countries. During the 1980's chronic diseases among aged populations comprised the major disease burden and during 1990-1994 emergences of preventable diseases worsened the nation's health status. Increased demand for health services on one hand and deprived economy on the other created the pressures, when finding the solution was not an easy task. Currently Georgia has a weak economy and morbidity that is characteristic of developed country.

The reform context is further complicated with the people's perceptions and expectations. Being used to *free* health services under the Soviet ruling, it is very hard for citizens to tolerate the situation where only a minor part of the services could be obtained at

^b Source: Report of the MoH 1998

^c According to the World Bank data in "Georgia at a Glance" in 1997, the GDP per capita was 840 US\$.

no cost. From the other end, the physician's political lobby strongly resists any public attempts towards rationalization of human resources in health care.

The year 1995 was a major year in Georgia's political life, i.e., adoption of a new constitution, parliamentary and presidential elections were scheduled and the government was conscious about the reforms. Even after 1995, with social issues being among the major bargaining topics, the electorate forced the MoH to slow down the pace and reshape the reforms several times.

Seventy years of Soviet ruling created a cohort of *Soviet-type Managers* that in most cases was not willing and sometimes not able to meet the changing demands of the environment. Proposed reforms required team-based management from people who were totally lacking these skills. Major changes in the country's legislation created certain confusion and further complicated the transition process for the managers.

Reform Directions

With the help of the World Bank, WHO and other donors new criteria for Georgia's health system were established that were in line with the new constitution^d, i.e.,

- Be in accordance with the strategic direction of the economic development of the country;
- The volume of services must be balanced with available financial and human resources; and,
- The system must be well controlled and aimed towards the rational utilization of all resources.

Based on these criteria the Government defined major directions for the "*Big-Bang*" reforms, which among other objectives entailed⁽³⁾:

- The decentralization of healthcare management;
- The transition from state-funded healthcare to the principles of medical insurance coverage;
- The initiation of the privatization process of healthcare providers;
- Accreditation and licensing of all medical institutions and personnel; and,
- Reform of medical education.

During the initial phase of the reform the Government mainly attempted to change the healthcare financing system, remove all healthcare personnel from the State payroll, decentralize the provider network by granting them autonomy, as well as *license and accredit the provider network and educational institutions to control the quality, quantity and availability of sufficient providers*.

Right after the reform initiation all hospitals became separate legal entities registered under the public law. As part of the reforms, the legal status of hospitals was changed from budget institution to "*State (Treasury) Enterprise*". *Autonomous status* took place. The main implication of this action was the creation of financial separation of health facilities from the national budget and introduction of a new case-based payment method. Simultaneously, *staff*

^d Since receiving independence in 1991 Georgia has drafted and adopted a **new constitution** on August 14, 1995. The latter amended the universal Constitutional right of free healthcare for every citizen (Soviet norm) to the State responsibility for free healthcare *only within its capacity*. This created legal ground for changes in the health sector to take place.

salaries were also removed from the budget and employees were no longer considered civil servants. This was an attempt to put in place the right incentives for improving the efficiency of the system and to divest the central government from many responsibilities it was no longer able to fulfill.

Supposedly the hospitals were to be governed by elected boards from the hospital staff, while *Chief Doctors* (Directors) were to be contracted by the Ministry of Health (MoH). Establishing an elected body in the hospitals was an attempt to introduce the principles of corporate management in hospitals. Most of the facilities have complied with the regulations and elected governing boards *de jure*. *De facto* these boards do not play any significant role.

Separating hospitals from the MoH, but still maintaining public ownership was the planned first step under the reform. Next was to privatize part of the facilities, thus creating a competing environment in the health sector and supporting evolution of the healthcare market. After the initial steps when almost all pharmacies and dental clinics were privatized, privatization of the hospital sector "failed" even though it was planned for 1997-1998^e. On 19 February, 1999, changes in general legislation^f forced the MoH to proceed with *corporatization* of hospitals. September 1st, 1999 is the scheduled deadline for all hospitals to become legal entities, i.e., Limited Liability Companies (LLC) or Joint Stock Companies (JSC), established under the "*Commercial Law*"⁽⁴⁾.

The State established "*State Medical Insurance Company*" (SMIC) and "*Municipal/Regional Health Funds*" to collect and administer public finances for the health sector. While SMIC collects mandatory health premiums^g and finances vertical programs^h across the country, *Municipal/Regional Health Funds* receive revenues from local municipal budgets and finance a number of programs that are developed in the municipality/region. Parts of the municipal health programs are mandatory, defined by the MoH at the beginning of fiscal year. Others are voluntary where municipality makes its own decisions which services to finance.

Hospitals are contracted by the SMIC and by their *Municipal/Regional Health Funds*. Part of the services offered to the population are paid by the SMIC and part by *Municipal/Regional Health Funds* according to the programs approved by the respective governments. However, **major financiers of health services are still patients in the form of co-payment and out-of pocket expenses** that are mostly unofficial and unregistered. According to 1997 data, the population bears 87% of national health expenditures, while the state only covers 13%.

^e The privatization failed because there was no clear policy how to proceed with privatization, what criteria to use and how to implement. Policy makers saw no desire on the part of hospitals. Also there were other contextual factors not directly related to the Health Care System, but rather to the general environment in the country. Only after Kaiser Permanent International (USA) and Curatio International Foundation developed a hospital restructuring master plan for Georgia it became possible to group hospitals in public, privatization and merger groups.

^f On 19 February 1999 Georgian parliament adopted amendments to the Law on Entrepreneurs, that eliminated "*Treasury Enterprise*" as one of the legal forms of organizing economic activity.

^g This premium was for 4% of payroll-3% being employer share and 1% employee share for those employed in formal sector.

^h SMIC Programs are developed by MoH in close collaboration with SMIC and other institutions and include for the year of 1999, 16 different programs, e.g., TB, Obstetrics, Children 0-3 years old, Psychiatry, Vulnerable, Oncology and etc.

Results of the reform

1. Changing role of the MoH

During the reforms the Ministry of Health assumed only the role of licensing health facilities and separated itself from being involved in the provision of services. The initial round of licensing was sensitive to the economic difficulties. MoH relied solely on foreign technical assistance in developing the licensing requirements. More recently Georgian authorities assumed control of the process and incorporated minimum standards of equipment, physical structure, and services for medical institutions. However, it has to be mentioned that further refinements in licensing procedures are still needed to create more effective and efficient system.

The process of licensing and accreditation of the providers has begun very slowly. This process has been supported in part by the loan from The World Bank. Yet these efforts have not rendered the desired results. Only part of the hospital facilities received a full license for practice. The majority of the hospitals, due to deteriorated physical conditions, are only granted with temporary licenses, which expire in the year 2000. Thus, most of the facilities, which need to be closed, are still left open and operating at the cost of the quality of service provided to the population.

2. Hospital autonomy

Hospital autonomy granted independence to the facilities and created a health care "market". But the public payer's decision to contract almost all facilities in the public domainⁱ and the MoH's licensing of all hospital facilities *never allowed the market forces to evolve*.

Coming from the Soviet era, where the centrally appointed *Chief Doctors* (Hospital Directors) exercised enormous power, it was naive to believe that the newly elected *Hospital Boards* would become immediately functional and efficient.

- At this stage of transition, Georgia lacks the experience of democracy, civil society and new forms of corporate governance. All of this creates the threat that granted autonomy to hospitals will be enjoyed only by hospital administrators. *Hospital Boards* do not play any significant role, but bring legitimacy to administrators' performance.
- Retained contracting rights of MoH with *Chief Doctors* left the effective means to directly or indirectly intervene in hospital macro- or micro-management in the hands of central and regional healthcare autocrats. Thus the notion of autonomy became to some extent irrelevant in the Georgian context.
- It is expected that hospital *corporatization*, which is scheduled for mid 1999 will "relieve" hospitals from the bureaucratic interventions, however it is unlikely that *Hospital Boards* will improve their performance in the near future. Managers are unlikely to make best use of any autonomy they are granted, unless the Government has a clear and effective policy to assure their accountability to the owners and stakeholders. In addition, it is yet unclear how the issue of residual claimant status^j will be resolved during the *corporatization* process.

ⁱ Health care provider network in Georgia is mainly represented by publicly owned facilities and the private sector has a very minimal share and role.

^j Residual claimant status means central public purse claims on revenue flows of the autonomized hospitals. It may impose a hard budget constraint on hospitals, allow hospitals to raise capital by selling shares to or borrowing from private investors, or subject hospitals to bankruptcy laws that limit the risk of private and public shareholders.

3. Hospital financing

Recent research on hospital sector financing carried out by the *Curatio International Foundation*⁽⁵⁾ revealed the weakness of state health authorities and hospital management in financial management and price setting for medical services. According to this report, most hospital services are under priced in order to politically justify the "sufficiency" of limited public funds for the assumed responsibility by the state in financing the population's health services. According to the study findings, in 1997 the payment received by hospitals through official sources (SMIC, *Municipal/Regional Funds* and official user charges) covered only **30%-35% of the total cost of hospital services**. The difference between the actual costs of producing services and the price rates was mainly borne by illegal out-of-pocket payments made by the patients. This led to widespread corruption as hospital personnel requested (and received) considerable illegal payments, which exceeded several times the official prices for the hospital services⁽⁵⁾. Widespread corruption in medical facilities threatens equity in access to hospital services. For example, the Poverty Assessment⁽⁶⁾ found that while physicians had one of the lowest official salaries, they had one of the highest incomes. Most of this income is from untaxed, out-of pocket spending, which costs the Government more than GEL 94 million (about US\$70 million) per year in tax revenues⁽⁷⁾.

This situation is further aggravated by several "illnesses" inherited by the majority of state owned hospitals. Excess capacity, in terms of both capital assets and human resources makes it impossible to have efficient operations in health care institutions. Management staff weaknesses at any hospital level contribute to the failure in meeting total financial requirements of the facilities.

On the other hand, the number of medical institutions "competing" for the public funds (to attract more patients and more illegal payments) is so high, that very few of them (except of specialized institutions) are loaded adequately. Because of the low level operations, the portion of fixed costs allocated per unit of service (either admissions or hospital days) is incredibly high and that limits the flexibility in management of costs for provision of hospital services. In order to bring the official price of hospital services to a more affordable level for both the public and private payers, many facilities unjustly lowered the capital consumption costs, or the cost of depreciation of fixed assets. As a result, adequate funds for maintenance and rehabilitation/replacement of buildings and medical equipment are not accumulated and spent by the facilities. A negative outcome of this situation is the rapid deterioration of capital assets owned by the state. Current governmental policies seem to overlook or ignore this alarming problem. There are strong reasons to believe that this situation will certainly have logical long-term negative consequences if not addressed in time. If a sustainable solution for this problem is not found in the immediate future, replacement costs of devastated hospital assets after a certain period will be unaffordable for the country, if not so already. An assessment of all hospitals in the capital city, Tbilisi, found that financing only civil works needed for these buildings to bring them up to minimal standards would cost US\$100 million. More than 80% of the existing medical equipment is either outdated or out of service and should be replaced as well⁽⁸⁾.

4. Positive changes

During the reform process, some positive changes were observed that could be attributed in summary to the reform strategies described above:

4.1 Total hospital bed capacity decreased by more than half (Figure 2).

However, this mainly occurred by decreasing the number of beds in the facilities and not by decreasing the actual number of hospitals. Currently, there are 287 hospitals with nearly 23,500 hospital beds (4.49 beds per 1000 population). This capacity is extremely high relative to demand, as average bed occupancy rate was **32.7%** and average length of stay (ALOS) was **11.72** days in 1998 (Figure 3 and 4). The turnover rate is thus approximately 10 patients/bed/year.

4.2 The number of physicians in the country decreased by 32.5%, from 26,850 in 1990, to 20,824 in 1998. However, there is a surplus of physicians, with one physician per 248 population compared with one per 400 population in the OECD (Figure 2). The highest concentration of physicians is seen in the capital of the country where one physician serves 134 inhabitants⁽⁹⁾, while in some rural areas there are shortages of medical personnel.

4.3 Efficiency improvements were observed in decreased ALOS (Figure 4) by 20.8% from 1990 to 1998. However hospital bed occupancy ratio has decreased even further and fell to 32.7% in 1998⁽⁹⁾ (Figure 3).

Figure 2 Impact of reforms on hospital bed capacity and number of doctors

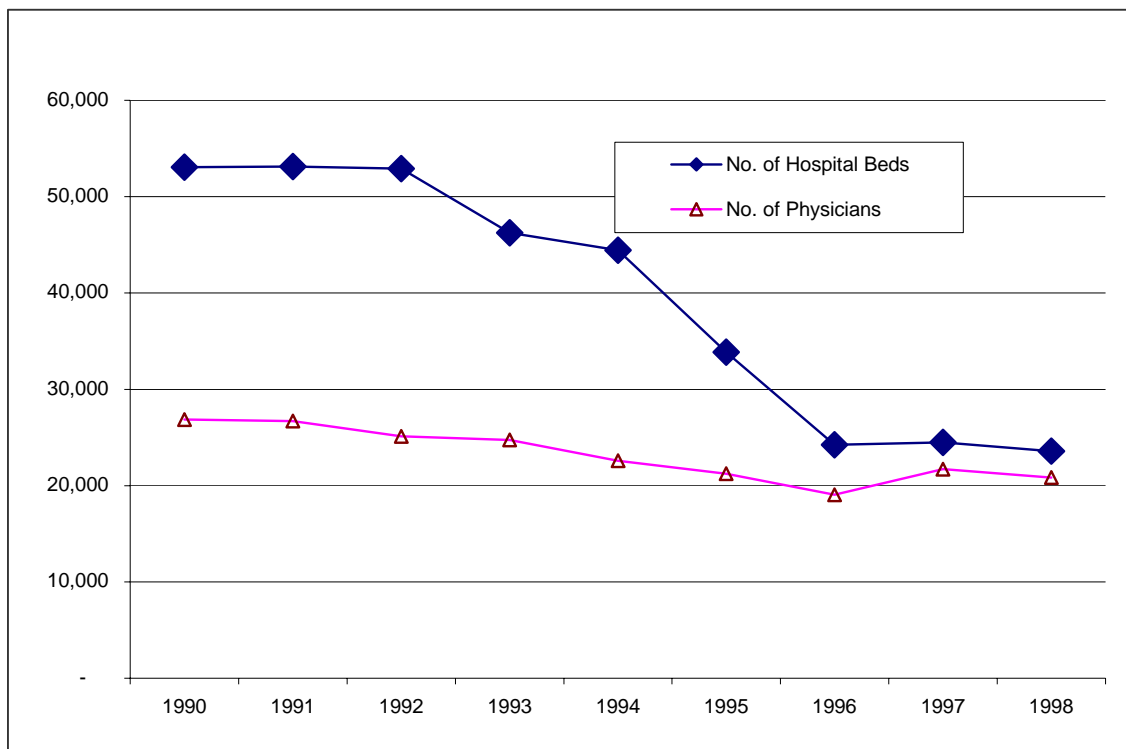


Figure 3 Impact of reforms on hospital bed occupancy rate

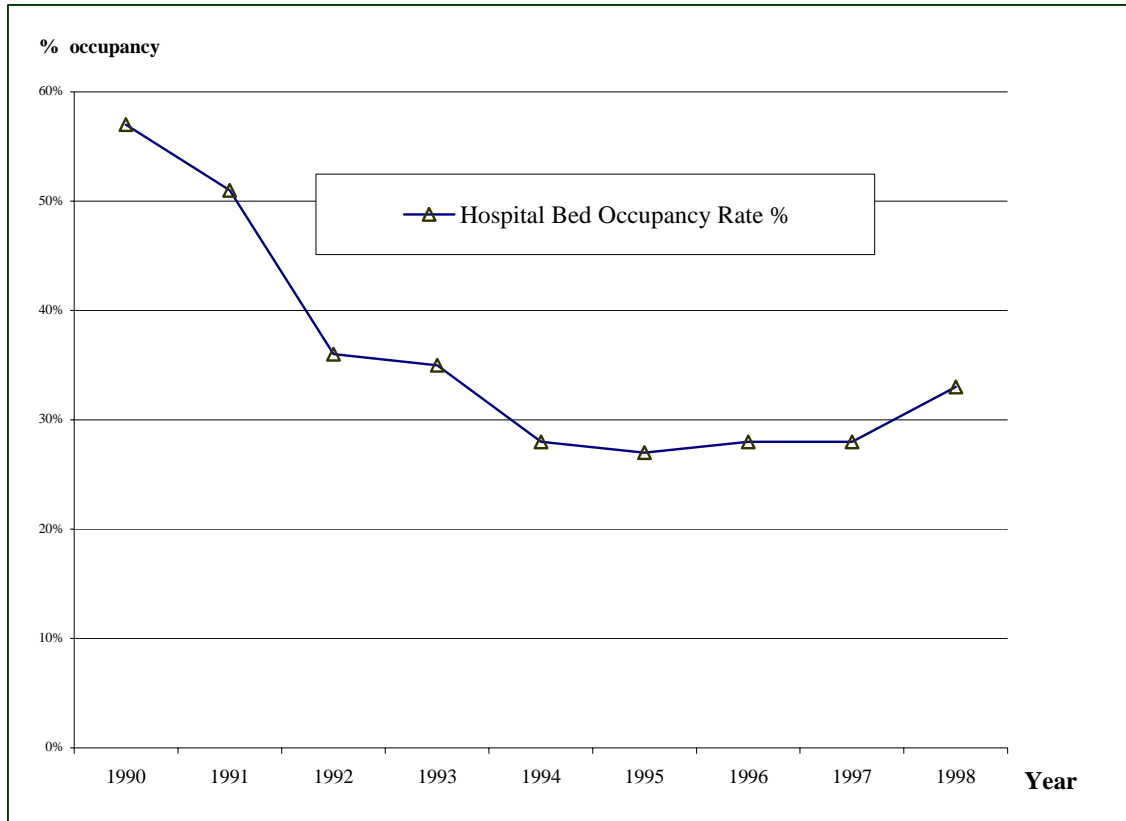
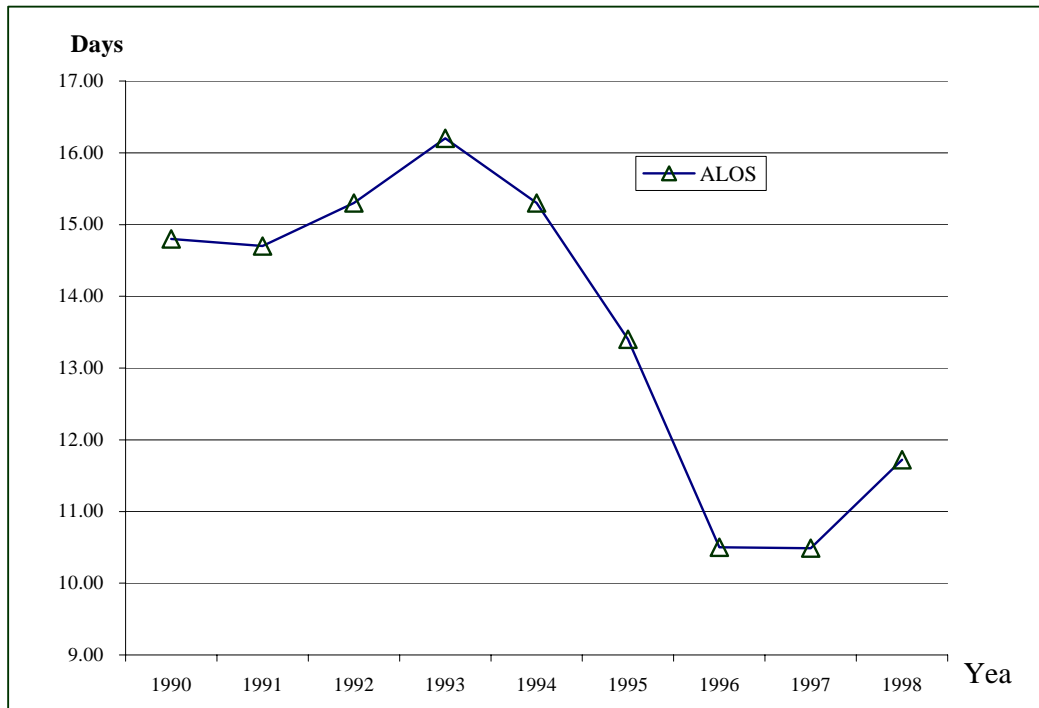


Figure 4 Impact of reforms on average length of stay in Georgian hospitals.



Discussion

The impact of the hospital sector reforms can be evaluated from the perspective of a) technical efficiency; b) allocative efficiency; c) quality of services rendered to the population; and d) equity. However, its impact on human resources development becomes very important.

1. Interventions for Organizational Reform

Before we move to the discussion of reform impact we thought it would be preferable to discuss the interventions for organizational reform, which could be grouped into four major categories:

- 1.1 Granting autonomy to the hospitals;
- 1.2 Exposure of hospitals to the market;
- 1.3 Public health functions of the hospitals that are subsidized by the government to assure that services offered are those for public benefit; and,
- 1.4 Improved accountability of hospital facilities.

1.1 Hospital Autonomy

Based on the results that were presented in the previous section it becomes obvious that granting autonomy to the hospitals in the Georgian context to some extent was a loss. Environmental factors had more impact on these processes than the MoH policy and direction. The legal form of "*State Enterprise*" proposed by the Georgian legislation proved to be deficient in practice. The quasi-public and quasi-commercial charter of "*State Enterprises*" contradicted a number of legal rules, which would normally apply to commercial entities or alternatively, to government agencies.

Generally, "*State Enterprises*" - although established to carry out commercial activities and generate profit - rarely proved economically viable and often depended on state subsidies. "*State Enterprises*" - 100% owned by the state - were set up by the decision of relevant government agency (by MoH in the case of hospitals), which also determined the area of its activities, appointed directors, established the scope of authority, etc. Nonetheless, in commercial transactions, "*State Enterprises*" acted as separate legal entities, with limited state control. Legally, the state was directly liable for the obligations of the not economically viable enterprises. However, in reality, the state - using various technicalities as an excuse - never honored this requirement of the law. Nevertheless, such unlimited exposure of the state to the liabilities of "*State Enterprises*" also played a significant role in the decision to abolish this legal form and mandate the transformation of "*State Enterprises*" to LLCs and JSCs⁽¹⁰⁾. Parliament was not able to undertake this complicated task of resolving legal contradictions. The next "best" choice was to simply eliminate the problem - legal form of "*State Enterprise*" - altogether, relieve the state from liabilities and mandate the transformation of all "*State Enterprises*" into LLCs and JSCs. However in the context of healthcare this decision of the Georgian Legislature may have several negative impacts, including:

(1) Due to the very short time given for transformation of State Enterprises into LLC and JSCs a lot of technical issues have been overlooked such as how LLC and JSCs, where the State owns 100% of shares, will be governed. How will the performance of executives be monitored? Who grants authority to a person who will represent the State's interest on the board of entity, etc.? Why should the board only be composed of Public Servants and why aren't employees of the facility (public control) and professional associations represented on the board?

(2) How will liabilities of the State Enterprises (that were accumulated over the time) be reflected and how will this burden the financial performance of newly established LLC and JSCs?

(3) Would State liability for outstanding debts to the hospitals be paid to newly established LLC and JSCs or will they be just written off overnight?

Thus *autonomy* and *corporatization* was rather a policy imposed on the MoH, than a well thought process. This is a continuous process continuous and if MoH is not proactive in defining proper mechanisms for transformation, another failure is unavoidable.

Expected *Corporatization* should certainly bring more autonomy to the hospitals. In both, LLCs and JSCs, the majority shareholder makes all vital decisions, which are to be specified in the "*Company (Hospital) Charter*", but may not contradict the requirements of the *Law on Entrepreneurs*⁽⁴⁾. After transformation, the state would hold 100% of stock shares. Although in case that the state decides to privatize the facility, the employees will be entitled to no less than 10% of shares of the hospitals^k according to the *Law on Privatization*⁽¹¹⁾. Currently medical institutions are under the "structural subordination" of the MoH. After *corporatization*, the Ministry of State Property Management (MSPM) - and not the MoH - will become the main shareholder of the LLCs and JSCs. However, it is planned that MSPM will delegate the governance authority to (a) MoH for large hospitals mainly in the capital and to (b) local municipalities for medium and small hospitals throughout the country. The impact of these developments is yet to be seen.

1.2 Exposure of Hospitals to the Market

The attempt of the government to expose hospitals to the "market forces" was accomplished. Definitely competition among the providers emerged, which was not in existence under Soviet times. Gradually providers became conscious about the market and the need for improved quality and efficiency. However, the imperfect nature of the health market in general, the weakness of MoH and SMIC policies in setting up adequate rules for market regulation to account for this imperfection, and the sustained oversupply of the provider network, all have hindered realization of positive market effects. Deteriorating infrastructure, insufficient funding of hospital facilities, under pricing of official rates for the medical services, low utilization of hospital services, shifted financial burden to the population and inequity in access, could be considered as logical results of policy failure. Instead of embarking on selective contracting on the part of state purchasers and fully enacting the power of licensing to control the size of provider network, the government chooses political compromise, which results in market failure. It was expected that, because the market is not the universal panacea (particularly for health care) touted by those who rejected planning (of the Soviet Union), the market operates best in the context of a strong government, the rule of law and economic stability, the respect for property rights, and the responsibility for the needs of the destitute⁽¹²⁾. Out of these requirements, almost none existed in the Georgian context.

1.3 Public Health Function of the Hospitals

Defining and subsidizing public health functions of the hospitals is very hard to evaluate. In Georgia, there was no attempt to distinguish hospital services that are purely private from those that reflect a public health function and to define and subsidize the public health functions of the hospital. Of course there are discussions regarding the public or

^k There are certain limitations imposed by the "Law on Privatization" on total value of shares that employees may own.

collective good characteristics of an individual hospital service. Some would argue that all care for non-infectious diseases is a “private good”. Others would counter that treatment of chronic diseases in the poor fills the public health function of providing a safety net for the most destitute. Still others argue that access to all health care services is a human right, which the government cannot morally deny to any citizen. In spite of these differences in views, it may be possible to arrive at a national consensus regarding ranking of hospital services from those carrying explicitly the public good features to those representing purely private good. Given such ranking, those designing an organizational reform experiment can rather arbitrarily select some of the services at the top of the list (i.e. those which are agreed to be almost exclusively public goods) and either transfer them altogether to government health care services or compartmentalize them within an administratively separate part of the hospital so as to insulate the rest of the hospital from the costs of their production⁽¹³⁾.

This exercise never occurred in Georgia. The Government never applied any agreed upon instrument to define which services should be subsidized by the state and which should remain individual responsibility. It could be said that decision was guided more with politics than with any economic or social argument. Publicly financed package of hospital services offered to the population seemed "politically marketable" and at the same time it was very hard for the consumer to understand the entitlements. As a result, scarce financial resources available to public purchasers were diluted among all hospital facilities and were not targeted to either improve the health status of the poor, or subsidize the services, which would decrease the burden to the taxpayer's purse and improve the health status of the population.

1.4 Hospital Accountability

Various reports that evaluated hospital sector and accountability issues proved that corruption is deeply rooted in the system. Providers continuously demand illegal payments from the patients, which create financial barriers for the poor and affect the volume of disposable income for the rich. These illegal payments along with legal ones on average amount to 323 GEL (about \$US170) per case of hospitalization⁽⁵⁾. *The mean average monthly income per capita* in the country is GEL 42.69 (about \$US22.47) according to the State Department of Statistics (SDS) Household Survey database¹, thus access and use of health care is strongly impeded by economic factors. According to SDS survey⁽¹⁴⁾ only 46% of individuals who were sick, sought professional treatment; the rest treated themselves or resorted to non-traditional forms of help. Out of those who were sick, but treated themselves, about 20% did so because they were unable to afford professional treatment^m. This situation could be attributed to inability or unwillingness of the government to adopt politically unpopular radical reforms of the hospital sector and enforce “fair rules” in provider-consumer relations in the health system. Another potential reason could be that the government is such a small player in financial terms, that its ability to influence the sector through financial incentives is limited. As stated above, only thirteen percent of health spending passes through government hands.

Most of the aspects discussed in this section do require further research before a final judgment is made. However, interventions for organizational reforms, so far, prove not to be adequate in order to attain the desired impact.

¹ The data reflects 1997 findings, average for all quarters.

^m There are other survey findings that report similar proportion of the population that refused to seek professional treatment solely because of inability to pay.

2. Impact of the Reforms

2.1 Efficiency

Looking at the impact of the reforms on hospital performance we think that government strategies – changing incentives through new provider payment mechanisms, denying the right to practice to those who do not pass minimum qualifying standards and exposure to competition - have been somewhat successful and explain partial efficiency gains: decrease in the actual number of beds, decrease in ALOS and decrease in the number of practicing physicians since 1995, when the reform program began. However, as has been seen in other countries, market mechanisms for capacity reduction alone are not sufficient to reach optimal supply levels. The health care market has many peculiarities including an asymmetry of information between providers and consumers and the ability of providers to generate their own demand. Market approaches must be complimented with a more proactive policy to liquidate government-owned excessive assets and limit entry into the medical profession⁽⁸⁾.

2.2 Quality of care

Because of information asymmetry, an essential aspect of measuring the impact of organizational reform is to track its impact on the quality of care. There is substantial discussion in the literature about how to measure quality of care⁽¹³⁾. "Quality of care" is clearly a multi-dimensional concept and one on which there is yet no consensus definition. There is, however, a basic reference point that is widely used by experts in the quality of care field. Using this reference, the distinction between structural, process and outcome dimensions of quality is commonly drawn in the literature⁽¹⁵⁾. Based on evaluation of input, process and final health outcome, it is **very hard to come up with objective quantitative and qualitative indicators**. Special research is required to obtain these indicators in Georgia. However some assumed conclusions could be drawn. In the hospital sector on average 1.7 doctors were serving 1 patient and the average hospital occupancy rate was only 32.7%⁽⁹⁾ in 1998. These figures may indicate that medical staff are very underutilized and thus may result in losing qualification, which may have negative impact on the quality of medical services offered to the population.

2.3 Equity

An analysis of the equity impact of reform can begin by examining the impact of the reform on the mix of patients to see if either the percentage or the number of poor patients served has fallen⁽¹³⁾. Evaluating input, process and outcome indicators, we could also state that the equity in health care delivery has changed since the initiation of the reforms in 1995. Various surveys carried out in Georgia confirm that the percentage of the poor population unable to access the health services due to economic reasons have increased.

2.4 Impact on Human Resources Employed in the Hospital Sector

Reforms initiated in Georgia resulted in a significant decrease of medical personnel employed by the sector, however the levels so far attained are not satisfactory. The country still has very high doctor to population ratio of 1 doctor for 252. In addition, the productivity of physicians in Georgia is low because they often perform tasks that would be performed by nurses or other paramedical personnel in more affluent countries. As stated above, 1.7 doctors are serving one patient in the hospital⁽⁵⁾. Georgia has fewer supporting staff than do Western Europe and other industrialized countries. For example, the ratio of physicians to nurses in Georgia was 1.4, which is about one third that in Canada (4.4) or other countries in Europe⁽¹⁶⁾. The observed impact on HR forced MoH not to undertake detailed workforce plans but gradually to reduce the excess medical staff based on regulated market

forces. Through already an established system of licensing of medical staff, those who cannot attain an acceptable professional quality or for whom there is insufficient work will leave the health care system. According to the licensing exams for the doctors, which were administered by the MoH after initiation of reforms, 18% decided not to undertake the exams and left medical practice, 31% failed the exams and only 51% passedⁿ. However it needs to be mentioned: this process is still ongoing. Yet MoH managed to license only several specialties (OB&Gyn, Generalists, Epidemiologists^o) while other specialties have to undertake licensing exams over the coming years.

GoG also offers several alternatives:

- Reorientation training of unemployed physicians, both those with inadequate qualifications and others who are excessively specialized to choose other emerging specialties in the health sector or outside.
- Redistribution of staff. Deployment strategies involve establishing incentives (financial and non-financial, such as targeted training) to promote work in areas suffering from a lack of staff, especially in rural areas.

However the principle of competition will be officially implemented for all kinds of health professionals applying for vacant posts. The thorough recruitment process will require analysis of the need for the job, new job descriptions, assessment of candidates and a selection interview. Reimbursement mechanisms will be based on the performance assessment, including new criteria and norms concerning quality of care, severity of cases, permanent improvement of professional qualifications and others. Thus, the rational use of human resources will be achieved through better management.

Lessons Learned from Georgian Experience

The transitional period characteristic for Georgia (a country with a transitional economy) coming from the Soviet system and moving towards a market economy has several specificities with major impact on the reform process.

Based on the presented findings, the following could be considered as the lessons learned from the Georgian experience:

4.1 Weakness of the Georgian Government (GoG) to fully consider all environmental factors, which directly or indirectly influence the reform process, resulted in development of an ambitious but, in certain aspects, unrealistic reform. Defining clear and attainable objectives for the reform, managing the process, understanding various factors that impacted the implementation and making timely corrections, became an overwhelmingly hard job for the GoG to cope with. This could be attributed to an overestimation of GoG's capacity by its external technical partners and to limited human resource capacity within the country to manage this process.

4.2 Dynamics, complexity and volatility of all developments (political, social, economical, demographic), which were, and still are, characteristic for most countries with transitional economies, create the environment where success of health reforms largely depends on progress in other sectors of the economy and the institutional capacity of the state in general. It seems almost impossible to manage the big-bang reform process in the health sector, when all other sectors are in drastically different stages of reform and the pace of

ⁿ Source Licensing Department of MoH, 1999.

^o Official name for this specialty is general hygiene.

transition varies widely. Well thought and well designed, effective inter-sectoral coordination mechanisms should be in place before initiating any radical reform of just one sector that might fall out from the general momentum of country development.

4.3 Weakness of civil society, democratic institutions and underdeveloped legislation seem to be the critical determinants for government officials and hospital administrators to abuse the powers granted to them. This results in permanent shifts in the reform direction, and most likely creates a vicious cycle instead of solving the problem.

4.4 If provider network rationalization is not placed at the vanguard of the reform processes (in the countries where capacity and human resources are excessive) and primary health care along with the hospital sector services are not considered in a holistic context, it is doubtful that health outcomes will be improved.

4.5 The reliance on laissez fair market only is not sufficient to carry out hospital sector reform. Market mechanisms (particularly in underdeveloped markets) must be complimented with a more proactive policy to optimize government-owned assets and properly manage the facilities with granted autonomy.

4.6 Politically acceptable but economically irrational under pricing of the hospital services resulted in shifting most health care costs to the patients. As the lion's share of these costs was illegal and in many cases unjust, only a small portion of them could be considered as contributions to the maintenance and development of the hospital sector. Private financial outlays on health care in the Georgian context have played a major role in creating economic barriers for poor populations to obtain access to the most basic health services, compromising the equity and access promised to the population.

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