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Preface

Open Society Georgia Foundation has been implementing the project titled as "Monitoring of the Medical Assistance State Program for the Population below the Poverty Line" since January 2006.

Medical Assistance State Program for the Population below the Poverty Line (hereafter the "program") is an important stage of Health Care reform being currently implemented in Georgia. The program aims at identifying the population below the poverty line, formation of the data base, creation of "basic health care package" enabling the state to acquire services considered by "basic package" for the poor population. The program is one of the most considerable and important among the state programs run in the country. Considering the fact the Open Society Georgia Foundation has decided to monitor the activities planned within the scopes of the program in order to ensure its effective implementation.

This report has been designed based on the materials obtained during the period from January till November 2006. The document covers the analysis of Program implementation in 2006 and results obtained in the period of 10 months of 2007.

Within the framework of the Program the working group has been closely cooperating with the Ministry of Labor, Health, and Social Affairs, Social Assistance and Employment State Agency, as well as with local and international non-governmental organizations operating in the field of Health care. The working group expresses its gratitude towards Open Society Institute, NY "Public Health Network Program" for the financial assistance rendered for the implementation of the Project, as well as towards experts from the "Economic Policy Research Center".

Introduction

Medical Assistance State Program for the Population below the Poverty Line can be freely regarded as one of the most important stages of the health care reform. The program aims at identifying the population below the poverty line, formation of data base, creation of "basic health care package" enabling the state to acquire services considered by "basic package" for the poor population.

The current project aims to carry out monitoring of the above mentioned Program, which is financed by the state and should provide free services for the patients below the poverty line and to identify weather the funds have been allocated effectively, as well as to monitor targeted and transparent spending of the Program funds and support establishment of transparency and accountability.

The socio-economic statistical data in Georgia is incomplete and inaccurate that hampers country to provide vulnerable population with full and valuable medical services. The problem is caused by the fact that the large number of Georgian population is employed informally that impairs income registration, taxation, and recording of statistical data in national socio-economic database. The fact leads to complication of complete identification of poor population and providing them appropriate assistance.

Thus, one of the most priority objectives of the first stage of the monitoring project was:

- Monitoring of Medical Assistance State Program for the population below the Poverty Line in order to examine the transparency and effective allocation of funds granted by the government for the program implementation

- Implementation of comparative analysis of the state budget of 2006-2007 in order to find out what are the funds in the state budget assigned for the program in 2007 compared with indicators of 2006.
- Adequacy of service monitoring and funding within the framework of the Program
- Evaluation of the cost effectiveness of state funds allocated in the Program
- Analysis of the economic effectiveness of the Program - most of the state programs start functioning without any preliminary economic analysis and estimations. The fact is the result of lack of professional staff, short planning period for the state programs, and other issues. Usually, due to inappropriate planning the result of the majority of such state financed programs are not effective and efficient enough.
- Raising public awareness on the Program implementation

General Problems of the Health Care Sector

Expensive and low quality healthcare services are common characteristics of the Georgian healthcare system. The healthcare reform — which at this point is unsatisfactory for both the patients and the healthcare professionals, needs the involvement of civil society in various aspects.

The major problems which occur in the Georgian healthcare system are the following:

- Fragmented character of the Health Care Reform
- The institutional structure of healthcare in Georgia is so frail that the majority of healthcare providers do not satisfy the minimal international standards.
- In most cases certifying and licensing procedures of health care professionals and providers are rather formal than practical.
- The regulatory basis of the health care sector is weak or, in most cases, does not function at all since contracts are drawn up with service providers who do not meet minimum standards of licensing.
- Purchaser of health care services (state in this case) does not use the contracting mechanisms in the optimal manner; contracts have annexes, which in case of optimal planning are very useful regulatory instruments. The annexes should include detailed, specific and precise requirements and norms for contract fulfillment procedures.
- Private health care sector (Private entities providing health care services and insurance companies) is poorly developed in Georgia that does not give an opportunity to distribute the responsibility of solving the above mentioned problems among the government and private sector.
- The population is poorly informed about its rights and privileges entitled them by the government.

Basic Directions of the Health Care Reform

Since 1995 the reforms directing at financing and institutional building of health care and social protection sectors have been implementing in Georgia. Despite the fact the country is still on the way of reformation. The shortcomings and fragmented implementation of the reform are reflected on the current stance of system which faces number of problems.

Transformation of the health care reform is one of the most important components of the reforms carried out by the Georgian Government. Shift to market economy has posed crucial objective and challenge of substituting Soviet health care system for more effective and efficient one.

Noteworthy that the period after the collapse of the Soviet Union has been loaded by hard social cataclysms that has negatively reflected on supply of quality of the health care services as well as on demands for these services. In 1992-1996 state expenses of the health care reform did not exceed 1 US Dollar per capita.

In the light of sharp deterioration of socio-economic situation the population finds it hard to acquire health care services due to price increase and decrease in their income. Despite the success attained in terms of economic growth the economic situation of substantial part of the population has worsened. As of today the high quality medical services are affordable for the smallest part of the population as for large part of the population cheaper medical services seem luxurious. Acquiring health care services must not be luxury since affordability to medical services is constitutional right of every citizen.

It is noteworthy that the researches conducted by donor organizations showed that one of major problems of poverty of the population is unexpected deterioration of health of individuals and their family members since urgent hospitalization of the patient calls for huge financial resources.

For tackling health care problems of poorest part of the population the government has carried out special activities that will ensure affordability to health care and quality improvement of services for vulnerable layers. Specifically, the Medical Assistance State Program for the Population below the Poverty Line has become affective. The program will serve 700 thousand beneficiaries.

One of the most crucial parts of the health care reform is gradual substitution of existing health care reforms for insurance products which will enable the population to purchase insurance products instead of purchasing medical products directly.

There are spheres which are regulated by the private market without government's intervention. Intervention of the government in functioning of the field of health care has been determined by two major reasons: 1) In most cases consumers (patient) are insufficiently and poorly informed about health care services and time is not sufficient for obtaining this kind of information. 2) Health care costs are so high that covering them by acquirer from their own pockets is actually impossible.

Georgian population spends substantial financial resources for acquiring medication services. As of today the private formal and informal payments (out of pocket payment) constitute 80 percent of health care costs. Expenses run up for acquiring services is so high that it may cause impoverishment of a family.

According to data of special survey conducted by the Department of Statistics (see: Daily Newspaper 24 Hours-11.19.2007) in 2007 fields of health care and social protection were financed by more than 1000.2 mln from expenditure part of annual budget equaling 5000.115 mln, 147 thousand GEL. 200 million was pledged for health care protection of the population. The data (data is not yet formally announced) of the research portray the structure of population expenditures as follows: Medications (drugs; medicine)-403 123 GEL (49%); hospital- 279 718 GEL (34%); ambulatory- 139 859 GEL (17%); In total 822 700 GEL (100%).

Generally, health care market is imperfect and calls for active government intervention. The role of state in controlling the health care sphere varies from utmost dominance (England, Scandinavia, Canada, post Soviet Union) to minimal intervention (Switzerland, developing countries with transition economy-Georgia among them).

There does not exist free health care. The system is financed either from taxes or through receiving direct service.

Basic resources of health care financing are the following: taxes (obligatory\mandatory) insurance contributions (social assistance program-mandatory; private insurance system-optional); direct private (out of pocket) costs-optional (informal); state budget expenses (200 million GEL). Out of pocket payments made by the population for health care and social programs achieve 160 million GEL of total costs (approx. 1 billion GEL in 2007).

For eradicating existing weaknesses the government has elaborated a plan for the healthcare reform. In 2007 the health care reform encompassed the following directions: general plan for developing health care system in Georgia; Medical Assistance State Program for the Population below the Poverty Line; Governmental Plan for Developing Medical Assistance; National Drug Policy; priority directions of human resources in the field of health care; Law on Public Health.

For the poverty reduction the government has chosen the strategy that implies financing basic health care costs of vulnerable layers. For this reason the government has elaborated the Medical Assistance State Program for the population below the Poverty Line. As already mentioned analysis of efficiency of the above program is the primary goal of the current report. Although until we start with the analysis it is necessary to overview formal statistical poverty indicators and to link the state financed programs with the poverty reduction.

Poverty Rate

Poverty can be regarded as one of the most severe social problems in Georgia. According to 2003 data the population below the poverty line exceeded 54%. In 2005 changes in calculation methodology of the poverty rate influenced poverty indicators and poverty rate parameters.

If before, calculations of poverty indicators where based on domestic economy the new approach suggests that object of observing ought to be an individual. If before the poverty rate was measured according to share in all domestic economies in the new approach the poverty rate is determined and defined as share of poor population in entire population.

Before 2005 calculation of poverty rate was made through normative-statistical method and grounded on composition of minimal consumer basket determined in 1992 which considered acquisition of 2500 kilogram calories per day. Following the 2005 year modification of methodology of calculating the poverty rate is based on actual minimal consumption of the population. As a result of calculating methodology the poverty rate of average consumer has decreased to 84 GEL from 138 GEL.

As already mentioned the welfare indicators applied for calculating formal indicators of the poverty represents consumer costs forecasted for one equivalent adult of domestic economy and this indicator is assigned to entire domestic economy as well as to its every member. Formal indicators of poverty line are calculated through application of formal poverty line that is poverty level.

In 2004 the Department of Statistics calculated the poverty rate. In 2005 adequate indicators versus updated\renewed poverty line (i. e poverty level) were calculated. By 2004 poverty rate reached 35.7 percent where as by 2005 it was 35,5 percent. Despite the statistic data prove the decrease of poverty rate the latter remains as one of the most crucial and severe problems for the country.

Unemployment is the basic factor and determinant of the poverty in the country. Accordingly, it is impossible to tackle the problem without reducing causing factors. Supporting economic development, improving business environment, and creation of new employment opportunities are directly proportional to poverty reduction. Elaborating consolidated effective social policy is of utmost importance as well.

Medical Assistance Program of the population below the Poverty Line

In 2005 the government has adapted the new statute (#51) on Poverty Rate Reduction and Perfection of Social Protection Activities. Aside from poverty reduction one of the major goals of the statute is effective and targeted implementation of social assistance. Poverty reduction and social protection of the population are priority directions of the document, Basic Data and Directions of Georgian government for the following years-2007-2010. This goal was emphasized in Economic Development and Poverty Reduction Strategy of 2005 suggested by International Monetary Fund (IMF), National Anti Corruption Strategy of Georgia, European Neighborhood Policy Action Plan etc. For reducing the poverty despite considerable assistance rendered to Georgia the problem remains unsolved and steps undertaken towards poverty reduction are implemented ineffectively.

The major goal of the document of Georgian government- Basic Data and Directions of 2007-2010 is reduction of extreme poverty through implementing reforms. Successful implementation of Medical Assistance program for the population below the Poverty Line is to "reduce severity of poverty of this part of the population" (Statute of the Government of Georgia 10.01.07; #2, Annex 3).

Since the health care and social protection is regarded as a top priority for the country considerable funds from the state budget are assigned to these issues. According to the policy of expenses funds assigned to health care and social protection occupied the first place in 2007 - 999,718 mln GEL (before modifications in state budget), and the second place in 2006-775 mln GEL. Despite the fact that following the sector of self-defense the largest funds are pledged for financing health care and social protection sectors the financial resources assigned are insufficient and resources are spent ineffectively.

Several programs of health care, education, and other sectors financed from the state budget run in Georgia. The Medical Insurance Program for the population below the Poverty Line is one of the largest among them. Unfortunately, most of the state programs are planned without any preliminary economic analysis, studies, and calculations. In most cases the decisions upon planning and execution of state programs are made according to the political will rather than on orientation on specific economic effect. As a result such programs and non-permanent campaigns often fail in producing desired results. The most of the decisions are made in a centralized way based on the political will and processes wherein actual needs, analysis evaluating effectiveness, long-term results (e.g. poverty rate reduction) etc. are not considered. At the same time spending public finances are inadequate to the Medium Term Expenditure Framework (MTEF). It is important that funding the health care sphere and policy should develop in line with long-term strategy of country's economic development.

In order ensure efficiency and success of monetary, provisional and other allowances it is essential to determine its impact on the poverty rate.

The Medical Program for the population below the Poverty Line considers providing necessary medical assistance for the population living in extreme poverty registered by Social Assistance and Employment State Agency. During 2003-2005 years an alternative program known as Individual Medical Assistance State Program for Socially Unprotected Population was implemented in Georgia where the number of beneficiaries was not determined that led to untargeted appropriation of allowances. Formation of target groups became necessary and in 2006 the new Program was launched.

The long-term goal set by the country in the framework of the Program should be poverty reduction on one hand and on the other hand, improving health care situation of the population below the poverty line. In the research process it is interesting to focus on the following two components: 1) whether the depth and severity of poverty has reduced after the programs implementation and 2) whether the programs could improve the health care situation of the population. Although it should be mentioned that it would be hard to assess the above mentioned outcomes at the first stage of the Program implementation. We can only assume and analyze assumed economic and social effects that might produce the Medical Assistance Program for the population below the Poverty Line for Georgia.

Database Formation of the Population below the Poverty Line

The goal of the state program for identifying, assessing, and database formation of the population below the poverty line is to establish the database of socially unprotected families based on their socio-economic status that will enable to plan and implement the monetary as well as other social assistance programs.

One of the most important preconditions of effective functioning of the Medical Assistance Program for the population below the Poverty Line for Georgia is to make correct choice when identifying assistance beneficiaries. This is the case particularly when we have to deal with the situation when existing resources are scarce and number of population below the poverty line is too high.

The Social Assistance and Employment State Agency has started working on the Poverty Reduction and Perfection Activities for Social Protection Program (03.17.05) and about Approving Methodology of Assessing socio-economic situation of socially unprotected families (domestic economy) according to statute of the Georgian Government.

Creation of database foresaw the following stages: Receiving applications of seekers (seeker family), application data processing, identifying families for registering them in the database, assigning rating scores in compliance with the methodology approved and assessing their socio-economic situation.

Basic features of the methodology:

- Calculating rating score (so called Welfare Index) that will comply with the level of the family's welfare according to determined rules.
- Procedure of calculating family welfare index grounds on the results obtained from questionnaire of social agents.
- Each of the indicators of the questionnaire are assigned suitable weights according to effects produced on family welfare index.
- Based on the family welfare index it is possible to range families according to poverty rates.

Monitoring of the Medical Assistance Program for the Population below the Poverty Line-2006

During 2003-2005 years Individual Medical Assistance State Program for the Socially Unprotected Families was implemented. During program implementation approximate contingent of program beneficiaries was not determined that increased the possibility of untargeted and non transparent spending of the state funds. As a result it became necessary to form the database of target groups. Accordingly, the Individual Medical Assistance State Program for the Socially Unprotected Families started in July 2006 considers providing medical assistance to population living in extreme poverty registered by the State Agency for Social Allowances and Employment.

In 2006 the budget determined by the Health care state program of Medical Assistance Program for the population below the Poverty Line was 18 million GEL. The program was launched in July 2006. For the time being, according to information State United Social Insurance Fund there are 865 998 beneficiaries registered in the database. By the end of 2006 out of the mentioned number 385 408 citizens have used medical services. Services considered in the framework of the program were the following:

- Obstetrical assistance
- Ambulatory services
- Planned stationary services, pre-operational investigations, computer tomography, magneto nuclear tomography
- Treatment of severe hospital cases
- Co-payment in the framework of all other state programs

Mentioned nosology was distributed according to regions in line with the following **table #1.**

Statistical data according to regions in the framework of the Medical Assistance State Program for the Population below the Poverty Line, July-December 2006

#	Region	Number of Beneficiaries	Number of Ambulatory Visits	Number of Severe Hospital Cases	Planned Stationary Assistance	Cases of Obstetrical Assistance	Child birth cases with "Free child birth card"
1	Tbilisi	88897	64536	4692	11604	6085	379
2	Imereti	157482	68002	2769	921	4197	256
3	Samegrelo-Zemo Svaneti (higher Svaneti)	116553	40176	2102	120	1382	1030
4	Adjara	101415	28897	1966	294	2802	325
5	Guria	37162	17483	442	218	832	109
6	Racha-Lechkhumi-Kemo Svanetii	21826	3301	578	9	62	17
7	Kvemo Kartli	90978	24453	729	48	3024	223

8	Shida Kartli	70494	22817	1357	94	1076	298
9	Kakheti	98271	34540	1632	261	1991	124
10	Mtskheta-Mtianeti	36354	9798	369		271	226
11	Samtskhe-Javakheti	46566	14770	579	78	958	106

Source: State United Social Insurance Fund (SUSIF)

In 2006 the Medical Assistance Program for the Population below the Poverty Line covered the following: Ambulatory assistance in the framework of Ambulatory Assistance State Program and Planned Stationary Medical Assistance. Both of them were considerable. There were series of problems concerning funding and treatment of so called severe hospital nosologies. (Nosologies that are not included in any of urgent and planned stationary assistance. Eg. Some of gastroenterological diseases).

According to operational information of the Ministry of Finance of Georgia in 2006 the funds pledged for financing Medical Assistance of the population below the Poverty Line Component of State United Social Insurance Fund were 15,362,185,92 GEL.

Due to the short term of the program in 2006 we have decided to focus on demonstrating problems that occurred in 2006 and which call for timely response and undertaking effective steps for improvement:

- It is necessary to analyze economic factors according to which the problems alike should be planned that in most cases are ignored and disregarded in process of elaborating state programs. Eg. In the framework of the Medical Assistance Program for the Population below the Poverty Line from July till December 2006 (6 months) the state budget foresaw spending of 18 million GEL during 6 months. In 2007 at primary stage the amount was automatically moved to state budget which by 12 months constituted 36 GEL. Later on, funding of the program has increased from 36 mln GEL to 43 mln. The fact proves that in process of program planning an inflation indicator of 2007 compared with 2006 was not considered and accordingly in 2007 the program was inefficiently funded.
- The system of informing beneficiaries was imperfect and inefficient. It is well known that the population below the poverty line is the contingent who find hard to access information sources. It is necessary to inform them individually about their rights.
- Delivering/Acquiring of planned medical assistance scheme to beneficiaries in the framework of the Program was complicated as well. The mentioned scheme designed for the citizens of the capital city of Georgia (Tbilisi) was as follows: beneficiary- policlinic (according to registration)-State United Social Insurance Fund –commission-policlinic-beneficiary-stationary. This scheme is more complicated for regional and rural dwellers: beneficiary-policlinic (according to registration) –regional branch of the fund-central office of fund-commission-regional branch of fund-policlinic-beneficiary-stationary (either in Tbilisi or in regional hospitals). For beneficiaries temporarily living in Tbilisi who are registered in regions\rayons. The centralized structure like this complicates delivery of medical services to beneficiaries stipulated by the law.
- Institute of ambulatory assistance is poorly developed in regions and rayons that further complicates effective operation of the above mentioned scheme.
- It is necessary to ensure transparency of population's registration in the database according to gradation of registration scores and elaboration of insurance packages of

diverse size. Medical insurance programs of the population below the Poverty Line should cover co payment considered by components of health care state programs, more preventive and inclusive ambulatory medical assistance and medicine supply in case of most spread chronic diseases.

- In many international countries there is consensus that each individual/person (reach or poor) must have an opportunity to enjoy basic medical assistance (egalitarian theory). The health care system as other budgetary spheres is financed by tax payers. These are the resources that ensure provision of medical assistance to poor. A government lacks resources of funding alike services for average layers that means that average layers are in unequal situation in this case.

Monitoring of Medical Assistance State Program for the Population below the Poverty Line- 2007

In 2007 in the framework of the Medical Assistance State Program for the population below the Poverty Line the following activities are being implemented:

- Urgent ambulatory and hospital treatment
- Planned hospital treatment
- Reimbursement of child birth related expenditures/costs
- State program for children's medical assistance, cancer diagnosing and treatment, and services considered under referral assistance component

Aside from the abovementioned the population below the poverty line benefits from the rest state health care programs.

In 2007 considering the mentioned program the contract was drawn up with 431 medical institutions, 194 contracts among hem were drawn up in the framework of planned stationary assistance program 78 contract among them in Tbilisi. Contracts were singed through individual negotiation.

In 2007 in the framework of the Medical Assistance program for the population below the poverty line 80 906 cases were registered.

Number of Cases According to Regions and Components Considered by the Program are given in Table #2

#	Region	Severe Hospital Treatment	Particularly Urgent	Obstetrical Assistance	Child Birth for Voucher Holders	Planned Stationary
1	Tbilisi	6438	497	7999	715	3102
2	Imereti	4337	318	4628	499	784
3	Samegrelo-Zemo Svaneti	3305	610	1914	977	239
4	Adjara	4253	628	3133	720	232
5	Guria	740	79	678	266	281
6	Racha-Lechkhumi; Kvemo Svaneti	1075	16	84	30	1041
7	Kvemo	866	61	2160	308	63

	Kartli					
8	Shida Kartli	2221	546	1802	203	162
9	Kakheti	2922	77	1639	251	546
10	Mtskheta-Mtianeti	879	68	1178	208	10
11	Samtskhe-Javakheti	808	51	1501	199	71

Along with nosology groups demonstrated in the table the following cases were present: Antirabic -694 cases, 2786 cases above 15; Oncology 6860 cases. Frequent nosologies among severe hospital cases are demonstrated in table # 3.

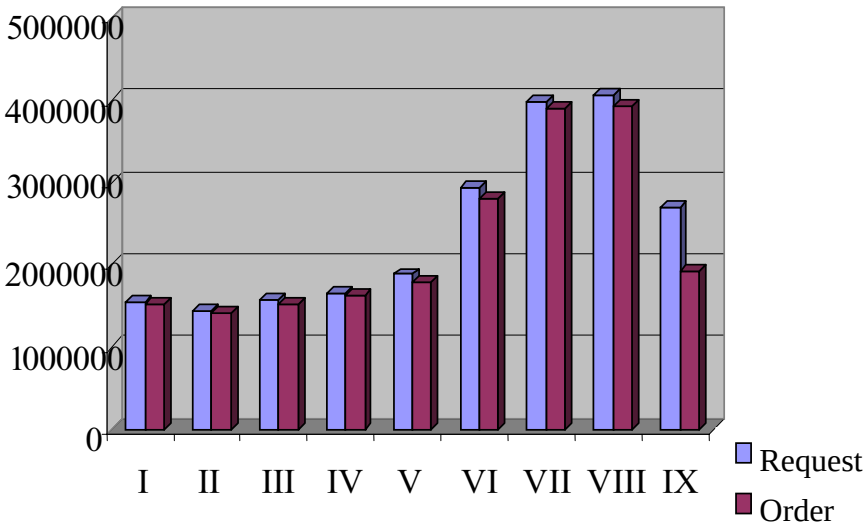
Unstable stenocardia	1147
Virus Pneumonia, non classified (average severity)	3461
Virus Pneumonia, non classified (severity)	

Considering sub component of stationary assistance nosology of frequently conducted operations since June 2007 is demonstrated in table #4.

Code	Nosology	Number of Cases
U 01209	Cataract; Operation with lens	965
U 00102*	Wound, Primary surgical assistance	558
U 00101*	Disjunction, Fracture\break of undetermined part, immobilization	276
U 01008	Implantation	237
U 01111	Tonsillectomy with local anesthesia	194
U 01799	Onco haematomic research	188
U 01431	Urological diagnostic study	159
U 01339	Chronic Tonsillitis, adenitis without narcosis	158
U 01237	Diagnostic study of ophthalmology	125
U 01502	Inguinal hernia	114

The sum requests during January-September of 2007 constituted 21 809 634.13 GEL where as order amount was 20 435 904.42 GEL. The data is given in table #5 and graph #1 according to months.

	I	II	III	IV	V	VI	VII	VIII
Request	1556424.5	1431961.4	1568747.3	1654836.3	1883527.03	2948229.04	3994913.32	4075531.83
Order	1529528.3	1404011.2	1523500.5	1622383.7	1782758.96	2805221.05	3911218.59	3936417.01



Increase of requests and orders since June 2007 is explained by drawing up contracts considered under sub component planned stationary assistance.

Decrease of requested sum is provoked by delivery of insurance vouchers to Tbilisi and Imereti Region population below the poverty line since September 2007.

As for the number of the citizens below poverty line throughout Georgia if in January 2007 were registered 609 081 beneficiaries. In September the number of insured made 672 963- 71 834 among them in Tbilisi, 129 227 in Imereti.

On the basis of incoming fulfillments from institutions the specific number of vouchers has used the services in one and the same institution. e.g.:

1. 1 case of using services for 20 times at Gvamichava National Center for Cancer –voucher №10103600001/02
2. 2 cases of using service for 18 times at Gvamichava National Center for Cancer –voucher №010302000333/01
3. 2 cases of using service for 17 times at Gvamichava National Center for Cancer –voucher №010103600001/02
4. 2 cases of using services for 16 times
5. 1 case of using services for 15 times
6. 2 cases of using services for 14 times
7. 17 cases of using services for 13 times
8. 9 cases of using services for 12 times
9. 18 cases of using services for 11 times
10. 17 cases of using services for 13 times
11. 32 cases of using services for 9 times
12. 44 cases of using services for 8 times
13. 61 cases of using services for 7 times
14. 102 cases of using services for 6 times (Tbilisi #4 Clinical Hospital)

According to statistics given above the mentioned issue requires on site\spot study of each such case.

According to data as of November 1 2007 13 580876.51 GEL from state budget was spent in the framework of the Medical Assistance Program for the Population below the Poverty Line.

For today, As of November 2007 there are 672 963 beneficiaries registered in Georgia. See table #6.

	Beneficiary	Voucher
Tbilisi	71 834	27 146*
Imereti	129 227	47 976*
Guria	33 874	
Racha	20 930	
Kakheti	83 400	
Mtkheta-Mtianeti	25 527	
Samegrelo-Zemo Svaneti	99 774	
Samtskhe-Javakheti	23 229	
Kvemo Kartli	53 726	
Shida Kartli	58 781	
Adjara	71 506	
Abkhazia	1 211	

Number of beneficiaries insured at private insurance companies

Already since September 2007 by the government's initiative the state purchased medical services of beneficiaries registered in Georgia and Tbilisi from private insurance companies. The attempt was carried out as an experiment.

Since August 10 2007 according to statute of the government the Agency for Health Care and Social Programs prepared voucher for the all of the families below the poverty line who had been registered by Agency of Subsidies in Imereti Region and Tbilisi until July 1 2007 and whose registration schools did not exceed 70 000. In line with the statute the Agency of Health Care and Social Programs of the Ministry of Health should have delivered vouchers to beneficiaries until August 31. After obtaining vouchers beneficiaries enjoyed an opportunity of choosing among insurance companies. Accordingly the received voucher will be exchanged for the vouchers of preferred insurance companies. In case the beneficiary fails to make a choice within the deadline\terms determined the Agency for Health and Social Assistance\Allowance will attach him\her to any of insurance companies.

On August 10 2007 the Agency for Health and Social Programs started delivering vouchers. Residents of the capital should have applied to policlinics determined by the agency according to registration of the place of residence. Policlinics were responsible for informing population in Tbilisi, where as in Imereti village ambulatories had to inform the people. e.g. All beneficiaries living in Gldani-Nadzaladevi rayon would receive vouchers at #31 Gldani policlinic; in Vake-Saburtalo rayon on Vazha-Pshavela avenue at #1 Medical Professional Center; All Internally Displaced Persons at one of Avchala Policlinics etc. In Imereti according to regions (schools were selected) until August 10-15 Samtredia, Khoni, Vani. Until August15-20 Kharagauli, Zestaponi, Tkibuli until August 20-25 Terjola, Chiatura. As monopolist, Insurance company "Kartu" served Sachkhere region.
Vouchers were distributed by the staff of the Agency for Health and Social Programs. The staff was prohibited to provide any recommendation to beneficiaries about services provided by any

insurance company. The staff of the insurance companies was also prohibited to enter premises of policlinics or schools.

The insurance companies benefited from low information obtained by beneficiaries and started so called "trading" with vouchers. Agents of the insurance companies gathered beneficiaries in villages and took them to regional centers by buses to get their vouchers. In return to getting the voucher, beneficiaries were offered money (from 5 Georgian Lari (GEL) to 20 GEL per one voucher), and food (sugar and flour). In addition, local TV stations started advertising lottery of vouchers. When beneficiaries, who obtained voucher, left the building they were "attacked" by agents of insurance companies and offered to sign agreement right away, "in the field", and paid them promised amount of money. 90% of "insured beneficiaries" did not have any information on at least basic package of the insurance company or about contractor medical institution's services. In most cases, those beneficiaries who have "given away" their voucher in return to money, have addressed the agency to get their vouchers again and inquired what to do in order to get the medical services they were eligible for.

Due to the created chaos and because most beneficiaries' rights were violated and they were deprived of the right to choose, the Agency for Health and Social Programs suspended issuance of vouchers on August 15 in Tbilisi as well as in Kutaisi. The Government made decision to entitle "National Movement" (President Micheil Saakashvili's Party) to distribute vouchers. Activists of the "National Movement" provided vouchers and information booklets to beneficiaries upon their residence.

Because of such unethical behavior, a memorandum was signed between the Ministry of Health and private insurance companies, binding the insurance companies not to use unethical methods of obtaining vouchers.

Although the fact that implementation and development of insurance systems in Georgia is very important, the experience has shown that moving to private insurance system is too early. The private insurance companies itself failed to be ready for such transition in the first place.

It should also be considered that beneficiaries represent socially vulnerable part of the society, they are not sufficiently informed on their rights and in most cases it is difficult for them to make their own choice.

How private insurance companies work?

Insurance Company ALDAGI – BCI: under the Medical Assistance Program for the Population below the Poverty Line the company has insured 36.5% (i.e. 56,660 persons) of all the population eligible for the program in Imereti region and Tbilisi.

As per the information of the company, as of the starting date of the program and through October 10, 2007 ALDAGI –BCI has reimbursed 358 urgent treatments. As to non-urgent treatment, such cases are financed after all relevant procedures are completed and there were no problems with this regard. As to time limits, as informed by the company, insured beneficiaries get their planned treatment within maximum of two months' period.

Insurance Company GPI Holding: As per the data of October 2007, 59,254 persons were insured in GPI Holding. The company started reimbursement of urgent treatments from September 1 and has already financed 200 such cases. As to non-urgent (planned) treatments, this service has already started. Each day lots of persons address insurance company with the guarantee letter for financing of planned treatments. In Tbilisi, as well as in Imereti region, such

guarantee letters were issued for the amount of 400,000 Georgian Lari (GEL). Almost, 550 insured persons used GPI insurance policy to receive planned treatments in 40 medical institutions located in Imereti region and Tbilisi. As to out-patient treatment costs, more than 6,000 patients were reimbursed for various types of out-patient costs.

International Insurance Company IRAO: In September 2007 the company reimbursed about 90 cases of urgent in-patient treatments and the company has received 80 applications with the request to finance planned treatments, part of which was financed in September. In addition, diagnostic treatments, 10 labors were financed and 11 patients are still undergoing chemotherapy treatment.

The company has contracts will all initial medical institutions in Tbilisi and Imereti region on out-patient services.

Insurance Company "People's [Sakhalkho] Insurance": As per the data of September 12, 23,000 beneficiaries are registered in "People's Insurance" under the Medical assistance state program for the population below the poverty line. 380 medical claims were registered at the company. Out of these 380, urgent cases – 150 and remaining 230 of planned treatment. 230 cases of planned treatment include: diagnostics (pre-surgery and diagnose verification tests) and surgeries. 40 planned treatments were already completed.

As per the data of November 2007 on Tbilisi and Imereti region, 69,462 poor families (187,822 persons) had already made their choice in favor of private insurance companies.

Company	Distributed Vouchers			Total for November		
	Person	Family	Amount	Person	Family	Amount
BCI	3,349	1,387	24,137.80	64,933	23,869	466,970.69
GPI	3,371	1,550	24,322.60	65,606	24,849	472,058.17
IRAO	1,496	638	10,774.72	28,721	9,950	206,290.04
People's	1,417	581	10,191.08	28,562	10,794	205,034.00
Total	9,633	4,156	69,426.20109	187,822	69,462	1,350,352.901

Results of Survey of Service Provider Organizations

Open Society Georgia Foundation had carried out survey of service provider organizations (medical institutions). The survey was conducted under the Medical Assistance State Program for the Population below the Poverty Line. About 100 staff of medical institutions was surveyed. Analysis of the questionnaire of the service providers has outlined the following results:

Main problems were identified in out-patient services. Most beneficiaries participating in the program require such services and the service providers are obliged by the Program to provide such services for minimal payment and in most cases for almost no cost. In 2006 under the Program, 3 visits of a doctor to the residence of a patient were mandatory and cost of each visit was GEL 0.40. Cost of out-patient instrumental-lab diagnostics for each beneficiary was GEL 0.25 (accumulated amount is divided among staff by the head of the hospital). Monthly payment for health specialists involved in out-patient program was GEL 144. Payment for medium and low degree health specialist was not considered at all, whereas most demand was on the latter's services.

Therefore, in the questionnaire, heads of hospitals identified low budget as a major problem and drawback of the Program. Almost all questioned persons agree that it is necessary to check eligibility of registered beneficiaries i.e. whether they really are “below the poverty line”. Most of the questioned persons know very well the social conditions of the registered beneficiaries and in most cases they don’t consider these beneficiaries as being “below the poverty line”.

As to questionnaires for heads of in-patient service providers, analysis of these questionnaires has shown the following: the main issue is complicated bureaucratic mechanism for receiving the planned in-patient service. A beneficiary must address a hospital and then his/her diagnosis from the hospital is discussed at the “commission” for the decision on financing of the treatment. The “commission” may decline the submitted diagnosis and decide that the beneficiary needs different treatment and the “commission” must again discuss the case with new diagnosis. The case becomes more complicated if the beneficiary is from a region.

Problematic are also those cases, where the hospital is addressed by patients with deceases that need in-patient therapeutic treatment (e.g. heart deceases, severe gastritis, liver insufficiency and etc) which are not covered under the Program.

Majority of questioned persons consider that provided services must be reimbursed according to actual works done, because the contract provides tariffs that are lower than the tariffs set by internal standards of the medical institution. It is also problematic that when setting the tariff pre-surgery diagnostics were not considered.

As to gynecological assistance component, majority of the questioned persons think that GEL 200 which was allocated for the service is very low payment.

Most of the questioned persons consider that main drawback of all components is low budget. Payment received for provided services can not cover utility costs, lab tests and most importantly, salaries for medical staff. However, despite drawbacks, all questioned persons agree that the Program must continue at least with the current volume and they will be happy if their concerns are considered.

The survey analysis evidenced that it is essential to continue the Program. All questioned persons mention that the Program allowed receipt of planned in-patient and out-patient medical services for those persons who would not be able to get relevant treatment without the Program. They have agreed that it would be good to have such questionnaires for beneficiaries of the Program and to consider their opinion during the Program implementation.

Since, starting from September 1 private insurance companies started to render medical assistance for the population below the poverty line, almost 90% of the beneficiaries have maid their choice already and got insurance policies. However, state agencies of health and social programs, as well as Ministry of Health of Georgia received applications from beneficiaries requesting abolishment of existing contracts and getting insurance with other insurance companies. Reason for such requests was that insurance companies of their choice have failed to provide adequate medical services. Main problem of course is getting planned in-patient and out-patient treatment. As a rule, a beneficiary first addresses a hospital, to get diagnosis and list of necessary treatment. In most cases, opinions of the doctor from the hospital and that of the “family doctor” of the insurance company contradict and this causes non-satisfaction of the beneficiary’s needs.

Therefore, there is a need of establishing the so called “commission for claims”. The commission includes representatives of the insurance company, agency of health and social programs and the Ministry of Health and each case is discussed separately.

Success of the pilot program in Tbilisi and Imereti region is evidenced by the analysis in October 2008[1] of works completed by insurance companies. It will be good to compare these works with the activities carried out by the agency, because it is planned from year 2008 to use private insurance companies to render services to all registered beneficiaries. It will be also interesting to compare contracts between service providers and the agency for health and social programs and private insurance companies with regards to costs for relevant nosologies.

Short review of the health sector financing and comparison with the countries of socialistic group

For the general economic assessment of the health sector we will shortly review the current situation in Georgia and will compare it to several countries of Eastern Europe and former Soviet Union. Such comparison is justified by the similarity of institutional structure and level of social and economic development.

The group of countries in the table N7 is composed according to the amount of gross domestic product (GDP) for one resident (taking into consideration the purchase ability). During the analysis of the table, one significant tendency becomes vivid: the seven countries having the highest amount of GDP are also leaders in the expenses made for health sector.

Table #7

	GDP per capita (PPP) USD 2006	Public Expenses on Health Sector per capita (PPP) USD 2004	Total Expenses for the Health Sector (PPP) USD 2004	Share of health expenses from GDP 2005
Estonia	16692	590	776	4.2
Poland	15149	567	810	4.5
Latvia	15806	387	750	3.3
Russia	12178	341	570	3.2
Bulgaria	10022	354	634	4.3
Kazakhstan	9568	245	393	2.4
Ukraine	7832	240	361	3.9
Azerbaijan	6476	39	159	0.9
Armenia	5177	74	320	1.3
Georgia	3642	66	209	1.8
Moldova	2744	114	202	4.2
Tajikistan	1494	19	83	1

It is worth mentioning that no correlation is visible between the level of the economic development of the country and the expenses for health service per capita, as well as private expenses. This might be pointing to the fact that the development of the private health sector is rather slightly related to the economic development of the country. This can be explained by the reason that in a particular country the private health service belongs to the expensive services of high level; therefore the administration expenses are high. We should also take into consideration that in the relatively developed seven countries given in the table, including Moldova, the expenses related to the health sector exceed the GDP with 2 %. All the countries having the high rates of health sector financing (except Kazakhstan) are located on European continent. This might be caused by the higher level of the economic structure and political governance of these countries and well as the stronger orientation of state funds on social sector.

The facts given in the table vividly underline the fact that in the period of transition the state financing of the health sector is of high importance. Unfortunately, according to the parameters given above, Georgia is leaving behind only Azerbaijan and Tajikistan and the expenses on health sector in these countries can be regarded as completely inadequate. It is noteworthy, that Moldova with less economic potential compared to Georgia, still manages to allocate more funds for the health sector.

According to the document of Georgian government on “Basic Data and Directions”, it is planned to increase the financing of the health sector by introducing health, treatment, social and investment programs. The total financing by 2007 is equal to 279 million GEL, which is approximately 1.9 % of GDP. This rate must increase to 377 millions by 2010 and will be equal to 1.9 % of GDP. It is planned to increase the financing of treatment programs more than two other components. Therefore the flow of state expenses for health will remain the same in relation with GDP. Due to this fact Georgia will still be located in one of the last places in the group of the countries with high state expenditures in health sector. Out of pocket payments for health will possibly grow but this will not be enough for the major change of the situation. If we imagine that the rate of private health expenditures (out of pocket payments) will become equal to the rate of the real growth of economics (10 %), their amount per capita will not be more than 200 USD. In the countries given in the list, the number of doctors for 100 000 residents is about 66-73 specialists. Judging by these circumstances and taking into account the low processing of health sector and possible reduction of the number of medical workers, the material condition of the medical workers will not change in the nearest future. This fact will not have a positive influence on the sector development. In the nearest future extremely slow growth of population and gradual ageing is expected. Taking into account this fact and the slow growth of the amount of state expenditures, the level of total expenses for health per capita will still remain rather low. This certainly is not sufficient for reaching the serious progress in the health sector, especially for improving the conditions of the poorest part of the population.

Brief overview of development trends of Insurance sector in Georgia

Despite the rapid growth during the last year, the insurance sector in Georgia still seems to be rather narrow compared to other developed countries. The total amount of the funds received from the assistance sector last year, was equal to 70 million GEL and this is approximately more than 16 GEL per resident. The insurance sector is growing rapidly and the average rate of its annual growth has exceeded 50 % during the last seven years, though recently the stabilization of the rate of growth has become vivid. The reimbursement implemented by the insurance companies during last year was equal to 23 million dollars. The total premium of the biggest insurance company “Aldagi” was 30 million GEL, more than 41 % of the whole market. It should be mentioned that the premium received in the medical assistance sphere was

approximately 19 million GEL, about 27 % of the whole insurance service market. The share of the medical assistance during the last years was stable and in 2001-2005 was between 18-19 percents. We should take into account the objective fact that the health insurance is a very expensive service and Georgian insurance companies have to reimburse 70 Tetri for each GEL of the premium. Judging by these criteria, this form of assistance is the most expensive service compared to others (car insurance, cargo, financial risk, life insurance, accidents, property insurance and etc.).

The information given above proves that the total turnover of the Georgian insurance companies is not yet sufficient for insuring the wide parts of the population. The amount of the funds issued for health insurance and premium show that the number of people using the insurance service is not large. If we consider the standard annual health insurance package in the amount of 150-200 GEL, it can be regarded that the number of the people using the health insurance service during the last year was equal to 100-140 000 residents. It is important that the corporate insurance dominates on Georgian health insurance market and this means the group insurance of the employees by the employer. The reason of this is quite understandable, since individual insurance is quite expensive and by the premium received by insuring the group of people, the insurance company manages to equalize the risks related to separate insurance of the individuals. Therefore, the current medical assistance market, despite the encouraging tendencies, is not yet ready for providing service to additional 700 000 people. On the other hand, the implementation of the state program might strongly encourage the future development of the sector in case the program administration and monitoring is implemented successfully. The accuracy of the program elaborated by the state, exact identification of the poor and definition of their needs, as well as thorough monitoring of the program, must play key roles in the process.

Conclusion

In our opinion, the Government of Georgia has chosen the right scheme in order to provide the medical assistance to the socially unprotected people and this might be the optimal choice judging by the following factors: 1. providing the service to the poor only by means of the state medical institutions would be much more expensive compared to the private sector involvement in the same process. Besides, the participation only from the government's side would cause corruption and inefficiency. 2. Transfer of the poor to the private service sector could result in condition where the poor would not be able to use the medical service at all. 3. Collaboration between the public and private sector and issuing vouchers to the population and insurance companies, creates the possibility of choice. This choice is the provoking factor for the creation of competitive prices and qualities in the market. Therefore we consider the directions chosen by the government to be solid, though from the three decisions given above the accurate planning, implementation, monitoring and definition of the economic agents' actions and preferences will be the most difficult to implement.

As we have mentioned above, the first stage of distributing vouchers was followed by some difficulties, this was caused by low level of informing population, insufficient amount of study work and insufficient preparedness of medical institutions to finance the program of the huge scale. Though the health assistance package aimed for each poor resident is not quite large, it can be counted as optimal because of two reasons: 1.Unfortunately the financial abilities of the country are still weak. 2. The distribution of more "expensive" vouchers might cause big losses due to the innovation of the program. It should be taken into account that the financial value of the program is equal to the total premium received by the medical assistance firms last year and this can create serious problems for the companies in administration field; these problems will be caused by lack of human, financial and institutional resources. In case the majority of the poor

use the insurance service, the number of the new clients will exceed the amount of the clients registered before and will certainly result in some obstacles.

We think it to be problematic to adhere the preferences of the chosen 700 000 people to the abilities of medical sphere. First of all, the most widely spread diseases in this group of people should have been identified and the assistance package was supposed to be created according to these factors. Unfortunately we do not have information whether this kind of study took place or not. This kind of practice is widely spread and is absolutely necessary for reaching the high efficiency of the public assistance programs. We can name Brazil as an example, where the budget of the country allocated billions of dollars for the poor annually, the major part of these funds was still given to the rich as well, since the government despite of good intents, was not able to identify the groups of people who really needed assistance from the country. Generally this type of assistance must be based on necessities. The following mechanism should be introduced: the product or service aimed for the poor must be specified, simple and cheap, so that only the poor have the willing to use it. Otherwise the public assistance service will be used by the people who need it least of all. It is important to know in advance whether any special disease (infectious for example) is more frequent among these 700 000 residents than any other people. It is crucial to know whether the ageing, educational, national or other characteristics of the poor are more different than those of the other people, it is also very important to get acquainted with the general culture of medical service usage and to determine whether it is better or not to insure people with medicaments. Without answering all these questions the work of assistance mechanisms will become more complicated.

The transactional expenditures related to usage of assistance package must be defined. For example, in case the client lives in a village and major administrative centers where he/she could receive medical treatment are not easily accessible; the real value of the policy would be less than nominal. This might cause the beneficiary to “sell” the voucher.

In case the target group is not chosen adequately, two fundamental problems typical for assistance sector will become vivid: diverse selection and moral hazard. In the first case the insurance companies will have to reduce the amount of service, since they will not have the ability to identify the basic characteristics of the group of their potential clients. In this case, the insurance company will provide service only to the persons with the highest hazard and the others will be left without any service. In case of moral hazard, the groups of the highest risk will become eager to use larger amount of the service than needed (in case the insurer is not capable to monitor their activities and risks).

Most of the state programs are planned without conducting relevant economic analysis and studies. The reason of this might be lack of professional staff, short terms of program planning and etc. In case of the wrong planning the final result of these programs is generally insufficient. In order to reach the maximal result, it is absolutely necessary to analyze the economic factors that play key roles in planning the programs. Such factors are very often neglected during the elaboration of state programs. The state programs must correspond to the system of the Medium Term Expenditure Framework. In order to increase the efficiency of the programs, these programs must be considered for midterm period.

To make a conclusion and taking into consideration the available information, we might state that the new program of the government is a theoretically good initiative, though its scales, innovation and problems existing in Georgian medical and insurance spheres might hinder the process of its successful implementation. For the beginning it would be better to prepare and implement the pilot program of less scale and amount and this could give us the possibility of better planning of the existing program. The future study of the people using the vouchers

distributed by the government will give us the opportunity for final assessment of the effectiveness and efficiency of the program