

Descriptive Background to Health Care Financing Reform Strategy Development in Georgia

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George Gotsadze
Cheryl Cashin
Akaki Zoidze
Jan Valdin

Curatio International Foundation
Abt Associates Inc.
Curatio International Foundation
Abt Associates, Int.

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Table of Contents

1. INTRODUCTION.....	3
2. HEALTH CARE REFORMS OF 1995-2003.....	4
2.1 HISTORICAL CONTEXT.....	4
2.2 THE MAIN POLICY DOCUMENTS	5
2.3 THE ELEMENTS OF HEALTH CARE FINANCING	7
3. RECENT POLITICAL DEVELOPMENTS	9
3.1 GOVERNMENT PERFORMANCE AND INITIAL RESULTS OF 2004	9
3.2 TRANSITION EFFECTS ON SOCIAL AND HEALTH SECTOR FINANCING.....	10
3.2.1 <i>Fiscal Sector Policies</i>	10
3.2.2 <i>Strategic view on social and health sector</i>	11
4. CURRENT STATUS AND PRINCIPLES FOR THE HEALTH FINANCING DEBATE..	12
4.1 A CONSOLIDATED HEALTH SECTOR STRATEGY.....	12
4.2 FRAMING THE CURRENT HEALTH FINANCING POLICY DEBATE	14
4.2.1 <i>Underlying Principles for a Consolidated Health Sector Strategy</i>	14
4.2.2 <i>Strengthening the Core Health Financing Functions</i>	19
4.3 HEALTH FINANCING POLICY PRIORITIES AND OPTIONS	23
4.3.1 <i>Health Financing Policy Priorities</i>	23
4.3.2 <i>Policy Options: Distributing Government Health Funds Across Services and Populations</i>	24
5. CONCLUSIONS AND NEXT STEPS.....	29
REFERENCES	31

List of Tables

Table 1	NHA Data for 2001-2003 in Georgia	16
Table 2	Health Sector Budget Allocations (2003 – 2005)	20

List of Figures

Figure 1	Set of Essential Health Care Services Under Government Health Financing Policy Umbrella	17
Figure 2	Expansion of Government Funding for Health Care	19
Figure 3	Current Coverage of Services and Population with Government Health Funding	25
Figure 4	C overage of Services and Population with Government Health Funding Under Option 1	25
Figure 5	Expansion of Coverage of Services and Population with Government Health Funding Under Option 1	26
Figure 6	Coverage of Services and Population with Government Health Funding Under Option 2	26
Figure 7	Expansion of Coverage of Services and Population with Government Health Funding Under Option 2	27
Figure 8	Coverage of Services and Population with Government Health Funding Under Option 3	27
Figure 9	Expansion of Coverage of Services and Population with Government Health Funding Under Option 3	28

1. Introduction

The purpose of the paper is to contribute to the current thinking within MoLHSA and the Government of Georgia (GoG) about health sector financing reforms. The paper takes a historical perspective in order to set the stage for a common understanding of the issues inherited by the health financing system of Georgia from the pre-“rose revolution” period. It aims to bring these issues into the policy discussion process, which is currently being set by the MoLHSA, and which involves all stakeholders (national experts and policy makers as well as international development partners). The paper attempts to identify clear priorities for the focus of health financing policy during coming years, and to frame the debate in order to carefully analyze the policy options available to the GoG for developing a realistic and appropriate strategy for health care financing.

The paper contains five sections. The first section describes the status of health sector reforms at the time of departure of the previous government in late 2003. The second section looks at the influence of the political processes of 2004 on health care financing policy formulation. The third section describes the current status of the health policy environment, and the main principles and priorities for further health financing policy development. The fourth section outlines several alternative options for setting priorities for allocating government health care funds for the GoG’s consideration. The fifth section presents conclusions and identifies possible next steps.

2. Health Care Reforms of 1995-2003

2.1 Historical context

Transition from a socialist system to a market economy caused economic recession and real gross domestic product (GDP) decline throughout Former Soviet Union (FSU) countries. A reduction in the size of the state sector and changes in the method of tax collection has further eroded the tax base and resulted in substantial reductions of public revenues.¹ During the period 1992-1996, there was a sharp decline in output in Georgia that resulted in the deepest economic dive among all FSU countries (a drop of 78 percent compared to the 1990 level).²

In 1995, in response to the economic crisis that brought public expenditures for health to a level of less than US\$1 per capita, the Government launched an ambitious health sector reform program and introduced a new model for health care financing, combining social insurance, tax revenues and out-of-pocket payments. Health services are offered through a publicly financed primary care network, and the state also finances “essential” hospital care (based on a limited positive list of services). While key health facilities remain in the public domain, others have been privatized. Competition between providers has been introduced through contracts signed with new public financial intermediaries established at the national and municipal levels.

Thus, Georgia moved away from a state-funded and input-based financing model to a purchaser-provider split and greater use of market mechanisms. Health care was to be predominantly funded through payroll taxes complemented by general and municipal budgets. However, a high unemployment rate, a large and growing informal sector, poor fiscal performance and low level of budget revenues undermined government intentions in this respect. The constitutional guarantee to free health care was removed in 1995, and user fees were allowed formally either to co-finance services in the publicly financed benefit package or to pay for services not covered by public programs.

As a result of reforms, the GoG introduced four critical sources of funding for the health sector³: i) payroll health taxes - introduced in 1995 to mobilize earmarked funds for the health sector; ii) state budget revenues – consisting of two parts: one being channelled through major health service purchasers in the country, and the second allocated to various government entities that own health care facilities (e.g. Ministry of Interior, Ministry of Defence, etc.); iii) local taxes - providing financial resources for municipalities to finance health services; iv) private contributions - consisting of formal co-payments (for publicly insured services), fee-for-service (for services outside the basic package), and private insurance premiums collected by private insurance companies.

The initiated reforms, while progressive in their design, failed to resolve the problems

¹ Ensor.T and Savelyeva.L. (1998) Informal Payment in Health Care in Former Soviet Union: Some Evidence from Kazakhstan. *Health Policy and Planning*; 13 (1):41-49.

² Bonilla-Chacin.M., Murrugarra E.and Temourov.M. 2003. Health Care During Transition and Health Systems Reform: Evidence From The Poorest CIS Countries. Paper presented at the Lucerne Conference of the CIS-7 Initiative, January 20-22, 2003.

³ Gotsadze G. and A. Dixon, 2003, Healthcare Financing in Georgia: a Functional Analysis. Curatio International Foundation. Tbilisi.

faced by the population. The health system continues to rely mainly on out-of-pocket payments, and public financing for the sector contributes only a marginal share. Therefore, financial access barriers still remain within the system and limit access, mainly by the poor, to needed services. Health care costs are a significant burden on household budgets, and a hospitalization could easily push even well-off households into transitional poverty. Moreover, for the poor layer of society, even appropriate outpatient care poses a significant financial burden. Thus, overall, health care financing reforms failed to secure adequate financial risk protection against illness for households in Georgia, both poor and well-off alike.

2.2 The Main Policy Documents

The problem of access to needed services and inadequate public financing was a problem well recognized by the previous government, and attempts were made to resolve this critical issue. Three major policy documents were developed during 1999-2003, which outlined planned improvements in state health policies. These major documents are:⁴

1. Georgian National Health Policy (NHP)
2. Strategic Health Plan for Georgia 2000-2009 (SHP)
3. Economic Development and Poverty Reduction Program of Georgia (EDPRP)

All of these documents are impressive pieces of work, but of course outdated in the sense that after the 2003 events, the new government is working from a different political platform. Meanwhile, however, these documents continue to be used by the current GoG as a starting point for future policy development.

The **National Health Policy (NHP)** is a solid document based on the WHO strategy *Health 21 – health for all in the 21st century* and the presidential programme of the time, *For a New Democratic Georgia*. The main weakness of this document is that it covers nearly all possible areas of intervention and presents a standard model of targets and actions, without being very specific in relation to conditions in Georgia. This document could be adopted by any government as a wish list for the future, which is a weakness that is common to many other countries' health policies and therefore not surprising in itself. The strengths of this document are found for the same reason, in that it details targets and strategies for each area of factors contributing to good health.

The **Strategic Health Plan for Georgia (SHP)** is a “process document,” clearly intended to push the strategic planning process ahead by suggesting specific steps and coordination mechanisms. This document covers many subjects on strategic planning, provides suggestions for implementation responsibilities and arrangements, and it also presents a budget estimate for the health sector over the period up to 2009. The total cost of implementation over the period was estimated to be US\$ 2.5 Billion.

The **Economic Development and Poverty Reduction Program (EDPRP)** from 2003 is the most recent of the three main policy documents, and it has taken into

⁴ Georgian National Health Policy, GoG, Tbilisi 1999, Strategic Health Plan for Georgia 2000-2009, GoG, no date [probably dated 2000], Economic Development and Poverty Reduction Program of Georgia, GoG, June 2003.

account more recent data and budget expenditures. The EDPRP is a solid paper, covering descriptive as well as analytical sections in depth. The document also addresses the social and the health sectors as smaller pieces of a total economic development and poverty reduction strategy. However, the sections dealing with social services and health are much more elaborated and better integrated into the full context of economic development than seen in many other similar country papers.

The EDPRP states that the health status of the population is conditioned by:⁵

- Low efficiency of public health care activities, especially in terms of introduction of healthy lifestyle promotion and prevention of diseases;
- Lack of a safe and healthy environment for the majority of the population, which increases vulnerability and deteriorates the health condition of the poor;
- Inefficiency of the primary health care system, which results in reduced accessibility to basic services.

In terms of the overall, broader issues of social security, the paper summarizes:⁶ “Three main problems can be distinguished in the social protection system:

- Insufficiency of the tax base, resulting from low remuneration of labor on one hand, and small number of the people employed in formal sector, on the other;
- Demographic changes – aging of population;
- Poorly targeted destination of social transfers.”

As can be noted from this quotation, **the health sector’s under-funding was not a sector-specific problem, but a general state of affairs caused by insufficient tax base and the weakness of the fiscal performance of the state.**

Finally, the EDPRP presents its version of the “medical poverty trap” in the following way:⁷

“Poverty and resource crunch is one of the main reasons for unhealthy life style, malnutrition and belated and insufficient treatment. The poor have no monies to take care of their health... Chronic diseases are characteristic of poverty. The danger of worsened health is higher among poor families, who make use of prevention measures to lesser extent. Drastic deterioration of health condition, require hospitalization or long-term healing and endanger a big part of non-poor households. Little expenses incurred on health by the households results in short and long-term negative impacts – the probability of serious deterioration of health and risk of lump sum entailed expenditures is high in such families. Gradual worsening of health condition without recovering (malnutrition, stress situations, inadequate prophylactics) lowers the labor productivity of human beings and ultimately the stamina to surmount poverty.”

Again, the EDPRP clearly puts the health sector in a broader context, just as the NHP document does, with its emphasis on lifestyle and environment.

⁵ EDPRP, op. cit., para 167.

⁶ Ibid, para 106.

⁷ Ibid, para 114.

Finally, it is obvious that all three of the documents discussed above were the result of close cooperation of the working groups from different sectors. **These documents offer a good model of integration of health policy into a broader economic development and poverty reduction strategy, often missing in similar exercises in other countries.** The new government of Georgia is expected to employ a similar integrated approach when advancing the health policy development process.

2.3 The Elements of Health Care Financing

The elements found in the described documents particularly related to health care financing are outlined below.

In 1999, the **NHP** concluded that the reforms of 1995 accomplished “institutional reorganization of the system” and shifted the financial mechanisms for “a considerable part of medical care” to “insurance principles”⁸. Nevertheless, the NHP admits that payroll taxes failed to generate sufficient funding for the sector and the main emphasis was placed on the Ministry of Finance (MOF) as the final source of funding.

The document also recognized the need to make a “basic health package” accessible for all through “state funding” and for the services “beyond the basic health package” offered with the support of “private, voluntary and community insurance”.

NHP⁹ offered a four-pillar approach to improving health sector financing:

- Increasing public expenditures as a share of GDP;
- Provision of a *Basic Package of Services* to all with public financing;
- Expanding coverage of the population with the help of state (social) insurance system;
- For the services not included in the *Basic Package*, facilitate the development of a private insurance system.

The **Strategic Health Plan 2000-2009** (SHP) further advanced these policy approaches and offered specific targets:¹⁰

- Increase the share of GDP devoted to health up to 4 percent by 2005 and up to 6 percent by 2010;
- Provide a *Basic Health Package* to all with financing from public funds;
- Increase coverage with social health insurance to the whole population by 2010;

The SHP document is a bit more explicit in terms of increasing the allocation of resources for health and mainly giving priority to prevention and primary health care. The SHP states that “considerable resources shall go for primary health care from hospital services.” Such statements were, however, mostly declarative, and when

⁸ NHP, p. 4.

⁹ Cf. next section for estimates of recent budget expenditures.

¹⁰ SHP, section 5.6

funding allocations under SHP are analyzed, different priorities in fact emerge. For example:

Despite the dominant priority of public health and environmental control activities on the SHP activity list, personal health care services account for 95 percent of the Strategy's aggregate cost. To clarify this estimation, most of the planned expenditures on health system strengthening and reforms are aimed to improve the provision of personal health care services, and are therefore classified into the respective category.

Recurrent expenditures account for 74 percent of the Strategy's projected cost. The remaining 26 percent reflects investments that in their broad definition include outlays on physical plant, human capital (e.g., medical training, rehabilitation of displaced health workers, patient education, and community mobilization), and institutional capacity building in the health-sector and related institutions.¹¹

The SHP also explicitly addresses the issue of informal payments and suggests channelling the out-of-pocket expenditures into the official health care system. The document fails, however, to identify and propose appropriate strategies for achieving this objective.

Thus, SHP is a comprehensive document that identifies well the problems of health care financing, points toward the appropriate policy options available for the government, but fails to allocate appropriate financial resources and define activities that will ensure effective policy implementation. Therefore, the SHP requires major revisions and rethinking in the context of recent political changes and improved performance of the new government (described in the following section).

In the EDPRP, the section on *Improvement of Health* provides no specific vision or recommendations on health care financing. The EDPRP clearly refers to the *Georgian National Health Policy* for programs to be implemented and adds that the **"implementation and funding of such programs go beyond the competence of a single government agency and require inter-sectoral, coordinated and comprehended efforts of the Government and society."**¹² As to financing, it proposes that equal opportunity for certain groups should be compensated through **"social assistance mechanisms"** (para 411).

¹¹ Telyukov A., Paterson M., Gotsadze G., Jugeli L. 2003 Situation Analysis for a New Strategy of Technical Assistance in the Health Care Sector of Georgia. PHRplus. Bethesda.

¹² EDPRP, para 410.

3. Recent Political Developments

The new government of Georgia inherited daunting economic and financial challenges. The weakening of the public finances, owing to widespread corruption and tax evasion during the years of Shevardnadze's government, has hampered the state's ability to remain current on wages and pensions and to deliver basic public goods and services. During the fall of 2003, pension and wage arrears along with falsified election results fuelled civil unrest led by opposition parties. The "*rose revolution*" brought the opposition into power and brought new hopes and opportunities for economic and social development in Georgia.

Trust in the new government and hope for future developments triggered donor interest, resulting in a pledge of US\$ 1 billion at an international donor conference held in Brussels on June 16, 2004. Currently, with support from development partners, **Georgia is embarking on a wide-ranging economic and social reform program to create the conditions for sustained and equitable economic growth and poverty reduction.**

According to the recent statement of the GOG, leadership intends to tackle corruption and governance issues, improve the efficiency, effectiveness and transparency of the government, and strengthen the country's macroeconomic fundamentals, which are critical steps for achieving long-term economic growth and poverty reduction set out in the Economic Development and Poverty Reduction Program (EDPRP).¹³ **The new government affirms its adherence to EDPRP priorities developed by the government of Shevardnadze during 2003 and its dedication to further economic and social reforms.** As a result, the International Monetary Fund (IMF) on June 4th, 2004 approved a three-year arrangement under the Poverty Reduction and Growth Facility (PRGF) in an amount equivalent to US\$144 million to support the government's economic program into June, 2007,¹⁴ and the World Bank and EC are providing additional financial assistance.

3.1 Government Performance and Initial Results of 2004

During 2004, the new government embarked on ambitious quick-fix efforts to:

- Dramatically improve governance and reduce the scope for corrupt practices by implementing a phased reform of the public sector, focusing initially on the civil service;
- Raise tax revenue by accelerating administrative reforms in the tax and customs areas, as well as through tax policy measures;
- Make further improvements in budgetary expenditure management and eliminate/decrease arrears accumulated by the previous government;
- Maintain a stable macroeconomic environment, supported by a prudent monetary policy and further fiscal consolidation;
- Accelerate other important structural reforms, improve the business climate

¹³ Letter of Intent sent to IMF on May 12, 2004 by the president and prime minister.

<http://www.imf.org/external/np/loi/2004/geo/01/index.htm#mefp> accessed on January 11, 2004

¹⁴ IMF, Press Release No. 04/107, June 4, 2004, <http://www.imf.org/external/news.htm> accessed on January 11, 2005

and create jobs.

At the time of preparing this document, the efforts of the government have generated the following initial results:

- Rapid gains in tax collections were achieved by the drive to curb tax evasion and corruption, which permitted a faster-than-expected clearance of domestic wage and pension arrears.¹⁵ Arrears to health care providers were also partially reduced.
- As a first step toward creating a professional civil service, the government reduced public employment by some 30,000 positions and used salary savings to increase the remuneration of remaining personnel. These changes have not yet affected all sectors, such as health, for example, but the process is underway.¹⁶
- An ambitious privatization program was announced, and supporting steps to improve the business/investment climate have been taken, which is expected to offer new jobs and employment in private sector;¹⁷
- A new streamlined/liberalized tax code was passed at the end of 2004, reducing the number of taxes from 21 to eight, and the social tax rate was decreased from 33 to 20 percent. As part of the tax code changes, the earmarked payroll tax for health (“3+1”) that was part of social tax was abolished;
- To encourage legalization of the informal economy, a one-off tax write-off has been proposed on undeclared tax obligations incurred by the end of 2003, and the legalization of undeclared property is proposed against payment of a one-time levy of one percent on the value of property.¹⁵

3.2 Transition Effects on Social and Health Sector Financing

Despite the fact that substantial progress has been observed in a short time under the new government, major challenges are still ahead. The sections below focus on the GoG’s fiscal and social policies in order to identify the linkages and/or impact of these reforms on health care financing policy development.

3.2.1. Fiscal Sector Policies

The intention of the government is to intensify the reforms even further and concentrate on key priority areas. In the fiscal sector, the main challenges will be to effectively implement the new tax reform and make the transition as smooth as

¹⁵ IMF Country report No.05/1, January 2005. Georgia: First Review under the Three-Year Arrangement under the Poverty Reduction and Growth Facility. p7.

¹⁶ During elections to secure sufficient electoral votes opposition (current government) promised health sector employees to protect their jobs and not to allow closing of hospitals or health facilities. Due to this reason plans to rationalize supply side of the health sector proposed by the previous government were criticized by the political opponents.

¹⁷ On January 11, 2005 TV evening news program “Kurier” of Rustavi 2 broadcasted prime ministers speech at privatization tender opening for two state enterprises to results in approximately 160-180 million revenues in 2005 instead of planned 94 million (for whole privatization program) under the budget law for 2005.

possible. Moreover, the government plans to introduce multi-year budgeting and closely link policies and national priorities with annual budgetary allocations. The year 2005 has been selected by the Ministry of Finance to pilot the Medium-Term Expenditure Framework (MTEF) as a means for effective expenditure management.¹⁸ The health sector has been one of three sectors (also including education and agriculture) to pilot, or “fast-track,” implementation of the MTEF process.

3.2.2. Strategic view on social and health sector

Social policy, pension arrears and poverty was the main election topic for the government to secure public support prior to the revolution and during elections. However, in 2004 the new government suspended major laws on social insurance that were approved in 2003, effectively abandoning the five-year-old social insurance model for developing the social and health sectors. Instead of the two-tiered pension system stipulated by the suspended laws on state pensions, the GoG focused on increasing flat-rate age pensions and **developing a system for means-tested targeted poverty benefits, for which details of implementation are being elaborated by MoLHSA.** According to the budget law for 2005, flat-rate age pensions have been increased to 28 Gel per month, and means-tested targeted poverty benefits will be initiated from November 1st, 2005.¹⁹

The new government recognized the need for developing policies and reform strategies for the comprehensive social welfare system, and during 2005 the MoLHSA embarked on policy elaboration with its development partners. The government’s intention is to view health and social sector jointly and develop integrated policies.

According to the minister of MoLHSA, 2004-2005 will be used by the ministry to elaborate clear strategies and policies for health sector reform, and actual implementation will commence in 2006.²⁰ Meanwhile the MoLHSA declared following priorities for the health sector for 2005:²¹

- Provide free ambulance service throughout country;
- Offer free outpatient services to all elderly and children in the country;
- Rehabilitate PHC facilities for rural areas, and retrain doctors into family physicians and general practitioners; and
- Invest/rehabilitate selected diagnostic and hospital facilities.

¹⁸ Stone S. October 2004. Georgia: Primary Health Care Reform Support Project: Budget Management for Health Care. Oxford Policy Management.

¹⁹ Law of Georgia on 2005 State Budget, Sakanonmdeblo Macne, December 30, 2004, Tbilisi (in Georgian).

²⁰ Speech of the minister of health at WHO organized workshop on Health Sector Financing, June 2004, Tbilisi.

²¹ Interview of the minister of health with the newspaper “Akhali Versia”, Jan.9, 2005.

http://www.versia-online.com/cgi-bin/n_versia.pl?f=show_statia&id=3546. Accessed on January 10, 2005.

4. Current Status and Principles for the Health Financing Debate

4.1 A Consolidated Health Sector Strategy

Although the priorities for the health sector have been identified by the MoLHSA, as listed above, a clear strategy for health sector reform has not yet been articulated. There are, however, three related processes currently underway in Georgia that are leading the MoLHSA to focus on further elaborating its strategies for the health sector and to link those strategies with budgetary allocations, broader health financing and service delivery reform, and appropriate structural changes in the ministry. First, the GoG is currently undertaking a **comprehensive initiative to reform the public sector**, beginning with a definition of the boundaries of the core functions of each government ministry. It is expected that this process will lead to reorganization of some ministries around the streamlined set of core functions and over-arching strategies that are identified. As part of this process, which is being led by the State Minister for Economic and Structural Reform, each ministry is expected to conduct a functional review, develop a clear mission statement, and draft a **strategy and action plan by mid-2005**. The MoLHSA presented its overall vision for future development of social protection, which includes development of the health sector, to the parliament in March, so the next step will be to further elaborate the strategy and translate that strategy into an action plan.

Second, as discussed above, the health sector has been selected as one of three pilot sectors to implement the Medium-Term Expenditure Framework (MTEF), which is a budget formation process that links budget preparation with sector strategies and priorities. The MTEF process comprises three “pillars”:²² (i) the development of the macro-fiscal framework (projections of the overall government revenue envelope); (ii) an analysis of cross-cutting public expenditure issues that could influence resource allocation across different sectors; and (iii) sectoral analysis and sector expenditure plans. The result of the MTEF process is a set of spending ceilings for each sector, which will provide the government resource envelope for the health sector. As part of the MTEF process, the health sector is currently developing a “strategic expenditure matrix,” which identifies the key program areas that will make up the expenditure plan for the sector, and includes a strategic analysis of each program area, including major issues, objectives, necessary reform actions, and implications for the health sector budget.²³

The third ongoing process is the preparation of the World Bank Poverty Reduction Support Credit (PRSC) that is expected to provide budgetary support to the GoG to pursue the overall development objectives outlined in the EDPRP. The PRSC will be approved by the World Bank if a set of pre-conditions are met, then it will be disbursed in three tranches as other “triggers” or milestones that are agreed upon with the government are achieved. Although the pre-conditions for the PRSC to be approved have not yet been finalized, it is anticipated that a health sector strategy and financing plan related to MTEF will be a part of any final set of conditions agreed

²² Ministry of Finance of Georgia. 2005. 2006-2008 Medium-Term Expenditure Framework: Inception Memorandum for the First Task Force Meeting. p. 2.

²³ MTEF Inception Memorandum, p. 4.

to by both the World Bank and the GoG. The PRSC is expected to be presented to the Board of the World Bank in September 2005, so any pre-conditions specified, including presumably the development of a health sector strategy, would have to be met by mid-July 2005.

Thus, there is a clear requirement for the development of a series of health sector strategy documents by July 2005. It is essential that as these three processes continue, the health sector strategic planning and the documents that are generated are brought together in one consolidated strategy with clear underlying principles. While the MoLHSA is in the process of developing its strategic view of the future health sector of the country, changes brought in the recent transition already have begun to set some boundaries for future policy options. The foundation of the major health policy documents drafted by the previous government of Georgia (National Health Policy, Strategic Health Plan, and Economic Development and Poverty Reduction Program) and the social policy priorities and strategies of the new government, therefore, form the point of departure for health financing policy debate in Georgia at this time.

With some revision and strengthening, the National Health Policy, Strategic Health Plan, and Economic Development and Poverty Reduction Program can provide the basis for developing a “flexible blueprint” for health sector development in Georgia, and in particular guiding principles for health financing reform. The NHP, SHP and EDPRP may be taken as the starting point for the newly revised and consolidated health sector strategy document, if they are strengthened in several important ways. First, a common flaw of the three documents is that they have all been outdated by the political changes of 2003 and the new government’s policies. A spectacular example is the new tax code, which abolished the earmarked payroll tax as a source for health care financing and moved away from the social insurance model. Having said that, it should be added that a lot of the common ground in the three documents is still part of the valid assumptions underlying the ongoing policy work of the new government. It is up to the government and parliament to pick what pieces of the former framework that may still be applied and what needs to be changed.

Another general area where the policy documents could benefit from improvements, especially the NHP and the SHP, is to strengthen the commitment to **inter-sectoral cooperation** and approach in the effort to improve the overall health status of the Georgian population. This is demonstrated in the NHP, but the actual strategic planning for joint approaches could be improved, as emphasized in the EPDRP quote above. This does not only apply to health care finance, where the ministries of economy (EPDRP), finance and health obviously need to have a joint approach, but also in the broader context of education, environment, accident and injuries, etc.

Both documents are constrained to the health sector, thus implicitly ignoring the overall weakness of the state’s revenue collection. **Health care financing reform needs to be planned and timed based on projected improvements in state revenues, i.e. the whole administrative reform program in the context of the MTEF.** Further, even within the health sector constraints, the envisaged combination of free BBP to all (based on an expanded public insurance system) and private insurance for the rest of the services, is a bit simplistic and unrealistic for a long time to come, given the budget constraints, the expected fee levels and the still to come development of the private financial sector. A minimal additional consideration must be to convert the huge amounts of informal financing into a system of co-payments and user fees (as indicated in the SHP, but not at all included in the action plans).

4.2 Framing the Current Health Financing Policy Debate

4.2.1 Underlying Principles for a Consolidated Health Sector Strategy

The major weakness in the NHP and the SHP is related to the vision of future financing system. The goal of health financing reform should be to create a policy framework that improves the efficiency of health care resource utilization, promotes better quality of care, and increases access to basic health services by providing individuals and families who use health services with financial risk protection through risk pooling. The existing health policy documents identify these issues and recommend broad approaches to addressing them. These documents do not, however, articulate the key principles of health financing policy that are required to improve access to basic services with financial risk protection for the entire population, nor do they specify the specific steps that need to be taken to support implementation of these principles. The following two principles should underpin the legal and regulatory framework for health financing, and thus they must be agreed upon at the highest levels of government and clearly articulated in all health sector strategy documents.

Principle 1: Distinguish Between Health Insurance and Social Assistance

The distinction between social assistance, or programs of budget social transfers to the poor, on the one hand, and the more specific principles of risk-sharing as the basis for a health insurance system on the other needs to be introduced in the policy thinking of Georgian ministries and parliamentarians. The current mix of programs for the poor (often by “categories” of the population) with the concept of insurance, often referred to in terms of solidarity, is not a sustainable road to health financing.²⁴ This is not to say that both are not needed. Social transfer programs will be needed for a large part of the Georgian population living under minimum standards for a long time to come (cf. EDPRP), even in spite of rapid economic development, as the benefits of the latter cannot be expected to be equally distributed. Health insurance must be part of any health care financing system due to the opportunities for risk-sharing. So both need to be reformed and implemented under the umbrella of the inter-sectoral approach to Georgia’s development. However, the risks of a conceptual confusion between the two are obvious and should be avoided by clearly distinguishing health insurance from general social transfers.

- The need for greater focus on health insurance and financial risk protection, both within government-funded health services and beyond, is well supported by the analysis of the **National Health Accounts** (NHA) for 2001-2003 and detailed in Table 1 below. The major conclusions from this analysis are following:
- Limited public financing of the health sector does not allow adequate financial protection for the population. During 2001-2003, the government only managed to finance 22-26 percent of hospital costs, and approximately 26-29 percent of PHC costs.
- The purchase of drugs was mainly left for private expenditures, which placed significant financial burden on the population. As documented elsewhere,^{25,26,27} the cost of pharmaceuticals is burdensome for most poor households in the country.
- Out-of-pocket health expenditures do not pose a financial burden only for the poor. The cost of hospital treatment burdens rich and poor households alike and contributes to transitional poverty.²⁸

²⁴ Donors are often willingly supporting budget transfers to the poor under the name of “insurance”, like for example in Vietnam. In donor supported technical documents in Georgia, this mix of two concepts may also be observed.

²⁵ Gotsadze et al. 2005. Health Care Seeking Behavior and Out-of-pocket Payments in Tbilisi, Georgia: Household Survey Findings. Forthcoming

²⁶ Gotsadze G., Gzirishvili D., Bennett S. and Ranson K. 2001. Health Service Utilisation and Expenditures in Tbilisi – 2000. Report of a household survey. Curatio International Foundation. Tbilisi. Georgia. p.60.

²⁷ Gotsadze G., Zoidze A., Vasadze O. 2005. Reform strategies in Georgia and their impact on health care provision in rural areas: evidence from a household survey. *Social Science & Medicine* 60: 809–821.

²⁸ World Bank (2001). Georgia Republic Poverty Profile Update. Report No. 22350-GE (pp. 11). Washington DC: The World Bank.

Table 1 NHA Data for 2001-2003 in Georgia

Categories	2001	2002	2003
Sources of Funds			
Public Sources			
Central budget allocations % of THE	7.1%	6.9%	4.1%
Central budget allocations % of total public spending	54%	62%	49%
Local budget allocations as % of THE	4.2%	4.2%	4.2%
Local budget allocations as % of total public spending	32%	38%	51%
Private Sources % of THE			
Mandatory Social Insurance Contributions	4.0%	3.6%	4.8%
Voluntary insurance contributions	0.75%	0.74%	0.80%
OOP	79%	78%	82%
Pooling of Funds			
Public entities			
% of public expenditure administered by SMIC/SISUF	44%	54%	61%
% of THE managed by SMIC/SISUF	7.4%	7.9%	8.6%
% of public expenditure administered by Public Health department	12%	13%	3%
% of THE administered by Public Health department	2.0%	1.9%	0.4%
Private entities			
% of THE administered by private insurance companies	0.94% ^a	0.47%	0.50%
% of THE spent on an OOP basis	79%	78%	82%
Financial Risk Protection			
% of hospital expenses covered by public spending	23%	26%	22%
% of outpatient expenses covered by public spending	29%	29%	26%
% of pharmaceutical expenses covered by public spending	1%	2%	2%

THE = Total Health Expenditure

a = in 2001 private insurance company Aldagi was contracted by Tbilisi municipality to administer municipal curative programs for the hospital treatment. Thus, higher share of private insurance companies in 2001 is caused due to these revenues.

To introduce the principle of insurance and access to basic services with financial risk protection, government health financing policy must govern both public and private health expenditures. The strategies for health sector development, and particularly health financing reform, should include financing policy for the entire set of essential health care services to which the population should have access, even if, as is currently the case in Georgia, the government only finances a small portion of that set of services (see Figure 1). Effective regulation of private spending has been the weakest link within Georgia's health sector financing. While private out-of-pocket payments were legally allowed since 1996, previous governments failed to effectively enforce the regulations and tackle the issues of growing informal payments. The new government must seriously consider solutions to this problem. If services that are not financed by the government are not explicitly included under the government health financing policy umbrella, over time it is likely that the MoLHSA will lose regulatory control over these essentially "privatized" services and thus the MoLHSA will not be

even as public funding increased.³³ A number of countries have therefore begun to move toward an integrated legal, policy, and regulatory for government-funded and privately financed health services in order to better strategically manage the health system and promote universal access to the entire set of essential health services. For example, the Government of Tajikistan recently revised legislation governing the state-funded guaranteed benefit package to also provide the regulatory framework for paid services.³⁴ In addition, the Brazilian government has taken steps to reduce the fragmentation of the health sector, and implement the unified health system specified in the constitution, by creating a new regulatory framework that defines the relationship between the publicly-funded system and the private insurance system, and firmly establishes the government's role in regulating the private insurance market to ensure access to essential services.^{35,36}

The current Law on Health Care of Georgia stipulates “universal and equal access to medical care **within the framework of State-funded medical programs.**”³⁷ Thus, the Government has no legal basis for an interest in access to those services outside of the State-funded medical programs, and no lever to regulate aspects of the financing of those services. Amendments to the legal, policy, and regulatory framework are necessary to give the GoG a legal mandate to ensure access to the entire set of essential services, integrate policies governing private sources of financing into broader health financing policy, and actively regulate the private health insurance market to ensure equitable access to essential services for the privately insured and avoid cream-skimming/dumping by private insurance companies.

³³ Liaropoulos, L. and Tragakes, E. 1998. Public/private financing in the Greek health care system: implications for equity. *Health Policy* 43: 153 – 169.

³⁴ Government of the Republic of Tajikistan. 2005. Program on providing medical care to the citizens of the Republic of Tajikistan for the year 2005.

³⁵ Constitution of the Federative Republic of Brazil, 1988.

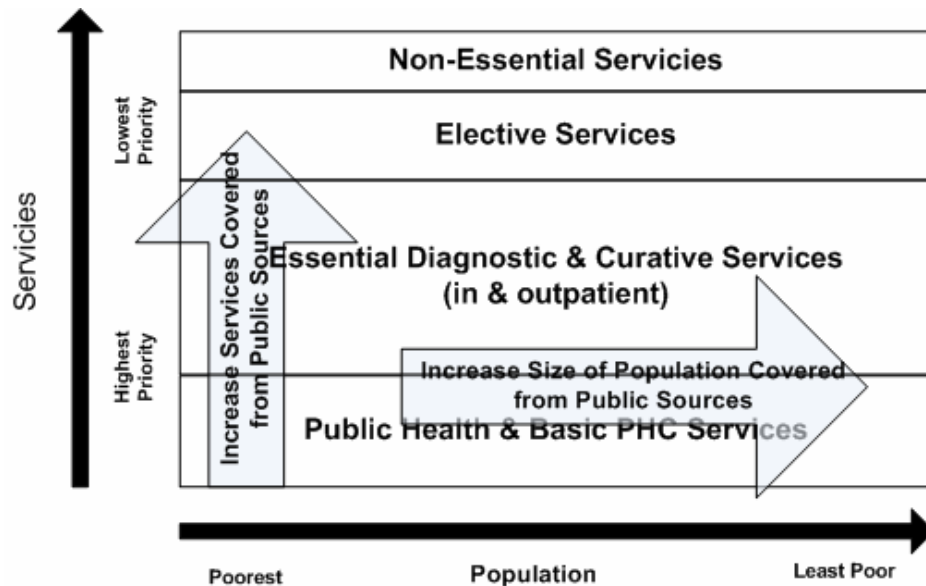
³⁶ Medici, A. 2002. Financing health policies in Brazil: achievements, challenges and proposals. Inter-American Development Bank.

³⁷ Law of Georgia of 10 December 1997 on Health Care.

Principle 2: Allocate government funding for health according to priority services and priority populations

Once the government commits to responsibility for creating a legal, policy, and regulation for the entire set of essential health care services, it is possible to develop effective policies that appropriately integrate public and private sources of financing, and ensures that as the availability of public funding for health increases, the range of services financed and the population covered will increase in an appropriate way that furthers the Government’s health policy priorities (see Figure 2). Health services can be ranked from highest priority to lowest priority (based on the Government’s policy objectives), and the population from most vulnerable to least vulnerable (according to socioeconomic or other criteria), which identifies the expansion path for government funding according to these priorities.

Figure 2 Expansion of Government Funding for Health Care



4.2.2 Strengthening the Core Health Financing Functions

Once these two general principles underlying health financing policy are established, the conditions are created for making appropriate policy decisions for the main health financing functions of resource generation, pooling, benefits/coverage and purchasing, as well as service provision.³⁸

³⁸ Kutzin, J. 2001. A descriptive framework for country-level analysis of health care financing arrangements. *Health Policy* 56: 171-204.

- (1) **Resource generation**, which is concerned with decisions about the most appropriate mix of *sources* of funds for the health sector (general taxes, social insurance contributions, private voluntary insurance, or direct out-of-pocket payments) and the *level* of resources to be allocated to the health sector.

Policy decisions regarding the *sources* of government health care funds have already been made, at least for the short term, in Georgia. Sources of health financing were partially altered as a result of new tax code GoG abolished earmarked payroll health tax (3+1) and shifted funding responsibility for the sector to central and municipal budgets. This policy debate may reopen some time in the future, however, particularly with regard to sources of funds for services not financed by the public budget (e.g. the development of mandatory or voluntary private insurance). The above framework for defining the set of essential services under the government health financing policy umbrella makes it possible to ensure the compatibility of public and private sources of funds to, for example, avoid “cream-skimming” by private insurers of the lowest risk beneficiaries.

Policy decisions surrounding resource generation currently focus on the *level* of funds to be allocated from the government budget. For 2005 health allocations under central budget increased marginally in volume terms up to 133 million Gel from 130 million in 2004. However, as a share of total expenditure planned for 2005, health allocations declined by 0.8 percentage point from the previous year, and now amount to 5.9 percent of the state budget (see **Table 2**). The MTEF process planned for the 2006 budget formation presents the main opportunity to defend financial needs of the sector and link budget formation with the expansion of coverage of priority population and priority services (see “Benefits and Coverage” below).

Table 2 Health Sector Budget Allocations (2003 – 2005)

Budget Categories	Allocations in ‘000 Gel		
	2003	2004	2005
Direct service provision			
Primary Health Care	13,195	14,593	19,513
Hospital care	48,950	50,381	46,768
Critical Pharmaceutical supply	5,700	8,662	9,062
Ambulance services	-	-	8,543
Preventive and Public Health Programs	6,622	3,405	2,575
Sub-Total Direct service provision	6,622	3,405	86,461
Investment programs with grants & credits	2,200	23,142	25,723
Health sector administration	3,458	5,681	7,957
Arrears of previous years	1,365	12,600	-
Other	8,878	9,104	8,036
Total	92,371	129,572	133,182
Health Expenditure as a per cent of State Budget*	6.3	6.7	5.9

* Per-cent is derived from budget plan (not actual) as a proxy measure of political commitment of the GoG

- (2) **Pooling of funds**, which is concerned with decisions about the appropriate pooling entity(ies) for health funds (e.g. national health ministry, regional health authorities, public insurance fund, private insurance agencies, etc.), the appropriate size and diversity of the risk pool, and the flow of funds.

Policy decisions about pooling of government funds have been made, at least for the

short term, in Georgia. Budget funds are effectively pooled at the national and regional/municipal levels, mainly through SUSIF, although the fiscal functions of SISUF were abolished as a result of the new tax code and after approval of the budget law for 2005. Under the new regulations, SUSIF will possess an account in the treasury and will manage funds credited from general revenues.³⁹ Without strict regulations over the treasury's decision-making process, adequate transparency measures, or introduction of effective public control, competing expenditure priorities of the government could possibly affect health sector financing levels. This is the only main risk in the new policy as of yet, although this is not much different from previous years, as SISUF largely depended not only on the 3+1 earmarked payroll tax, but also on central budget transfers, which usually underperformed.

There is possibly an opportunity to improve the equity of the risk pools by exploring needs-based resource allocation formulas to reallocate across regions. There is likely to be very limited benefit to this approach, however, unless funds from Tbilisi are available to be reallocated to rural areas, which does not seem to be realistic at this time. Therefore, pooling of public health care funds does not appear to be a health financing policy priority at the present time.

Exploring options to improve pooling of private funds, however, is an urgent priority. The high level of out-of-pocket payments and the risk of catastrophic health expenditures driving households into, or further into, poverty call for creative solutions to pooling private health payments. The options for risk-pooling for private funds include mandatory or voluntary, public or private insurance schemes. These risk-pooling mechanisms for private expenditures should be designed under the national health financing policy umbrella to be either complementary or supplementary to the government health financing system in order to move toward universal access to essential services with financial risk-protection. These alternative insurance schemes to pool private funds can contribute to this overall objective, and serve as a transition mechanism to a more integrated or unified national risk pool, while limited government health expenditures are targeted to priority services for the most vulnerable groups.

- (3) **Benefits and coverage**, which is concerned with defining the population that will be covered by the pooled government funds and which benefits they will be entitled to, and copayment policies for benefits that are not completely covered by governing funding.

Defining the benefits and population that will be covered by government funds is currently the main policy priority for 2005 and is being addressed the MTEF process and the development of targeting mechanisms for social benefits. The framework for defining the set of health care services under the government health financing policy umbrella should provide the principles that drive this policy debate.

The historical, and recent, patterns of resource allocation show a clear need for more appropriately identifying benefits and coverage to allocate limited budget resources to the highest priority groups. A crude analysis of resource allocation by the GoG for the health sector and by the MoLHSA within the available resource envelope is presented above in the Table 2. The following main trends emerge, which demonstrate that government health expenditures have not been targeted primarily

³⁹ IMF Country report No.05/1, January 2005. Georgia: First Review under the Three-Year Arrangement under the Poverty Reduction and Growth Facility. p47.

to priority services and population groups:

- **Low priority given to the health sector** within the new government. Planned allocations for health from the state budget declined even below 2003 levels and reached only 5.9 percent of total planned government expenditures in 2005, which is less than both the 2003 and 2004 budget allocations.
- **Resources allocated toward “declared political priorities”** for 2005:
 - **PHC allocations** increased by approximately 5 million Gel, but the obligations also increased. Financing of PHC in the capital city of Tbilisi that covers one third of the population of Georgia was previously the responsibility of the city budget, but in 2005, the state budget assumed responsibility to finance services for Tbilisi residents. Thus, in per capita terms, PHC allocation only increased from 4.46 Gel in 2004 to 4.48 Gel in 2005. It is doubtful that such a marginal increase will enable the MoLHSA to meet its promises of free PHC services to elderly and children without removing entitlements to other age groups.
 - A new program – **ambulance services** - emerged in the budget with 8.5 million Gel. Resources for this program were partly mobilized at the cost of decreased financing for hospital services and for public health.
 - **Rehabilitation of PHC facilities** is planned under the state budget. The GoG allocated 2.2 million Gel within the state budget, and 11.9 million Gel from World Bank credit resources. In addition, financing from the EC will be used in Kakheti for PHC rehabilitation.
 - For **investment and rehabilitation of selected diagnostic and hospital facilities**, the GoG provided allocations of 3.4 million Gel from the 2005 state budget.

Superficial analysis clearly shows that the MoLHSA managed to secure allocations for the declared priorities for 2005. The definition of strategic objectives within the MTEF process should follow the principle of allocating government funds to priority services and population groups. When appropriate sectoral strategies are elaborated in 2005 through the MTEF process, the MoLHSA should use this process effectively to secure budgetary allocations for these strategic objectives.

The policy area of benefits and coverage must also be addressed in the broader context of designing schemes for risk-pooling for private expenditures that are complementary to government funding for priority populations and services. The essential package of services should be defined and universal access to this package promoted through government funding policies and complementary risk-pooling schemes for private health expenditures.

- (4) **Purchasing**, which is concerned with the mechanisms by which pooled funds are transferred to providers in exchange for services (provider payment systems), and the conditions of payment (contracting mechanisms, quality monitoring, etc.).

The purchasing function for health care services will be retained within SUSIF in 2005. According to the 2005 budget law SUSIF will effectively administer 64 percent of health sector allocations and will purchase 95 percent of services from providers on behalf of Georgian population. Thus for centrally financed curative and preventive services SISUF will be single state purchaser on behalf of the population.

Although SUSIF purchases health care services through contracts, this has only minimally been used as an active purchasing strategy. The policy debate surrounding purchasing in Georgia has focused on provider payment systems for primary health care. Further policy debate on health care purchasing may be a priority once other health financing policy decisions have been made and the broader framework defined. **Retaining effective purchasing function in the sector and further strengthening it should remain policy focus area for the MoLHSA.**

- (5) **Service delivery**, which, as part of health financing policy, is concerned with the relationship between health financing and the structure of health care providers.

The **health sector restructuring** proposed by the previous government has not been implemented as of yet. To address the issue of overcapacity, a reform program was implemented on a small scale, which included 65 health care institutions in the capital city Tbilisi. A Special Hospital Restructuring Fund (HRF) was established under the program that received proceeds from all privatized health care facilities and reinvested the proceeds in the sector. It appears that the program had some initial successes (e.g. an increase in staff salaries in the consolidated facilities by 264 percent; an increase in the productivity of the hospital bed stock of over 50 percent). Nevertheless, the program also had some design and implementation shortcomings.

The new government has to address these weaknesses and further hospital sector restructuring. The Government plans to review the experience of the program and update it according to current policy directions and political feasibility, as well as future technological innovations and international experiences. This work is supported under the Structural Reform Support Project under the coordination of the Health Policy Unit at the National Institute for Health (NIH).⁴⁰ Under the 2005 budget, GoG allocated 6.8 million Gel to hospital restructuring, out of which approximately 4.1 million will be provided by the state budget. An additional 30 million Gel is anticipated for these purposes to be allocated from privatization proceeds by the end of 2005.

4.3 Health Financing Policy Priorities and Options

4.3.1 Health Financing Policy Priorities

The main health financing policy priorities for the GoG at the present time appear to be:

- (1) Establishing the mandate to include the entire set of essential health services, and both public and private health expenditures, under the health financing policy umbrella.

This is a political decision that will require endorsement at the highest level of government and should be reflected in all relevant legal and policy documents, including the charter and strategy documents of the MoLHSA.

- (2) Defining the benefits and population covered with limited public funds for health in 2006.

⁴⁰ The World Bank November 2004, Aide Memoire of the World Bank – Supported Health Portfolio in Georgia.

This policy decision has both a political and a technical component. The political component is to choose among three options for distributing the current limited health budget across services and populations (see below). The technical component is to develop the specific content of the package of services to be covered within the envelop of available resources and the appropriate targeting mechanism to identify the beneficiary population.

- (3) Identifying the expansion path for covered services and population as government funding increases in future years.

This policy decision also has a political and a technical component. The political component is the decision about how increased government funding for health increases will be distributed between increasing coverage of services and increasing the population covered. The technical component is to calculate the costs of expanding coverage of services and population to support budget formation, and to present the budgetary implications of alternative scenarios of expanding coverage. **An area of improvement where work is ongoing in many donor-funded projects is the area of defining and costing the basic benefits package (BBP).** This does not need elaboration here, but it should be noted that **similar efforts in secondary and tertiary care levels are also necessary** to arrive at improved estimates of future financing needs.

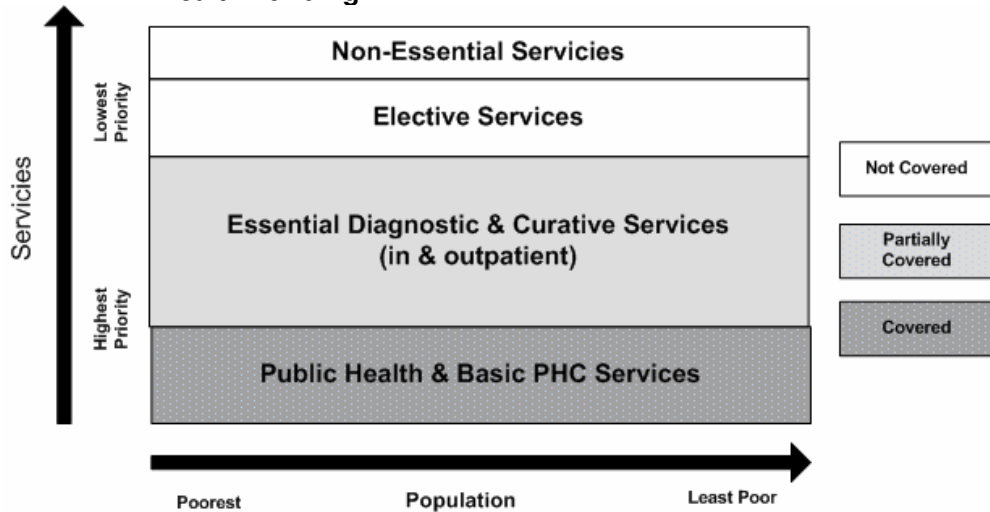
- (4) Developing risk-pooling schemes for private health expenditures as part of overall reforms to be initiated after 2006.

This policy decision will require significant institutional development to create or foster risk-pooling entities for private funds, and to design the regulatory framework required to ensure that such risk-pooling schemes are complementary or supplementary to public funding rather than competitive or duplicative.

4.3.2 Policy Options: Distributing Government Health Funds Across Services and Populations

In order to develop the health financing policy priority areas discussed above, the main decision needs to be made about how the government intends to prioritize limited public funding for health. Other policy areas can then be developed to support and complement the implementation of that decision. Figure 3 shows the current distribution of government funding for health across services and population groups. A limited package of basic primary health care (PHC) is provided to the entire population. Essential diagnostic and curative services (both outpatient and inpatient) are partially covered for most of the population, with some lack of clarity in exactly which population groups are entitled to how much coverage for which services.

Figure 3 Current Coverage of Services and Population with Government Health Funding



If the Government of Georgia decides to establish the mandate to include the entire set of essential health services under the health financing policy umbrella and identify the expansion path for increasing government funding for health care along priority services and priority populations, the following options for allocating current government budget funds across services and populations are the following:

Option 1: Everyone gets the same
[The entire population is entitled to the same limited set of services]

Under Option 1, government budget funds are used to cover the entire population with the same set of services. Given the current health resource envelop, this would result in a very limited package of services being covered for everyone (Figure 4). The expansion path for coverage with government funds under this option would be to gradually increase the services covered for the entire population (Figure 5).

Figure 4 Coverage of Services and Population with Government Health Funding Under Option 1

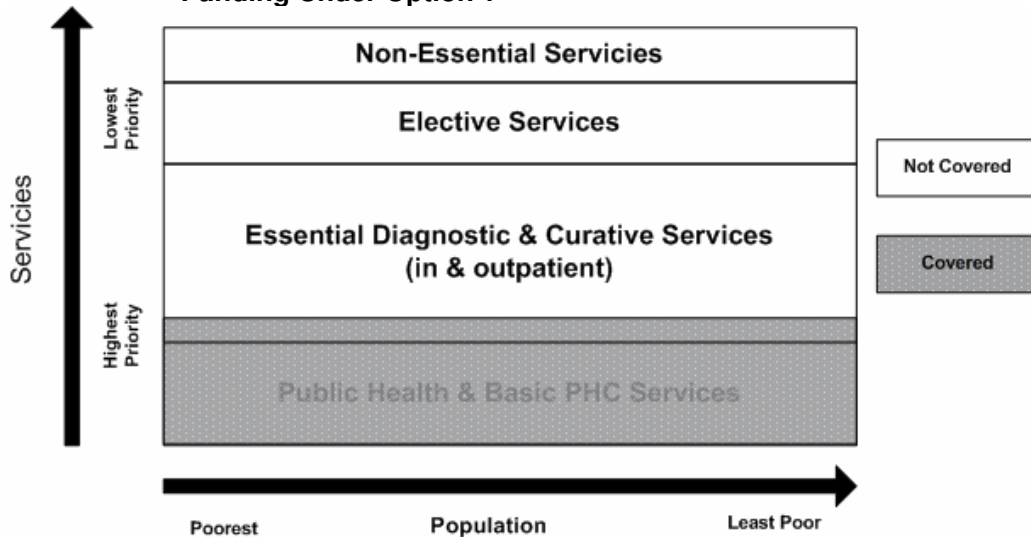
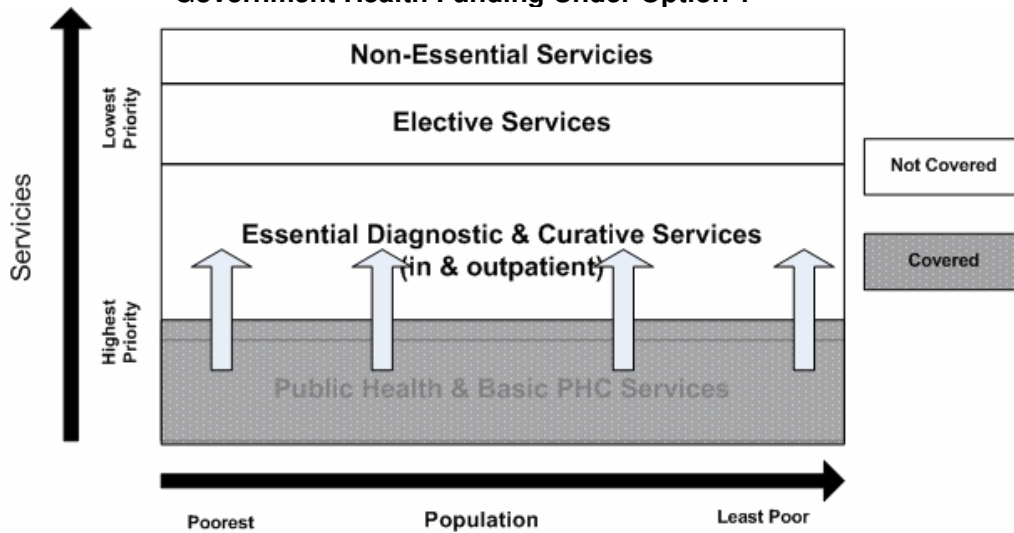


Figure 5 Expansion of Coverage of Services and Population with Government Health Funding Under Option 1



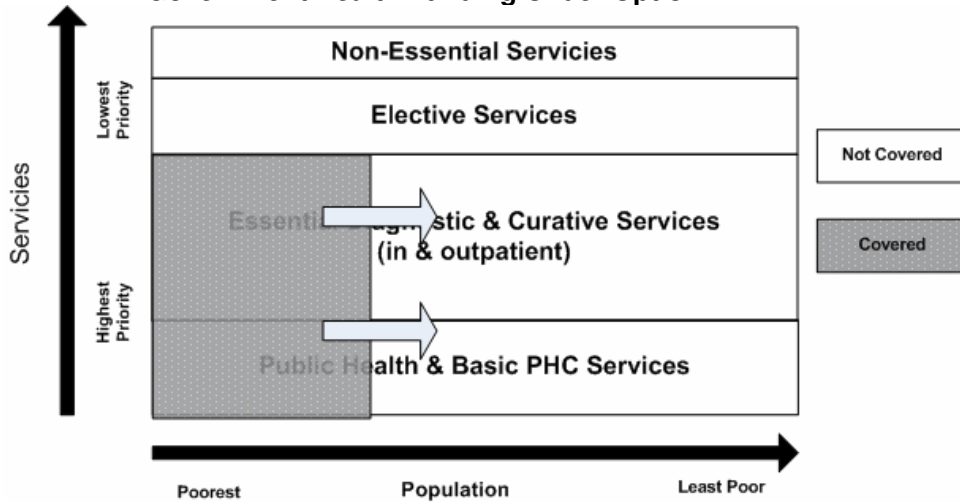
Option 2: Only the poor are covered
[Only the poorest population is entitled to government-funded services]

Under Option 2, government funds are targeted only to the poorest population group, so a more comprehensive package of services can be covered (Figure 6). Most of the population, however, would be left to finance health care completely out-of-pocket. This option creates the risk of households who are currently on the margin of poverty, or even significantly above the poverty line, falling into poverty when faced with catastrophic health expenditures. The expansion path for coverage with government funds under option 2 would be to expand coverage to include more of the population with a comprehensive set of services (Figure 7).

Figure 6 Coverage of Services and Population with Government Health Funding Under Option 2



Figure 7 Expansion of Coverage of Services and Population with Government Health Funding Under Option 2



Option 2 is theoretically possible, and should therefore be included in the universe of options to be considered. In practice, however, this option is neither realistic nor desirable. The basic set of public health services include public goods, such as disease surveillance and community-based disease prevention, and “quasi-public goods,” such as immunization and diagnosis and treatment of infectious diseases, that are not adequately provided, or not provided at all in the case of pure public goods, if left to the market and entirely out-of-pocket payments.

Option 3: Combination of Universal Coverage and Targeting to the Poor
[The entire population is entitled to a limited set of basic services, and the poor are entitled to an expanded set of services]

Under Option 3, the government funds a limited set of basic services for the entire population, and also funds an additional set of services for the poorest population (Figure 8). The expansion path for coverage with government funds under option 2 would be to expand coverage to cover a combination of both more of the population and a more comprehensive set of services (Figure 8).

Figure 8 Coverage of Services and Population with Government Health Funding Under Option 3

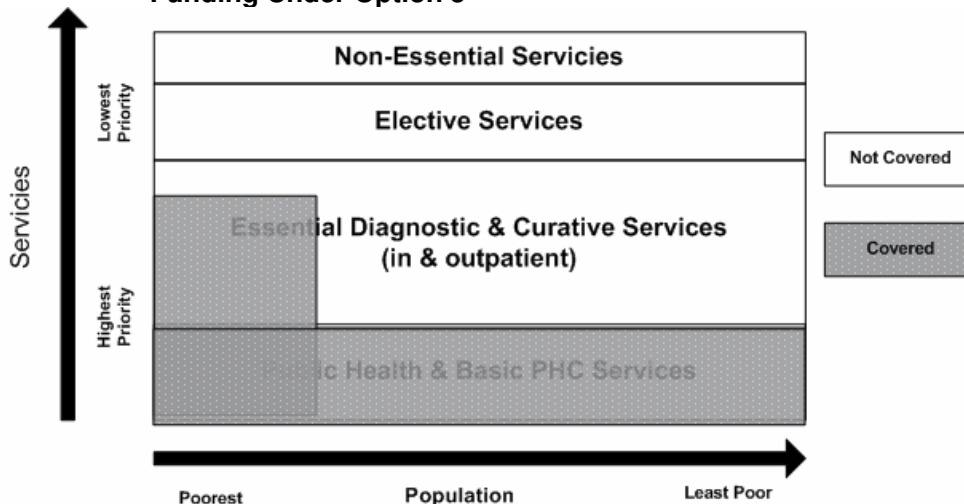
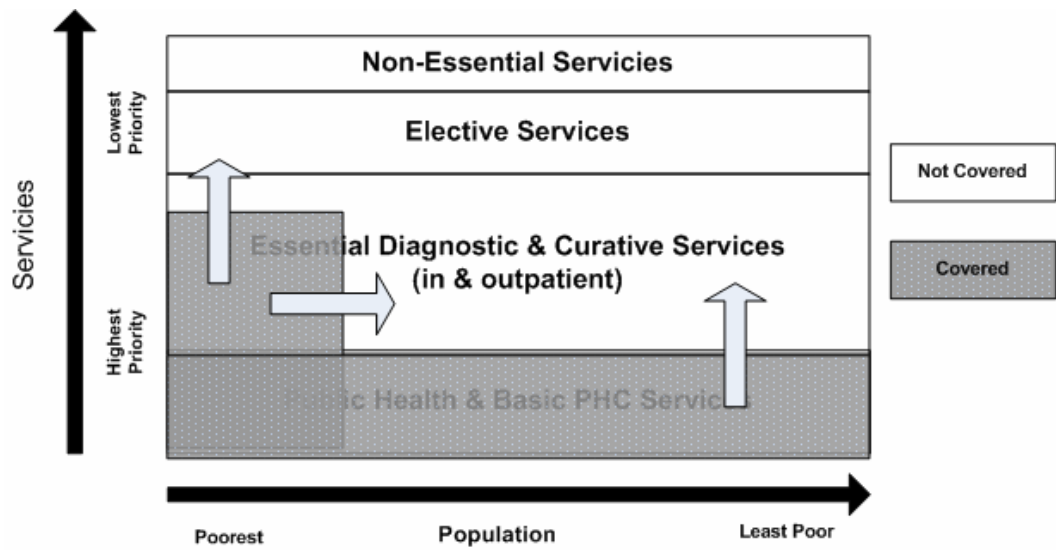


Figure 9 Expansion of Coverage of Services and Population with Government Health Funding Under Option 3



5. Conclusions and Next Steps

The main health financing policy directions for Georgia over the next three years should focus on the priority of providing a larger share of the population with access to essential health care services through: (1) increased budget allocations to the health sector; (2) allocation of government funding prioritized by services and population groups covered; and (3) the development, support and regulation of risk-pooling mechanisms for private health expenditures. These health financing priorities were identified in health sector strategy documents prior to the rose revolution, and they continue to be the most urgent health financing issues to be addressed by the new administration.

The immediate policy decision that must be made is how to prioritize limited public funding for health based on the three options discussed in Section 4. When this decision is made, the following next steps are suggested:

Legal, policy and regulatory framework:

1. Arrive at a consensus on the policy and regulatory role of the state in overall health financing, as discussed above. Decisions should be made on issues such as integrated health financing policy for both public and private sources of health care funds, risk-pooling for private health expenditures as a transition to an integrated or unified national risk pool using public funds, insurance supervision and regulation, integrated policy for purchasing and provider payment, and health sector optimization.

Allocation of government funding for health care:

2. Initiate policy discussions on the overall funding allocations for health to be reflected in the MTEF.
3. Conduct an analysis of the overall resource requirements to provide essential health care services to the population, financing all inputs at adequate levels (including salary increases for health professionals) under the current service delivery structure and alternative structures. Estimates currently exist for the cost of fully financing PHC (conducted with support from OPM and GVG projects for PHC financing), and hospital and drug expenditures may be estimated from the national health accounts.
4. Based on the analysis in #3, conduct a cost analysis and simulation of alternative definitions of the package of health services to be financed from government funds and different definitions of the populations to receive varying levels of coverage. These estimates can be used as a basis for defining government commitments for health care in 2006, and through the MTEF process as a basis to expand health sector budget allocations in future years. These estimates will also provide guidance for intra-sectoral allocation of the government health budget, including relative allocations for public health, primary health care, and hospital care, as well as allocations across population groups.

Future health reform strategy:

5. Draft a consolidated health sector strategy that reflects health financing policy decisions related to:
 - a. Overall legal and regulatory framework for health financing
 - b. Legal and regulatory framework for risk-pooling for private expenditures (public and/or private insurance market)
 - c. Institutional structure of the health sector
 - d. Revenue collection and flow of funds
 - e. Benefits and coverage
 - i. Definition of essential set of health care services
 - ii. Allocation of government health sector funds to priority services and populations
 - f. Institutional development of public and/or private insurance market
 - g. Purchasing (contracting and provider payment)
 - h. Structure of the service delivery system

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