

H N P D I S C U S S I O N P A P E R

# Qualitative Study on Informal Payments for Health Services in Georgia

Paolo Belli, Helen Shahriari and Curtio Medical Group

November 2002





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HEALTH SERVICES IN GEORGIA**

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## Health, Nutrition and Population (HNP) Discussion Paper

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# Health, Nutrition and Population (HNP) Discussion Paper

## QUALITATIVE STUDY ON INFORMAL PAYMENTS FOR HEALTH SERVICES IN GEORGIA

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Paper prepared as part of a regional Study on Informal Payments for  
Health Services in Georgia

**Abstract:** This paper focuses on the specific dimension of informal payments by health users in Georgia, a growing pattern within many ECA (East Europe and Central Asia) countries. Using newly collected data from in-depth interviews and focus groups in rural and urban areas of the country, it investigates the determinants of out-of-pocket payments for health services that are supposed to be delivered free of charge under the Georgian Basic Benefit Package (BBP). The study finds that the demarcation between formal and informal components of these Out-of-Pocket payments is extremely imprecise because of: (a) the spread of “health rights unawareness” around the country and, (b) the prices outside the BBP differ from provider to provider.

The study also found that some informal payments are based on cultural/social patterns ingrained in the Georgian tradition. Georgian now about the low health sector salaries and compensate the doctors with small payments. Finally, some recommendations to help the Georgian government to break the *vicious cycle* (excess capacity, decreasing demand of health services, lack of accountability) are proposed in this study, including greater role of the government in leading reforms, and the wider participation of the private sector in designing new governance arrangements in the future.

**Keywords:** Informal Payments; Health Sector Reform; Out-of-pocket Payments; Excess Supply; Lack of Accountability.

**Disclaimer:** The findings, interpretations and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

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## FOREWORD

The authors of this Discussion Paper make a valuable contribution to our understanding of the problem of informal payments for health services in Georgia. Informal payments to doctors, nurses, hospital administrators and others working on health service delivery is a common pattern within many ECA (East Europe and Central Asia) countries. This qualitative study aims at investigating the nature and process of collection and of distribution of **Out-of-Pocket Payments** (OPP), identifying the causes why they occur, understanding their consequences and informing the policy debate on how to design potential solutions. These payments have critical implications for governance of health systems and undermine equity and access to them.

The study shows how the Georgian health system is trapped in a *vicious circle* due to supply and demand unbalances: when Georgia gained independence after the collapse of the Former Soviet Union, the government's financial input into the health system substantially declined. Prior to independence, the Georgian health system was characterized by extreme excess supply (human and capital resources). The overcapacity of the system combined with the low income of providers led to the emergence of informal payments (which, to a lesser extent, already existed during Soviet times).

The findings of this study reveal that even if the informal payments are sometimes spontaneous, to express gratitude, in most cases the physicians or health personnel explicitly demand them; moreover, the dynamics of payment collection are quite diverse (to a cashier or directly to the doctor) and the money received is normally kept by the physician as a supplementary personal income. Surprisingly, some of the interviewed doctors indicated that they invested out-of-pocket payments in non-labor costs.

Overall, and as far as equity is concerned, the Georgian case shows how the informal payments are restricting access to health services of the ones that cannot pay them. The informal payments also perpetuate the governance problem in the Georgian health administration and fuel corruption. Remarkably, this qualitative study compiles the results of on-field interviews with health providers and health users. The Georgian policy makers might want to take into account those answers when designing future reforms.

In general, informal payments are only a symptom of major imbalances present within the health system, as the Georgian case shows. Those payments originated in past government failures and, due to distorted perceptions, will undermine any future government health priority or resource allocation. The current situation fosters and maintains those imbalances and a real policy change is desired.

It is in this spirit that we hope this Discussion Paper, fruit of demanding on-field research and the revision of the existent bibliography on informal payments, will stimulate more debate within and outside Georgia.

*Alexander S. Preker*

Chief Economist  
Health, Nutrition, and Population (HNP)  
Editor of the HNP Publication Series



## PREFACE

The study consists of four main sections.

The first section – Executive Summary – presents in a concise form objectives of the study, main findings and recommendations.

The second section - Overview of the Study – describes in detail the study objectives, its methodology (qualitative research techniques, sampling, etc.) and it presents the background information, such as the institutional framework and the share of out-of-pocket payments (OPP), with references to other relevant research conducted in Georgia.

The third section presents results of the study concerning the nature, extent and dynamics of out-of-pocket payments, their causes and consequences.

The fourth section – Conclusions and Recommendations- summarizes the paper’s policy recommendations, and it provides more in-depth analysis of the causes and consequences of out-of-pocket payments in Georgia.

The study assumes that the reader is already familiar with some background information on Georgia, and on its health system. Refer to the documents contained in the list of references for an introduction, particularly the “Georgia Public Expenditure Review, 2002” (PER).

Extracts from respondents’ answers are quoted in italic text throughout the report.



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This study is the product of teamwork, from beginning to end. First we would like to thank the local research team, headed by Curatio, who assisted us by gathering data and providing us with their valuable inputs and analysis.

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Finally, this report would not exist without the gracious consent of doctors, nurses, and patients or their families who agreed to be interviewed, and frankly shared their perceptions, experience, concerns, and expectations. We hope this report can contribute in some small way to addressing their concerns.

The authors of this Report are grateful to the World Bank for having published the Report as an HNP Discussion Paper.



## A. EXECUTIVE SUMMARY

### A.1 STUDY OBJECTIVES AND METHODOLOGY

The main purpose of the study is to:

- Understand the extent and dynamics of out-of-pocket payments (**OPP**) and, where possible, try to separate formal and informal parts of it;
- Identify and explain why they occur;
- Understand their consequences, especially on access and perceived quality, for both the providers and for the recipients of health care services;
- Identify possible recommendations to address the issue of OPP and informal payments at a policy level.

OPP refer to those payments for health services which are borne directly by the patients or their households. The informal component of payments is defined as the payments (cash or in kind) made to service providers (person or institution) by patients, in addition to any legally defined payment. The demarcation between the formal and the informal component of payments, which in theory is clear-cut, is in fact blurred in the Georgian context. Thus, most of our findings concerning the extent, the dynamics and the consequences of direct payments apply to all OPP, and not only to the informal component of OPP. Two key elements of the OPP definition are the **informality**, meaning that the economic activity provided is not registered, and the **illegality** of some of these payments; note that not all informal payments are illegal (i.e. spontaneous gifts of gratitude). In the Georgian case, an almost certain judgment about the informality of payments is problematic: it is to be considered as formal any payment for services *not included* in the set of the Basic Benefit Package (BBP henceforth, see Annex 4), and as informal payments for services *included* in the set of such entitlements (above the legal co-payment, if services are only partially subsidized by the government). This straightforward distinction is difficult to apply when all the services outside the BBP are subject to different prices according to type of service and type of facility and when the Georgian population is not aware of their entitlements upon the BBP and is not able to say whether a certain payment for a service is formal or it is informal.

The study utilizes in-depth interviews and focus groups as the main instruments to collect information. The focus groups (FG) were selected taking into account two dimensions: the differences between socio-economic groups, age and gender and the urban/rural differences, after observing how different Tbilisi, the capital of Georgia, is from the rest of the country. For the in-depth interviews 40 providers and 99 patients were selected. The study is complete with the results of recent quantitative research carried out in Georgia (Gotsadze et al, 2001) and uses its result as well as other data and information whenever possible. Two rayons –Tbilisi and Gori- one mainly urban and the other one mainly rural, were selected as the study sites and two target audiences were considered: providers and patients.

### A.2 MAIN FINDINGS

In Georgia, a profound reform of the health care system organization and funding has occurred since the beginning of the transition. During Soviet times, the health system was primarily funded through taxation but it was partially replaced by the revenues collected at the point of services in the form of OPP to health providers. The Georgian government has been carrying on different reforms with the aim of solving the issues of overcapacity, inefficiency and fiscal sustainability of the system (see page 10). However, some of the existing problems observed during this study and developed below are: excessive number of

hospitals and health staff, poor definition of the Basic Benefit Package, under-funding, poor performance of health personnel, lack of health services access for low income families and lack of accountability of health centers administrators. These problems are part of the causes which contribute to maintaining the widespread informal payments dynamic, a vicious circle trapping the system and damaging any potential improvement of the Georgian health care standards.

Paying for health services was found to be a “common practice” in Georgia, and the study captured several forms of OPP and of informal payments (cash, in-kind and gifts), as well as various circumstances in which they occur. In few cases patients seem to pay providers spontaneously or voluntarily, but in most cases payment is explicitly demanded. The payment is generally requested ex-ante or during the treatment, coercing the patient to pay if she/he wants the treatment completed. Concerning the voluntary payments, the study observed that they are more common in the rural areas and for outpatient services as an expression of gratitude or as a social/cultural “norm”.

As aforementioned, the study also found that the population has a vague idea about the publicly funded programs (services that are part of the Basic Benefit Package - BBP<sup>1</sup>) and that they generally pay for those services. The cases of the maternity health care and the ambulances services are two examples of the spread “health rights unawareness” around the country.

The dynamics of payment collection captured by the interviews with providers are also quite diverse, though some common characteristics can be found. Payments occur through formal transactions at the cashier, as well as through direct transactions with the physician, with roughly an equal proportion of the two types. There are no general rules for sharing informal income, whereas for formal contributions paid at the cashier doctors lamented to receive a very small part of it, or nothing. Concerning utilization of informal payments, in the majority of cases physicians indicated that they pocket informal payments as personal income, in public facilities with few patients, the physicians try to maximize the informal portion of their income through “rotations”, so that each one can be reasonably busy when on duty. Surprisingly our study also encountered a number of cases where providers claimed to use informal “cash” to pay for essential non-labor costs, primarily essential drugs.

Prices vary according to the facility, the type of service, and providers’ assessment of patient’s ability to pay. Sometimes price negotiations take place between providers and patients. The study captured two distinct occasions when such negotiations take place:

1. For delivery services, physicians are approached well ahead of time to secure their availability for the delivery and this is when the negotiations takes place.
2. Negotiation concerning the price of inpatient and outpatient curative services, guided by the official price list that sets a price for each service, and by the physician’s assessment concerning the patient’s ability to pay. In many cases, physician/patient reach an agreement in which the official part of the payment is reduced in exchange for a higher informal payment. This “get-a-discount-if-you-pay-me” mechanism may increase the total cost of treatment for the patient, may have zero effect on the price she/he pays, or may event reduce it.

The study also found that in computing the total burden of OPP on households it is always the case to just add the formal and the informal components of payment. One of the corrective measures to limit informal payments advocated in the literature is to legalize or to increase the level of formal co-payments

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<sup>1</sup> In theory, in Georgia the law on health entitlements states that patients have the right to services included in the Basic Benefit Package (BBP) for free or in exchange for low co-payments (set by law and equal throughout the country). See discussion in the text and Annex 4.

(see, for instance, Lewis 2001). It is argued that formal payments could substitute for informal payments by providing an extra-official source of revenue for providers. However, our research shows that in the current Georgian context raising the level of formal OPP may actually lead to increase providers' incentive to ask for informal payments. That is because in Georgia government enforcement of regulations is practically non-existent, facility managers have almost total freedom in managing facility funds, and physicians/nurses have a certain level of freedom in charging fees to patients. In particular, physicians can move part (or all) of formal OPP to the informal part, where the funds are not taxed, and do not contribute, or contribute to less extent, to finance other cost items. In such a context, with the “get-a-discount-if-you-pay-me” strategy, the level of informal payments bears either a zero or a negative impact on the total price paid by the patient, whenever doctors and patients are able to reach an agreement whereby, instead of paying the official price for any given treatment, the doctor changes the diagnosis to a less costly one<sup>2</sup>, or to a government-subsidized treatment. The patient is formally charged less (or becomes eligible for public subsidies), and the doctor pockets part of the money saved by the patient.

### A.2.1 Causes of Informal Payments

In Georgia, the health system seems to be trap in a *vicious cycle*, that determines the persistence of widespread OPP, creates significant access barriers to the population and bears negative impact on health outcomes. The causes of these informal payments are both supply/demand-related, as well as contextual.

The government's financial inputs into the health system collapsed after the disintegration of the Former Soviet Union. At the time, the Georgian health system was characterized by **extreme excess capacity**, both in terms of human as well as capital resources (see Annex 3). After 1994-95, a few policy changes meant to address the poor health funding and the excess-capacity problems, in fact made the situation perhaps even worse. In 1995, the government introduced the purchaser-provider split, granted *de facto* full-autonomy as regards internal management to facility administrators, moved from an input to an **output-based payment system** for provider units, and limited reimbursement to a Basic Benefit Package<sup>3</sup>. The government hoped that these measures would lead to the financial strangling of all underutilized facilities, and to the reduction of (underemployed) health workers.

In fact, such components of the health reforms, justifiable in a different context, in the context of overcapacity and a drastically declining public funding for health had the only result of establishing a system *de facto* operating as a private market, although still under a public shell (Lewis, 2001). Considering that on average physicians receive a share equal to only 78% of the total revenue they generate per unit of service (and a monthly salary of approximately \$23.5-\$26.5, below the average monthly salary in the country) they found a new way to make ends meet through informal OPP payments. The poor performance of purchasers (SMIC), the unclear and ever **changing definition of services included in the BBP**, the **lack of accountability and often the corruption of facility administrators** all contributed to create this situation. Moving or reducing inputs as proved more difficult than initially expected, and just changing the formal rules according to which public funds should be allocated has proved insufficient.

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<sup>2</sup> This is because there is a detailed price list for each category of treatments provided by the government. For instance, there is one for appendectomy and one for appendectomy with complication. Doctors can negotiate with the patients to put the diagnosis from the one with complication, which is more expensive and there fore also more costly for the patients, to without complications as long as the patient pays a portion of the difference directly to the doctor.

<sup>3</sup> See Annex E-4.

Furthermore, due to the level of direct payments, the economic recession and the increasing inequality and poverty, the **level of demand declined** consistently. From 1990 to 1999 hospital admission rates dropped by 68%, down to 4.3%, hospital *Bed Occupancy Rate (BOR)* decreased from 51% to 29% (Zoidze et al. 1999), utilization of outpatient services declined by 81% (from 7.3 visit per person per year to 1.42), and calls for ambulance services fell from 0.22 to 0.03 per person per year. In summary, over the decade the demand for medical services declined dramatically, starting from utilization rates comparable to those of West Europe down to levels comparable to those of the poorer countries of Sub-Saharan Africa and Asia<sup>4</sup>.

Finally, other demand-side factors that contribute to the diffusion of informal payments are based on cultural/social patterns ingrained in the Georgian tradition: a gift to express gratitude, the fear to be denied treatment, the desire to support doctors and the lack of trust in government are some of them.

### A.2.2 Policy Implications of the Research

Based on the study findings, further government interventions must address both the supply and the demand side. The Georgian government must put the bases for a new virtuous cycle, where demand is stimulated, prices are lowered and quality of services is improved. On the **supply side**, one of the more important elements in the strategy must be to strengthen the process of rationalization which so far only timidly implemented. The elimination of existing duplications, and of a significant number of underutilized facilities and personnel, will help to mobilize more internal resources of the system to increase the volume of services and improve their quality.

**On the demand** side, a necessary step in order to stimulate services' utilization, particularly by the poor, is to address the existing financial barriers, through a health financing reform that increases the share of total resources for health harnessed on a pre-payment basis. Ability to pay for health services will naturally increase with economic growth, but most probably not fast enough and not equally for everyone. Increasing demand for health services, would also relax the tight financial constraint physicians presently face, and may spontaneously lead to informal payment reduction. Specifically:

- Strengthen resource mobilization on a pre-paid basis. Since there is very little trust in the system and a very difficult environment, at least in the short run one possible option for organizing and testing any pre-paid scheme could be provider-based or community-based insurance schemes<sup>5</sup>. However, there are limitations of such local schemes, frequently unable to pool enough resources to really cover catastrophic risks, and plagued by managerial, adverse selection and moral hazard problems (see Bennett, S., et al, and Preker et al., 2002).
- To face informal payments, Georgia also needs to revise the public-private mix in health provision, where the current system is characterized by facilities “formally” still public, but *de facto* managed as if they were private, and where physicians and other health employees earn most of their income through informal payments. People are paying anyway, unless they have some political connections, regardless the health center or the service they are using. The boundaries between the public and private sectors ought to be defined more sharply and in a different way. Recommendations in this regard include:

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<sup>4</sup> See discussion in the text in the section: Conclusions and Recommendations.

<sup>5</sup> Our study found that people usually have a long-lasting and fairly frequent relationship with physicians at the polyclinic level, and that they would be willing to assign them also a financial responsibility to manage a pre-payment scheme.

- Design new governance arrangements that permit to control autonomous providers.
  - Reform the criteria according to which health providers and health personnel are paid. For health personnel, one option could be to reinstate a salary-basic remuneration, and then selectively pay an increment bonus based on observable criteria which is financed from official payments.
  - Allow the private sector to play a greater role in health provision. Currently, there is a plurality of private providers, registered as well as unregistered, and supplying mainly ambulatory and outpatient care services. For low cost services, the private sector has in many places already become the key player. Then, government's effort should be mostly focused on quality controls, and to make sure that services are accessible particularly to the more vulnerable segments of the population. Training programs for private providers, accreditation processes, health promotion campaigns and programs to strengthen the community participation in providers' monitoring are means to improve quality of service provision in the private sector. Subsidies or exemption schemes in favor of elderly, children and other vulnerable groups, direct provision of essential drugs, participation in community-based pre-payment schemes, are some of the means to increase accessibility of services.
- The solution for inpatient care must be different for several reasons. Among them, the following three are critical.
  - Because the issue of accessibility is much more severe for inpatient services, where all socio-economic groups face difficulties to be able to afford inpatient care.
  - Because currently the potential to rely on private insurance schemes is limited given people's perceptions and low incomes.
  - Because in Georgia, considering the difficult environment, the private sector does not seem to have the ability yet nor the willingness to take the risk of investing in costly activities, such as buying and/or running hospitals.

Thus, at least in the short-medium term the government must play a greater role than the private sector in the provision of inpatient health services, at least for the vulnerable groups. A necessary precondition to create a more efficient and sustainable public delivery system is that the process of rationalization of human and capital resources deployed in the hospital sector be deepened. Once the number of providers is reduced to sustainable levels, in order to harness private resources without compromising equity, rooms/wards for paying patients and/or the possibility to exercise *intra-mural* private activities should be created. If the two types of wards are separated, there should not be different salary levels for staff in the two types, or alternatively, there should be rotation of personnel between them. Moreover, direct government subsidies linked to the number of admitted patients would preserve the quality of services for non-paying patients. In Tbilisi, some strategic selections to determining how many maternity centers should be state-funded and the creation of paying/non-paying wards are current initiatives that might contain informal payments. In any resource-contained environment, such as the Georgian one, it will be ingenious to believe that public policies could totally eliminate informal OPP, however, the trend could be reversed if the government softens the financial barriers to access and improves the efficiency and the quality on the supply side.



## B. INTRODUCTION

*“The results of the health reforms are terrible. It left patient without doctors and doctors are left without money to live.”*

*Focus Group Participant*

### B. 1 STUDY OBJECTIVES AND METHODOLOGY

The main purpose of the study is to:

- Investigate the nature, the process of collection and of distribution of Out-of-Pocket Payments (OPP)<sup>6</sup>.
- Identify and explain why they occur.
- Understand their consequences, especially on access and perceived quality for both the providers and for the recipients of health care services.
- Identify possible ways to address the issue of informal payments.

The phenomenon of OPP and particularly of informal payments in former socialist economies has been well documented (see Lewis, 2000). However, there is still a lack of qualitative research on the process of collection, on the determinants of informal payments and their impact on providers and on the population, to inform the policy debate on how to address the current situation<sup>7</sup>. This study is meant to contribute to fill this knowledge gap.

In order to study OPP patterns and processes, two target audiences were considered: patients<sup>8</sup> and service providers (physicians and nurses). Patients were engaged in in-depth interviews and focus group discussions, while for providers in-depth interviews were conducted. Patients' in-depth interviews were aimed at exploring the consequences of OPP on accessibility of health services, as well as the mechanisms of payment, the reasons for paying, and the sources of funds to pay for health services. During Focus Group discussions participants were asked not only to report their experience with health services' utilization, but also their perception regarding different alternatives to deal with the existing situation. Particular attention was given to exploring households' willingness to contribute to pre-payment schemes. Provider interviews were aimed at exploring the flow of funds within health facilities (hospitals and polyclinics), the mechanisms of payment collection, distribution, and utilization of revenues from OPP, as well as at exploring providers' reaction to different policy initiatives to contain informal payments.

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<sup>6</sup> OPP includes informal payments.

<sup>7</sup> One of the few qualitative studies similar to that presented here was carried out in 1999 in Poland (Shahriari et al., 2001). However, this study shows that the nature, extent and causes of OPP are very different in Georgia and in Poland (see analysis in the text, sections 2 and 3).

<sup>8</sup> Sometimes it was not possible to directly interview the person who had undergone an episode of care, but somebody else in his/her household, most often his/her mother/spouse. For children under 15-16 years, their mothers were chosen as respondents. Most of the surveys conducted in Georgia confirm that women seem to be well-informed about health related issues in their household. They also proved to be much more willing than men to be engaged in focus group discussions.

Two geographical localities were selected for the study: the capital city of Tbilisi, and a country-representative *Rayon* (district)<sup>9</sup>-Gori- with its urban and rural settings. The sample-selection criteria were meant to capture the following:

- a) Urban/rural differences
  - b) Differences between different socio-economic (SES) groups, age and gender.
- A total of 12 Focus Groups (FG) and 139 in-depth interviews were carried out.

### Focus groups

For the purpose of selecting FGs participants, two main dimensions (Tbilisi and Rayon, low SES and high SES) were included. The argument for using only two major dimensions was based on various survey findings, and included the following:

- a) SES is one of the most critical dimensions, which significantly impacts on utilization, access and other issues related to our subject matter.
- b) In addition, Tbilisi is quite different from the rest of the country.

Besides these two major dimensions, age and gender of participants were also considered.

**Table 0-1: Sample distribution for the focus groups**

	Poor	Rich	Total
Tbilisi	3	3	6
Gori	3	3	6
<b>Total</b>	<b>6</b>	<b>6</b>	<b>12</b>

Each FG included 8-10 persons, mainly women between 30-64 years old. One group representing only pensioners was created for each locality and each economic group in order to obtain pensioners' perspective as well. We developed special criteria to select the FG participants in a way that could provide information with regards to health service utilization by children, middle aged, and elderly, as well as for men and women. Details of the participants are provided in Annex 0.

### In-Depth Interviews

40 providers and 99 patients were selected for in-depth interviews.

The hospital sample was composed of 3 hospitals in Tbilisi: 1) a general hospital; 2) a pediatric hospital; 3) a maternity home. A total of 5 doctors and 2 nurses from each hospital were interviewed from different departments. The objective was to identify general dynamics and distribution of payments, both formal and informal, observed in all hospital facilities, and any specific norms characterizing any specific type of hospital. In Gori 3 doctors from the *Rayonal General Hospital* and 3 doctors from a maternity home were interviewed.

Providers for the outpatient group in Tbilisi were chosen from one adult polyclinic and one pediatric polyclinic, 5 (3 doctors and 2 nurses) from each. In the Gori *Rayon*, 3 doctors from various rural ambulatories were selected.

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<sup>9</sup> Rayon is the smallest administrative-territorial unit in the country.

The sample matrix for in-depth interviews is presented in Table 0-2.

**Table 0-2: Matrix for In-Depth Interviews**

	Providers		Patients		<b>Total</b>
	Hospital	Outpatient	Urban	Rural	
Tbilisi	21	10	58		<b>98</b>
Gori	6	3	15	26	<b>42</b>
<b>Total</b>	<b>27</b>	<b>13</b>	<b>73</b>	<b>26</b>	<b>139</b>

For the in-depth interviews, a “snowball”-sampling method was used to select those respondents that had used hospital services for any member of the household (HH) over the 3 months prior to the interview, or outpatient services over the previous 30 days. The sample of users from urban and rural areas was further disaggregated into sub-sets according to inpatient-outpatient, pregnancy and child delivery, pediatric, male-female and poor-rich. The detailed breakdown of selected individuals/HHs for in-depth interviews is presented in Annex 0on page 37. A specific tool (pre-questionnaire) was developed to allow adequate representation of various groups, and for enrollment in the study. The field-work was carried out during June-July-August 2001. Annex E.1 also contains summary tables with the principal quantitative results of the study.

## B.2 BRIEF DESCRIPTION OF THE SITES

*Tbilisi* is the capital city of Georgia. Its territory reaches more than 350 sq. kilometers, and its population is equal to 1,187 millions<sup>10</sup> (CMSI<sup>11</sup>, 1999). The city is the major economic, cultural and political center of the country.

Tbilisi is characterized by an extremely high unemployment rate, due to the closure during the 90s of the old manufacturing facilities constructed in the city during Soviet times. Those factories had attracted a significant part of the labor force from the other regions of Georgia in the post-war period. Still, Tbilisi is the center where the majority of the new economic activities started over the transition years are concentrated, and where the wealthiest minority segments of the Georgian population live. Also, the more important healthcare facilities of the country are located in the city: 74 hospitals, 123 polyclinics and 16 dispensaries, staffed by 9991 doctors and 9294 nurse/midwives. The doctor to population ratio in Tbilisi is equal to 1 doctor per 118.6 individuals, and there is one hospital bed per 135 individuals, with utilization rates equal to only 32% (CMSI 1999). Almost 45% of the total national health spending occurs in Tbilisi (Georgia State Department of Statistics [SDS], 2000<sup>b</sup>).

*Gori* is part of one of the six *Rayons* (districts) in the *Shida Kartli* region. The town of Gori is the administrative and cultural center of a large agricultural district, and it is an industrial town with a population of more than 60,000. A total of 181,988 individuals are estimated to reside in the whole rayon (KPI 1998<sup>12</sup>). The population is served by four hospital facilities (including a 90 bed maternity home), with a total bed capacity of 586 beds, 2 *rayonal* polyclinics and 22 rural ambulatories located in the surrounding villages. Facilities are staffed with 457 doctors and 648 nurse/midwives. There is one doctor for every 131.3 individuals, and one hospital bed per 102 individuals (CMSI 2000).

Gori rayon is quite representative of all the other parts of Georgia, with the exception of a few marginal and for the most part mountainous areas or areas that are mainly populated by other ethnic groups (for instance, the Kvemo Kartli or Imereti regions), where the levels of poverty and economic deprivation are even starker than in the rest of the country.

## B.3 BACKGROUND INFORMATION<sup>13</sup>

Georgia has a population of approximately 4.5 million in a geographical area of 70,000-sq. km., bounded by the Black Sea, Russia, Azerbaijan, Armenia and Turkey. At the time of independence, on April 9th 1991, Georgia appeared to be a relatively well off republic with good potential for growth. However, in the '90s the country has suffered a devastating civil war, other ethnic conflicts, and uneven commitments to economic reform that resulted in a burden of approximately 350,000 displaced people. The disruption of trade within the Former Soviet Union (FSU) and the economic shocks of the first transition years further aggravated the existing economic and social situation (Gotsadze and Rose 2000). In 1991-1994 the Georgian economy suffered a severe economic recession, and in 1995 GNP per capita amounted to

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<sup>10</sup> Tbilisi houses one third of the country's population.

<sup>11</sup> Center for Medical Statistics and Information, Tbilisi.

<sup>12</sup> Hospital Restructuring Plan for Georgia, Kaiser Permanente International, Tbilisi, 1998

<sup>13</sup> For a more throughout presentation of the economic and fiscal situation in Georgia, please refer to PER (2002) or to other readings indicated in the References.

US\$620, only 65% of its 1990 level (World Bank 2000). The sharp economic decline significantly lowered standards of living for the majority of the population.

Since 1994 the government has made progress towards restoring political stability, law and order. It has focused on rebuilding the economy on the basis of a program of structural reforms, and it has expressed a commitment to restoring macroeconomic stability. Macroeconomic stabilization made important advances during 1995-1997. Then, the country was trapped again in a period of economic stagnation and uncertainties, following the crisis in Russia. In recent years Georgia has been restored on a path of economic growth, although high unemployment, raising inequalities and poverty levels, uncertain economic as well as political prospects still deeply plague the country.

### **Health reforms (financing, resource allocation and purchasing)**

The economic crisis had a huge impact on the health care system of the country. First, the impact was financial. Public health expenditure drastically decreased, down to 0.81 USD per person per annum in 1994 (World Bank 1999). From this collapse, with the added effect of declining per capita incomes, resulted a deterioration in health status indicators: between 1990 and 1997 the maternal mortality rate increased by approximately 46%; deaths caused by cardiovascular disease increased by 35% and the overall age-adjusted mortality rate increased by 18%. In 1994 there were severe outbreaks of diphtheria and measles and the number of new tuberculosis cases almost tripled from 1,531 cases in 1991 to 4,515 cases in 1999 (Public Expenditure Review, World Bank, 2002).

Before the transition years, the health system was primarily funded through taxation, but as funding from the government as a share of total health sector resources sharply declined over the transition, it was partially replaced by the revenues collected at the point of services in the form of out-of-pocket payments to health providers. The same trend, although perhaps less dramatic than in Georgia, was observed throughout much of the former socialist countries (Preker et al. 1999, World Bank, 2000a, Lewis, 2001).

In order to fill the widening gap between means and ends, the Georgian government implemented the following measures:

- It removed entitlement to free health care from the new Constitution that was enacted in 1995. During the Soviet time OPP were illegal, as entitlement to free healthcare services was constitutionally ensured. However, there is anecdotal evidence that informal payments existed and were significant, although not to the extent after the transition. In order to implement official user charges Georgia made necessary changes in the new Constitution, which was adopted in 1995.
- Public funding was limited to services that were part of a Basic Benefit Package (BBP)<sup>14</sup>. It officially introduced formal out-of-pocket payments for services that are not covered under public funding.
- It modified health financing, by introducing a 4% payroll tax (3% being employers' share and 1%-employees') and it made provision in the budget laws according to which central government has to meet with direct budget transfers shortfalls of the payroll tax (see Box 1).
- It defined central and local governments' responsibilities to fund health services by distinguishing between the central and the municipal portions of the Basic Benefit Package (BBP)<sup>15</sup>.

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<sup>14</sup> See discussion of the essential package of services policy implemented by the government in sections C and D, and Annex 4.

<sup>15</sup> *General Budget:*

The majority of budget allocations to health come from general revenue, but they can also be tied to specific revenue sources, for example, federal government allocations to the SMIC in 1999 were tied to revenues from the privatization programs. In 1999 health expenditure was equal to 3% of total central budget expenditure (Gel 33.2 million – 1Gel ≈ US\$0.5- for health out of Gel 904.8 million of total central budget spending [Source: Georgian Economic Trends 2000]).

In parallel, a profound reform of the health delivery system's organization and funding criteria occurred. Georgia, being part of the Soviet Union, was characterized by the health delivery system known in the literature as the "Siemaszko" model. It was an integrated health delivery system, mainly based on single-specialty hospitals, financed from central budget. Financing was primarily based on inputs or bed-days, rather than on outputs, and resources were used extremely inefficiently.

During the transition years, the need for health reforms able to tackle the issues of excess capacity and inefficiency became compelling as the health systems became fiscally unsustainable. The 1995 reforms introduced the purchaser-provider split. Purchasing<sup>16</sup> responsibilities were transferred to the State Medical Insurance Company (SMIC)<sup>17</sup>, to the Municipal Funds<sup>18</sup> or to the Public Health Department (PHD)<sup>19</sup>. At the same time, hospitals and other service providers were transformed into semi-autonomous juridical entities, reimbursed for the services covered under the public programs (BBP administered by SMIC and PHD, plus municipal governments' programs). For all the other services providers should charge fees, according to a "nosology"-based classification system (a classification system based on diagnosis and treatment, including more than 5,000 categories) and to government-approved prices. Providers could retain revenues from OPP and utilize them to pay for recurrent expenditures.

What the 1995 health reforms achieved, or failed to achieve, is discussed throughout the paper. See in particular the section that analyzes the importance of contextual factors as determinants of informal payments.

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#### *Payroll Taxes:*

Georgia introduced social health insurance (SHI) in 1995, and a semi-autonomous organization – SMIC – was created to organize the allocation of SHI revenue to providers. Participation in SMIC is mandatory for all formal sector employees from the public and private sectors. Financial support for SMIC comes from employees, who make payroll contributions, currently equivalent to 1% of salaries, and by employers, who contribute 3% of the formal wage bill. Revenues from this "3+1" financing, as it is popularly known, are managed by SMIC.

#### *Allocations from Municipalities*

Besides general budget financing and payroll taxes, municipalities are the third main source of public sector funds. Municipalities spend approximately 5.2% of their total expenditures on health (average across all municipalities), which is higher than the 3% spent by the central government. However, there is great variability in health spending across municipalities, with some of them such as Tbilisi that spend almost 10% of their total expenditures on health, while others such as Kazbegi that spend only 0.3% of their total budget on health [Source: *Public PER, 2002*].

The Ministry of Labor, Health and Social Affairs (MoLHSA) mandates that local governments spend at least Gel 2.5 per capita per year, or 10% of the municipal budget on health care, whichever is greater. In 1999, total spending by local governments was equal to 320.1 million Gel, and they spent on health 16 million, equal to 4.9% of the total [Source Paata Bolashvili, 2000 Fiscal Autonomy Problems of Local Government in Georgia].

<sup>16</sup> Purchasing refers to the choice of service providers, the definition of the conditions of service provision (price, volumes, etc.), and the monitoring of quality. These functions in Georgia are exercised by the central and local governments and by SMIC, the State Insurance Company.

<sup>17</sup> SMIC is the public semi-independent agency entrusted with the role of managing the social health insurance scheme, whose funding is limited to a set of services that are part of the Basic Benefit Package.

<sup>18</sup> Municipal Funds contribute alongside SMIC to fund providers, for emergency services, for child care (3-14), for some outpatient services and for other minor services.

<sup>19</sup> PHD is part of the Ministry of Health and it is responsible for administering public health programs.

## Definition of out-of-pocket payments (OPP) and of informal payments, Different types of OPP in Georgia

Out-of-pocket payments (OPP) refer to those payments for health services which are borne directly by the patients, or their households. The emphasis of this definition is on the direct nature of the payments, which distinguish them from the other major sources of health care financing, private health insurance, compulsory social insurance and taxation<sup>20</sup>. The informal component of OPP is defined as the payments (cash or in kind) made to service providers (person or institution) by users who are entitled to free services above any legally defined payment. This can take several forms including direct cash payments, gift, or the in kind provision of certain elements of services, such as drugs, nursing or meals in inpatient care, which should otherwise be the responsibility of the provider.

In order to facilitate a common understanding of informal payments, we would emphasize the following key elements of this definition (Belli, Gaal, et al., 2002):

**1. Informality:** Informality means that the economic activity is not registered. This is a common feature of all types of informal payments. But not all unregistered payments given to service providers are informal payments according to the above definition. We are not interested for instance in those payments that are due to the provider according to a set price for a determined service, but for which the provider does not give a receipt to avoid paying tax.

**2. Illegality:** A second important defining dimension of informal payments is legality/illegality. Laws and regulations in each country determine the definition of informal payments, by determining entitlements for health services. They define (or should define) who is entitled to which services, in exchange for what (i.e. what could be charged formally for the services). Not all informal payments – as they aren't in Georgia, though, are illegal. They are not illegal if patients give them spontaneously, as an expression of gratitude or of appreciation for an extra-service received, without any pressure from the provider (such liberal payment can be compared to an extra-tip given to a waiter in a restaurant). On the other hand, it is true that everything that is illegal payment is also informal by definition.

In general, it is empirically impossible to ascertain whether a certain informal payment (a payment for a service to which the patient is entitled for free, or a payment above the legally set fee) is also illegal. Thus, the definition of informal payments in the text, which is the only one empirically viable, also includes legal but unrecorded payments. Moreover, it is easier to ascertain informal payments when patients are entitled for a service completely free of charge. It is more difficult to identify informal payments if a nationally defined formal co-payment can be charged for the service concerned, and it is even more difficult when each provider, as in the Georgian case for all services that are not part of the essential package of services (BBP), can charge a different price for the same services.

According to the above definition, given the set of health entitlements in Georgia, namely the rights to free or subsidized access to health services as defined by law, it is to be considered as formal any payment for services not included in the set, and as informal payments for services included in the set of such entitlements (above the legal co-payment, if services are only partially subsidized by the government). This seemingly straightforward distinction, however, is extremely difficult to apply empirically in the case of Georgia. In theory, the law on health entitlements states that patients have the right to services included in the Basic Benefit Package (BBP) for free or in exchange for low co-payments, and that for all other services every medical provider should determine the prices at the point of service. Such prices

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<sup>20</sup> The latter all share the common feature of being pre-payment mechanisms: people pay in advance, according to different criteria in the various mechanisms (according to their health risk in case of private insurance, or to their ability to pay in case of social insurance or taxes), but then their health consumption is partially or totally subsidized at the point of service.

vary according to type of service and type of facility. In practice, we found that the Georgian population generally is unable to say whether a certain payment for a service is formal or it is informal. First, the population has sometimes a vague idea of their rights to free services, or they do not know the official co-payment rates, nor they know the official prices for the services not included in the BBP. Second, with the exception of the services which are part of the BBP, it is also impossible to separate formal from informal payments in the phase of data-analysis from households' responses concerning the amount paid for different type of services, because prices vary in different facilities. Furthermore, we discovered that it is sometimes difficult to distinguish between the two from providers' interviews.

Thus, the study investigates all OPP, and not specifically the *informal component*, although some sections are exclusively dealing with the informal component of payments. For specific services/programs, which should be fully covered by public purchasers, an almost certain judgment about the informality of payments is possible. From providers' interviews, the study was also able to capture some interesting information linking formal and informal OPP<sup>21</sup>. In summary, considering formal and informal components, in Georgia private OPP are given in five ways (Gotsadze and Rose, 2000):

1. Fee-for-service payments for the services that are not part of the BBP. Patients should cover all costs for such services, according to prices set by each single medical provider. These prices are reviewed and approved by the MoHLSA licensing department during the process of licensing and they become official fee schedules for the facilities.
2. Co-payments for those services that are part of BBP, but not fully covered by public resources. Official payments mainly exist for those services that belong to the municipal part of the BBP. For instance, in year 2001, hospital services for adults (15+) that were part of the municipal BBP were subject to a fifty percent co-payment of the cost, whilst hospital services for children (3-14) were meant to be entirely for free at the point of service.
3. Private payments for drugs. Private spending on pharmaceuticals is estimated to be somewhere between 26% and 53% of total private spending on healthcare (Gotsadze et al. 2001, SDS 2000<sup>p</sup>, Skarbinksy 1999, Mays and Schaefer 1999). Except for drug-prescriptions within services that are part of the BBP (for instance, pain-killers for terminally-ill patients, or drugs for emergencies)<sup>22</sup>, there is no other form of drug provision on a pre-paid basis.
4. Direct payments to physicians and other personnel, both for services that are part of the BBP and for those that are not, mainly on an informal basis.
5. Co-payments for services partially covered by private insurers. In Georgia a few private medical insurance companies are operating, although their scope is still extremely limited. During 1998-1999 the share of private health insurance over the total private insurance premium collection rose from 5% to 7.9%. However, in 1999 health premiums revenue totaled only 468,000 GEL ( $\approx$  US\$ 234,000, ISSS 1999), which in per capita terms is hardly US\$ 0.045, and approximately 0.15% of total estimated private spending.

### **The extent of Out-Of-Pocket Payments**

In Georgia all sources of information agree in showing that currently OPP constitute a significant share of total health financing <sup>23</sup>. However, the different data sources vary considerably in their estimates

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<sup>21</sup> See section How much is paid. Relationship between the formal and informal components of OPP.

<sup>22</sup> In fact, a minimum share of expenditure within the BBP is allocated to drugs (only 5% of public funds).

<sup>23</sup> Georgia is not the exception in the region: private spending amounts to 82% in Azerbaijan, 80% in Moldova and 60% in Kyrgyz Republic of total healthcare expenditure (Preker et al. 1999). Comparable trends are observed in other developing countries (Hotchkiss and Karmacharya 1998).

concerning the extent of OPP and informal payments. ‘One of the first assessments was made in 1998 based on a 1995 UNICEF household survey, which estimated private expenditure on health to be almost 272.7 million GEL. Since then, several national household surveys have been conducted, especially in recent years. Results of these surveys vary, and it is difficult to say with certainty how much is spent out-of-pocket on health care. For example, a recent study by the State Department of Statistics found that out-of-pocket payments were approximately 73 percent of total health expenditures. In 2000, according to the Tbilisi Household Survey and the Quarterly Survey of Georgian Households (see Gotsadze et al. 2001), total out-of-pocket expenditures amounted to 132 million GEL, or about 66% of total spending on health<sup>24</sup>. Most of the out-of-pocket payments go towards the purchase of drugs (53%), followed by hospitalization (23%), and outpatient services (17%). (PER, 2002)’.

In per capita terms, OPP estimates are comprised between US\$ 25.3 (Tbilisi Household Survey, 2001), and US\$ 38.8 (Actuarial Research Corporation, see Mays, et al., 1999). Considering just those who utilized inpatient care, according to the Tbilisi survey (Gotsadze et al. 2001, p.37) on average a single episode of hospitalization costs GEL 879 (US\$418<sup>25</sup>). A sum far beyond the average monthly household salary in the country, which is equal to GEL 82.8. Thus, private OPPs are the major source for healthcare financing in the country.

## C. STUDY FINDINGS

In this section we present the evidence on the process through which OPP for outpatient and inpatient health services occur, and on the sharing and utilization of informal payments within hospitals. We also discuss the criteria according to which the population chooses providers, and how they cope with OPP.

### C.1 NATURE, MECHANISMS OF COLLECTION AND DISTRIBUTION OF OUT-OF-POCKET PAYMENTS

#### C.1.1. Payments: demanded or voluntary?

*“...There are various forms of payment and various reasons why patients pay informal fees: gifts, money demanded or voluntarily paid. I have not researched into this issue but I am sure all these forms exist in our facility”.* Hospital Provider Interview, Tbilisi.

Paying for health services was found to be a “common practice” in Georgia, and the study captured several forms of OPP and of informal payments, as well as various circumstances in which they occur. In a few cases patients seem to pay providers spontaneously, but in most cases payment is explicitly

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<sup>24</sup> It is hard to assess the different estimates, also because some of the studies do not present their methodology clearly enough. However, there are some possible arguments that could indicate in favor of the lower estimates concerning the share of OPP. Georgia receives large amounts of technical and material assistance from various multilateral, bilateral and private agencies: WHO, UNICEF, The World Bank and others. National Health Accounts matrices developed by the ARC do not include these amounts. This gives us grounds to estimate that private participation in funding Georgian health sector could be lower if volumes of donor contribution are factored in. However, there are other arguments that could counterbalance the donor participation in Georgian health sector. For instance, during recent years private funding has been spent on capital improvements. This trend is observed across the country and particularly in large urban areas. Private investment funding was not included in the 1997 NHAs. In fact, it is very hard to estimate the volumes and exact sources. Also part of such private investment may be funded by user charges, which were accounted in the NHAs.

<sup>25</sup> Exchange rate of GEL 2.1 per US\$ 1 at the time of the research.

demanded. The general perception is that, unless one has good connections at the political level or directly with doctors, to receive treatment patients have to pay: “You go to polyclinic to get registered and have to pay, you see a doctor and have to pay, call ambulance and have to pay, need the drug and have to pay”. FG, Low Income.

For services that are not part of the BBP, patients are charged either according to official price lists, or according to informal fees negotiated with providers (see discussion hereafter). For services that are part of the BBP and for which patients might expect not to pay, doctors and nurses use various methods, some “softer” and others more blunt, in order to ask payments, such as complaining about the economic problems in the doctor’s family, not paying adequate attention to the patient until he/she pays, being rude with the patient, explicitly asking his/her family, etc. For example, a mother who had delivered a baby a couple of months before the interview said: *“It is unbearable what happens in that maternity. Nobody will pay attention to you until you pay. Even nurses, if you do not pay them 10 Gel they are not going to bathe the infant.”* Patient Interview, Tbilisi.

When payment is explicitly demanded, it is in general requested ex-ante or during treatment, as a precondition to access treatment or to complete it. A significant number of individuals recalled stories where physicians and sometimes nurses demanded payment from the patient before or during the treatment process: *“When you call an ambulance, before they even inquire about the patient's condition, they ask you if you have 10 Gel, and they will come only if you have money to pay.”* FG, Gori. In a few cases, patients felt so directly forced to pay that they remembered the experience as an “extortion”: *“...They made it clear that if I did not pay I would not be treated. In fact this was simple extortion”.* FG, Gori.

However, the study also encountered a minority of cases in which physicians provided services without ex-ante asking any payment. In few of these cases, treatment was provided completely for free, while in the others payment was given only before discharge.

Finally, the study captured few instances where payment was apparently given in a completely voluntary way, as an expression of gratitude or/and because it is perceived as the “norm”: *“It is a habit to pay doctor in order to express thankfulness. As an example my co-worker took the child for vaccination that is free, but she paid money. When I asked why she did so, she responded that she felt uncomfortable not to pay the provider”.* FG., Tbilisi. Voluntary payments seem to be more prevalent in rural areas, and for outpatient services rather than for inpatient services. *“...We are very pleased with our village doctors. They are doing well, they are knowledgeable and available whenever we need them. We try just to thank them at the best of our ability”.* Household Interview, Gori.

Our study did not capture any instance in which voluntary extra-payments were given in the private sector.

## **Types of payments**

### *Cash*

The vast majority of payments patients reported were in cash. These were much higher and problematic for the inpatient care cases. Payments for outpatient services and particularly drug purchases were more widespread but less onerous. Money is not only demanded for treatment or drug purchases, but it is sometimes demanded also to provide sickness certificates, or simply for admission. We also encountered a few cases where providers exploited existing regulations meant to favor patients to their advantage. For instance, the State Medical Insurance Company should issue an insurance card for all children who are entitled to free public coverage under the “Children 0-3 Program”, one of the programs that is part of the BBP. Providers should distribute the insurance card for free whenever an eligible child comes to the facility. However, the study documented a few cases where parents were charged to obtain the insurance card, and then they also paid for the health services received by their children: *“I had to pay for the*

insurance card 25 Gel. The document said the treatment for my child was free<sup>26</sup>. I think the government pays the cost. I was told that if I do not accept the card I had to pay a fine in the amount of 210 Gel [about 100 US\$]. Now I have this insurance card, but I still have to pay every time I go to the hospital (although she would pay less for services). Everybody who goes to that facility has the card and everybody had to pay for it". FG, Gori.

### Gifts

Sometimes presents are given to providers alongside, or more rarely instead of, cash payments. Gifts are particularly common when there is a personal relationship between the patient and the physician/nurse, and offering cash would be embarrassing for the patient, but also leaving the provider's office without expressing gratitude would be culturally not acceptable. According to our study findings, however, gifts to providers are rare and of symbolic value (such as a chocolate box, or cheese, or flowers). The study also captured a difference between urban and rural areas, where more people gave gifts to express their gratitude.

### In-kind contributions

In Georgia it is common for households to contribute some of the supplies needed when patients are hospitalized, most often medicines and food, but also syringes, bandages, and sheets or blankets. In-kind contributions make up for inputs that are most often missing within facilities, and can sometimes be extremely expensive and difficult to find for households (such as drugs, or even blood needed for transfusions). As one poor household reported: "I had my parent hospitalized. We were asked to bring drugs, syringes, to pay doctors, etc. These expenses were really difficult to meet for our household". FG, Low-income.

### Payments for services that are part of the Basic Benefit Package (BBP)

By law, services that are part of the BBP should for the most part be given for free; a small co-payment exists only for those services that belong to the part of the BBP funded by municipal governments<sup>27</sup>. However, in general our study did not capture a systematic difference in the amount paid, related to the fact that a certain service is or is not part of the BBP, although in few cases patients reported to have received a "discount" for services that were part of the BBP: "My sister has a child and they possess the SMIC insurance policy for 0-3 years old. The child needed surgery and the cost was 800 GEL. The insurance partially covered the surgery cost, and we had to pay only 300 GEL<sup>28</sup>. Due to the financial assistance received under the SMIC scheme the cost of the surgery was bearable for our family". FG, Tbilisi.

Our findings confirm results from previous studies (see, for instance, Gotsadze and Nanitashvili 2000) that the population does not precisely know which services are part of the BBP, and the amount of the legal co-payments for these services (see also section on "Causes of informal payments", hereafter). For instance, one parent who had heard about the program for children 0-3 was still skeptical when she joined the Focus Group, and she inquired with the other participants: "My friend told me that in their polyclinic children receive services for free... I do not know if there is any age limitation. I think this is an initiative of their polyclinic". FG, Low-income. Several households had heard in the media messages about free-health services, but they did not trust them because they were in contrast with their daily experience of paying for health services: "We hear on the media that services for pregnant mothers are for free. Probably some lab test are free, or maybe something else, but our experience is that when we go to

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<sup>26</sup> This case concerns the SMIC program for children 0-3 years old. All children within this age group are entitled to public coverage and pediatric polyclinics should issue the insurance card for free to all those with children in that age group.

<sup>27</sup> See previous discussion in the text about different types of OPP and informal payments in Georgia.

<sup>28</sup> According to law, the service in question should have been provided completely for free.

*hospital they always charge us". FG, Low income mother. In fact, several couples were planning to accumulate sufficient savings before having a baby, to pay for maternity health expenses<sup>29</sup>. Women generally choose a specific physician at the maternity hospital to assist them throughout their pregnancy and for delivery, and for these services physicians regularly demanded payments<sup>30</sup>. A mother that was interviewed and who had recently given birth in a maternity home in Tbilisi seemed to know and to accept the rules governing payments for "extra-services" in maternity hospitals: "For the delivery we had to pay the doctor 200 Gel... We were informed about the price by doctor. They also told us that as long as we arrange for their private services (their guaranteed assistance during delivery) several month prior to delivery, the public coverage does not work, and we are not eligible for free services". Patient Interview, Tbilisi.*

Other patients believed that ambulance services were for free and they were frustrated when they had to pay for them. In fact, ambulance services are part of the BBP services funded by municipal governments, and they can be subject to user-fees, but not in case of emergencies. Frequently, ambulances are called by elderly patients, also because their services are perceived as cheaper, although patients are always charged something, if only a small sum<sup>31</sup>: "We thought ambulance service was free, but when we called it for an emergency we were asked to pay 15Gel, and we were not able to". FG Low income

Several physicians admitted to asking payment for services that are part of the BBP and that they should have provided for free. They justified themselves by complaining that their low official income forced them to extract extra-payment from patients.

### **Who collects payments?**

The dynamics of payment collection captured by the study are quite diverse, though some common characteristics can be found. Payments occur through formal transactions at the cashier, as well as through direct transactions with the physician, with roughly an equal proportion of the two types: "... Out of 20 such transactions only 10 are recorded on the official books (deposited with cashier), while revenues from the other 10 are shared among various physicians that were involved in the patient's treatment process. Almost 50% of transactions are informal and 50% are formal." Provider interview, Tbilisi.

In hospitals both forms of payment exist simultaneously, while for outpatient services direct payments to physicians seem to be more common: "In public outpatient facilities you mainly pay directly to the doctor and later the doctor may deposit funds with the cashier". Provider interview, Tbilisi.

The process of payment also varies by type of ownership:

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<sup>29</sup> Note that maternity services in Tbilisi are undergoing significant changes, with the introduction of selective contracting and of private wards in public maternity hospitals. We present the new regulations in the policy discussion (see section D). They seem to be one of the more interesting attempts to address informal payments. However, our study, carried out soon after such changes occurred, was not able to capture any significant difference in payments due to the new financial arrangements for maternity services. It would be useful to monitor the reform of maternity services by administering the same questionnaire to a representative sample of women that gave birth in Tbilisi after such changes have been fully phased in.

<sup>30</sup> Supposedly, maternity services are part of the BBP, and they should be free at the point of service, but it is not clear whether services covered by public insurance include services such as guaranteed assistance during delivery by a particular physician.

<sup>31</sup> Not all the ambulance calls we encountered could be regarded as medical emergencies. It is not clear, though, who should decide, and according to which criteria, whether a certain ambulance call is an emergency.

- Established private providers only collect payments through cashiers, and according to posted prices: *“In private clinics staff immediately informs you about the price of services and only after receiving treatment you pay your dues at the cashier, for which you get receipt”*. Provider interview, Tbilisi.
- In public facilities [in both localities Tbilisi and Gori] payments are given either to the cashier (in case of formal payments), or directly to the provider.

Moreover, in public facilities physicians try to find arrangements in order to optimize the informal portion of their income, given the lack of patients<sup>32</sup>, they sometimes agree on “rotations” with the other physicians in their same ward, so that each one can be reasonably busy when on duty, and collect at least some revenue: *“We are too many compared to the workload, and our income depends on our performance in terms of output. Thus doctors have an internal agreement, whereby we ‘rotate’: one week one doctor serves all patients, and the following week another. The exceptions only exist when a patient asks for a specific doctor”*. Hospital Provider Interview, Tbilisi.

*“We have been asked to make an internal arrangement among all the doctors, such that on a rotational basis we take non-paid leave. This arrangement increases the potential revenue for those that are left in the hospital, and it allows the others to find other opportunities”*. Hospital Provider Interview, Tbilisi.

## Arrangements for sharing and utilization of OPP revenues

### *Sharing of OPP revenues*

Interviews with providers were not able to capture general rules for sharing informal income, whereas for formal contributions paid at the cashier doctors lamented receiving a very small part of it, or nothing at all.

In most cases, informal payments are collected by one of the physicians who treats the patient, or who oversees his/her treatment. Then, sometimes the physician simply pockets it, sometimes he/she shares it with other physicians belonging to the same ward, and sometimes he/she shares part of it with nurses, or with the administration. In polyclinics sharing arrangements are more rare. A physician working in a polyclinic in Tbilisi described the distribution of informal revenues as follows: *“...In the hospitals doctors tell the patient: “Give us XXX amount and we will distribute among the medical staff. Hospital doctors do this, but this is not a common practice in outpatient facilities.”* In few circumstances, when there are “extra-funds” available, physicians give something to nurses as well: *“If we are given sufficient amount by the patient we do try to share a part of this informal income with the nurses.”* Hospital Provider Interview, Gori.

### *Utilization of informal revenues*

While in the majority of cases physicians indicated that they pocket informal payments as personal income, surprisingly<sup>33</sup> in our study we also encountered a number of cases where providers claimed to use informal “cash” to pay for essential non-labor costs, primarily essential drugs. These “investments” are guided by the desire to attract more patients and generate more income. The phenomenon seems to be more prevalent in Tbilisi, where the size of the health care market and households’ higher income allow the collection of enough funds for such investments. *“Part of the informal income generated by the medical staff was accumulated in a special fund. Staff agreed and voluntarily contributed to this fund.*

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<sup>32</sup> The Georgian health system is characterized by low utilization and excessive staffing of facilities (the ratio of physicians per occupied bed is 1.5 (PER, 2002).

<sup>33</sup> This circumstance never occurred in our previous study in Poland (see, Shahriari, Belli, and Lewis (2001).

*The money from the fund was used to renovate the facility. Also, it contributed to purchase some stock of most needed medicines.” Hospital Provider Interview, Tbilisi.*

Some facilities have created an informal drug revolving fund. *“For a long time we had shortage of drugs. Thus, a few years ago doctors decided to take an agreed percentage from the income generated from the patients and used it to pay for emergency drugs. Since then we have always had a fund to pay for emergency drugs. When such a fund is depleted we replenish it with new contributions.” Hospital Provider Interview, Tbilisi.*

*“...Our head of department collects money from the staff, which is spent to purchase cleaning materials, lamps, paper and pencils and for the other things that are needed. Otherwise nobody provides these things to our department.” Hospital Provider Interview, Gori.*

### **How much is paid. Relationship between the formal and informal components of OPP**

Prices vary according to the facility, the type of service, and providers’ assessment of patient’s ability to pay. Sometimes price negotiations take place between providers and patients. The study captured two distinct occasions when such negotiations take place.

1. For maternity services, physicians are approached well ahead of time to secure their availability for the expected delivery date. The price of their service becomes subject to negotiation: *“I tell the patient that cost of my services will be X amount, and that official payment will amount to Y, that needs to be paid to the facility. If she values my services she has to pay this amount. If she doesn’t, then she can find another provider.” Provider Interview, Tbilisi.*
2. Negotiation concerning the price of inpatient and outpatient curative services. During these negotiations physicians utilize the official price list that sets a price for each service<sup>34</sup> (which is known to the provider but not always to the patient) as a benchmark for charging the patient, and she/he is also guided by her/his perception concerning the patient’s ability to pay. These negotiations serve two distinct purposes:
  - a. determine prices that will be “affordable”<sup>35</sup> for the patient. Thus, some degree of price discrimination among patients does takes place, such that poorer patients can receive the same services for a lower price than the better off: *“...The price is set after negotiations with the patient and according to her/his ability to pay. However the price does not determine what kind of services the patient will receive.” Gori, Provider Interview.* In a few cases, patients from well-off households complained that they were asked to pay more, or that they had to undergo additional examinations (see section on Supply Induced Demand), when doctors suspected they were wealthy: *“...I think we had to pay 500 Gel, but they asked us to pay 1,000 Gel. Probably they noticed that we had money and demanded more.” Patient Interview, Tbilisi.* The price-discrimination strategies described above are different from explicit cross-subsidies in favor of the poor. They both enhance accessibility of services for the poor, but, while in the latter case, in Ensor’s and Killingsworth’s words: (Ensor and Killingsworth, 2001, p. 8) *“The poor are unambiguously subsidized by the better off, in the former case, willingness to pay determines contribution. ...While willingness to pay may often accord with ability to pay, this need not be the case. Those on lower income with fewer opportunities for obtaining treatment elsewhere and an immediate requirement for medical care may have high*

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<sup>34</sup> Note that the price charged for the same service can be different in different facilities.

<sup>35</sup> We do not necessarily mean that the price will be always affordable, and that the patient will not be forced to either sell the assets or borrow the funds, or find other ways to cover the cost. But we rather mean that patient will be able to find some ways to cover the cost, which is agreed (see text, above).

*willingness to pay to the extent that they borrow or sell goods in order to obtain the necessary funding”.*

- b. reach an agreement through which physicians reduce the official part of payment, in exchange for a higher informal payment. The disproportionately low share of official revenues received by physicians and the increase in the official prices charged for services not part of the BBP have created some disincentive for physicians to charge the real prices. Both physicians as well as patients try to find ways to circumvent or to exploit the rules to maximize their gain. Physicians can reduce the price charged to patients either by manipulating the diagnosis so that the service can be covered by one of the BBP publicly funded programs, or simply by not reporting the service to the administration, so that revenues must not be shared. Part of the sum that the patient could in principle save in fact becomes informal payment for the physician. Thus, providers who receive OPP frequently arrange these in a way that is advantageous both to her/him as well as to the patient.

This is one of the more interesting findings of our research: given physicians’ strategies here described, in Georgia informal payments may increase the total cost of treatment for the patient, may have zero effect on the price she/he pays, or may even reduce it. This is remarkably different from the study findings in Poland (see Shariari and Belli, 2001), where we found that demand-side motivations (skipping the queue, receiving extra-services, etc.) were nearly always behind informal payments, so that the latter always increased the total amount patients paid.

Following is an abstract from one of the several cases where patients believed they could be charged less by paying informally: *“...We were told that the surgery officially will cost 1200 Gel and that we will be expected to pay more to various staff. However, the doctor proposed to change the diagnosis and in that case the government would cover the cost of treatment and we would have to pay only 600 Gel to the doctor”. Patient Interview, Tbilisi.*

Providers also reported similar episodes: *“...Sometimes patients approach doctors directly, when they want to avoid official fees. For example official fee for a doctor consultation is set at 15 Gel and for a professor consultation at 20 Gel. When patients strike a deal with the doctor they pay less (e.g. 5-10 Gel). Of course this payment bypasses the cashier, so payment is not recorded and the money becomes the doctor’s personal income”. Provider, Tbilisi.*

Providers endorse this “get-a-discount-if-you-pay-me” strategy because they feel that they receive a small and unfair share of the official income they are able to generate for their facility, when they report it: *“...Doctors are not pleased that they generate 4 Gel for the facility and get less than 1 Gel as their share. They prefer to receive 3 Gel informally, which is cheaper for patient and preferred by the doctor. Everybody knows this, but nobody complains. These arrangements suit everybody”. Provider Interview, Tbilisi.* Patients’ incentive to find these informal and mutually beneficial agreements with physicians has increased with the rise in the official prices charged for services not covered by the BBP: *“...There was a period when physicians tried to cheat patients in order to charge informal fees. The administration and department heads mainly did. We, doctors, had the following arrangement: we charged patients and then we deposited the revenue according to the established price list, which was lower. Thus there was a portion of funds that was informally kept by medical staff, which formed our informal income. But nowadays the increased official prices for our services do not allow us to use the same practice. Now patients pay less if they pay us directly” Hospital Provider, Tbilisi.*

### *Criteria for choosing providers and for finding out their prices*

The 1995 health reforms gave patients the possibility to freely choose among providers<sup>36</sup>. According to our study findings, financial considerations, providers' perceived professionalism, and geographic location are the main criteria patients follow to decide to seek formal treatment and to choose among different providers. The single most important constraint patients consider is their financial situation and the price charged by providers: "...*Before, when we had sufficient income, we used to choose the best provider and the best healthcare facility. But now when we are in need, we try to seek services from those providers that could offer treatment at a lower price*". Interview, Gori.

A number of users in Gori who had severe health complications traveled a long distance (95 Km.) to seek better care in Tbilisi. In Tbilisi patients reported to frequently travel from one end of the city to the other in order to receive services of better perceived quality. Thus, if in the case of Gori travel is mostly determined by non-availability of certain services in the area, in Tbilisi it is mostly determined by perceived better quality.

It is also quite common that the population tends to seek care from the same physician, whom they have built an established relationship over the course of years. This is common for all services, but particularly for outpatient services, and it is also done in the hope that the cost of treatment might be less than with new providers. Our study findings suggest that personally knowing a practitioner is the best guarantee for a patient to receive services at affordable rates and in a timely manner.

Information on treatment prices is gathered in various ways, depending on the type of services, and on geographical location.

- Prices for rural ambulatory services are estimated by talking to neighbors, friends and relatives. No price list has been presented to any interviewed person for rural outpatient services.
- Prices for hospital services and for outpatient services in Tbilisi are in most cases "estimated" with the help of an informal network, and then further clarified during the visit to the facility either by consulting the official price list or by talking to a physician.
  - For inpatient services [with the exception of maternity services, where prices are negotiated with the provider well in advance of the onset of labor], patients and their families receive information from physicians, and in rare cases from price lists.
  - For outpatient services, the number of individuals who saw an official price list and those who received information directly from physicians was equal. Those who asked information about prices directly to the physicians never inquired about an official price list.

### **Sources of funds to pay for health services**

In general, OPP place a significant financial burden on households. There is a significant difference, though, between the burden posed by outpatient (OP) and inpatient services. OP consultations, diagnostic tests and medications seem to be affordable for the majority of respondents, and the primary source of funds to pay for them is households' cash. However, our study found a significant minority of poorer households for whom cash income or savings are not sufficient, and who are forced to borrow from friends and relatives or to sell valuables also to pay for outpatient specialist care.

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<sup>36</sup> Thus, today the phenomenon of OPP cannot be attributed to the lack of competition. On the contrary, during the Former Soviet Union times patients were assigned to a certain facility and to a certain provider. This arrangement guaranteed a set market for any given doctor/nurse.

*“...The cost of treatment was too high. Though we somehow managed to cover the costs it totally consumed our savings”. Interview No. 63, Tbilisi, Outpatient case.*

*“...Two weeks ago I had poisoning and I needed 12 Gel for the medicines. My monthly salary is 15 Gel, and it is usually paid with significant delay. Due to this reason I had to borrow money and now I have to pay it back”. FG, Poor- Gori Outpatient case.*

*“...When I fell sick I was unemployed and had to borrow from relatives to cover the cost of treatment. Though later I sold some of my household’s valuables to repay the debt”. Interview, Tbilisi, outpatient case.*

On the contrary, inpatient care cases, and particularly catastrophic cases (serious injuries and chronic diseases) are in general disruptive for households’ finances for all socio-economic groups, with the exception of the very richest segments of the population<sup>37</sup>. In most cases of catastrophic illness income and savings are not sufficient to cover health expenditures, and the primary source of financing is borrowing from relatives or friends. A young man from a relatively well off household in Tbilisi reported: *“My grandfather had urgent abdominal problems and we took him to the hospital. He had surgery, which cost approximately 1,100 Gel. This was quite significant for us and we had to seek support of friends in order to meet the costs”. FG I Tbilisi well off.*

Another common source of financing for inpatient care is to sell assets and valuables, such as jewelry in urban areas and livestock or agricultural assets in rural areas. A young woman from a poorer household, for example, felt guilty because her mother had sold her valuables to pay for her care.

If they can, households resort to personal connections with medical personnel or with politicians in order to “have discounts”: *“My mother had to undergo surgery on her thyroid gland and the price quoted was 1500 GEL. We were not able to afford it, and because my mother is a retired doctor we approached MOHLSA for financial assistance to cover the cost of surgery”. FG I well off, Tbilisi.*

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<sup>37</sup> For further discussion of this point, see section on Equity, hereafter.

## Causes of Informal Payments

This section focuses on the informal component of OPP, and investigates its causes. A plurality of factors, which can be grouped into three broad categories, contribute to explain the prevalence of informal payments. The three broad categories are:

- Contextual factors.
- Supply side factors.
- Demand side factors.

### A Contextual Factors

The study captured a set of contextual factors related to the supply side that contribute to aggravate the phenomenon of informal OPP. Such factors, echoed in several of the interviews with providers and with patients, can be summarized as follows:

- a) Overcapacity in the delivery system
- b) Georgian government's systematic under-funding of health services.
- c) Poor definition of the publicly funded benefit package (BBP).

In general, systemic failings, such as overcapacity, poor definition of the BBP and poor purchasing<sup>38</sup>, were mentioned as important contributing factors for increased OPP. In fact, they lie behind the single most important factor individuated by this study, which is the low level of physicians' official income.

#### *Overcapacity*

A key problem is the overcapacity of the delivery system, despite the effort by the government to rationalize it. At the beginning of the decade the physical capacity and the human resources employed in the Georgian health sector were comparable to those of North America. Presently, they are significantly reduced, but they are still larger than in countries with comparable levels of income per capita (see also Annex0 Various recent studies carried out by various agencies in the country have showed that :

- 287 hospitals with nearly 23,296 hospital beds (4.57 beds per 1000 population) are serving a population of only 5.1 million (CMSI 2000).
- Due to extremely high capacity relative to demand, the average occupancy rate is equal to 29% (Zoidze et al. 1999).
- Out of 253 hospitals sampled in a study, 119 had less than 15% utilization rate, 49 had up to 25%, 58 hospitals were utilized at 35%, 17 hospitals had 60% of their beds occupied, and only 10 hospitals were found to have utilization rate up to 80% (KPI, 1999).
- The National average is of 1.5 doctor per occupied bed (Zoidze et al. 1999).
- Fixed costs are 80% of total hospital costs, due to excessive human resources and excess capacity (Zoidze et al. 1999).
- The triplicate structure of PHC services (PHC services to the population are offered by children polyclinics, women consultations and adult polyclinics) lead to duplication of services. It is also

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<sup>38</sup> See footnote 20 on the meaning of "purchasing".

excessive relative to the existing demand of PHC services (Gotsadze, G. and Kvitashvili, A 2000<sup>39</sup>).

After 1995, the government tried to achieve a progressive rationalization of the delivery system, by granting autonomy to provider units, by introducing an out-based payment system, by limiting reimbursement of health facilities to basic benefit package, and by requiring a new certification to existing providers. The government hoped that the new payment and priority setting policies would lead to the financial strangling of all underutilized facilities, and to the reduction of underemployed health workers. In fact, the supply rationalization policies have not been pursued courageously enough<sup>40</sup>, and the new regulations have been implemented very slowly. Overall, there are no clear objectives as to what the licensing/certification process has to accomplish, and human resource planning for the sector has not received much attention as of yet. The MoLHSA has not yet developed targets for each specialty area, or for each geographical region. In fact, a government intervention containing the enlargement of medical schools, which would also be critical, has not been considered at all: medical universities and schools are still “producing” a significant number of new doctors annually (it is estimated that each year up to 3,000 new doctors finish their degree and start practicing).

Physicians and other medical personnel have increasingly compensated for their low and erratic official incomes by asking patients to pay directly for health services. The health system *de facto* found a way to continue to function through informal OPP payments (see section Conclusions and Recommendations).

#### *Government systematic under-funding of health compared to existing health entitlements*

Over the last decade, in Georgia tax revenues amount to less than 10% of GDP. Poor fiscal performance, and low priority assigned to health expenditure in the government budget have contributed to funding crisis in health facilities.

**Table C-1: Public Expenditures on Health in Georgia Expenditures (1997-2000)**

	1997	1998	1999	2000
Public Expenditure on Health (millions, lari)	37.7	44.9	42.7	46.9
Public Expenditures on Health (millions, US\$)	18.8	22.2	21.2	23.2
Public Expenditures on Health (% of GDP)	0.83	0.83	0.81	--
Public expenditure per capita (lari)	6.98	8.301	7.90	8.70
Real Public expenditure per capita (lari, 2000 prices)	8.31	9.35	8.15	8.70
Real Public expenditures per capita (US\$. 2000 prices)	4.14	4.63	4.03	4.29

Source: PER (2002), World Bank, based on MoLHSA data

Moreover, since the introduction of health reforms, a major issue in government funding of the health sector has been the gap between budgeted and actual expenditures. Over the last seven years the total budget execution levels for the Ministry of Labor, Health and Social Affairs (MoLHSA) have ranged between 45% and 62% (PER, 2002). In addition, the flow of funds to the health sector has been extremely erratic. For example, in 1999, 30% of the annual budget for health care was released in May,

<sup>39</sup> Thus, the two authors argue in favor of a more radical rationalization of the PHC from its current form to Family Medicine/General Practice based PHC.

<sup>40</sup> The government started to implement a Hospital Master Plan, just limited to the capital city of Tbilisi and with severe limitations, only at the end of the '90s.

while during the other months funding levels varied between 1%-14%.<sup>41</sup>. Continuous under funding caused accumulation of debts by SMIC and other purchasers *vis-à-vis* providers, a debt that in 1999 was already equal to 81 million GEL (Rhodes 2000) and that has increased systematically ever since.

Also municipal/regional governments have not been able to actually pledge the full amount of health care funds approved under their respective budgets. Even in the municipalities where actual fiscal revenues exceeded the planned amounts, healthcare has not been adequately funded.

All of the above factors have caused significant delays and reductions in providers' reimbursements (Gotsadze and Rose 2000).

#### *Poor definition of the basic benefit package of health services (BBP)*

The list of services included in the BBP is extremely complex and convoluted (see Annex, p. 57), so that only a minority of the population, those who are more educated and informed, know which health services should be available for free and which they should pay for. Sometimes it is difficult even for healthcare professionals to precisely understand which services are covered by the BBP-based social insurance scheme (Gotsadze and Rose 2000).

Immunization services are a good example to show how a weakly designed BBP, with blurred and continuously changing boundaries between free and non-free services, has created a fertile ground for informal payments. According to previous evidence (Gotsadze and Nanitashvili, 2000), the portion of the BBP administered by the PHD, consisted of public health services such as immunizations and were the more easily discernible part of the BBP to the public. Georgia benefits from the Expanded Program for Immunization (EPI), with the assistance of UNICEF and other donors, and through EPI a fully funded set of vaccinations is made available to the population at no cost.

By contrast, our study found that, whilst some mothers generally from wealthier backgrounds still received immunizations for free, others were paying for these services, or were confused as to whether immunizations services were still available at no cost. The explanation is that recently, political pressure "forced" the Ministry of Labor, Health, and Social Affairs (MoLHSA) to add immunization against mumps and hepatitis to the schedule of vaccinations covered in the BBP (they were not covered previously under basic package). However, these recent additions were not strongly supported by the donor community<sup>42</sup>, and the Georgian government, on its part, has been unable to fund the provision of the new vaccines. Thus, when children are immunized for mumps or hepatitis there are official charges that need to be paid, whilst according to law all other vaccines continue to be free for the population<sup>43</sup>.

This suggests that providers have started to ask payments for immunizing for some communicable diseases, which should still be available for free according to BBP and donors. Mothers from poorer households are less likely to know which immunization services are still free and which are subject to formal charges, and so are more likely to pay as requested. For example, a mother from a poor household lamented: *"Immunization that used to be free can now be charged. They demand money for syringe and other things"*. FG Low income.

#### *Poor Performance of Public Purchasers*

Since the initiation of health reforms, public purchasers: SMIC, PHD and municipal/regional health funds, have all performed poorly. As discussed earlier, public purchasers are not fully funded and receive

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<sup>41</sup> World Bank. 2001. Georgia Health Care Financing Note. The World Bank, Washington DC

<sup>42</sup> In early 2002 GAVI approved Georgian application for the supply of Hepatitis vaccine.

<sup>43</sup> Author interviews with government officials from National Center for Disease Control.

only a percentage of what is designated for them under the budget. Moreover, BBP is poorly defined, both contributing to the poor performance of public purchasers (Gotsadze and Rose 2000) In addition, here we discuss Purchasers' abuse of their control over resource allocation decisions which is a reason for their poor performance.

Public purchasers (SMIC, central and local government) can prioritize and reimburse providers based on this prioritization. In fact, according to law, public purchasers have an obligation to reimburse for the services rendered to the public all providers with which they sign a contractual agreement. In reality, the chronic under funding from central or municipal/regional budgets, and the lack of control mechanisms over their actions and decision, gives purchasers the excuse to refuse payment to some providers, or to give priority to certain services over others among those that are part of the BBP.

The purchasers' ability to decide which providers to reimburse creates room for corruption, and inequities in the distribution of funding. For example, during interviews with various polyclinics' staff in the capital city of Tbilisi, it was found that over the past 3 years municipal health funds had fully reimbursed 2 out of 5 facilities, while 3 had an increased volume of unpaid claims. There was apparently no objective argument that could explain such discrepancy in funding of five relatively closely located and similar facilities in the same district.

This prioritization based on a not very transparent way followed by public purchasing agencies in distributing public funds have contributed to create a situation where funds are disbursed erratically and with long delays. This has affected the incomes of those doctors/nurses who deliver publicly financed health services to the population. For instance, one doctor employed in the maternity home in Gori, echoing the complaints of several colleagues, lamented: "*The workload in the maternity is not high, and earnings [from hospital] are low. Moreover, the government owes us our pay for the past 13 months*". *Provider Interview, Gori*. A nurse from the same facility said: "*...It has been several years since the government, supposedly due to limited financial resources, has reimbursed our facility*". *Provider Interview, Gori*

Similar complaints were also reported in several of the interviews in Tbilisi. One senior doctor complained about the situation in his department: "*... We have not received our incomes since last August (almost 12 month) due to delayed payments from Tbilisi municipality. Our doctors sometimes do not have money to purchase a loaf of bread*". *Provider interview N7 Tbilisi*

## **B Supply Side Factors**

Our findings suggest that supply-related factors are the more important determinants of informal payments. Among these, two main factors that emerged during the interviews were insufficient official income, and the lack of transparency in the administration of provider units.

### **Medical staff low official income**

Another important determinant of informal payments seems to be the extremely low and erratic income of medical personnel. According to formal rules, the official transfers from the government to the medical facilities and the official revenues generated by the latter ones should cover all recurrent costs, taxes and compensation of administration and medical staff. In reality, providers' revenue base is too thin to meet all of the several competing claims. Moreover, facility directors seem to enjoy a sort of monopoly power over official funds' distribution within the hospital. Excess supply of physicians, even for highly specialized disciplines, contributes to this situation. As a result, medical professionals' income generated from official payments is utterly insufficient<sup>44</sup>. Our findings suggest that on average physicians receive a share equal to only 7-8% of the total revenue they generate per unit of service for their facility<sup>45</sup>, which translates into a monthly net income, for their services in the hospital, of approximately 48-54 GEL ( $\approx 23.5$ - $26.5$  US\$), well below the average monthly salary in the country, which is GEL 82.8 for formal sector employees (GET 2001). Our findings are in contrast with the official figures that in terms of economic classification of expenditures show 80% of all public spending going to the payment of labor inputs in then health sector (PER 2002)<sup>46</sup>.

In the interviews, all providers expressed extreme frustration because they perceived that their remuneration was not proportional to their contribution to their facility's revenue. In the words of one of the surgeons interviewed in Tbilisi: "...When I do surgery I have to deposit 300 Gel with the accounting office. These funds should pay the anesthesiologist, nurses, and other staff. However, I prefer to keep this money and share it with the other staff rather than to deposit it with the accounting office. When I generate 1000 Gel for the facility I only receive 46 Gel. This is unacceptable". Provider interview. Another senior physician in a Tbilisi hospital complained: "...Our department generates revenues of 4,000-5,000 Gel every month and department staff only receives a total of 200 Gel". Provider interview<sup>47</sup>. The share of physicians' earnings never accounted for more than 10% of total generated revenues, which is extremely low by any standard in a labor-intensive sector such as the health sector.

The situation is even more problematic for nurses, because nurses are less able than physicians to make up for their low official income by asking for informal payments. Over the past decade, mainly because of their below-subsistence-level official incomes, the country "lost" almost half of its nurses (presently, the nurse to population ratio is equal to 579 per 100,000 pop, compared to 1058 per 100,000 in 1991). Georgia is now characterized by one of the lowest nursing staff-to-population ratio and nurse-to-doctor ratios in the region. Despite the sharp decline in the number of nurses, nurses' official incomes continue to be extremely low. One of the nurses interviewed said: "*Nurses' official income is very low. We*

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<sup>44</sup> According to the health financing regulation, the government does not pay salaries to doctors, but reimburses providers, who employ medical staff under an output-based contract. See also the following section on supply induced demand. Therefore, in this paper income or earning is used interchangeably instead of salary, even though they refer to monthly earnings.

<sup>45</sup> The variation in physicians' reported official remuneration over the total of their facility's revenues should not be surprising, as regulation of contracting with the medical staff varies from one facility to the other.

<sup>46</sup> According to official figures, approximately 10% of the total is spent on equipment, 5% on utilities, 4.5% on maintenance, and 0.5% is imputed to capital depreciation (PER 2002)

<sup>47</sup> Note that the first quote says how much the individual surgeon received from the total amount of the funds generated for the facility, while the second one points to the share of incomes received by the whole department staff over the total.

receive around 4% of revenue from the hospital. My monthly net official income<sup>48</sup> amounts to 9-15 Gel only". Provider Interview, Tbilisi.

Physicians' and nurses' perception of their current economic situation can be well summarized by a quote from a physician interviewed in Tbilisi: "Doctors are presently in a very poor condition. Petty traders on the street earn more than doctors". FG Discussions, Tbilisi.

#### *Lack of Accountability in the Administration of Facilities*

Reforms initiated in 1995 promoted greater decentralization<sup>49</sup> and they led to the "corporatization" or "autonomization" of health provider units. All providers of medical services became incorporated by law (Gotsadze and Rose 2000).

Presently, even if 100% of the shares of public facilities still belonged to the government and the Ministry of Health, Labor and Social Affairs appoints the Boards who govern the facilities, the real power rests with executive directors, who are appointed by the Boards. Thus, with the institutional changes introduced since 1995 the central government almost completely withdrew from the administration of health provider units. At the same time, arms-length control and accountability mechanisms have remained extremely weak. Laws of corporate governance in Georgia have a very recent history, they are fragmentary, and many of the basic principles of sound corporate governance practices are ignored (Gotsadze et al. 2000). Local governments, which in many cases took over the role of monitoring and planning health services, proved to be ill-prepared and subject to influential local interest groups. In summary, given the absence of clear regulatory/accountability mechanisms, the 1995 process of hospitals' autonomization, in practice gave "unlimited" power to hospital directors who have been taken advantage of this power.

Our study could not interview directors, or conduct independent inquiries over the use of official funds, but it found a striking consistency in physicians' and nurses' complaints concerning the alleged misuse of official funds within their facilities. Practically all physicians interviewed mentioned that the total of official revenues generated by their facility and the transfers received by the government were only known to directors, and that directors did not share any information on the use of such funds: "Administration says that generated revenues are spent for utility costs, medical supplies, payment to the staff, and that a portion goes to the state budget. However, what it is really spent on nobody knows but administrators". Provider Interview, Gori. "...I do not know where the rest of the money went and if I decide to find this out I will be told by management to back off". Hospital Provider Gori.

A majority of physicians did not believe directors were honestly fulfilling their obligations. Some openly lamented that directors' compensation was disproportionably high, and said that they were asking patients to pay informally because they did not trust the official channels, and wanted to bypass them. Other physicians openly complained with us about what they perceived as the 'corruption' of their directors.

However, others admitted that, in exchange for accepting such a low share of the government official transfers, directors had granted them freedom to charge and to collect informal payments from patients. One of the providers interviewed thus described the situation: "The reason for informal payment is the extremely low official income of medical staff. For example, doctors are not interested in generating 4

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<sup>48</sup> What they officially are entitled based on revenue generated by the facility.

<sup>49</sup> Our study, among others, indicates that MoLHSA efforts in this direction were not successful. Self-management was aimed at empowering service-provider units as autonomous centers to take responsibility, to fulfill objectives and to administer resources. Unfortunately, the government effort to decentralize the power and to grant autonomy to health care providers was not followed by policies to develop local capacity, nor to introduce effective regulatory/accountability mechanisms, and since hiring, salaries and policies were set centrally, decentralized units were highly dependent.

*Gel for the facility and to receive less than 1 Gel as their share. Thus they prefer to informally collect 3 Gel. The situation forces them to act this way. At the same time everybody knows about it [informal payments], but nobody reacts because it serves everybody's interests: the administration's as well as doctors' ". Provider Interview, Tbilisi.*

#### *Supply-induced Demand as a Consequence of Output-based Payment System for physicians*

Provider induced demand is a phenomenon typical of the health sector, due to the asymmetry of information between doctors and patients and to the particular psychological condition of patients. Whenever the payment system is activity or output-based physicians have an interest in providing services beyond the point that an informed patient would choose, to increase their revenue. In Georgia, the 1995 health reforms put doctors and nurses at the forefront to demand money from patients. According to the new payment systems implemented in the '90s, provider facilities as well as individual physicians are paid according to the volume and complexity of treatments provided (case-based payment system for facilities and fee-for-service payment system for physicians).

Several of the physicians that we interviewed felt under constant pressure from the administration to generate at least a minimum amount of revenue for the facility and for themselves (this minimum and the consequences for physicians that are not able to generate it differ from facility to facility). More and more sophisticated treatments would also mean higher potential informal revenue for them. So, our study captured several cases where patients felt that providers had prescribed unnecessary treatment, or diagnostic tests in order to charge patients. For example, one of the young mothers interviewed in Tbilisi reported: *"They planned an appendectomy while my kid had problems with gall bladder. Only assistance of a relative [doctor] saved my child from unneeded surgery"*.

## C Demand side factors

Factors linked with patients' tastes, expectations and fears, as well as cultural norms ingrained in the Georgian tradition, also contribute to the diffusion of informal payments. However, unlike other former socialist countries where informal payments are less widespread (for example, Poland, see Shahriari, Belli and Lewis, 2001), in Georgia the "usual" demand-related factors, such as willingness to get additional or better-quality services, or to skip waiting lists, do not seem to be critical reasons for paying. In Georgia, over the last decade the collapse of the formal health financing channels (tax, social security, etc.) has been so dramatic that presently almost everybody pays directly for health, formally and/or informally. Thus, the general attitude in the population is one of submission to this reality whenever health care is sought. Demand-related reasons for paying include:

### *Gratitude*

*"... When a doctor saves your life you want to thank them". Household Interview, Tbilisi*

Almost everybody is willing to pay physicians to express gratitude: Cash payment rather than in kind gifts, in urban as well as in rural areas, are commonly used to express gratitude: *"... We are paying just to express our thankfulness and respect for the doctor's work". Patient Interview, Tbilisi.* Several of the poor households interviewed regretted that they did not have enough money to pay: *"Unfortunately, I do not have enough, though I always want to thank doctors and nurses for their help". Patient Interview, Gori.*

### *Cultural Reasons*

It seems that paying providers has been a cultural norm in Georgia since socialist times, and even before. Several patients admitted that they used to pay providers also during the "old Soviet days", although on a different scale. *"When I do not have money I do not go to a doctor. I will be embarrassed to show up and not be able to pay. We have always paid for health services", Patient interview, Gori.*

### *Fear to be denied treatment*

A number of cases were reported during in-depth interviews and FG discussions where, because of experiences heard from relatives and friends, patients were frightened that treatment would be denied without timely payment. Thus, they decided to pay as soon as they met the physician, and before anything had been explicitly requested. The physician accepted these "envelope payments", but patients were later on left with the impression that he/she would have treated them regardless. Thus, patients' perception is such that they pay even in situations and for services where no payment is explicitly demanded.

### *Desire to Support Doctors*

In general, the Georgian population appear to have a high respect for physicians and believes that health workers are suffering from the same economic hardships as the others. They are willing to help by paying directly in exchange for medical services: *"Doctors suffer and they do have families that need support. This is the reason they are forced to charge informal payments. If they could have higher incomes, I am sure they would never do this". FG, Tbilisi*

### *Lack of trust in government and in private insurers*

*"The State cheated us so many times, that there is no way we can trust them. Just looking at the experience of our savings that disappeared [in banking crisis in the mid '90s] is a sufficient example of this". FG, Gori*

The vast majority of the households as well as of providers interviewed expressed a complete distrust of the government, central and local. The majority of them did not trust private for-profit insurers either: *"Today it is impossible to trust anybody. Nothing is stable in this country. If you have money you better keep it at home". FG, Low income, Tbilisi.*

*"These companies [private insurance companies] will disappear like the banks did in the past and we will be left with nothing". FG, Well off, Gori.*

Such distrust, also confirmed elsewhere (see for instance Bennett and Gotsadze, 2001), hinders the possibility of introducing new insurance and/or pre-payment schemes, or to expand existing ones. When asked about the possibility of contributing, or contributing more, to a social or a private insurance scheme, people said that they would not trust that they would receive any additional benefits. The only institutions people trusted were grass-roots level ones, such as schools and local clinics. People ultimately prefer to rely on services that can be obtained through direct market transactions.

## **C.2 CONSEQUENCES OF OUT-OF-POCKET PAYMENTS**

### **Accessibility of health services**

Direct payments create a significant barrier to access medical services for the population, and our study confirmed findings of the previous quantitative surveys that the population faces major financial problems in accessing health services. *"One of my neighbors is a doctor and last year his wife was pregnant. They had no money to cover the delivery costs and had to deliver the baby at home". FG, Tbilisi.*

In our sample, such delays in visiting doctors/ health facilities in a few cases had severe and even extreme negative health consequences. A respondent explained that her neighbor had died of pneumonia, because she did not visit a doctor and did not take antibiotics. One respondent reported the story of a neighbor who had died, probably of stomach cancer: *"I had a neighbor, who had symptoms of gastric problems. He could not afford to visit the doctor and self treated himself. When the disease got really unbearable they were forced to go to the hospital, but it was already too late and doctors could not save him". FG, Tbilisi.*

### **Underutilization**

Once of the consequences of OPP, which in turn is a result of some of the supply and contextual factors such as oversupply and under funding, is severe underutilization of the health care system. In all the interviews with providers, they complained that there were fewer and fewer patients seeking care, which directly affected their formal and informal income: *"...Now the number of patients is much lower compared to when the facility was established and the doctors recruited. Now on average we have 7-9 patients and 14 doctors are serving them". Hospital Provider Interview, Tbilisi.*

*"We are not occupied. Sometimes I come on duty and there is not a single patient in the ward. In our department we have times when for whole weeks no single patient would be admitted". Hospital Provider Interview, Gori.*

Existing data support our findings in showing remarkably low utilization rates for inpatient as well as outpatient health facilities (see section on "Impact", below). As we shall discuss, such situation can be characterized as a vicious cycle in the sense that households use the facilities less and less because they simply cannot afford to pay, and so providers try to maintain their income by extracting more from a shrinking pool of patients. This creates a vicious cycle, perpetuating and raising informal payments, which in turn further limit access.

### **Equity issues**

Payments are affecting different socio-economic groups differently. As we discussed in a previous section ('Sources of funds to pay for health services'), poorer households sometimes face access problems even for primary and for specialist outpatient services, while these do not seem to impact on wealthier

households. Frequently drug purchases pose the more severe financial burden, particularly for elderly chronically ill patients.

Our findings confirm recent data (see for example, PER, 2002, and Gotsadze et al. 2001), showing that socio-economic disparities in the country have widened, that the poor are disproportionately suffering from disease, and that for them an increasing number of conditions remain untreated, even for outpatient care cases.

**Table C-2: Incidence of Illness (not requiring hospitalization)**

Quintile Group	Percentage Reporting Illnesses	Percentage Requiring Out-Patient Medical Care	Percentage Seeking Care
1 poorest	23.2	21.5	67.2
2	17.4	25.4	79.6
3	18.4	23.7	82.1
4	19.1	23.5	82.1
5 richest	17.7	28.2	87.2
TOTAL	18.8	24.6	80.9

Source: PER (2002), World Bank

By contrast, in general the cost of inpatient care is difficult to bear for all socio-economic groups. For example a relatively wealthy couple that was saving money to pay for a cardiac operation for their child, complained: *“The cost of this open heart operation is US\$5000. Though 50% of this cost is subsidized and we have to pay only 2500 USD, this is a very significant amount for us. We need the surgery for our child but yet have to secure enough money”*. FG II Tbilisi.

Sometimes households delay elective surgeries, or maternities, and save for a while until they accumulate enough financial means to pay for them. However, in case of emergencies and catastrophic events, households must cope by selling valuables or assets, or by borrowing, mainly from friends.

*“As a consequence of a car accident, my husband had to be hospitalized. The whole treatment cost was 600 GEL. Though we have income and are able to meet this cost over a period of time, when we needed it immediately it became a problem for us”*. FG, Gori, well off.

Poorer households more frequently reported to have renounced seeking treatment, or interrupted it because they were unable to pay. *“I was burned with hot water and taken to the burn center. They put ice on the wound and then asked us to buy drugs that we cannot afford. So I had to leave the hospital and go home”*. FG Low income

*“My husband has a chronic disease and we have not seen a doctor for the past 3 years because we can not afford the treatment”*. FG Low incomer.

*“My father was hospitalized. After 4 days in the middle of treatment we were asked to pay 250 Gel (approximately, US\$ 119). We only had 150 Gel (approximately, US\$ 71). We paid and took my father home without completing the treatment”*. FG Low income.

However, we also interviewed a minority group of richer households, who seemed to be able to afford any type of care with no constraints, showing that there is a new class of wealthy Georgians who are increasingly demanding and using Western-standard medicine provided in private facilities, without any financial constraint. *“I had a positive experience in the hospital. The quality of equipment and services has improved significantly. If previously you had to go to a hospital well in advance of surgery, now you*

*go there on the day when surgery is planned, because they do all tests and diagnostics before on an outpatient basis. You get operated, recover soon and leave the hospital in a timely manner. It is nice to be able to pay and get good quality service". FG Rich, Tbilisi.*

*"There is a private eye clinic where you get top of the line surgery and good quality services; you pay the fee and you are pleased with everything. I enjoyed their services". FG Rich, Tbilisi.*

#### *Geographical differences in access*

Another difference that in-depth interviews captured is between the rural (including Gori city) and the Tbilisi population in seeking different levels of care.

The rural population has to travel to the city (Gori or Tbilisi) for any complex health treatment. Thus, cost of treatment and transportation/travel expenses deter a large number of households from seeking higher levels of care. Urban residents in Gori face the same problem: whenever they need a specialty service not available locally, but all the associated costs induce patients to delay treatment until they can accumulate enough resources to pay for them.

At the same time, in Gori, the excessively low workloads and the deterioration of infrastructure create working conditions in which it is becoming harder to deliver quality services: *"...We lack the most essential equipment for routine examination/diagnostics. E.g. when we need to make EKG we have to send the patient to another facility". Provider Interview, Gori.*

#### *Arbitrariness of existing arrangements*

Some patients resent not so much that they had to pay, but more the way payments were imposed in public facilities. They felt that they were at the mercy of a totally arbitrary system. Thus, they stressed that they would rather know in advance the cost of treatment. *"I think it is better to pay a one time official payment, and later not to guess how much should be given and to whom. Then providers would not be expecting extra payment from you." FG, Low income, Gori.*

Several providers expressed a similar frustration regarding the non-transparency and arbitrariness of the situation. In general, and perhaps surprisingly, they voiced a negative attitude towards informal payments. Most physicians and nurses were aware that the incentives in the system were detrimental to patient's well being, and underscored that they had to ask informal payments because it was the only way for them to make ends meet. They also felt uncomfortable talking about money with patients, something they said they would not do in the past. *"Existence of informal payment is a violation of all ethical norms. Doctors are not supposed to deal with financial issues with the patient. This puts them [doctors] in a very difficult situation". Provider Interview, Tbilisi.*

Some of the physicians were in favor of tackling informal payments by raising official OPP, but the majority of them were against this alternative, fearing that it would significantly increase the total cost of treatment, and it would create even more severe problems of access to health services for the poor. All providers were in general in favor of a scaling-up of insurance and pre-paid health financing mechanisms, raising taxes, social security contributions (SMIC administered programs), and private insurance premiums.

### **Impact on Efficiency of Health Care System**

The limited financial resources officially available are not enough to adequately maintain or replace depreciated medical equipment and/or to improve the condition of the existing infrastructure. *"In the public facilities that are "cheaper" the situation is disastrous. Beds are terrible, windows are broken and they do not have medications". FG, well off, Tbilisi.*

The problem of severe under-funding of key input items was mentioned almost by every respondent from the medical facilities, as well as documented elsewhere (Zoidze et al. 1999, KPI 1999). In fact, our findings show that a portion of funds, formal and informal, is currently used to improve quality of

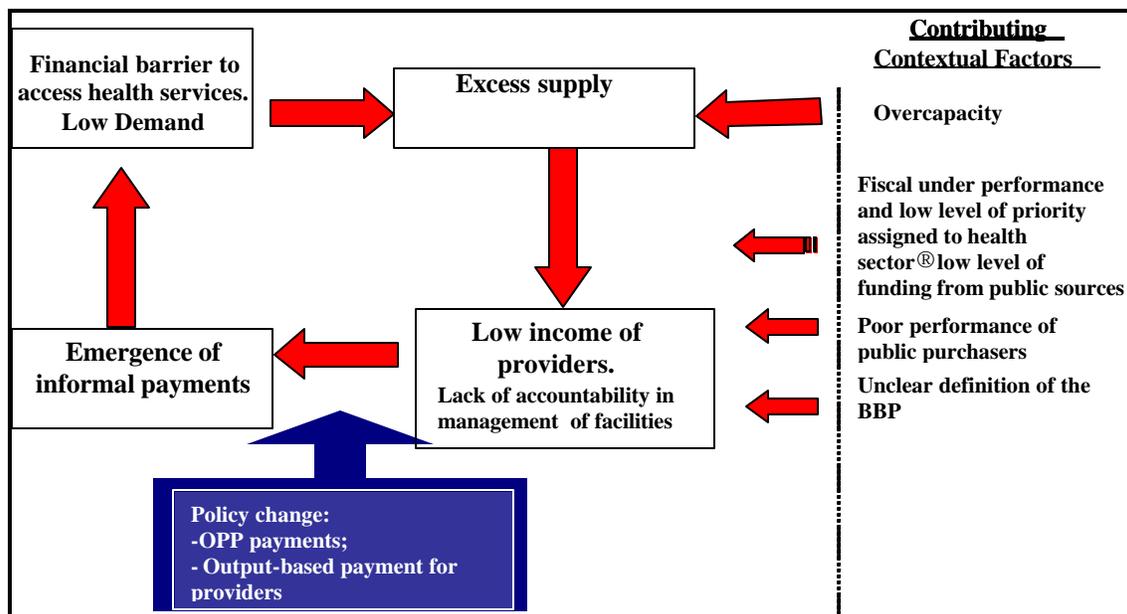
services (drugs, emergency tool-kits, etc., see section on "Arrangements for Sharing and Utilization of Informal Income"). However, such funds are inadequate, also because of the severe underutilization of facilities. All providers lamented the lack of patients and the fact that they are idle in hospitals/polyclinics wards for most of the day.

## CONCLUSIONS AND RECOMMENDATIONS

Based on our research findings, we propose the following conceptual framework to understand the reason behind the prevalence of OPP.

Georgia's healthcare system seems to be trapped in a *vicious cycle*, that determines the persistence of widespread OPPs, creates significant access barriers to the population and bears negative impact on health outcomes. Let us illustrate the origins and the dynamics of this cycle through the following figure:

**Figure D-1 Vicious cycle, due to supply and demand unbalances**



The above figure should be read starting from the upper-right corner, by looking at the first two contextual factors. The government's financial inputs into the health system collapsed after the disintegration of the Former Soviet Union. At the time, the Georgian health system was characterized by extreme excess capacity, both in terms of human as well as capital resources (see Annex 3). To say it with a metaphor, the plane was large and heavy, perhaps flying in the wrong direction, and at the beginning of the '90s the situation precipitated because, due to the income and fiscal collapse, the fuel signal turned red.

The collapse of public funding at the time of excess supply led to increased informal payments, which were already existing but not as pervasive during the communist times. Then, after 1994-95, a few policy changes meant to address the poor health funding and the excess-capacity problems, in fact made the situation perhaps even worse. In 1995, the government introduced the purchaser-provider split, granted *de facto* full-autonomy as regards internal management to facility administrators, moved from an input to an output-based payment system for provider units, and limited reimbursement to a Basic Benefit Package<sup>50</sup>. The government hoped that these measures would lead to the financial strangling of all underutilized facilities, and to the reduction of (underemployed) health workers.

<sup>50</sup> See Gotsadze and Rose (2000) and Belli, (2001). We have already discussed in the text the introduction of the BBP and the autonomization of facilities. On the human resources front, government policies aimed at limiting the number of doctors and nurses by requiring licensing and certification of all medical providers/doctors.

In fact, such components of the health reforms, justifiable in a different context, in the context of a drastically declining public funding for health had the only result of establishing a system *de facto* operating as a private market, although still under a public shell (Lewis, 2001). Administrators and physicians found a new way to make ends meet through informal OPP payments. As we explained before, the new payment system for providers and for physicians (which were increasingly paid on a fee-for-service basis) contributed to the increasing reliance on informal payments, by making health workers' income totally dependent on utilization of facilities by the population, and at the same time by allowing medical staff and administrators to ask patients to pay directly for services, formally as well as informally. The poor performance of purchasers (SMIC), the unclear and ever changing definition of services part of the BBP, the lack of accountability and often the corruption of facility administrators all contributed to make the situation worse.

Then from 1990 to 1999 hospital rates dropped by 68%, down to 4.3%, *Bed Occupancy Rate (BOR)* decreased to 29% (Zoidze et al. 1999), utilization of services declined by 81% (from 7.3 visit per year to 1.42), and calls for ambulance fell from 0.22 to 0.03 per person per year. summary, over the decade the demand for services declined dramatically, reaching the poorer countries of Sub-Saharan Asia<sup>51</sup>.

Thus, a plummeting spiral has driven demand and supply, always keeping the between the two<sup>52</sup>. As a result, presently there is a vast area of unmet medical which is paradoxical given the existing oversupply of doctors and facilities. The has become particularly unbearable for and more vulnerable segments of society.

Based on these analysis, it is clear that government interventions must address supply well as the demand side, trying to the decline in demand. The Georgian government should provide the bases for "virtuous cycle, where demand is stimulated, prices are lowered and quality of services is improved. On the supply side, one of the more important elements in the strategy must be to strengthen the process of rationalization so far only timidly implemented. The elimination of existing duplications, and of a significant number of underutilized

**Box 1: Relation doctor/patient at the polyclinic level**

The study found that people usually have a long-lasting and fairly frequent (although not like in the past, as the previous sections showed) relationship with physicians at the polyclinic level, and that they would be willing to assign them also a financial responsibility to manage a pre-payment scheme. Echoing a majority opinion, one respondent stressed the stability of the relationship that linked her community to a specific polyclinic: *"We are attached to this polyclinic; since early childhood, they have our records... it is easy to oversee them and relationship with them is easier. Also they can not disappear immediately"* FG, Low income, Tbilisi. Another respondent stressed a similar point: *"In the policlinic they would treat me for those conditions that they can manage. And for other things they would send me to other places. It is easy to oversee polyclinic, it is close to our house, and we know almost everybody there and everybody there knows us. Also these facilities have existed for a long time and will continue to exist."* FG, Well off Tbilisi.

admission hospital from 51% outpatient per person services In medical those of Africa and down both unbalance in Georgia need, situation the poorer further both the contain a new

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However, the new regulations have been implemented very slowly. See discussion in the text (previous section on Health Reforms).

<sup>51</sup> Actually, we are not aware of any other country that has OP utilization rates as low as those of Georgia (1.42 contacts per year). In Uganda and Tanzania, for instance, two of the poorer countries in Africa, OP visits are equal to 2.5 contacts per person per year.

<sup>52</sup> See discussion in the text under the section on Overcapacity.

facilities and personnel, will help to mobilize more internal resources of the system to increase the volume of services and improve their quality.

On the demand side, a necessary step in order to stimulate services' utilization particularly by the poor is to address the existing financial barriers, through a health financing reform that increases the share of total resources for health harnessed on a pre-payment basis. Ability to pay for health services will naturally increase with economic growth, but most probably not fast enough and not equally for everyone. Increasing demand for health services, would also relax the tight financial constraint physicians presently face, and may spontaneously lead to informal payment reduction (if there was a larger pool of patients from which to ask, may be individual prices could be lowered).

Thus, it is critical to define new ways to mobilize funds, and to streamline existing public allocation criteria. Recommendations include:

- Strengthen resource mobilization on a pre-paid basis. According to our study findings, the consensus base for this task presents one major element of strength and one of weakness. The element of strength is that the vast majority of people interviewed expressed an urgent need for health insurance and new pre-payment schemes, and their willingness to pay for it <sup>53</sup>. The element of weakness is that presently in Georgia any publicly managed or privately run insurance scheme, unless managed at the grass-root level (for instance by a school or by a local health center), would operate in a very difficult environment. The vast majority of people would not trust it and would try by all means to avoid contributing to it. Thus, in the present circumstances, at least in the short period the more promising option for organizing and testing any pre-paid scheme should probably rely on provider-based or community-based insurance schemes (see box 1). However, we are also aware of the limitations of such local schemes, frequently unable to pool enough resources to really cover catastrophic risks, and plagued by managerial, adverse selection and moral hazard problems (see Bennett, S., et al, and Preker et al., 2002).
- Streamline existing public funds' resource allocation criteria, such that public subsidies for health services should guarantee financial support for the poorer segments of the population, at least in cases of catastrophic illness. The current situation is characterized by a base of public funding, in theory focused on the most cost-effective services, but in practice assigned according to totally un-transparent and discretionary criteria, above which there is widespread private OPP-based funding, mostly informal and distributed according to a mix of criteria, such as willingness-to-pay for different services, market power, etc. For example, SMIC is already managing a program for vulnerable groups, but at least in our sample of interviews, we did not find a single patient who was benefiting from this scheme. People are paying anyway, unless they have some connections, wherever they go and whatever service they are using. We suggest that any element of discretionary power in the assignment of the SMIC and municipal funds for vulnerable groups and for the other BBP services be eliminated. The allocation criteria should be as objective and as rigid as possible. We also recommend the current fragmentation in purchasing: all public resources should be channeled to providers through one single purchasing agency.

To face informal payments, Georgia also needs to revise the public-private mix in health provision, where the current system is characterized by facilities "formally" still public, but *de facto* managed as if they were private, and where physicians and other health employees earn most of their income through

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<sup>53</sup> In the words of one focus group participant in Tbilisi: "*Of course it is better to pay on a monthly basis a certain amount and to know that when emergency arises you are guaranteed that service will be covered*". FG, Low Income, Tbilisi.

informal payments. The boundaries between the public and private sectors ought to be defined more sharply and in a different way. For the public sector, we recommend to:

- Strengthen existing and design new governance arrangements to increase level of control on autonomous providers.
- Reform the criteria according to which health providers and health personnel are paid. For health personnel, one option could be to reinstate a salary-basic remuneration, and then selectively pay an increment bonus based on observable criteria or even volume. The bonuses should be financed from official payments<sup>54</sup>. For provider units, further work and consultations need to be carried out that could help develop new reimbursement mechanisms, but our study shows that the current service-based (BBP) approach has not achieved any of the goals for which it was first introduced.

At the same time, we believe there is a potential for the private sector to play a more significant and at the same time more orderly role in health provision. Currently, the situation is characterized by a plurality of private providers, registered as well as unregistered, and supplying mainly ambulatory and outpatient care services. The private sector can and should be allowed to grow and to become a real alternative to the public sector, but with a clearer division of roles. On the basis of our research findings, we would recommend a different solution for outpatient and for inpatient care, and slightly distinct strategies in rural and urban areas.

- For all services that are low cost, high probability the private sector has in many places already become the key player. Then, government's effort should be mostly focused on quality controls to make sure that services are accessible particularly to the more vulnerable segments of the population. The Georgian PHC program for rural populations is already proving successful, and, in addition, there are several instruments at the government's disposal to further improve things on both the quality and accessibility dimensions. Training programs for private providers, accreditation processes, health promotion campaigns and programs to strengthen the community participation in providers' monitoring are means to improve quality of service provision in the private sector. Subsidies or exemption schemes in favor of elderly, children and other vulnerable groups, direct provision of essential drugs, participation in community-based pre-payment schemes, are means to increase accessibility of services.
- The solution for inpatient care must be different for several reasons. Among them, the following three are critical.
  - Because the issue of accessibility of services is much more severe for inpatient services, few people in Georgia would be able to afford inpatient care, should services patients bear the full-cost.
  - Because currently the potential to rely on private insurance schemes is limited given perceptions and low incomes.
  - Because in Georgia the potential private sector has not showed yet the ability nor the willingness to take the risk of investing in costly activities, such as buying and/or running hospitals<sup>55</sup>.

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<sup>54</sup> See Ensor and Killingsworth, 2001, p. 12.

<sup>55</sup> Significant difference as regards the role of the private sector was observed among hospital staff in Tbilisi and in Gori. In Tbilisi, hospital staff did not seem concerned that they might not be able to find patients in case they left their jobs with public facilities. Such concern was on the contrary prevailing among Gori hospital staff.

Thus, at least in the short-medium term the government must play a greater role than the private sector in the provision of inpatient health services. In fact, a necessary precondition to create a more efficient and sustainable public delivery system is that the ongoing process of rationalization of human and capital resources deployed in the hospital sector be deepened. Once the number of providers is reduced to sustainable levels, in order to harness private resources without compromising equity, rooms/wards for paying patients<sup>56</sup> and/or the possibility to exercise *intra-mural* private activities should be created. If the two types of wards are separated, there should not be different salary levels for staff in the two types, or alternatively, there should be rotation of personnel between them. It is also important to preserve the quality of clinical services in the wards for non-paying patients, by providing direct government subsidies linked to the number of patients admitted there.

Once the number of providers is reduced to sustainable levels, in order to diversify sources of health financing, wards for paying patients and/or the possibility of exercising *intra-moenia* private activities should be created. In our study, physicians underscored the need to maintain facilities that offer surgery and inpatient care services directly financed by government, by the church or through donations, and all respondents, with the exception of Gori hospital staff, agreed that for inpatient care subsidized and privately funded medical services should exist simultaneously. All of them also deplored that the program for vulnerable groups currently managed by SMIC is not performing. Targeting services to the poor seems an impossible task in Georgia in the present circumstances, and so the best the government can hope for is perhaps to stimulate some form of self-selection among hospital patients. One way to do that could be to separate wards in two sections, for paying and for not paying patients, characterized by different levels of comfort. This should not be accompanied by different salary levels for staff in the two types of wards, or alternatively, there should be rotation of personnel between the two parts of wards. It is also important to preserve the quality of clinical services in the wards for non-paying patients.

One interesting example of a combination of some of the above measures to contain informal payments is that being implemented in maternity hospitals in Tbilisi, where<sup>57</sup>:

- Private wards for paying patients have been established alongside public wards for non-paying patients<sup>58</sup>.

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Gori hospital has quite low utilization rates that affect levels of income as well as hopes for moving outside of the public facility.

<sup>56</sup> In our study, physicians underscored the need to maintain facilities that offer surgery and inpatient care services directly financed by government, by the church or through donations, and all respondents, with the exception of Gori hospital staff, agreed that for inpatient care subsidized and privately funded medical services should exist simultaneously.

<sup>57</sup> However, our study was not able to capture any evidence on the impact of such new arrangements on the level of informal payments paid in maternity wards. It would be interesting to monitor this reform component by administering our same questionnaire to a representative sample of women gave birth in Tbilisi after the above changes have become fully operational.

<sup>58</sup> Note, however, that doctors are paid more if they deliver the babies in the wards for paying patients and this is likely to lead to inequitable quality differentials in the two wards. One of the physicians thus explained the new arrangements in his maternity hospital: "... *We have set up the private department in the facility where the private patients come and pay 400 Gel for delivery, whereas in the public part the delivery is free. Price for these services is paid to the cashier and we receive higher earnings from these payments*". *Hospital Provider No. 12. Tbilisi.*

- Instead of the 12 maternities contracted in previous years, SMIC moved to selective contracting and decided to fund only 3 maternities in the course of 2001. They also increased reimbursement per case from GEL 100 to GEL 256, under the condition that there will be no informal payments or additional charges to the patient.

In conclusion, our study suggests multidimensional policies to reduce the prevalence of OPP and informal payments and their negative impact on access to health services, particularly for the poor. Moreover, it shows that it would be naïve to consider that in a tightly resource-constrained environment, such as Georgia, effective public policies will totally eliminate informal OPP. However, if our interpretation of the vicious cycle in which the Georgian health system is trapped is correct, there is scope for hope: if the government is able to reverse the decline in demand for health services by addressing the existing financial barriers to access, and to stimulate improvements in efficiency and quality of services on the supply side, a new virtuous cycle can be initiated.



## ANNEXES

### E.1 DESCRIPTION OF STUDY PARTICIPANTS

Description of households (HHs) that were selected for the in-depth interview:

**Table 0-1: Sample Matrix for In-depth Interviews with Patients**

Location	Income Group	N	Percent
Tbilisi	Poor	21	36.2
	Rich	37	63.8
<b>Subtotal</b>		<b>58</b>	<b>100.0</b>
Gori	Poor	13	86.7
	Rich	2	13.3
<b>Subtotal</b>		<b>15</b>	<b>100.0</b>
Villages	Poor	22	84.6
	Rich	4	15.4
<b>Subtotal</b>		<b>26</b>	<b>100.0</b>
<b>Total</b>	Poor	<b>56</b>	56.6
	Rich	<b>43</b>	43.4
<b>Grand Total</b>		<b>99</b>	<b>100.0</b>

**Table 0-2: Average HH monthly Total Expenditure per Geographic Location**

Location	Mean	95% Confidence Interval for Mean		Median	Minimum	Maximum
		Lower Bound	Upper Bound			
		Tbilisi	422.3			
Gori	149.9	100.5	199.2	100	28	300
Villages	153.8	58.5	249.0	75	14	1200
<b>Sample Average</b>	<b>310.5</b>	<b>249.2</b>	<b>371.8</b>	<b>200</b>	<b>14</b>	<b>2000</b>

Total number of individuals residing in the HHs that were interviewed was equal to 411 individuals, out of which 146 individuals (35.8%) reported having used health services (because of illness, prevention or because they were pregnant) during the 3 month prior to interview.

Average size of HHs differed by income groups and by type of residence. Details of the findings are presented in Table 0-3.

**Table 0-3: Average Size of HHs by different groups**

	Poor	Rich	Residence			Total For Sample
			Tbilisi	Gori	Villages	
			N	56	43	
<b>Mean size</b>	<b>3.8</b>	<b>4.6</b>	<b>3.8</b>	<b>4.6</b>	<b>4.6</b>	<b>4.1</b>

Considering that only HHs that used formal health services were selected for the interviews, 146 cases of service utilization were recorded. Details of service utilization are provided in Table 0-4.

**Table 0-4: Type of Services Used by the Individuals from Selected HHs**

Type of Service used	N	%
Outpatient polyclinic/ambulatory	35	24.0%
Specialist at hospital	39	26.7%
Private doctor	26	17.8%
Hospitalised +surgery	19	13.0%
Diagnostic Service	15	10.3%
Home visit by doctor/health professional	8	5.5%
Surgery	4	2.7%
<b>Total</b>	<b>146</b>	<b>100.0</b>

**Table 0-5: Description of Cash Expenses by Different Income Groups Gel**

	Poor		Rich	
	N. of cases	Mean payment	N. of cases	Mean payment
Drugs		52.2		91.7
Doctor's Fee		13.3		39.2
Hospital stay		3.7		34.0
Surgery		2.0		90.3
Diagnostic		23.0		43.9
In-kind supply (bed linen, food, etc)		1.1		4.8
Total number of cases where cash payment occurred	<b>58</b>		<b>65</b>	
<b>Total</b>	<b>72</b>	<b>150.4</b>	<b>74</b>	<b>477.0</b>

**Table 0-6: Description of Expenses by Type of Residence (Gel)**

	<b>Tbilisi</b>		<b>Gori</b>		<b>Villages</b>	
	<b>N</b>	<b>Mean</b>	<b>N</b>	<b>Mean</b>	<b>N</b>	<b>Mean</b>
Drugs		81.2		18.4		81.1
Doctor's Fee		34.8		8.8		14.4
Hospital stay		29.5		-		2.2
Surgery		72.9		-		5.6
Diagnostic		48.9		3.9		8.0
In-kind supply (bed linen, food, etc)		4.2		0.1		1.4
Total number of cases where cash payment occurred	80		16		27	
<b>Total</b>	<b>97</b>	<b>371.4</b>	<b>18</b>	<b>106.1</b>	<b>31</b>	<b>264.1</b>

type of service used	Drugs		DOCTOR'S Fee		admission/ stay		Surgery		Diagnostic service		supply (bed linen, food, etc.)		Total	
	N	Mean	N	Mean	N	Mean	N	Mean	N	Mean	N	Mean	N	Mean
at polyclinic/ambulatory	27	35.3	27	39.0	27	-	27	20.2	27	27.0	27	-	35	199.6
t at hospital	34	75.9	34	21.4	34	31.0	34	36.0	34	31.8	34	1.5	39	537.7
octor	24	40.9	24	17.7	24	0.2	24	-	24	47.7	24	-	26	115.2
sed	18	154.0	18	46.9	18	75.7	18	234.1	18	40.4	18	18. 2	23	547.7
ic Service	13	51.2	13	4.0	13	-	13	-	13	37.2	13	-	15	80.7
sit by doctor/health nal	7	147.1	7	30.4	7	-	7	-	7	3.1	7	-	8	170.6

## Description of Focus Group Participants

A total of 119 individuals were selected to participate in the focus group discussions. Average age of participant was 39.2 years. The participant distribution by various age groups is presented in the following table:

**Table 0-8: Focus Group Participant Distribution by Different Age Groups**

	N	%
25-35 Years old	52	43.7
36-45 years old	32	26.9
46-55 years old	28	23.5
56-65 years old	5	4.2
66 + years old	2	1.7
<b>Total</b>	<b>119</b>	<b>100.0</b>

Participants were chosen according to the criteria discussed in the introduction:

**Table 0-9: Participant distribution by various groups and their Characteristics.**

Group	N	%	Mean HH Monthly Spending Gel
Tbilisi rich	29	24.4	634.8
Tbilisi poor	30	25.2	219.0
Gori rich	30	25.2	396.5
Gori poor	30	25.2	126.3
<b>Total</b>	<b>119</b>	<b>100.0</b>	<b>344</b>

**Table 0-10: Educational Level of Participants by Income Groups %**

	Tbilisi rich	Tbilisi poor	Gori rich	Gori poor
01 to 11 years of secondary school completed	10.3	43.3	23.3	36.7
Completed technical school (PTU or SPTU)	10.3	20.0	10.0	23.3
Completed higher/bachelors	79.3	33.3	60.0	40.0
Incomplete higher/bachelors		3.3	6.7	
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>
<b>N</b>	<b>29</b>	<b>30</b>	<b>30</b>	<b>30</b>

**Table 0-11: Primary occupation of FG Participants by Income Groups %**

	<b>Tbilisi rich</b>	<b>Tbilisi poor</b>	<b>Gori rich</b>	<b>Gori poor</b>
Unemployed	3.4	3.3	13.3	16.7
Self-employed		16.7	26.7	3.3
Business person/entrepreneur	13.8			
White collar worker	62.1	23.3	46.7	40.0
Agricultural worker			6.7	10.0
Retired/pensioner		33.3		
Domestic work	20.7	23.3	6.7	30.0
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>
<b>N</b>	<b>29</b>	<b>30</b>	<b>30</b>	<b>30</b>

### Description of Providers

Among interviewed providers on average doctors had 18.2 years of experience and nurses 22.4.

**Table 0-12: Distribution of Interviewed Doctors and Nurses by Specialty Area**

	<b>Physician</b>	<b>Nurse</b>
Obstetrics	20.0	20.0
Trauma	10.0	
Surgery	3.3	10.0
Department of general medicine	20.0	10.0
Laboratory	3.3	
Intensive care unit	3.3	
Department of the anaesthesiology	3.3	
Outpatient department		10.0
Insurance department	3.3	
Paediatric (children) department	10.0	20.0
Rehabilitation department	3.3	
Neurology department	6.7	
Cerebral palsy rehabilitation centre	3.3	
Diagnostic centre	3.3	
General medicine (adults)		10.0
Women's consultation	3.3	
Department infected pregnancy undelivered		10.0
Cardiology department	3.3	
Allergy department		10.0
<b>Total</b>	<b>100.0</b>	<b>100.0</b>
<b>N</b>	<b>30</b>	<b>10</b>

**Table 0-13: Sufficiency of Providers Income Perceived by Providers Themselves**

	Physicia n	Nurse
Sufficient only for basic needs	6	1
Insufficient for a normal existence	24	9

## E.2 RESEARCH TOOLS

### Focus Group Guideline

#### Introduction

Moderator: Good evening and thank you for coming. We invited you to participate in the group discussion on the issue of the costs of obtaining medical services in our country. The project is financed by the World Bank and it is aimed at improving the situation in health care system and developing with your assistance new policy recommendations. We are interested in patients' attitudes toward the following issues: how they evaluate recent health care reforms, what experience they have in relation with different medical institutions, their experiences and perceptions on the costs of medical services. Our discussion will continue for 1.5 hour, it will be recorded and analyzed by our experts. In the final report we will describe your ideas only in general form, with confidentiality. In addition, I would like to stress that there is no right and wrong statements; we only want to hear your ideas about the issues.

Now please shortly introduce yourselves: name, age, profession and occupation.

#### Warm-UP

##### **Let's speak about Current Health care in Georgia**

- What do you think has changed in Georgia's healthcare during past several years?
- What are positive and negative new elements (strong and weak points) these changes brought?

##### **Users' perceptions about medical care and payment**

- Do you know any free health services that are offered to the population and financed by the government? Have you or any of your HH members and/or relative/friend received free services and if not, why?
- For those that received service for **free**, which medical services were provided for free and why? (*Probe: provider was friend; friend/relative paid for the services; public financiers paid the services; I had private insurance that covered the cost of treatment*).
- Were services for children 0-3 in your knowledge less costly than the others? Do you think that in general it has been difficult for you or your family to meet health bills (ask about their family experience)?
- Do you see any relationship between quality and cost. If "yes", in which cases? Can you name specific examples?

If the government had enough money to provide just 3 services for free which ones do you think it should guarantee? Rank then (1, 2 and 3)

- Chronic outpatient for elderly
- Emergency and hospitalization services
- Surgery.
- Maternity and child services.

-Medicines

-Diagnostic services

- Outpatient care for children under 15

Why? (*Probe: Services who are best for improving health, services who are more costly, or people who deserve more*)

- ◆ Now, for all the other services, we must find other ways to fund them. What do you think it is the best way to pay for these services?
- ◆ Do you prefer to pay when you get sick, or would you prefer to pay something each month in order to get services for free when you get sick?
- ◆ If you are willing to pay something each month, whom would you trust more for managing this pre-payment scheme (explain what we means by it), so that when you get sick you are sure of getting (almost) free services:
  - ◆ Central Government/MoLHSA
  - ◆ Sakrebulo
  - ◆ Polyclinic for Tbilisi, and health center/or hospitals for rural areas
  - ◆ Private insurance
  - ◆ School
  - ◆ Employer
  - ◆ Labor union
  - ◆ Other. Who?
- Why?
- ◆ Which change would be needed to increase your trust? Can something be done to increase your trust in any of the above agents?
- ◆ Do you know how much different health services would cost you before you go? Do you think that having a price list posted at the door of any facility (polyclinic and hospital) would be of help you?
- If you were told that your health care expenses would be paid you back if you can present receipts, would you be able to demand and get receipts/formal confirmation from a doctor and/or a health care institution?

### **Attitude towards physicians, their motivation and regulation of payments**

- ◆ How would you rate the size of a physician's income?

Privileged	1
Sufficient for a good standard of living	2
Sufficient only for basic needs	3
Insufficient for a normal existence	4
- ◆ How would you assess physicians' and nurses' income, in comparison to other professions? Are their income really so low? Please describe physicians and nurses separately.
- ◆ How would you assess incomes of people working in the area of the health administration?
- ◆ Do you think that informal payments/gifts increase substantially the incomes of physicians? Nurses? Health facility administrators? Please describe separately.
- ◆ What do you think, should the giving of presents or cash payment as an additional remuneration of physicians be regulated in some way, or banned, as a system? What is your recommendation, how should this be arranged?

**Moderator: Thank you once more for coming.**



### **Financing of the facility/waiting lists**

16. Do you think that your health facility has sufficient financial resources in order to provide the patients with the services they need?

### **Payments and Gifts**

17. In your facility are there payments made by the patients? How much officially and how much unofficially?
18. Can you please describe in which form these payments occur [*PROBE: cash directly paid to doctor/nurse; there is always a person designated to collect all informal payments from patients; payment is made at the cashier's desk and there is a system that distributes the funds among providers, etc*]
19. Can you please give us as many details as possible about the informal component of payments – (*Probe: ex-ante or ex-post, the form of payment gifts, in kind or money*)?
20. What is the percentage of payments that goes officially to the facility? Give just your estimates; we are not looking for precise figures.
21. For all the rest, who benefits? [*PROBE: the individual who receives; the money is distributed among various facility staff; facility; patient (please inquire why patient?)*]
22. Who administers these funds and how? When money is paid, is it distributed across a group of people, or it is paid individually to medical staff? If it goes to team, is the distribution fair? Can you please describe the process in detail? [*PROBE: there is a set amount that every doctor/nurse should give to the facility, administration imposes the rules, collects the funds and makes decision; doctors/nurses accumulate agreed amount make joint decision how to spend it, etc*]
23. Does any portion of the amount paid by the patient go for institutional development of facilities? If “yes” who decides how much should go for this purposes.
24. Can you explain how the rates for informal payment are set at your facility? (*Probe: Who sets rates? How rates are set? Is it negotiated on ad-hoc basis, or there are some established scales by organizations, by specialties or by individuals? Nobody sets the rates but patients pay as much as they can.*)
25. Do you charge different prices for the same service to poor and rich? How do you discriminate rich and poor?
26. Do you prescribe more services from rich than from poor?
27. Would you say that payments are made voluntarily by patients or that providers demand these payments [*PROBE: check maybe doctors are not demanding, but nurses are, maybe administration demands maybe there are other reasons. try to collect information on various individuals/departments in the facility*]
28. *If providers demand, then ask:*
29. What is the reason for their existence? [*PROBE: insufficient income for providers; widespread corruption; poor governmental policies; demands placed by facility administrators; short supply of equipment/material; high taxes.*] Please prioritize them. Which one of the reasons is most important?

### **If patients pay voluntarily, then ask:**

30. Why are patients accepting to pay voluntarily? [*Probe: they pay to skip queues, to receive more careful attention, to receive additional services, to express gratitude, to buy drugs or other materials/consumables while under treatment, etc...*]
31. Do they think a treatment can be interrupted/stopped if a patient refuses or is unable to pay? Does this happen at your facility and if yes how often?

**Potential solutions, given the present financial constraint on the public side:**

32. Do you think that informal payments are a serious problem? For patients? For doctors? Do you think the system as it is frustrates your expectations/ethical believes?

So far, we have discussed how the situation is. Can we spend a few minutes discussing possible changes to the current system?

33. Do you think it is advisable/desirable to make informal payments that occur at your facility official? Please explain why you think so?

33. If all informal payments are legalized, what consequences they may have on providers and on patients? [*Probe: prices are more transparent, but health care might become more expensive*].

34. In alternative, do you think that the delivery system should be organized such that some services are provided for free and others are paid for? The services offered for free could be either financed by government, or by money collected from fee-based services. For example, hospitals could develop private wards for paying patients alongside public wards for poor patients. Have you thought about this possibility? How do you think services in the two kinds of wards should be regulated?

35. Do you think it would be better to guarantee public insurance coverage for primary/outpatient care or for inpatient care, and for which reasons? Other possibilities?

36. Another possibility is to allow and encourage private practice outside the hospital (and forbid it inside). Would it be easy for physicians/nurses to find patients outside the hospital? Is it a risky step?

**Interview guide for users/patients**

**Interview Code** \_\_\_\_\_

**INTERVIEW GUIDE FOR USERS OF HEALTH SERVICES FOR THE INFORMAL PAYMENT FOR HEALTH IN GEORGIA**

**Interviewer :**We are representing company IPM and my name is\_\_\_\_\_

Good evening and thank you for agreeing to be interviewed. At our company, we specialize in research of public opinion about various aspects of our life. We are here to ask you some questions about cost of obtaining medical services in our country. We are interested in patients' experience with relation to different doctors and medical facilities they have visited, and their thoughts on the main problems concerning access to health services in Georgia. With your answers you may contribute to the improvement of health services in our country.

In the final report we will describe your ideas only in general form, without mentioning particular names. Thus we guarantee that confidentiality of your statements will be safeguarded. In addition, I would like to stress that there is no right and wrong statements; we only want to hear your ideas about these issues.

Now please shortly introduce yourselves: name, age, and occupation

1. Have you or any member of your household (HH, we will define as members of the same household people who live under the same roof and that share the same budget) used medical services during past 3 month?

Yes *Continue administering the questionnaire*

No *Move to different HH*

**MODULE 1**

2. For which particular health problem or any other reason (for example, pregnancy) did you use medical services?

3. Which medical services were used?

A. Outpatient (includes visit to polyclinic, ambulatory, health center, diagnostic service) 1 *Continue administering the questionnaire*

B. Hospitalized for more then 1 day 2 *Continue administering the questionnaire*

D. Alternative healthcare provider 4 *Move to Different HH*

**Profile of respondent**

1. Age     years
2. Sex Male Female
3. What is the highest level of education that you have attained? *Instruction: for those with only secondary school education, please indicate the number of years of education (from 01 to 11). For others use proposed coding.*

No education	00	Completed higher/bachelors	13
01 to 11 years of secondary school completed to 11	01	Incomplete higher/bachelors	14
Completed technical school (PTU or SPTU)	12	Other	15
		Don't know/Refused to answer	99

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4. What is your primary occupation? *Interviewer: if a respondent is engaged in several occupations, then ask "which one does the person spend the most time at" and report this as primary occupation.*

Pre-school	01	Unskilled worker	08
Pupil or Student	02	Agricultural worker	09
Unemployed	03	Retired/pensioner	10
Self-employed	04	Domestic work/homemaker	11
Business person/entrepreneur	05	Other	12
White collar worker	06	Don't know/refused to answer	99
Blue collar worker	07		

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5. What sector is the person employed in? (Please ask this for only those respondents that are engaged in paid work)

Agriculture	01	Hotels and Restaurants	07
Mining	02	Transportation and communication	08
Manufacturing	03	Financial services and real estate	09
Electricity, gas, water	04	Public administration and defense	10
Construction	05	Education	11
Trade	06	Health and social services	12
		Other personal services	13

6. How many people live in your household ? (Interviewer: if someone has been visiting, and staying with, the household for most of the last 30 days, then they should be included as a household member.)

7. Approximately how much your HH spends on various things per month? Please come up with total figure and include all expenses that your HH faces (PROBE: food, utilities, transportation, education, leisure, healthcare, cigarettes and alcohol, presents etc)     lari
8. Please can you give us more details about the major episodes of utilization of health services (for simplicity referred to as "episodes of illness") in you household over the last three-month?

**Table 0-14: Major episodes of illness that occurred during last 3 month in the HH, followed by at least one doctor visit.**

<b>CODE</b>		<b>Name of person</b>	<b>Age</b>	<b>Health problem</b>	<b>Type of service used **</b>	<b>Total price paid</b>
01	1 <sup>st</sup> Episode of illness					
02	2 <sup>nd</sup> episode					
03	3 <sup>rd</sup> episode					
04	4 <sup>th</sup> episode					

Instruction: Interviewer please fill-out the table for at most 4 episodes of illness, which required at least seeing a doctor. It is not mandatory to always collect 4 episodes.

\*\* Use following codes for the Type of Service:

- a. Outpatient polyclinic/ambulatory,
- b. Specialist at hospital,
- c. Private doctor
- d. Hospitalized,
- e. Diagnostic
- f. Home visit by doctor/health professional
- g. Other \_\_\_\_\_(please specify)

**Instructions for interviewer: MODULE 2 of the tool is administered separately for each episode of illness. For every new episode please take new set of the MODULE 2. Whenever you inquire about the episode please note the name of the person from the Table 0-14 the disease they had and services they used. Ask all the questions for this person and for the given episode only and when you finish administering the MODULE 2, take new one and start with the next person and/or episode.**

## MODULE 2

Interview Code \_\_\_\_\_

Person/Disease Code from Table 0-14 \_\_\_\_\_

### Information, accessibility and affordability

- ◆ After the onset of illness did \_\_\_\_\_ (the name of person from Table 0-14) immediately go to a provider or did s/he wait? If yes, why? [*PROBE: the illness was serious; had illness for a long time and knew how to treat it; had no money; provider is not available in close proximity, etc.*]
- ◆ Can you please describe how s/he selected the provider? (*Probe: due to quality, proximity from residence, due to cost, through friendship, etc*). Please provide as much details as possible [in the case of outpatient ask the individual if possible], or member of your family [in the case of hospital]?
- ◆ Has the criteria of selection changed during past years? If “yes” how and why?
- ◆ What are the main difficulties your HH faced while had to go to a physician/hospital? [*Probe: such as transportation costs, waiting lists, inability to pay for services, registration procedures, bad quality of available medical services, not having provider/hospital in close proximity*]

### Contact with clinical staff

- ◆ Did s/he have to wait for provider and if yes how long did s/he have to wait in the line once reached the medical facility before being seen by a doctor/provider?
- ◆ Has he/she interrupted or not fulfilled completely treatment? How? [*He/she was referred to a diagnostic service, but did not go, he/she did not buy all the drugs that were prescribed and he/she did not take all the drugs that he/she bought*].
- ◆ For what reason did he/she interrupt treatment? [*Probe: such as transportation costs, waiting lists, inability to pay for services, registration procedures, bad quality of available medical services, not having provider/hospital in close proximity*].
- ◆ Whom did you go to receive treatment/care instead? [*PROBE: drug shop, private physician, healer, friend/neighbor, other*]
- ◆ Has he/she aware of the possible consequences for her/his health of this interruption/ change of service?

**Payments and gifts**

- ◆ Please give a description of expenses for that particular episode of illness [*PROBE: collect information separately for the payments made to facility; doctor; nurse; diagnostics; pharmaceuticals; other; specify which, private or public*]

	Drugs	Physician consultation	Hospital admission/stay	Surgery	Diagnostic services	Nurse service	In kind supply of services (bed linen, food in hospital, etc)	Total
Episode of illness								

- ◆ Please give as many details as possible – the form of payment, for what services, when? To whom? Has he/she received any services free? [*PROBE: was payment voluntary or demanded; was payment in cash or in-kind; were services given for credit and payment was made later; were they asked to pay before (ex-ante) treatment or after (ex-post) treatment was completed etc*]
- ◆ How did he/she receive information about payment – (*ex. they know this from friends before visiting hospital/polyclinic, they saw the price list there, they sign the contract (?), the personal gave them information verbally, they saw price list*).
- ◆ What was the consequence of payment on level/quality of service? Have he/she received better service? What would happen if he/she did not pay?
- ◆ Did he/she recover fast? Was full recovery achieved?
- ◆ Did he/she buy all the drugs that the doctor prescribed? If not, why?
- ◆ During/after treatment, did he/she give gifts? If “Yes” did he/she give gifts besides payment or instead of them? To whom, in which form (*Probe: e.g. flowers, chocolates, cash or in another way?*)
- ◆ How would they assess the fee for this episode of illness (unaffordable, very high, high, just, etc)?
- ◆ What was the consequence of fee on family budget? [*Probe: they had to spend all cash income, all savings, take loan, and sell car, land, or house, borrowing from family and friends, borrowing elsewhere. If several sources were used, give precise share of each*]
- ◆ Would you go to the same facility again? Why would you do so can you please explain?

### MODULE 3

Interview Code \_\_\_\_\_

MODULE 3 OF THE TOOL IS ADMINISTERED FOR THE WHOLE HH AND NOT FOR THE INDIVIDUAL AND/OR EPISODE OF ILLNESS

#### **Willingness to pay for insurance, attitude towards government, perception of changes in the health system**

- ◆ Do you know any person in Georgia who received your same health services completely for free? (Probe: provider was friend; friend/relative paid for the services; government paid the services; he had social or private insurance that covered the cost of treatment).
- ◆ Did you or any member of your household ever receive health services for free in the past, and if yes, why? (Probe: provider was friend; friend/relative paid for the services; government paid the services; he had social or private insurance that covered the cost of treatment).
- ◆ Do you have children in your household under 3 years old?

#### *If no, skip next three questions*

- ◆ If yes, has he/she ever received medical services for free?
- ◆ Have you immunized him/her? Against which infection have you immunized?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- ◆ Have you paid anything to the health facility for this immunization?

Yes                    1    How much? \_\_\_\_\_

No                     2

- ◆ What do you think has changed in the Georgian healthcare system during past few years?
- ◆ What are advantages and disadvantages (strong and weak points) these changes brought?
- ◆ What sum would you willing to pay monthly for all member of your HH for the convenience of a physician to be at your disposal 24 hours per day and to receive services when you need them at no cost?
- ◆ If you are willing to pay something each month, whom would you trust more for managing this pre-payment so that when you get sick you are sure of getting free services:
  - ◆ Government
  - ◆ Social insurance (SMIC)
  - ◆ Private insurance
  - ◆ Other. Please specify:

Which change would be needed to increase your trust? Can something be done to increase your trust in any of the above agents?

### Attitude towards physicians, their motivation and regulation of payments

- ◆ How would you rate the size of a physician's income?

Privileged	1
Sufficient for a good standard of living	2
Sufficient only for basic needs	3
Insufficient for a normal existence	4
  
- ◆ How would you assess physicians' and nurses' income, in comparison to other professions? Are their income really so low? Please describe physicians and nurses separately.
  
- ◆ How would you assess incomes of people working in the area of the health administration?
  
- ◆ Do you think that informal payments/gifts increase substantially the incomes of physicians? Nurses? Health facility administrators? Please describe separately.
  
- ◆ Should the giving of presents or cash payment as an additional remuneration of physicians be regulated in some way, or be banned? What is your recommendation, how should this be arranged?

### **E.3 THE EVOLUTION OF THE HEALTH DELIVERY SYSTEM IN GEORGIA**

In this Annex we present information concerning the evolution of the human resources employed in the health system over the last decade. Since initiation of health sector reforms in 1995 and “marketization” of healthcare provision, human resources have changed significantly. By 1999 the actual number of practicing physicians had drop by almost 25% compared to 1991 levels, and number of nurses by 59% (*See Figure 2*). However, due to significant demographic processes (civil conflicts in some regions of Georgia, economic hardship that forced significant portion of population out of the country, declined birth rates, etc), which took place in the country during 1991-1999, total population declined, and physician to population ratio has not been affected significantly, hovering around 4.5 per 1,000, the highest doctor to population ratio then any other country in the region (*See Figure 3 below*).

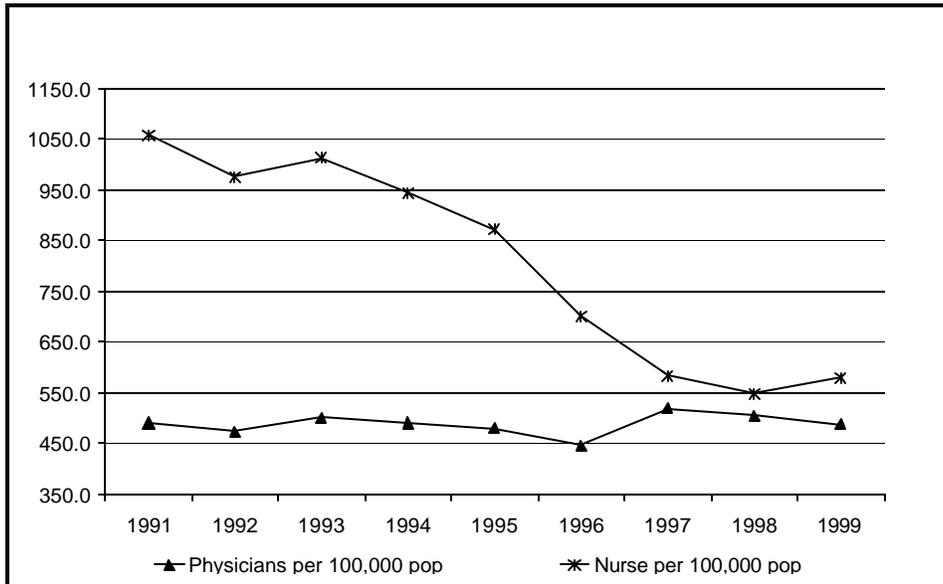
The situation with nurses proves to be very different, and characterized by a sharp decline of the nursing staff to population ratio (579 per 100,000 pop. in 1999 from 1058 in 1991). Presently, Georgia has one of the lowest nursing staff to population ratio, together with Armenia and Tajikistan (461 and 480 per 100,000 population respectively). Also the nurse to doctor ratio declined sharply and currently Georgia has the lowest ratio in the region -1.19 nurses per one doctor (compared to an average 1.84 for NIS) (*See Figure below*)

These changes resulted in a lower decline of nurses' income relative to doctors'. However, real value of annual officially reported income is still extremely low for both <sup>59</sup> (420-3,600 Gel for doctors and 360-720 Gel for nurse), and it hardly compares with the minimum individual annual subsistence level of 1,080 Gel (World Bank 2001).

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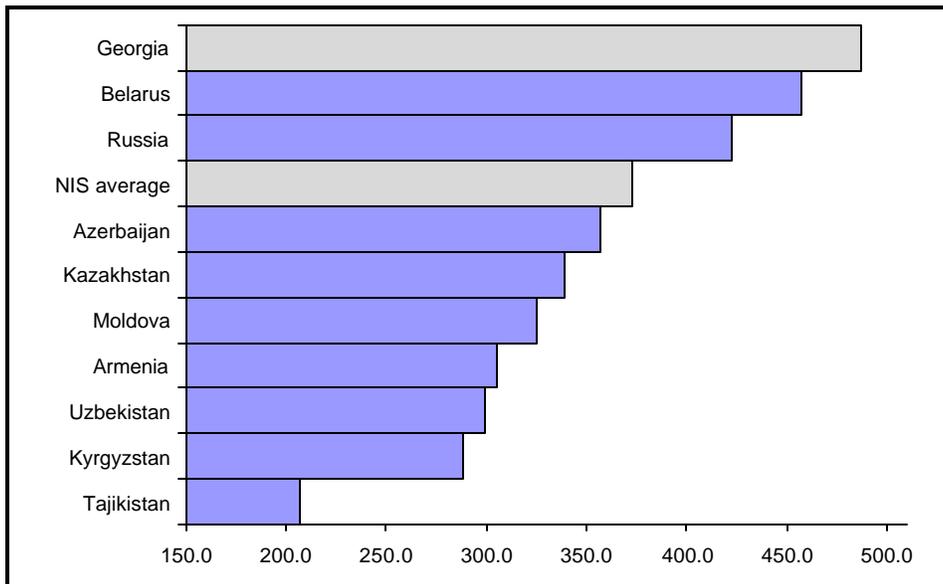
<sup>59</sup> These figures are derived from our study and vary significantly by type of facility (e.g. general hospital, maternity home, polyclinic and also by geographic location).

**Figure 2 Georgia's Health Human Resources circa 1991-1999**



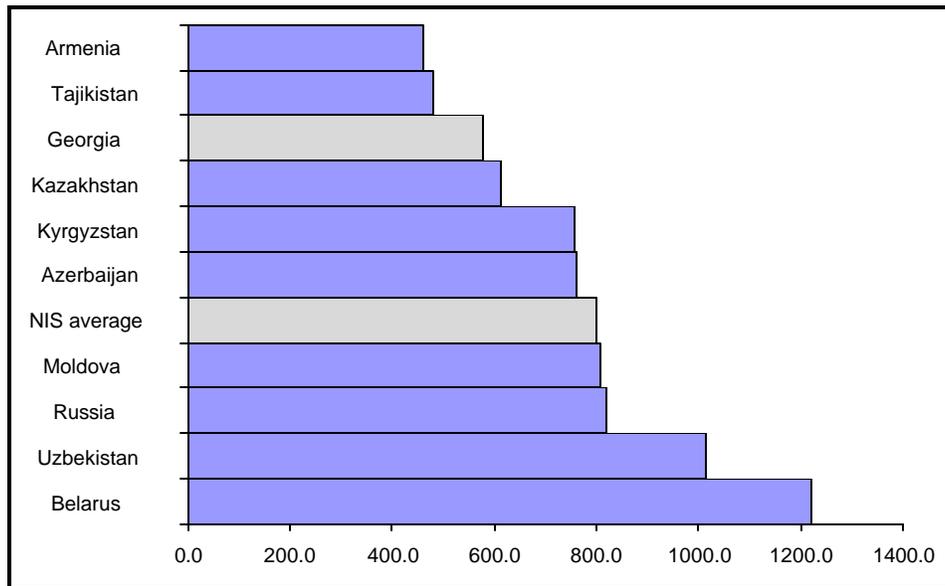
Source WHO Health for All Database

**Figure 3 Physicians per 100,000 Population (1999 Data)**



Source WHO Health for All Database

**Figure 4 Nurses to Physician Ratio (1999 Data)**



*Source WHO Health for All Database*

**Annex 3: Table: Provider Network of Georgia, Circa 1988-1999**

<b>Type of Medical Facility ( including non MoLHSA Facilities)</b>	<b>1988</b>	<b>1994</b>	<b>1995</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>
Hospitals	402	321	289	264	287	272	287
Outpatient facilities in the hospitals	301	247	185	111	115	114	94
Independent outpatient facilities (ambulatories & polyclinics)	841	805	828	840	829	859	977
Dispensaries <sup>60</sup>	99	82	79	82	83	81	79
Independent dental clinics	56	53	53	51	51	56	62
Medical posts	613	502	180	33	47	53	33
Midwife posts	1,198	748	781	479	386	512	438
Independent ambulance stations	11	7	5	5	24	25	21
Blood banks	8	7	6	5	6	6	8
Infant orphanages	3	3	3	3	3	2	2
Scientific research institutes	19	19	19	19	19	19	18
Medical Centers					22	27	49

Source: Zoidze et al. 1999

## **BASIC BENEFIT PACKAGE**

BBP is very convoluted in its design. It is hard even for healthcare professionals to understand what services are covered and what are not (Gotsadze and Rose 2000).

Eligibility criteria for inclusion in the BBP are according to four criteria:

1. Special disease or condition (e.g. TB, Kidney failure, Oncology Disease, etc. under the State Medical Insurance Company, and a positive list of emergency conditions that cause catastrophic expenses under Municipal funding);
2. Age (e.g. children 0-3 years old);
3. Specific geographical location (e.g. residents of high mountainous areas, Tskhinvali residents) and
4. Vulnerable status.

Historical evolution of the BBP also contributed to the complex design. Initially only 6 programs were financed by SMIC portion of BBP (MoHLSA 1998). For the year 1999, the total number of programs included in the BBP increased to 14 (Schaapveld K. 2000). Partly, some high-value low impact services were included (such as, pediatric cardiac surgery, kidney transplantation, ischaemic heart disease), and partly the BBP was expanded because some of the programs that initially were financed by the MoLHSA were included. With this increase, one trend was obvious – financial means did not meet ends. So, the

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<sup>60</sup> Dispensaries = Specialized outpatient facilities (e.g. TB Dispensaries, STD, Psycho-Neurological, etc.).

balance was artificially achieved by lowering unit cost of reimbursement for services included in the BBP. All of this forced providers to seek funding from the population.

Services included in the BBP can be separated in three parts, based on the public purchasers that manage them (SMIC, PHD and Municipalities).

**Annex 4 Development of Central Government Funding and BBP During 1997-1999**

<b>1997</b>	<b>1998</b>	<b>1999</b>
<p><u>SMIC Programs</u></p> <ol style="list-style-type: none"> <li>1. Treatment of Psychiatric Patients</li> <li>2. Treatment of TB Patients</li> <li>3. Prenatal Care and Delivery</li> <li>4. Treatment of Children Under 1 years</li> <li>5. Program for Vulnerable Population</li> <li>6. Treatment of Oncology Patients</li> </ol>	<p><u>SMIC Programs</u></p> <ol style="list-style-type: none"> <li>1. Treatment of Psychiatric Patients</li> <li>2. Treatment of TB Patients</li> <li>3. Prenatal Care and Delivery</li> <li>4. Treatment of Children 0-2 years old</li> <li>5. Program for Vulnerable Population</li> <li>6. Treatment of Oncology Patients</li> <li>7. Pediatric Cardio surgery</li> <li>8. Renal dialysis</li> <li>9. Infectious diseases</li> </ol>	<p><u>SMIC Programs</u></p> <ol style="list-style-type: none"> <li>1. Treatment of Psychiatric Patients</li> <li>2. Treatment of TB Patients</li> <li>3. Prenatal Care and Delivery</li> <li>4. Treatment of Children 0-3 years old</li> <li>5. Program for Vulnerable Population</li> <li>6. Treatment of Oncology Patients</li> <li>7. Infectious diseases</li> <li>8. Renal dialysis</li> <li>9. Surgical Treatment of Ischemic Heart Disease</li> <li>10. Organ transplantation</li> <li>11. Provision of Selected Chronic Patients with Pharmaceuticals</li> <li>12. Rural PHC Program</li> <li>13. Special medical program for Tskhinvali*</li> <li>14. Additional Medical Care for Highlanders**</li> </ol>
<p><u>MoHLSA Programs</u></p> <ol style="list-style-type: none"> <li>1. Additional Medical Care for Highlanders</li> <li>2. Renal Dialysis</li> <li>3. Diabetes Mellitus Program</li> <li>4. Additional Medical Care for War Veterans</li> <li>5. Medical program for mandatory military service</li> <li>6. Medical program for orphans in orphanages</li> <li>7. Pediatric cardio surgery program</li> </ol>	<p><u>MoHLSA Programs</u></p> <ol style="list-style-type: none"> <li>1. Additional Medical Care for Highlanders</li> <li>2. Program for State border regions</li> <li>3. Diabetes Mellitus Program</li> <li>4. Program for special patients</li> <li>5. Medical program for mandatory military service</li> <li>6. Medical program for orphans in orphanages</li> <li>7. Surgical Treatment of Alchemic Heart Disease</li> </ol>	<p><u>MoHLSA Programs</u></p> <ol style="list-style-type: none"> <li>1. Medical program for mandatory military service</li> <li>2. Medical Emergency Programs</li> <li>3. Medical science and education</li> <li>4. Critical medical facility rehabilitation program</li> <li>5. Management of reforms</li> <li>6. State sanitary surveillance</li> </ol>
<ol style="list-style-type: none"> <li>8. Medical Emergency Programs</li> <li>9. Medical science and education</li> <li>10. Critical medical facility rehabilitation program</li> <li>11. Management of reforms</li> <li>12. State sanitary surveillance</li> </ol>	<ol style="list-style-type: none"> <li>8. Medical Emergency Programs</li> <li>9. Medical science and education</li> <li>10. Critical medical facility rehabilitation program</li> <li>11. Management of reforms</li> <li>12. State sanitary surveillance</li> <li>13. Medical criminal expertise</li> </ol>	

<b>1997</b>	<b>1998</b>	<b>1999</b>
		Medical criminal expertise
<p align="center"><b><u>PHD Programs</u></b></p> <ol style="list-style-type: none"> <li>1.Expanded Program of Immunization</li> <li>2.Prevention of Infectious Diseases</li> <li>3.Health Promotion</li> <li>4.STD Program</li> <li>5.AIDS Program</li> <li>6.Medical Information program</li> <li>7.Prevention of drug addiction</li> <li>8.Radiation and Iodine Deficiency</li> <li>9.Safe blood program</li> <li>10. Active screening of diseases</li> </ol>	<p align="center"><b><u>PHD Programs</u></b></p> <ol style="list-style-type: none"> <li>1.Expanded Program of Immunization</li> <li>2.Prevention of Infectious Diseases</li> <li>3.Health Promotion</li> <li>4.STD Program</li> <li>5.AIDS Program</li> <li>6.Medical Information program</li> <li>7.Prevention of drug addiction</li> <li>8.Radiation and Iodine Deficiency</li> <li>9.Safe blood program</li> <li>10. Active screening of diseases</li> <li>11. Micronutrient deficiency program</li> </ol>	<p align="center"><b><u>PHD Programs</u></b></p> <ol style="list-style-type: none"> <li>1.Expanded Program of Immunization</li> <li>2.Prevention of Infectious Diseases</li> <li>3.Health Promotion</li> <li>4.STD, AIDS &amp; safe blood program</li> <li>5.Medical Information program</li> <li>6.Prevention of drug addiction</li> <li>7.Radiation and Iodine Deficiency</li> <li>8. Active screening of diseases</li> <li>9. Micronutrient Deficiency</li> <li>10. Screening of cancer diseases</li> <li>11. Screening of cardiovascular diseases</li> <li>12. Trauma prevention</li> </ol>



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