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Analyzing Success and Failure of Two Health Reforms in Independent Georgia

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Abstract

Having worked in 2013 under tuition of famous German Health Economist, Professor Dr. Mathias Graf von der Schulenburg at Hanover Leibnitz University, being supported by German Academic Exchange Service-DAAD, as a Guest Professor at the Institute of Insurance Business Administration IVBL, I tried to analyze two health reforms in the history of independent Georgia. Health reform policy analyze is important for two reasons:"It can help explain why certain health issues receive political attention, and others do not, such as by enabling identification of which stakeholders may support or resist policy reforms, and why" (Buse, Dickinson, Gilson, & Murray, 2007).

Two health reforms were undertaken by Georgian government. The first in 1994-1995, when the country started to build some mix from social health Insurance (SHI) and taxed finance (TF) system, but failed due to the lack of financing, proper management and bribing. And the second in 2004-2007, when the new, more private forms of health finance and service delivering were implemented. The model of 2004-2007 was totally new and it can be entitled as a Model of Bendukidze (MB), since Georgian vice Prime Minister Bendukidze supported its birth and implementation into health system of the country. The author of this article being hired by Georgian Government as a Health Economist in 2007 was also part of health reform team establishing its main strategy.

Because two totally different types of health reforms had already implemented in Georgia during such a short period, it would be interesting to assess their main features and reasons for choosing these models of healthcare among other possible alternatives and discuss their effectiveness for the country.

The article is based on a literature review of scientific publications about health of Georgia and focus group interviews undertaken in 2013 at international Black Sea University.

Keywords: health economics, health financing model, health reform
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Introduction

After elimination of funding from Moscow, Georgia no longer had the resources to deliver free healthcare services that were characteristic of the soviet health system" (Collins, 2006). In the 90s the former Soviet Union "countries shifted away from Communism, several looked to SHI (Wagstaff & Moreno-Serrab, 2009)."Two principles guided the soviet system. The territorial principle assigned each citizen to a polyclinic or feldsher station according to place of residence" (Ensor & Rittmann, 1997). "The old system of Georgian Health Care (Semashko Model)…is comparable to that of the United Kingdom ("Beveridge" model) and guarantees universal access to health-care services" (Collins, 2005). "In the "Beveridge" model of national health system, all citizens have protection in the case of illness, independently from what kind of efforts they did" (Grainer, Graf, Schulenburg, & Vauth, 2008).

After demise of the Soviet Union, independent republics started to look for the right model of the health system for their countries. They had two possible choices: tax-financed health care system or social health insurance system. Because "Many developing countries had relied largely on general revenues (and out-of-pocket payments) to finance their health systems have introduced SHI" (Wagstaff & Moreno-Serrab, 2009).Georgia had chosen some mixed model from the social health insurance and the taxed financing.

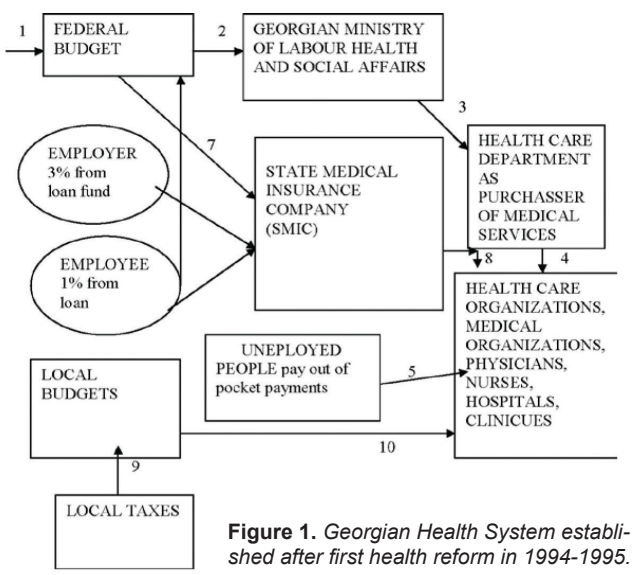

Figure 1. *Georgian Health System established after first health reform in 1994-1995.*

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Strategic view of the first Georgian Health Reform

"At the time of its independence, April 9, 1991, Georgia appeared to be relatively well off republic with fairly good growth potential" (Collins, 2005). But Republic of Georgia lacked"risk-pooling mechanisms to distribute the burden of health care expenditure" (Skarbinski et al., 2002). That made also clear the fact that the country has no insurance culture at all.

Having received loan from the World Bank, Georgian government in 1994 started first health care reform with following major directions:

- Creation of legal basis for new health system
- Decentralization of health system management, transition to program based funding
- Priority importance to primary health care
- Transition to principles of health insurance
- Support of privatization process
- Accreditation and licensing of health facilities and medical personnel
- Reform of medical education. (Georgian Health System Reorientation; Major Directions 1995)

Explanation of the figure 1: 1)The revenues of the central Budget; 2) Central budget funds the Ministry of Labor, Health and Social Affairs (MoLHSA); 3) MoLHSA funds the purchaser of health care services – the Health care Department; 4) Health Care department contracts and funds health care organizations (; 5) People pay out of pocket;. 6) Employee and employer pay social taxes (3+1%) to the Central Budget; 7) The Central Budget funds the State medical insurance company SMIC; 8) SMIC contracts and funds Hospitals and clinics; 9) Local taxes directed to the local budgets. 10) Local budgets fund some health cases in rural area.

Over five-year period (1995-2000), 448 healthcare institutions were privatized, the number of hospital beds decreased from 57,300 to 44,481, before 44.5 beds for 1000 people. But the number of physicians was high in 2000, one for every 245 residents of Georgia. The medical insurance law enacted by the parliament and signed by the president provided social insurance coverage and private insurance basics. "Decentralization is the core element of health care reform in Georgia. At present 12 regional governments have regional health administrations, which are entitled to consider their own strategies and define priorities based on local needs" (Collins, 2005). In theory, since 1995, basic health care (primary and essential hospital care) has been covered by the state-funded programs through new public financial intermediaries at the national and municipal levels (currently abolished), and for preventive health activities, from central government sources. The state guarantees limited services, with co-payments for some of these, and official fees at the point of use for services not covered by the state. Formal and informal out-of-pocket payments constitute a large part of total health care expenditures 74.7% in 2003 (World Health Organization, 2009).

But health care was only formally free for people with many chronic diseases, especially for groups defined as vulnerable (children under 15, adults over 65, and people living in isolated rural areas). Patients with diabetes are entitled to a certain number of laboratory tests (e.g. six blood glucose tests), but face no restrictions on the number of subsequent contacts with specialists if they are referred by a primary care physician. "Most patients reported paying formally or informally for each visit to the district physician" (Balabanova et al., 2009).

To collect health-care payments and fund for the insurance program, Georgian government had created the State Medical Insurance Company (SMIC). Program-based health care financing were divided in Georgia into some programs, which had different sources:

- State preventive programs: immunization, prevention of infectious diseases including Sexually transmitted Diseases STD, HIV/AIDS, prevention of endemic goiter, prevention of drug abuse, development of health information system, blood safety were carried out by means of transfer from the central budget managed by the Department of Public Health within the Ministry of Labor, Health, Social Affairs (MoLHSA).
- Programs funded by the State Medical Insurance Company: psychiatry, TB, obstetrics, treatment of children under 3 years of age, additional medical care of vulnerable population, prevention and treatment of oncology patients, treatment of infectious diseases, hemodialysis, pediatric cardio surgery. These programs were funded from special obligatory fees paid by employers from giving monthly salary in amount of 3 % and employee from receiving monthly salary in amount of 1%. This scheme entitled as 3+1 was not enough to fund full program and deficit was covered by central budget transfer.
- So called "other health programs": medical care for the residents of mountainous areas and borderland regions, treatment for parentless children, disaster and emergency services, medical science and education. All these were funded from central budget.
- Municipal health programs: having had local budgets and allocating 2.5 GEL per capita, receiving funds from central budget.
- Other sector's health programs: employees of different ministries having had health services for their employees.
- Paid health services, with cost-sharing among municipalities and consumers, paid 50% of the fee while municipality covered the rest.

In 2000, there were 39 programs funded by State Medical Insurance Company. In 1999, nearly 700 health care providers carried out work on 1300 contracts (with the State Medical Insurance Company - SMIC) (Gamkrelidze, Rifat, Gotsadze, & Maclehose, 2002). But "Poor fiscal performance and budgetary arrears further lowered the government resources, and finally, tax evasion, which is rampant in both the shrinking formal sector and the growing informal sector, also limits the scope for government budgetary

financing" (Gotsadze, Bennet, Ranson, & Gzirishvili, 2005). "Under the new system, most healthcare expenditures are financed through out-of-pocket payments, which indicate the failure of social insurance system to establish adequate risk-pooling mechanisms to ensure unimpeded access to health services for the population"(Collins, 2006).

In the countries of "central Asia and the Caucasus, out of pocket payments, rose rapidly and previously high levels of financial protection were lost" (Kutzin, Cashin, Jakab, Fidler, & Menabde, 2010). "As the WHO report noted, a policy-maker may only have five years at best in which to act-the "honeymoon" of reforms" (Berman & Mukesh, 2000). "After more than a decade of reform implementation, however, the results have been disappointing" (Collins, 2003). Accordingly, due to the shortage of funding, state medical standards approved by the Ministry of Labor, Health and Social Affairs (MOLHSA) failed and lost their image in healthcare market of the country. In 1999 Georgia spent 0, 59 percent of its GDP on health care. The WHO, s unified index for health system's performance – the DALE (Disability Adjusted Life Expectancy) for "health expenditures" per capita ranked the country 125th."In 2002, the Georgian health system almost collapsed owing to a lack of state funding" (Federal Office of Migration BFM, 2011).

Why did the first Health Reform fail? Analyzing reasons of failure

Some health reform destroyers are identified:

- **Large Corruption in the countryside and especially in healthcare system** – it was large corruption in the Georgian health failed the system. Risks of corruption in the health sector are able to damage even good incentives. As Savedoff (2006) explains, "the health sector is particularly vulnerable to corruption due to: uncertainty surrounding the demand for services (who will fall ill, when, and what will they need); many dispersed actors including regulators, payers, providers, consumers and suppliers interacting in complex ways; and asymmetric information among the different actors, making it difficult to identify and control for diverging interests" (Savedoff, 2006).

- **Global processes, failure of country's economy and a fiscal crisis** –Two vulnerable failures of the early transition period greatly affected the performance of health system. "The first was the fiscal shock that greatly reduced the ability of governments to spend; the second was their integration into world economy and consequent change in relative input prices in particular for medicines and energy" (Kutzin et al., 2010).The evidence of the failure of the reform appeared soon after its beginning. "The country failed into fiscal crisis, due to big corruption and lack of skilful managers" (Busse & Riesberg, 2004). "The most pressing problem that SHI aimed to tacklewas the decline in health spending caused by a decline in government Revenues as a share of GDP" (Wagstaff & Morreno-Serrab, 2009).

- **Non Rationality in strategy** - Collins says that "despite its commitments to minimize market failures by assuming a regulatory role in the process of transition to a market-based economy, the government of Georgia often neglects the areas where its interventions could be most beneficial. Instead, it continues to focus on producing curative services and building state-of-the-art tertiary level hospitals largely by borrowed money. This obvious neglect of economic rationality can be explained mainly by political rather than economic factors" (Collins, 2003).

- **Poor structure and no linkages in healthcare delivery** -"There are poor linkages between primary and secondary care and ineffective patient follow-up or monitoring of outcomes" (Balabanova et al., 2009). There is a shortage of nurses and it must be taken into consideration by Georgian government. Another problem which emerges from the analysis is the equity issue between urban and rural residents in the countryside. In general, residents of rural areas seem to have benefited most as a result of PHC financing reforms: they have better access to providers (61.7% vs.54%) and are less likely to self-treat than urban residents (12% vs.20.6%) " (Gotsadze et al., 2005).

- **Low participation of civil society into reform** –Georgian people were not attentive to social reforms undertaken in the country. After the collapse of the reform they were only criticizing failure of government in health care policy. "After more than 70 years of Soviet rule, there is no established culture of citizens' participation in political processes, and decision-making is often left to a small circle of political elites" (Collins, 2006).

The Second Georgian Health Reform, after Rose Revolution

In 2004-2006, having analyzed the reasons of the first health reform failure, health policy makers tried to shift resources to poor population.The vision, idea creation and the scope design for the second Georgian Health Care, started in 2006 were mostly influenced by Prime Minister and economic think tank of Georgian government – Mr. Kakha Bendukidze. The book of Milton Friedman – "Capitalism and freedom" (Friedman, 1982) had influenced Mr.Bendukidze so greatly that he has started to offer Georgian government Friedman's liberal ideas for Health Care Financing Reform. Milton Friedman's book – ''Capitalism and freedom'' gives several realistic places in which a market can and should replace government's regulation. Friedman advocated the system of vouchers for school education and also ending the licensing for doctors. Before health care reforming, Georgian educational reform involving special vouchers for students who successfully passed the state examinations financed by the state was successful implemented. Accordingly the Government of Georgia decided to implement the same approach to health financing and give the voucher to those who could not afford the payment for the health care. One Georgian politician said: "In

the current situation, it is better to be a bit poorer" (Hauschild & Berkhout, 2009).

The second health reform, consisted of: a) Privatization of health care infrastructure, b) Targeting of the most vulnerable population groups with comprehensive health insurance coverage, c) Channeling of public funding to targeted vulnerable groups through private insurance companies, d)Reduction of health sector regulation to an essential minimum, and e) Retaining of the most essential public health functions as governmental responsibility(UNICEF Report, 2010). The problem of not standardized knowledge occurred: "As in the other former Soviet states, the standard of training is in principle relatively high. However, theabsence of state regulation meant that medical training establishments were not for a long time subject to binding training guidelines" (Federal Office of Migration, 2011).The main goal for healthcare financing reform was to ensure financial accessibility to the Medical services for the population.

In 2009, the government introduced an insurance package for the whole population (so-called 'cheap insurance scheme'). It covered a certain package of outpatient services, which people are expected to buy (Hauschild & Berkhout, 2009).

Due to a very active internal, so called, zero tolerance policy, encouraged by the President of Georgia Mikhail Saakashvili, corruption and the bribing was fast defeated and corrupt state managers were imprisoned. This policy increased budget of the country. "Starting from 2004 the Government of Georgia (GOG) has dramatically increased its budget allocation for the health sector. In 2003 public spending on health constituted 0.6% of GDP. While still very low as compared to developed nations, in 2010 the figure reached 1.8%. Starting in 2007, Georgian Government initiated a new round of bold reforms in the health care sector, relying on market mechanisms to increase the population's access to health care; improve the quality of care; and increase the efficiency of service provision" (UNICEF Report, 2010). The reforms from 2006 were mostly aimed primarily at safeguarding basic medical care. "They pursued two main goals: firstly, the aim was to prevent patients from contacting specialist/ hospitals directly. To this end, the focus was on a family doctor system, the so-called family medicine system. General practitioners are the first point of contact, and refer patients to specialist hospitals if necessary. Secondly, the privatization of healthcare facilities, and thus competition on the free market, was expected to lead to an improvement in infrastructure and medical services without placing too great a strain on the national budget" (The Federal Office of Migration, 2011).

Reform also touched the primary care - "the development of the Primary Health Care Master Plan began in 2003 with support from the international aid sources. According to the official records and literature review, the plan was outlined to consolidate the 750 existing primary health care facilities outside of Tbilisi into 549 facilities that would serve approximately 30,000 people each" (Rukhadze, 2013). Oxfam, Increasing attention to Georgian healthcare reform from civil-society perspective, gives such observations: "According to WHO statistics, total expenditure on health in Georgia as a percentage of GDP, at 8.6 per cent in 2005, is comparable to the European average. But the role of the state in the health sector has been severely weakened since the 1990s, and more than three-quarters of total expenditure on health in Georgia is now private expenditure. A study by the Genesis Association revealed that in 2007, the MoLHSA's budget for health-care programs was about GEL 167 million (about €65 million or $95 million). This is only about GEL 39 (€14 or $22) per person per year for all health-care services subsidized by the state, including in-hospital, outpatient, public health and other specialized services" (Hauschild & Berkhout, 2009).

Some results of the second Health Reform in Georgia achieved in very early phase

It seems that Georgia established its unique way of health finance and delivery of healthcareby the second health Reform. "In this section we describe the effects of the reform on employment insurance and government finances by comparing two steady conditions, before and after" (Pashchenko & Porapakkarm, 2013). "SHI is thus far from the panacea it is often portrayed to be. Tax-financing is, of course, not without its problems" (Wagstaff, 2009). Thus, ways for innovation in health financing were open. Now we can see the achievements in the early phase of reform development:

a) Extended public funding of population and state-private alliance to cover all of the country-A social welfare program has been in place since 2006 for households below the poverty line. It includes free health insurance, which covers the following service:

- Consultation with the Family Doctor once every two months
- Postpartum care
- Emergency operations
- Planned inpatient treatment
- Up to 50% of the cost of medication will be refunded, up to a maximum of
- GEL 50 (EUR 22).

People living below the poverty line are divided into two groups: people living in poverty, i.e. who have less than USD 2 per day, and people living in extreme poverty (USD 1-1.25). Both groups receive free health insurance. Employees of the Ministry of Labor, Health and Social Affairs evaluate local households based on a points" (Federal Office of Migration BFM, 2011).

A big part of the government's privatization plans involves the introduction of private health insurance schemes nationwide. Nowadays, health insurance companies are purchasing health care services for individuals below the poverty line. The estimated number of health insurance beneficiaries is 750,838. (Hauschild & Berkhout, 2009). "In no other European country does the private sector pay as high a propor-

tion of healthcare costs as in Georgia. The infrastructure and services and the qualifications of medical staff have improved significantly in the last few years. The switch to the family doctor system for basic care is also well advanced in some regions" (Federal Office of Migration BFM, 2011).

"Four years after the initiation of reforms, 1.2 million people (out of approximately 4.6 million total country population) are covered by health insurance by private insurance companies through public funding. Largely due to limited insurance literacy of beneficiaries and their inability to differentiate between offerings of various insurance companies, the GOG last year decided to replace the voucher mechanism with a new tender mechanism" (UNICEF Report, 2010).

b) State encouraged the growth of health insurance culture among population-more than 400,000 Georgians now have private voluntary (corporate or individual) health insurance, as compared to 40,000 in 2005 (UNICEF Report, 2010).

c) Hospital privatization-The hospital privatization process that was stalled in 2008 due to the Russia-Georgia conflict and financial crisis has now been redesigned by the GOG and is underway...Along with the obligation to provide the state-defined health insurance package, the bidders were also requested to build small hospitals in designated districts by September 2011(UNICEF Report, 2010)."Beginning in January 2007, the reform resulted in the replacement of the existing hospital infrastructure by transferring ownership rights from the state to the private sector. Hospital locations were chosen based on the principle of 45-min geographic accessibility, with the number of beds based on population size and health needs" (Rukhadze, 2013).

New healthcare system after second healthcare reform of Georgia

The Georgian health system includes the following medical institutions:

- Emergency centre
- Centers for outpatient treatment and (outpatient or inpatient) polyclinics\
- Specialist hospitals and birthing centers
- Medical research institutions (with patient beds)
- Dental surgeries
- Pharmacies
- Each town has at least one hospital and one centre for outpatient treatment.
- A Family Doctor and a nurse are stationed in each village (Federal Office of Migration BFM, 2011).

The evaluation of reforms by focus groups

Focus groups are especially helpful when understanding nuances of attitudes, beliefs, or opinions is a major objective. For this reason, focus groups are popular in market research.In the beginning of 2013, focus group research was started at International Black Sea University. To compare old and new health systems and to analyze satisfaction of Georgian customers by Health System of Georgia 10 focus groups were gathered and more than hundred people were invited to it. According Word Bank population of Georgia in 2012 was estimated as 4.512 million. If the confidence interval will be maintainedto 10 and confidence level 95%, according sample size calculator software 96 personalities should be accurately chosen. That's why personalities were selected for focus group participa-

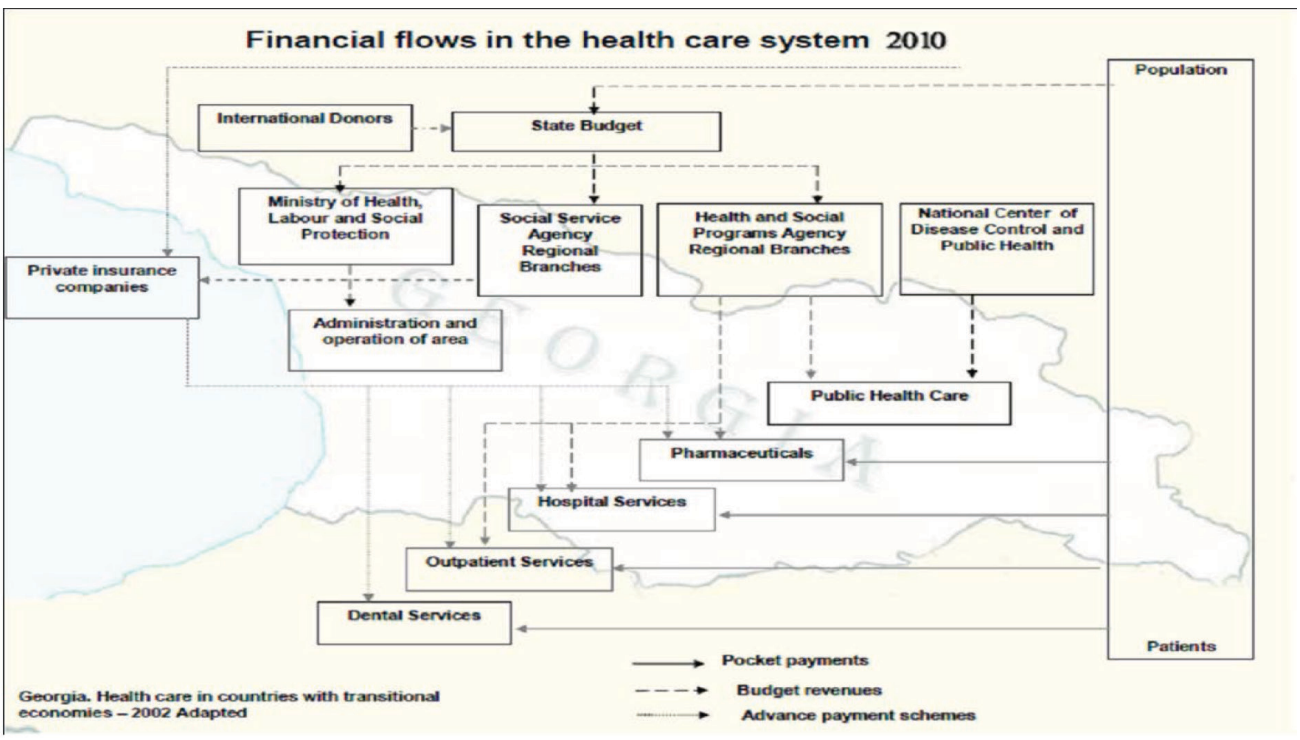

Figure 2. *Financial flow in health care system in Georgia (Rukhadze, 2013).*

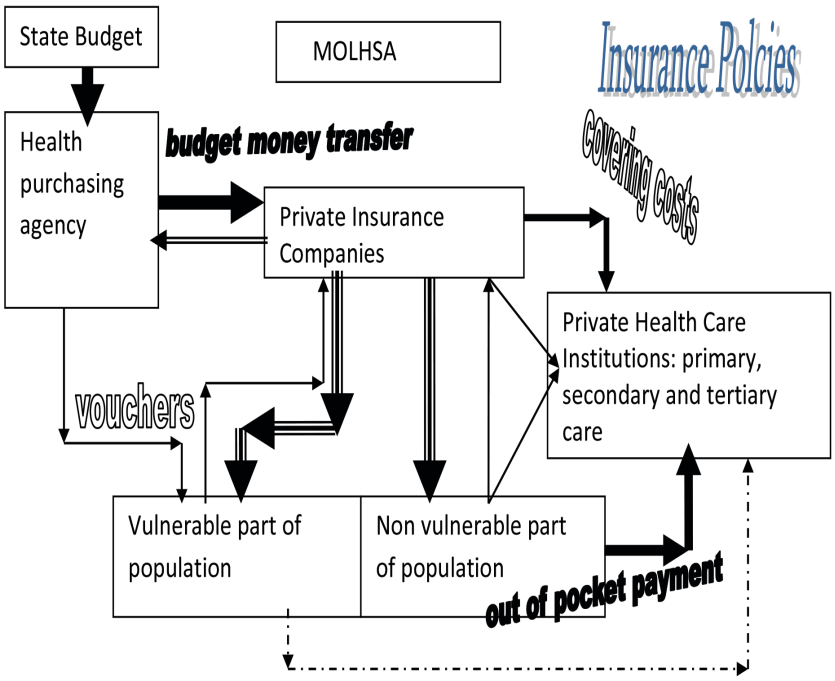

Figure 3. *One of the state programs of vulnerable population funding.*

tion according income groups, according experience to be aware about health service quality in Georgia from 1991 to current time (Creative Research Systems, 2013).

The research methodology was simple. The facilitators were asking to focus group members to recall their health related case and describe it, writing no more than 600 words about them. The cases were generalized and discussed with focus group members. After that simple questions were asked to them about: a) how well Georgian health system, established by the 1st health reform could manage the case? b) How well the health system of Georgia, established after the second health care reform was able to solve the case? The possible answers could be: a) Health system was able to satisfy customer needs, b) system was average able to satisfy customer needs, c) system was quiet unable to satisfy customer needs. The focus groups consisted of middle aged people, from different income groups, that had experienced all health systems of the last 23 years of the history of Georgia. Having divided focus group member stories into primary, secondary and tertiary health care cases, researchers tried to discuss them differently from each other. Accordingly, we received several logical flows to health systems of Georgia before and after 2004.

To minimize the bias in the design or conduct of research what could occur in the form of selection of focus group members (Selection bias), or information obtained from them (Information Bias), the lack of objectivity among those who measured patient responses (Observer Bias), interviewer influence on focus group members (interviewer bias), the researchers used some appropriate methods. The goal of all bias elimination has been achieved through randomization, or systematic recruitment of the focus group members and standardization of measurement process. The researchers knew that when bias cannot be eliminated totally some percentage of overestimation must be considered. Accordingly,when conclusions were drawn from the research, 5% percent of the overestimation or underestimation degree was considered.

The result of the focus group research with the goal to assess the satisfaction of patients with health systems, created from the first and the second health reforms was following: the satisfaction of patients by the second health reform and the system established by it is growing. The social health care for vulnerable population has the most satisfaction. The tertiary health care has the lowest satisfaction and should be the target of the reform continuation in the direction of finance and quality. Focus group members decided that the second health reform is better than its predecessor.

Discussion

The second health care reform was directed primarily atsafeguarding basic medical care of the vulnerable population of Georgia. It also pursued other goals: firstly, to prevent patients from contacting specialist hospitals directly. To this end, the focus was on family doctor system, the so-called Family Medicine System. Secondly it wanted to encourage competition between service providers in health market, by privatization of health facilities and liberal market policy. Throughout the year of 2004 government of Georgia defeated corruption. In 2007 government started health insurance voucher distribution to social vulnerable population and covered them fully in two years. In 2009, the government introduced so-called cheap insurance scheme,

Table 1
Comparison of Systems Established by 1st and the 2nd Health Reforms of Georgia, by Satisfaction of Customers in Percentage

	Unsatisfied %	Average satisfied %	Satisfied %
1st reform			
primary care	69	31	
secondary care	88	9	3
tertiary care	89	9	2
social health care for vulnerable	96	2	2
2nd reform			
primary care	20	35	45
secondary care	10	35	55
tertiary care	68	22	10
social health care for vulnerable	3	3	94

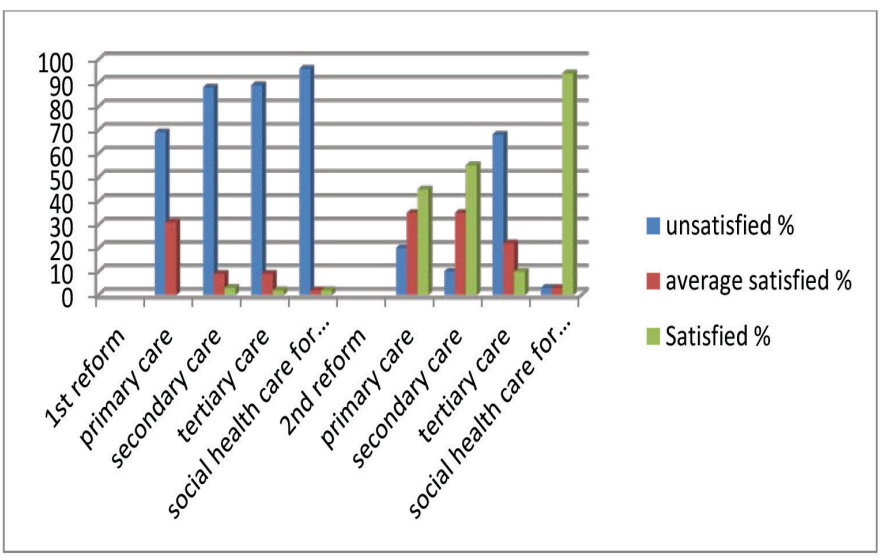

Figure 4. *Graphical view of Table 1.*

an additional insurance package for the whole population. After more than five years of thesecond health reform implementation, the results are encouraging. A lot of tangible accomplishments have been achieved in terms of equity, quality, and access to services. The Main question is about the accessibility, affordability and appropriateness of the health care in Georgia.

In 2011 the Federal Office of Migration BFM analyzed Georgian healthcare system, structure services and access and decided that: "In 2009, the World Health organization estimated that 80% of the population would normally be treated by a doctor within 30minutes in a medical emergency. In rural areas, the percentage is 72%. Only those people living in very isolated areas need to travel longer distances for medical treatment. This has traditionally applied to the mountain regions of Kvemo Kartli and Samtskhe-Javakheti. According to official figures, access stood at 95% in 2011. One respondent even stated that treatment could be obtained in 15 minutes in 2011" (Federal Office of Migration BFM, 2011).

But some problems occurred during the Second health Reform:

- **Low level of patient's involvement in reform planning and implementation:** It seems that "as in other former Soviet countries, Georgian reforms have rarely taken account of patients' interests (especially where chronic diseases require long-term care) and they have uniformly relied on direct out-of-pocket payments which obstruct access to care (Lewis, 2002). The application of the framework proposed here offers an alternative, as it places the users and providers at the centre of the system, providing a starting point from which to explore the continuum of care and to identify the inputs required at each stage (Balananova et al., 2009).

- **Big gaps between insured and non-insured society:** During the second reform planning policy

makers have not recognized biggest gap between vulnerable people and those who are poor but not below poverty line. “This group (between 70000-200000 degrees of assessment by social office) is neither poor enough to receive free medical care, nor rich enough to afford out-of-pocket payments (in case of serious illness) nor the premium of private health insurance (for less serious illnesses). An employee of a Georgian insurance company pointed out that: The decision to set up 70,000 points as the ceiling for receiving vouchers is a political decision. It is not based on the needs of the population. Many more people need subsidization. In 2010, 70% of health costs were paid directly by patients to medical institutions” (Federal Office of Migration BFM, 2011).

- **Problem of Monopolization:** One of the major concerns about privatization is the issue of ownership of facilities. Because regulatory environment was not shaped before the reforms took place, interested companies were able to establish monopolies in particular areas. Large, state-owned hospitals were mostly bought up by a limited number of private interests, including banks, pharmaceutical companies and insurance companies. Acquisitions of healthcare facilities by importers of pharmacy, or private insurance companies led to some monopolization.

- **Problem of financing those who became poor as a result of health problems:** Current reforms, as mentioned above, envisage a state-funded supplemental package for the poor. However, the targeting exercise does not cover population groups who may become poor as a result of paying for needed health services, for example the chronically ill and elderly” (Balabanova et al., 2009).

- **Information system is not well planed:** The existing Health Management Information System (HMIS) is not available to provide timely and accurate data to support evidence based decision making” UNICEF Report (2010).

- **Some communicable illnesses affecting society are not still managed by health system established after the second health reform:** “Although hepatitis is widespread in Georgia, hepatitis treatment is not paid for by the state. In order to receive state benefits for mental illnesses, patients must register for a state disability pension. A diagnosis at a psychiatric hospital and a positive decision by the State United Social Insurance Fund is necessary for this. The disability benefit amounts to GEL 55 (EUR 23) per month (official subsistence level in 2010 approximately EUR 64) ” (Federal Office of Migration BFM, 2011).

Conclusion

In the short history of Georgian independence already two health reforms with totally different strategies took place. The first health reform of 1994-95 mixed its social health insurance and taxed finance intentions. It failed due to unsustainable and weak economy, corruption and inappropriate state management. The second Georgian health reform was interesting stage of solution seeking country without strong economy and steady social condition. In such situation country, having more unemployment than employment, has a little chance to health system improvement. But despite such economic and social condition, Georgian health reforming was really an effective stage in the country’s development, encouraging its economic stability and growth. The second health care reform encouraged private insurance companies and improved health insurance culture in Georgian people. The number of vulnerable population exceeded more than one million persons. They became fully covered by Georgian health system, working closer with private insurance companies. In 2011 reform expanded to cover health care risks of old people and Pensioners and a lot of them received very expensive surgery operation services with high quality and much improved chances to live longer.

The second health reform of Georgia comprehensively touched all aspects of health financing and health care, improving quality, accessibility and affordability of health services. In the case of macroeconomic sustainability of the country the system established by the second health reform, involving state, public and private insurance cooperation can expand its influence on society and encourage social peace in the country.

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Abbreviations:

MoLHSA - Ministry of Labor, Health and Social Affairs (MoLHSA)

SHI -Social Health Insurance (SHI)

TF -Taxed Finance (TF)

MB -Model of Bendukidze (MB)

SMIC -State Medical Insurance Company SMIC

WHO -World Health Organization WHO

DALE - Disability Adjusted Life Expectancy DALE

GDP- Gross Domestic Product GDP

UNICEF- United Nations Children's Fund

DAAD – German Academic Exchange Service