INDEPENDENT GEORGIA – HEALTH AND SOCIAL PROTECTION SYSTEMS

OPEN SOCIETY GEORGIA FOUNDATION
ფონდი ღია საზოგადოება საქართველო

2012

INDEPENDENT GEORGIA – HEALTH AND SOCIAL PROTECTION SYSTEMS

Analytical Review

Tbilisi, 2012

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ISBN: 978-9941-0-4400-7

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INTRODUCTION

FOR WHOM IS THE ANALYTICAL REVIEW INTENDED?

The analytical review is intended for a large audience, for all people interested in answering the question: "what is the state of affairs in the field of health and social protection in Georgia?"

WHY AN ANALYTICAL RATHER THAN AN ORDINARY REVIEW?

Many interesting developments have occurred in Georgia's health and social protection system since independence, though not all of them were of an equal importance in establishing or reforming the system. Frequently, the most essential events remained unnoticed by a public whereas readily noticeable topics used to attract a lot of attention.

In contrast to a general review, an analytical review is valuable because it helps the reader to see the most essential events which changed the situation or based on which the current situation has evolved. It shows cause-and-effect relations between these events and major characteristics of the system.

WHY A SYSTEM-WIDE (SYSTEMIC) ANALYSIS IS VALUABLE?

Social protection (including health care) covers relationships among rather many phenomena, depends on other areas of social life (state system, public administration, economic situation or development, values and standards and so on) and, in turn, exerts its influence on them.

If we want to find out how or why things happened or what we have got in the result, i.e. to understand the gist of developments then we need to systematize these events and factors the way that they become readily intelligible by a nonprofessional person interested in the subject area.

When facts are organized it is becomes much easier to see relationships among them, i.e. to differentiate between causes and effects and come to independent conclusions - what the result of making changes to one factor was, or what the cause of one or another widely known event was.

CAN AN ANALYTICAL REVIEW BE OBJECTIVE?

Yes, if it limits itself to systematizing (organizing) various developments and leaves room for readers to make their own conclusions.

Social or health systems are quite widely known and recognized constructs (so-called "theoretical models") and the choice among them does not depend on the author's preferences.

To minimize the risk of subjectivity **in the assessment of** events an analytical reviewer must build sound and logical frameworks and arrange these events according to one of the system models. Thus, it will be easy for a social or health protection expert (who may have different opinion) to determine whether the review is balanced, equitable and adequate (i.e. objective) or not.

The assessment of developments through the prism of an analytical review does not allow the author to impose his or her opinion and attitude on the reader. In such a case, "the assessment" is just an attempt to organize events in an orderly way based on the known facts (sources must be indicated). When evidence (e.g. government's arguments in support of certain decisions) is lacking, an analytic reviewer may offer his or her suggestions (considerations that may be disputable) or leave room for the reader to make his or her judgment.

HOW THE ANALYTICAL REVIEW IS STRUCTURED?

The analytical review starts with chapter 1 - "Main Concepts and Approaches". This chapter is interesting because it defines a number of popular[1] terms (what they mean in this document) right away to avoid any misunderstanding. Next, the chapter gives reasons for selecting system models and explains the logic of dividing the review into three blocs ("waves" of changes).

Chapter - "Changes in the System" - conventionally divides the changes occurring in the social and health protection system since the recognition of Georgia's independence into three waves and reviews each of them in a separate subchapter:

- **Period of Inertia** – covers the period from 1989 to 1995. This subchapter describes the system existing in the Soviet era (which is still in the memories of a lot of people and causes nostalgic feelings) and the process of its disintegration which took 5 years;

- **The First Wave of System Changes** – covers the period from 1995 to 2003 marked by the inception of statehood building, implementation of extensive healthcare reforms (building of a new system), understanding of poverty and development of a strategy for its elimination. By the end of this period (2001-2003) the controversy about the development model of a social protection system (including healthcare) emerged between two groups of stakeholders and it created conceptual grounds for considerable changes (the second wave).

- **The Second Wave of System Changes** – covers the period from 2004 up to date during which the building of systems of social and health protection completely different from those of the first wave has started (and continues up to date).

1 "Popular" - means frequently used, though not always immediately understandable for all.

Each of the three subchapters assesses events in a number of aspects, such as:

- Governance (public administration, political system)
- Economic situation and trends;
- Situation in social protection;
- Situation in healthcare

Finally, the analytical review lists in a chronological order all major events that have occurred in the field of social or health protection and have influenced changes in the systems. Chapter 2 - Chronology of Events - is devoted to this description.

Chapter "Summary" presents an authors' attempt to explain (based on available evidence) what caused the described changes in the system.

Chapter "Annexes" presents the most essential evidence (in the form of tables or figures) based on which the system's assessment was conducted in previous chapters.

The paper concludes with references to sources of factual data or to materials where the reader may find more details about an interesting issue (e.g. alternative considerations).

1. MAIN CONCEPTS AND APPROACHES

1.1. DEFINITIONS

SOCIAL PROTECTION AND SOCIAL SECURITY

Terms: "Social Protection" and "Social Security" are commonly used as synonyms in a number of countries and it is difficult to distinguish between them clearly (International Labour Organization, 2010).

We may agree (provisionally) that social protection is a broader field that incorporates social security – a component of social protection in the realm of which the applied measures are mandatory. (Paas, et al., 2004). The definition of social security by International Social Security Association is a good illustration of the point:

> *"Social security maybe defined as any programme of social protection established by legislation, or any other mandatory arrangement, that provide individuals with a degree of income security when faced with the contingencies of old age, survivorship, incapacity, disability, unemployment or rearing children. It may also offer access to curative or preventive medical care." (International Social Security Association, 2011)*

A number of authors think that the term "Social Security" applies mostly to the developed countries of the West and the term: "Social Safety Net" – to the developing world, whereas the term: "social protection" denotes a broader concept:

> *"Social protection refers to the public actions taken in response to levels of vulnerability, risk and deprivation which are deemed socially unacceptable within a given polity or society." (Norton, et al., 2001)*

Definitions of social protection vary from quite general to relatively narrow formulations (see Figure 20, p. 59).

The World Bank suggested the most innovative and useful definition[2]:

> *"Social protection is seen as public interventions that assist individuals, households, and communities to manage risk better and that provide support to the critically poor" (The World Bank, 2000).*

This definition bases itself on the concept of Social Risk Management (SRM) developed by various authors in the end of the last century (Neubourg, 2001), (Holzmann & Jorgensen, 1999), (Siegel & Neubourg, 2011). The overlap between conceptual frameworks of social protection and social risk management is shown schematically in the annexes (see Figure 21, p. 59).

2 It is noteworthy, that the WB has been preparing the new social protection strategy and it cannot be excluded that current conceptual understanding of social protection is revised (The World Bank, 2011).

SOCIAL WELFARE

The term: "Social Welfare" or "Welfare State" appears in different contexts (in fact, it is a technical jargon), though it is difficult to find its proper equivalent. The word "Welfare" means fortune, happiness, wellbeing and comes from the 14th century Old English word "welfaren" (wellfare ="good journey"). Nowadays, it also conveys the meaning of social allowance or benefit (financial assistance). The Russian equivalent of the term is "социальное обеспечение". In Georgian as well in Russian its root means easy circumstances (or well-being), the same as "обеспеченность", from which the word "обеспечение" is derived.

The term "social welfare" applies to countries in which the burden of social protection is mainly borne by the government (society) to ensure the well-being of an individual. Therefore, a country is a welfare state if it assumes primary responsibility for the well-being and the standard of living of an individual. Countries referred to as welfare states are Sweden, Finland, and Denmark (sometimes, Norway). Hence, one can use the term "socially secured state" or shortly "secured state" as a Georgian equivalent for a welfare state.

COMPONENTS OF A SOCIAL PROTECTION SYSTEM

Conventionally, the system of social protection encompasses four major components: social insurance, social assistance, social compensations and social safety net. Just by means of these components benefits are delivered to beneficiaries i.e. consumers of social protection (see Figure 22, p. 60).

Social insurance is understood as a set of measures directed at alleviating the negative impact of certain risks and compensating for them based on a risk sharing (solidarity) principle, notwithstanding whether it is financed and administered by the government or the private sector. In general, social insurance is mandatory and is funded by means of insurance premiums, though social insurance can also be voluntary when the government encourages (through financial incentives) people's participation in a solidarity mechanism.

Social assistance is regarded as a mechanism of redistribution of public resources aimed at improving circumstances of individuals (households) in need who would fall into poverty without this assistance. Social assistance can be either monetary (referred to as "allowance") or non-monetary, in the form of benefits and social services.

Social compensations are considered as mechanisms of public reimbursement of the damage inflicted to a certain group of population. The damage can be associated with socially beneficial activity (such as damaging health in the result of participation in works to eliminate the consequences of the accident at Chernobyl nuclear plant) or natural disasters (loss of shelter / home or assets, loss of income source, ill-health and so on).

Social safety net is deemed as a part of social protection measures serving directly the purpose of protecting people from falling into poverty (foremost) or pulling them out of poverty (in certain cases). Social safety net is not a separate (organizational, structural) component of a social protection system but rather it is a set of

measures characterized by such a specific functional feature. For example, unemployment insurance (it is a part of social insurance) protects an individual (a household) form falling into poverty for a certain period, in particular, until he or she finds another job or until the insurance period is exhausted. If one fails to find a job and faces the risk of a dramatic deterioration of his or her standard of living, then the mechanism of a social safety net (pertains to the component of social assistance) comes into action for a definite or indefinite period of time, with some preconditions (e.g. the obligation to do socially useful work) or without them.

SELECTIVITY AND UNIVERSALITY

These concepts characterize the principle of providing social assistance (cash or services): for all or for only the poorest population. With the selectivity principle, loss of income (e.g. because of dismissal from job) is not enough to become a beneficiary but an additional criterion – the need – is also considered.

In fact, selectivity or universality is only the tip of an iceberg differentiating countries by values and polity and it is closely associated with such concepts as institutional and residual models of social protection (for details see Figure 17 p. 57).

1.2. APPROACHES

It is rather difficult to describe and evaluate public systems, i.e. to describe clearly, what happens in real life along with its numerous elements (system "objects") – participants with their own roles (rights, capabilities, duties and responsibilities) and relationships and with written and unwritten rules, resources, goals or desires, and risks or hindrances.

Models – schematic representations ("diagrams" or "constructs") of the aspects of events we are interested in - are useful to depict and perceive reality.

This review uses four types of models:

- To analyze social protection system:

  - Models of organization of a social protection system (Esping-Andersen);
  - Social risk management model (WB).

- To analyze healthcare system:

  - Health system performance model (WHO);
  - Health system performance assessment model (HSPA).

1.2.1. MODELS OF SOCIAL PROTECTION SYSTEMS

TYPOLOGY OF SOCIAL WELFARE

Danish sociologist Esping-Andersen was first to develop the typology of social protection systems in 1990 and a theoretical, methodological or empirical criticism of this typology has not stopped since then (Bambra, 2007).

Esping-Andersen divided 18 OECD countries into three groups by liberal, conservative and social-democratic welfare regimes. This division bases itself mainly upon three criteria: decommodification, social stratification and private-public mix:

- Decommodification[3] catches to what extent an individual's well-being is dependent on a market especially in terms of pension, unemployment benefit and health insurance. The lower is the dependence the higher is the extent of decommodification.

- Social stratification reflects the role of a social protection system in maintaining or splitting (layering) the structure of a society. More generally, stratification expresses social heterogeneity, segregation of a society, differences in the social standing of its members and social groups, their social inequality (Gelitashvili, 2011).

- Public and private mix reflects the role of four institutions – state, (civil) family, society and market – in providing social welfare.

Many typologies of social protection systems have been developed since 1990 (see Figure 32, p. 66). Proposed 20 years ago, the categorization of countries by welfare regimes "grew old" very quickly, whereas the landscape of social welfare proved to be rather dynamic. Moreover, such issues as globalization, population aging and difficulties with financial sustainability have posed new challenges to a number of countries, however not all of them have chosen the same solution (Esping-Andersen, 2000) (Gensche, 2004), (Kwiek, 2006). Thus, the need in revising the concept of social welfare and in defining its new paradigm has become apparent (Gilbert, 1999), (Young Academics Network, 2011)."

An attempt was made to fit Eastern European and former Soviet Union states into Esping-Andersen typology by applying the method of hierarchical clustering (Fenger, 2007) or cluster analysis (Farkas, 2011). However, the attempt was not successful in practical terms since it proved to be impossible to attribute several countries, specifically, Georgia, Moldova and Romania, to any of the categories.

The European Social Model developed by Ebbinghaus in 1999 is the most optimal one. It is also good for the Baltic States (see Figure 33, p. 68) and, in fact, echoes four European models by Andre Sapir (see Figure 18 and Figure 19, p, 57).

3 The term itself was coined by Karl Polanyi, who reckoned that capitalism needs to consider labor as commodity intended for exchange similar to other commodities. Since labour (labour force) is not an ordinary commodity it requires auxiliary systems for decommodification to maintain or improve it even when it is not exchanged (sold) on a labour market.

SOCIAL RISK MANAGEMENT MODEL

The model bases itself on the concept of social protection as the social management of risks. International development agencies widely use this model (The World Bank, 2000, Asian Development Bank, 2003).

Many events may pose threat to the well-being and quality of life of an individual or a certain group of population (see Figure 24 Risks faced by individual and society and their management by public (social) institutions", p. 60), though not all of them or risks associated with them need to be intervened or addressed by the society.

Conventionally, the model of social management of risks deals with four types of risks:

1. Loss of income:
1.1 old age;
1.2 temporary inability to work;
1.3 extended inability to work (disability);
1.4 loss of a breadwinner;
1.5 unemployment;
1.6 industrial injury, disability due to an occupational disease.

2. Health related expenses

3. Burden of childbearing and child rearing

4. Poverty

The model of social management of risks considers three agents and three approaches:

- Agents (institutions)
  - government (public sector)
  - market (private sector)
  - individual (informal sector)

- Approaches:
  - reducing risk factors (prevention)
  - alleviating risks
  - addressing risks

Details of the management of social risks by institutions and approaches are given in the annexes (see Figure 25, p. 62).

A two dimensional matrix (see Figure 26, p. 62) will be used in the analytical review to describe the role of various institutions in social risk management.

1.2.2. MODELS OF HEALTH SYSTEMS

HEALTH SYSTEM PERFORMANCE FRAMEWORK

It is a widely accepted approach to categorize healthcare models into three - Bismarck, Beveridge and Semashko – groups of models. Such a division builds on characteristics of financing and employs the principle that health system's organization is largely determined by healthcare financing. This division is still useful for a comparative analysis of specific features of health systems (e.g. Tawfik-Shukor, et al., 2007).

The analytical review does not use this classical typology for several reasons:

- Since we consider that healthcare is a subsystem of social protection, it is sufficient to use models of organization of social protection systems;

- Because of numerous methodological inaccuracies, countries with social insurance model in healthcare are automatically ascribed to the Bismarck model (e.g. Germany). In effect, such attribution is quite superficial as evidenced by Kyrgyzstan and Armenia the system of financing (and healthcare organization) of which has nothing in common with Germany;

- There is a more useful and disaggregated (relatively deeper) conceptual framework specific to a health system, which we will discuss here in detail.

Joseph Futzing developed the conceptual framework of health financing (Kutzin, 2000). Based on so-called functional approach the framework identifies four functions (collection of funds, pooling of funds, purchasing / financing of services, provision of services) of health financing (see Figure 27, p. 63). Such a functional division will help in understanding how the health system in Georgia has transformed in the past 20 years.

Based on this approach the analytical review will use a more detailed health financing framework where sources of financing, intermediary agents and types of financial flows are indicated (see Figure 28 The conceptual framework of health care financing by sources and financial flows", p. 64).

HEALTH SYSTEM PERFORMANCE ASSESSMENT MODEL

The reconsideration of a health system that helped in structuring the goals and functions of the system is associated with the World Health Report 2000 (World Health Organization, 2000).

In the same period the health system performance assessment model based on this conceptual consideration was developed (Murray & Frenk, 2000, Murray & Evans, 2003). One of its varieties is shown in the annexes (see Figure 34, p. 69).

The analytical review will use a simple variety of the model which will disclose relationships among system performance (in four dimensions: services, resources, stewardship, and financing), external factors, and impact on ultimate outcomes (health, responsiveness, fair financing).

1.3. ANALYSIS AND CONCLUSIONS

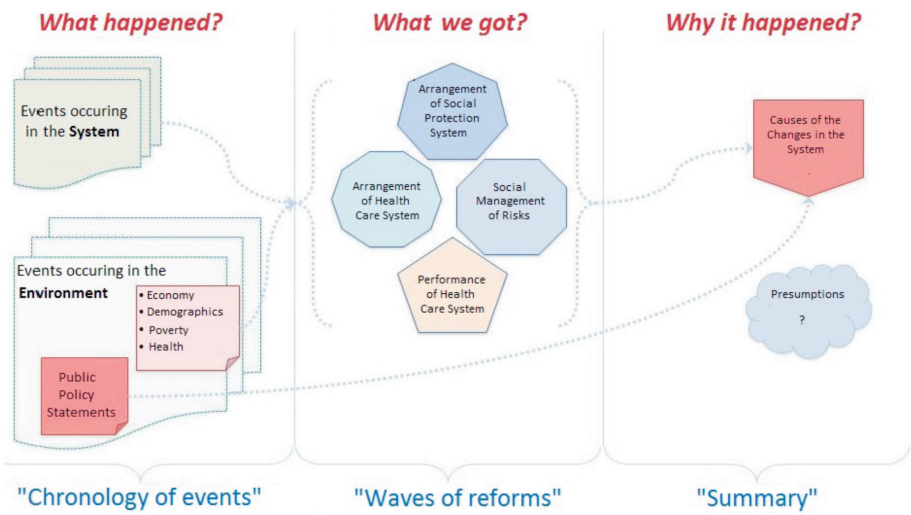
The analytical review was carried out in three stages (see Figure 1, below):

1. In the first stage, we gathered data about all essential developments occurring in or having a direct impact on the system of healthcare. We also included environmental developments (associated with the system of social or health protection) and then divided the whole set of events into two groups: "Developments" and "Changes in the System". A chronological list of events was developed using two matrices (see Figure 35 Changes in the system", p. 70 and Figure 36 Matrix of indicators associated with social and health protection Comparative description of institutional and residual models of social protection", p. 75). We added explanations to some particularly important events included in the matrices. Hence, in this stage we answered the question "what happened?" and put relevant answers under chapter "Chronology of Events".

2. In the second stage, we "rearranged" these developments in system's models used to describe system changes in each of the three waves of changes (1990-1994, 1995-2003 and 2004-2010). Thus, we answered the question "What have we got?" – chapter "Changes in the System".

3. In the third and the last stage, we used each piece of evidence (collected in the first stage) available in the public policy environment in an attempt to explain what determined these changes and answer the question "Why it happened?" (what was the goal or the driving force of a decision-maker). When there was no relevant evidence available from public policy sources, we confined ourselves to offering our conjectures.

Figure 1 Stages of the analytical review



2. CHRONOLOGY OF EVENTS

2.1. DEVELOPMENTS IN THE SOCIAL DOMAIN

2.1.1. HEALTH CARE

Major developments associated with the system of social and health protection are described and summarized in the relevant matrix (see Figure 35, p. 70).

Nothing important had happened in the field of healthcare for 5 years since 1990. The system, more precisely, certain components of the system continued to work under their own inertia (Gzirishvili, et al., 1997).

Health services were provided by primary, secondary and tertiary level public (budgetary) organizations. Formally, health services in the public sector were free of charge. Healthcare financing from the state budget declined dramatically (Hauschild & Bekrhout, 2009) - while per capita expenditure equaled to $13 in 1990, the same indicator dropped to less than $1 in 1994 (Gamkrelidze, et al., 2002). The share of government expenditures in total expenditures on health slumped to 4.9% in 1995, whereas state expenditures on health were only 1.3% of the state budget in 1994 (see Figure 36, p. 75). On average, expenditures on health amounted to 4.5% of GDP in 1990-1995 (Gzirishvili, et al., 1997).

The state financing of medical facilities was based on historic budgets pursuant to standards (developed in the Soviet era) associated with bed capacity or personnel arrangements. According to Health Utilization and Expenditures Survey (HUES) conducted by the UNICEF in 1994, despite the large share of out-of-pocket expenditures only one fifth of the respondents expressed dissatisfaction about informal payments in hospitals (on average, $5 a day) and almost half of them expressed satisfaction (Gzirishvili, et al., 1997).

According to the report on vulnerability assessment in Georgia (Dershem, et al., 1996), only 4.5% of households (or 7.1% of individuals) were considered vulnerable in terms of health care[4].

In this period, there were no tangible changes in the number of health personnel employed in the sector and this number per 100,000 people equaled to almost 500 for doctors and 1000 for nurses. However, it was in 1994 when a seven percent reduction in the number of nurses was registered for the first time (thus, the ratio of nurses to physicians declined gradually from 2.2 in 1991 to 1.9 in 1994). (World Health Organization, Regional Office for Europe, 2011).

4 In the context of health, the vulnerability of a household meant that there was a (self-perceived) need in getting health services that was unmet due to the lack of geographic or/and financial accessibility.

First private health care providers (specialist healthcare services, diagnostic tests, emergency medical services) appeared in 1992-1994, though private, formalized, legal entrepreneurial activity in healthcare originated in the second half of the 80s.

The average life expectancy reduced by 3 years and amounted to 70.3 years in 1995. By 1995 the maternal mortality rate has doubled compared to 1990 figures (55.1 and 20.5 respectively). The infant mortality in the same period was growing year by year from 20.7 to 28.6.

In 1993-1994 the work to develop the concept and the implementation plan of a healthcare reform was performed by interested parties with the support of the WB and on the initiative of the Ministry of Health.

The concept of healthcare system's reorientation was formally declared by the Head of State's Decree #400 as of 23.12.1994. Article 11 of the decree covered all facets of the first stage (start date – January 1, 1995[5]) of healthcare system's reorganization and determined the legal framework of changes to be implemented in the following years as well as the organizational arrangement and the principles of financing of the sector.

It is difficult to identify developments that occurred in the first stage of health system's reorientation and arrange them by their importance. Developments occurring in the system in 1995-2000 could be regarded as attempts not only to improve the existing situation (what the term "reform" generally means) but also to restore the order in the sector that was almost ruined in 1990-1994 and at the same time to turn back to the past, i.e. to establish qualitatively new relationships in the system to get in line with the requirements of political and economic developments in the country rather than to revitalize Soviet style Semashko model[6] (Gzirishvili, et al., 1997). "The health sector reform was one of the first state reforms carried out in the recent history of Georgia" (Gamkrelidze, 2004).

The state declared for the first time (1995 Constitution of Georgia, article 37) that the burden of responsibilities for healthcare would be shared across various subjects of the state and that medical care would no longer be free of charge. State responsibilities were no longer universal and were determined by state healthcare programs as well as by sectorial governance (regulatory) mechanisms. The society was left with the right to access medical care provided for by state healthcare programs (either free of charge or with co-payments).

Along with the right to access medical care under state healthcare programs, the society was obliged to share in the financial burden in the form of mandatory health insurance premiums paid to the account of the State Medical Insurance Company. Pursuant to the law, employers were obliged to contribute 3% and employees – 1% of salaries (gross). In the initial edition of the law (Law of the Republic of Georgia "On Medical Tax") this amount was referred to as a medical "tax" to be paid to the State Healthcare Fund. In 1997, the term "insurance contribution" was substituted for the term "tax" and the term "State Medical Insurance Company" – for the term

5 In fact, activities started a bit later – in August, 1995.

6 For your information, the Semashko model of healthcare (with minor modifications) continues to work in some of the former republics of the USSR, namely in Belorussia, Azerbaijan and in the Ukraine.

"State Healthcare Fund"[7]. Hence, except for terminological changes there were no essential changes in the public policy on health[8].

In 1995, state owned health service providers were turned from government funded organizations into state public enterprises and then, in 1999, – into private entities (in the form of limited liability or joint stock companies with 100% of shares owned by the state). Consequently, their governance autonomy also increased. After turning into entrepreneurial entities, the Ministry of Health was no longer involved in the direct administration of these facilities and so-called "corporate governance" mechanisms defined by entrepreneurship legislation remained the only way of participating in their management.

Starting from 1995, state owned health care providers were receiving financing for participating (based on contracts with the payer) in the state healthcare programs instead of getting funds directly from the state budget.

It was for the first time[9] in the post-Soviet space when the functions of service provision and financing were separated from each other in public sector. Instead of direct (economic) administration of healthcare facilities, the government limited itself to defining healthcare policies and used the mechanism of financing and regulation for implementing these policies[10] (The World Bank, 2002).

With regard to the financing, state expenditures were linked to measurable outcomes. The state asserted for the first time that it was necessary to balance the volume of state obligations with the available resources.

In 1997, the Law of Georgia "On health insurance" introduced the definition of an insurance system in the public policy environment and determined the types of the system: state mandatory health insurance and voluntary health insurance. Then, the State Medical Insurance Company was founded and the medical tax (3+1%) introduced in 1995 was transformed into the state mandatory insurance contribution[11]. This law along with the law of Georgia "On insurance" regulated insurance business in the healthcare sector. The State Medical Insurance Company (irrespective of its name), basically, had never been engaged in the insurance business but rather had been collecting[12] and expending finances that were necessary for the implementation of the state healthcare programs.

The reimbursement of healthcare facilities was based on price rates determined by state healthcare programs and actual amounts were calculated according to the state healthcare standards. The standards incorporated

7 Law of Georgia "On changes to the Law of the Republic of Georgia on "Medical Tax" as of May 28, 1997 #737–IIs.

8 In fact, it was done to "color the truth"– a real targeted tax was formalized as an insurance contribution.

9 It is the established view in the international literature that radical reforms in the post-Soviet space started in Kyrgyzstan. Actually, the analogue of Georgia's State Medical Insurance Company in Kyrgyzstan was established two years later in 1997 and, in contrast to Georgia, Kyrgyzstan retained direct government administration of state-owned medical facilities (European Observatory on Health Care System, 2000).

10 It is notable that neither at that moment nor later similar steps were made in other alike areas of public policy, e.g. in education.

11 Law of Georgia "On health insurance" as of April 18, 1997 .#660–IIs

12 Transfers from the state budget comprised increasingly larger share in the State Medical Insurance Company's income, since the funds generated by the mandatory insurance contribution (3+1%) were not sufficient to meet the obligations.

all cases (diseases or nosologies) covered by state healthcare programs and determined the volume and cost of (diagnostic or curative) interventions by diagnosis. The state standards were used not only for calculating the amount of financing and reimbursing for provided services but also for regulating (the first attempt) medical activity (the predecessor of current "guidelines" and "protocols"). From 1997, the state had changed (simplified) the funding mechanism through introducing global budget[13] and limiting per-diem (financing by bed days) methods of reimbursing[14]. The state healthcare standards gradually became the instrument of an advisory nature. (Price ceilings for state healthcare standards were fixed in 2002). In a short period, Georgia introduced and tested almost all mechanisms of healthcare financing (Gzirishvili, et al., 1997).

In parallel with changes in the funding mechanism, the burden of public financing was shared between central and local governments. Local authorities used to transfer at least $2 per capita in local healthcare funds to finance so-called municipal healthcare programs. The central government used to determine the minimum scope of these programs. Healthcare administration became decentralized and powers of central governance were delegated to local authorities (e.g. the affiliation of public health authorities with local governance bodies) (Gzirishvili, et al., 1997).

Eventually, three financial agents shared and expended budget allotments for health. These were the State Medical Insurance Company, Municipal Healthcare Funds and Public Health Department (The World Bank, 2002). Public Health Department financed or directly implemented a number of public health programs such as immunization of population or promotion of healthy lifestyle.

From 2001, the implementation of the state healthcare program for rural and high-mountainous districts had started as well.

In addition to using the state healthcare standards, medical facilities were also determining so-called internal price rates according to which they charged patients for provided health services (if these services were not reimbursed by state healthcare programs). Medical facilities used, at their own discretion, the income received for provided services both from state healthcare programs and from patients' co-payments.

The state started to regulate the health market with respect to the provision of health services as well as the turnover of pharmaceuticals (Association of Young Economists of Georgia, 2003).

The definition of a medical facility was introduced in the legislation. Any legal entity regardless of its organizational or legal form could practice medicine after getting a relevant license. Certain tax breaks were introduced for providing medical services (e.g. medical services were exempted from the value-added tax). Later, in 2003, medial facilities were exempted from all major taxes (including property levy and profit tax) (Gamkrelidze, 2004).

13 The form of financing of a medical facility that provides for the existence of an upper threshold (limit) of expenditures. The facility is reimbursed through a global budget that can be calculated based on various approaches (e.g. historic, per-capita or standard-based). The global budget method is primarily used for the financing of hospitals (Dredge, 2004).

14 The decree of the President of Georgia # 158 (30.03.1997, Tbilisi) "On improving economic mechanisms of the ongoing reform in Georgia's healthcare system".

In 1999, there were 492 physicians per 100,000 people in Georgia (mean value for the Soviet Union was 390 and for the EU - 310). In 1997, there was about one nurse per physician in the country (for comparison: the nurse to physician ratio in the UK was seven and in Germany – 2.74). Starting from 1995, medical personnel had ceased to receive salaries from the state budget. Terms of their employment and labour earnings were determined by contracts concluded with medical facilities. The state hoped that market forces, without any government intervention (Gamkrelidze, et al., 2002), would mediate the optimization of staffing (elimination of redundancy and unequal distribution by geographic areas or healthcare levels).

Figure 2 Comparison between healthcare resources of Georgia (1990) and those of other countries

	PHYSICIANS PER 1000 POPULATION	HOSPITAL BEDS PER 1000 POPULATION
Georgia	4,9	9,7
European Union	3,1	8,5
Central & Eastern Europe	2,4	8,0
CIS countries	3,9	13.3

Source: (Bennett & Gzirishvili, 2000)

Due to the functioning of 50 private higher medical schools, about 3000 doctors were getting their diplomas each year (whereas the need did not exceed 300). Thus, starting from 1995, the inflow of human resources to the health market had increased dramatically. In the second half of the 90s, the government made qualitative changes to the medical education system. The government introduced unified state medical exams, developed the sectoral classification of health services[15], elaborated the list of specialties[16] and the system of physicians' certification and continued professional education[17] (Chanturidze, et al., 2009), introduced extended residency training of medical specialists (under relevant state programs), and the state accreditation of short courses and programs for continued medical education (Gamkrelidze, 2004). The initial stage of the system reform resulted in the reduction of the number of physicians (one physician per 252 people). Only 51% of them passed the certification exams (in the specialties of obstetrics and gynaecology, general practice and epidemiology) successfully (Gotsadze, et al., 1999). Since 2005, it has been made voluntary for a physician certified for independent practice to participate in the continued professional development (Talakvadze, et al., 2011).

By reforming the system of professional education the state regulatory mechanism of supply of human resources to the healthcare market was created: the Ministry of Labour, Health and Social Affairs of Georgia was determining the number of residency seats by specialties and was financing them. However, the state financing of medical residency programs has ceased since 2005 (Chanturidze, et al., 2009).

15 The order of the Minister of Labour, Health and Social Affairs #13n, as of October 3, 2000.

16 Eventually it was put into legislation after adopting the law of Georgia "on medical practice" in 2001.

17 According to the law of Georgia "on medical practice", continued professional development consists of four components: continued medical education, continued practice of medicine, vocational rehabilitation and continued improvement of health care quality.

The privatization of medical facilities (pharmacies, outpatient clinics, polyclinics and hospitals) actually started from 1996[18]. About 400 facilities, mainly pharmacies and dental clinics (Gamkrelidze, et al., 2002), were sold in 1996-1997 and brought in 2.1 million of GELs in revenue.

287 hospitals with a total bed capacity of about 25 thousands of beds (on average, 4.5 beds per 1000 population) were functioning by 1994. Bed occupancy rate equaled to 28%, and in more than 100 hospitals it did not exceed 10%. The average length of stay was 10.5 days and the average number of doctors per hospital bed equaled to 1.5 (The World Bank, 2007). State financing of hospitals met only one third of total financial needs.

Total per capita expenditures on health (in USD PPP) doubled: if it equaled to $107 (PPP) in 1995 then by 2003 it had already reached $237 (PPP).

Compared to 1994, the share of expenditures on heath in the state budget had increased 3.5 times (4.4%) by 1996 but actually had never exceeded 6% up to and including 2003 (Ministry of Labour, Health and Social Affairs, 2003).

The share of government allotments in the total expenditures on health increased considerably in 1996 (11.6% as opposed to 4.9% in the previous year), though it had never exceeded 18% up to and including 2003. Compared to 1994, state expenditures on health had increased 20 times and reached 33 GELs (per capita) by 2004. This amount was 10-15 times less than the level before country's independence (Ministry of Labour, Health and Social Affairs, 2003).

In 1998, the average annual income of a physician was 573 GELs (formally), whereas the annual subsistence minimum was 1080 GELs per person.

The state conducted an in-depth assessment of hospitals' infrastructure according to which 90% of buildings were unsafe and more than 80% of medical equipment was obsolete and needed replacement. About 100 million US dollars were needed for the rehabilitation of hospitals to bring them up to the minimum standards and more than 200 million US dollars were required for their full renovation. At the same time, the state budget for health did not exceed 35 million US dollars per year, whereas the total state budget was around 600 million US dollars.

The government strategic plan for optimizing the hospital sector provided for a sizeable reduction in bed capacity (e.g. leaving 3 600 instead of 12 000 beds in Tbilisi), selling of excessive assets and the full renovation of remaining hospitals using income generated by the sale.

In 2000, the Hospital Restructuring Fund of Georgia was established to pool monies from selling of assets and rental of property and invest these funds in the rehabilitation of priority facilities. Later, the Fund along with the

18 However, the Government's normative act on privatizing medical facilities was adopted much earlier: Resolution of the Cabinet of Ministers #728 as of October 10, 1994.

National Institute of Health and Social Affairs merged with Georgia Health and Social Projects Implementation Center (in 2006).

The study of hospital financing conducted in this period showed that had service prices (rates) during hospitals' optimization (that halved the number of hospital beds and dismissed 45% of personnel) reflected the real cost price of services the expenditures for hospital services would have risen 2.5 times (Zoidze, et al., 1999).

Compared to the earlier period the utilization of outpatient-polyclinic services decreased: whereas in 1990 the average number of doctor visits per person was 8, by 1998 this number had already decreased to 2.6 and until 2003 it had never exceeded the mark of 1.8 visits.

In the same period, maternal and child mortality rates started to decrease: the maternal mortality rate hit its maximum (70.1) in 1997 and decreased to 45.06 by 2002, whereas the child mortality rate varied from 28 to 23.

The mortality rate among beneficiaries of the state program for pediatric oncohematology decreased to 80% in 1994. It further decreased by 20% in 2002. As for combating contagious diseases, polio was eliminated and large-scale diphtheria and large-scale epidemics of diphtheria and amoebiasis were averted (Gamkrelidze 2004).

Because of continuous difficulties in mobilizing financial resources for health and financing healthcare programs in full (e.g. on average, in 1997-2000 state budget execution in the field of healthcare was 50% (The World Bank, 2002)), the state tried to change mechanisms of financing and tightened executive discipline in the chain of governance. In 2001, the government adopted the medium-term government program for 2001-2003 to reduce the size of a shadow economy and combat corruption in the system of the Ministry of Labour, Health and Social Affairs of Georgia[19].

In 1997, 40% of total expenditures on health fell on inpatient services, 31% - on outpatient services and only 27% - on drugs (Gamkrelidze, et al., 2002).

According to sociological surveys conducted in Tbilisi, out-of-pocket payments for health totaled to 132 million GELs in 2000. One-half of this money was spent on drugs (The World Bank, 2002). Expenditures on outpatient care comprised 17% of households' budget. This figure was even higher in the poorest quintile (23%). Eleven percent of patients did not consult a doctor (mainly poor people) and 60% resorted to self-treatment mainly due to affordability problems (however, subjective perception of health also played a role). Among those who utilized medical services when they were ill, only 52% used to consult a medical specialist and avoided a primary health care physician. Pediatric services prevailed over other types of services provided by doctors at the district level. In most cases of ill health, patients sought emergency medical care (e.g. 21% of the poor used to call for an ambulance in the first place rather than summon an outpatient physician). According to experts' opinion, this situation was indicative of the weakness of primary health care services (Gotsadze, et al., 2006)

19 The decree of the President of Georgia #69 as of February 23, 2001

as well as of the fact that the basic benefits package introduced and financed by the state did not manage to optimize medical services (The World Bank, 2002).

In 2002, the World Bank and the Government of Georgia summarized the challenges to the healthcare system as follows:

- Poor health status of the population (high maternal and child mortality rates and an unfavorable situation with communicable (e.g. TB) and non-communicable (e.g. cardiovascular and oncological) diseases);
- Problems in accessibility to quality and essential medical services;
- Deficiency in the government's mobilization of financial resources for health and a low share of state resources in total expenditures on health;
- Shortcomings in contractual relationships with health service providers under the framework of state programs;
- Fragmentation of the healthcare system, in general, and that of health service providers in particular; non-optimal distribution (by geographic areas or health care levels) of health care capacities.

The Government of Georgia developed and initiated the Primary Healthcare Development Project with the support the WB. In the outset, the project provided for creating primary healthcare centers and reference laboratories, developing referral mechanisms from a primary (healthcare centers in rural and high-mountainous districts) to a higher level of care (for maternal and child health), building-up institutional capacities in health care (creating training facilities for primary health care, strengthening management capabilities in primary health care, improving health management information systems, facilitating health care financing reforms). Other donors (USAID, DFID, etc.) also endorsed government efforts and made considerable investments in human resources and infrastructure in 2002-2005.

Considering government's policy of the period, important pieces of healthcare legislation were enacted in 1995-2003. A number of laws were updated in the following years (e.g. in 2006 - law Georgia "on psychiatric care", in 2007 - law of Georgia "on public health care", in 2009 – law of Georgia "on HIV/AIDS"), however there were still many imperfections in the legislation. Some of these imperfections required the reconsideration of the system's conceptual integrity or the attainment of a broad consensus on key issues, while the others were just technical or legal flaws (Talakvadze, et al., 2011).

By introducing Georgia National Health Accounts[20] in 2006 (the work on technical details of National Health Accounts actually started in 2002-2003) the government made an important step forward in respect of public policy and management practices[21].

20 The resolution of the Government of Georgia # 11 as of January 18, 2006

21 To be objective, please, note that there is no evidence of using this tool and its outputs in the process of decision-making.

In 2007, the state started to address the problem of health care accessibility for the population living below the poverty line through the mechanism of health insurance and this was a matter of principle for two reasons:

- Instead of ensuring the accessibility to certain types of health services for all, the government gradually redirected financial resources to the poorest groups of population to cover their health care costs, i.e. the principle of universality was replaced by selectivity;

- Instead of purchasing medical services, government's funds were used for buying primary health insurance on the market. Specifically, instead of reimbursing for services provided by medical facilities the state was paying a regular insurance contribution (premium) to the insurers and by doing so was buying an insurance product from them.

Initially, the novelty was introduced in Tbilisi and Imereti region. Beneficiaries (citizens of Georgia living in households which were registered with the "Integrated Database of Socially Vulnerable Households" maintained by the Social Subsidy Agency by July 1, 2007 and the rating score of which equaled to or was less than 70,000) living in these areas received insurance vouchers ("financial medium of exchange"). Beneficiaries enjoyed the right to choose an insurer – a licensed insurance organization which previously agreed in writing to issue an insurance policy (complying with terms and conditions defined by the Government) in exchange of an insurance voucher[22].

From 2008, government-funded health insurance coverage of the population below the poverty line by was extended throughout Georgia[23]. The voucher mechanism mediated insurance coverage in this case too. Beneficiaries could choose insurers freely as well. The annual insurance premium was set at 132.12 GELs on average (the monthly premium amounted to 9.24 GELs in the age group 0-64 and at 15.01 GELs in the age-group ≥65).

By the end of 2008, 666,651 people living below the poverty line held insurance policies; the pure loss ratio amounted to 76.6% and the combined loss ratio[24] - to 96% (Jadugishvili, 2010).

In 2009, the insurance coverage expanded to include not only the population below the poverty line but also families of IDPs, families who fled their homes in the result of the Russian Federation's occupation of Georgian territories as well as beneficiaries of children rearing institutions, family-type small group homes and boarding schools. In this case, the average annual premium amounted to 180 GELs[25].

The state further expanded the group of beneficiaries of health insurance by starting the implementation of

22 The resolution of the Government of Georgia #166 as of July 31, 2007

23 The resolution of the Government of Georgia #92 as of April 8, 2008

24 The pure loss ratio implies the ratio of per se losses (the sum of paid, outstanding and incurred but not reported losses) to the earned premium, whereas the combined loss ratio accounts for not only losses but also for administrative and acquisition expense. Therefore the combined loss ratio reflects more fully how attractive (justified), in commercial terms, was a certain insurance product.

25 The resolution of the Government of Georgia #32, as of February 19, 2009.

such programs as "Health Insurance of the Population below the Poverty Line", "Health Insurance of People's Artists, People's Painters and Laureates of Shota Rustaveli Award", "Health Insurance of IDPs living in Compact Settlements" and "Health Insurance of Children Deprived of Parental Care" in 2010[26]. The insurance premium was set at 180 GELs on average (the monthly premium amounted to 12.93 GELs in the age group 0-64 and at 21.43 GELs in the age group ≥65).

Four months later, in April 2010, the government changed the terms and conditions of health insurance[27]. Instead of the voucher mechanism prospective beneficiaries were distributed among insurers in 26 health districts on the basis of a tendering procedure, i.e. beneficiaries' freedom of choice of the insurers had been restricted for 3 years. The maximum amount of the annual insurance premium was reduced from 180 GELs to 144 GELs; however, a new component - 50% co-payment for drugs, limited by the annual ceiling for this type of insurance payments (50 GELs) – was added to the insurance package. The cardinal novelty was that insurers were obliged to renovate/build and operate hospitals in their health districts in the defined period, specifically by the end of 2011.

The number of beneficiaries covered by the government-provided health insurance was 888368 in 2010 (Jadugishvili, 2010). Most of them were individuals living below the poverty line (see Figure 3, below).

In 2009, the Government developed a targeted state program to promote voluntary health insurance of the population. Its goal was as follows: "Improve the financial accessibility of health services to Georgian citizens by increasing their enrollment in a voluntary health insurance[28]". The citizens or residents of Georgia in the age group of 3 to 65 were eligible to participate in the program provided, that they had no insurance coverage provided at the expense of the state budget or the budget of a local /autonomous governing body. The insurance premium consisted of "the state's share and the insured's share"[29]. The basic annual insurance premium amounted to 60 GELs. The state covered 40.2 GELs of this amount. An insured person could choose a more expensive insurance product at his or her own expense. The basic insurance policy provided for the coverage of primary health care services as well as emergency inpatient and outpatient services up to the annual limit of 8000 GELs in insurance payments. The Government expected that 300,000 to 500,000 people would participate in the program. In fact, only 122,000 people purchased the insurance product (Jadugishvili, 2010).

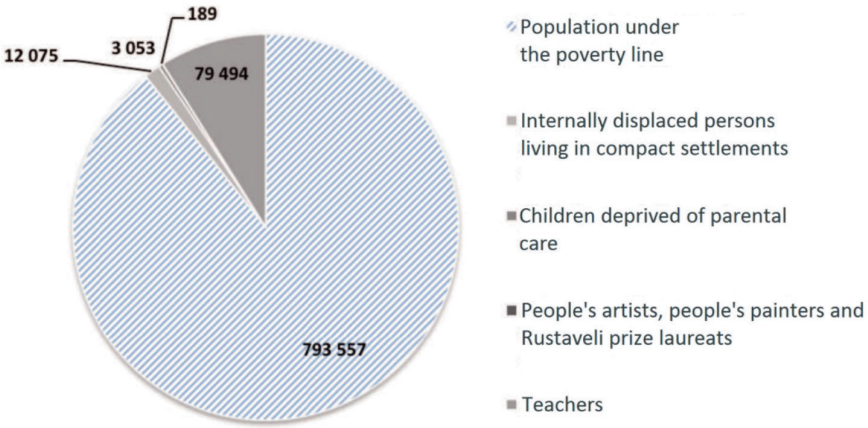
26 The resolution of the Government of Georgia #218 as of December 9, 2009

27 The resolution of the Government of Georgia #110 as of April 9, 2010

28 The resolution of the Government of Georgia #33 as of February 26, 2009

29 The resolution of the Government of Georgia #53 as of March 19, 2009

Figure 3 Beneficiaries of the state program for health insurance – 2010 data



As of 2010 about 2/3 of Georgia's population was not covered by health insurance and had to incur health related out-of-pocket expenses, amounting to 324 GELs on average annually. Of this amount 194 GELs, i.e. 60% was used for drugs - it was by 10 percentage points higher than in 2007 (50%, 203 GELS and 10 5GELs, respectively).

Hence, in 2004-2010 total expenditures on health increased considerably: compared to 2003 ($ 237 in PPP), per capita expenditures made up $ 432 (in PPP) in 2008. The growth rate of total expenditures on health exceeded that of GDP. Therefore, while total expenditures on health amounted to 8.5% of GDP in 2003, similar expenses comprised 10.1% of GDP by 2009, notwithstanding the increase in state financing of healthcare. The state's share in total expenditures on health had never exceeded 25%. The share of expenditures on health in the state budget decreased compared to 2002-2003 and varied from six to seven percent, whereas the share of state expenditures on health in GDP had never exceeded 1.8%.

"In addition to developing insurance programs, the Health Insurance Mediation Service – a non-for-profit, nongovernmental and neutral body with the primary goal to assist subjects of insurance relations in an out-of-court-dispute resolution – was established in 2008 and functioned successfully." (Jadugishvili, 2010).

In parallel with the Department of Public Health, the Department of Sanitary Supervision and Hygienic Standards of the Ministry of Labour, Health and Social Affairs (MoLHSA) was established in 1995 by the resolution of the Chamber of Ministers #389 (Gamkrelidze, et al., 2002). From 2001, the Central Inspection of State Sanitary Supervision and the State Sanitary Inspection at the State Border Checkpoints had been functioning as lower organizations of the Ministry of Labour, Health and Social Affairs[30]. In 2004, the Government of Georgia decided to centralize the service of sanitary oversight and established the Legal Entity of Public Law – the State Sanitary

30 The Decree of the President of Georgia #411 "On approving the charter of the Ministry of Labour, Health and Social Affairs of Georgia" as of October 17, 2001, Tbilisi.

Supervision Inspection of the Ministry of Labour, Health and Social Affairs of Georgia[31]. This body provided methodological guidance to and supervision of municipal and district institutions of state sanitary supervision, which jointly comprised an integrated functional system of state sanitary supervision in the country. The competencies of the inspection included a sanitary supervision over environmental factors having adverse effects on the health status of population. The State Sanitary Supervision Inspection was abolished in 2006[32]. Some of its functions were transferred to the relevant bodies of state governance.

To renew the infrastructure of the hospital sector, the Government of Georgia initiated a new wave of privatization of medical facilities in 2007[33]. The goal of the Hospital Sector Development Master Plan (known to public as "100 hospitals' plan") was to build the capacities of hospital medical services and to provide accessibility to quality inpatient medial services. The Government decided to sell some of the state-owned hospital assets though not for money but for new hospitals to be located in geographic areas, having required capacity, and meeting at least minimum standards as determined by the authorities.

An investor was required to build a new hospital and bring it into operation within time limits determined by a contract with the Ministry of Economy and Sustainable Development. Only after fulfilling the obligation the investor could exercise in full the right to dispose of the acquired assets, though the owner was still obliged to operate the newly built hospital for next 7 years. The Government plan intended to reduce the number of hospital beds from 14,600 in 2007 to 7,800 in 2010 (of which 1,860 beds would remain in state ownership and the rest of them (76%) in private ownership). Investors were expected to create 4,905 new hospital beds instead of 11,705 beds offered for sale (see Figure 15, p. 54). By 2010, the number of old hospital beds sold in exchange for 2,245 new hospital beds equaled to 5660. The fate of the remaining number of beds offered for sale remained unclear. It is noticeable that the majority of investors were so-called "developer" companies whose primary incentive was to receive income from selling assets transferred to them and whose success was dependent on the conditions in the real estate market and the accessibility of capital.

In 2010, the Government decided to adjust the Hospital Sector Development Master Plan[34] and defined that insurance companies under the State Health Insurance Program should build new hospitals by the end of 2011[35]. According to the new approach, 7,800 hospital beds planned initially were distributed by ownership the following way (see Figure 16, p. 55): 36% of a hospital stock would remain in state ownership, 43% (i.e. 1,105 beds) of a total capacity of newly built hospitals (3,320 beds) was to be created by insurance organizations and the rest of hospital beds (2,205) - by private investors, based on the contract with the Ministry of Economy and Sustainable Development. The fate of 638 hospital beds remained unclear (whether they would be left in state ownership or be offered for sale to private investors).

31 The order of the Minister of Labour, Health and Social Affairs of Georgia #172 as of July 22, 2004.

32 The order of the Minister of Labour, Health and Social Affairs of Georgia #178 as of June 22, 2006.

33 The resolution of the Government of Georgia #11 as of January 26, 2007.

34 Formally, no changes were made to the Hospital Sector Development Master Plan itself.

35 The resolutions of the Government of Georgia #85 as of March 30, 2010 and #110 as of April 10, 2010.

2.1.2. SOCIAL PROTECTION

The independent Republic of Georgia inherited the Soviet model of social protection which was based on four pillars as prescribed by the 1936 Constitution of the USSR (Tvalchrelidze, 2003):

- A free health care;
- A pension system;
- A state insurance system;
- Trade union members' benefits.

In 1991, social contributions (38% for public and private enterprises and 27% for government-financed organizations) transferred to the Unified Pensions and Health Insurance Fund were used for payment of pensions, family allowances and sickness benefits. These expenditures comprised 11.5% of GDP; payments for old-age, disability, survivors' and social pensions amounted to 10% of GDP. The pension replacement rate was 70%, on average. Old-age pensioners comprised 40% of all pensioners. In 1992, the Fund's income was 50-60% of the planned amount leading to irregularities in pension payments and the cessation of payment of sickness benefits (The World Bank, 1993).

In 1996, the Government raised the pensionable age. It was set at 60 years for females and at 65 years for males for the labour pension and at 65 years for females and at 70 years for males for the social pension (for people who never paid social contributions). In the result of these changes, the dependency rate that equaled to 67% in 1994 had reduced to 55% by 1996, whereas the pension replacement rate increased from 14.5% to 27.6% (Julukhadze, 2009).

The introduction of old-age pension as well as the determination of its amount was linked with steps for market liberalization. For example, in 1996 the state took a number of prior steps: "to encourage private enterprise, imported wheat shall be exempted from the import duty and VAT. Additional privileges shall be introduced, if necessary, to prevent such an increase in prices during transition to free pricing that will lead to the drop in the purchasing capacity (already limited as it is) of the population. Additional prior measures to increase wages, pensions and targeted benefits shall be carried out to ensure social protection"[36]. Since in 1997 the state set the market price for electricity at 4.5 tetri per kwh[37], pensions for nonworking pensioners (as well as allowances for "refugees, migrants and IDPs") were increased by 2 GELs and reached 11.8 GELs per month. Based on the same principle, pensions and allowances increased to 14 GELs per month in the following year[38]. Only since 2005, when the amount of pension

36 The Decree of the President of Georgia #252 as of April 3, 1996.

37 The Decree of the President of Georgia #389 as of July 28, 1997.

38 The Decree of the President of Georgia #469 as of August 11, 1998.

doubled[39], the increase in pensions has never been connected with the state's market interventions. Along with the doubling of pensions in 2005, the Government of Georgia made up past arrears (in pensions worth of 14 GELs per month)[40] and managed to pay pensions in full and in timely manner since then.

In the same period, the Government introduced additional benefits and compensation allowances for 14 social categories (e.g. war invalids, the WW2 veterans over 70, persons put on the same footing as war veterans and so on) and needy households[41].

It is worth noticing that in 2007 the state abolished in kind benefits and introduced utilities subsidies for certain social categories[42], i.e. instead of covering the cost of utility services the state started to give out cash allowances to the beneficiaries (so-called "monetization of social benefits" was carried out).

In 1997, the concept of a "subsistence minimum" appeared in the public policy space. In Georgian legislation, it was defined as "the basis of Georgian citizens' social protection and social guarantees to support disadvantaged population and serve as a basis for implementing a targeted social policy by the state[43]". The food basket of an able-bodied male served as a basis for calculating the subsistence minimum[44].

The targeted social assistance program for needy families has been introduced and financed from the state budget in 1997. It provided for basic social allowances that were improving year by year in terms of both quantity and quality. In 1998, up to 46,000 families benefited from the program. By 2003, the number of beneficiary families had increased to 72,000; 33% of individual beneficiaries were people with disabilities and 16% of them – children. These facts were indicative of the targeted and addressed nature of the program (Partnership for Social Initiatives, 2003).

The Civil Code adopted in 1997[45] defined reciprocal duties of family members with regard to social protection, in particular the duty of spouses to give material support to each other (articles 1182-1186), the duties of parents with respect to children (article 1198 – rearing children and taking care of them, article 1212 – maintenance of children), the duties of children with respect to parents (article 1218 – maintaining parents and taking care of them, article 1220 – participation of the children in the extra expenses), siblings' reciprocal duty of maintenance (article 1223 - maintenance), the duty of support from grandparents to grandchildren (article 1225 - maintenance), the duty of support from a grandchild to disabled grandparents (article 1224 - maintenance), the duty of support by stepparents (article 1226 - maintenance), the duty of support by a

39 The resolution of the Government of Georgia #12 as of January 25, 2005.

40 The resolution of the Government of Georgia #74 as of April 19, 2005.

41 The orders of the Minister of Labour, Health and Social Affairs of Georgia #44/n as of February 9, 2006 and #.158/n as of June 9, 2006.

42 The resolution of the Government of Georgia #4 as of January 11, 2007.

43 Law of Georgia "On subsistence minimum" (as of April 17, 1997 .#649–IIs).

44 According to the law of Georgia (.#4469–Is as of March 22, 2011) "the approval and the amendment of the methodology for calculating the subsistence minimum shall be effected by the decree of the President of Georgia based on the suggestions of the Legal Entity of Public Law – National Statistics Office of Georgia (GeoStat), the Ministry of Labour, Health and Social Affairs of Georgia, and the Ministry of Economy and Sustainable Development of Georgia".

45 Law of Georgia "The Civil code of Georgia" as of June 26, 1997 .#786–IIs)

stepchild (article 1227 - maintenance), and the duty of maintenance of a child taken into permanent upbringing and maintenance (article 1228 - maintenance).

The rule for granting workers' compensation for a work related injury was adopted in 1999 (it was in effect until February 2007)[46].

In the result of merging two ministries in 2000, an integrated entity – the Ministry of Labour, Health and Social Affairs of Georgia – was established[47].

In 2001, the state adopted the plan of actions for the first stage of the employment reform and created the State Employment Agency[48]. Pursuant to the charter adopted in 2002, the goals of the agency were to promote implementation of the state policy on employment and carry out measures of social protection of the unemployed[49].

The conceptual grounds of social development were elaborated for the first time in 2000. The comprehensive plan for developing social protection was adopted by the state in 2002. It was done in the form of "the strategic plan of implementation of the presidential program for social development of Georgia (2002-2007)" emphasizing two areas – regulation of labour relations, effective use of labour resources and increase of employment, on the one hand, and improvement of pension provision of the population, on the other.

The principle of financing of a minimal social benefits package was adopted that obliged local governance bodies to allot 10% of their budgets for social expenses. These funds were intended for financing the benefits and compensations for categories entitled to them under the social legislation (war invalids, veterans and persons put on the same footing as war veterans, victims of political repressions, people injured on the 9th of April, 1989, liquidators of Chernobyl nuclear power station accident, single pensioners, pensioners getting a merit pension, miners, people with disabilities) and targeted social programs for other disadvantaged families (large families, single mothers, minors deprived of a breadwinner, children without care, 100 years old and older citizens, young families, people disabled from childhood).

In 2001, the Government started to work on the Poverty Reduction Program with the support of donors and the broad participation of stakeholders (The work on "the Economic Development and Poverty Reduction Program of Georgia" was completed in summer 2003. It was adopted in autumn, 2003 as a comprehensive strategic document of country's development.). It was the first document in the public policy space that considered problems of healthcare, social protection and educations from the perspective of **human capital**. "Human development" along with "equality of opportunities" was declared as one of the fundamental principles of

46 The decree of the President of Georgia #93 (as of February 6, 2007) "On voiding the decree of the President of Georgia #48 (as of February 9, 1999) "On the rule of granting workers' compensation for a work-related injury".

47 The decree of the President of Georgia #179, as of May 7, 2000.

48 The decree of the President of Georgia #63, as of February 22, 2001.

49 The decree of the President of Georgia #402 (as of September 13, 2002, Tbilisi) "On charter of the Legal Entity of Public Law – the State Employment Agency".

country's development. The state acknowledged that "169) Ineffective performance of social security sector is going on with inertia. There are no sufficient financial resources for universal social assistance. For the purpose of efficient provision with **targeted assistance**, it is necessary to establish adequate organizational infrastructure and alternative mechanisms. Pension arrears are not repaid on time. The amount of pensions and other types of social allowances is less than subsistence minimum and produces very little positive effect on poverty reduction even if paid on time.". In order to achieve two strategic objectives ("fast and sustainable economic development" and "poverty reduction") the state defined priorities including "**development of human capital**" and "**social risks management** and improvement of social security". It is noteworthy, that the following approaches were suggested to implement the intended measures in social sphere:

- "Actions towards the human capital development, enhancement **of the labour force mobility** and its reproduction level;
- Actions towards improving standard of living of the **marginal groups**;
- Actions towards **preventing drastic deterioration of the living conditions**".

The postulate declared in 2003, "Improvement of the level of the labor force mobility and reproduction is one of the Program's short-term objectives. The labor force mobility represents one of the prerequisites for the economic development through increased availability of the resources and reduction of transaction costs" was partially realized[50] 4 years later with the adoption of the new labour code.

To reduce the risk of vulnerability (sharp drop in the standard of living) government decided to "promote the enforcement of **all possible adequate mechanisms of social risk management** through such institutions as **market, community based organizations and families**".

The state declared clearly that instead of universal social protection mechanisms for improving the welfare its priority was to care for decent living and social integration of those citizens who "are not capable to secure social protection themselves due to objective reasons". At the same time, the state viewed its role in creating such conditions in which any member of the society could acquire social protection (security) from any risk. In fact, the Government differentiated between social assistance and social security mechanisms[51] .

In the same period (in June, 2003) the Parliament of Georgia discussed and adopted the package consisting of three draft laws[52] providing for the introduction of universal social insurance (including healthcare), and,

50 The simplification of labour relations is necessary but not sufficient to improve labour mobility and labour reproduction; it requires the institutional development of a labour market to reconcile demand and supply of a labour force and to link the requirements of a labour force in vocational development and the services provided by the system of education.

51 In effect, it meant the transition to the residual model of social protection.

52 Law of Georgia "On mandatory insurance pensions" (#2419–IIs, as of June 20, 2003); law of Georgia "On the individual registration (personification) and the introduction of personal accounts in the field of mandatory social insurance" (#2413–IIs, as of June 20, 2003), and law of Georgia "On mandatory social insurance" (#2416–IIs, as of June 20, 2003).

among other things, of mandatory insurance pensions. The laws were intended to come into effect in 2004, thought the new Parliament postponed them twice and, eventually, abolished them by giving effect to the law of Georgia "On the state pension"[53] from January 1, 2006.

In 2005, the Government of Georgia defined priorities of its social security policy as follows:

- "Eradicating extreme poverty and social exclusion, reducing poverty, improving living standards and facilitating the development of a strong middle class;
- Curtailing high unemployment, providing opportunities for employment, especially in regions, and increasing labor mobility;
- Establishing a modern education system, ensuring primary and secondary education for every citizen of Georgia, improving the quality of higher education through its alignment with the requirements of the national and global labor market and conforming with international science and education systems;
- Reforming pension and social protection systems**, developing targeted social assistance programs, gradually covering arrears in pensions and other debts**;
- Reforming the healthcare system so that availability of high quality health care is guaranteed, developing an effective insurance market and promoting healthy lifestyles and environment;
- Preventing socially dangerous diseases such as tuberculosis, AIDS and drug-addiction.[54]"

In 2005, the Government introduced state compensations and state academic stipends for certain groups of population (e.g. former officials who worked in various branches of government, scientists and etc.) to be paid in case of reaching the pensionable age, completing the length of service as prescribed by the law, granting the status of a person with disabilities or losing a breadwinner.

In 2005-2006 the Government adopted and gradually gave effect to a whole package of legal acts, in particular:

- Created the unified database of socially vulnerable households[55] "to the end of poverty reduction in the country and purposeful planning and implementation of measures for improving social protection of the population"; the profession of social agents was introduced[56];

53 Law of Georgia "On the state pension" (.#2442–rs as of December 23, 2005).

54 The resolution of the Parliament of Georgia "On adopting the National Security Concept of Georgia" (# 1895-rs, as of July 8, 2005).

55 The resolution of the Government of Georgia #51 as of March 17, 2005.

56 The rule on formation of the united database of socially vulnerable households was changed and by 2010 was defined by the resolution of the Government of Georgia #126 as of April 24, 2010.

- Established[57] the new system for assessing social-economic conditions of population and introduced the notions of a "welfare index" and a "rating score"[58];

- Introduced (in March, 2006) targeted social assistance for households living below the poverty line and adopted the rule of calculation and payment of social assistance[59];

- Adopted (in July, 2006) the rule of calculation, financing and payment of subsistence subsidies (family allowances)[60]. Its amount was set at 30 GELs per month for households consisting of only one member; for households consisting of two or more members this amount was increased by 12 GELs for the second and each additional household member. One month later the Ministry of Labour, Health and Social Affairs of Georgia specified the rule for granting and paying out social assistance[61].

- Adopted (by the end of 2006) the law of Georgia "On social assistance" which aimed at "providing population with fair, targeted and effective means of support through establishing a consistent system of social protection"[62].

It is noticeable that the preamble of the resolution of the Government of Georgia on Targeted Social Assistance includes the following assertion: "the existing system of social assistance undergoes qualitative changes aimed at directing government resources to the population living in extreme poverty".

The rule for awarding and administering family allowances was revised in 2009. Family allowance was defined as "cash social assistance awarded to the categories of needy families (including families of IDPs) as prescribed by Georgian legislation". The monthly family allowance was given to families consisting of a single nonworking pensioner in the amount of 22 GELs, to families of two or more nonworking pensioners – in the amount of 35 GELs, to orphans under 18 deprived of both parents, despite of the ability to work of a guardian, – in the amount of 22 GELs per child, to large families with 7 or more children under 18 – in the amount of 35 GELs[63].

In 2006, the state approved a new labour code[64] and by abolishing state lower organization "labour inspection"[65] cut the state's labour market regulation to the bone. The new labour code was considered as one of the most daring steps towards liberalizing the economy and got mixed opinions over its merits from certain groups of the society and international organizations.

57 The resolution of the Government of Georgia #126 as of August 4, 2005.

58 The resolution of the Government of Georgia #241 as of December 17, 2008.

59 The resolution of the Government of Georgia #59 as of March 16, 2006.

60 The resolution of the Government of Georgia #145 as of July 28, 2006.

61 The order of the Minister of Labour, Health and Social Affairs of Georgia #1225 as of August 22, 2006.

62 Law of Georgia "On social assistance" (#4289–rs as of December 29, 2006).

63 The order of the Minister of Labour, Health and Social Affairs of Georgia #238 as of August 31, 2006.

64 Law of Georgia "Labour Code of Georgia" #3132-Is, as of May 25, 1996.

65 The order of the Minister of Labour, Health and Social Affairs of Georgia #177 as of August 28, 2006.

In 2009 citizens' action group initiated the procedure for submitting to the Parliament of Georgia draft laws "On changing and amending the labour code of Georgia" and "On awarding unemployment benefits in Georgia"[66]. The Parliament did not discuss these draft laws.

"Georgia lacks a national concept of labour protection, national council for the issues of labour protection, commissions, boards of directors, committees and other bodies responsible for the periodic revision of the national legislation on labour protection. This function is fulfilled by respective ministries and parliamentary committees" (Labour Safety Information Center of the LEPL – State Inspection of State Technical Supervision, Georgian Employers' Association, 2008).

In 2009, in order to create decent living conditions for people with disabilities, the elderly and children deprived of care one Legal Entity of Public Law – Agency for Providing Care to People with Disabilities, the Elderly and Children Deprived of Care" was founded instead of 28 residential institutions - rest homes for the elderly, child rearing institutions, infants' orphanages and a specialized nursing home for people with disabilities. In the following year the name of the entity was changed to "State Care Agency"[67].

In 2010, several small family group homes for children started to operate under the framework of state support to the development of alternative childcare services[68].

2.2. DEVELOPMENTS IN THE SURROUNDING ENVIRONMENT

The matrix presented in Figure 36 (see on p. 74) will be used to describe developments in the surrounding environment.

The first "critical" election in Georgia was held in 1990 when the ruling Communist Party got only 29.6% of votes and forces from national movement came into power. Four parliamentary (1990, 1992[69], 1995, and 1999), four presidential (1991, 1992, 1995, 2000) and three local (1991, 1998, 2002) elections were held in Georgia from 1990 to 2003.

Government bodies elected in 1990 and 1991 were forcedly overturned in the result of 1991-1992 coup d'état. All elections after adopting the 1995 constitution were held within the constitutional time limits and in a relatively organized way. "The governing party won in all the following parliamentary and presidential elections" (Usufashvili & Nodia, 2003).

66 Information bulletin of the Parliament of Georgia, February 6, 2009, http://www.parliament.ge/print.php?gg=1&sec_id=385&info_id=22610&lang_id=GEO.

67 The order of the Minister of Labour, Health and Social Affairs of Georgia #339 as of October 18, 2010.

68 The resolution of the Government of Georgia #373 as of December 8, 2010.

69 In 1992 citizens elected through direct voting the Chair of the Parliament who at the same time should become the Chief of the State. Hence, legislators avoided the need of establishing the legally formalized institute of presidency, though, in fact, vested this position with presidential powers. Therefore we count this voting as a presidential election (Usufashvili & Nodia, 2003).

After the breakdown of the USSR, the economic downturn became apparent in all of the former Soviet republics. The extremely alarming situation was registered in Georgia. Compared to GDP in 1989, it was (in percentage terms) 84.9% in 1990, 67.0% in 1991, 36.9% in 1992, 26.1% in 1993, 23.4% in 1994, 24.0% in 1995, 26.6% in 1996, 29.6% in 1997, 30.0% in 1998 (Tetruashvili & Tetruashvili-Kardava, 2006). GDP per capita (expressed in USD PPP) hit the lowest bound – 1323 – in 1994, doubled in the following decade, reached 2951 in 2003 and then skyrocketed up to 4774 in 2009. It is noteworthy that despite the economic growth the United Nations' Composite Human Development Index has remained almost unchanged for the last 5 years and has varied from 0.679 – 0.698 (the highest value is 1).

In the period from the declaration of independence in March of 1991 to 1993, Georgia suffered from a civil war and two armed conflicts that rendered the social-economic situation in the country even more aggravated. 80-90% of hospital beds available by that time were occupied by the IDPs from Abkhazia and Samachablo (Gamkrelidze, et al., 2002).

In 1991, revenues of the state budget were executed at 78.3% and planned expenditures – at 75.3% (Kakulia & Babunashvili, 2005).

"In 1992 Georgia started to develop the state budget for the first time without intervention from "the center". It was from that time that allotments for the Ministry of Defense and, in general, for financing security, defense and law enforcement agencies were included in the expenditures of the state budget. It is worth noticing that considering the circumstances in the country the adoption of the state budget in 1992-1994 used to be performed by months and by quarters. Moreover, only expenditures of the budget used to be elaborated and determined, whereas the revenues were never adopted. In 1992-1994, during the second stage of a tax system's formation the State Tax Administration was separated from the Ministry of Finance and, by (the second half of) 1993, the Tax Inspectorate of Georgia was established. It was exactly during the second stage, namely in December 1993, that the Parliament of the Republic of Georgia adopted the first package of tax system's laws – in total eight legal acts the goal and purpose of which was to regulate tax administration under the legal framework (Modebadze, 2003).

From 1994, the Government of Georgia had started to restore macroeconomic stability and to build country's economy with the support of the WB and the IMF. In April-May 1995, inflation rate decreased to 1% and the Government of Georgia introduced new Georgian currency – the Lari – with a stable exchange rate against the US dollar. At the same time, drastic changes were occurring in the field of public administration and financing. The number of people employed in the public sector decreased by 30% (The World Bank, 1996).

The second stage of recovery in economy and country's development is associated with the issuance of the decree of the President of Georgia #600 in 1997 "On the main directions for the second stage of the economic reform". Four years later the state initiated the program for social-economic recovery and economic growth[70].

70 The decree of the President of Georgia #89 (March 10, 2001, Tbilisi) "On approving the program for social-economic recovery and economic growth".

According to the Prosecutor General's Office of Georgia, one billion and seven hundred million GELs used to be lost in the country each year (Tetruashvili & Tetruashvili-Kardava, 2006). A persistently low ratio of the revenues mobilized in the state budget to GDP was indicative of the size of shadow economy as well (United Nations Development Programme, 2003): in 1995 the government managed for the first time to collect 12.7% of GDP in total revenues of the state budget (after 1990 when this indicator amounted to 30%). Up to 2004 the highest ratio – 24% – was reached only in 1996 and since then it was declining each year to become 18.8% in 2003. The situation had changed cardinally since 2004 when the record-breaking ratio in the history of independent Georgia – 24.6% – was registered (with the old tax regime). Since then the value of this indicator had steadily increased and reached 36.4% in 2008 by means of the reduction of the number of taxes and tax rates and the toughening of tax administration.

The social tax appeared for the first time in the Tax Code adopted in 1997. The amount of the social tax to be paid to the social fund was set at 27% of wage income payable by employer and 1% of wage income payable by employee. The social tax also incorporated 1% of wage income to be paid to the State Employment Fund (in total 29%=27%+1%+1%). In 2002 the term "social insurance tax" was substituted for the term "social tax" and an employer was obliged to pay 31% (no less than 16 GELs per month per employee) and an employee – 2% of the taxable income to the State United Social Insurance Fund. Despite the disappearance of the tax payable to the State Employment Fund as well as of the health insurance contribution, the total amount of the social insurance tax remained 33%. It can be said that from 2002 the burden of healthcare financing borne by the society has been "blurred" and integrated with overall social responsibility. Since then the issue of financing of health and social affairs in the public policy sector has completely been incorporated in the realm of economic (tax) regulation.

By adopting the new Tax Code, the state substituted the notion of "social tax" for "social contribution" (and reduced its rate to 20%). Along with the income tax (12%) the overall tax burden on labour comprised 36% (e.g. the payment of 100 GELs in wages cost 120 GELs to an employer, the net wage received by an employee was 100-12=88 GELs , i.e. 120-88=32 GELs comprised 36% of 88 GELs given to the employee) (see Figure 4, below). The "social tax" was completely eliminated and only the income tax of 25% was left in the tax regulations. In fact, the tax burden on labour reduced from 36% to 33%. In 2009 income tax was further reduced to 20% in the result of which the tax burden on labour alleviated considerably and comprised 25%.

Figure 4 Payroll taxes by years

TAX	Years					
	1990	1995	1995	2004	2008	2009
Income	20	20	20	12	25	20
Social	37	27+1	31+2	20		
Health Care		3+1				
Employment	3	1				
Tax Burden	76	66	66	36	33	25

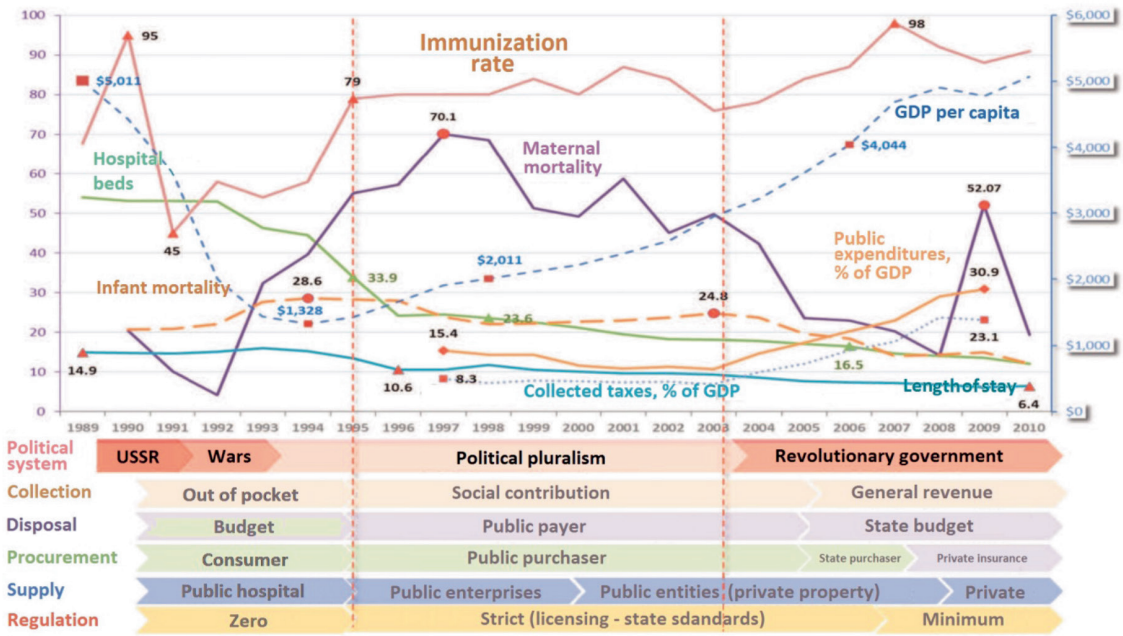
It is estimated that in the result of external migration in 1960-2007 1,639,000 people left Georgia and in the

same period half a million people entered the country, i.e. the balance was negative and equaled to 1,197,000 people. Only in 1992-1996 the negative balance was 745,000 people, of which 72% moved to Russian Federation (Shubitidze, 2011). According to expert opinion, the number of labour migrants from Georgia to the CIS countries only was about 400-450 thousands of people and the aggregate volume of remittances in 2005-2006 varied from 800 million to 1 billion US dollars (Kakulia, 2007). The amount of remittances from labour migrants only in 2010 was 4.8 times higher than in 2003 and and has become increasingly larger than the volume of foreign direct investments (Archvadze, 2011). In the authors view, "nowadays, Georgia is one of the several countries the number of nationals of which in hired employment abroad exceeds (by at least 30%) that of nationals employed locally, in their motherland".

2.3. OVERALL PICTURE

The summary of political, economic or social developments and the dynamics of their impact on population's health or welfare are given schematically on the illustration below.

Figure 5 Major developments



The division of developments into three waves coincides with the changes in the political arena: the first stage was characterized by the "velvet" change of Communists' power, armed conflicts and the collapse of

state governance institutions. The second stage began from the restoration of constitutional order and the attempts for statehood building, against the background of political pluralism and the activation of civil society. In this period the country made a clear choice in favor of the integration with the West and the Euro-Atlantic space and tried to steer country's development into the creation of a so-called "socially oriented" economic system (Kurashvili, 2008). The extent of pluralism in the political system as well as the activity of civil society has diminished since 2004. The ruling political force with a constitutional majority in the Parliament and a concentrated power in the executive branch of the government initiated active reforms and headed to building the state with liberal economy. In parallel to the reduction of government intervention in pubic or market relations the effectiveness of executive bodies has improved dramatically. It is clearly confirmed by a sharp increase in the volume of collected taxes against the background of the reduction of tax pressure: if taxes amounted to 8.3% of GDP in 1997 this figure had increased to 23.1% (see Figure 5, above) by 2009.

The low ratio of collected taxes to GDP in the second stage of changes and its increase may, at first glance, contradict to the principle of liberalization of economy, however in this case the trend indicates not to swerving from the principle of liberal or social economy but rather to state's ability to carry out one of its main functions. At the same time, the high figure of government spending as share of GDP (30.9% in 2009) is, to some extent, out of line with the principles of liberal economy and it would be advisable to reduce it to 25% in conjunction with the decrease in foreign debt and in budget deficit (Bendukidze, 2011).

GDP per capita (expressed in current prices in USD PPP) is used on the graph as the indicator of economic growth. Owing to high growth rate of the economy in 2004-2008 GDP per capita had reached the level of 1989 (5,011 in USD PPP).

The government's regulatory role in healthcare has changed several times in line with variations in the political system and country's development policy: in the period of inertia the government was, in fact, unable to interfere with the evolution of events, 1995-2003 was marked by developing a legal framework and strengthening state's regulation of the sector, which 2-3 years later was replaced by minimum government intervention in healthcare market (like to other markets).

Essential changes were made to the source of financing and to the mechanisms of attracting resources to the financial pool (denoted by term "collection" on the graph) of the system of health and social protection. If starting from 1992 major transactions were made as out-of-pocket payments bypassing government institutions (which is natural when the state lacks both a budget and an actual national currency) then by 1995 social (insurance) contributions had appeared as the mechanism of attracting resources necessary for the implementation of a state policy in the field of health and social protection. The latter was in full compliance with the concept of developing socially oriented economy since financial resources were directed to the stand-alone government agency[71]. Since 2004, the notion of "social contribution" or "social tax" has been gradually eliminated from the sphere of public policy. Instead, the resources needed for implementing the state policy in the aforementioned areas are mobilized in the state budget. The mechanisms and institutions for procuring

71 The government agency (for simplicity referred to as public payer) whose functions and name had changed several times from 1995 to 2003.

respective services have changed as well (since 2008, private insurers have started to procure health services using public funds in addition to other government agencies[72]). The graph also shows clearly that the role of legal entities under private law in providing health services has become apparent since 1999. However it cannot be considered as a total privatization of medical facilities: what changed was only the form of business organization, however the government still owned 100% of medical facilities' shares. The transfer of these facilities to private ownership (privatization) has scaled up only from 2007.

Immunization coverage rate can be used as the indicator of a substandard performance of the health system. Whereas the coverage was 95% in 1990, it reduced disastrously to 45% in the following years and only after 1995 (the year when the restoration of order started and the reforms initiated) it returned to the more or less acceptable level (79%). It decreased slightly in 2003-2005 (for convenience, in the stage of transition from the old to the new system) and by 2007 it had already reached the highest level – 98%.

There are two key indicators – maternal mortality rate and infant mortality rate – that respond with a time lag to the state of soundness (order) of a healthcare system. One or two years later after the breakdown of the healthcare system in 1992-1994 infant mortality rate increased to 28.6 and the value of this indicator has been steadily decreasing since then. Maternal mortality rate hit the highest level – 70.1[73] – in 1997 and has also been gradually decreasing since then.

Two extra indicators – hospitals' bed capacity and average length of stay – denote clearly the trend of optimizing healthcare system's capacity. The volume of infrastructure shirked considerably from 1989 to 1996 coupled with the increase in the cost-effectiveness of inpatient services (average length of stay decreased from 14.9 to 10.6). Since 1996 redundancies in bed capacity have been reducing year by year, though the most impressive improvement in the indicator of cost-effectiveness of hospital beds' usage was registered in 2009 (ALOS decreased to 5 for general hospitals which was much ahead of the average values for the Europe ranging from 6.7 to 9.0).

72 Government agencies in charge of spending of budgetary resources for health and social protection have changed several times since 2003. Provisionally, they are referred to as "public payer" on the graph.

73 To be objective, it should be noted that the increase in maternal and child mortality rates can be partially explained by the improved registration and careful consideration is warranted when it comes to interpreting data within one or two year-long period. In this particular case, it could not be excluded that maternal mortality rates in 1993-1995 would have also been high had the registration and reporting of cases not been as accurate as in 1997. The (large) range of variation of maternal mortality rate in 2005-2010 indirectly indicates that the reliability of the system of routine registration is compromised (however, the steps made by the government in this area, namely the introduction and joint usage of information technologies by Public Registry and the Ministry of Labour, Health and Social Affairs give strong reason for optimism).

3. CHANGES IN THE SYSTEM

When it comes to the analysis of changes in Georgia's social and health protection systems it is necessary to consider two – formal (what was declared or envisaged, and, respectively, put on paper) and real (what happened in reality in spite of how well the duties and responsibilities were fulfilled) - aspects of developments.

3.1. PERIOD OF INERTIA

3.1.1. SOCIAL PROTECTION

If efficiency and equity are considered, formally the social protection model corresponds most closely to the Nordic model. Up to 1994, the system had been functioning in accordance with the legislation pertinent to the socialist state system and cardinal structural changes had not even been made to it yet. However, universal social protection was declared but the expenditures had not met actual needs since 1992. Government's intervention in the labour market was quite strong (a private market as well as official private actors were almost absent) and the state was obliged to take care of universal employment, though due to the 1992-1994 crisis of governance the state was no longer able to fulfill this commitment. As of 1991 and in the later period as well the unemployment rate was very low, though employment no longer enabled workers to maintain a decent standard of living. Though the system of social protection was still in place (providing noncash benefits), but it could not serve its purpose due to the lack of financial resources.

One may conclude that in the period of inertia the social protection system was working similar to the Nordic model, though, in fact, it ceased to exist and no longer had a substantial impact on people's life.

According to the social risks management model existing in the 1990s, all four types of risks (loss of income, health related expenses, burden of childbearing and child rearing, and poverty) were formally covered by the government institutions, though, in fact, the society was involved in its financing by means of social taxes (despite the fact that in 1992-1993 the country almost lacked a state budget).

In effect, since 1992 the social burden had almost completely fallen on individuals and informal mechanisms, on so-called direct social monetary transfers and social services (shelter, care and nursing). With the lapse of time savings and other assets of the society were exhausted making it more and more difficult for the society to bear the burden of social risks management. As a result, poverty and vulnerability of the population increased (the fact that was later confirmed empirically as well (Dershem & Gzirishvili, 1998)).

3.1.2. HEALTH CARE

In 1990-1994, the healthcare system maintained only formally the configuration of Soviet style Semashko model (European Observatory on Health Care System, 2000) and the functions of its financing were distributed as follows:

- Healthcare monies to be accumulated in the health and social fund were collected by the government though the major part of resources was attracted from general revenues of the budget;

- The functions of collection and accumulation of monies were integrated and governed by the Ministry of Health in accordance with the budget adopted in advance;

- Services were not procured. Funds were "virtually" directed to health facilities to cover the only a part of expenses (basically, only salaries and temporary duty travel allowances). As for the rest of expenditures, they were covered "in kind" – medical facilities were provided with drugs, equipment and utilities services by respective state agencies free of charge. One may say that almost no financial transactions were made except for the remuneration of labour whereas other expenses remained "invisible";

- Services were provided by publicly owned and government-financed medical facilities that did not have any level of governing autonomy. In fact, they were ruled from superior bodies of the healthcare system with the strict observance of the administrative chain of command. Health governing bodies determined not only the need in human resources (staffing) but also appointed staff members of facilities. It should be mentioned here that there existed alternative, so-called departmental health services with their own medical facilities, budget and management (e.g. Railway Medical Service).

The healthcare system was utterly centralized. It was governed in a top-down manner, based on orders similar to other fields of national economy in Soviet times.

Despite a sharp decline in the financing of the system, a chain of command and the expectation of directions (executive discipline) still remained in 1990-1994 (and had persisted for several additional years by inertia).

The shortcomings inherited from Soviet times exacerbated in the conditions of growing shortages in state financing and provision. First of all, it applies to patients' informal (and in those times - illegal) out of pocket payments: if in the beginning these payments traditionally served as a source of additional income for medical personnel, then gradually they had to be used for covering the cost of drugs, other pharmaceuticals, items of hygiene, and, sometimes, for covering the expenses on fuel and meals. The share of these transactions had been growing with a disastrous rate and, one could say that, by 1994 current healthcare expenses were completely borne by consumers of services (it had continued for several years by inertia as evidenced by a number of empiric findings). In some cases certain services appeared to be completely paralyzed (e.g. in Tbilisi and other cities ambulance services almost ceased to function). The healthcare market was at its incipient stage and though it tried to close the gap spontaneously, these attempts had no substantial impact on the situation at large.

The collection of funds in accordance with healthcare financing functions described schematically was stopped and monies were directed through informal channels, "via a shortcut", straight to a health care provider.

Consequently, the healthcare system in the period of inertia no longer fit into Semashko model (though retained a "visual" resemblance), activities or transactions were performed in the informal environment, i.e. outside the reach of public policy and administrative measures. The situation was very much like of the chaos and agony of the old state system and there was almost no room for sound market relations.

If the health system assessment framework is used to analyze developments occurring in 1990-1994, one would get the following picture:

THE PURPOSE OF THE SYSTEM (IMPACT ON THE FINAL OUTCOME)

There was no substantial deterioration of population's health, though the increase in maternal and child mortality rates at the end of this period indicated to the inability of the system to serve one of its major purposes;

No assessment of the system's responsiveness was performed in that period and, even if performed, opinions (perceptions) of people who got through several most critical military, political, social or economic crises would anyways never be suitable to get an actual picture;

As for the equity in the distribution of a financial burden, it is evident that at the end of the period the system did not serve its purpose.

IMMEDIATE OUTCOMES OF THE SYSTEM'S PERFORMANCE

Services were provided with excessive infrastructure and medical personnel. It explains a decrease in the occupancy rates of service provision capacities against the background of a decline in the service utilization rates due to a worsening of affordability. The need in maintaining / updating of excessive and inefficiently distributed capacities was a heavy burden for the government and eventually led to the deterioration (exhaustion) of the system. Nevertheless, the system still retained the ability to deliver inpatient, outpatient and specialized health services.

The system failed to cope with the objective of resource mobilization. Notwithstanding the fact that the development of professional manpower and its supply to the system continued by inertia (making the system's operation even more inflexible and uneconomical against the background of a surplus of physicians), the outflow of nurses had already become apparent. The system did not manifest the ability of optimizing resources (and it is not unexpected considering the lack of experience and the shortness of time period).

As for governance, the system retained a strict administrative chain of command, used legal norms developed in the Soviet times and made almost no changes to the mechanisms of administration. The fact for which the system's governance can be credited is that the conceptualization and development of a plan for the system's reorganization (that, in fact, created a theoretical basis for reforms carried out in the later period) started as early as in 1993.

As for financing, the system failed to cope with this function, though considering a general situation, the failure was not specific to the healthcare system but rather was the problem of public administration in all facets of public policy.

3.1.3. CONCLUSION

In the period of inertia (1990-1994), only at the beginning:

- The system of social protection was in line with the Nordic Social Model, the burden of social risks management mainly fell on the government;

- The healthcare system embodied the Soviet style Semashko model in which all functions of financing, service provision, and resource mobilization were accumulated in the public sector and the system was completely centralized.

By the end of this period, there was only an outward (formal) resemblance of both health and social protection systems to their European analogues. In reality, main developments were occurring outside the public policy space where informal institutions along with their limited resources played a decisive role.

3.2. THE FIRST WAVE OF SYSTEM CHANGES

3.2.1. SOCIAL PROTECTION SYSTEM

Based on of efficiency and equity characteristics Georgia shifted "abruptly" from the upper-right ("Nordic") to the lower-left (Mediterranean) quadrant of the typology of European social model. It differed from the other three models by a poverty rate and the low level of employment. In 1995-2003, the poverty rate increased and exceeded half of the population. The level of employment was low (including so-called self-employed rural population working in their own farms);

If one takes into account more detailed criteria of European social models, it becomes problematic to attribute Georgia to the Mediterranean (or any other) model:

- **Officially**, the social protection system in Georgia was concentrated around old-age pensions (despite its low rate of replacement and unconvincing impact on poverty) and based on this criterion it partially matched with the **Mediterranean model,** however dissimilar to the latter, incentives for early retirement were not observed in Georgia. Considering **that in reality** old-age pensions along with other types of allowances pertain more to the measures of social assistance, based on this criterion Georgia **matched most closely to the Anglo-Saxon model**;

- Based on the labour market as well, Georgia's model was the closest match to the Anglo-Saxon model both formally and informally: trade unions were weak, there was no practice of determining wages by means of collective negotiations, also there was a big variation in the amount of wages (especially, if informal wages were considered). Therefore Georgia met all criteria of the **Anglo-Saxon model** for this component;

- The level of employment in this period ranged from 55% to 59% and matched most closely to **the Mediterranean model** that stands out from the other models by a comparatively low level of employment. The actual level of employment (in the informal sector) was higher and, thus, based on this criterion, Georgia could be attributed to the Mediterranean model.

- If one takes into account that the unemployment rate in 15-24 years-old population was not different from the unemployment rate in other segments of the labour force (aggregated) and that in this period it predominantly varied in the range of 10% to 13%, then based on such criterion the social protection system could be attributed to the **Anglo-Saxon model**.

	Anglo-Saxon	Mediterranean
Social Welfare	Actually	Formally
Labour Market	Completely	
Employment		Completely
Unemployment	Completely	
Social Assistance	Formally	Actually

- As for social assistance, only people not covered with social insurance were officially entitled to it. Therefore, Georgia's social protection system, at first glance, fit more into the Continental model. So far as there was no fully fledged social insurance system by that time and the government made certain steps towards it only at the end of the period, Georgia's social protection system did not meet this criterion of the Continental model even formally. Though **officially** the social assistance coverage (if old-age pensions are also counted here) of various groups and categories of population was broad and based on this feature Georgia's social protection system resembled more to the Anglo-Saxon model, but in reality the role of social assistance payments in maintaining population's standard of living was very low. Hence, according to this feature, Georgia's social protection system, **in fact**, got closer to the **Mediterranean model**.

Based on the analysis of individual components of Georgia's social protection system in 1995-2003, it could eventually be said that the system was in between of two European models – Anglo-Saxon and Mediterranean (See figure above) models. By its performance outcomes (in terms of equity and efficiency) the system fit into the Mediterranean model.

At a glimpse, market institutions played a modest role in the social management of risks since they were held financially liable (to pay benefits) only for one type of risk (disability caused by industrial injury / occupational disease). However, if one considers that employers paid 27% of wages in social insurance contributions, the market institutions' (acting as a financing agent) share would seem quite important in government institutions' management of risks by means of a social insurance mechanism.

Figure 6 Brief review of the social protection benefits/schemes by social risks and social protection institutions (1995-2003)

	INSTITUTIONS OF SOCIAL PROTECTION		
RISKS	**PUBLIC**	**MARKET**	**INFORMAL**
1. Loss of income:			
1.1. Old-age	Old-age pension	Voluntary accumulative pension insurance	Reciprocal duties of family members
1.2. Long-term inability to work (disability)	Social pension		Reciprocal duties of family members
1.3. Loss of a breadwinner	Social pension		
1.4. Temporary inability to work	State social insurance benefit		Reciprocal duties of family members
1.5. Unemployment	Unemployment benefit	Voluntary unemployment insurance	Reciprocal duties of family members
1.6. Disability caused by Industrial injury / occupational disease[1]		Employer: monthly allowance + reimbursement of additional expenses	Reciprocal duties of family members
2. Health related expenditures	State healthcare programs		Reciprocal duties of children and parents
3. Burden of childbearing and child rearing	• Maternity benefit • One-time benefit for foster families	Reimbursement of maternity leave	Reciprocal duties of family members
4. Poverty	Social (family) allowance (by categories)		Duties of children with respect to parents

Government institutions were involved in the management of all types of risks (in the administration all of them and in the financing of some of them) except for those associated with the loss of income caused by industrial injuries or occupational diseases or with health related expenses. It is enough to add up the amount of social cash benefits

administered and paid out by government institutions and evaluate the resultant sum relative to the subsistence minimum to arrive at a conclusion that the participation of government institutions was more of a formal nature, whereas in reality the burden was borne by informal institutions.

It should be noted here that it is quite difficult to fit Georgia's social protection system (especially the one existed in 1995-2003) into European models since the cornerstones of all European models are labour that guarantees a decent standard of living ("well being") and a labour market in which relations and interactions among employers, employees and the government determines for the most part the overall configuration (model) of social protection. In the period under consideration the government did not take real measures for developing the labour market except for some (basically formal) interventions in employment. Much of the labour was performed in the shadow economy and simply could not ensure a decent standard of living. This fundamental difference separated Georgia's social protection system from European social models and, as a natural consequence, it is a formality to search for and almost impossible to find the analogue of the system.

It is evident that the development of system of social protection was prompted by the aspiration for the institutional model that almost prevails in Europe (in various forms), but Georgia found itself short of financial resources to meet the needs of the model (and it could not be expected either taking into account the level of economic development). Eventually, this aspiration resulted in an outward resemblance to European models (e.g. by declaring the adoption of principles of universality and high level of social solidarity as a basis of the social protection system) and the system essentially failed to serve its purpose (see details in the annex, Figure 13 The summary of situation in the social sector by 2003", p. 52). Since 2000, in parallel to the attempts to organize a labor market, the idea that it was necessity to get a fundamental understanding of the directions of a social protection system's development and to make a choice among them had matured.

Controversies in visions about the ways of country's development and the organization of social protection system led to the formation of two camps of thinkers and stakeholders – proponents of residual and institutional models. The outcome of their argument[74] was that in parallel with each other (Summer, 2003) the principles of a residual model were reflected in the Economic Development and Poverty Reduction Program and the principles of a conceptually opposite residual model – in the public policy environment, namely in three draft laws concerning social insurance adopted by the Parliament.

3.2.2. HEALTH CARE SYSTEM

In spite of wide variety of developments occurring in the healthcare system in 1995-2003, main parameters of the system clearly came into sight in this period. It becomes evident in the process of analysis of healthcare financing functions.

74 Controversies never got beyond the open exchange of views and reasoning and was an outstanding example of high public interest, participation in decision-making and partnership with the government as regards to social protection policy in the short history of Georgia's democratic development.

The analysis of healthcare financing functions in 1995-2003 reveals the following picture:

- Various financial agents (at first these were the State Health Fund and Municipal Health Funds, afterwards - the State Medical Insurance Company, then for some time – Tax Office, and finally the State United Social Insurance Fund) were engaged in collecting healthcare funds (mandatory health contributions). At the same time funds were collected from general revenues of the state budget; then

- At the initial stage of decentralization, funds were pooled in the State Medical Insurance Fund as well as in Municipal Health Funds and after the decentralization - only in the State Medical Insurance Fund, a sole financial agent. Some of the finances (for public health programs) were channeled to the Public Health Department;

- In the beginning services were procured by the State Medical Insurance Company and Municipal Health Fund and then – only by the State Medical Insurance Company (and later its legal successor) with the participation of branch offices of regional health bodies (deconcentration of functions). Services were procured under the framework of the state healthcare programs, on a contractual basis. Reimbursement mechanisms by these programs incorporated global budgets (number of cases per diagnosis) as well as per-capita financing. Reimbursement mechanisms, service prices or limits of payment were determined by the Ministry (were specified in the state programs). Patients also participated in the procurement of services in the form of co-payment;

- Services were provided by licensed medical facilities regardless of their organizational-legal form and ownership. State public enterprises comprised the majority of service providers. They were turned into private legal entities in 1999[75].

According to the health system assessment framework, the healthcare system in 1995-2003 looks as follows:

THE PURPOSE OF THE SYSTEM (IMPACT ON THE FINAL OUTCOME)

Though there was no substantial deterioration of population's health and maternal and child mortality rates improved and the burden of a number of communicable and non-communicable diseases either increased or remained high. WHO measured the system's responsiveness in that period, though findings of the study were not published (?). Similar to the previous period, the system still did not serve its purpose in terms of equity in the distribution of a financial burden despite the more or less improved regulation of financial flows and the introduction of a basic benefits package.

75 Law of Georgia "On entrepreneurs", article 70; Resolution of the Parliament of Georgia "On changing and amending the law of Georgia "On entrepreneurs", as of February 12, 1999.

IMMEDIATE OUTCOMES OF THE SYSTEM'S PERFORMANCE

The issue of optimization of health care providers remained unsolved: deficiencies in the provision of primary health care services (in terms of both quality and quantity) became apparent against the background of redundant hospital capacities. The pace and scale of optimization in the hospital sector were lower than planned. The volume of the provided outpatient services decreased. The rates of inpatient service utilization/ provision looked relatively better. The role of private medical facilities in providing health care services increased, though their share in a total production of services remained low. If primary health care is not taken into account, the health care system (with the financing available to it) achieved good results in terms of its performance with regard to which a significant improvement was registered compared to the previous year.

As for the mobilization of resources, the system did not manage to reduce the excess of physicians and attain their geographic redistribution. It also was unable to tackle the problem of a catastrophic decline in the number of nurses. At the end of the period, the number of physicians exceeded that of nurses seriously jeopardizing system's quality of performance, cost-effectiveness and sustainability (in the long term).

The system achieved its best results in terms of governance: along with steering reform processes it managed to develop and enforce a serious legal base almost from scratch. Governance bodies appeared in the system: the Ministry of Health distanced itself clearly from the functions of administration and financing of service provision and focused on the implementation of a national health policy (determination of financial flows in the process of elaboration of state healthcare programs, introduction of health regulations and supervision of their observance). At the same time, healthcare governing bodies (including the respective Parliamentary Committee) cooperated fruitfully with other state bodies, international organizations, donors and the representatives a civil society. The processes of decentralization were taking place in the system of public administration of healthcare.

The healthcare system still could not cope with the function of financing. Despite the introduction of innovative schemes the deficit in the budget for healthcare persisted (allotments for state healthcare programs comprised 4.58% of the state budget in 2003 and the annual per capita expenditures on health were 18.35 GELs in the same year), the share of government expenditure in total expenditures on health remained low and the accessibility of health services for the public decreased.

When talking about the model of healthcare organization in the period under consideration it is a common practice to draw parallels with solidarity-based social insurance systems[76] and the so-called Bismarck model. It was not by chance that in the terminology the emphasis was put on mandatory insurance contributions for healthcare (that were accumulated in the State United Social Insurance Fund, in the end). In reality, the healthcare system of that period had nothing in common (except for appearance) with the Bismarck model of social insurance:

76 In that period a strange term – "insurance medicine" – was established in the area of public policy (as a way of survival of the system).

In a well-organized healthcare system based on the principle of social insurance such as in the system existing in Germany (the cradle of the Bismarck model) an insurance contribution implies not only reciprocal duties (benefit, the coverage of healthcare costs in return of a contribution) but also limitations in usage of this insurance confined only to the contributor (as represented by household members).

This model of social insurance is closed and can balance liabilities and contributions. In Georgia everyone was eligible for the basic benefits package, though only a small portion of the population (people employed in the formal sector) was making contributions. Indeed, such an understanding of equity had nothing in common with the model built on corporate traditions. The Bismarck corporate model implies an agreement about prices to be reached on the basis of negotiations among independent actors – insurance funds and hospitals' and physicians' associations, without any government intervention. It creates the opportunity for engaging in and maintaining sound economic relations. In Georgia prices of medical services were set by the Government at its own discretion (excluding the chance to balance liabilities and finances due to political reasons) and health care providers had to sign contracts using these prices and provide medical services. The difference in these two fundamental aspects is enough to demonstrate that the social insurance in Georgia had nothing to do with the Bismarck model.

If one draws on the algorithm of health care financing models (see Figure 29, p. 62), it would become noticeable that the healthcare system in 1995-2003 did not fit into any of the three traditional models (Bismarck, Beveridge, Semashko) and could be attributed to **the model of state social insurance** in which the financing of mandatory plans defined by the government was based on the principle of demogrant (contributions are made by some, though eligible are all) and was carried out using general revenues of the budget (budgetary transfers) as in the Beveridge model. Health care systems of this type exist in the majority of post-soviet countries where WHO or the WB actively cooperated with governments in the process of preparation and implementation of reforms (e.g. Armenia, Kyrgyzstan, Tajikistan, Moldova)[77].

3.2.3. CONCLUSION

In the period from 1995 to 2003 the whole system of healthcare and a big part of the system of social protection was created out of the chaos, so to speak. The state aspired for bringing both of them closer to the traditions of solidarity, equality, universality and well-being inherent to the most advanced European models. It might well be true that there, indeed, were some objective grounds for such an optimism against the background of stabilization and growth of the economy in 1995-1997, however the state's capacities to cope with the financial burden of European models of health and social protection turned out to be much lower than it was required for such an ambition intention. In the end, the country faced two realities: an outward resemblance (on the paper) to the advanced European models of health and social protection and, in reality, ineffective and unstable systems that fulfilled their functions only partially leaving the burden of social risks management to an individual, once again. Only by the end of this period, the state expressed its desire to revise essentially the foundations of social and health protection and choose the most relevant route of development.

77 Unfortunately, there is no convincing evidence about sustainability and effectiveness of the model despite the desire of interested parties to recognize it as successful.

3.3. THE SECOND WAVE OF SYSTEM CHANGES

3.3.1. SOCIAL PROTECTION SYSTEM

If one relies on the official data on poverty reduction and takes into account that social protection schemes do not stifle the desire to be employed, then by the features of equity and efficiency Georgia's social protection system would stand most closely to the Anglo-Saxon model.

The analysis of compliance of Georgia's social protection system of 2004-2010 with European social models gives the following picture:

The system focused on social assistance and considered it as a social safety net. If other mechanisms of social risks management (with minimum government intervention) failed and a citizen found itself in poverty then social assistance would act as his or her ultimate savior. In spite of the fact that there was a considerable increase in the amount of social assistance in that period, it did not match with the subsistence minimum and, hence, was not enough to sustain a basic standard of living. Therefore, the everyday reality completely differed from the formal one. Nevertheless, based on this criterion Georgia's social protection system corresponded to the **Anglo-Saxon model**.

Labour market relations were regulated even to a much lower extent than in the previous period. By virtue of the new labour code, the role of trade unions was further reduced, whereas the share of low-paid jobs remained high. Georgia's social protection system **was closer to the Anglo-Saxon model** by this feature too.

The employment rate in Georgia remained low in 2004-2010, whereas the Anglo-Saxon model differs from other European models exactly by a comparatively higher employment rate. Formally, according to this feature Georgia's social protection system was closer to **the Mediterranean model**.

If one assumes that there is no essential difference among the unemployed by their age, then Georgia's social protection system can be fitted into **the Anglo-Saxon model** by the feature of the unemployment rate.

Finally, social assistance including old-age pensions comprised the biggest part of Georgia's social protection system (since old-age pension in its essence is a type of social assistance) and therefore the latter can freely be attributed to **the Anglo-Saxon model** by even this feature too.

Except for employment, the social protection system approached even closer to **the Anglo-Saxon model** compared to the previous period in the result of changes implemented in 2004-2010. It is noticeable, that a flat rate old-age pension exists also in Great Britain, though such a non-contributory pension i.e. the one financed as a demogrant (out of general revenues) is given to only two categories of residents.

The role of informal institutions in the social risks management did not change. The government entrusted the management of one of the risks – unemployment – to market institutions. As for the risk of temporary inability to work its management was almost completely left to informal institutions (see Figure 7 below).

The principle of managing the risk of burden associated with childbearing and child rearing was changed (pursuant to 2007 law of Georgia "On social protection"). As for the management of risks associated with poverty and deterioration of health the government started to use state programs for the population living below the poverty line and other categories of people.

Figure 7 Brief review of the social protection benefits/plans by social risks and social protection institutions (2004-2010)

	INSTITUTIONS OF SOCIAL PROTECTION		
RISKS	**PUBLIC**	**MARKET**	**INFORMAL**
5. Loss of income:			
5.1. Old-age	Old-age pension	Voluntary accumulative pension insurance	Reciprocal duties of family members
5.2. Long-term inability to work (disability)	Social pension		Reciprocal duties of family members
5.3. Loss of a breadwinner	Social pension		
5.4. Temporary inability to work		Unpaid leave	Reciprocal duties of family members
5.5. Unemployment	Unemployment benefit	• One-month's severance pay • Voluntary unemployment insurance	Reciprocal duties of family members
5.6. Disability caused by Industrial injury / occupational disease[2]		Employer: monthly allowance + reimbursement of additional expenses	Reciprocal duties of family members
6. Health related expenditures	• State healthcare programs • State insurance programs		Reciprocal duties of children and parents
7. Burden of childbearing and child rearing	• Maternity benefit • Allowance for foster families • Non-cash social assistance	Reimbursement of maternity leave	Reciprocal duties of family members
8. Poverty	• Social assistance • Health insurance		Duties of children with respect to parents

When one assesses a social protection system in terms of managing the risk of loss of income due to old-age, it is easy to note that there is no example of social assistance linked only with old-age (with so-called beneficiaries of the pension system and certain categories of labour pensioners) in European countries. Compared to 1995-2003 there was no qualitative breakthrough in the organization of pension schemes in 2004-2010 (as opposed to other components of the social protection system). Only the amount of benefits along with the effectiveness of administration was increased. The pension system was left "up in the air" (similar to the development of the

labour market) during the entire period and not only created a dissonance in the architecture of social system's organization but also became a heavy burden for the state budget.

3.3.2. HEALTH CARE SYSTEM

In 2004-2010 (except for the first year) state resources for health used to be collected completely from budget revenues (the concept of a medical insurance contribution or tax has been eliminated from tax regulations and the legislation since 2005). The collection of healthcare funds in the form of advance payments increased also in the private sector.

Finances to be used for procuring health care services (both through state insurance programs and private insurance schemes) were pooled in private insurance companies. The largest part of state budget's allotments for health was used for non-insurance based state healthcare programs. These funds were accumulated in the Health and Social Programmes Agency for some time and then in L. Sakvarelidze National Center for Disease Control and Public Health.

A part of healthcare services under state health insurance programs was procured by private insurers, whereas the rest of them - by the "disbursing entities" mentioned above (financial agents).

Health care services were provided predominantly by private medical facilities whose share in the provided services was growing year by year.

The analysis of changes occurring in the healthcare system after organizing health financing functions according to the scheme described above clearly indicates that the role of market relations in the implementation of state policy on health had improved[78]. This is true not only for the provision but also, and first of all, for the public financing of health care services.

In line with the liberalization of economy the state's preference in the field of health care was also given to entrusting the responsibility of procuring health services (and of providing them as well) to the market players (insurance companies) that had already got relevant experience. It is impossible to find an analogue of the health care system existing in 2010 in the Europe or to draw comparisons with any of the European models. Parallels can mostly be drawn with the United States since the US Government incorporated insurance companies (and managed health organizations) in the administration of Medicaid program which is the analogue of Georgia's state healthcare program for the population living below the poverty line.

In addition to increasing the role of a health market, the government reduced sectoral regulation to the minimum compared to the previous period.

78 In 2004-2010 there was no comprehensive document reflecting state policy on health published openly.

A health system performance assessment based on WHO modified framework was conducted for the first time in Georgia (WHO, 2009) – 9 dimensions of health system performance were defined and each of them was assessed with indicators.

The assessment showed that population's health had been improving to a certain extent: in the period from 1995-2007 life expectancy improved from 70.3 to 75.1, infant mortality rate was reduced to 14.1 and maternal mortality rate – to 20.2 (though the latter increased substantially – up to 52.07 – in 2009). The assessment report concluded "there is still some way to go to achieve the Millennium Development Goal target for child mortality rate -7.0 and maternal mortality rate – 12.3 by 2015."

In the assessment of certain dimensions of health system's performance the achievements considered as successful were identified with regard to the stewardship function, namely in terms of health system's preparedness for emergency situations and the implementation of an evidence-based policy cycle (including efficient allocation of resources). At the same time regulation of the health sector was assessed as unsatisfactory.

As for functions of allocating health system resources and providing health services, low ratings were given to the optimization of health system infrastructure and technology and to the adequacy of supply of well-trained and motivated human resources in the health sector. The same was true with regard to staff productivity. However, a higher rating was given to the system for the efficiency and effectiveness of inpatient services. Due to a high growth rate of per capita private expenditures disbursed mainly on health, a big attention was given to the performance of the system in terms of functioning of private insurance schemes.

Health system performance received a positive assessment for the improvement of geographic accessibility and a negative one – for the unequal distribution of the burden of the health system financing (this drawback has persisted in the health care system since 1990).

3.3.3. CONCLUSION

The state made a cardinal change and headed for a residual rather than an institutional model of organization of the social protection system, though no clear statement concerning this issue was made publicly[79].

- The notion of "social tax" was substituted for "social insurance contribution" and thus:

  - The government's responsibility to provide social protection to a tax payer, who earlier was a social insurance contributor, was eliminated. After that the government collected taxes unconditionally from citizens and decided on its own how to fulfill its responsibilities in the social field;

79 A coherent policy document on the development or functioning of social protection has been absent so far.

- Tax lost its targeted nature i.e. it was equated with other sources of state budget revenues. Social tax was no more different from income tax in terms of generating social responsibility with regard to a tax payer;

- Later the notion of "social tax" was also eliminated and replaced by "income tax". As for social protection policy there was no mentioning of a social dimension in the reciprocal duties of the state and a tax payer in the realm of public policy. It meant that when state allocated resources on social issues it was simply a good will rather than the action carried out to fulfill any responsibility before a tax payer.;

- The state had abrogated laws of Georgia "On social insurance" before they even entered into force;

- The last and symbolic manifestation of redirecting the system was the abolishment of the State United Social Insurance Fund and the transfer of its functions to the Social Subsidy Agency (later, "Social Service Agency").

The system of healthcare came closer to the system of social protection both conceptually and functionally (the level of "coherence" increased). Moreover, the health system's performance with regard to increasing the accessibility of healthcare by means of health insurance became completely dependent on the tools of the targeted social assistance. A key principle of the residual model of social protection – selectivity – was also reflected appropriately in the healthcare system.

4. SUMMARY

4.1. WHAT HAVE WE GOT?

"The eyes are similar, aren't they, sir? ... Yes they are. The nose is similar, isn't it, sir? … Yes it is! What about lips and chin? … Aren't they similar?. Yes they are alike. What do you want from me, then? … It is not my mother-in-law, whatsoever … "

The dialogue from the movie "Unusual exhibition"

Georgia tried for 20 years to change the Nordic model (characteristic to social-democratic regimes) inherited from Soviet times firstly by conservative (distinguished by social insurance) and then by the Anglo-Saxon model. The society that perfectly remembered the taste of social welfare of the the Soviet era had to experience the benefit or bitterness of completely different systems of organization of health and social protection. It is next to impossible to find another country that will be similar to Georgia in terms of such a big range of changes in the field of health and social protection.

In 2002-2003 the government faced the choice: to continue its movement towards developing socially oriented (welfare) state or discard the dream inappropriate for the country's economic development and be content with much modest system of social protection characteristic to a liberal model which, first of all, would not hinder economic development and would bring actual benefit to the society considering available resources.

The choice has been revealed since 2004 by the actions of authorities which redirected abruptly the development of the social protection system from an institutional to a residual model of organization.

This redirection was abrupt but not full-fledged: one of the major components of the social protection system – "old age pensions" – was still left intact in terms of the amount of consumed resources, number of beneficiaries and public interest, thus creating a huge dissonance in the architecture of the new system.

In the result we have got the social protection system one half of which has gone to one extreme and the other has been lost in space and time. It is not by chance that pensions are insulated from social protection (though in reality pensions are integral part of social assistance) on the graph (see Figure 8, below): otherwise it would not be possible to make it clear where the starting point of the evolution of the social protection was and where it has arrived. If old-age pensions are excluded it becomes possible to track the trajectory of a "journey" of Georgia's social protection system towards one or another European model. This is the movement from the Nordic (social-democratic) model to the conservative (pertinent to continental Europe[80]) and then to the Anglo-Saxon model. The trajectory of "evolution" of Georgia's healthcare system is even

80 According to Esping-Anderson typology the Mediterranean model falls into the category of conservative regimes.

steeper: it shifted abruptly from a conservative (social insurance) model towards a liberal one, more specifically towards the model based on a free market (i.e. moved ahead of the social protection system in terms of decommodification).

Figure 8 "Evolution" of health and social protection systems in Georgia

What we denoted by the term "pensions" on the graph to imply old-age pensions is not essentially the old-age pension or the social assistance. Therefore, it is not possible to categorize the social protection system according to plans' topologies:

- The design of an old-age pension plan did not change from 1995 to 2010. Changes were made only to the amount payable and to the logic of revising this amount, which was first linked to market liberalization and then mainly to political cycles.

- During the first wave of changes (1995-2004) the old-age pension plan:

  - initially was perceived as a PAYG (intergenerational solidarity) social insurance mechanism that should maintain a sizeable standard of living if not from the beginning to the end at least starting from the moment of losing income due to old-age. Since the replacement rate was very low, the old-age pension, in its essence, diverged considerably from its intended status.

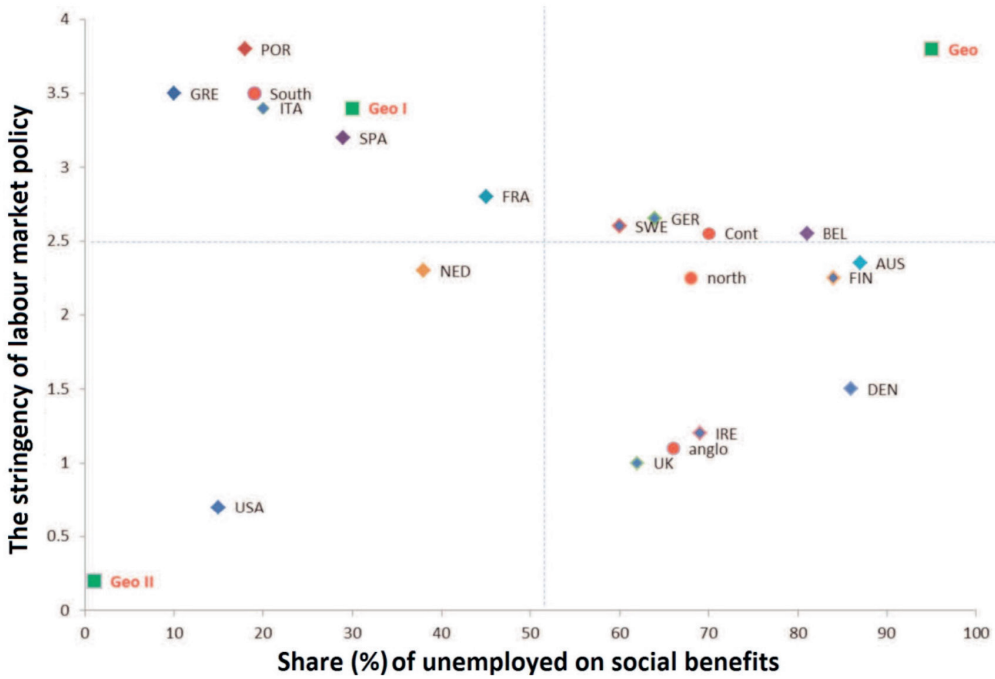
  - later was counted as one of the main tools for poverty elimination i.e. as a social assistance scheme (financed by social insurance contributions in addition to funding from general budget revenues). However, its impact on poverty reduction was insignificant due to its universal nature (see Figure 31, p. 62).

- During the second wave of changes (2004-2010) the old-age pension plan assumed the form of social assistance and its source of financing changed (general budget revenues – i.e. in this regard it became a demogrant). However, under the new configuration, it was no longer in conformity with one of the fundamental principles of the system – selectivity. Social assistance was given to those who cannot manage the social risk – "poverty", i.e. it was selective and targeted in nature, whereas the old-age pension covered all people who reach pensionable age.

This divergence in time and space (from system's perspective) of old-age pensions is not simply an issue for an academic debate. The existence of old-age pensions in such a form is very costly for the country and puts the system's development under a serious threat in terms of its sustainability and residual organization.

If we consider the approaches by which the place of the Baltic states (Paas, et al, 2004) and the new EU members (Rovelli, 2007) was determined in European social models as well as the classification of European social models based on state labour market policies (Bertola, et al., 2001) then we will have to place Georgia in a separate column (see Figure 38, p. 79).

Figure 9 Social protection systems of the EU by the level of protection from the uninsurable risks of a labour market



Source: (Rovelli, 2007), adapted by the authors.

The graph presents the distribution of countries by two main features of a labour market – the legal protection

of employment rights (strictness of legislation/regulation) and the level of social protection of the unemployed, and the place of Georgia in this framework (green rectangle, Geo – the beginning of the period of inertia, Geo I – the first wave of changes, Geo II – the second wave of changes). The illustration (see Figure 9, above) shows that Georgia shifted from the upper-right quadrant in the opposite direction to the lower left quadrant and moved ahead of the US and diverged from all EU states (15) in terms of liberalism and the principle of residually.

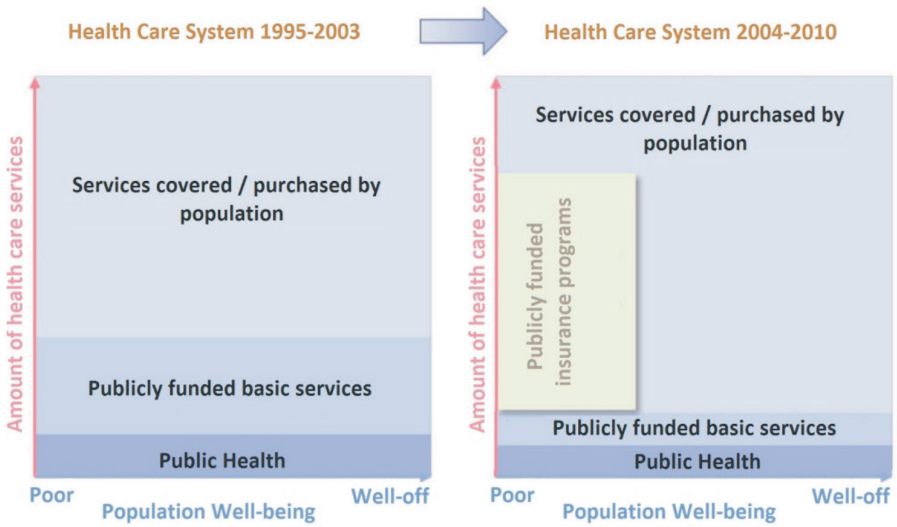
The healthcare system turned to be less "susceptible" to the eclecticism pertinent to the social protection system's organization: no longer there is an ostentatious façade in the system, everyday reality almost coincides with the one on the paper; however, system's critical components themselves are not yet well-balanced (institutional underdevelopment of the healthcare market is one of the noticeable illustrations of such a situation) and only at the level of assumptions it is possible to talk about system's desirable or final configuration.

The examples of imbalances at various levels of the healthcare system are as follows:

COMPONENT/LEVEL OF THE SYSTEM	DESCRIPTION
Sharing of responsibilities for health care (between the state and the society)	The state has clearly confined its responsibility to ensuring pubic health care (and has fulfilled this responsibility it in a due manner), though the society jas not understand to full extent the weight of burden placed on its shoulders as evidenced by inadequate expectations and behaviors (the failure of the so-called the "5 GELs insurance" program is one of the examples). In the end, official distribution and understanding of responsibilities are not equal.
Distribution of roles in the health care market	The influence of different players on the market is asymmetric (a universally recognized feature of health market). There are no actors protecting users' (patients') rights or expressing their rights. The same can be said about health care providers. It is best evidenced by the (irrational) pattern of health care utilization (unnaturally high expenditures on drugs, low share of outpatient services, ratio of nurses to physicians).
Professional responsibilities and patients' rights	The quality of (medical) services is not influenced by self-regulation mechanisms of medial professions (professional associations, internal quality assurance of health care providers), neither by a qualified purchaser of services, and nor by the state (the high rate of C-section deliveries – 14.4% in 2005 (Serbanescu, et al., 2009) and 23.9% in 2009 (UNICEF, 2010) is a good illustration of this assertion).

The most essential thing that we eventually got was a clear articulation of state's responsibilities in terms of ensuring the accessibility of health care services for a certain group of population and addressing certain health problems for the entire population. The balance was reached between commitments and available resources.

Figure 10 State responsibilities in health care by the well-being of population and the volume of provided services



It is quite understandable that many people might be dissatisfied with the volume of state responsibilities in the field of health care (and with the amount of resources allocated to fulfill them). It is natural for the sound process of public administration to discuss this issue publicly and give priority to health care in the government's agenda. Most importantly, clear mechanisms linking outcomes and resources have emerged in the system. The situation in which government expenditures on health are less than desired by many people is not a shortcoming of the health care system but rather the outcome of a current practice of public policy decision-making (determination of priorities). Current system gives better opportunity to calculate what additional benefits the doubling of state budget's allotments on health will bring in. However, it was difficult even for a person with an expert knowledge of the system to guess in 2010 the answer to a simple but fundamental question what these doubled resources would be used for - e.g. to increase the number of poor people covered with current commitments, or to expand current commitments for a target population that was already covered, or to increase the production of a public good (e.g. promotion of preventive health care measures) (yet another example of a problem with balancing the system).

4.2. WHY IT HAPPENED?

Is it possible or not to change the social protection system twice and, furthermore, in two completely opposite directions in 20 years? Alternatively, how it can be that the social protection system is so eclectic?

Why it happened that completely opposite systems of social protection emerged in a short period of time?

Decades are needed for the development of a social protection system when it emerges naturally (based on evolution). At least 5-10 years are needed to correct or accelerate the development of its certain component (considering the sluggishness of pension systems, it may require a generational change).

Can such a quick rearrangement and the eclectic nature of the social protection system in Georgia be explained by the fact that the system was not established neither during the first wave nor during the second wave of changes but rather what happened was the imitation – a construct was built that resembled a social protection system only by appearance but not by its actual content?

To answer this question let us go into details of the essence of social protection systems in those countries where the system emerged naturally, based on evolution.

Imagine a grown-up who was provided with human capital by his or her family, the social-cultural environment and the systems of education and health care.

What is needed to convert human capital into the means of a person's well-being?

Let us assume that three ingredients of a person's well-being are: finances (money), mental and physical health (wellness), and human relationship (sharing of warm feelings, care, and so on).

Let us assume that one of the ingredients of human capital – metal and physical health – has already contributed to a person's well-being. Two ingredients – finances and relationships – are still missing.

An individual can obtain finances needed for his or her well-being only by selling labour. To sell labour there should be such a labour market where the individual can get decent (from material point of view) earnings needed for living in exchange of labour sold. In order to transform human capital into material earnings through the labour market, it is natural that economy (business) should exist.

This means that it is decisive for a person's well-being that there is such a labour market where selling of labour makes it possible to get decent earnings for living.

To put it differently, material basis for a person's well-being in any country is linked with a labour market proper functioning of which is exactly what determines prosperity of developed societies.

Is it possible for people in Georgia to earn living and maintain dependants (family members) by means of labour?

Whether or not the labour market in Georgia allows a person to get enough earnings for subsistence or decent living depends on many factors (labour demand by economy's stage of development and profile, institutional

organization and the level of development of the labour market and etc.) and their consideration for the systemic analysis of Georgian labour market is a topic for a separate discussion. To measure the properness of functioning of the labour market we limit ourselves by a single feature (which will reflect not only the institutional organization of the labour market but also the condition of national economy).

Employment (wage) income received during the first wave of changes did not allow maintaining a decent standard of living, neither it allowed escaping poverty. The situation did not improve substantially during the second wave of changes: in 2010 the subsistence minimum for the average consumer amounted to 118 GELs per month, whereas monthly income from labour (including income from sale of agricultural produce) equaled to 81 GELs, i.e. 68% of the subsistence minimum!

It appears that the labour market in Georgia did not serve its purpose in terms of attaining societal well-being (monetization of human capital) – only selling labour could not sustain one's living (needless to say a word about a decent standard of living). A massive labour migration (selling of labour on other countries' labour markets) and the inflow of remittances after attaining independence are indicative of this observation.

What was the original function of social protection in countries, where selling of labour ensured a decent standard of living?

It had the sole function – to prevent the worsening of a person's standard of living when he or she was unable to sell labour on a labour market, i.e. the system of social protection was required to replace temporarily (or permanently) the labour market when selling of labour would not be enough to maintain a decent standard of living or a person would no longer be able to work.

In such a society, there was a primacy of a labour market for ensuring a person's well-being, whereas social protection served as a backup mechanism.

This principle is followed strictly in all European or other developed countries. What differs is only the mechanism. In these countries the system of social protection was gradually built upon a labour market to prevent a person from falling into poverty (e.g. Anglo-Saxon model) or enable him or her to maintain a decent standard of living (conservative and social-democratic models) in case of failure in selling his or her labour.

In a certain stage of development, the role of a social protection system increased, especially in Europe: in addition to the function of replacing a labour market, the system was charged with a new function of reducing social exclusion (marginalization).

Schematically it looks as follows: by participating in public life a person acquires social capital and enters into relationships as a full member of the society. Due to some material problems or other reasons he or she may no longer participate in public life, lose circle of contacts and be excluded from society.

If a person, regardless of the reason (though it is often associated with material standing), is unable to accumulate social capital in due time or loses this capital later and finds himself or herself excluded, then a social protection system will try to replace social relations and integrate the person into society. Due to ethno-psychological and cultural specificities, this function of a social protection system has had different appearances in European countries.

For the moment, it is too early to talk about this function of social protection in Georgia.

It turns out that both attempts to build social protection systems in Georgia were made in the presence of such conditions on the labour market (and in the economy) that labour was not enough to sustain one's living. Hence, both times, the burden that was unbearable for a social protection system of any developed country automatically fell on the shoulders of social protection.

There was no foundation for the emergence of the system of social protection in Georgia. If the main system – the labour market – was not serving its purpose then the backup system would by no means be able to do so. In other words, the time has not yet come for the emergence of modern, European style social protection systems in an evolutionary way.

Certain structures (not a whole system) of social protection were created in Georgia, artificially rather than gradually, at the will of the state and without any foundation. Regardless of external similarities, the actual social protection system that would serve its main purpose was not established in 20 years. Instead of this only the façade of a social protection system –a much lighter structure than the one built upon and rooted in the labour market, was created. Therefore, it is perfectly possible to dismantle a light structure and construct a new one in a short period of time the way that one of the sizable parts of the façade (pension plan) will remain intact.

The answer to the first question, whether or not it was possible to develop completely opposite social systems in 20 years is as follows:

Yes, it was possible, since there was only an imitation of a social protection system in Georgia. The situation will remain so until the labour market will be formed and people will be able to sustain their living (at least) and attain material well-being by means of labour.

It is not at all surprising that the whole review of Georgia's social protection system based on (the typology of) European social models was devoted to the search for its resemblances with rather than to its actual ascription to one or another social model. It will be possible to attribute Georgia's social protection system to one or another European model only after the labour market formation. Currently, save pensions, the social protection system meets the requirements of the society and economic development:

- It is no longer a burden (in the form of social taxes or contributions) for the economy and, specifically, for labour and it no longer poses a threat of spreading shadow economic (labour) relations;

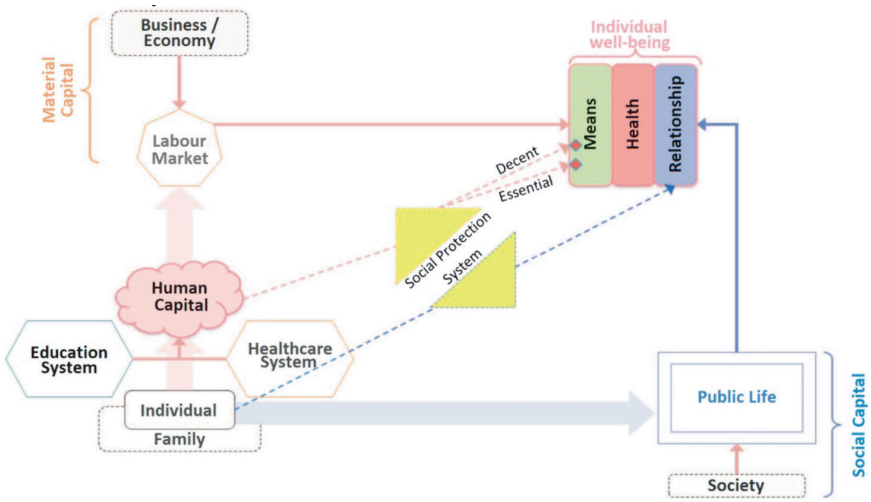
- It alleviates hardships of the extreme poor who are not able to earn their living by supplying their labour.

WHAT ARE THE REASONS FOR GEORGIA'S SOCIAL PROTECTION SYSTEM TO BE ECLECTIC?

The architecture of a social protection system is completely determined by characteristic features of a labour market and specificities of public life (which reflect values and norms of the society):

- The labour market determines the **objective** of social protection and the relation between the system of social protection and the labour market. The labour market is a foundation for the system of social protection;

- The society, its structure, lifestyle, and values determine the mechanisms of social protection (i.e. how social protection should meet its objective, how collective i.e. common resources should be collected and utilized). The societal tissue is what determines the "walls" of the system;

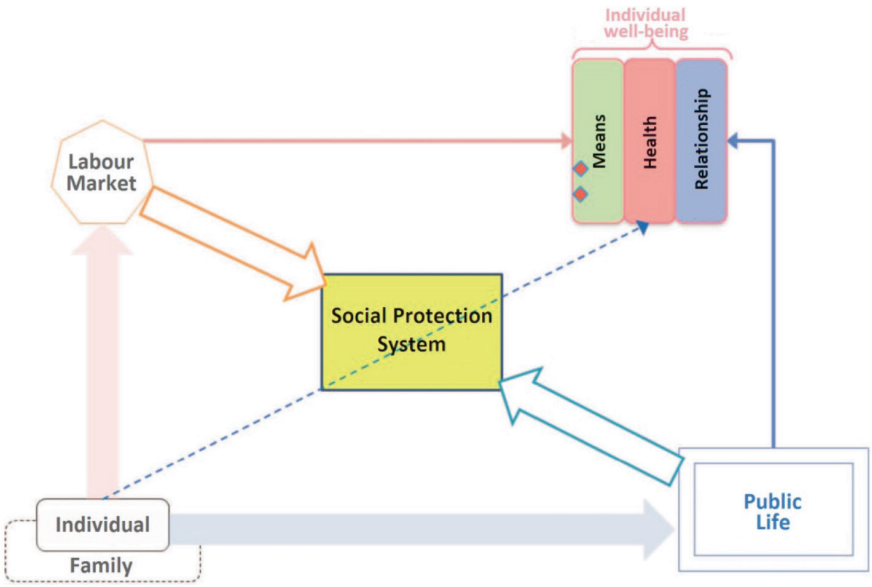


There was no labour market, i.e. a reference point for system's formation, during the first and the second waves of changes in Georgia.

During the first wave of changes even no one studied public values and expectations, e.g. what a person's well-being or solidarity meant for Georgian society; or whether a person's well-being was a collective responsibility or an individual responsibility. The building of the system was going on under the slogan of social insurance so that no one knew in reality how much of a solidarity burden the society was ready to bear and what the society wanted in return for contributions made to a common moneybox. The same could be said about the second wave of changes – system's organization was based rather on the belief that such an arrangement was the best one and was needed by the society (or since it resembled a certain European model it brought us closer to Europe) than on some evidence.

To explain the eclecticism it is enough to note that when the system, in its essence, is just a façade based on a non-existent labour market and established in a hurry ignoring the societal factor it will never be organic (intimate) for the country and will never be balanced.

WHY THERE EMERGED A LACK OF BALANCING IN THE HEALTH CARE SYSTEM?



The lack of balancing should not be considered as a shortcoming of the selected organization (model) of the system. The reason is hidden in the "technological process" rather than in the system's configuration as such.

The gradual evolution of any public system means that critical components of the latter are balanced. The risk of its disintegration emerges when the system is developed or changed rapidly, i.e. artificially.

Historically, in countries where market relations with minimal government intervention served as a basis of models of healthcare systems were developing with a "bottom-up" approach.

Gradually market relations were evolving and redistribution of powers was taking place leading to a balance of powers, as the market matured. The government used to intervene only in such cases, when an "external force" was necessary to reach a balance, i.e. the distribution of roles among the government, the market and the society was taking place naturally and this process was changing periodically as a new reality emerged (e.g. as in the US in the 70s, when federal and state healthcare programs Medicare and Medicaid were established).

The current system of healthcare in Georgia was established with a "top-down" approach: responsibilities were handed over to the market and the society by the government so that the latter neither explained clearly its intentions nor calculated how prepared market and social (informal) institutions were first to understand the weight of the burden and then to bear it. A top-down reform may not disturb the balance if a state healthcare system with a vertical administration is created (given that this balance is provided for in the design). When the system of healthcare based on market relations is created on initiatives coming top-down it is inevitable and natural that imbalances will emerge.

4.3. CONCLUSION

During 20 years of independence, Georgia has tried to build two completely opposite systems of health care and social protection out of the ruins of the system inherited from soviet times (what was in line with a general direction of state development).

None of the systems merged naturally with government, market or social institutions.

Despite successful functioning of certain components, it is possible to search for systems' analogues in the developed Western world or to find similarities with some European models only by external features rather than a content of the systems.

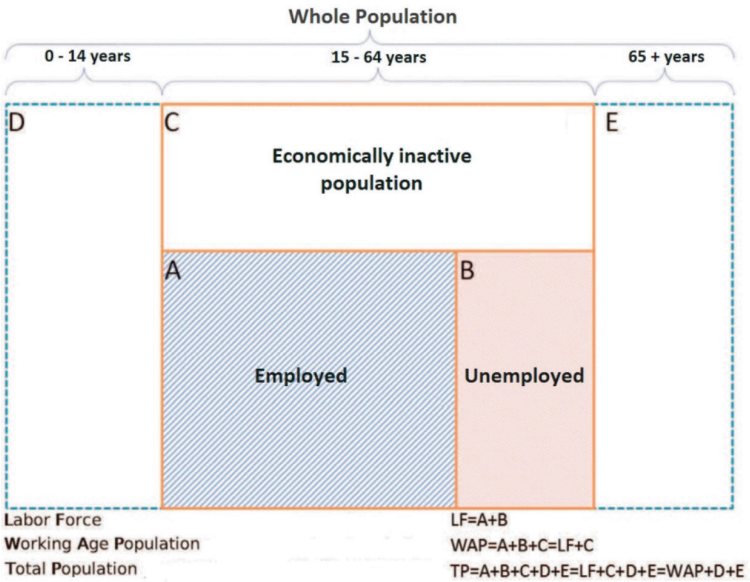
It is paradoxical but true that the development of institutions of the labor market - the central link connecting economic and social systems and the foundation of a solid, sustainable and effective social protection system - has been ignored in the public policy environment against the background of changes of governments and courses of state development.

ANNEXES

Figure 11 Definition of terms

Economically active population	All persons of either sex 15 years old and older who are engaged in economic activities or are unemployed The same as Labour Force On the graph, below: LF=A+B
Economic activity rate	Percentage share of economically active population in the national population of the same age range. The same as labour force participation rate or labour force activity rate or labour force activity rate On the graph: (A+B)/(A+B+C) or LF/WAP
Labour force rate	Percentage share of economically active population in the whole population On the graph: A+B/A+B+C+D+E or LF/TP
Employed	People 15 years-old and older who are engaged in economic activities On the graph: B
Unemployment rate	Percentage share of the unemployed in the economically active population On the graph: A/(A+B) or A/LF
Maternal mortality	The death of a woman at the end of pregnancy (after 28 weeks of gestation), during labour and delivery and in the puerperal period (during 6 weeks after the parturition)
Infant mortality	The ratio of the number of deaths of infants under one year of age to the number of live births; it is the probability of death of an infant during his or her first year of life.
Life expectancy at birth	The average number of years that a person from a generation of newborns is expected to live provided that age-specific death rates of a given period will not change.

Figure 12 Main provisions of the National Health Policy of Georgia



Main areas of health sector reorientation:

Criteria of the new healthcare system:

- Should be in line with main directions of country's economic development;
- The workload should be balanced with human and material resources;
- The system should become manageable and serve the purpose of efficient use of resources.

Main areas of system's reorientation:

- Development of legal basis for the new health system;
- Decentralization of health care administration & management;
- Development of new economic and financing mechanisms, moving toward program financing;
- Prioritizing Primary Health Care;
- Reform of Sanitary and epidemiological service;
- Introduction principles of Health Insurance;
- Social protection of the medical personnel.

Figure 13 The summary of situation in the social sector by 2003

1 14% of population lives in extreme poverty (income/expenditures per equivalent adult <52 GELs/ month), and more than a half – in poverty (The World Bank, 2002);

2 Income from employment (wage income) not only does not ensure a decent standard of living but also does not allow escaping poverty (so-called phenomenon of "employed poor" see Figure 14, p. 50). Median consumption per equivalent adult is less than the official subsistence minimum (State Department of Statistics of Georgia, 2002);

3 A large part of the labour market (<-60-70%) is in the extralegal space (Rashid & Rutkowski, 2001), mainly because of high labour costs due to social taxes (Lindeman, et al., 2000) (The World Bank, 2002);

4 The ratio of social taxes ("contributions" to social benefits) is inadequate – there are not enough incentives for legalization of income (The World Bank, 2002). While Georgia stands much ahead of the most developed countries in terms of the ratio of a pension insurance contribution to a total cost of labour, it lags behind of the least developed countries in terms of the replacement rate with regard to the average per capita income (8% according to 1997 data) (The World Bank, 2000);

5 The amount of benefits (social, labour and disability pensions, social allowances) paid by the state (public) social protection system is very low (≈6.4 USD per month) and stands far below the level needed for pulling a pensioner out of poverty, i.e. it does not serve even the basic function of a protective mechanism, however they comprise 31-36% of state budget expenditures and ≈2.4% of GDP (The World Bank, 2000);

6 "In its current form [Georgia's pension system] meets none of the objectives of public pension systems: neither it prevents from poverty in old-age nor it preserves a consumption level after reaching retirement age. Georgia confronts a serious problem – it should develop a new pension system that will serve both of these purposes and, at the same time, promote economic development" (The World Bank, 2000);

7 The ratio of the number of social taxpayers to the number of beneficiaries is around 0.8-0.9. Under the current system a considerable part of economically active population (≈ 1.2 million people (farmers, self-employed)) does not/cannot participate in covering social expenditures;

8 State liabilities (social/labour pensions) to people amount to 225 million GELs (200 million GELs in "frozen" arrears and 25 million GELs in current arrears);

9 Because of pension arrears the public's level of trust in government (especially the trust of those participating in the mandatory social protection scheme) was low making it even more unreal that people will entrust their old-age security to the government in the long-term;

10 There is a trend of population aging;

11 The considerable part of the burden of social protection rests on the family institution (The World Bank, 2000), that is characteristic of a great majority of low-income countries (Norton, et al., 2001);

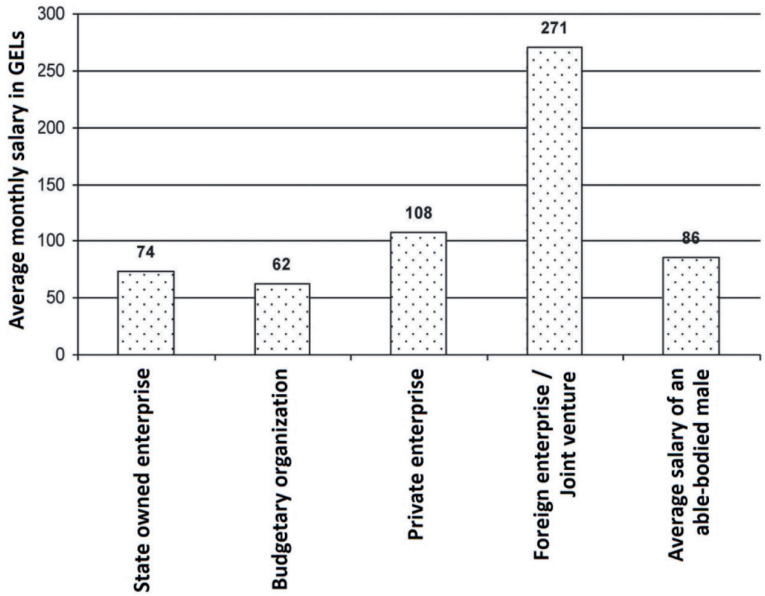
12 In the conditions of the low growth rate of economy the share of vulnerable population (households) is increasing (the probability of falling into poverty in case of realization of certain risks);

13 The official number of people in hired employment comprises 39% of economically active population (according to data for 2000 (The World Bank, 2002)), among them 2/3 are employed in a public sector (government-funded or public enterprises) (The World Bank, 2000). The share of employed in small enterprises comprises 40% (Mitra & Stera, 2003);

14 More than 80% of self-employed (61% of economically active population) are engaged in rural employment (State Department of Statistics of Georgia, 2002);

15 The variance (inequality) of salaries in hired employment in Georgia is very high even compared to countries with transitional economies: 25% of hired employees receive less than 2/3 of the median salary, and approximately 32% receive 1.5 times more than the median salary (Rashid & Rutkowski, 2001).

Figure 14 Mean monthly salary of hired employees, 2000



Source: State Department of Statistics of Georgia, 2002)

Figure 15 Initial plan of hospitals' renewal ("100 hospitals' plan")

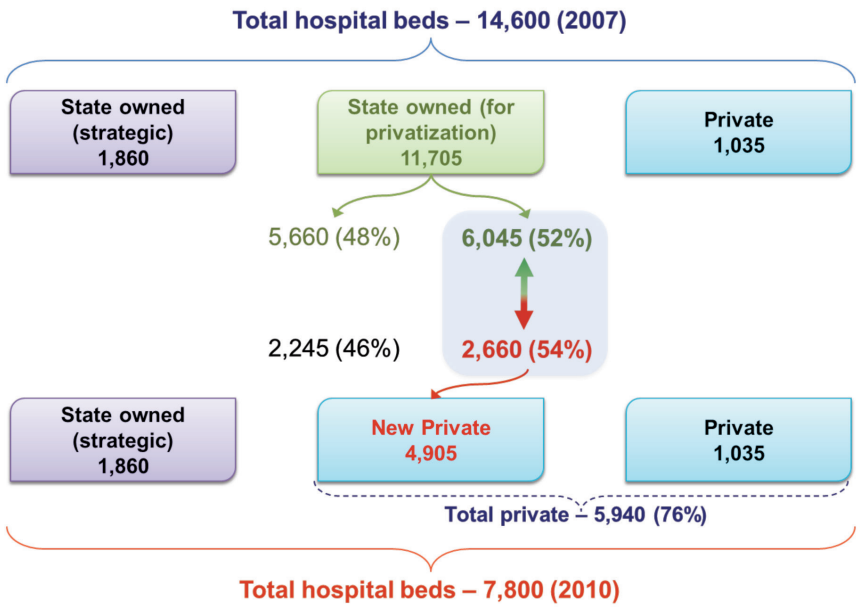


Figure 16 Revised plan of hospitals' renewal

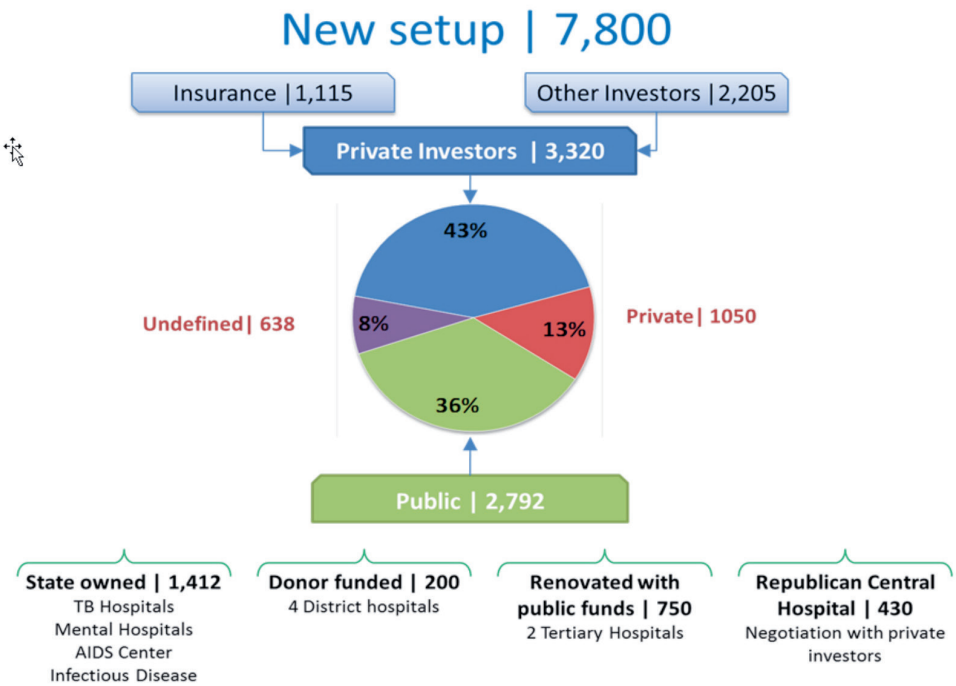


Figure 17 Comparative description of institutional and residual models of social protection

	INSTITUTIONAL MODEL OF SOCIAL PROTECTION	RESIDUAL MODEL OF SOCIAL PROTECTION
The goal of social protection	Provision of social welfare is one of the cardinal functions of the society. The state that is oriented on institutional social welfare aims at securing a decent standard of living of its citizens and gives an unconditional guarantee of full implementation of civil rights	Public social welfare kicks in when natural mechanisms of support – family, market and charity, cannot (do not) fulfill their function any more. The basis for a government action is hardship (the need) rather than civil right of an individual. The state provides social protection of the poorest population only and this assistance is brought to the level of a vital necessity. If an individual lives above the poverty line his or her social protection is not recognized as a function of the state. The state is only the remedy of last resort.
Approach to employment	Full employment when the state acts as a "primary employer". The right to employment is guaranteed by the concept of citizenship of a social state. This concept implies active government interventions so far as the right to employment is institutionalized and does not depend on a labour market.	Minimal government intervention with the focus on a labour market. The state acts as "the highest authority of appeal".
The basis of social protection	Universality	Selectivity
Effectiveness	The high or very high number of satisfied demands	The variable (usually, low) number of satisfied demand.
Correspondence with a policy objective	Excessive consumption of resources	Effective consumption of resources
Administrative costs	High	Low
Expectations with regard to public expenditures	Requires relatively bigger government expenditures	Places a relatively low burden on the state budget
Social expenses and social benefits	The absence of stigma; Promotes social integration and applies to everyone on an equal basis	Considerable stigmatization; There is a social segregation Fair redistribution
Values	Collective values The state provides social protection to compensate for unfavorable outcomes of market relations	Individualistic values
Coverage	Producing services and ensuring universal accessibility to them. The emphasis is put on a social right of all citizens to get publicly provided services regardless of their individual needs (civil right).	Producing services and ensuring accessibility to them for those individuals who meet defined criteria – experience hardship.
Connection with poverty	Relative poverty	Absolute poverty
Philosophical foundation	Collectivism, egalitarianism	Individualism

Figure 18 European social models (Sapir, 2006)

PARAMETERS	ANGLO-SAXON	CONTINENTAL	MEDITERRANEAN	NORDIC
Countries	Ireland Great Brittan	Austria Belgium France Germany Luxembourg	Greece Italy Spain Portugal	Denmark Finland Sweden Netherlands
Social protection / Universal coverage	Social allowances for all as a means of last resort	Population is covered by social insurance benefits and unemployment	Focuses on old-age pensions, the amount of and coverage with benefits are segmented; early retirement is encouraged	Universal coverage / social welfare; large expenditures on social protection
Labour market	Weak trade unions; large share of low paid employment, big variation in wages	Strong trade unions; wages are subject to collective bargaining	Wages in formal sector are subject to collective bargaining though the share of informal transactions in the labour market is big	Large-scale financial interventions in a labour market; strong trade unions and uniform wages
Employment	High (72%)	Average (63%)	Average (62%)	High (69%)
Unemployment (15 24 years-old)	Low (13%)	High (34%)	High (40%)	Low (10%)
Social assistance	Quite sizeable	Only for people not covered by social insurance	Minimal	Sizeable

Source (Sapir, 2006)

Figure 19 The four European models: a typology

		Efficiency	
Low		High	
Equity	High	Continental	Nordic
	Low	Mediterranean	Anglo-Saxon

Source: (Sapir, 2006)

Efficiency – is defined by incentive to work and is manifested by employment rate: as efficiency goes up so does the rate of employment.

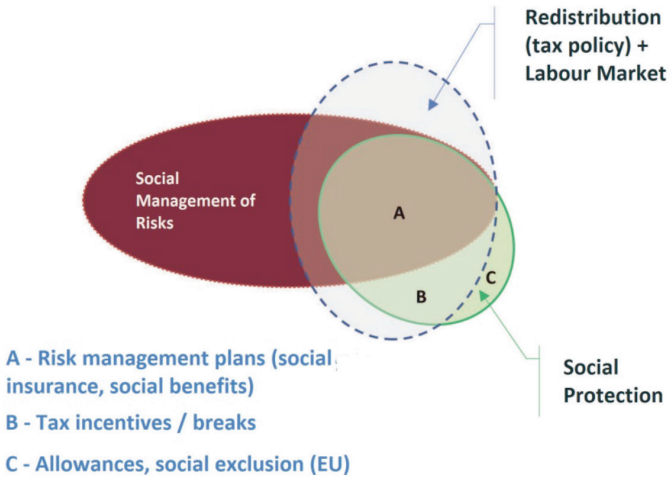
Equity – is defined by the level of poverty and is manifested by the risk of falling in poverty: as equity increases the risk of impoverishing goes down

Figure 20 Definitions of Social Protection

AUTHORS	DEFINITION	CONCEPTUAL EMPHASIS
ILO	1. The provision of benefits to households and individuals through public or collective arrangements to protect against low or declining living standards 2. The protection which society provides for its members – through a series of public measures – against the economic and social distress that otherwise would be caused by the stoppage, or substantial reduction, of earnings resulting from sickness, maternity, employment injury, unemployment, invalidity, old age and death; the provision of medical care; and the provision of subsidies for families with children 3. The aim of social security is to provide assistance, financial or otherwise, in the event of loss or reduction of income	Insurance and extension of provision to those in the informal sector
WB	Public measures intended to assist individuals, households and communities in managing income risks in order to reduce vulnerability and downward fluctuations in incomes, improve consumption smoothing and enhancing equity	Risk management which frames social protection as both safety net, and spring board through human capital development
ADB	Social protection refers to the public actions taken in response to levels of vulnerability, risk and deprivation which are deemed socially unacceptable within a given polity or society	People are vulnerable to risk without social protection; deleterious effect of the lack of social protection on human and physical capital.
ODI	Social protection refers to the public actions taken in response to levels of vulnerability, risk and deprivation which are deemed socially unacceptable within a given polity or society	Contextually specific understanding of vulnerability and deprivation. Social protection is targeted at the poorest and most vulnerable.
Danny Pieters	The protection society provides for its members against the threat of economic loss and of specific costs through a process of social solidarity	Solidarity (against individual measures of protecting against risks)
Sabates Wheeler &Macauslan	The range of public, private, formal and informal measures that address actors' (individuals', households' and communities') vulnerability to outcomes that negatively affect their well-being (typically defined in terms of consumption and income)	Range of measures by institutions and vulnerability to negative outcomes (risks)

Source: (Sabates-Wheeler & Waite, 2003) – adapted by the author

Figure 21 Social protection, social management and redistribution of risks



Source: The World Bank, 2000, adapted by the author

Figure 22 The components of a social protection system

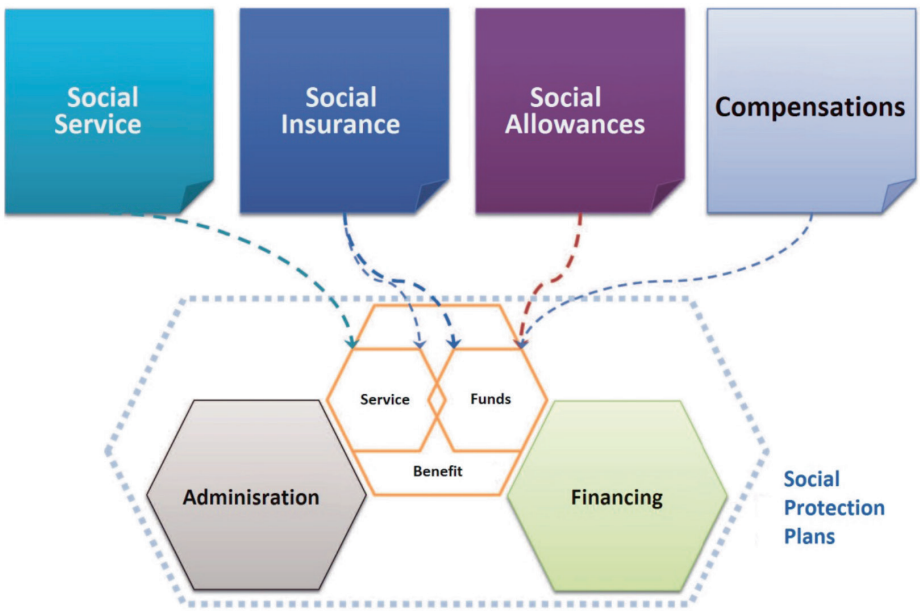


Figure 23 Typology of public schemes in social protection systems

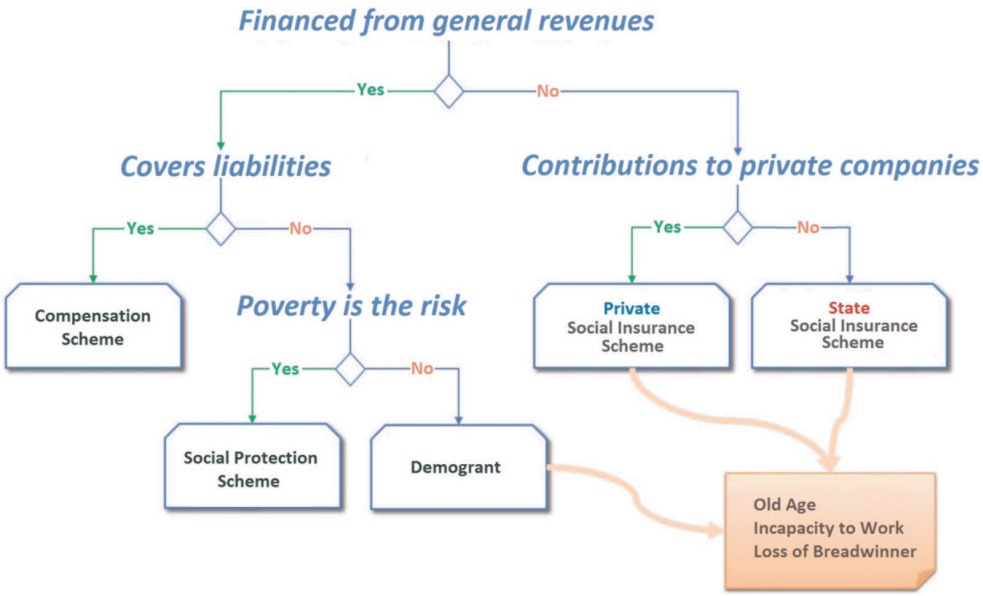


Figure 24 Risks faced by individual and society and their management by public (social) institutions

TYPES OF RISKS (FOR POOR)	RISK MANAGEMENT MECHANISMS / APPROACHES		
	INFORMAL MECHANISMS (INDIVIDUAL, FAMILY)	OPTIONS FOR INTERVENTIONS BY PUBLIC SECTOR	OPTIONS FOR INTERVENTIONS BY PRIVATE SECTOR
1. Life cycle related			
1.1. Hunger 1.2. Illness 1.3. Disability 1.4. Old-age 1.5. Death	• Women contribute to the well-being of their families • Extended families (several generations) • Hygiene, preventive medicine • Spending of assets / savings • Taking loans	• Nutritional healthcare programs • Social insurance policy; mandatory health, disability, life and old-age insurance; micro-insurance • Social assistance • Protection of children	• Provision of health services • Health, disability and life insurance and reinsurance • Micro insurance • Old-age annuities
2. Economic			
2.1. The loss of means of subsistence 2.2. Unemployment 2.3. Low income 2.4. Rise in prices of basic necessities 2.5. Economic crisis/reforms	• Sources are diversified • Private transfers / extended • Spending of assets / savings • Reducing consumption of basic items • Taking loans • Migration	• Proper macroeconomic and sectoral policy aimed at developing economic capacities (opportunities) • Regional and rural development policy including micro-insurance • Labour market policy • Education and training • Social funds	• Investments in private sector to generate employment • Insurance, reinsurance and micro-insurance of agricultural produce • Banking services for poor, micro financing • Training-retraining
3. Related with natural environment			
3.1. Drought 3.2. Inundation 3.3. Landslide 3.4. Earthquake	• Migration • Public (community) involvement in resource management • Private transfers / support from extended family • Spending of assets / savings	• Environmental policy and investments in infrastructure • Programs for disaster prevention and mitigation including insurance against natural disaster	• Insurance, reinsurance and micro-insurance of agricultural produce
4. Social and governance related			
4.1. Exclusion, loss of social status 4.2. Corruption 4.3. Criminal / violence / anomie 4.4. Political instability	• Maintaining social (community) contacts (social capital) • Public pressure • Interest groups • Migration	• Fostering good governance, antidiscrimination policy and measures against corruption • Public awareness campaigns • Ensuring equal accessibility of courts and legal defense	• Non-governmental organizations and community associations (the third sector) • Good corporative governance ensuring fair employment opportunities

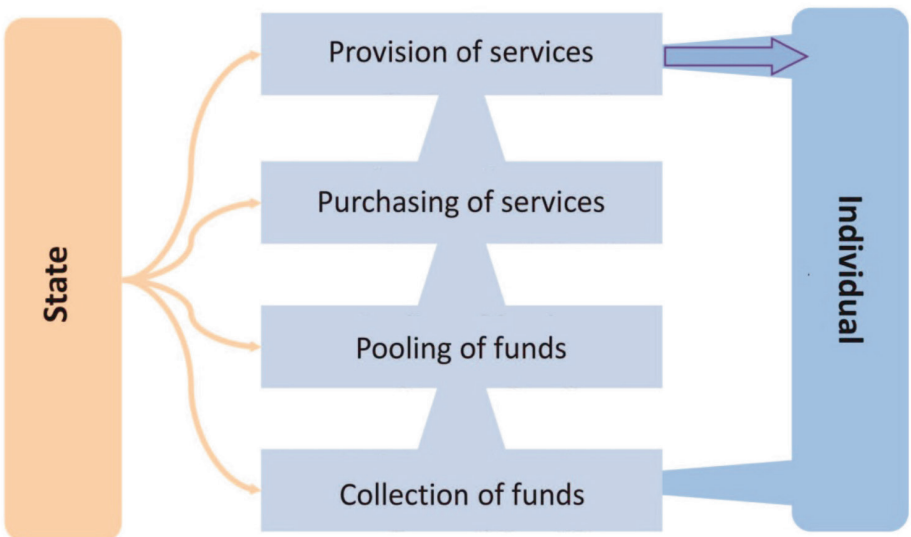
Figure 25 Possible options for risk management by types of risk management and institutions of social protection

STRATEGIES	INFORMAL	MARKET	PUBLIC
Risk reduction (prevention)			
	• Less risky production • Migration • Proper practice of nutrition and breastfeeding • Hygiene and other preventive measures	• On the job training • Knowledge of financial markets • Company-based and market-regulated labour standards	• Good macroeconomic policy • Pre-service training • Labour market policy • Labour standards • Reduction of child labour • Disability policy • Prevention of AIDS and other diseases
Risk mitigation			
Portfolio	• Holding several jobs • Investment in human, physical and fixed capital assets • Investment in social capital (customs, presenting gifts to each other)	• Investments in various financial assets • Micro financing	• Pension systems • Transfer of supplies • Protection against poverty (especially women) • Promoting wider access to financial markets for the poor
Insurance	• Marriage / family • Community schemes • Shared rental • Workfare loyalty	• Annual income in old-age • Disability, accident and other types of insurance (yield insurance)	• Mandatory / proposed insurance against unemployment, old-age, disability, loss of a breadwinner, ill-health and so on.
Guarantees	• Extended family • Employment contracts		
Risk resistance			
	• Selling of fixed assets • Borrowing from neighbors • Intra-community transfers / charity • Sending children for work • Seasonal / temporary migration • Outflow of human capital	• Selling of financial assets • Borrowing from banks	• Alleviation of misfortune / problem • Transfers / social assistance • Subsidies • Civil service

Figure 26 Matrix for the analysis of social risk management

	INSTITUTIONS OF SOCIAL PROTECTION		
RISKS	**PUBLIC**	**MARKET**	**INFORMAL**
1. Loss of income:			
1.1. Old-age			
1.2. Long-term inability to work (disability)			
1.3. Loss of a breadwinner			
1.4. Temporary inability to work			
1.5. Unemployment			
1.6. Disability caused by Industrial injury / occupational disease			
2. Health related expenditures			
3. Burden of childbearing and child rearing			
4. Poverty			

Figure 27 Functions of health care financing



Source: Kutzin, 2000

Figure 28 The conceptual framework of health care financing by sources and financial flows

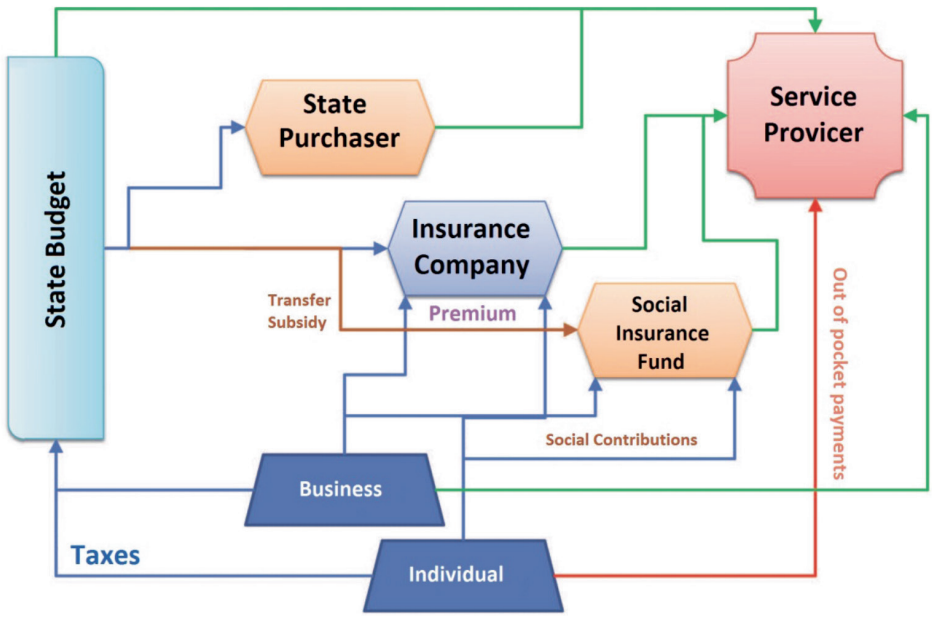


Figure 29 The algorithm of health care financing models

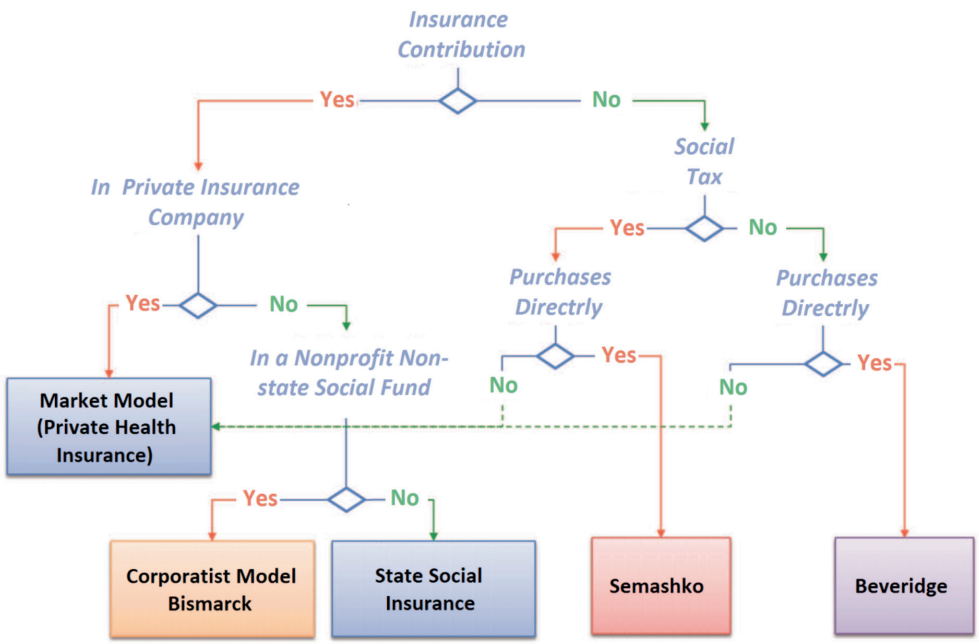
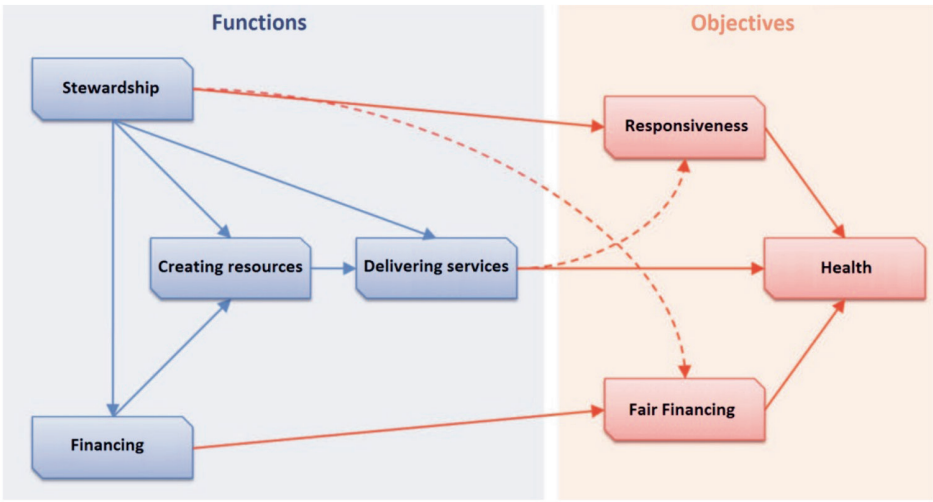


Figure 30 Relations between functions and objectives of a health system



Source: World Health Organization, 2000, adapted by the author

Figure 31 The effectiveness of government social transfers (20002002)

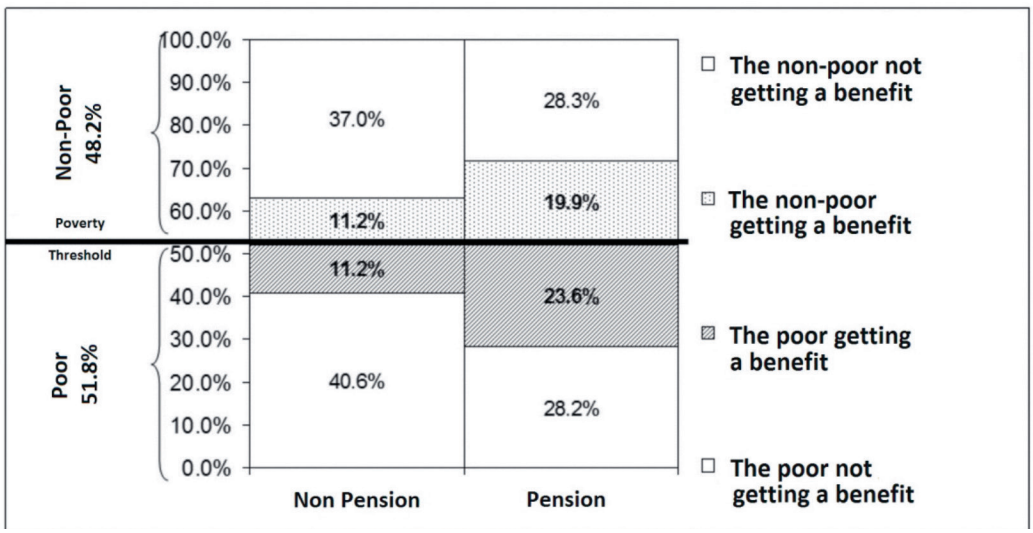


Figure 32 Typology of social security regimes by authors

Author	Measures	Welfare state regimes				
Esping-Andersen (1990)[13]	**18 countries**	**Liberal**	**Conservative**	**Social Democratic**		
	• Decommodification	Australia	Finland	Austria		
	• Social stratification	Canada	France	Belgium		
	• Private-public mix	Ireland	Germany	The Netherlands		
		New Zealand	Japan	Denmark		
		UK	Italy	Norway		
		USA	Switzerland	Sweden		
Leibfried (1992)[19]	**15 countries**	**Anglo-Saxon**	**Bismarck**	**Scandinavian**	**Latin rim**	
	• Characteristics	Australia	Austria	Denmark	**France**	
	• Rights	New Zealand	Germany	Finland	**Greece**	
	• Basic income	UK		Norway	**Italy**	
		USA		Sweden	**Portugal**	
					Spain	
Castles and Mitchell (1993)22	**14 countries**	**Liberal**	**Conservative**	**Non-right hegemony**		**Radical**
	• Aggregate welfare expenditure	Ireland	Germany	Belgium		**Australia**
	• Benefit equality	Japan	Italy	Denmark		**New Zealand**
		Switzerland	The Netherlands	Norway		**UK**
		USA		Sweden		
Kangas (1994)39	**15 countries**	**Liberal**	**Conservative**	**Social democratic**		**Radical**
	• Cluster analysis of	Canada	Austria	Denmark		**Australia**
	Decommodification	USA	Germany	Finland		**Ireland**
			Italy	Norway		**New Zealand**
			Japan	Sweden		**UK**
			The Netherlands			
Ragin (1994)40	**18 countries**	**Liberal**	**Corporatist**	**Social democratic**	**Undefined**	
	• BOOLEAN comparative	Australia	Austria	Denmark	**Germany**	
	analysis of pensions	Canada	Belgium	Sweden	**Ireland**	
	Decommodification	Switzerland	Finland	Norway	**Japan**	
		USA	France		**The Netherlands**	
			Italy		**New Zealand**	
					UK	
Ferrera (1996)18	**15 countries**	**Anglo-Saxon**	**Bismarck**	**Scandinavian**	**Southern**	
	• Coverage	Ireland	Austria	Denmark	**Greece**	
	• Replacement rates	UK	Belgium	Finland	**Italy**	
	• Poverty rates		France	Norway	**Portugal**	
			Germany	Sweden	**Spain**	
			Luxembourg			
			The Netherlands			
			Switzerland			
Bonoli (1997)17	**16 countries**	**British**	**Continental**	**Nordic**	**Southern**	
	• Social expenditure as % GDP	Ireland	Belgium	Denmark	**Greece**	
	• Social expenditure financed	UK	France	Finland	**Italy**	
	via contributions		Germany	Norway	**Portugal**	
			Luxembourg	Sweden	**Spain**	
			The Netherlands		**Switzerland**	

Author	Measures	Welfare state regimes				
Korpi and Palme (1998)32	**18 countries**	**Basic security**	**Corporatist**	**Encompassing**		**Targeted**
	• Social expenditure as % GDP	Canada	Austria	Finland		**Australia**
	• Luxembourg income study	Denmark	Belgium	Norway		
	• Institutional characteristics	Ireland	France	Sweden		
		The Netherlands	Germany			
		New Zealand	Italy			
		Switzerland	Japan			
		UK				
		USA				
Pitzurello (1999)41	**18 countries**	**Liberal**	**Conservative**	**Social Democratic**	**Conservative-**	**Radical**
	• Cluster analysis	Canada	Germany	Belgium	**Bismarckian**	**Australia**
	of Decommodification	Ireland	The Netherlands	Denmark	**Austria**	**New Zealand**
		UK	Switzerland	Norway	**Finland**	
		USA		Sweden	**France**	
					Italy	
					Japan	
Navarro and Shi (2001)	**18 countries**	**Liberal-Anglo Saxon**	**Christian Democrat**	**Social Democratic**	**Ex-fascist**	
	• Political tradition	Canada	Belgium	Sweden	**Spain**	
		Ireland	The Netherlands	Norway	**Greece**	
		UK	Germany	Denmark	**Portugal**	
		USA	France	Finland		
			Italy	Austria		
			Switzerland			
Kautto (2002)	**15 countries**		**Transfer approach**	**Service approach**	**Low approach**	
	• Expenditure on services and		Belgium	Sweden	**Ireland**	
	social transfers		The Netherlands	Norway	**Greece**	
			Austria	Finland	**Portugal**	
			Italy	Germany $_{UK}$	**Spain**	
Bambra (2005)	**18 countries**	**Liberal**	**Conservative**	**Social Democratic**	**Conservative sub-group**	**Liberal sub-group**
	• Healthcare services and	Australia	Austria	Finland	**Germany**	**Ireland**
	Decommodification	Japan	Belgium	Norway	**Switzerland**	**UK**
		USA	Canada	Sweden	**The Netherlands**	**New Zealand**
			Denmark			
			France			
			Italy			

Source: (Bambra, 2007)

Figure 33 Social protection and labour market institutions in Baltic States and other European countries

	SCANDINAVIAN	CENTRAL EUROPEAN	SOUTHERN EUROPEAN	ANGLO-SAXON	BALTIC
Social security	Universal welfare state, oriented on social services	Oriented on social insurance and tax transfers	Oriented on tax transfers	Liberal welfare state, increased privatization	Liberal, oriented on social insurance and tax transfers
Welfare state financing	High, financed mainly by taxes	Average, financed mainly by taxes on wages	Average, financed mainly by government debt and taxes on wages	Average, financed by taxes and private investments	Average, financed by taxes on wages
Labour market regulations	Regulated, lifetime employment	Regulated, lifetime employment	Regulated, high share of hidden sector employment	Deregulated	Regulated, no emphasis on life-time employment
Bargaining system	Coordinated wage negotiations, centralized unions, high union density	"Social partnership", coordinated wage negotiations, centralized unions	Decentralized wage negotiations, weak unions	Decentralized wage negotiations, small unions	Decentralized wage negotiations, small unions

Source: (Paas, et al., 2004)

Figure 34 Health System Assessment Model

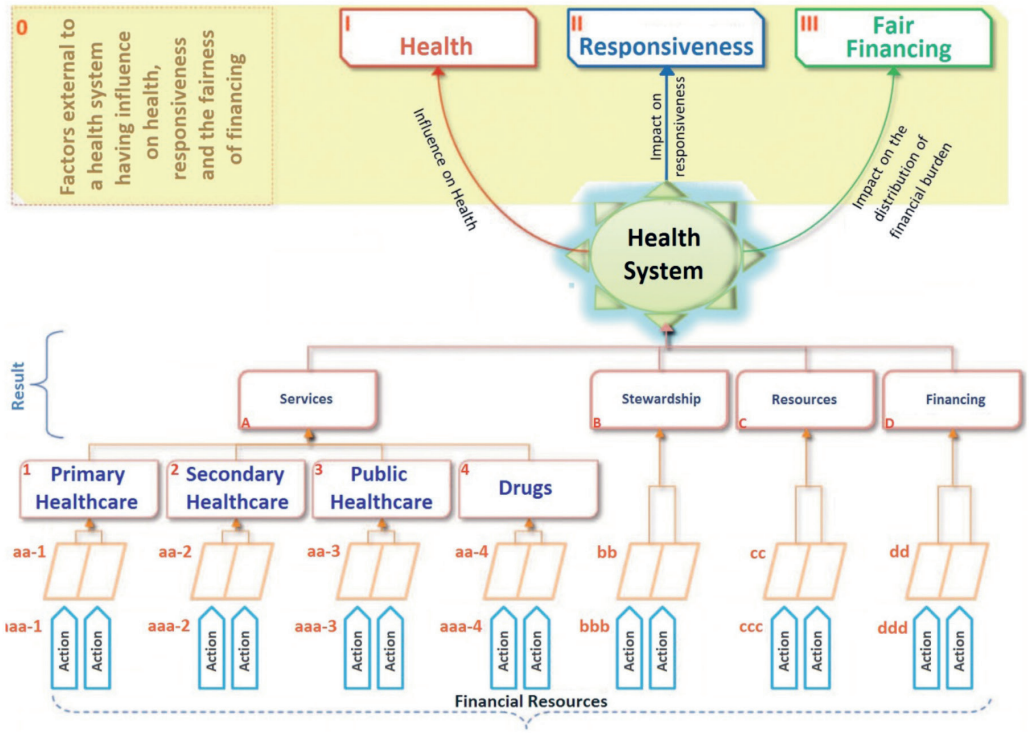


Figure 35 Changes in the system

YEARS	SOCIAL PROTECTION				LABOUR	HEALTHCARE	TAX / ECONOMY
	PENSION	ALLOWANCES	EMPLOYMENT	OTHER			
1990	Pension replacement rate – 70%, on average	Lump sum allowance for childbearing equaling to the average monthly salary; maternity benefit for 126 days-long maternity leave and child allowance during 6 years			State employment agency		Social tax amounted to 37%+1% of salary; \ Employment fund contribution – 3% of wages
1991			Employment Fund was established (with 12 regional offices)				
1992	Pensions are paid irregularly		Unemployment benefit for 12 months (average replacement rate – 60%)				
1993							
1994						12 health regions, regional health funds and hospitals of tertiary level are established[1]	
1995	Allowance for pensioners (in the amount of 7 GELs) to compensate for an increase in price of bread is introduced	The state sets the notion of a minimum standard of living and conditions of its provision (article 32 of the constitution)	The state retains the obligation to promote the unemployed citizen to be employed (article 32 of the constitution)	The state introduces social protection of persons with disabilities [2]	The state recognizes the protection of labour rights in the constitution (article 30.4)	• It was set for the first time (indirectly) that health services are paid (article 37 of the constitution) • The right to enjoy health insurance was defined • The State Health Fund was established • The guaranteed package of health services was defined • Government funded health care facilities were turned into state public enterprises`	• A new currency – Georgian Lari – was introduced • The amount of mandatory contribution to SMIC - 3%+1% of salary – was defined
1996	• Pensionable age for the social pension was increased by 5 years					The mechanisms of privatization of health care facilities were defined[3]	

YEARS	SOCIAL PROTECTION				LABOUR	HEALTHCARE	TAX / ECONOMY
	PENSION	ALLOWANCES	EMPLOYMENT	OTHER			
1997	The old-age pension is increased to 11.8 GELs per month	Allowance for refugees and IDPs is increased to 11.8 GELs per month		Principles of calculation of the subsistence minimum and the rule of its adoption and revision was defined[4]		• The State Health Fund was transformed to the State Medical Insurance Company[5] • Regional health departments are established • District (municipal) public health centers are held responsible for the function of administration and coordination of healthcare • District health funds are abolished and regional health funds are created[6]	
1998	• Private (non-state) pension insurance emerged[7] • The old-age pension is increased to 14 GELs per month[8]	Allowance for refugees and IDPs is increased to 14 GELs per month	Unemployment benefit is increased to 14 GELs per month	A lump-sum allowance in the amount of 500 GELs was introduced for guardianship and care of orphaned children in foster families[9]			
	Establishment of the State United Social Security and Medical Insurance Fund[10]						
1999	Social allowance for single non-working pensioners[11]="twice the amount of physical person's minimal income exempted from income tax" (18 GELs per month)				Rules for industrial injury benefits were defined[12]	• National Health Care Policy was adopted • Transformation of state public enterprises (medical facilities) into legal entities of private law pursuant to the law "On entrepreneurial activity"[13]	

YEARS	SOCIAL PROTECTION				LABOUR	HEALTHCARE	TAX / ECONOMY
	PENSION	ALLOWANCES	EMPLOYMENT	OTHER			
2000		Social (family) allowances for the poor		Conceptual foundations of Georgia's social development were adopted[14]		• Strategic plan for Georgia's health care development was defined • The Ministry of Labour, Health and Social Affairs was established as a consolidated entity[15,16] • Regional health administration departments are abolished and 12 territorial bodies of MoLHSA are established instead[17] • The Hospital Restructurization Fund is established[18]	
2001					• The legal act to establish lower organization – labour inspection – was adopted[19] • State employment agency was created[20]	• Revision of state medical standards[21] and adoption prices[22] • The List of medical specialties was defined[23] • Inspection of quality control of pharmaceutical activity was established • Inspection of controlling the legal circulation of narcotic drugs was established • Inspection of quality control of medical activity was established • State Sanitary Inspection at the State Border Checkpoints was established • State Supervision Inspection of Sanitary-Hygienic Standards and Rules was established • Georgia Health Projects Implementation Center was established[24]	The Economic Development and Poverty Reduction Program of Georgia was adopted[25]

YEARS	SOCIAL PROTECTION				LABOUR	HEALTHCARE	TAX / ECONOMY
	PENSION	ALLOWANCES	EMPLOYMENT	OTHER			
2002		• Revision of social allowances for poor families[26] (e.g. the amount of allowance for a family consisting of a single non-working pensioner was set to 22 GELs per month) • Payment of stipends and unemployment benefits[27]	• The abolishment of Georgia State United Employment Fund • Creation of State Employment Agency[28]	• Grant contract for Social Protection Reform Project entered into force[29] • (2003-2006) Strategic plan of implementation of the Presidential Program for Georgia's Social Development was adopted[30]		Price ceilings for State Medical Standards are defined	• All aspects of control over the administration and recovery of social taxes (contributions) and mandatory health insurance contributions were transferred to the State United Social Insurance Fund • The social tax was replaced by a social contribution[32]
	Creation of a legal entity of public law – State United Social Insurance Fund[33]					The State Medical Insurance Company was abolished	
2003	Legislation on introduction of mandatory social insurance is adopted[34]					The Central Inspection of State Sanitary Supervision of the Ministry of Labour, Health and Social Affairs is established[35] L. Sakvarelidze National Center for Disease Control and Medical Statistics is created[36]	Medical facilities are exempted from taxes on property, land, economic activity, profit and road fund duties[37]
2004	The process of gradual elimination of pension arrears and increase of pensions (increments) started[38]	The State Agency for Social Assistance and Employment is established[39]	Cardinal directions of social policy on protecting rights of children with disabilities were determined[40]			Reorganization of the Central Inspection of State Sanitary Supervision of the Ministry of Labour, Health and Social Affairs[41] Inspection of quality control of medical assistance was created[42]	
		Unemployment benefit was set at the level of 20 GELs per month[43]					
2005		A poverty assessment system and the united database is introduced[44]					
	Al laws on introduction of mandatory social insurance are cancelled[45]					The European Social Charter entered into force[46]	

YEARS	SOCIAL PROTECTION				LABOUR	HEALTHCARE	TAX / ECONOMY
	PENSION	ALLOWANCES	EMPLOYMENT	OTHER			
2006		• The State Agency for Social Assistance and Employment is established[47] • Types of social assistance were defined by law[48]			• Adoption of the Labour Code • Abolishment of the state lower organization – "Labour Inspection"	Georgia Hospitals Restructuring Fund and National Institute of Social and Health was merged with Georgia Health and Social Projects Implementation Center[49]	
2007		• State compensations and state academic stipends are introduced[50]		Benefit for temporary inability to work is abolished (pursuant to the labour code)		Hospitals' development plan (100 hospitals" plan)[51] Inspection of State Sanitary Supervision of the Ministry of Labour, Health and Social Affairs is abolished	
	The State United Social Insurance Fund is abolished[52] and its functions are transferred to two entities: Georgia Health and Social Projects Implementation Center[53] and LEPL Social Subsidy Agency[54]						
2008						Health insurance of the population living below the poverty line started	The social tax is abolished and only the income tax in the amount of 25% is left[55]
2009		The Social Subsidy Agency was transformed to the Social Service Agency[56]		The Legal Entity of Public Law – Agency for Providing Care to People with Disabilities, the Elderly and Children Deprived of Care was established[57] (The State Care Agency from 2010)			The income tax is reduced to 20%
2010		• LEPL "State Agency for Social Assistance and Employment" is reorganized to Social Subsidy Agency[58] • The Health and Social Projects Agency was abolished[59]					

Figure 36 Matrix of indicators associated with social and health protection Comparative description of institutional and residual models of social protection

Parameters	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Economic																					
1. GDP per capita ($)	1492	1231	727	541	513	559	653	751	782	614	678	723	772	922	1187	1470	1761	2318	2919	2449	2629
1.1. GDP per capita (in PPP$)	4,433	3,591	2,005	1,437	1,328	1,431	1,661	1,906	2,011	2,115	2,218	2,394	2,584	2,951	3,220	3,611	4,044	4,687	4,905	4,776	5,073
1.2. GDP per capita (in 1990 PPP$)	15,636	12,469	8,720	6,821	6,263	6,503	7,046	7,772	8,551	8,791	8,433	8,655	9,321	10,493	11,303	12,661	13,828	15,929	16,670		
2. National income (% of GEP)								12.2	10.8	11.5	10.4	10.4	10.5	10.3	16.0	18.1	22.5	24.0	25.7	25.2	
3. Government expenditures (% of GDP)								15.4	14.4	14.4	11.6	10.8	11.3	10.7	14.6	17.3	20.3	22.9	29.1	30.9	
4. Collected taxes (% of GDP)								8.3	7.2	7.9	7.7	7.4	7.6	7.0	9.9	12.1	15.4	17.7	23.8	23.1	
5. Share of socilal[3] expenditures in GDP (%)																					
5.1. Total																					
5.2. Government														9.8	14.0	17.3	15.3	21.9	25.9	24.5	21.0
6. Share of expenditures on health in GDP (%)						5.3	7.6	8	6.7	6.4	7.4	7.8	8.7	8.5	8.5	8.6	8.4	8.2	8.7	10.1	
6.1. Government					0.3	0.9	1.3	1.2	1.0	1.2	2.1	2.5	1.9	1.8	1.9	2.3	2.2	2.7	2.9	2.9	
6.2. Private						4.9	6.6	6.5	5.4	5.2	5.8	5.7	6.2	6.6	6.7	6.7	6.2	5.9	6.0	7.2	
7. Total per capita expenditures on health (in PPP$)						107	118	140	124	125	152	175	212	237	262	303	339	384	432		
7.1. Total per capita expenditures on health (in 2005 PPP$)						102.5	113.6	134.7	119.3	119.1	141.7	172.1	209.0	232.9	262.1	302.9	339.1	384.6	433.0	499.0	
8. Government per capita expenditures on health ($)					0.81	3.68															
9. Consolidated state budget (million GELs)[60]													1,114	1,261	1,836	2,426	2,979	4,379	5,411	5,397	5,480
9.1. Social welfare (million GELs)													315	379	548	558	661	934	1,347	1,506	1,624
9.2. Social welfare (% of the state budget)													28	30	30	23	22	21	25	28	30
10. Share of health expenditures in the state budget (%)[4]					1.3	2.3	4.4	5.5	5.2	4.9	4.6	5.63	4.29	5.87	5.4	6.0	5.7	4.2	7.3	7.5	
11. Share of government expenditures on health in total expenditures on health (%)						4.9	11.6	16.4	17.9	16.2	16.7	17.9	16.3	15	15.4	19.5	21.6	18.4	20.7		

Parameters	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
12. Social and health budget																					
12.1. GELs (in millions)											260.9	266.2	306.8	323.7	511.6	694.3	760	997	1,284	1,503	1,605
12.2. % of the state budget											31.3	29.4	29.2	26.8	26.5	26.5	22.2	21.3	24.9	27.9	29.6
13. Mean salary																					
13.1. Mean nominal monthly salary in hired employment (in GELs)						13.5	29	42.5	55.4	67.5	72.6	94.6	113.5	125.9	156.6	204.2	277.88	368.1	534.9	556.8	
13.2. Mean nominal monthly salary (in GELs)															156.6	204.2	277.9	368.1	534.9	556.8	631.3
13.3. Mean nominal monthly salary in hired employment in public sector (in GELs)											66.6	85.7	104.1	114.5	144.3	193.6	249.2	312.3	481.3	512.6	
13.4. Mean nominal monthly salary in hired employment in private sector (in GELs)											94.8	123.5	145.1	167.1	190.9	227.6	316.3	437.8	603.4	608.5	
14. Subsistence minimum:																					
14.1. Subsistence minimum of average consumer															74.7	84.9	94.4	105.0	113.3	114.1	119.0
14.2. Subsistence minimum of average household															141.5	160.7	178.7	198.9	214.6	216.0	225.3
15. Poverty																					
15.1. 15.1 PPP$ 2 consumption (% of population)							14	15.18	20.03	23.15	25.31	25.36	33.96	36.7		30.18			32.21		
15.2. 15.2 PPP$ 1 consumption (% of population)							4.71	4.58	7.85	9.43	9.59	9.98	15.73	17.65		14.09			15.27		
15.3. W. R. T. the National Poverty line (%)								13.7	19.8	23.2	23.1							23.6			
15.4. Population below 60% of median consumption															24.6	24.1	23.3	21.3	22.1	21.0	
15.5. Population below 40% of median consumption															10.9	10.1	9.4	9.2	9.5	8.8	
16. GINI Index							37.13	36.08	37.26	38.05	38.85	36.9	40.31	40.37		40.78			41.34		
17. Beneficiaries of subsistence subsidy																		279,474	368,431	436,309	430,603
18. Share of subsistence subsidy in total population (%)																		6.4	8.4	9.9	9.7
19. Exchange rate with $ (at the end of the year)						1.230	1.276	1.304	1.800	1.930	1.975	2.060	2.090	2.075	1.799	1.793	1.714	1.592	1.667	1.686	1.773
20. Annual inflation rate (%)	4.8	79	810	3,126	15,607										7.5	6.2	8.8	11.0	5.5	3.0	11.2
21. Average annual inflation (average , 12 months) , %		79	746	1,278								4.7	5.6	4.8	5.7	8.2	9.2	9.2	10	1.9	7.1

Parameters	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Demographic and labour																					
22. Population (thousands)	5,438.9	5,460.4	5,406.6	5,137.9	4,862.1	4,734.4	4,616.5	4,531.7	4,487.4	4,452.5	4,435.2	4,401.4	4,371.5	4,342.6	4,315.2	4,321.5	4,401.3	4,394.7	4,382.1	4,385.4	4436.4
22.1. Population (except for those living in uncontrolled territories)	4,802.0	4,835.9	4,873.5	4,911.1	4,861.6	4,734.0	4,616.1	4,531.6	4,487.3	4,452.5	4,418.3	4,386.4	4,357.0	4,328.9	4,318.3	4,361.2	4,398.0	4,388.4	4,383.7	4,410.8	4,452.8
23. Age structure (in %)																					
23.1. 0-14 years-old	24.6	24.5	24.5	24.4	24.3	24.2	23.9	23.5	23.1	22.5	22.0	21.3	20.5	19.8	19.0	18.4	17.8	17.4	17.0	16.7	16.6
23.2. 15-64 years-old	66.1	65.8	65.5	65.1	64.8	64.6	64.6	64.7	65.0	65.3	65.6	65.8	66.1	66.3	66.6	67.0	67.5	68.0	68.5	68.9	69.1
23.3. 65+ years-old	9.3	9.6	10.0	10.5	10.9	11.3	11.6	11.8	12.0	12.2	12.5	12.9	13.4	13.9	14.3	14.6	14.7	14.7	14.5	14.4	14.3
24. Birth rate (per 1000 people)	17.07	16.32	13.43	11.99	11.79	11.9	11.73	11.66	11.05	10.52	10.58	10.49	10.7	10.67	11.48	10.66	10.87	11.23	12.9	14.37	
25. Number of newborns (in thousands)	92.8	89.1	72.6	61.6	57.3	56.3	55.0	54.0	51.5	48.7	48.8	47.6	46.6	46.2	49.6	46.5	47.8	49.3	56.6	63.4	
26. Average life expectancy	73	73.06	72.93		73.16	70.3	70.7	70.9	71.2	71.4	71.3	71.5	71.5	72	71.4	73.1				73.77	
27. Annual population growth rate (%)	0.775	0.769	-1.013	-2.660	-2.522	-1.848	-0.982	-0.779	-0.771	-0.725	-0.673	-0.647	-0.245	0.989	0.840	-0.219	-0.107	0.616	0.948	0.775	0.769
28. Labour market																					
29. Work force[61]	2,480	2,496	2,450	2,382	2,328	2,287	2,273	2,270	2,268	2,273	2,193	2,279	2,212	2,264	2,234	2,267	2,298	2,306	2,318	2,340	
29.1. Work force with higher education (%)										41.8			27.2		26.6			29.9			
29.2. Labour force activity rate (%)[62]	68.5	68.4	66.6	64.2	63.3	63.7	64.7	65.5	65.7	65.9	63.6	66	63.9	65.2	63.9	63.7	63.6	63.6	63.7	63.7	
29.3. Employment rate (%)[63]		57.9	55.9	54.3	54.3	54.1	56.7	57.4	56.2	56.8	56.8	58.6	55.8	57.7	55.8	54.9	55	55.2	53.2	52.9	53.8
29.4. Share of self-employed in the employed population									56	56.7	62	64.3	64.4	65.8	66.2	65.3	65.3	63.3	64.2		
29.5. Share of hired workers in the employed population									43.2	42.2	37.2	34.9	35.4	34.1	33.7	34.4	34.6	36.7	35.7		
29.6. Unemployment rate (%)			0.7	2		15.564	28.965	7.5	12.3	10.3	10.3	11	12.6	11.5	12.6	13.8	13.8	13.3	16.5	16.9	16.366
a) Unemployment rate (12-24 years-old)										24.6	21.1	20.1	27.9	24.9	28.3	28.3		31.5	35.5		
30. Ratio of dependants (65+):																					
30.1. to employees											3.34	3.35	3.29	3.15	3.01	2.88	2.77	2.65	2.49	2.63	2.62
30.2. to hired employees											1.24	1.17	1.17	1.07	1.01	0.99	0.96	0.97	0.89	0.95	0.99
30.3. to working age population (in %)	16.1	16.8	17.5	17.9	18.2	18.4	18.6	19.0	19.6	20.2	20.9	21.5	21.8	21.8	21.6	21.2	20.9	20.7	16.1	16.8	17.5

Parameters	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Health																					
31. Child mortality rate	20.7	20.8	22.1	27.6	28.6	28.2	28	23.9	22	22.2	22.6	22.9	23.8	24.8	23.8	19.7	18.4	14.1	14.3	14.91	12.0
32. Maternity mortality rate	20.47	10.1	4.13	32.4	39.6	55.1	57.25	70.1	68.56	51.25	49.18	58.69	45.06	49.79	42.36	23.65	23.01	20.29	14.14	52.07	19.4
33. Immunization rate	95	45	58	54	58	79	80	80	80	84	80	87	84	76	78	84	87	98	92	88	91
34. Physicians per 100 thousand people	493	490	473	500	490	479	446	519	504	487	473	464	484	489	466	468	455	493			
35. Nurses per 100 thousand people	981	1,057	974	1,013	943	872	701	582	548	579	471	432	434	397	396	379	363	981			
36. Bed capacity per 10 thousand people	53.1	53.1	52.9	46.3	44.4	33.9	24.2	24.5	23.6	22.5	21.2	19.5	18.3	18.2	17.8	17.1	16.5	14.6	14.1		
36.1. The same according to WHO	97.6	97.3	97.8	90	91.4	71.5	52.5	54	52.5	52.3	48.1	44.5	42	41.9	41.2	39.2	37.4	33.2		30.9	
36.2. Beds for short-term care per 10 thousand people	85.4	85.2	85.6	79.3	80.5	63.5	47.3			47.6	43.8	40.1	37.7	37.8	37.1	38.4	34.4	29.2		26.9	
36.3. Number of psychiatric hospital beds per 10 thousand people	8.5	8.4	8.5	7.5	7.6	5.1	3.7	3.3	2.6	2.4	2.7	2.7	2.9	2.9	2.9	2.9	3.5	2.8		3	
37. Number of hospitals										229	251	251	248	246	242	244	245	244	241	229	
38. Number of hospital beds										21.2	19.6	18.3	18.2	17.8	17.1	16.5	14.6	14.1	13.6	21.2	
39. Average length of stay (general hospitals) (WHO)	12.8	14.2	12.8	13.2	12.9	10.9	8.3			8.3	7.8	7.4	7.4	7.4	6.7	6.1	6.4	5.7	5.4	5	
40. Hospital occupancy rate (WHO)	54.8	55.3	34.2	31.8	26.8	26.1	23.8			23.2	22	23.2	25.4	25.8	27.2	26.8	32.3	34.4	38.4	36.1	
41. Number of hospital admissions per 100 people	13.31	12.14	8.34	7.02	6.09	5.55	4.95	5	5.13	4.87	4.51	4.59	4.72	4.81	5.49	5.71	6.01	6.33	7	7.09	
42. Number of outpatient facilities										1,015	1,055	1,089	1,100	1,113	1,123	1,124	1,140	1,090	1,604	1,015	
43. Annual number of outpatient visits per capita	8	7.3	6.2	5.3	4.7	2.63	1.6	1.6	1.6	1.6	1.4	1.5	1.6	1.8	2	2.1	2.2	1.95	2.1	2	
44. Share of out-of-pocket expenditures in private expenditures on health						100.0	100.0	99.9	99.9	99.8	99.4	98.7	99.4	99.5	99.0	99.0	98.5	97.9	96.3	94.1	
Social																					
45. Number of pensioners (in thousands)[67]	1,105	1,022	979	968	924	900	896	904	900	895	902	892	837	842	838	836	1,105	1,022	979	968	924
45.1. Old-age pensioners (in thousands)	815	761	716	699	655	626	620	620	604	600	593	588	612	658	660	662	815	761	716	699	655
46. The lowest amount of state pension						6.0	8.5	11.8	14.0	14.0	14.0	14.0	14.0	14.0	14.0	28.0	38.0	55.0	70.0	80.0	80.0
47. Average amount of old-age pension (GELs)											14.0	14.0	14.0	14.0	14.0	28.0	38.0	62.5	77.6	87.1	87.4

Figure 37 Distribution of adult (15 years-old and older) population by economic activity 1991-2010

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total labour force	2,495.90	2,450.50	2,382.10	2,328.20	2,287.10	2,273.40	1,999.00	1,972.80	1,939.30	2,049.20	2,113.30	2,104.20	2,050.80	2,041.00	2,023.90	2,021.80	1,965.30	1,917.80	1,991.80	1,944.90
Employed	2,112.80	2,056.80	2,014.70	1,997.20	1,942.40	1,992.30	1,848.00	1,728.50	1,694.40	1,837.20	1,877.70	1,839.20	1,814.90	1,783.30	1,744.60	1,747.30	1,704.30	1,601.90	1,656.10	1,628.10
Hired							673	724.4	697.5	683.9	654.3	650.9	618.5	600.9	600.5	603.9	625.4	572.4	596	618.6
Self-employed							1,071.00	987.1	918.6	1,041.20	1,136.10	1,184.90	1,195.20	1,180.80	1,143.30	1,141.60	1,078.80	1,028.50	1,059.00	1,007.10
Not-identified worker							1040	170	784	1121	873	34	13	16	8	18	1	11	12	24
Unemployed	383.1	393.7	367.4	331	344.7	281.1	152	244.2	244.9	212	235.6	265	235.9	257.6	279.3	274.5	261	315.8	335.6	316.9
Population outside labour force	686.9	739.9	814	819.9	769.5	706.5	933.2	1,044.00	1,086.90	1,092.30	1,077.70	1,135.30	1,048.40	1,105.90	1,136.10	1,228.00	1,138.60	1,145.20	1,139.30	1,083.30
Unemployment rate (%)	15.3	16.1	15.4	14.2	15.1	12.4	7.6	12.4	12.6	10.3	11.1	12.6	11.5	12.6	13.8	13.6	13.3	16.5	16.9	16.3
Economic activity rate (%)	78.4	76.8	74.5	74	74.8	76.3	68.2	65.4	64.1	65.2	66.2	65	66.2	64.9	64	62.2	63.3	62.6	63.6	64.2
Employment rate (%)	66.4	64.5	63	63.4	63.5	66.9	63	57.3	56	58.5	58.8	56.8	58.6	56.7	55.2	53.8	54.9	52.3	52.9	53.8
Total population[5]	4,835.90	4,873.50	4,911.10	4,861.60	4,734.00	4,616.10	4,531.70	4,487.40	4,452.50	4,435.20	4,401.40	4,371.50	4,342.60	4,315.20	4,321.50	4,401.30	4,394.70	4,382.10	4,385.40	4,436.40
Working age population	3,182.80	3,190.40	3,196.10	3,148.10	3,056.60	2,979.90	2,932.20	3,016.80	3,026.20	3,141.60	3,191.00	3,239.50	3,099.10	3,146.90	3,159.90	3,249.80	3,103.80	3,062.90	3,131.10	3,028.30
Share of working age population (%)	65.8	65.5	65.1	64.8	64.6	64.6	64.7	67.2	68	70.8	72.5	74.1	71.4	72.9	73.1	73.8	70.6	69.9	71.4	68.3
Population over 65	466.3	489	514.3	530	533.8	533.9	533.8	536.6	541.9	550.4	560.1	558.6	576.9	592.2	605	630.9	643.3	642.9	630.3	621.9
Ratio to the hired workers					1.26	1.35	1.29	1.24	1.17	1.17	1.07	1.01	0.99	0.96	0.97	0.89	0.95	0.99		
Ratio to the labour force	5.35	5.01	4.63	4.39	4.28	4.26	4.25	4.23	4.19	3.34	3.35	3.29	3.15	3.01	2.88	2.77	2.65	2.49	2.63	2.62

Source: State Department of Statistics (1998-2010) and The World Bank

Figure 38 Comparison of Georgia's social protection system and traditional European and Baltic States' models

	SCANDINAVIAN	CENTRAL EUROPEAN	SOUTHERN EUROPEAN	ANGLO-SAXON	BALTIC	GEORGIA
Social security	Universal welfare state, oriented on social services	Oriented on social insurance and tax transfers	Oriented on tax transfers	Liberal welfare state, increased privatization	Liberal, oriented on social insurance and tax transfers	Liberal Mainly general and special social allowances
Welfare state financing	High, financed mainly by taxes	Average, financed mainly by taxes on wages	Average, financed mainly by government debt and taxes on wages	Average, financed by taxes and private investments	Average, financed by taxes on wages	Low General taxes
Labour market regulations	Regulated, lifetime employment	Regulated, lifetime employment	Regulated, high share of hidden sector employment	Deregulated	Regulated, no emphasis on life-time employment	Deregulated
Bargaining system	Coordinated wage negotiations, centralized unions, high union density	"Social partnership", coordinated wage negotiations, centralized unions	Decentralized wage negotiations, weak unions	Decentralized wage negotiations, small unions	Decentralized wage negotiations, small unions	Minimum wage does not exit Minimal practice of collective wage negotiations
Countries	Sweden Norway Finland Netherlands	Germany Austria France Belgium	Spain Portugal Italy Greece	Great Britain Ireland	Latvia Lithuania Estonia	

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ISBN 978-994-10-4400-7

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INDEPENDENT GEORGIA – HEALTH AND SOCIAL PROTECTION SYSTEMS

Tbilisi 2012