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Participation of Georgian Local Authorities in the Process of Hospital Care Reforms

Ana Tegetashvili, Ph.D, Dean of the School of Medicine
Otar Gerzmava
Griogol Robakidze University, School of Medicine, Tbilisi, Georgia

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Abstract

The article addresses power distribution issues within the context of scientific discourse and explores potential solutions to be implemented by local authorities in the realm of Hospital Care reforms in Georgia, particularly in the conditions of authority decentralization. The significance of addressing this scientific issue stems from the financial challenges faced by many communities, especially in economically depressed Georgian regions. Prior to the reform, the network of hospital facilities relied on subsidies from higher-level budgets.

The methodological approach involves the use of desk research, secondary analysis of literary, research, and analytical sources, along with regulatory methods. The research spans from 1991 to 2022, focusing on the power of local self-governments, both their inherent powers and those delegated to them, given that almost 60% of medical services are provided at the territorial community level.

The article presents empirical analysis results regarding the distribution of financial power in the new model of Hospital care management. It demonstrates that, fundamentally, the new model remains budget-funded, consistent with the pre-reform structure. The research empirically and theoretically supports the assertion that the overall direction of reforms has

been appropriately chosen, a sentiment echoed by positive assessments from international experts.
The findings of the research can be valuable for local authorities representing the interests of territorial communities and for local executive authorities involved in the implementation of these reforms. Additionally, the research aligns with Georgia's commitment to the path towards European integration changes.
This process is developing very slowly in Georgia. This is a loss of opportunity to raise the standard of living of local communities.

Keywords: Local self-government, Hospital care reform, powers, Georgia

1. Introduction

In the conditions of the state of Georgia implementing the selected course towards European integration changes, the Hospital care reform is one of the most complicated, as its implementation does not involve the transformation of the archaic Hospital care management model dating back to the USSR. Instead, it envisions the complete dismantling of this model and the construction of a new model of social relations in the field of Hospital care.
The management model currently under development in Georgia is based on the foundations of a new European policy in the field of Hospital care, involving the implementation of completely new public management subjects at all levels. Moreover, the implementation of this sectoral reform is occurring simultaneously with the implementation of the local self-government reform, complicating the process of double reformation that includes both local self-government and medical reforms. This process requires a detailed analysis, examination of successful reformation expertise in EU countries, the development of a state change strategy, and efficient managerial decisions.

When transferring powers in the field of Hospital care from the national level to the local self-government level, a number of economic, property, social, and legal issues arise that require immediate attention from local self-governments. Delaying the resolution of these issues threatens to slow down the reformation process and limit citizens' access to quality medical services.

However, considering that the Hospital care reform in the history of independent Georgia is taking place for the first time, research work on management issues in the reformation of the medical field in Georgia is extremely limited. Some authors believe that for countries that were once part of the USSR and are in the stage of transitional economy (Georgia was part of the USSR until 1991), the most efficient approach to the reformation of the national Hospital care system would be a state and insurance Hospital care

model with priority given to the development of primary medical care institutions.

It's worth noting that the reformation of national Hospital care systems in most highly developed countries began at the end of the 20th century. Reform scenarios aimed to limit increasing expenses for the medical sphere and had certain differences in the implementation of reformation organizational policy. For instance, Germany and Great Britain had officially approved Hospital care reformation programs; other countries implemented limited reform strategies for solving specific tasks (Blank, R. 2004).

Researchers Richard B. Saltman and Josep Figueras, having conducted a thorough research on reformation strategies for national Hospital care systems in Eastern and Western European countries, concluded that, in essence, medical reform is a coordinated set of government activities providing changes in legislative, economic, and organizational securement of providing medical services to the population (Saltman R. et al., 1998). The most successful step of governmental programs in the reformation of the medical services sector in EU countries was decentralization of responsibility for state Hospital care facilities, passing their management on to regional and municipal authorities. This also included implementing autonomous hospital management during the decentralization process through self-governing foundations and civic companies.

Researchers Robert Baldwin and Martin Cave, considering theories and practices for state regulation in various spheres of social life, note that in the field of social policy, which includes

Analyzing successful Hospital care reformation practices in foreign countries, it is possible to note that reforms took place according to both the revolutionary scenario (short-term changes) and the evolutionary scenario (gradual changes). Evolutionary development of the Hospital care reform is inherent in most national Hospital care systems in EU countries. This scenario is characterized by the gradual attenuation of state functions in providing medical services and the emergence of social institutions that carry out the organization and management of medical services consumption. Thus, the evolutionary way of the medical field reformation is implemented within public transformation and the transfer of state management to public governance, which stipulates the extension of powers for local self-government in the organization of providing medical aid. Taking into account everything mentioned above, we come to the conclusion that it is vital to examine more thoroughly management issues and perspectives for Hospital care decentralization at the local self-government level.

The aim of this work is to define the powers of local self-governments in the field of Hospital care at the basic, district, and regional levels, and their

compliance with the tasks of power decentralization and Hospital care system decentralization.

3. Methodology

The methodological foundation of the study relies on the scientific works of both domestic and foreign scientists, as well as insights from leading experts. Additionally, statistical and analytical materials from state authorities, along with orders from the Georgian Ministry of Health, constitute essential sources.

The theoretical underpinning of the study employs an interdisciplinary synthesis toolkit, incorporating social and philosophical methods, methodological approaches, and concepts and hypotheses from classical science. Another methodological approach applied involves the comparison of statutory regulations.

Results are derived through various methods, including abstract-logical methods for theoretical generalization and formulation of conclusions. These methods aid in identifying key areas of interaction between local government and the state in the field of medicine.

Content analysis - for studying and comparing new functions of local government in providing medical services.

SWOT analysis -to identify the strengths and weaknesses, opportunities, and threats of medical reform and the decentralization of power in Georgia.

To fulfill the study's objectives, desk research was conducted, involving the analysis of information on managerial functions of local self-government in the field of health services in Georgia during the medical reform. The study covers the period from 1991 to 2022 in Georgia.

The search process involved using the most frequently used words associated with the topic, such as managerial functions, local self-government, medical reform, power, decentralization, and state. Dialectic analysis and synthesis, generalization, comparative analysis, complex analysis, and system analysis were employed to analyze issues related to the research subject. This included exploring characteristics of providing medical services at various management levels (basic, district, and regional). The research comprehensively investigates the managerial aspects of exercising powers by local self-governments during both administrative and sectoral reforms.

A graphical presentation method is employed to illustrate the main contents of the research and facilitate the preparation of conclusions.

4. Results of the research and discussion

Furthermore, alongside systemic issues in Hospital care management, Georgia is undergoing an administrative-territorial reform, introducing new

challenges and problems that necessitate consideration and solutions for local self-governments. All of the above emphasizes the relevance of research on this subject.

According to Georgian legislation, most powers of local self-governments in the Hospital care field are vested in the executive authorities of village, town, and city councils. These powers encompass both councils' own authorities and those delegated to them. Within their own power, executive city councils can manage Hospital care and wellness institutions belonging to territorial communities or transferred to them. They also organize the material and financial infrastructure of these institutions and provide support to non-governmental and non-profit organizations operating in the field of Hospital care.

Delegated powers include submitting proposals to relevant authorities concerning the licensing of individual entrepreneurial activities in the field of Hospital care. Additionally, the delegated powers of executive authorities of local councils in the field of population welfare encompass providing benefits as stipulated by Georgian laws, offering additional funding, and providing housing and transportation to Hospital care professionals residing in rural areas.

Therefore, the management of Hospital care facilities emerges as a crucial issue at the basic level of local self-government, influencing the efficiency of various functions and the implementation of power in managing communal property objects. Consequently, this issue establishes a significant measure of social responsibility for local self-government authorities as owners of Hospital care institutions, impacting decisions related to their closure, optimization, and repurposing.

According to the Constitution of Georgia, territorial communities, either directly or through bodies of local self-government established by them, possess the authority to manage communal property, reorganize and close down communal enterprises, as well as oversee organizations and establishments. They also have the ability to unite communal facilities on contractual terms, combine budget funding for joint projects, and create bodies and services for these purposes. Additionally, objects jointly owned by territorial communities are managed by district and regional councils, as per the Constitution of Georgia.

As of 2022, the network of Hospital care institutions in Georgia comprises 269 hospitals with 17,948 beds and 2,284 outpatient clinics (excluding the temporarily occupied territory of Abkhazia and Samatshablo). The financial capacity to support such a vast network of Hospital care institutions becomes a crucial consideration.

In line with Georgian legislation, territorial communities serve as the main bearers of functions and powers of local self-government. Considerable

changes in providing medical services to citizens are occurring at the territorial community level. Some experts recommend providing support on the subnational level, based on an analysis of state funding of Hospital care in other countries. The approaches to the distribution of power in Hospital care in various countries include transferring powers to regional and municipal authorities, delegating self-regulating powers to private organizations (licensing, insurance), and creating national bodies independent from the government.

Some researchers propose the creation of a special executive body within unified territorial communities, authorized to manage funding, including medical subsidies. However, this approach raises questions about administrative decentralization and its alignment with local self-government and territorial authority organization reforms.

The new Georgian model of Hospital care management lacks structural subjects of public management like independent insurance funds seen in European countries. Insurance funds act as independent players in the medical services market, accumulating funds and contracting service providers without owning their property, ensuring transparency and minimizing corruption risks.

Cooperation among territorial communities could be a significant mechanism to strengthen the funding abilities of communal Hospital care institutions. However, this mechanism has not seen significant use in the field of Hospital care.

In areas that have not undergone unification, the old system of operation and funding for basic local self-government authorities persists, leading to non-compliance between decentralization and medical reform. The formation of city agglomerations could serve as a joint interaction mechanism for both territorial communities and unified territorial communities.

At the district and regional levels, the absence of executive authorities in district and regional councils hampers the effectiveness of local self-government in providing Hospital care development. This underscores the need for creating executive authorities at the district and regional council levels as part of local self-government and territorial power organization reforms.

Simultaneously, the reform results have revealed new problematic issues, including challenges related to the overlay of management levels, derogation of district self-government, and uncertainty and inconsistency in power decentralization implementation. Intensification of hospital district introduction under such conditions threatens to render them inadequate to the final administrative structure, complicating the designation of central district hospitals.

As per the local self-government reform, the distribution of powers in the Hospital care field on various levels includes providing emergency

services and disease prevention at the basic level, offering secondary medical services at the district level, and providing highly specialized medical aid at the regional level.

In the concept of the Hospital care funding reform, chief managers of budget funding, i.e., relevant state authorities and local self-government authorities, continue to be the general contractors for medical services in the beginner and middle reform levels. The procurement of services through a single national contractor is envisioned as the final result of the new management system, although the legal basis for budget funding (by category) for Hospital care institutions is yet to be established.

Hospital care, state decentralization regulation can be most successful and can ensure a positive outcome of the changes provided it follows the following scenarios:

- Replacement of state control with audit by state authorities (inspections, services, agencies) reduction of "self-regulating" activity format.
- Introduction of stimulating tools for financial regulation (taxes, subsidies).
- Implementation of market mechanisms for the regulation of subjects' activities (legislation, contracts, etc.).
- Implementation of measures to ensure openness and transparency.
- Direct activities of the government.
- Legal rights and responsibilities.
- Programs of state compensation and welfare insurance (Baldwin, R. et al., 1999).

Conclusion

Key conclusions drawn from the research include:

Georgia grapples with challenges and inconsistencies between the local self-government reform and medical reform, particularly concerning the decentralization of funding for the basic level of local self-government and inconsistencies in creating hospital districts and altering administrative territorial divisions at the district level.

The new model of Hospital care management in Georgia retains a state-funded structure, a fundamental departure from European models that involve a combination of state and insurance funding.

The Georgian government is implementing Hospital Care reforms through an evolutionary scenario, progressing through three stages: pilot planning, active reforms, and integration into a unified national model.

Local authorities, serving as facility owners and funding agents, play a crucial role. However, further political dialogue is necessary to reconcile

decentralized roles and align priorities with the national policy in the field of Hospital care.

To stabilize the transformation of the Hospital care system, it is imperative to establish divided ownership for reform implementation among key stakeholders, including local self-governments, service providers, and citizens. United territorial communities have the opportunity to enhance the quality of medical services through the conclusion of cooperation agreements.

Challenges and Inconsistencies: Georgia faces challenges and inconsistencies between the local self-government reform and medical reform. This is particularly evident in the decentralization of funding for the basic level of local self-government and the inconsistencies in creating hospital districts and changes in administrative territorial divisions at the district level.

State-Funded Model: The new model of Hospital care management in Georgia remains state-funded, resembling the structure during the USSR times. This stands as a fundamental difference between the Georgian model and European models that involve a combination of state and insurance funding.

Evolutionary Scenario: The Georgian government is implementing Hospital Care reforms through an evolutionary scenario, which involves three stages: pilot planning, active reforms, and integration into a unified national model.

Role of Local Authorities: Local authorities play a crucial role as facility owners and funding agents. However, further political dialogue is necessary to reconcile decentralized roles and align priorities with the national policy in the field of Hospital care.

Importance of Divided Ownership: To stabilize the transformation of the Hospital care system, it is essential to establish divided ownership for reform implementation among key stakeholders, including local self-governments, service providers, and citizens.

Opportunity for United Territorial Communities: United territorial communities have the opportunity to enhance the quality of medical services through the conclusion of cooperation agreements. However, the slow development of this process in Georgia represents a missed opportunity to improve the standard of living in local communities.

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Data Availability: All of the data are included in the content of the paper.

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