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# Health Worker Motivation in Georgia: Contextual Analysis

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Partnerships  
for Health  
Reform



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# Abstract

This paper represents the first phase of a larger study examining health worker motivation in two hospitals in Tbilisi, Georgia. The paper analyzes the context within which health workers are located and describes historic trends in the position of health workers and the current efforts to reform the health sector. It also provides a detailed analysis of work conditions and organizational features of the two study hospitals. Data was collected through literature review and in-depth interviews. The paper is designed to be read in conjunction with further, individual-level analyses of the determinants and consequences of worker motivation in Georgia.

Very radical changes have taken place in the position of health workers in Georgia since the breakup of the Soviet Union. Health workers were formerly accustomed to regularly paid and relatively adequate salaries; however, since the break-up, formal salaries have declined dramatically, leaving health workers largely dependent upon earnings from informal incomes. The highly developed Soviet system of promotions and rewards for good performance has also disintegrated and workers are now paid based purely on the quantity of services they provide. Funding for all aspects of health care has declined, leading to resource shortages and poor maintenance of facilities. It is not surprising that in this resource-starved context workers appear to place considerable importance upon social relationships in the work place.

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# Table of Contents

Acronyms.....	vii
Acknowledgments .....	ix
Foreword.....	xi
1. Introduction.....	1
2. Historical, Socio-Cultural, and Health Sector Reform Context.....	3
2.1 Historical Context .....	3
2.2 Socio-cultural Context .....	5
2.3 Health Sector Reform in Georgia.....	6
3. Overview of the Two Study Hospitals and Relationships with Catchment Communities.....	7
4. Organizational Context.....	9
4.1 Organizational Structure .....	9
4.2 Resource Availability .....	10
4.3 Organizational Culture.....	11
5. Human Resource Management Practices.....	13
5.1 Selection and Recruitment Procedures .....	13
5.2 Remuneration .....	14
5.3 Rewarding Good Performance, Punishing Poor Performance .....	18
5.4 Firing Staff and Unpaid Leave .....	19
5.5 Training and Skills Development .....	20
5.6 Miscellaneous Aspects of Human Resources Management.....	21
6. Conclusions.....	23
Annex A: List of Interviewees .....	25
Annex B: Details of Employment Contracts.....	27
Annex C: Bibliography .....	29

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## List of Tables

Table 1. Health Care Resources in Georgia (1990) Compared with Other Countries.....	3
Table 2. Changes in Numbers of Health Personnel since Independence (per 100,000 population).....	4
Table 3. Basic Data on Study Hospitals.....	7

Table 4. Basic Data Trends at Children’s Republican Hospital, 1995-99.....8

Table 5. Staff Meetings at Study Hospitals ..... 10

Table 6. Basis for Calculating Formal Salaries ..... 16

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# Acronyms

<b>BOR</b>	Bed Occupancy Rate
<b>CH5</b>	City Hospital No. 5
<b>CRH</b>	Children's Republican Hospital
<b>GEL</b>	Georgian Lari
<b>HR</b>	Human Resources
<b>MOH</b>	Ministry of Health
<b>SMIC</b>	State Medical Insurance Company

## Currency Conversion:

GEL 1 = US\$ 0.50



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# Foreword

Part of the mission of the Partnerships in Health Reform Project (PHR) is to advance “knowledge and methodologies to develop, implement, and monitor health reforms and their impact.” This goal is addressed not only through PHR’s technical assistance work but also through its Applied Research program, designed to complement and support technical assistance activities. The program comprises Major Applied Research studies and Small Applied Research grants.

The Major Applied Research topics that PHR is pursuing are those in which there is substantial interest on the part of policymakers, but only limited hard empirical evidence to guide policymakers and policy implementors. Currently researchers are investigating six main areas:

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- > The impact of alternative provider payment systems
- > Expanded coverage of priority services through the private sector
- > Equity of health sector revenue generation and allocation patterns
- > Impact of health sector reform on public sector health worker motivation
- > Decentralization: local level priority setting and allocation

Each Major Applied Research Area yields working papers and technical papers. Working papers reflect the first phase of the research process. The papers are varied; they include literature reviews, conceptual papers, single country-case studies, and document reviews. None of the papers is a polished final product; rather, they are intended to further the research process—shedding further light on what seemed to be a promising avenue for research or exploring the literature around a particular issue. While they are written primarily to help guide the research team, they are also likely to be of interest to other researchers, or policymakers interested in particular issues or countries.

Ultimately, the working papers will contribute to more final and thorough pieces of research work, such as multi-country studies and reports presenting methodological developments or policy relevant conclusions. These more polished pieces will be published as technical papers.

All reports will be disseminated by the PHR Resource Center and via the PHR website.

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# 1. Introduction

This paper is the product of the first phase of a study on health worker motivation in Georgia. The overall aim of the study is to analyze the determinants and outcomes of health worker motivation in two Georgian hospitals. A parallel study, using the same methodology, is being conducted in the Hashemite Kingdom of Jordan. This component of the study analyzes the organizational structures and culture of the study hospitals and their relationship to broader societal culture. It also analyzes how ongoing health sector reforms and broader economic reforms are likely to affect health worker motivation. Further phases of the research will explore the determinants and consequences of worker motivation using both qualitative and quantitative techniques. The contextual analysis is designed to help explain findings regarding motivation at the individual level, which will come from future phases of the research.

The structure of this paper draws upon the conceptual framework developed for the research (Bennett and Franco 1999). It considers the:

- > historical and socio-cultural context;
- > relationships with the community;
- > organizational features of the hospital, notably organizational structure, resource availability, organizational culture, and human resource management practices.

The two hospitals studied in Georgia were the Children's Republican Hospital (CRH) and City Hospital No. 5 (CH5). Both are general hospitals located in Tbilisi. They were selected for the way they met the following criteria:

- > *size*: they are both large hospitals with a large staffing complement;
- > *prestige*: the CRH is a prestigious institution whereas the CH5 is not;
- > *homogeneity and degree of unity*: many hospitals in Tbilisi are very fragmented with different departments privatized and run more or less independently. These two hospitals retain a high degree of unity and homogeneity, which both simplifies the organizational assessment and facilitates comparisons between the hospitals;
- > *existence "post-optimization"*: the government is in the process of implementing a hospital "optimization" plan which will close or merge many of the hospitals in the Tbilisi area; according to the plan the two selected hospitals will continue to exist and function more or less in their present form.

The information contained in this paper is based upon two sources: first, document review, particularly of the gray literature, including project documents and reviews prepared by donors and

government agencies in Georgia; second, in-depth interviews conducted with six senior managers in each of the two study hospitals.<sup>1</sup>

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<sup>1</sup> See Annex A for a list of interviews conducted.

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## 2. Historical, Socio-cultural, and Health Sector Reform Context

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### 2.1 Historical Context

During the past decade Georgia has undergone a remarkable transition from being part of the former Soviet Union to becoming an independent democratic state. This transition, which in many senses is still ongoing, has had dramatic and far-reaching effects upon health workers. During the communist period, a well-resourced and extensive network of health care facilities was established, and many people were trained as professional health workers. Data from the period suggest that in terms of physical infrastructure and personnel the Soviet system was better resourced than health care systems in many Western European countries. Within the Soviet Union, Georgia was among the best resourced of the republics in terms of physicians.

**Table 1. Health Care Resources in Georgia (1990) Compared with Other Countries**

	<b>Physicians per 1000 population</b>	<b>Hospital beds per 1000 population</b>
Georgia	4.9	9.7
European Union average	3.1	8.5
Central/Eastern Europe average	2.4	8.0
New Independent States average	3.9	13.3

*Source: Ministry of Health 1999*

Physicians during the Soviet period were relatively well respected, particularly if they were highly qualified specialists. They received regular and adequate salaries, although during the latter days of the Soviet regime salaries did not keep pace with cost of living increases. A structured system of promotion existed: based upon the number of years for which an employee had been in a particular post, s/he was entitled to further training and to sit examinations for further qualifications. In turn these qualifications entitled the staff member to promotions and salary increases. Unemployment was unknown. Medical staff, particularly physicians, also perceived themselves to be part of the entire Soviet medical system, with access to Soviet journals and new technologies.

Following the collapse of the Soviet regime, Georgia experienced a period of extreme instability (1992-93) and civil disturbance. During this period there was an almost complete collapse of the economy and of the legitimacy of the state. Since 1994 both of these dimensions have been gradually rebuilt; however, the combination of the economic recession, combined with the government's limited ability to generate revenue and a consistently low priority afforded to the health sector has resulted in very low and declining resource allocations to health care (World Bank undated). Current budgeted state spending on health is in the region of \$11 per capita; however, in reality only a fraction of this (in 1998 approximately 40 percent) is actually transferred to the health care sector bringing public expenditure on health care down to a level comparable with some low-income countries in Sub-Saharan Africa and Asia (World Bank undated).

This level of funding is clearly inadequate to support the extensive health sector infrastructure established during the Soviet period. Table 2 shows the total number of health personnel in Georgia for the period 1995-98. While there has been a decline in the number of nurses and midwives, there does not appear to have been any substantive decline in the number of working doctors. It is likely that many physicians are now unemployed, underemployed, or working in a different profession.

**Table 2. Changes in Numbers of Health Personnel since Independence (per 100,000 population)**

	1995	1996	1997	1998
Working doctors/Georgia	412	369	421	404
Internal medicine	61	45	57	48
Surgeon	16	17	21	21
Pediatrician	48	41	47	44
Neurologist	13	12	14	14
Obstetrician/Gynecologist	29	28	32	32
Tuberculosis specialist	5	5	4	4
Working doctors/Tbilisi				759
Working nurses/midwives per 100,000	747	581	577	555
Hospitals/Georgia	5.60	5.12	5.56	5.27
Hospitals/Tbilisi			5.15	5.31
Hospital beds/Georgia			474	457
Hospital beds/Tbilisi			732	690

While it is thought that there has been some reduction in the number of staff working in public sector facilities, accurate data are not available. There were no mandatory redundancies; instead, staff who retired were not replaced, and many of the more entrepreneurially minded young professional staff also left the public sector and were not replaced. Nonetheless there are still inadequate resources to properly fund staff salaries: payments to staff are frequently below a living wage and payment is irregular. The form of payment has also changed from a fixed salary to a piece rate basis<sup>2</sup> for all professional staff.

As a direct consequence of the extreme inadequacy of government funding for health care, all cadres of health staff directly involved in health care provision have become much more reliant upon financial contributions from patients (primarily informal payments). This in turn has changed considerably the relationship between health worker and client. One respondent suggested that physicians are much more vulnerable and unprotected than they were formerly. The fact that “the patient has no money and the doctor no salary” (interviewee CRH) creates tension in the relationship. Health workers not directly involved in the delivery of health services may also seek other ways to use their position to supplement their salary (e.g., through “selling” jobs, seeking commission on contracts, leasing hospital assets, etc.).

The situation differs somewhat by category of health worker. The reduction in staffing is largely among non-professional cadres such as hospital attendants. As there are few alternative more-

<sup>2</sup> More precise details of existing formal salary structures are given in section 5.2.

remunerative job openings, physicians and nurses have been unwilling to voluntarily leave their posts. Unskilled staff, on the other hand, may be able to find work in the private sector.

Health workers are not alone in experiencing this decline in salary. Many professionals in Georgia (engineers, economists, teachers) have experienced a similar decline in fortunes. In some respects health staff may be better off than certain other professionals as there is still a demand for their services among the general population. However it is clear that the majority of health workers are not part of the emerging new elite class, and that their salary and status are relatively lower today than they were 20 years ago.

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## 2.2 Socio-cultural Context

In Georgia, as in other post-communist countries, the collapse of the Soviet Union has been accompanied by a painful process of revaluation. Several studies since independence have helped build up a profile of Georgian attitudes towards work.

Data collected in 1996 under the auspices of the World Values Survey ranked six key values in Georgia as follows:

Family (2.7)

Friends (2.4)

Work (2.4)

Religion (1.97)

Free time (1.96)

Politics (1.07).

Scores (from a four-point scale) are shown in brackets. According to the authors of the study the society is characterized by high rate of depression, while the main behavioral strategy is passivity (adjustment, escape) (Young Scientists' Works 1998). Another study of work values conducted among employees of seven large industrial companies found that social solidarity was the *only* key value in the companies.

These data have much in common with the findings of Schwartz's Study on the Eastern European Value System. This study showed that in former communist countries of Central and Eastern Europe the most dominant values are those that do not correspond to democratic development. Indicators of values such as egalitarianism (overcoming selfish values and care for others' well-being) and autonomy are low. Fatalism (exteriorization of responsibility and external locus of control) was found to be a key feature of the so-called "post-communist syndrome." This syndrome is characterized by an acquired sense of helplessness and lack of civil culture. The 70-year Soviet experience also fostered a negative attitude to state and legal institutions. As a result of repression of generally recognized values (equality and trust in others), the attitudes associated with the "post-communist syndrome" formed as survival strategy. However, under new circumstances, the persistence of these passive and anti-civic attitudes and behaviors is problematic.

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## 2.3 Health Sector Reform in Georgia

The government of Georgia embarked upon a program of health sector reform in 1995. Key thrusts of this reform program include (Gzirishvili and Mataradze 1999):

- > Decentralization;
- > The development of new and innovative financing schemes;
- > Transition from government budget-financed health care to an insurance-based system;
- > Prioritization of primary care;
- > Support for privatization.

In practice, there frequently has not been sufficient political will to implement the reform agenda set out, particularly when it embodies unpopular elements such as privatization and reduction of staffing. Some elements of reform have proceeded. For example, out-of-pocket payments for health care outside of the basic benefit package have been legitimized and the legal status of hospitals has changed, giving them substantially more managerial autonomy. A State Health Fund was established; however, due to problems in implementation it was necessary to re-launch this as the State Medical Insurance Company (SMIC). Although insurance has been espoused as the basis for health care financing, the SMIC does not really operate on the lines of an insurance company: a mandatory tax is levied on all formal sector employees, while benefits are provided to everyone. Limited progress has been made with privatization despite the large over-supply of hospital beds. A hospital restructuring plan exists but discussions are still underway about how best it may be implemented.

Some elements of the reform program have specifically targeted health workers. For example, the Georgian government is in the process of relicensing all physicians and nurses. This process is designed to identify and prevent from practicing those professionals whose skills are inadequate. The relicensing process for physicians includes a multiple choice examination, an oral examination, and an interview with a special licensing board. The process should have been completed recently but is running considerably behind schedule.

In summary it is probably the case that most of the major changes within the health sector have occurred as a result of the limited public finance base for the health sector, combined with the economic collapse, rather than the reform program per se. However the process of health sector reform adds a further dimension of change and probably contributes to the degree of risk and uncertainty felt by health workers.

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### 3. Overview of the Two Study Hospitals and Relationships with Catchment Communities

Basic data on the two study hospitals are provided in Table 3.

City Hospital No. 5 was built by the Ministry of Production to serve workers at the nearby military factory<sup>3</sup> and their families. The hospital was originally planned to have 450 beds, but now only 310 are in operation. A hospital and polyclinic are located on the same site. The City Children's Hospital No. 5, previously a separate facility, was closed in 1999 and absorbed into the CH5's Maternal and Child Health department.

CH5 is located in Samgora, on the outskirts of Tbilisi. It currently has a catchment population of 220,000 people. Previously the catchment population was 300-400 thousand people, but, due to the collapse of the factory, there has been much out-migration from the area. Employment at the military factory fell from 30,000 people during the Soviet period to only 1,500 persons. Accordingly incomes in the area have decreased dramatically and the hospital now serves a largely poor population who have limited ability to pay for health care. Previously the hospital had a big contract with the factory to provide care for factory workers, but the factory is no longer profitable and ran up a large debt (300,000 Georgian lari [GEL]<sup>4</sup>) with the hospital. Consequently the hospital terminated the contract.

**Table 3. Basic Data on Study Hospitals**

	<b>City Hospital No. 5</b>	<b>Children's Republican Hospital</b>
<b>Total beds</b>	310	415
<b>Total staff</b>	480	890
Physicians	150	241
Nurses	200	363
Hospital attendants	80	144
Other	50	142
Percent staff on unpaid leave	7%	25%

The Children's Republican Hospital is a multi-profile hospital with virtually all specialties represented. It is located close to four or five other tertiary hospitals. Patients come from throughout Tbilisi to seek services at the hospital. CHR not only provides medical services but also serves as a teaching hospital and scientific center. Formerly it provided methodological support and supervision to other health care facilities in Tbilisi, but this is no longer the case (interview data).

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<sup>3</sup> The military factory used to produce aircraft for the former USSR.

<sup>4</sup> GEL 1 = US\$ 0.50

Table 4 shows the gradual decline in staffing and hospital beds at the CRH since 1995. Similar data are not available for CH5.

**Table 4. Basic Data Trends at Children’s Republican Hospital, 1995-99**

	1995	1996	1997	1998	1999
Number of working doctors	314	333	297	230	227
Number of working nurses/midwives	415	384	387	386	363
Number of hospital beds	650	650	650	650	424

*Source: Zoidze et al. 1999*

Neither hospital had any formal mechanism for seeking either community views about the hospital or feedback from patients using the hospital. Patients registered complaints with the hospital if they felt they had been poorly treated. While gratitude to the hospital was most likely expressed at the departmental level, complaints were more likely to be addressed to senior hospital management (interview data). Complaints at the Children’s Republican Hospital were said to focus on lack of certain resources (such as drugs) or be related to lack of cordiality and attention from staff. Respondents there thought that the community perceived the hospital to be a leading hospital for children who needed qualified medical care. Articles about the hospital are carried relatively frequently in the media, and they generally focus on very unique or difficult cases that the hospital has treated.

Respondents at City Hospital No. 5 appeared much more likely to focus upon the relationship between the hospital and its catchment community than did respondents at the Children’s Republican Hospital. For example, one respondent describing the mission of CH5 emphasized that it served a high density, economically deprived catchment area. Another respondent talked about the need to understand and empathize with patients and that being a health professional was a “gift from God.”

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## 4. Organizational Context

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### 4.1 Organizational Structure

The Children's Republican Hospital has two boards: the Executive Board and the Supervisory Board. The Executive Board comprises heads of all the directorates within the hospital. The Supervisory Board has three positions: Two are reserved for Ministry of Health (MOH) officials, although in practice the MOH has appointed two members of the hospital staff to fill these positions. The third position is held by the hospital director, who also heads the board. The hospital director heads the Supervisory Board, and, although the MOH should occupy the other two positions, it has in fact appointed two members of staff at the hospital to sit in these positions.<sup>5</sup>

The Supervisory Board at City Hospital No. 5 consists of 15 staff members who are elected by the staff to serve a one-year term. The head of the board is elected by board members. The board was established nearly two years ago, after the MOH recommended it. The board discusses managerial and administrative issues, but it was not clear how much authority it had within the hospital.

The Children's Republican Hospital recently changed status from a treasury enterprise<sup>6</sup> to a "joint stock" company. At the time there was some discussion of employee share-holding, but the employees were never formally consulted on this, and in the end the hospital remained 100 percent state owned. The City Hospital No. 5 was incorporated as a limited liability company. The state (through the Ministry of Property) owns 100 percent of shares. These changes in hospital status were associated with MOH policies to increase hospital autonomy; the formal change in ownership status also necessitated the implementation of the various boards described above.

In both hospitals front line health workers reported in the first instance to their head of department. Chief nursing officers in both hospitals have some responsibility for supervising middle-level staff (nurses and hospital attendants) but this responsibility must always be exercised in coordination with heads of department. Similarly, hospital deputy directors have responsibility for certain aspects of technical quality of care, but any reviews or training they conduct must be coordinated through heads of department. Despite a fairly traditional organizational structure, both hospitals appeared to have quite decentralized decision-making processes, due in part to the dependence upon revenues generated from informal charges at the departmental level.

Neither of the hospitals had a clear mission statement. Although senior staff interviewed were able to identify what they thought to be the mission of the hospital, what they said varied considerably, and it was clear that there had been no discussion, even at this level, of what the organizational mission was.

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<sup>5</sup> After the completion of this contextual analysis and the 360 degree analysis but while the in-depth study of determinants of motivation was in progress, the MOH changed the structure of the board at CRH in order bring new management into the hospital.

<sup>6</sup> A special form of incorporation existed before: the enterprise was established by the state (central or local government) by special decree (interview data). The state owned all assets, approved the budget, and designated the director. The enterprise was accountable only to state officials. Treasury enterprises were exempted from property taxes.

Both hospitals also had quite clear and well-established patterns of staff meetings (see Table 5), which occurred at different levels of the hospital and among different cadres of staff.

**Table 5. Staff Meetings at Study Hospitals**

<b>Children’s Republican Hospital</b>	<b>City Hospital No. 5</b>
Hospital-wide senior staff meetings held informally on a daily basis	Hospital-wide senior management meeting three times a week, early in the morning
Fifteen-minute medical records reviews for surgery departments on a daily basis.	Medical records review and establishment of clinical guidelines (all senior medical staff) every two weeks.
Monthly training sessions for nursing staff	Monthly theoretical conferences for nursing staff
Daily departmental meetings—mostly informal, degree of formality varies by departments	Frequent departmental meetings—mostly informal, degree of formality varies by department

These staff meetings were seen by hospital staff as one of the principal ways in which to promote quality of care. Staff at the Children’s Republican Hospital also mentioned the recently installed computer network with internet connection, which helped keep staff up-to-date. Staff at both hospitals noted that during the communist period they received Soviet medical journals, which kept them abreast of recent technical developments, but because of the economic crisis, such journals were no longer received. As one respondent observed, for five years, “we were in a vacuum.”

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## **4.2 Resource Availability**

Both of these hospitals are largely funded by reimbursements made by state programs, notably the State Medical Insurance Corporation and Tbilisi Municipality, for care provided to patients. As is the case for all hospitals in Georgia, funding from the state programs is far from adequate and often paid late, or not at all. Hospitals are also allowed to charge user fees for services provided outside these state programs. However at both hospitals such formal fees account for a very limited proportion of income. As a consequence, both hospitals are sorely under-funded. A further important funding source is informal payments from patients. These are paid directly to staff at the departmental level or below and help to supplement health worker incomes as well as cover the cost of certain critical medical supplies and drugs. There is no record of how much either hospital receives in informal payments. This funding structure means that there are virtually no resources available for funding maintenance or other hospital-level operating costs such as utilities. During the study period City Hospital No. 5 was facing critical problems in meeting electricity bills and was under threat of having its electricity supply cut off.

Both hospitals are located in large buildings which are now very underutilized. Although City Hospital No. 5 was only built in 1983, the buildings are already quite rundown. Space that is well used (e.g., operating theaters, offices of senior staff) is clean and well-kept in both hospitals, but public space is often dirtier and, in winter, very cold. Both hospitals have water and electricity, but telephones at CH5 do not function well.

Senior staff at both hospitals acknowledged that equipment was often out-of-date and sometimes not functioning well. Staff felt that the hospitals were very behind in the acquisition of new

technology (interview data). Little new technology had been purchased in the past 10 years. However it was asserted by one respondent that this was not a real source of frustration for doctors. At the Children's Republican Hospital the situation is now beginning to change. For example Japanese aid funds are being used to develop a new diagnostic center. At City Hospital No. 5 the situation appeared worse. For example, three of the four X-ray machines at the hospital were not functioning.<sup>7</sup>

At City Hospital No. 5 a shortage of basic supplies, such as drugs and disposables, also appeared problematic (interview data). One respondent noted that part of the problem was very tight central hospital level, "bureaucratic" control over such resources.

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### 4.3 Organizational Culture

Staff at the hospitals were not unionized, and there were no staff associations. Although professional associations exist in Georgia and many physicians are members of them, at the moment this is largely a formalistic association. There are no membership dues, and the associations have little real power.

Each hospital had a distinctive organizational culture. Several respondents at the Children's Republican Hospital mentioned the very close social connections between hospital staff; indeed, one said "we are all relatives." He attributed this closeness to a good staff selection process when the hospital was established, and with social rituals (such as celebrations of birthdays, weddings) that helped to reinforce this closeness. Another respondent at the CRH agreed that staff used to be very friendly, but added that as life has become more difficult and people have "hungry children at home," it was less easy to maintain this friendliness.

This social solidarity among staff at CRH was reflected in how the hospital had handled the need to cut staff. One respondent said that the hospital tried to keep as many doctors for as long as possible. As a consequence it was common for the salary of two or three positions to be shared across five persons.

A new staff member at City Hospital No. 5 argued that the hospital had a very particular organizational culture that was probably due to its association with the military factory. He argued that it was more centralized than other hospitals and more "manageable." He attributed this to the fact that many staff had family members in the military or working at the military factory, and consequently many had a "military" attitude.

Staff at CH5 appeared more connected to the community that they served than staff at the Children's Republican Hospital. During one period transportation to the city hospital was very poor. Many staff left at this time; those who stayed, particularly the nurses and ancillary staff, tended to be those who lived close by.<sup>8</sup> Respondents at CH5 mentioned more frequently the importance of serving the local community or religious motivation for their work.

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<sup>7</sup> Unfortunately all items of equipment at City Hospital No. 5 purchased during the Soviet era came from Russia, and because the factory had regular flights to Moscow they were also serviced in Russia. Now the hospital does not even have technical manuals so that equipment can be serviced locally.

<sup>8</sup> Others who stayed would get a bus from the center of town as close as they could to the hospital and then walk the remaining distance (4-5 kilometers).

Two respondents at City Hospital No. 5 mentioned the social relationships among staff, but these now seemed to be of less importance than at the Children's Republican Hospital. As one respondent noted: "Before the whole hospital was like one family, there was responsibility between members. But this is no longer the case...if someone comes late and you ask them why, they will respond 'well,

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# 5. Human Resource Management Practices

This section covers a number of different aspects of human resources (HR) management practices including:

- > Selection and recruitment procedures
- > Remuneration
- > Consequences of performance
- > Firing staff and unpaid leave
- > Training and skills development.

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## 5.1 Selection and Recruitment Procedures

Neither hospital had recruited new physicians, as both facilities already had an excess. There was occasional recruitment of nursing staff and very frequent recruitment of hospital attendants. The frequent recruitment of attendants was due to the high turnover among this category of staff. Hospital attendants have low and irregularly paid official salaries, difficult hours (20-hour shifts at CH5, and 24-hour at CRH) and only limited opportunity to supplement their official salaries through unofficial earnings. Consequently many leave to work in restaurants or other private sector enterprises. It was estimated at City Hospital No. 5 that one new hospital attendant was hired each week.

It appeared to the study that neither hospital had a formal, transparent set of procedures for hiring new staff.

People seeking work as hospital attendants generally presented themselves directly to the HR managers at the hospitals. There was no need to advertise for this category of employee. People heard about vacancies through word of mouth. Human resource managers at both hospitals stressed that they tried to warn applicants of the difficult conditions. At the Children's Republican Hospital the HR manager emphasized to applicants the fact that salaries were unlikely to be paid on time, and sometimes were not paid at all. At City Hospital No. 5 the HR manager sent job seekers to the department to work for 2-3 days without a contract so that they could understand the true nature of the job before formally hiring them.

Unemployed nurses occasionally came to the HR manager at the Children's Republican Hospital, asking if there were any vacancies. If the HR manager thought there was any hope of employment, she would refer them on to the relevant head of department and to the chief nursing officer for interview. If the nurse was accepted, she was given a one-month trial period, at the end of which the head of department decided whether or not to keep her. The HR manager could not remember of anyone having to leave at the end of the trial period.

Previously at City Hospital No. 5, nursing vacancies were advertised on the notice board and applicants would apply to the HR department, which would then refer them to the chief nursing

officer. The chief nursing officer would interview candidates and evaluate their appropriateness for employment. Now, new nurses are appointed by the head of department with support from the head doctor. The chief nursing officer sees the nurse only after her appointment. Heads of department are responsible for outlining to prospective hires the roles and responsibilities of their position.

It is very common in Georgia for people to pay for posts at hospitals, even in not particularly prestigious hospitals such as City Hospital No. 5. As the CH5 chief nursing officer made clear that she would not accept bribes of any sort, it was possible that she was now being bypassed in the selection process so as to make recruitment a more remunerative activity for other staff members. The hospital director also reported that one of the good recent changes in staffing procedures was that he was allowed to recruit staff directly without having to seek permission from the municipality.

Hospitals in Georgia still use the labor book system established during Soviet times. Thus at the time of recruitment staff members present their labor book to the human resource department. This book includes information on qualifications and jobs previously held.

New staff joining the hospital sign an employment contract. Generic forms of these contracts were provided by the MOH and hospitals have made minor adaptations. Contracts are reviewed and revised every five years, but the hospital can in the meantime revise remuneration rates without changing the contract. Annex B describes the main clauses in the contract. While a list of responsibilities is provided in the contract, it is not very specific. Furthermore the HR manager at the Children's Republican Hospital suggested that staff had very little awareness of the contract despite signing it when joining the hospital. She stated that no one ever referred to a contract in the case of a dispute or problem. In August 1995, when the new contracts were introduced, staff were very suspicious of them; there was little understanding among them about the notion of a contract. Many refused to sign, and it took almost a year to collect all the contracts.

In terms of finding candidates to fill senior management positions such as head of department posts, City Hospital No. 5 used a variety of approaches. For the three new heads of department recently appointed, one was an external person recommended by the chief surgeon. Another post was advertised, and, from a short list of three including two internal applicants, the outsider got the job. For the final position, an internal staff member was promoted to an acting position; this was later changed to a permanent position once hospital management was convinced that the person could do the job.

At the Children's Republican Hospital it appeared much more likely that promotions would be made internally. The hospital Medical Board would interview all candidates and select based upon the candidate's performance to date and age (hires should be less than 50 years) (interview data).

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## **5.2 Remuneration**

### ***Formal salaries***

Since the Soviet period there has been a dramatic change in the remuneration system. To explain this system clearly it is necessary to provide some background on overall hospital financing and payment mechanisms.

Hospitals in Tbilisi derive revenues principally from two sources: programs run by the Tbilisi municipality and state programs run by the State Medical Insurance Company. These programs pay

for the care provided to the vast majority of patients at both hospitals.<sup>9</sup> Hospitals quite openly stated that physicians would shift diagnosis so that the patient fell under an existing program. Both of the payers basically pay on a fee-for-service basis.<sup>10</sup> In addition the hospital has its own “internal standards” or price list.

Although hospitals have a considerable formal degree of flexibility in setting salary rates for staff, in practice this flexibility is curtailed by municipal and state program payment standards. These standards define how much the programs will pay for different health care services; in most cases staff payments are directly derived from these standards. For each patient, a form is completed listing all procedures conducted and which staff member was responsible for what. Staff are then paid on a fee-for-service basis.

There is a range of payment norms for staff. For example, a doctor can be paid from GEL 80 to GEL 140 for 50 bed days. Hospitals decide where to appoint a doctor on this scale. Rates tend to differ by specialty. For example surgeons have higher rates than specialists in internal medicine, but even within the same specialty there are small rate differences. The amount due on a fee-for-service basis is then weighted according to the department’s bed occupancy rates. So departments with high bed occupancy rates will receive a higher weighting than those with low bed occupancy rates.<sup>11</sup>

The system described above was used for paying all staff directly involved in the delivery of health care services. For administrative staff, senior managers, and hospital attendants, other payment mechanisms were used. At City Hospital No. 5 all administrative staff were on fixed salary. At the Children’s Republican Hospital the salary for administrative staff was linked to total hospital bed occupancy rate.<sup>12</sup> Hospital attendants at both hospitals were paid more or less on a flat rate basis, though at CH5 the pay of a hospital attendant who worked for a single department was weighted by the departmental bed occupancy rate.

Heads of department at both hospitals practiced medicine and therefore received an official income from this practice, but they also received a salary related to their management duties. This salary also came from reimbursements from state programs. Previously at the Children’s Republican Hospital this salary was related to departmental bed occupancy rate. However the financial manager at the hospital had recently changed means of paying heads of department and the head doctor. With the change, heads of department earned approximately 1.2-1.3 times the average salary of physicians in their department, and the head doctor earned 1.4 times the average salary of heads of department.<sup>13</sup> This system was set up to create incentives for managers to encourage the productivity of staff within their department. It also created incentives to get rid of underperforming staff.

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<sup>9</sup> At the Children’s Republican Hospital it was estimated that about 80 percent of revenues came from SMIC and 20 percent from municipal programs. Only 1-2 percent of patients are not covered by a program.

<sup>10</sup> Although this payment system is frequently referred to in official documents as being a system of case based payment, its structure is not case based at all. Payments are linked to specific procedures rendered.

<sup>11</sup> Note this creates conflicting incentives for staff and management in terms of closing beds. Staff at the departmental level will want bed occupancy rates as high as possible to get high salary weightings, but it is in the interests of senior management to have low bed occupancy rates so that there are low salary weightings.

<sup>12</sup> So if the bed occupancy rate was 35 percent then administrative staff may be paid their “notional” full salary multiplied by a loading of 0.35. This means that remuneration is higher for such central-level staff when hospital occupancy rates are higher (and therefore hospital income is also higher).

<sup>13</sup> Curiously, the ratios used as the basis for calculating salaries for heads of department and the head doctor were derived from typical salary ratios between these levels of doctor during the Soviet period.

Table 6 summarizes the payment mechanisms for different categories of staff within the hospitals.

**Table 6. Basis for Calculating Formal Salaries**

	<b>Children’s Republican Hospital</b>	<b>City Hospital No. 5</b>
Physicians	Fee for service (according to rate defined in contract) weighted by bed occupancy rate (BOR).	Fee for service (according to rate defined in contract), weighted by BOR
Nurses	Fee for service weighted by BOR	Fee for service weighted by BOR
Hospital attendant (attached to department)	Lump sum salary weighted by departmental BOR	Lump sum salary weighted by BOR
Hospital attendant (not attached)	Lump sum salary	Lump sum salary
Administrative staff	Lump sum salary weighted by hospital BOR	Lump sum salary
Heads of department	Salary set at 1.2-1.3 times the average salary of physician in department	Lump sum salary weighted by departmental BOR
Head doctor	Salary set at 1.4 times average salary of head of department	Unclear

This labyrinthine system of remuneration accounts for a small proportion (30-40 percent) of the income of most hospital workers. Typical formal salaries for doctors may only be GEL 30-40 per month and for other health workers less than GEL 30. Health workers (or at least physicians, nurses, and allied health workers such as X-ray technicians) themselves do not pay much attention to the complex way in which their formal salaries are calculated, as they are much more concerned about informal earnings.

***Informal earnings***

Opportunities for informal earnings are normally defined at the departmental level. As only one of the interviews conducted for this contextual analysis was at this level, this study cannot provide a detailed description of how informal earnings work in the two hospitals. The information presented here is derived from what senior managers knew and were prepared to discuss<sup>14</sup> and from the broader literature on informal payments in the Georgian health sector.

Respondents stressed the unrealistically low level of formal salaries. For example, at the Children’s Republican Hospital, doctors received roughly GEL 0.25 per hospital inpatient day. Given the size of the hospital and the number of physicians, the maximum doctors could receive was about GEL 68 per month. In reality doctors only had on average two cases at a time—worth about GEL

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<sup>14</sup> Very senior respondents, such as the hospital director at the Children’s Republican Hospital were quite open about issues related to informal payments within the hospital. Less-senior staff were frequently more concerned about saying something inappropriate.

0.50 a day. Similarly the maximum price for a diagnostic procedure was GEL 15, of which only 30 percent went to the doctor. Official rates were too low to make a living wage, and hence informal charges were inevitable.

Respondents among senior management in general claimed that they did not know how much staff were earning from unofficial fees. Fortunately there are other sources that provide information on the level of informal charges.

Household survey data from 1997 found that for certain employment sectors, notably health care, consumption per household was considerably higher than declared income per household. This gap was attributed primarily to informal, undeclared earnings. For workers in health and social services consumption per household was GEL 261 per month compared to a declared total income of GEL 130. This gap was one of the highest found among employment groups, with the exceptions of those employed in electricity, gas and water, hotels and restaurants, and public administration and defense<sup>15</sup> (World Bank 1999). In focus group discussions health workers “hesitated to talk about their own income and also found it very difficult to determine the average income of physicians” (GORBI 2000). The figures given by these focus groups suggest a very wide range of informal wages. One physician noted that informal payments accounted for about 70 percent of his income (his salary was GEL 75 per month). It was estimated that middle-level physicians earned 100-150 GEL per month from informal payments. Nurses stated that they had very low incomes, averaging about GEL 20 per month, but that nurses working in certain departments (e.g., surgery) could earn considerably more, say GEL 100 per month from informal sources.

All respondents were clear that there were considerable differences in ability to earn from informal payments. At City Hospital No. 5 it was asserted that obstetrics/gynecology nurses earn the most of all nurses, followed by nurses in surgery; nurses in internal medicine earn the least (interview data). Other studies confirm this pattern. Ultrasound operators in particular were perceived to do very well from informal payments, earning up to GEL 1500 per month; gynecologists, dentists, and surgeons also had good earnings (GORBI 2000).

The system through which informal payments are managed in a hospital may be more or less organized, and this has implications for the distribution of revenues. During the early post-reform period, the head doctor at the Children’s Republican Hospital had attempted to manage informal payments on a hospital-wide basis: doctors were asked to pay their informal earnings to the cashier, and they would then receive a percentage back. However, as state financing of salaries deteriorated, this policy became untenable. The study found that informal earnings at the Children’s Republican Hospital appeared to be well managed. In general, payments were shared across the team of staff working for a patient. Before being hired new employees would find out about how informal payments are distributed across the team, although they were not given an indication of how much to expect in informal earnings (interview data). Several informants stated that there were rarely if ever any complaints about how informal earnings were distributed among staff, and few patients complained.

In many hospitals there is a “trickle-up” system for informal payments in which a percentage of earnings is passed up to senior management. Some senior staff may refuse to participate in this system as it makes them feel indebted to the managers below them and hence reduces their sphere of independent action. One respondent at City Hospital No. 5 asserted that she would take no cut of

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<sup>15</sup> These categories support the authors’ assertion that the gap is due to informal undeclared cash incomes. All of the other categories listed have significant opportunities for informal payments.

informal earnings for this reason (interview data), but it seems likely that the practice of taking cuts from the informal earnings of subordinates does prevail at the hospital. At the Children's Republican Hospital it seemed less likely that the practice existed: respondents repeatedly asserted that informal fees were a departmental-level issue and the senior staff interviewed claimed they had no involvement in it.

Senior staff do however have other opportunities for supplementing their state salaries. For example, senior staff may also earn income from large contracts (e.g., for equipment or maintenance) and from "selling" jobs. The latter can be a particularly pernicious form of informal payment as it sorely limits actions that can be taken against the staff member at a later date.

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### 5.3 Rewarding Good Performance, Punishing Poor Performance

Neither hospital had any formal system of performance appraisal; indeed, such systems are not common in Georgia. Furthermore the formal payment system, described above does not distinguish between good performance and bad performance of individual workers; payment is linked only to the number of patients seen and procedures conducted.<sup>16</sup> There is now no formal system of promotion through grades: payment rates are not increased according to seniority or performance, nor is there any change in grade, title, or responsibilities. The only scope for promotion would be to a supervisory position; however, the attractiveness of such a position is unclear, as it is not particularly well remunerated. When probed about the lack of a formal promotion system, respondents frequently claimed that good doctors get more patients and therefore higher payments. However non-medical staff at the Children's Republican Hospital observed that there was also a lot of bad practice among doctors at the hospital in order to attract patients.

During the Soviet period there was a well established system of non-financial rewards: staff who did particularly well had a congratulatory note put in their file or received a doctor-of-the-month award. But in general these specific, formal, non-financial awards seemed not to be valued by staff members now (interview data). Instead respondents noted a variety of more informal means of rewarding good performance including:

- > Verbal expressions of gratitude
- > Moving a nurse to a department with a higher workload
- > Paying good ancillary staff in a more timely manner than poor staff
- > Providing better conditions, for example, redecorating a doctor's office (which in turn may help attract more patients)
- > Redirecting informal payments from the head of department to the staff member
- > Directing public praise to good performance, for example, by announcing good performance at a staff meeting
- > Being more flexible in terms of timing of vacation time

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<sup>16</sup> Ironically many of the respondents interviewed referred to this system as "performance-related pay."

Despite these mechanisms, respondents indicated that they had very limited options in terms of rewarding good staff.

Both hospitals had formal processes to deal with poor performance by medical personnel. If a specific problem arose, such as a complaint from a patient, then in the first instance a small group, including the head of department and a deputy hospital director, would review the relevant medical charts. If they thought that there was a serious problem, the case would be referred to a special medical board (made up of hospital staff members) for review. All respondents who discussed the topic made a clear distinction between mistakes due to ignorance and problems resulting from unethical behavior or “personal” mistakes. Mistakes due to ignorance were said to be treated in a more lenient fashion, with an emphasis upon improving the skills of the staff member, than problems due to “bad” behavior. A variety of methods to “punish” poorly performing staff were identified including:

- > Administrative penalties: Doctors are dismissed after earning three “bad marks.” It appeared that this system was now very rarely used;
- > Public “shaming”: This was mentioned only at City Hospital No. 5 and included making a public announcement about the staff members behavior, downgrading their position so that a doctor might have to work for a month on the wards as a nurse,<sup>17</sup> or putting a doctor on unpopular duties such as community service or house visits;
- > Suspension of employment;
- > Applying financial penalties;
- > Informal admonishment.

Which of these punishments were used would depend largely upon the nature of the offense. Respondents at the Children’s Republican Hospital emphasized that the majority of cases could be dealt with in an informal manner and that there was only a small minority of cases where more formal measures were necessary. Respondents at both hospitals stated that nurses would commonly resign if they had been severely reprimanded rather than bear greater shame in the hospital.

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## 5.4 Firing Staff and Unpaid Leave

The question of firing staff is not relevant solely to bad performance but also as a practical measure to reduce excess staffing within the hospitals. Respondents universally agreed that it was very difficult to fire staff, particularly because of the 1984 labor law that has not yet been amended. In order to dismiss someone under the law, a considerable body of evidence has to be collected to prove that the person is not capable of doing a good job. An example was given of one staff member, directly involved in patient care, who became mentally ill. It took the hospital 10 years to dismiss her, and this was only done after the individual had been certified insane.<sup>18</sup> Similarly, at the Children’s Republican Hospital, there were cases of strong circumstantial evidence that an employee had stolen

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<sup>17</sup> It was acknowledged that this action might have a financial impact too, but it was clear that the force of the sanction was in the “shaming” element.

<sup>18</sup> In the end, although it was possible for the hospital to dismiss her, they chose to remove her to an administrative position where she would have no contact with patients.

from the hospital, but without calling in the police (and incurring additional problems) and getting a conviction the individual could not be dismissed. The hospitals fear that the individual concerned will sue them for unfair dismissal if all the paperwork is not in order.

Other issues also make firing staff very difficult. One respondent suggested that even if the labor code were changed there would be very strong resistance from doctors to layoffs, particularly because the hospital is publicly owned. On the one hand, there is still an attitude that the state should provide jobs, and, on the other, many doctors feel that they have contributed all their life to the hospital and the hospital has a moral responsibility to employ them (interview data). This attitude was confirmed by another (physician) respondent at the Children's Republican Hospital who emphasized how doctors would try to protect each other's jobs in the face of impending staffing cuts. However things do appear to be beginning to change: another respondent stated that one of the most important changes among staff in recent years was that doctors were now very concerned about not losing their job. Previously no one was unemployed, but they now knew that it was possible that they may become unemployed (interview data).

In order to cope with the excess staffing levels and the associated low salaries, both hospitals, but particularly the Children's Republican Hospital, had a large number of staff on unpaid leave. Approximately 20-30 percent of CHR staff was on unpaid leave, compared to approximately 7 percent at City Hospital No. 5 (where 30-35 of its total staffing complement of 480 were on unpaid leave). The percentage is higher at CHR because that hospital uses unpaid leave to circumvent a presidential decree that states that doctors who do not meet the specified minimum workload requirements for at least two months in a year should be fired. (CH5 ignores this rule.) The number of staff on unpaid leave at the CRH probably also is higher because the facility is more prestigious; thus, staff wish to maintain their association with it while seeking employment opportunities elsewhere.

Respondents at both hospitals stated that a request for unpaid leave was always initiated by the employee, although at the Children's Republican Hospital certain staff members may be encouraged to consider it as an option. There appeared to be two very different types of people taking unpaid leave: (1) those who should be laid off, but whom the hospital provides unpaid leave to as a psychological buffer before facing unemployment, and (2) people in departments where there is an informal agreement or rotating schedule of unpaid leaves to avoid regulations set out in the presidential decree concerning minimum workload. The most common length of unpaid leave at CRH is six months.

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## 5.5 Training and Skills Development

While the relicensing process described in section 2.3 above was seen to be a spur to improving skills and keeping knowledge up-to-date, many respondents were also skeptical about how fair the process would be. One respondent suggested that those doctors who were not motivated to study would probably manage to "find a way round" the licensing procedures.

Basic medical training in Georgia is remarkably weak in terms of providing practical skills, particularly for nurses. Thus if hospitals hire new graduates, then the hospitals must be prepared to provide intensive support to the new employees in terms of adapting their theoretical knowledge to the workplace. This process commonly seems to help bind the staff member to the department (interview data).

According to state regulations every doctor must take a four-month continuous education course at the Medical Academy every five years. The fee of GEL 28 must be paid by the doctor. Similar

courses are required of nurses, although the duration and cost is rather less. Nurses also may opt to attend practical seminars organized at the hospital on an ongoing basis. As these seminars are free and do not involve a long absence from work, nurses usually prefer them.

Senior physicians interviewed also saw the meetings for medical case review as being an important way to maintain skills (interview data)

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## **5.6 Miscellaneous Aspects of Human Resources Management**

### ***Turnover***

While turnover among ancillary staff is extremely high, it is extremely low among professional staff. Many of the managers interviewed had been at the same hospital for almost all their career, which means many had been working there for 15-20 years, and in one case for 51 years. Even among less senior categories of staff, workers have often spent their entire career at the same hospital.

At the Children's Republican Hospital the chief nursing officer interviewed all nurses leaving the hospital, to confirm that they were not leaving due to internal issues that could be resolved. She stated that in general if a nurse left the hospital then she was leaving the profession altogether, perhaps going to the rural areas to do agricultural work, or to start a family. Financial reasons were not significant reasons for leaving because it was unlikely that she would be able to find more remunerative work.

One respondent contrasted the attitudes of physicians and administrative staff to the current situation, saying that administrative staff were mentally much better prepared for redundancies whereas medical staff really could not conceive of alternative employment: "They still come to the hospital and sit with their legs crossed all day, despite the fact that there is nothing to do...they are in

### ***Rotations***

Rotations between departments were rare for doctors, more common for nurses. Nurses might be rotated so that they could broaden their skills and knowledge or so that they could benefit from a higher workload (interview data).

### ***Grievances***

At the Children's Republican Hospital there was said to be an employee grievance procedure. However the HR manager said that she could not recall an instance when she had had to initiate this since she joined the hospital in 1985. In general it was much more culturally acceptable for grievances to be resolved in an informal manner at the departmental level or below.



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## 6. Conclusions

This paper is largely descriptive in nature. The information it contains will become more valuable when it is combined with individual-level data on determinants of motivation. However there are a number of features of the Georgian context that are unique and likely to have significant implications for the individual-level analysis. These include:

- > The **dramatic nature of the changes** that have occurred in the society, in the health sector, and specifically for health staff since 1990. The collapse of the Soviet Union has inevitably led to multiple tiers of changes, from reform of the terms and conditions of health workers, to changes in the way hospitals are managed, to wider societal change from a command-and-control economy toward one based upon market principles. The ability of both hospital management and individuals to assimilate and manage change is probably a critical factor affecting motivation.
- > **Acute problems of funding** have plagued the health sector since independence. Government expenditure on health care is strikingly low, particularly when considered in the context of historically high levels of funding to the health sector.
- > **The payment structure** for staff in Georgia is quite unlike that commonly encountered in public health care systems. First, it is extraordinarily complex, and, given the complexities of the payment structure, it seems unlikely that staff fully comprehend the basis upon which they are paid. Second, this payment structure rewards productivity, but not the quality of work. Finally formal payments account for a relatively small proportion of the total income of health workers.
- > Unlike most public health care systems there is **no clearly defined career structure**; payments do not increase with seniority or experience, and there are no formal mechanisms for performance assessment.
- > The **importance of social relationships between workers** have not only been identified in other studies of worker motivation in Georgia but were repeatedly raised as an issue by respondents during this study.



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# Annex A: List of Interviewees

## **Children’s Republican Hospital**

Dr Tengiz Bakradze - Head Doctor

Mr Gela Beroshvili - Financial Manager

Ms Rosa Tsanakidze - Chief Nursing Officer

Dr Tariel Chincharauli - Deputy Head Doctor, Surgery

Ms Marina Lomidze - Head, Human Resource Department

Dr Soso Chanturia - Deputy Head Doctor, Medical Practice

## **City Hospital No. 5**

Dr Tamas Sharashidze - Head Doctor

Dr Jumber Bagashvili - Head of Department, Orthopaedics and Traumatology

Mr Alecko Turzeladze - Financial Manager

Dr Tariel Meshveliani - Deputy Head Director, Medical Practice

Ms Marika Baliashvili - Chief Nursing Officer

Ms Dodo Kochlamazashvili - Human Resource Manager



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# Annex B: Details of Employment Contracts

The main sections in the contract cover the following:

1. Title of position
2. Responsibilities (e.g., to take patients, make rounds, implement new treatment methods)
3. Remuneration
4. Obligations (e.g., must treat according to standards, look after employers property, follow internal rules, maintain sanitary and hygienic conditions, follow medical ethics, keep medical records, participate in rounds and conferences)

Contracts for hospital attendants define and classify the space that the person must keep clean (e.g., 35 sq. meters of wood, 20 sq. meters of synthetic material).



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