SURVEY OF BARRIERS TO ACCESS TO SOCIAL SERVICES

Georgia 2010

Why not all poor families get social benefits and services

Survey Report

Tbilisi

November, 2011

Acknowledgements

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EXECUTIVE SUMMARY

According to the 2009 Welfare Monitoring Survey, nearly a quarter of the households in Georgia are living in poverty. Georgian children are disproportionally represented among the poorest households (28%). The study also revealed that pensions and targeted social assistance (TSA) play an important role in reducing poverty. However, at the time of the study, over a third of officially poor households were not receiving social assistance of any kind. The Barriers to Access to Social Services Survey (BASS) was developed to gain a better understanding of why significant shares of poor households in Georgia are not accessing their entitlements. For this purpose, the respondents in the bottom consumption quintile from the 2009 survey were revisited and interviewed. The BASS is particularly important for addressing child poverty. Vulnerable families who have access to basic support and services can provide better care for their children; and a child's basic right to health, education, protection and a decent standard of living is greatly impacted by what support is in place to assist the families in which they live and grow up. This summary is broken up into the key findings of 8 sections: Social Assistance, Pensions, the United Database of Socially Unprotected Families, Health Insurance for Vulnerable Families, Social Work, Programs for People with Disabilities, Early Childhood Development, and Documentation Services / Birth Registration.

Social Assistance: 72 % of the households reported that they received some kind of monetary social assistance. 61% of the households have at least one member in the family who receives a pension during the past year and 25% 'TSA'. For 86% of the families, this assistance is the 'only source' or 'main source' of income. Households in the west part of Georgia are more likely to receive assistance. Less Families of Azeri background receive any assistance than families with Georgian background. The proportion of households receiving TSA is the lowest among the Azeri and Armenian households.

Pensions: Only 4% of respondent families encountered a problem with accessing pension benefits. The two problems that were reported are: (i) problems reaching the Social Services Agency (SSA) due to distance; and (ii) being unclear as to what kinds of documents are required.

The United Database of Socially Unprotected Families: Awareness of 'the database' for which families need to apply for in order to be considered for TSA and health insurance is high (96%). Main sources of information about the database are television (55%) and neighbours and friends (31%). The different level of importance regarding the different information sources among minority groups needs to be considered in future information campaigns. Nearly everybody is aware that the database is the mechanism used by poor households to receive cash assistance (92%) and health insurance (87%). About three quarters of all families in the bottom quintile (72%) have applied at some point to be registered in the database. Poor families from Tbilisi and from Azeri and Armenian background are less likely to have applied.

Barriers among those who are not registered - The main reasons for the 24% that have heard of the database but did not apply are related to negative attitudes towards the application system, as well as unawareness. The perception that the assessment will not be accurate prevents people from applying. There are a number of barriers (documentation, language, distance, absence of permanent residence) which impact a small group of people. The majority of non-applicants do not know how to apply for the database (76%) or are misinformed (10%). A large share has the intention to apply. Additional information campaigns are needed to inform these vulnerable families, including in minority languages. The application forms for the database need to be made available in Azeri and Armenian as well.

Barriers among the registered - Very few respondents who applied for the database experienced any delay (4%). Nearly all applicants were visited by an SSA agent in order to complete a declaration form (96%); nearly all within 3 months of submitting an application. 77% of the respondents rate the social agent's work as 'normal' and 'very good'. The application and review function of the database is implemented efficiently by the SSA. Half of the respondents (49%) know how to appeal if they encounter any problem during the process. Of those who submitted a complaint (9%), in more than a third of the cases, the complaints were (partly) satisfied. However, the socio-economic situation of the majority of families that applied to the database was rated above the 'cut-off' score to receive cash assistance (about 66%) and a third did not qualify for health insurance. An elevation of the 'cut-off score' should be considered to increase the reach and impact of TSA & MAP.

Health Insurance for vulnerable families (MAP): 53% of the families report that they have health insurance. Of these insured families, a vast majority are insured under the Medical Assistance Program for Poor (MAP insurance) or other governmental health insurance programs that provide family coverage of health insurance benefits similar to MAP – total of 48.4% have such insurances. Families in west Georgia are nearly twice as likely to have some kind of health insurance (59%). The main reasons for not having insurance are a combination of 'not qualifying for the 'MAP' and 'lack of money to purchase a private insurance policy'. Lack of information on where and to whom to apply to get insured by state/municipal programs is also an issue. The main sources of information for families enrolled in a State Insurance Program (including MAP) were the 'social agent of the SSA' (41%); 'Doctors' (22%); and 'Relatives' (12%).

Barriers among MAP insured - 12% of MAP beneficiaries reported that it took too long to actually receive the policy. The majority of insured report someone in their family has read the insurance policy (80%). A quarter of them reported a desire or need in the past to obtain some information regarding their insurance (24%). Fifty-seven per cent (57%) of the insured families (any kind of insurance) reported that they used their insurance during the last 12 months prior to the survey. Three-fourths of them report that they would not have been able to cover the cost of the treatment in absence of insurance. The majority was satisfied with the insurance company's service (77%). Over 90% of MAP and MAP-like insurance beneficiaries did not feel that doctors provided lower quality because they possessed MAP insurance. Among families that did not use the policy, the main reasons aside from an absence of health problem are 'health services used are not covered by policy' & 'limited knowledge of how to use the insurance.'

Use of health services – 82% of all families reported one or more family members requiring care (chronic illness that required long-term treatment; acute health problems requiring surgery; or serious illness requiring permanent care). Families who have health insurance are more likely to use health services. Fully insured families (mainly MAP and MAP like) are more likely to use a family doctor (36%) as compared to non-insured families 22%. The large majority of respondents are not dissatisfied with the health services they receive. Patients seem to be more satisfied with 'in-patient' services compared to 'out-patient services.'

Barriers to access health services - The main barrier to access health services for the bottom welfare quintile is related to cost of services. The second challenge, much less than cost, is related to physical distance to a health facility. The majority (56%) reported that the burden of health care costs (excluding medicines) were '*quite heavy*' or '*Extremely heavy'*. There is a large difference in the degree of burden between MAP and MAP-like insured and non-insured families (non-insured families: 78% MAP and MAP like insured families: 39%). The cost of medicines seems to be a higher burden than other health services. Nearly all families purchased medicines during the past 12 months before the survey. A significant proportion of respondents use medicine on a daily basis (40%). Over three quarters of the respondents considered the purchase of medi-

cines to be 'quite heavy' or an 'extremely heavy' burden (79%). There was no difference in degree of burden between MAP and MAP like insured and non-insured families.

Social Work – less than one in ten of the respondents had heard of social workers (9%). The majority of people who have heard of social workers are unclear as to the kind of specific services a social worker provides (62%) and do not know where to apply in case they need a social worker's support (53%).

Programs for people with disabilities - The majority of respondents with one or more family members who suffer from a physical, sensory or mental disability living in the family (n=138) are unaware of the disability benefits that are provided by the SSA (62%). The sample with children with disabilities was too small to draw meaningful conclusions on barriers to services available to them (n=13).

Early Childhood Development – Slightly more than half of all children 3-5 years old (56%) are attending preschool. A large majority are satisfied with the kindergarten their child attends (88%). Reasons for not accessing early childhood education are the absence of a kindergarten close to the family home (33%) and cost of the kindergarten (21%). The majority of children do not have access to children's books (69%) at home. Inadequate care by parents is an issue - 13% of the caregivers had put the child at physical danger (13%) during the last week before the survey. 70% of children aged 36-59 months are on track developmentally overall (at least 3 of 4 domains of an Early Child Development Index). However, 78% of the 3-5 year olds are developmentally not on target in the Literacy & Numeracy Domain.

Documentation Services / Birth Registration - 14% of the respondents reported that a member of their household has attempted to obtain a birth certificate or personal ID within the past year. Among these households, (n=113), 14% were unable to obtain documentation despite several attempts. The main reason for not getting the documentation was the inability to pay the fees related to the documentation.

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Chapter 1 - INTRODUCTION

BACKGROUND

In 2004, Georgia began a major reform of its welfare system. The first wave of the reforms focused on the pension system. This included the clearing of pension arrears inherited from the previous government, the mainstreaming of 84 different types of pensions into several categories: the gradual increase of pensions, removing the minimum contribution requirement, changing the mode of delivery from individual hand-in-hand deliveries to electronic transfers and shifting the funding source from earmarked taxes to general taxation.

The second phase of the reform effort began in 2006. The main objective of the reform was to improve the targeting of social assistance to ensure that scarce financial resources would be channelled to those with the utmost need. This implied a shift from category-based social assistance to means-tested assistance. For this purpose, a sophisticated targeting system was set up (for details please see the section on targeted social assistance). The categorical benefits are closed for new entrants, and will be gradually phased-out. Additionally, in-kind benefits were monetised.

In addition, the government of Georgia has embarked on an ambitious reform of child welfare reform, placing a heavy emphasis on closing large Soviet-style institutions. To support this process, alternative child care services, including small group homes, day care centres, foster care and other community-based care services were introduced. In 2000, there were only 19 state statutory social workers, while today, the Social Services Agency employs about 200 social workers in the field of child care, and intends to increase this number by an additional 50 social workers by the end of 2011. There are also other state-employed social workers in the fields of juvenile justice, domestic violence, etc. Families of institutionalized children are offered financial and family support services in order to reintegrate children back into safe families. As a result, the number of children in institutions has decreased from 4,100 in 2003 to 906 in 2010.

SOCIAL SERVICES AGENCY (SSA)

The Social Services Agency (SSA) was formed in 2007 as a result of a merger between two government agencies – the State United Social Insurance Fund (SUSIF) and the State Agency for Employment and Social Assistance (SAESA). The agency SSA is the main executive arm of the Ministry of Labour, Health and Social Affairs and is responsible for administering all central social programs. These include pensions, social assistance, child care and disability programs. In addition, the agency is responsible for administering the database of socially vulnerable families, which is the primary means-testing mechanism for the provision of social assistance and free health insurance. The agency employs over 2,000 staff employed across 11 regional offices and 71 district offices. In 2011, SSA's annual budget was around 1.5 billion GEL, making it the largest spending state agency in Georgia.

TYPES OF SOCIAL ENTITLEMENTS

There are several types of entitlements to social benefits. The main social benefit is pensions, which are available for four categories: males aged over 65 and females over 60; survivors; persons with the first category of disability; and war veterans/victims of Soviet repression. In addition, there are state compensations and aca-

demic stipends. They serve the same purpose as pensions for certain former public servants and members of academia who retired between 2005 and 2007. The main difference between pensions and compensations/ stipends is that the former are flat-rate benefits for different categories, while the latter are calculated based on the number of years in service and the current salary of persons in the same positions.

In addition to pensions there are two types of social assistance – category-based and means-tested. **Category-based social assistance** includes family assistance, utilities subsidies and IDP benefits. *Family assistance* is a phasing-out benefit and has been available to the following groups: a) single pensioner; b) pensioner couple; c) disabled child; d) person with 1st category disability; e) families with 7 or more children. This entitlement is limited to those families who applied for assistance before 2007. *Utilities subsidies* are available for 12 categories including war veterans, victims of Soviet repression, etc. The *IDP benefit* is available to all individuals displaced as a result of conflicts in Abkhazia, Georgia and South Ossetia, Georgia in the 1990s and August 2008.[1] **Means-tested cash assistance** is available for those families who apply to the SSA for assistance, are registered in the *database of socially vulnerable families* and whose means-testing score is below a certain cut-off point (currently standing at 57 001). Families below the ranking score of 70 001 are entitled to **free health insurance vouchers** which can be exchanged into health insurance.

BENEFICIARIES (ROUTINE STATS)

As of November 2010, 841,460 people were receiving pensions. Of these, 665,910 received old-age pensions, 32,314 received survivor pensions, 140,100 received disability pensions and 2,580 received war veteran/victims of repression pensions (346 received pensions based on the number of years in which they were employed).[2] Academic stipends were received by 1,951 and state compensations by 20,417 persons. As for social assistance, 381,727 people living in 139,997 households were receiving targeted social assistance, 20,586 received different forms of family assistance and 78,564 received utilities subsidy.[3]

WELFARE MONITORING SURVEY 2009

In 2009, the UNICEF Georgia country office commissioned the Institute of Social Studies and Analysis (ISSA) to conduct a Welfare Monitoring Survey in order to understand the impact of the financial crisis on Georgian families. The Welfare Monitoring Survey was a nationally representative survey that covered 4,808 households across Georgia. The primary objective was to understand how the crisis affected Georgian households and the coping mechanisms to which the latter resorted to in order to mitigate the impact of the crisis. In addition, the survey explored a host of various indicators of well-being in Georgian households – incomes, consumption, access to basic services, housing conditions, access to health care and subjective perceptions of well-being. The obtained data provided an opportunity to measure poverty against different thresholds (1.25 USD a day and 2.5 USD a day per adult equivalent; 60% of median income) and different dimensions (consumption, housing, subjective perceptions), as well as measure the impact of social transfers on poverty.

According to the WMS, nearly a quarter of households in Georgia were living in poverty (below the official poverty threshold). These poor households included 28% of Georgia's children. Differences in standards of liv-

[1] Persons displaced as a result of August 2008 events are automatically entitled to targeted social assistance
[2] SSA (2010) Statistical Data, available at: http://ssa.gov.ge/index.php?id=25&lang=1
[3] Ibid

ing indicate considerable inequities among different localities and groups within the population. The negative impact of the crisis was widely felt as 51% of respondents reported that their economic situation worsened or significantly worsened over the 12-month period before the survey. The study also revealed that pensions and targeted social assistance have a meaningful impact on reducing poverty. Without pensions, more than half of pensioners would fall below the official poverty line. Compared to pensioners, children benefit disproportionately less from social transfers, as there are no specific benefits for them. The main family benefit, targeted social assistance, has an important impact on households that receive it, but the benefit only reaches 20% of those officially defined as poor. Over a third of the officially poor households do not receive social assistance of any kind. Additionally, 'extremely poor households' (bottom decile) are less-likely to receive social assistance than the relatively 'better-off poor households'.

In almost 60% of all households in 2008-2009, at least one person needed medical services or medicine, which the household could not afford to purchase. For the poorest fifth of households, the figure was more than 75%. Financial costs act as a barrier to healthcare in a higher percentage of rural households than they do in urban households. In the poorest quintile, over three-quarters of the households went without certain medical services and/or medicines in the last year because they were unaffordable. Free health insurance, aimed at people in vulnerable families, is concentrated in the poorest fifth of households- but even in these households, only just over a fifth (21.3%) of the population was covered at the time of the WMS.

This lack of access to social assistance (including health insurance) by the poorest groups has prompted SSA, UNICEF and USAID HSSP to consider exploring this issue in-depth by conducting an additional survey which would specifically target the poorest quintile. Additionally, this survey would seek to understand the extent to which this group would benefit from the different social services and transfers.

Chapter 2 - METHODOLOGY

Sample - The sample of the Barriers to Access to Social Services study was drawn from the database of the Welfare Monitoring Survey[4]. For this purpose, the WMS households were divided into five quintiles, according to their welfare level. The first quintile represented the poorest 20% of the households of the sample. Accordingly, the fifth quintile contained the richest 20% of the sample. The '**welfare level**' was defined as *monthly expenses of households counted for one equivalent adult (15-65 years old male)* and considering scale-effect. The first quintile included those households whose monthly expenses were less than 117.5 GEL counted for one equivalent adult in this household. Anticipating a possible non-response/refusal rate of 15%, 212 households from the second quintile were added to the sample. The total sample included 1,078 households. They were distributed across all regions of Georgia.

Survey tools – The questionnaire was designed on the basis of focus group discussions. In total, eight specific focus groups were convened: a) Beneficiaries of SSA; b) Applicants of TSA; c) Social workers and social agents; d) Principles and teachers of secondary schools and kindergartens; e) Representatives of civil registry agencies; f) Representatives of insurance companies; g) Representatives of the health care system; and h) Representatives of local authorities. The draft questionnaire was presented by ISSA. The advisory committee provided comments and suggestions. The questionnaire was field-tested with 20 households both in urban as well as rural settlements. After the piloting the questionnaire was finalised and interviewers were trained. The questionnaire was translated and published in three languages (Georgian, Armenian and Azeri).

Fieldwork - Throughout the study 10 interview teams were deployed, each one comprising of 1 supervisor and 1 to 6 interviewers depending on the size of the region. The duration of one interview was on average 1 hour. During the period 10 November – 1 December, 2010, in total 902 interviews were conducted across Georgia. This corresponds to 83.7 per cent response rate.

Table A1: The distribution of completed interviews and non-responses by region

REGION	NUMBER OF COMPLETED INTERVIEWS	NUMBER OF NON-RESPONSES
Tbilisi	111	12
Adjara	21	10
Imereti	191	32
Shida Kartli	57	9
Kvemo Kartli	137	38
Samtskhe-Javakheti	39	10
Samegrelo	81	16
Guria	64	20
Kakheti	127	14
Mtskheta-Mtianeti	57	14
Racha	17	1
Total	**902**	**176**

[4] For details sampling methodology WMS 2009: How do Georgian children and their families cope with the impact of the financial crisis: Report on analysis of the Georgia Welfare Monitoring Survey data, 2009 at http://www.unicef.org/georgia/WMS_draft_eng.pdf (accessed 23 May 2011).

The main three reasons for non-response were: a) Households having changed the address; b) Death of the member of single households; c) Inaccessibility of adult family members (despite several visits by the interviewer).

Data Processing - The completed questionnaires were coded after the field work was completed.
The coded questionnaires were entered into SPSS (13 software). Data cleaning consisted of two steps. The first step entailed a frequency count for each variable, in order to check 'wild codes' in the data. During the second stage, the statistician checked the frequency listing for inconsistencies and identified problematic cases. The cleaned data was weighted according to weights defined in the framework of the WMS. Weighted data were processed on the basis of different statistical methods: distribution of frequencies, cross-tabulations, mean, mode, median, etc.

Data is presented by different categories- it is divided by Tbilisi, West Georgia and East Georgia and by ethnic groups Georgian, Armenian and Azerbaijanian. For the purposes of this report the sample is also divided by insurance status of the household.

Chapter 3 – RESULTS

3.1 ACCESS TO SOCIAL TRANSFERS

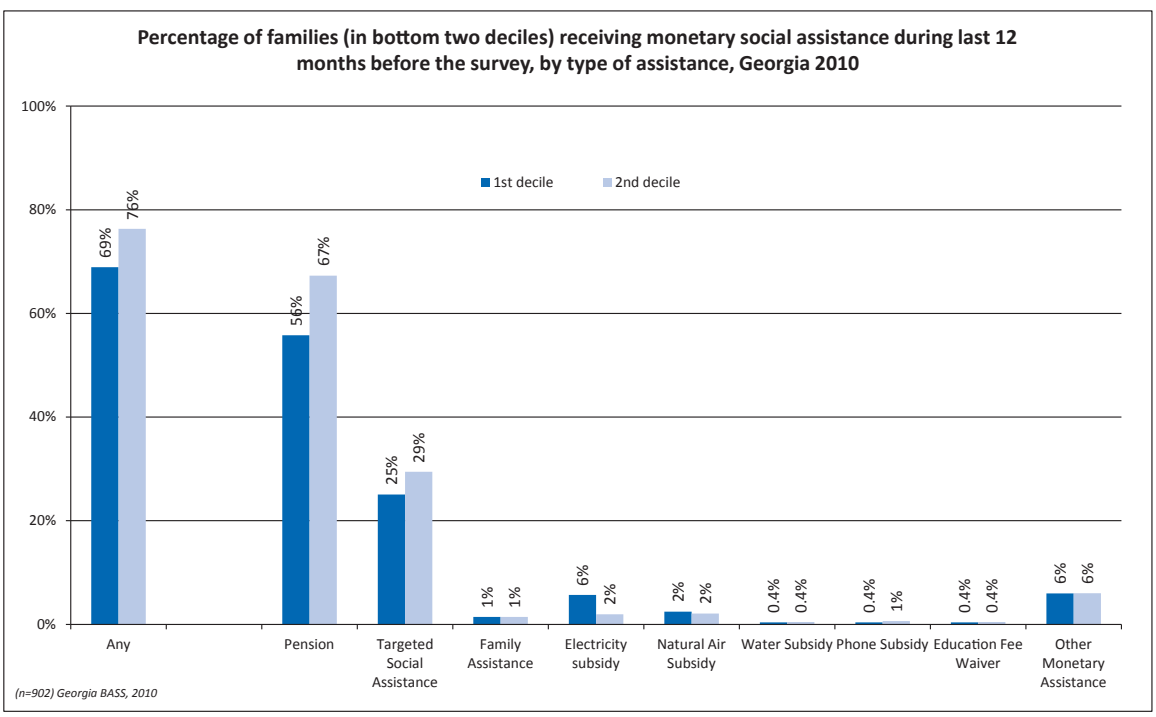
INTRODUCTION

According to the 2009 WMS, 838,493 persons received some type of social transfers[5]. 59% of Georgian households received at least one social transfer and 12% received more than one type of social transfer.[6] The most wide-spread benefit is pensions, which reached 54% of all households, while Targeted Social Assistance (TSA) covered 11.5% and categorical benefits 7% of households.

The WMS showed that over a third of the households that fell below the official poverty line[7] received no social transfers at all. Most importantly, extremely poor households (with consumption of less than a dollar a day per adult equivalent) were less likely to receive any social transfers than the relatively better-off poor[8].

RESULTS FROM THE SURVEY

Overall, 72% of the households in the BASS survey reported that they received some kind of monetary social assistance (pensions, social assistance, utilities subsidy, etc.) during the last 12 months before the survey. The main support received by these families was 'pensions' and 'TSA'



[5] Currently all social transfers administered by the central authorities are provided through the banking system. The banking service is provided by Liberty Bank. Each pensioner and household receiving social transfers are provided with plastic banking cards that they can use to withdraw cash from Liberty Bank branches or ATM machines across the country. Those who are not able to travel because of physical disability can request the SSA to deliver the transfer to them at home.

[6] UNICEF (2010) Welfare Monitoring Survey, pp.39-40.

[7] different from proxy means-testing score, measured against 60%of median consumption)

[8] (ibid, p.40)

The families in the second decile are more likely to have received a pension or TSA than families in the bottom decile. This can be at least partly explained by the fact that the government cash assistance programs are moving the recipients out of the bottom group as was previously found in the 2009 WMS[9].

Table: Percentage of households that have received monetary social assistance during the last 12 months before the survey by region and ethnic group in Georgia, 2010

	Tbilisi N=111	West Georgia N=374	East Georgia N=417	Georgians N=756	Azeris N=93	Armenians N=33	Total N=902
Received any cash assistance							
▪ **Yes**	70%	79%	66%	74%	55%	73%	72%
▪ **No**	30%	21%	34%	26%	45%	27%	28%
Received a pension							
▪ **Yes**	61%	67%	55%	62%	49%	67%	61%
▪ **No**	9%	13%	11%	12%	6%	6%	11%
▪ **No cash assistance received last 12 months**	30%	21%	34%	26%	45%	27%	28%
Received TSA							
▪ **Yes**	16%	34%	23%	28%	11%	2%	25%
▪ **No**	54%	45%	44%	46%	44%	71%	47%
▪ **No cash assistance received last 12 months**	30%	21%	34%	26%	45%	27%	28%

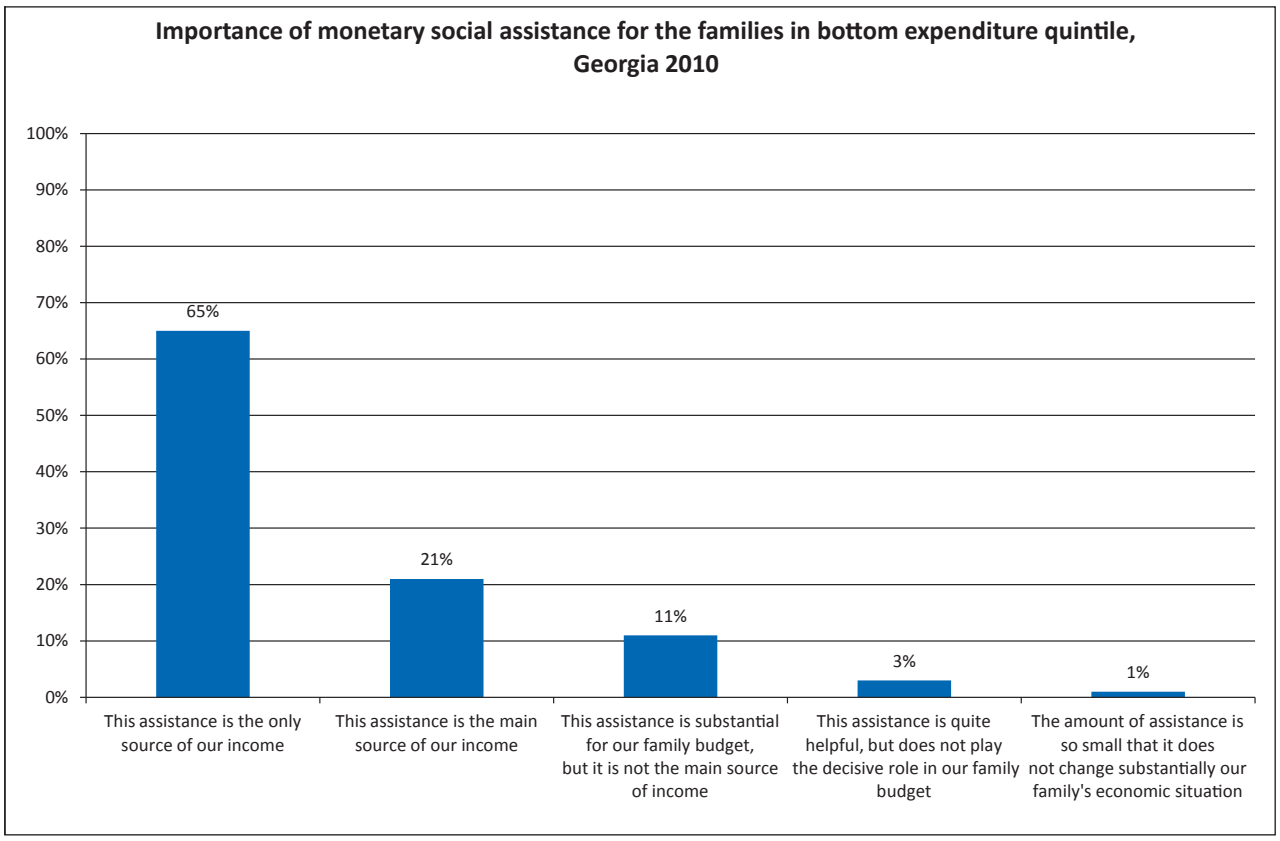
Households in eastern Georgia and of Azeri background are less likely to receive cash assistance. The proportion receiving TSA is especially low among inhabitants from Tbilisi Azeri and Armenian minority groups.

Respondents were asked how the economic situation in their family changed over the last year before the survey. 2% reported that the economic situation had improved, for 39% it stayed the same and for 59%, the situation worsened (slightly worsened: 28%/significantly worsened 31%).

[9] TSA covered nearly two fifths (39%) of households in the lowest decile when household monthly PAE consumption figures were reduced by the amount of TSA income received PAE. After adding the TSA only 17% in the bottom decile were receiving TSA.

IMPORTANCE OF MONETARY SOCIAL ASSISTANCE

Cash social assistance is considered by most families as an important source of their income. For 86% it is the only or main source of income.



3.2 PENSIONS

INTRODUCTION

Pensions in Georgia fell in four main categories. The first category is flat-rate old pensions to which all women above 60 years of age and men above 65 are automatically entitled. Other categories include: survivors (orphan children under 18); disabled persons; other (war veterans, family members of people killed in the wars for the territorial integrity of Georgia, persons who participated in the liquidation of the Chernobyl disaster results; and those who were physically damaged during the violent dispersal of peaceful demonstrators by Soviet troops in Tbilisi on 9th of April 1989). These pensions are also flat-rate, but may vary for specific categories – e.g. 1st category disabled receive 80 GEL while 2nd & 3rd category disabled receive 70 GEL.

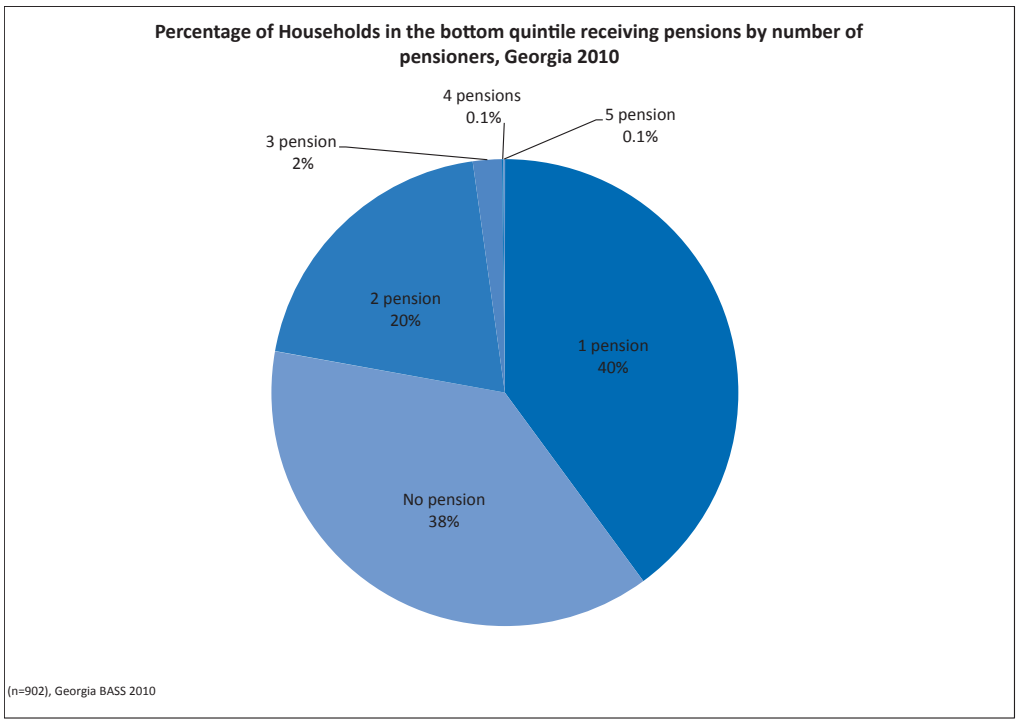
The application for most types of pensions are fairly simple, requiring a small number of documents confirming the basis for the pension (age, loss of parent(s), participation in war/armed conflict, etc.) Disability pension application also requires a document from medical-social expertise outlining which category of disability the person has. The application has to be submitted at the local SSA office. However, people with old-age pensions do not qualify for the disability pension at the same time.

In addition there are state compensations for certain groups of public servants (military, police, judges, MPs, diplomats, etc.) and academic stipends are provided for former members of academia who retired between 2005 and 2007. Both of these in essence are pensions. They are calculated based on the number of years in service and the current salary of persons in the same positions. However, state compensations are capped at 560 GEL, except for the former employees of the Constitutional Court and Supreme Court who once held high positions, as well as families of deceased high-ranking political figures.

The 2009 WMS showed that in every second household in Georgia (54%), there was at least one person who received some type of pension. Because of the universal nature of old-age pensions (all women above 60 and men above 65 are entitled to some kind of pension), the take-up for pensions is almost 100% across all income groups, with a minor exception of the richest decile. Because of the wide coverage, but also higher level of benefit than for other social transfers, pensions have a large impact on reducing poverty. Without pensions, the share of families in extreme poverty (measured as less than 1.25 USD a day per adult equivalent) would increase by almost 18 percentage points. Similarly, the official poverty rate (measured as 60% of median consumption) would increase by 17 percentage points.

RESULTS FROM THE SURVEY

The majority of households in the Barriers Study received some kind of pension (62%). In a third of these households two or more members received a pension (35%).



APPLICATION PROCESS FOR PENSIONS

Of the people who received a pension, 8% started receiving their pension or had changed the type of pension during the last two years. 40% reported that the time between submitting the application and receiving the pension or the time required to change the type of pension was more than one month.

Very few people encountered a problem starting or receiving a pension (4%). Two types of problems were reported: (i) problems with going to the Social Services Agency because of distance; and (ii) Social Services Agency employees could not explain what kind of documents were required.

About 10% of the respondents reported that there is a family member in their household who they think should be receiving pension but for some reason does not receive it. Main reasons provided for not receiving a pension where: (i) The legislation does not allow (29%); (ii) Could not collect necessary documents (24%); (iii) Not able to go the Social Services Agency because of physical conditions (11%); and (iv) Did not have time (11%).

3.3 TARGETED SOCIAL ASSISTANCE

INTRODUCTION

Targeted social assistance is the main cash benefit available for families experiencing financial and material hardship. In order to qualify for the assistance, a family must submit an application to the local office of the Social Services Agency. The application is then processed and entered into the database of socially vulnerable families. At the end of 2009 - 539,256 households comprising 1,761,191 people were registered in the unified database of socially vulnerable families[10].

Once the application is processed, a social agent visits the family and records various indicators of the families' socio-economic situation (employment, assets, special needs, etc). These are later entered into the database and then electronic software processes the ranking score which can range from 0 to 200, 000. Currently families with a ranking score below 57,001 are entitled to cash assistance and free health insurance vouchers which can be exchanged into health insurance. The size of the benefit is 30 GEL for the first member of the family plus 24 GEL for each additional member. Families who rank between 57,001 and 70,000 are entitled to free health insurance vouchers.

By the end of 2009, 153,400 families in Georgia (15.2%), corresponding to 420,800 (9.6%) of the population[11] were receiving a monthly cash benefit "subsistence allowance" in the country - Targeted Social Assistance (TSA).

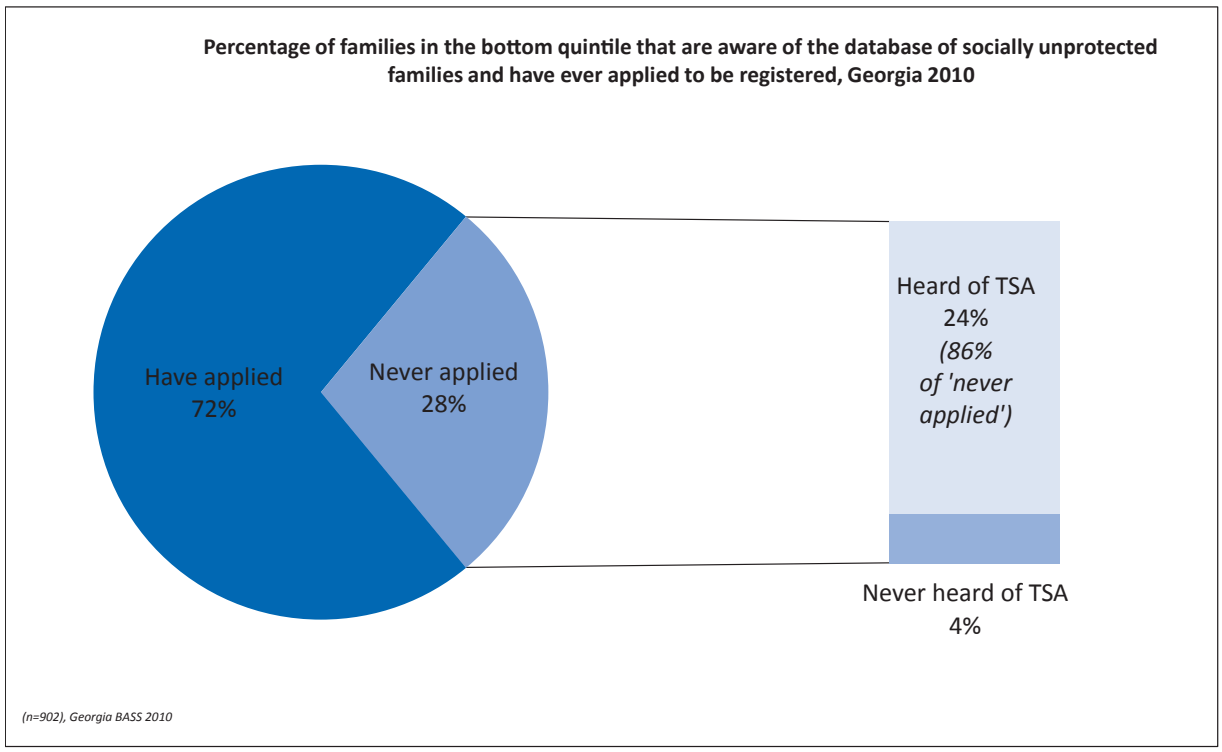
In 2009, the WMS showed that out of all social transfers, TSA is best targeted at the poor. 39% of the poorest decile received it (for pre-TSA PAE consumption) in contrast to 0.9% in the richest decile. Accordingly, TSA reduced extreme poverty (measured as less than 1.25 USD a day per adult equivalent) by 3.5 percentage points and official poverty (measured as 60% of median consumption) by 2.6 percentage points. On the other hand, it failed to reach 61% of the poorest decile. This statistic triggered this survey to gain a better understanding of the reasons behind this low coverage.

[10] Social Statistics 2009. Social Service Agency. 2010.
[11] Social Statistics 2009. Social Service Agency. 2010.

RESULTS FROM THE SURVEY

Awareness of the united database of socially unprotected families

Nearly all households were aware of or have heard of the united database for socially unprotected families. Only 4% of the entire sample was unaware of the system.

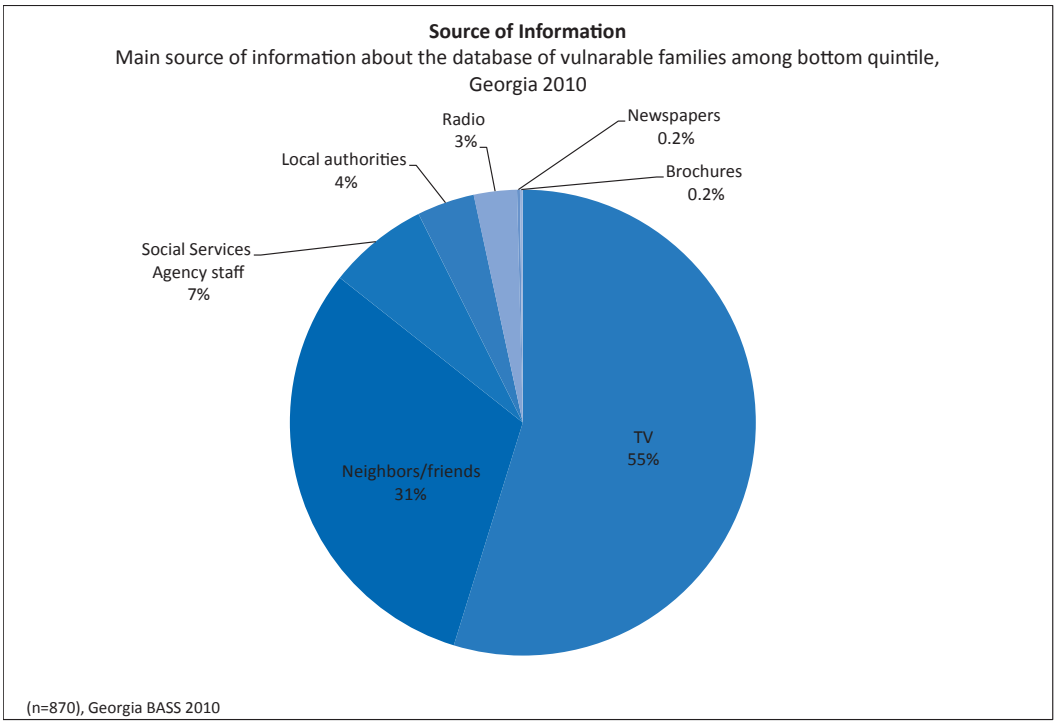


Respondents were asked who they think are the beneficiaries of the social assistance that is allocated through the database. Awareness that it is meant for poor families is high (92%).

Reported categories of beneficiaries according to respondents that heard of the database (n=870)
▪ **Poor families – 92%**
▪ **Disabled – 14%**
▪ **Pensioners – 9%**
▪ **Families with many children – 9%**
▪ **IDPs/refugees – 7%**
▪ **War veterans – 2%**
▪ **Other – 2%**
▪ **Difficult to answer – 6%**

Information source

Respondents who had heard about the data base of vulnerable families were asked what their main source of information about the database is. Television (55%) and neighbours and friends (31%) are the most important sources.



The importance of different sources of information differs to a certain extent by region and ethnic group. While TV is the main source of information for Georgians, Azeri's seem to depend more on their neighbours and friends for information.

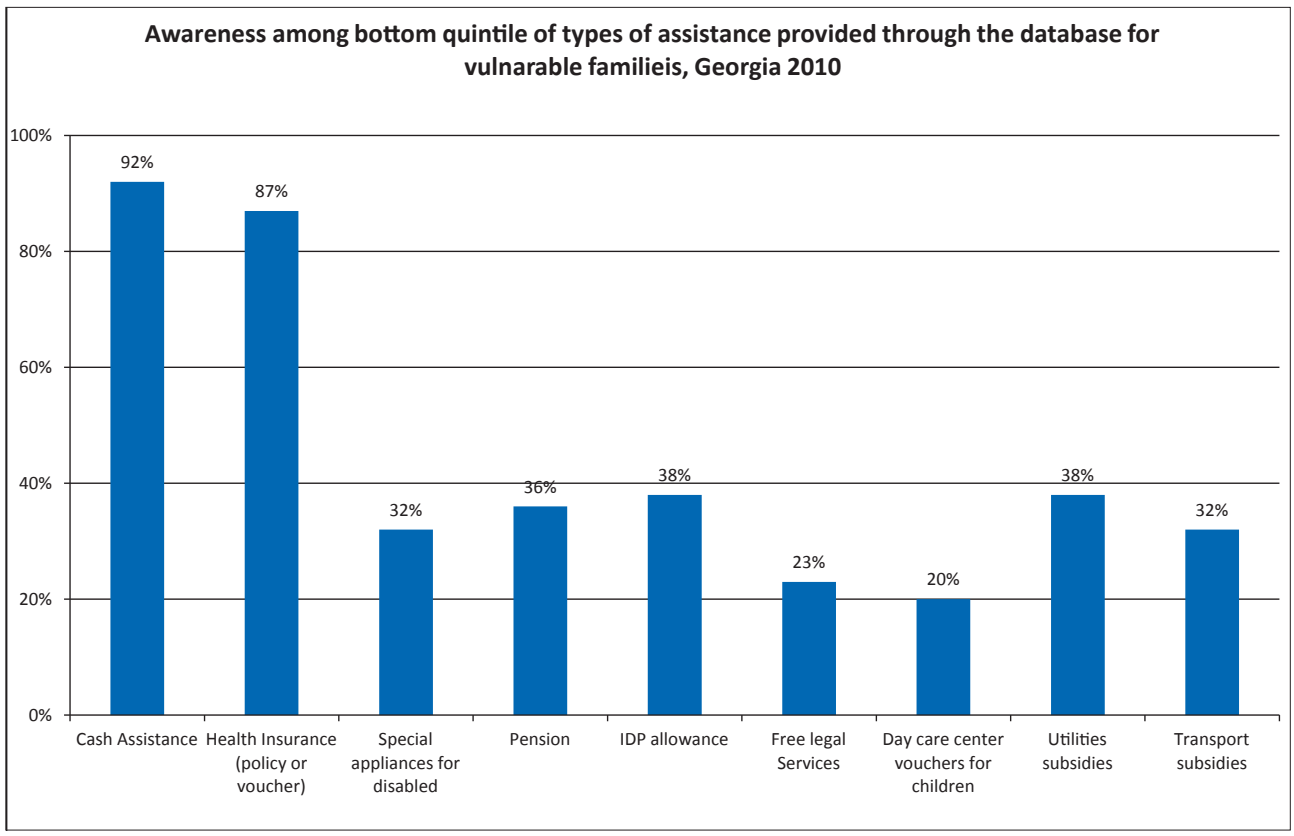
Table: Percentage of households that have heard of the database and source of information by region and ethnic background in Georgia, 2010

	Tbilisi N=111	West Georgia N=374	East Georgia N=417	Georgians N=756	Azeris N=93	Armenians N=33	Total N=902
Heard of Database	97%	94%	97%	96%	98%	93%	96%
Source of information							
▪ **Radio**	1%	4%	5%	4%	-	10%	3%
▪ **TV**	53%	61%	42%	56%	21%	55%	52%
▪ **Newspaper**	-	0.5%	0.2%	0.3%	-	-	0.2%
▪ **Local authorities**	1%	6%	4%	5%	-	3%	4%
▪ **Social Services Agency staff**	2%	6%	11%	5%	19%	6%	6%
▪ **Neighbours/ Friends**	37%	21%	33%	28%	51%	27%	30%
▪ **Brochures**	-	1%	-	0.2%	-	-	0.2%
▪ **Difficult to answer**	6%	2%	6%	3%	9%	-	4%

Although local authorities are expected to play a role, they are not a significant source of information (4%). There is a need to understand and agree how their role can be strengthened. While not in their core mandate, the SSA staff is playing a role in raising awareness (6%). An expansion of their role in providing information could be considered.

Awareness of Services

The respondents were asked to specify categories of assistance provided through the database. The types of assistance which were most frequently mentioned are as follows: Cash assistance (78%); Health Insurance (55%); and utility subsidies (7%). Following the general question, respondents were asked from a list of specific types of assistance if inclusion in the database for vulnerable families is a requirement to benefit from this specific service.



92% of the respondents aware of the database identified the need to register for the database in order to be able to receive cash assistance. 87% confirmed the need to be registered in order to be eligible for health insurance.

This means that from the entire sample (including those not heard of the database), 13% are unaware that cash assistance and 18% are unaware that health insurance is provided by the Social Service Agency. Awareness for other services available through the database is limited. This will need to be considered for future information campaigns. An increase in TV outreach through the network of regional channels should be considered with clear messages on what is and is not included.

Access to the united database of socially unprotected families

Nearly three quarters of the households (72%) have at one time applied to be registered at the database of socially unprotected families. 24% have never applied and 4% have never heard of the database. Thus, 75% of the families who have heard of the database have ever applied. Inhabitants from Tbilisi and people with Azeri and Armenian ethnic background seem to be less likely to apply.

Table: Percentage of households that have ever applied to register at the database of socially unprotected families by region and ethnic background in Georgia, 2010

	Tbilisi N=107	West Georgia N=357	East Georgia N=406	Georgians N=730	Azeris N=91	Armenians N=30	Total N=870
Ever applied							
▪ **Yes**	58%	83%	80%	77%	67%	64%	75%
▪ **No**	42%	17%	20%	23%	33%	36%	25%

3.3.1 INFORMATION ON FAMILIES THAT NEVER APPLIED TO THE DATABASE OF SOCIALLY UNPROTECTED FAMILIES

This section presents specific information on the 24% of households that have heard of the database of socially unprotected families, but never applied. It explores reasons for not applying and possible obstacles to applying.

Reasons for not applying

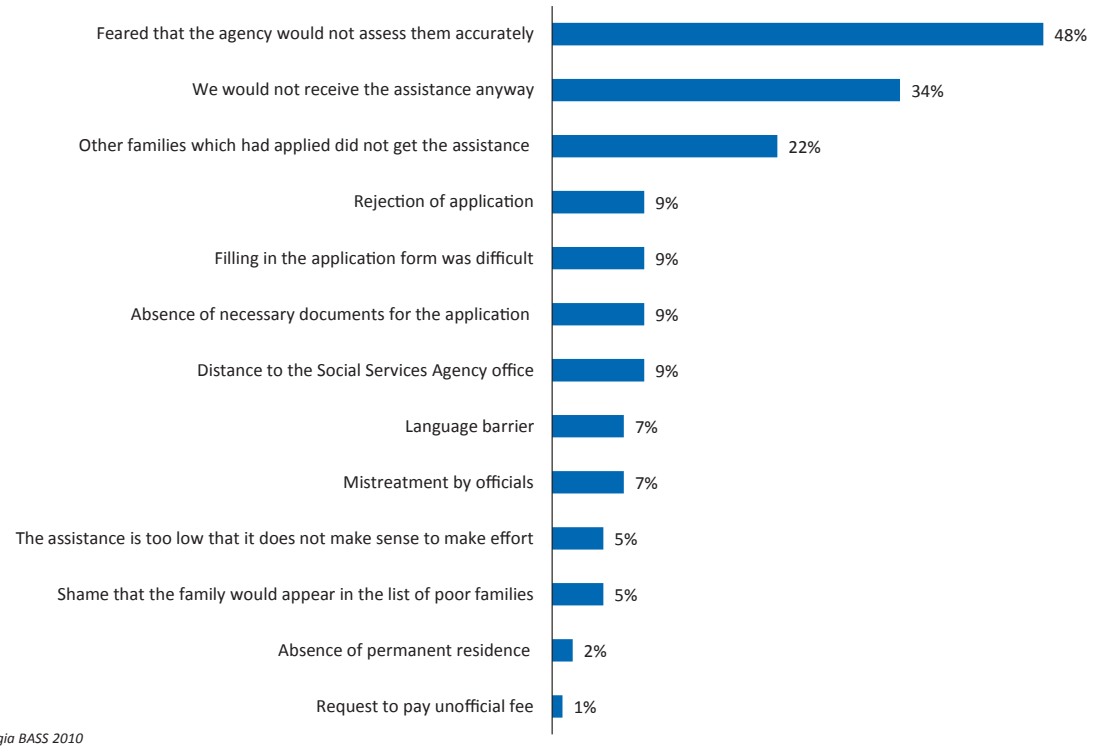
The main reasons for which respondents that have heard of the database but have not submitted an application form for registration in the database for socially unprotected population are related to a negative attitude towards the application system as well as unawareness. The perception that the assessment will not be accurate prevents people from applying. There is also a perception among people who haven't applied that they will not qualify and therefore don't bother to apply.

Reasons for not applying to the database of socially unprotected families (n=176)
▪ **We were afraid that the evaluation would not be carried out correctly - 33%**
▪ **We did not know where to submit the application - 24%**
▪ **We think that we do not qualify for it - 16%**
▪ **There was no need - 8%**
▪ **Our application was rejected - 8%**
▪ **Difficult to answer - 6%**
▪ **He/she is not able physically - 5%**
▪ **We would have to travel far for it - 5%**
▪ **We did not have the necessary documents - 4%**
▪ **Our friends advised us not to - 3%**
▪ **Because of the language barrier - 3%**
▪ **We were concerned that our family would be called "poor" - 3%**
▪ **The assistance is too low, does not make sense to make an effort - 3%**

The respondents who never applied for the database but had heard of the database were provided with a list of possible reasons why one would not have applied. For each of the reasons the respondents were specifically asked if it affected the family not applying to register in the database.

There are a number of barriers (documentation, language, distance, absence of permanent residence) which impact a small group of people.

Reasons for not applying to the database of socially unprotected families among families in bottom quintile who have heard of the database, Georgia 2010



(n=176), Georgia BASS 2010

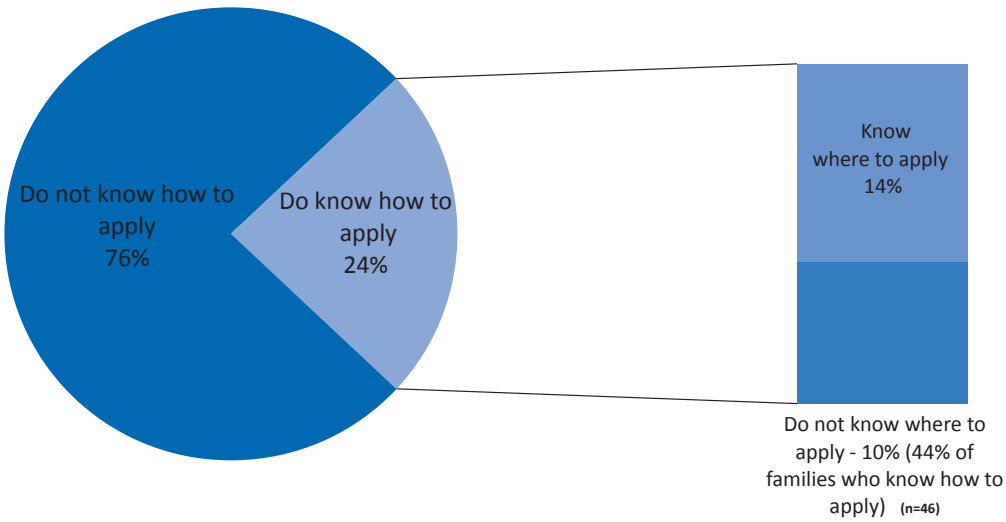
Knowledge how and where to register

Among the quarter of the people that has heard of the database of socially unprotected families but never applied, the majority would not know how to apply for these services (76%). Information campaigns should be very clear in where and how to apply. Language barriers need to be considered. Simplification of the application form should be considered as well as translation into minority languages.

Among the 24% who report they know what a family needs to do in order to register, around half (44%) does not know where to actually register. Four out of every 10 respondents who state they know where to apply (n=32) identify incorrect venues when they are asked to agree or disagree with listed venues.

Awareness of application process

Knowledge of what a family needs to do in order to register on the database of socially unprotected families --- among families in the bottom quintile that are not registered, Georgia 2010



(n=176), Georgia BASS 2010

Familiarity with application process

About 60% of the families that have heard of the database but have never applied are aware that they have to apply in order to register in the database and that initially, the Agency employees in principle don't come to them. 20% assumed that the SSA would visit their house and another 20% were not sure.

Visit to SSA office by unregistered families

Of the people who never applied for the database, 86% have never been in a Social Service Agency office. Among the small minority that have visited an SSA office, less than one in five (18%) has visited the SSA office during the past 24 months.

Familiarity with application forms by unregistered families

Of the people who never applied for the database, 95% have never seen an application form. Among the 5% who have seen an application form, two-thirds (68%) read the form and only 10% have tried to complete the form.

Future plans to apply

Among this group that never applied, 42% reported that they were planning to apply; an equal percentage reported that it was not planning to apply and 16% were not sure. Nearly half of the families (45%) who are not planning to apply would submit an application if non-governmental organisations would help the family at each stage of submitting the application. Among those who thought 'why bother to apply, I don't qualify anyway' nearly half are planning to apply in the future.

3.3.2 INFORMATION ON FAMILIES THAT HAVE APPLIED TO THE DATABASE OF SOCIALLY UNPROTECTED FAMILIES

This section presents specific information on the 72% of the households that have ever applied to the database of socially unprotected families. It explores obstacles they encountered, the perceived quality of services provided by the Social Service Agency, awareness and the use of rebuttal procedures.

Perception of eligibility

All respondents that have ever applied to register in the database of socially unprotected families felt that they were qualifying for social assistance (99%).

Timing of application

Among the families that have ever applied to be registered on the database of socially unprotected families, 27% applied during the past 12 months before the survey.

Time elapsed since family applied to database of socially unprotected families (n=694)
▪ **Less than three months - 6%**
▪ **Three to six months - 7%**
▪ **Six months to a year - 14%**
▪ **More than a year - 67%**
▪ **Difficult to answer - 6%**

Barriers delaying submission of application

Very few respondents who applied for the database encountered a barrier which delayed the process of submitting the application (4%).

Reasons why the application process was delayed (n=26)
▪ **Mistreatment by officials – 10 out of 26 reporting a delay**
▪ **Fear that the assessment would not be correct – 7/26**
▪ **We could not fill in the application form – 2/26**
▪ **We did not know where to apply – 2/26**
▪ **Not able physically – 2/26**
▪ **Absence of relevant documents – 1/26**

The respondents who reported a delay (n=26) were provided with a list of possible reasons. For each of the barriers the respondents were specifically asked whether or not it was a barrier during the process of applying to register to the database of socially unprotected families.

Identified barriers among respondents that reported a delay in the application process (n=26)
▪ Fear of incorrect assessment – 14 out of 26 families reporting a delay
▪ Difficulty in filling in the application form – 10/26
▪ Mistreatment by officials – 11/26
▪ We would not get assistance anyway – 9/26
▪ Absence of permanent residence – 6/26
▪ Other families that applied did not receive assistance – 6/26
▪ Long distance to the Social Services Agency office – 5/26
▪ Absence of necessary documents – 6/26
▪ Language barrier – 4/26
▪ Request to pay an unofficial fee – 3/26
▪ Shame that the family would be in the list of poor – 2/26
▪ Low level of assistance – 0/26

Household visit by SSA Agent

Nearly all respondents who applied were visited by an SSA agent in order to complete a declaration form (96%).

Reasons for not being visited by SSA Agent

Among the respondents that were not visited by an SSA agent (n=32) to fill in a declaration 20 did not know why they were not visited.

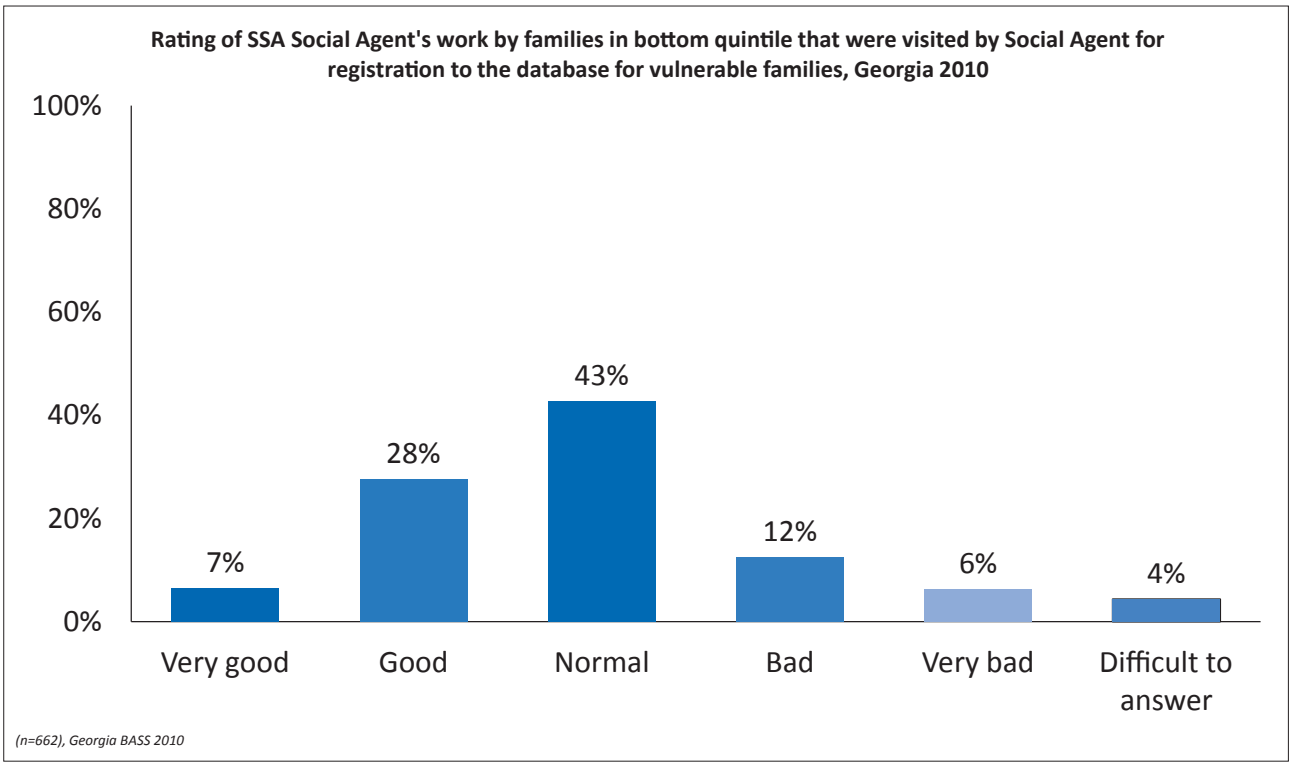
Reasons for not being visited by an SSA Agent among families not visited (n=32)
▪ We don't know –20 / 32 households that reported they were not visited
▪ We are still waiting for assessment – 8/32
▪ We were informed that we did not qualify – 3/32
▪ We were not home when the social agent came – 1/32

Timing of visit by SSA Agent

The majority of the applicant families who were visited (96%), were visited within a month (54%). Three-quarters of the families were visited within 3 months. 5% of the respondents said that the visit took place after 6 months. A significant percentage could not recall the time between their application and the visit by the social agent (15%). Among the people who remember when they were assessed 90% report that they were assessed within 3 months.

Satisfaction with work SSA agent

The level of satisfaction with regard to the SSA agent was measured by asking the respondents to rate the social agent on a scale of 1 (very good) to 5 (very bad). 78% of the respondents rated the social agent's work between 3 (normal [43%]), 2 (good [28%]), and 1 (very good [7%]). 19% rated the social agent's work between 4 (bad [12%]) and 5 (very bad [6%]). People who score above 70,000 points are more likely to be dissatisfied.



71% of those households that did not qualify for social assistance assess the social agent positively.

The respondents that rated the social agent's work as 'bad' or 'very bad' were asked why they rated the work low. The following reasons were provided.

Reasons for rating SSA Social Agents 'bad' or 'very bad' (n=127)
• **Did not assess us objectively - 50%**
• **Told us that we were not qualified for the assistance - 20%**
• **Did the assessment superficially - 17%**
• **He/she talked to us arrogantly – 7 %**
• **He/she was very rude. He/she humiliated us - 2%**
• **Difficult to answer - 2%**
• **He/she expressed disgust at our living conditions - 0.7%**
• **He/she has lost all data - 0.7%**
• **He/she took money - 0.6%**
• **He/she said we were eligible, but nobody visited us - 0.4%**

Conflict with Social Agent/SSA

Among the 18% of respondents that rated the social agent's work as 'bad' or 'very bad' a small proportion report to have had a conflict (verbal or physical) with the agent – 7% (= 1.2% of all people visited by a social agent).
Less than one percent (0.4%) of the people who were dissatisfied by the social agent's work (rated 'bad' or 'very bad') reported to have had a conflict (verbal or physical) with other employees of the SSA (not social agent visiting home).

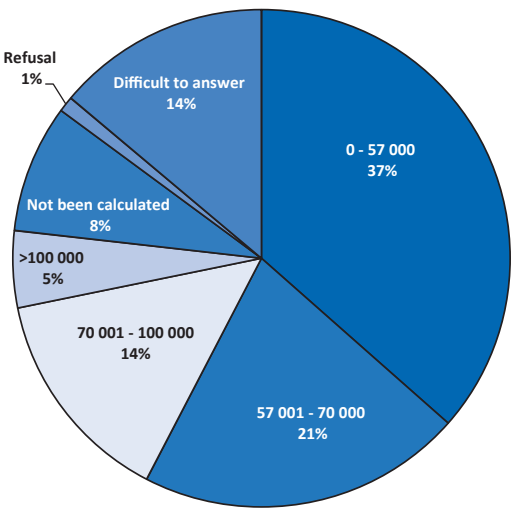
Awareness of content of assessment/declaration prepared by Social Agent during home visit

About half of the families that were visited by an SSA social agent (n=662) read the declaration completed by SA before signing. The document was thoroughly read before signing by 49% and 10% read it superficially.

Assessed score

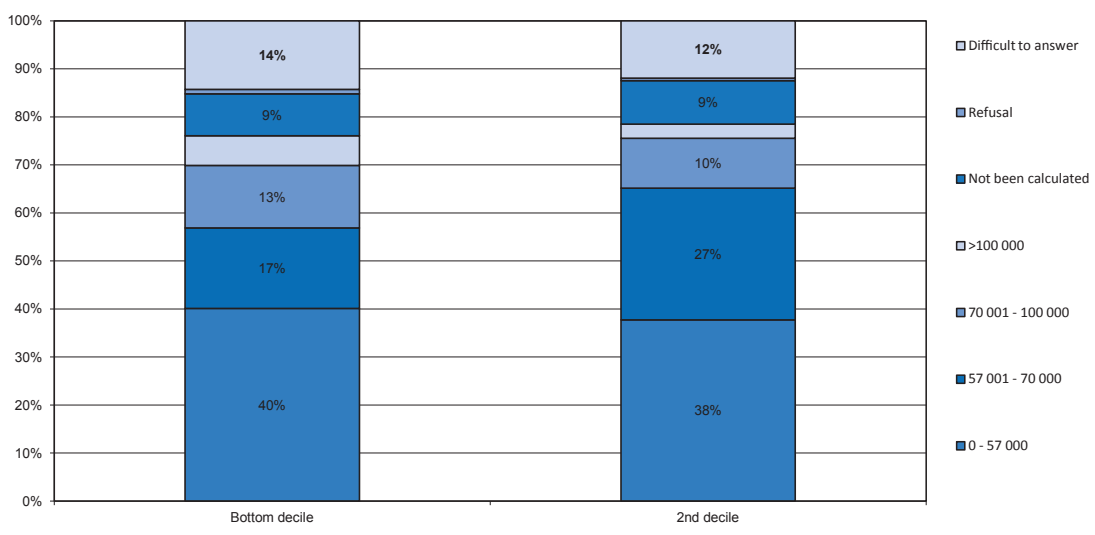
Respondents were asked the score they received by the SSA agent based on the means-test consisting of over 100 components. Over a third of the respondents (37%) reported a score of 57,000 or below. One-fifth reported a score of between 57,000 and 70,000. About 14% are unable to recall the score.

Percentage distribution of household scores which applied to be registered by SSA to the database for vulnerable families, Georgia 2010



(n=662), Georgia BASS, 2010

Percentage distribution of household scores which applied to be registered by SSA to the database for vulnerable families, Georgia 2010



(n=520), Georgia BASS, 2010

Respondents' perception of ranking score compared to their family's economic situation

Among the respondents who recalled their score, 51% felt that their family's economic situation was worse than assessed. Two out of five (42%) felt that the score corresponds approximately with their family situation. Only 2% felt that their family's economic situation is better than the assessed score. 5% found it difficult to answer the question. Nine out of 10 households reporting that their economic situation is worse than assessed are not receiving a cash benefit.

Perception of 'complexity' of application process

Respondents who requested TSA and were visited by a Social Agent were asked about the complexity of the process for registering for the TSA database and receiving assistance. The respondents could rate the process from 1 (very simple) to 5 (Very complex). Half of the respondents (49%) rated the process 'complex' (39%) or 'very complex' (11%).

Knowledge of complaints procedures

Half of the respondents (49%) who had ever applied to be registered at the database of socially unprotected families know how to appeal if they encounter any problem during the process of registration for TSA. The following entities/officials were identified by respondents as resources for where they can appeal should they encounter any problem during the process of registration for TSA:

Reported places where a complaint can be issued among all families registered in the database (n=338)
▪ **Rayon office of the Social Services Agency - 68%**
▪ **Central office of the Social Services Agency - 15%**
▪ **Local authorities - 12%**
▪ **Regional office of the Social Services Agency - 11%**
▪ **On the hot line - 2%**
▪ **Court - 1%**
▪ **The Ministry of Labour, Health and Social Affairs - 0.3%**
▪ **Georgian Young Lawyer Association - 0.3%**
▪ **Police - 0.2%**
▪ **President - 0.2%**

The applicants who have lodged a complaint

The families that have been visited by the SSA at their homes (n=662) were asked if they had ever tried to submit a complaint against the procedure of the assessment (ranking score, social agent's actions, methodology, etc.). Nearly one in ten families assessed claimed to have submitted a complaint (9%). Complaints are taken seriously. The results of the inquiry into the complaints submitted against the procedure of the TSA assessment was as follows:

Outcome of complaints issued against the procedure of the assessment (n=62)
▪ **The complaint was satisfied - 24%**
▪ **The complaint was partially satisfied - 12%**
▪ **The complaint was not satisfied - 42%**
▪ **The complaint is being reviewed - 16%**
▪ **Difficult to answer - 6%**

3.4 HEALTH INSURANCE

INTRODUCTION

State provision of health insurance for vulnerable families was introduced in 2006 under the framework of the Medical Assistance Program (MAP). Its main objective is to ensure that socially vulnerable populations have access to health care services and to protect them from catastrophic healthcare costs. The mechanism for targeting free health insurance is the same as for the TSA – families need to register in the database of socially vulnerable families and are subject to proxy means-testing. The only difference is that the threshold for health insurance is higher than for cash assistance; currently it stands at the score of 70,001. Families below this ranking score receive health care vouchers, which they need in exchange for health insurance at one of the insurance companies contracted by the Ministry of Labor Health and Social Affairs. Since 2008, certain categories (IDPs displaced after the August 2008 events, IDPs living in public housing, actors and artists who in the past have won state prizes, children in different forms of state care and institutionalized elderly people) are also entitled to free health insurance without the means-testing requirement. Health care vouchers are delivered by village doctors and social agents. Beneficiaries are entitled to a comprehensive package of primary and secondary healthcare services while the state provides monthly premiums for each insured in the amount of 11 GEL (except for the capital city where the monthly premium is 9.7GEL). Currently, the MAP is the largest health program and according to the SSA, accounts for 45% of the health budget[12]. In 2009, it covered 297,700 families (904,900 persons) representing 29.5% of all families in the country (20.6% of the total population)[13]. In 2009, the WMS confirmed that about a quarter of Georgia's population had health insurance. Of those who had it, a majority were the beneficiaries of the MAP. The study also revealed that of the population who were entitled to free health insurance, many were not accessing it or were not aware of their entitlements. Just over a fifth (21.3%) of the population in the bottom quintile was covered by MAP. The focus of the current study was on exploring the reasons for low coverage and potential barriers for potential beneficiaries.

In order to compare some key variables between the insured and uninsured households, the comparative data by insurance status is presented for the following two groups:
1) Families with no insurance (N=435) (families with no family member insured), and
2) Families with 'MAP and MAP-like insurance' (N=432): families who reported to be insured under governmental insurance programs such as MAP, IDP insurance and certain municipal programs all of which are designed to provide health insurance coverage for the whole family (in this group we also included those 49 households who reported that they have MAP insurance but some members of their family are not covered by their insurance).

A small group of families with 'other insurance' (35 families who have one family member insured under some individual state or private health insurance plan) is included in the analysis of the total sample as well as for certain variables analysed among the families with some type of insurance. However, they are excluded from the comparative analysis of insured and uninsured families as the size of the group with 'other insurance' is too small to draw valid conclusions separately on this group, nor combining these families with other insurance status groups would be a valid approach for comparison purposes.

[12] Ministry of Finance (2010) Law on State Budget 2010

[13] Social Statistics 2009. Social Service Agency. 2010.

RESULTS FROM THE SURVEY

Awareness of the content of MAP health insurance package

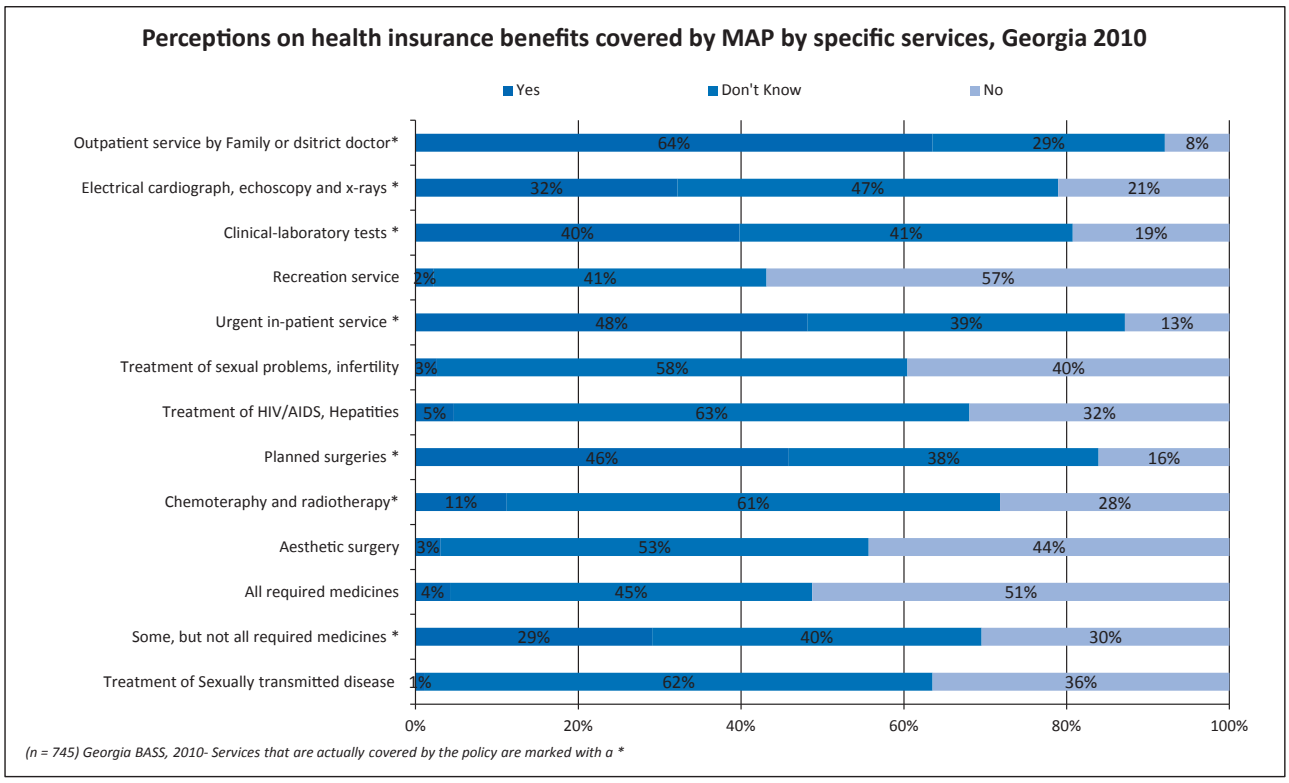
The respondents who were aware of the fact that health insurance is part of the assistance provided through the database of vulnerable families, (87%; See section 3.3. *Awareness of Services)* were asked to identify which services are covered by the MAP insurance policy.

Perceptions on health insurance benefits covered by MAP (n=745)

- Out-**patient** services (family doctor/district doctor)*** - 44%**
- Planned **surgeries* - 31%**
- **Don't know - 34%**
- Urgent inpatient care*** - 21%**
- Laboratory tests*** - 14%**
- Electrocardiographic, ultrasound and X-ray examinations *** - 10%**
- Medicines - 9%
- Child delivery* - 6%
- Chemotherapy and radiotherapy * - 0.8%
- Some (but not all required) medicines** - 0.2%
- Only medicines produced in Georgia - 0.1%

[Services that are covered by the policy are marked with a ""]. ** [Costs of medicine are covered only within a certain limit, which stands at the moments as 50 GEL with 50% patient co-payment]

First, the respondents were asked to list the services they think are covered under the Medical Assistance Program for the Poor (MAP) provided through the database of vulnerable families (see the table above). The respondents were then provided with a list of specific types of medical services. For each type of service, the respondents were asked to identify whether or not the given service is covered by MAP. A large proportion of the respondents were unsure as to whether or not the services are covered under the policy. Depending on the type of service, between 29% - 63% of the respondents were not able to tell if the service is covered by MAP insurance and a significant share had incorrect knowledge of the covered benefits.



Insured families have better awareness of covered services (Respondents say DK=20%) than non-insured (46%) and partly insured (48%).

Preferred sources of Information about health insurance programs

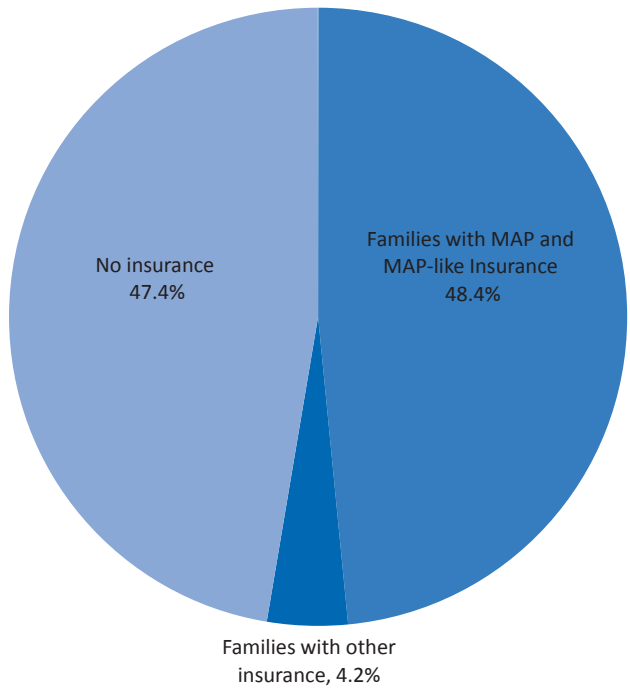
All respondents were asked about the preferred sources of information on state-subsidized health insurance programs. According to the results of the survey, television is the most preferred source (84%). Other preferred sources include: family doctor/polyclinic doctor (28%); Information booklets (20%); Newspapers/Journals (12%); and special meetings organized by qualified persons in a workplace or place of residence (11%).

Health insurance coverage

About half of the interviewed families (53%) report that they have at least some kind of health insurance in their family. The vast majority of these households are insured under the Medical Assistance Program for the Poor (MAP insurance) or other governmental health insurance programs that provide family coverage of health insurance benefits similar to MAP (namely, health insurance for IDPs and certain municipal health insurance programs for poor families). These programs are referred to as 'MAP and MAP-like insurance' in the current report. A small portion (4%) of households report having a family member who has some other type of state or private health insurance that often covers only an individual member of the family (such as the insurance for public school teachers referred as 'other insurance' in this report).

Health Insurance Coverage

Distribution of bottom wealth quintile families by health insurance status and type of insurance, Georgia 2010



(n=902), Georgia BASS, 2010

The bottom wealth quintile families in west Georgia are more likely to have health insurance (59% of families in west Georgia some kind of insurance as opposed to 44% in east). Families from minority ethnic groups are less-likely to be insured.

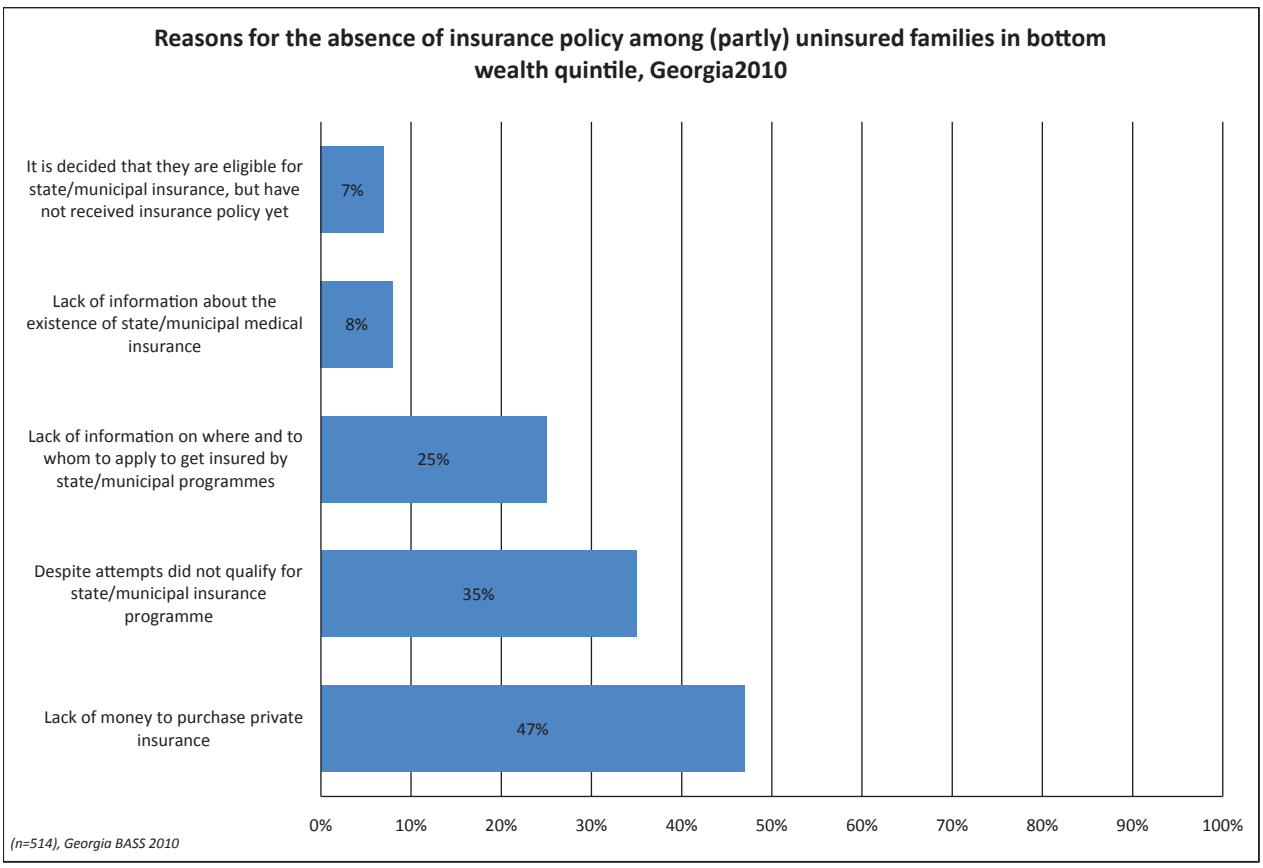
Table: Percentage of households that have health insurance by region/ethnic group in Georgia, 2010

	Tbilisi N=111	West Georgia N=374	East Georgia N=417	Georgians N=756	Azeris N=93	Armenians N=33	Total N=902
Insured (MAP & MAP-like insurance)	50%	54%	41%	51%	32%	16%	48.4%
Insured - other	5%	5%	3%	5%	0%	0%	4.2%
Uninsured	45%	41%	56%	44%	68%	76%	47.4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

3.4.1 INFORMATION ON FAMILIES THAT HAVE NO INSURANCE OR ARE PARTLY INSURED

Barriers to accessing health insurance

Among the families who reported having no health insurance, different factors were explored as possible reasons for the absence of health insurance. The main reasons for not being insured are reported to be a combination of lack of money to purchase private health insurance (47%) and not qualifying for the Medical Assistance Program (35%). A lack of information on where and who to apply to get insured by state/municipal programs also seems to be a major factor (25%).



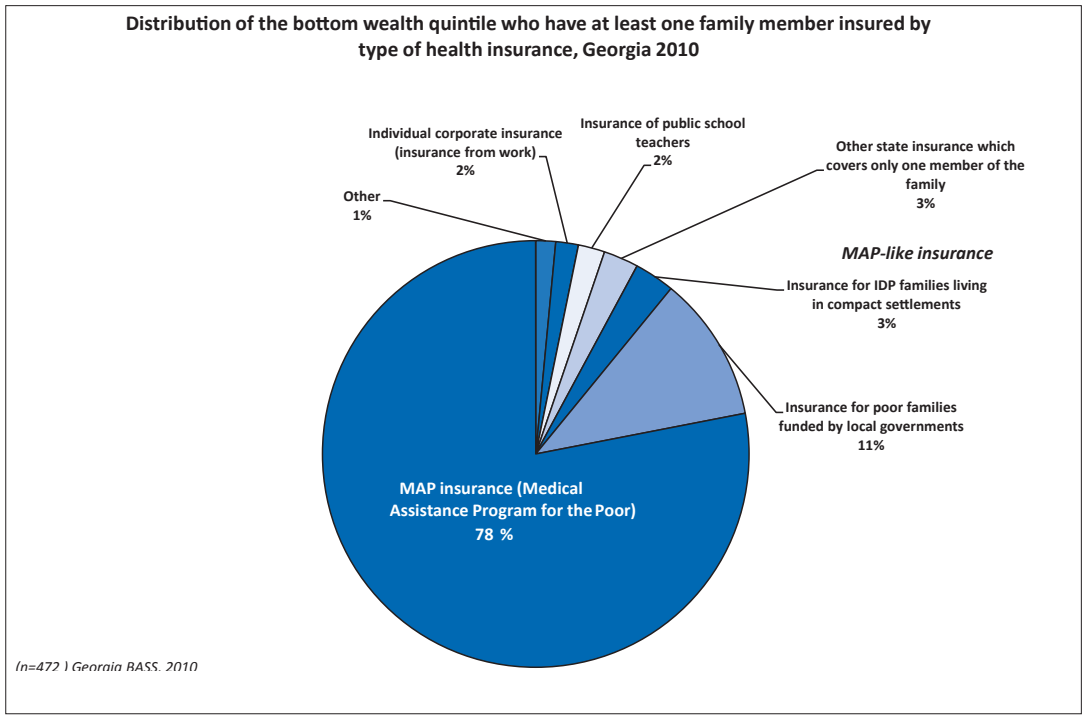
The 'lack of money to purchase private insurance' is a dominant factor reported as a reason for not being insured by the respondents residing in Tbilisi (90%). Households from other areas do not seem to have considered purchasing health insurance as an option. All groups have a significant share that, despite attempts, did not qualify for state/municipal health insurance, especially among the households residing in east Georgia. The lack of information on how to apply for governmental health insurance programs seems to be a major obstacle for the Azeri group.

Table: Reasons for the absence of health insurance among bottom wealth quintile families by region and ethnic group in Georgia, 2010

	Tbilisi N=67	West Georgia N=181	East Georgia N=266	Georgians N=409	Azeris N=68	Armenians N=25	Total N=514
Lack of information about existence of Government Health Insurance Programs (GHIP)	9%	5%	10%	6%	25%	..	8%
Lack of information on how to apply for GHIP	36%	17%	24%	20%	61%	36%	25%
Despite attempts did not qualify for GHIP	25%	39%	50%	36%	43%	18%	36%
They qualified for GHIP but have not received the insurance policy yet	3%	12%	6%	8%	1%	11%	7%
Lack of money to purchase private health insurance	90%	16%	39%	51%	3%	45%	47%

3.4.2 INFORMATION ON FAMILIES THAT HAVE INSURANCE

As mentioned above, slightly over half of the interviewed households report that they have some type of health insurance in the family (at least one member insured). A vast majority (92%) of these families are insured under the Medical Assistance Program for the Poor or other governmental health insurance programs which offer similar health insurance benefits for the beneficiary families (insurance for IDPs living in Compact Settlements, some municipal programs that target poor families). These governmental programs are referred as 'MAP and MAP-like insurance' in the current report.



Sources of Information on State Health Insurance Programs

The families that have MAP, IDP or other State/Municipality-funded MAP-like health insurance were asked where they had learned about their health insurance program. The main sources of information were the social agent of the SSA (41%); Doctors (22%); and Friends/Relatives (12%).

Source of information on health insurance programs among the families insured under MAP and MAP-like programs, Georgia, 2010 (n=432)	
Social agent	41%
Doctor	22%
Fiends/relatives	12%
Health insurance company agent	10%
TV	8%
Received the information at work	3%
Representatives of local authorities	1%
Other	3%
Difficult to answer	7%

Length of Insurance Enrolment

About one-third of the beneficiaries of the MAP and MAP-like insurance programs offered by the state/ municipalities have been insured for less than 1 -year (average length of insurance enrolment is 22 months).

Length of insurance enrolment among the bottom wealth quintile families with 'MAP and MAP-like insurance', Georgia, 2010 (N=432)	
0-6 months	14%
7-12 months	20%
13-24 months	23%
25 months or longer ago	23%
Difficult to answer	20%

Waiting period for MAP insurance policy

About one-quarter of respondents were not able to recall the time period that had passed between qualifying for MAP insurance and receiving the respective insurance policy. Approximately 70% of the families who had applied for MAP health insurance during the 12 months before the survey and were able to recall this time period reported that the time that had passed between qualifying for state MAP insurance and receiving the insurance policy was between 0 to 3 months. On average, it takes 2 months between qualifying for MAP insurance and receiving the MAP health insurance policy.

Time between qualifying for MAP insurance and receiving the insurance policy, Georgia 2010 (n=349)		
0-3 months	35%	(72%)*
4-6 months	9%	(20%)*
7-12 months	4%	(8%)*
Received the insurance policy more than 1 year ago	28%	
Difficult to answer	24%	
**Value in () = value excluding the families who received the insurance policy more than one year ago and/or were not able to recall the time period, N=148*		

Challenges during the application process for health insurance

The families who had applied for governmental health insurance programs were specifically asked if they had any particular problems with receiving their insurance policy. 12% reported that it took too long to actually receive the policy.

Problems with receiving the insurance policy among the families with 'MAP and MAP-like insurance' (n=440)
▪ **They were late - 12%**
▪ **They did not bring it home and we had to go there - 8%**
▪ **We had to go there many times - 4%**
▪ **We were mistreated (treated rudely) - 3%**

Clarity of the insurance policy (Any kind of health insurance)

Approximately 80% of the respondents who have some kind of insurance in their family report that there is at least one member in the family who has read the insurance policy. In 17% of cases, none of the family members has ever read the insurance policy.

Reading the insurance policy (all families with any type of insurance n=467)
▪ **Yes, I have read it - 54%**
▪ **Yes, both me and my family member have read it - 15%**
▪ **I have not read it, but my family member has read it - 10%**
▪ **No, none of us have read it - 17%**
▪ **I have not read it and not sure whether any other family member has read it - 5%**

According to a large majority of the respondents who have read the insurance policy, the content of the policy is absolutely clear to them and their family members (87%).

Clarity of the insurance policy (n=353)
▪ **Absolutely clear - 87%**
▪ **Partially clear - 11%**
▪ **Absolutely unclear - 0.7%**
▪ **Missing - 1%**

The respondents who reported that the content of the insurance policy was not absolutely clear for them raised several clarity-related issues that they had problems with.

Unclear issues related with the contents of the insurance policy (n=81)
▪ **What services are covered by the insurance - 40%**
▪ **To whom to apply to when we are encountering problems with receiving services which we think are covered by our insurance - 26%**
▪ **Co-payment system - 23%**
▪ **Costs of which medicine are covered - 23%**
▪ **Which medical facility we should refer to when we have a health problem and need medical assistance - 16%**
▪ **Almost everything is unclear - 14%**
▪ **Exceptions (the list of services which are not covered) - 10%**

A quarter of all respondents that have some kind of insurance in the family reported that they have ever had a desire or need in the past to obtain some additional information regarding their insurance: (24%).

These respondents were further asked what sources they usually use when they need some information regarding their health insurance. Referring to 'friends/relatives with similar insurance' for the information seems to be the most popular source (40%), followed by 'reading the insurance policy' (36%) and 'asking the doctor' (30%) to obtain the desired information. The insurance company hotline is among the most rarely used sources (13%).

Sources insured families use to obtain information about their health insurance (n=145)
▪ **We ask friends/relatives, who have similar insurance – 40%**
▪ **We read the policy – 36%**
▪ **We ask a doctor – 30%**
▪ **We call the 24 hour hotline service of the insurance company – 13%**
▪ **We refer to the mediation information service (555 115) – 5%**
▪ **We refer to Social Services Agency – 4%**
▪ **We refer to the Ministry of Health – 2%**
▪ **We refer to local authorities – 1%**

Use of health insurance (Any kind of health insurance)

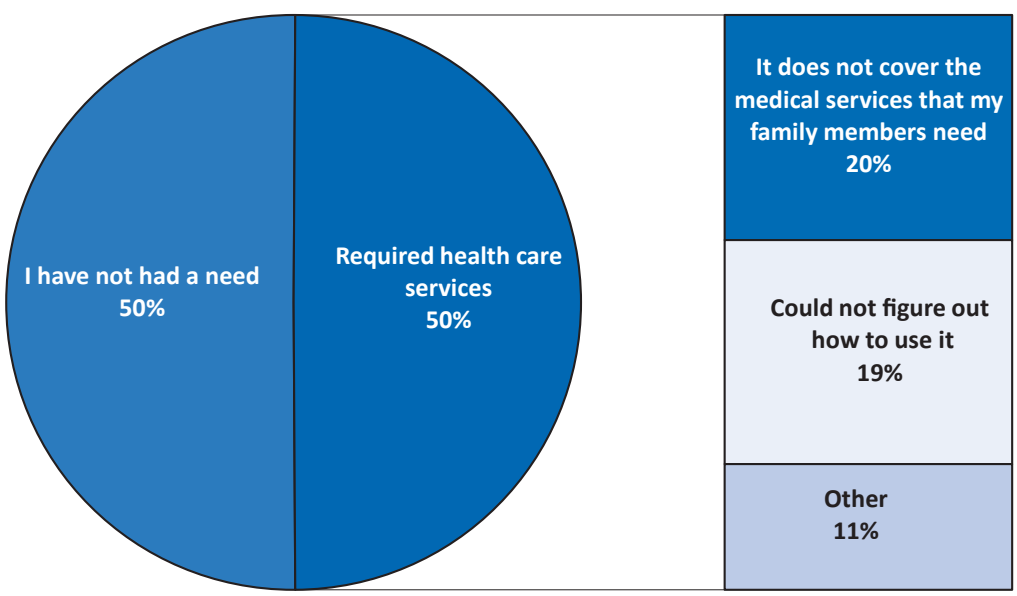
Fifty-seven per cent (57%) of the (fully or partly) insured families reported that at least one family member had used the health insurance (or medical service- the costs of which were covered by the insurance company) at least once during the 12 months prior to the survey.

Reasons for not using health insurance (Any kind of health insurance)

The families who had not used their health insurance during the 12 months before the survey were asked to indicate the reasons for not using the insurance services. About half of the respondents report that they had no need (i.e. had no health problems). As for those respondents who did not use health insurance despite the need for healthcare services, the main reasons for not using the health insurance included: *the needed health services were not covered by the insurance policy and limited knowledge about how to use the insurance*.

Non-use of Health Insurance

Reasons for not using health insurance among the bottom quintile families who have some insurance but have not used it during the past 12 months, Georgia 2010



Satisfaction with insurance company services (Any kind of insurance)

The majority of families that reported using their insurance (or medical services the costs of which were covered by the insurance company) at least once during the 12 months prior to the survey report that they are 'very satisfied' or 'quite satisfied' with their insurance company's services (77%). 21% of families report they were 'neither satisfied nor dissatisfied'

(Note: in this question, the respondents were specifically asked to consider the insurance company services only, not the medical services covered by the insurance).

Satisfaction with insurance company's service (n=269)
▪ Very satisfied - 31%
▪ Quite satisfied - 46%
▪ Neither satisfied, nor dissatisfied - 21%
▪ Somewhat dissatisfied - 2%
▪ Dissatisfied – 0.4%

A small proportion of insurance users reported that they encountered some bureaucratic difficulties with covering the cost of the treatment by the insurance company (4%). The reported problems include:

Satisfaction with insurance company's services: bureaucratic difficulties (n=26)
▪ They did not cover the service that I needed - (4 families)
▪ We always have to wait for long, there are long lines - (2 families)
▪ We were treated very carelessly/rudely - (2 families)
▪ Reimbursement/preparation of guarantee letter was delayed - (1 family)
▪ The required information was not provided to me fully and in an understandable manner - (1 family)
▪ They requested payment for the services that are covered by the insurance-policy - (1 family)
▪ I do not like the medical facility selected by the insurance company - (1 family)

Disputes with Insurance Companies (Any kind of insurance)

No cases of legal disputes with insurance companies were reported. 3% of the respondents had some kind of misunderstanding with the insurance company. Six families reported that the disagreement/misunderstanding was because the insurance company refused to cover the costs of medical treatment. One respondent complained that the family was mistreated by the insurance company/misinformed.

Attitude towards the beneficiaries of governmental health insurance programs (MAP and MAP-like insurance, including partially insured families)

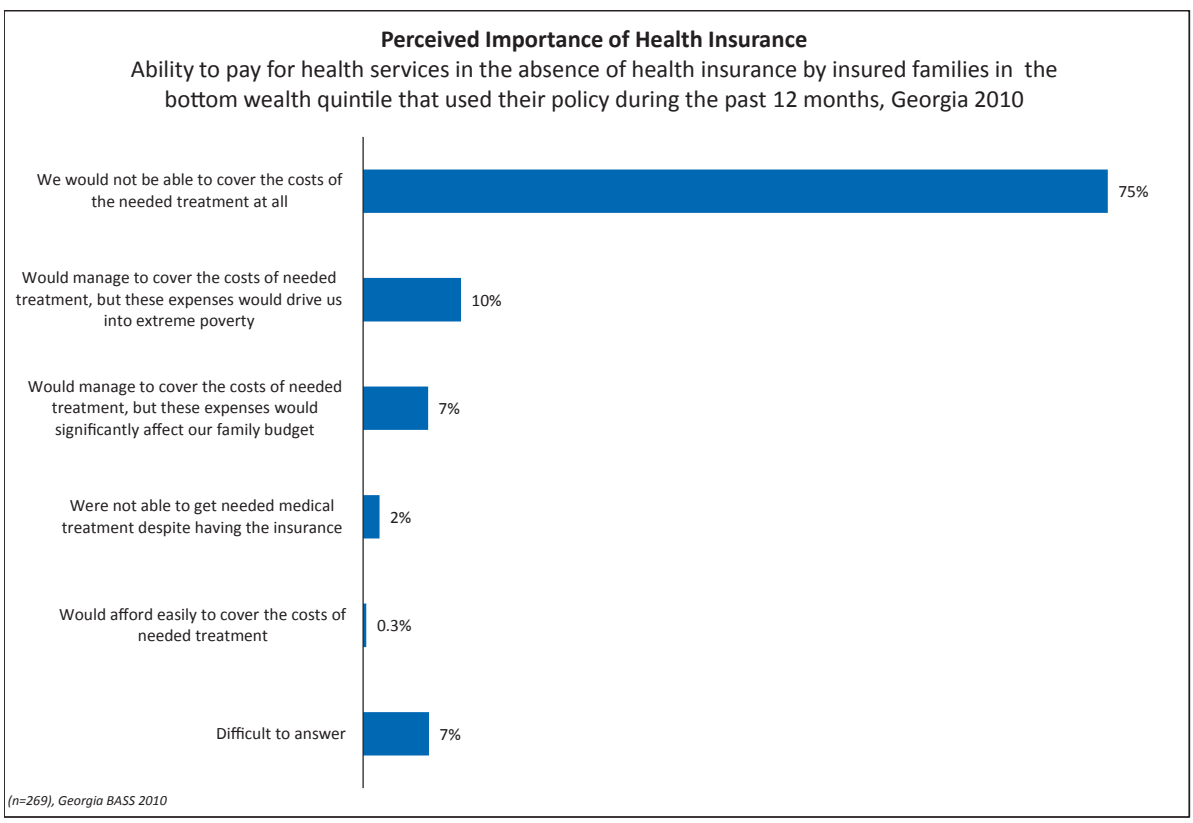
The families with government subsidized health insurance (beneficiaries of MAP and MAP-like programs) who had used their insurance during the 12 months before the survey were asked if they felt an arrogant/careless approach from the insurance company or medical staff because they have state/ municipality provided insurance. Over 90% of the respondents did not experience any kind of attitude problems either with the insurance company personnel or the health service providers. A negative attitude from doctors was experienced by 8% of the respondents (Seldom: 5%/ Often: 3%/Always: 0.4%). The negative experience was less likely to occur from insurance company staff – 4% (Often: 3.5%/Seldom: 0.5%).

About one in ten beneficiaries of governmental health insurance programs indicate that the medical services they receive is different from the services provided to other (uninsured) patients who pay for the services themselves. The majority of respondents (77%) do not feel that they are treated differently.

Perceived quality of medical services provided to patients with governmental health insurance compared to uninsured patients among insured families who used services during the past 12 months before the survey (n=269)
▪ You get the same quality care that you would receive if you were paying for the service yourself - 77%
▪ You get good medical treatment, but personally you are treated more carelessly, may be even rudely - 9%
▪ You get worse quality care in all respects (both medical and personal treatment), because you "come with insurance" and are not paying yourself - 2%
▪ Difficult to answer - 11%

Perceived importance of health insurance in terms of improving the financial accessibility of healthcare (Any kind of insurance)

Families who had used their health insurance during the 12 months before the survey were asked to what extent they would have been able to cover the costs of medical treatment of their family members if they did not have health insurance. Three quarters of the respondents report that they would not be able to cover the cost of the treatment at all, and a further 17% indicate that these expenses would drive them into extreme poverty or significantly affect their family budget.

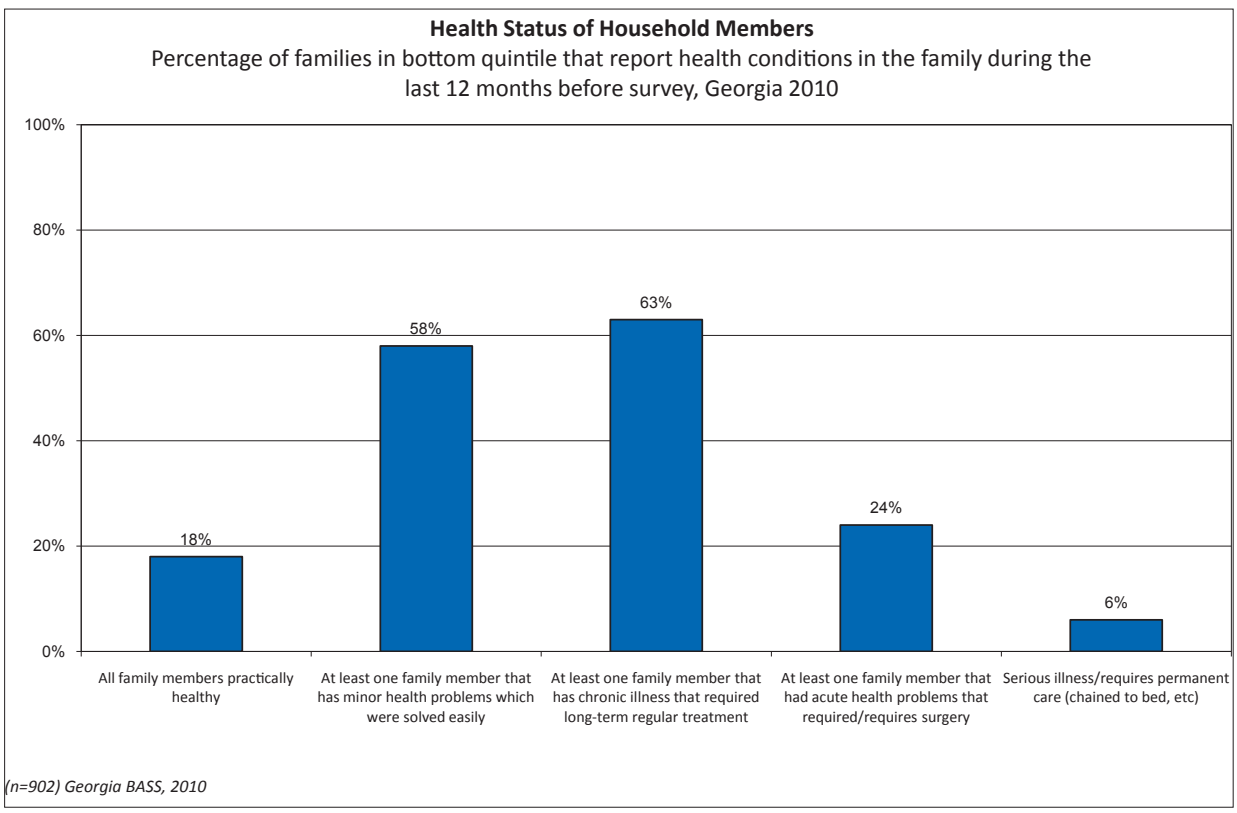


3.4.3 HEALTHCARE SEEKING BEHAVIOR

Self-reported Health Status

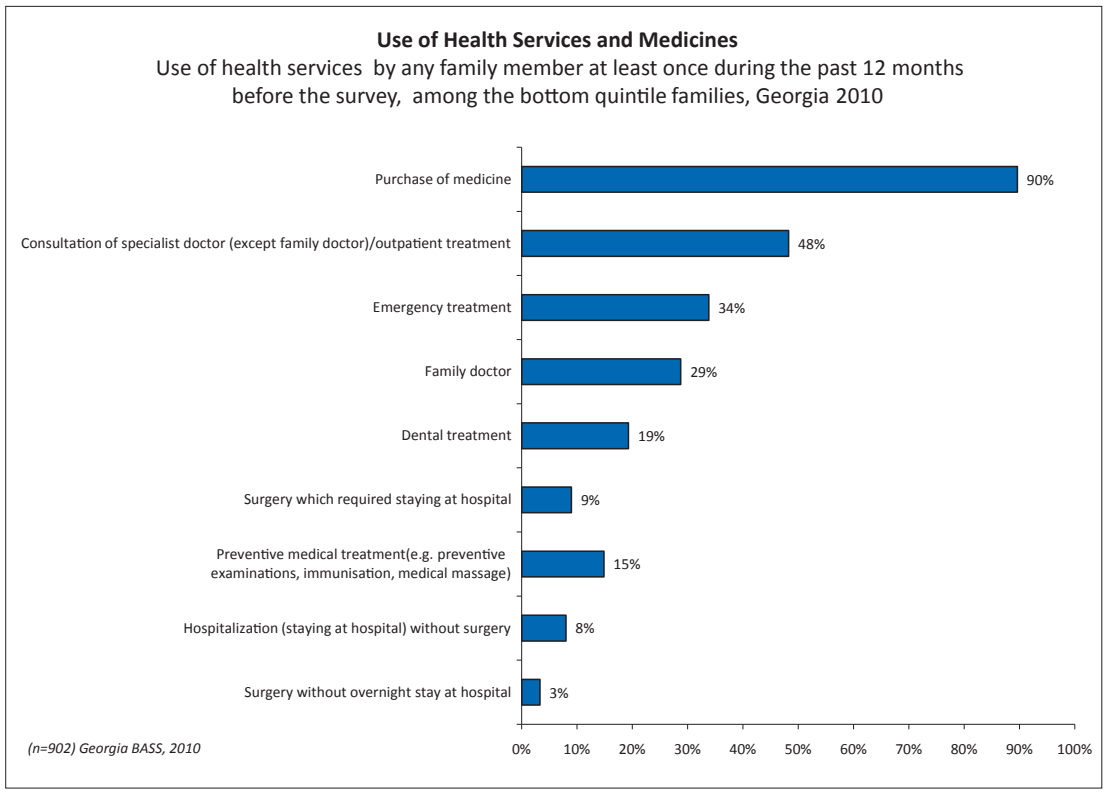
A large majority of families (82%) reported that one or more of their family members required medical care: a) Chronic illness that required long-term (more than 1 year) regular treatment ; b) Acute health problems, which required/requires surgery; c) Serious illness/requires permanent care (patient is bedridden), during the 12 months before the survey.

58% of the households report that they have one or more family members that have had minor health problems during the past 12 months that were solved easily. Nearly two-thirds of the households (62%) report that they have one or more family members that have required long-term (more than 1 year) regular treatment. About a quarter of the households (24%) report that they have one or more family members that suffer from acute health problems which required (or still requires) surgery. 6% of the households report that one or more family members have a serious chronic illness which requires permanent care/nursing (the patient is bedridden).

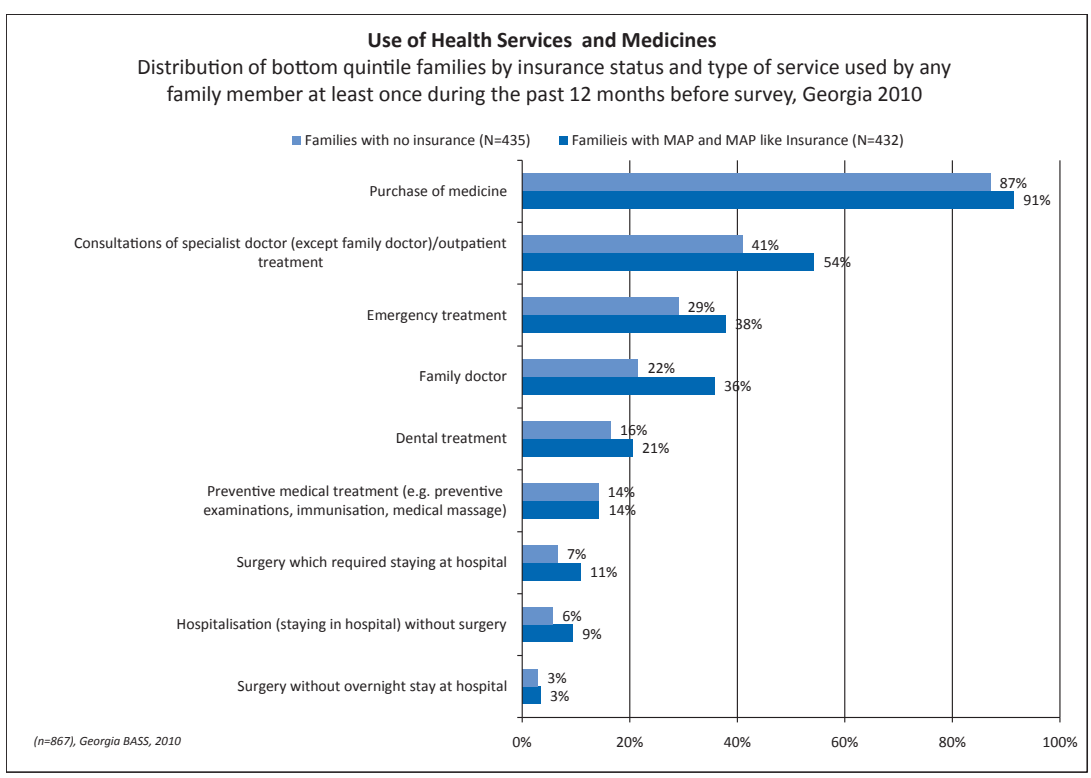


Use of Healthcare Services and Medicines

The utilization of healthcare services and medicines was explored during the 12 months before the survey. Overall, among the bottom quintile population, specialist doctors providing outpatient care are the most used health services (in 48% of households, at least one member has used the service during the last 12 months). Ambulance service is the second most likely service to be used (34%). Less than one third (29%) of households have referred to the family doctor's services. Preventive services are used quite rarely (15%). The overwhelming majority reported purchasing medicines (90%).



Overall, families who have health insurance are more likely to use health services. Families with MAP and MAP-like health insurance are more likely to use all types of health services than uninsured families, except for preventive services and outpatient surgery. For example, they are more likely to use family doctors' services, (36% as compared to 22%), specialist doctors' services and inpatient services compared to non-insured families. Overall, these results suggest that having health insurance encourages healthcare utilization-rates by removing or reducing the financial barriers.



Use of medicines

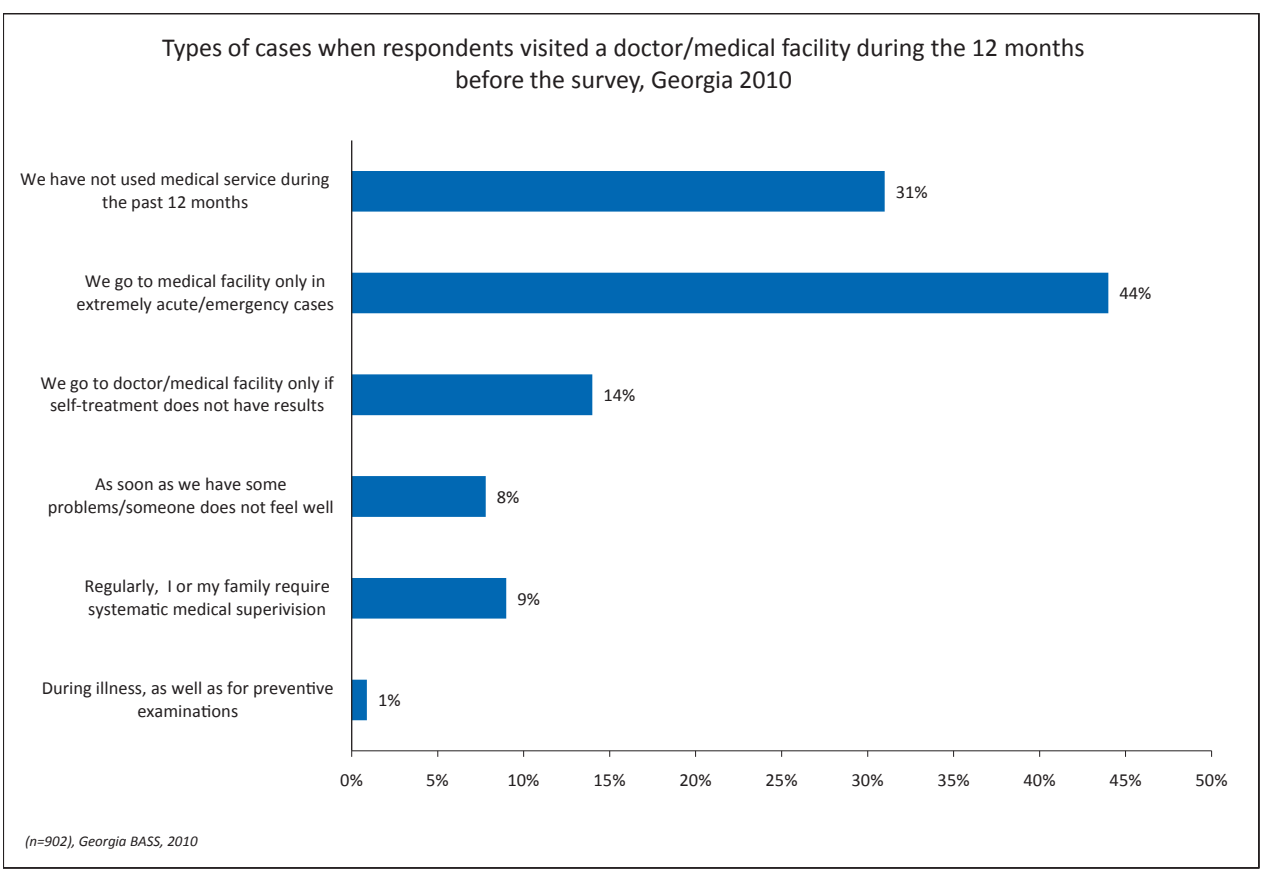
Nearly all respondents reported purchasing medicines during the past 12 months before the survey. Almost similar utilization patterns are observed among insured and non-uninsured families (presumably due to the fact that insurance provides no, or very limited coverage of drug benefits). A significant proportion of respondents use medicine on a daily basis (40%).

Table: Use of medicines among bottom wealth quintile families by insurance status, Georgia 2010

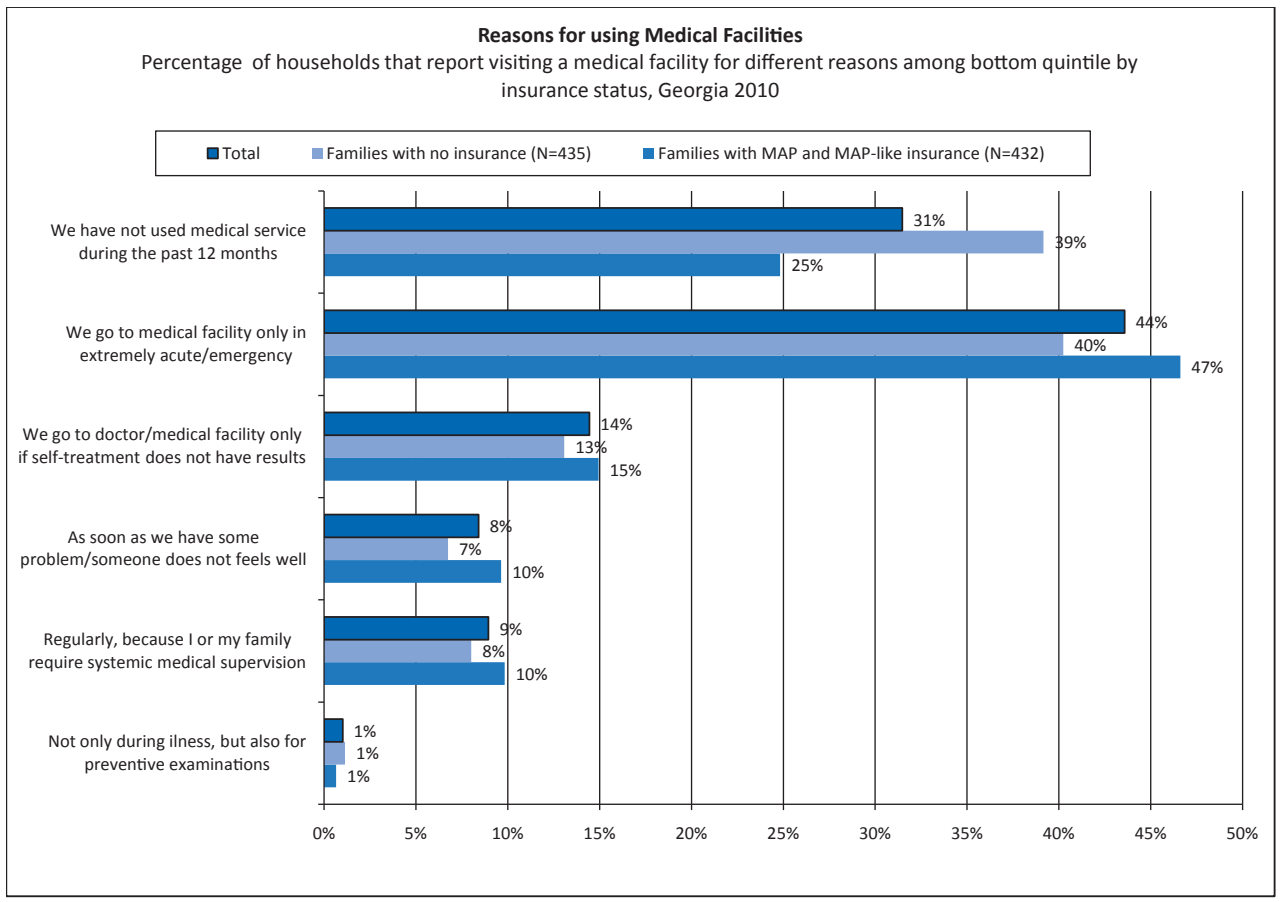
	Families with MAP &MAP-like insurance (N=432)	Families with no insurance (N=435)	Total (N=902)
On a daily basis	40%	40%	40%
We had to carry out medicamentous therapy courses on a regular basis	14%	15%	14%
We used medicines non-regularly, when sick	41%	39%	40%
During last 12 months we practically did not need to take medicines	5%	7%	6%

Reasons for visiting medical facilities

Respondents were asked in which cases they and their family members visited medical facilities. The following reasons for use of medical services were provided:



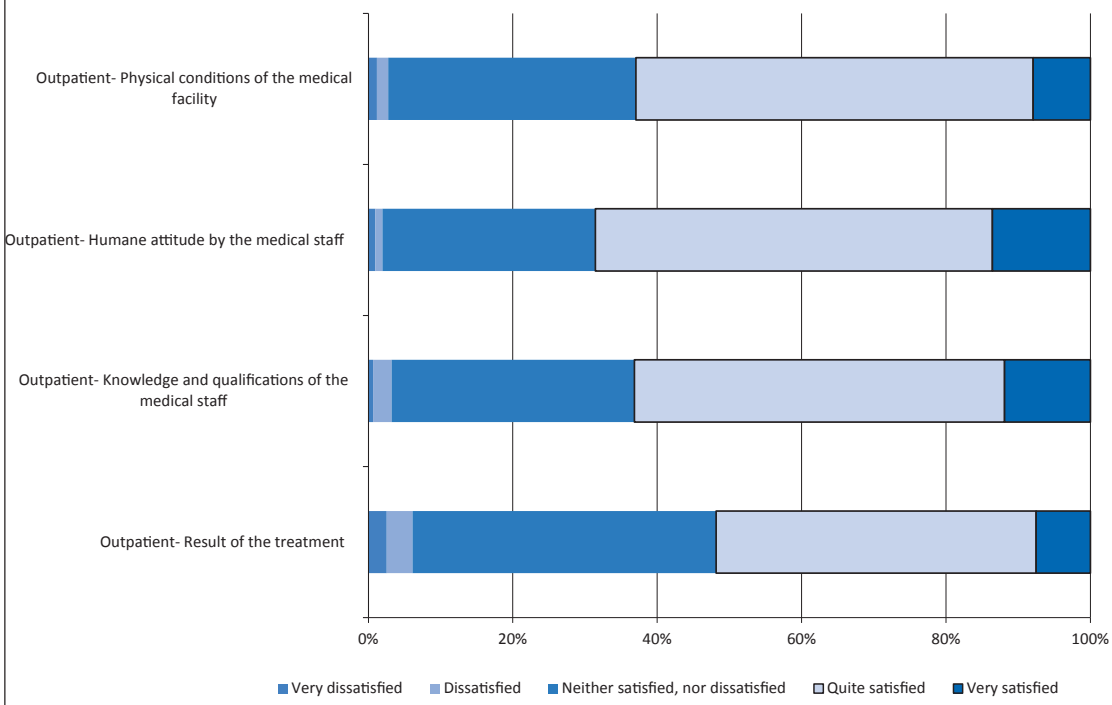
A significant portion of respondents (44%) report that they visit a medical facility only in cases of life-threatening conditions. 14% practice self-treatment first, and visit a medical facility only if self-treatment proves ineffective. Visiting a medical facility for preventive examinations is virtually not practiced.



Satisfaction with provided healthcare services

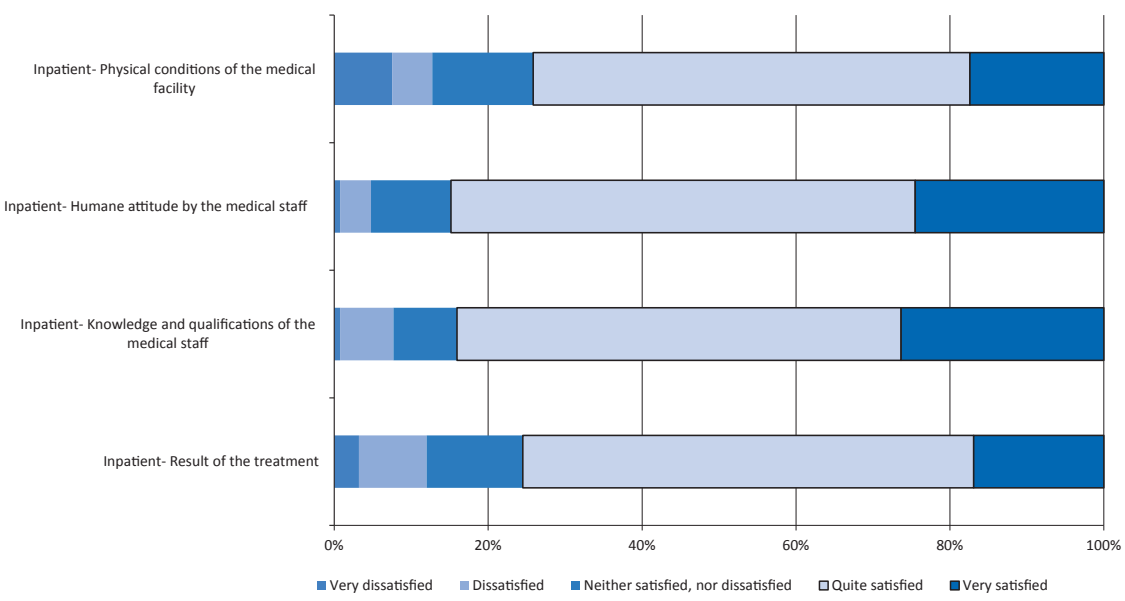
Respondents are mostly satisfied with the healthcare services they receive. Overall, patients seem to be more satisfied with 'in-patient services' compared to 'out-patient' services. Patients are the least satisfied with the *outcomes* of outpatient care.

Level of satisfaction with 'out-patient' services among those who used health services, 12 months before the survey among bottom quintile families, Georgia 2010



(n=546), Georgia BASS 2010

Level of satisfaction with 'in-patient' services among those who used health services, 12 months before the survey among bottom quintile families, Georgia 2010



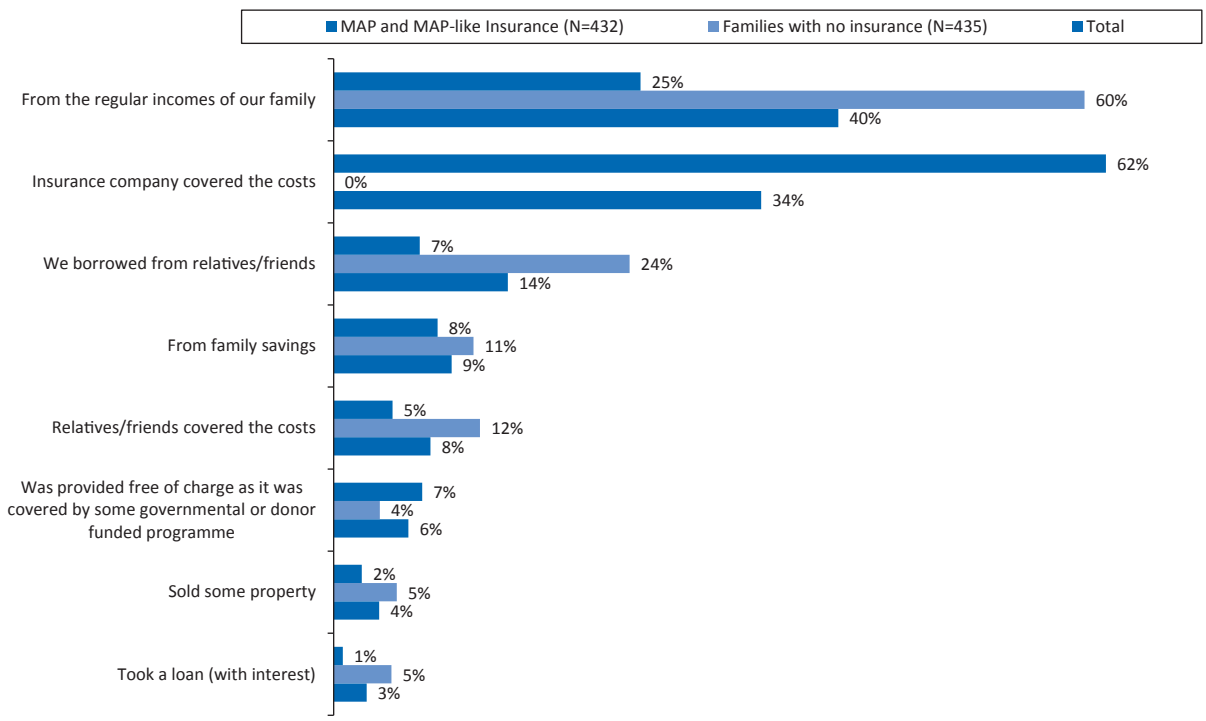
(n=164), Georgia BASS 2010

Financing medical treatment

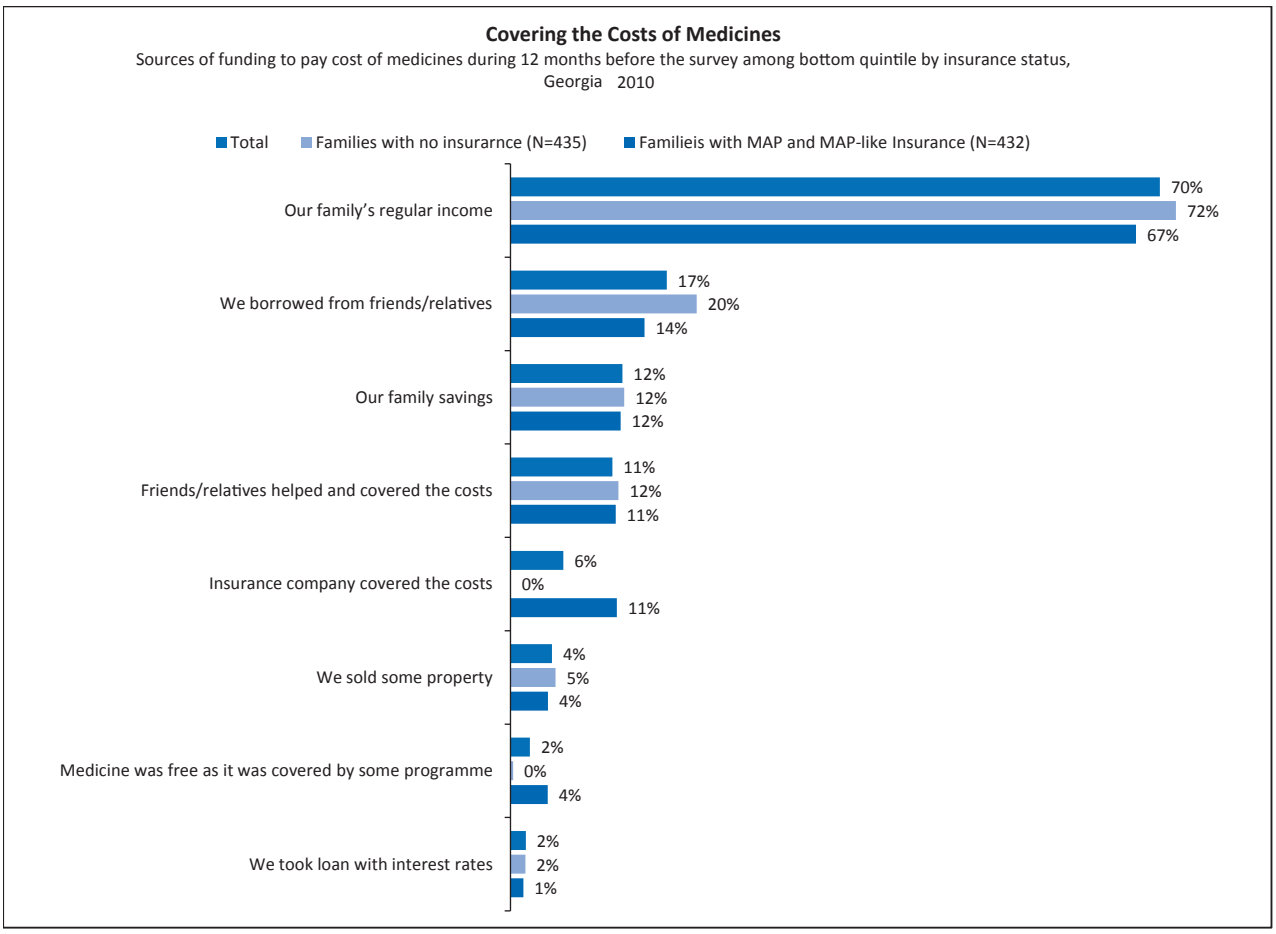
The main source of paying for medical treatment (other than medicine) during the 12 months prior to the survey is via the 'regular income' of a family (40%) followed by 'Insurance' (34%). Borrowing is a coping mechanism for 14% of the families. For families with MAP and MAP-like insurance, the main source for covering the cost is their insurance company (62%). They are less likely to pay from their regular income (25%) than uninsured families (60%). Non-insured families are more likely to use unsustainable coping mechanisms.

Covering the Costs of Health Services

Sources of funding health services received during the 12 months before the survey among the bottom quintile families by insurance status, Georgia 2010



The main source for purchasing medicines are 'regular income' (70%) and 'borrowing' (17%). There is no significant difference between insured and un-insured families. Medicines are less likely to be financed by a respondent's insurance policy compared to medical treatment.



Burden of Health Expenditures

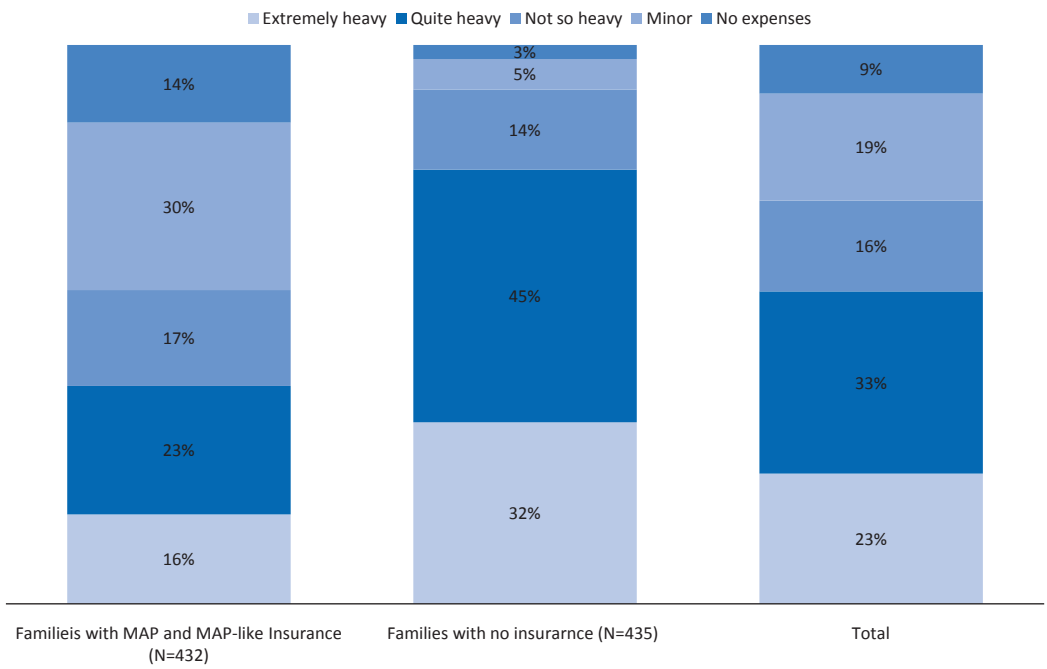
Further, perceived burden of health expenditures (incurred during the 12 months before the survey) were explored separately for health services and medicines. The majority (56%) reported that the burden of health care costs - excluding medicines - was '*quite heavy*' or '*Extremely heavy'*.

- Extremely heavy – these costs basically forced us into extreme poverty - 23%
- Quite heavy – these costs significantly affected our family budget - 33%
- Not so heavy – it affected the budget, but not significantly - 16%
- Minor – these costs have almost had no effect on our budget - 19%
- No expenses - 9%

There is a large difference in degree of burden between MAP & MAP-like insured and uninsured families. 78% of uninsured families report that the burden of health care cost was '*quite heavy*' or '*extremely heavy'* compared to 39% among insured families.

Burden of Health Expenditures (excluding medicines)

Burden of health expenditure (excl. medicines) on household budget during 12 months before the survey among bottom quintile families by insurance status, Georgia 2010



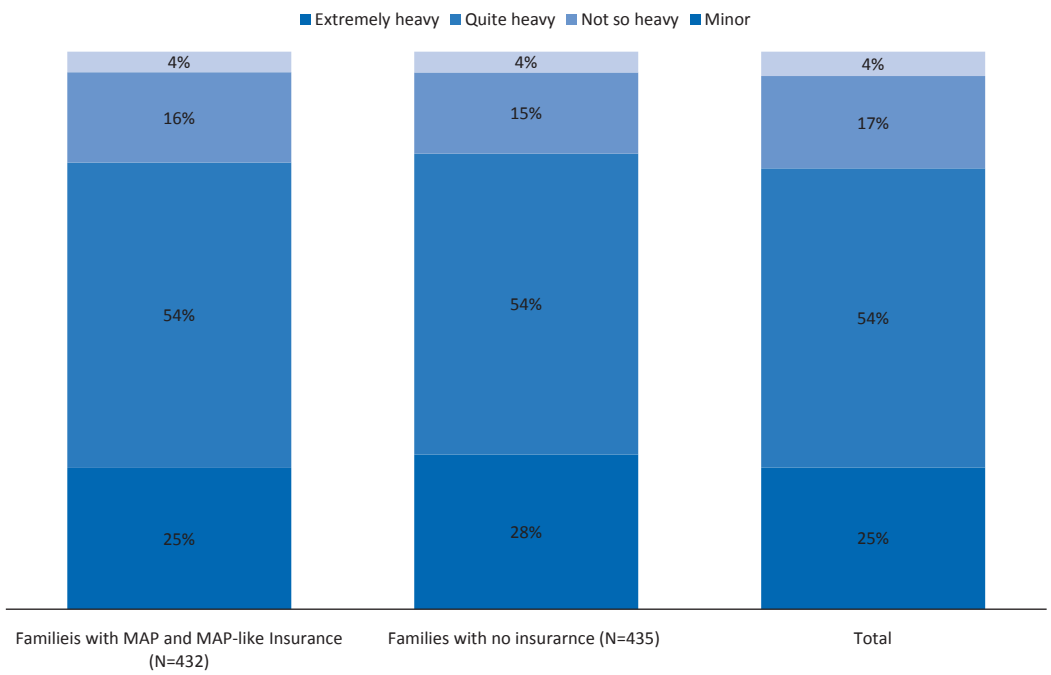
The cost of medicines seems to be a higher financial burden than other health services. Three quarters of the respondents considered the cost of medicines - even when taking into account the existing exemptions (implying medical insurance and programs, but not support from friends/relatives, loan, savings, income) - as 'quite heavy' or an 'extremely heavy' burden (79%).

- Extremely heavy – these costs basically forced us into extreme poverty – 25%
- Quite heavy – these costs significantly affected our family budget – 54%
- Not so heavy – it affected the budget, but not significantly – 17%
- Minor – these costs have almost had no effect on our budget – 4%

There is no real difference in degree of burden between insured and non-insured families.

Burden of Expenditures on Medicines

Burden of expenditures on medicines on household budget during 12 months before the survey among bottom quintile families by insurance status, Georgia 2010



Financial and geographic barriers to access health services

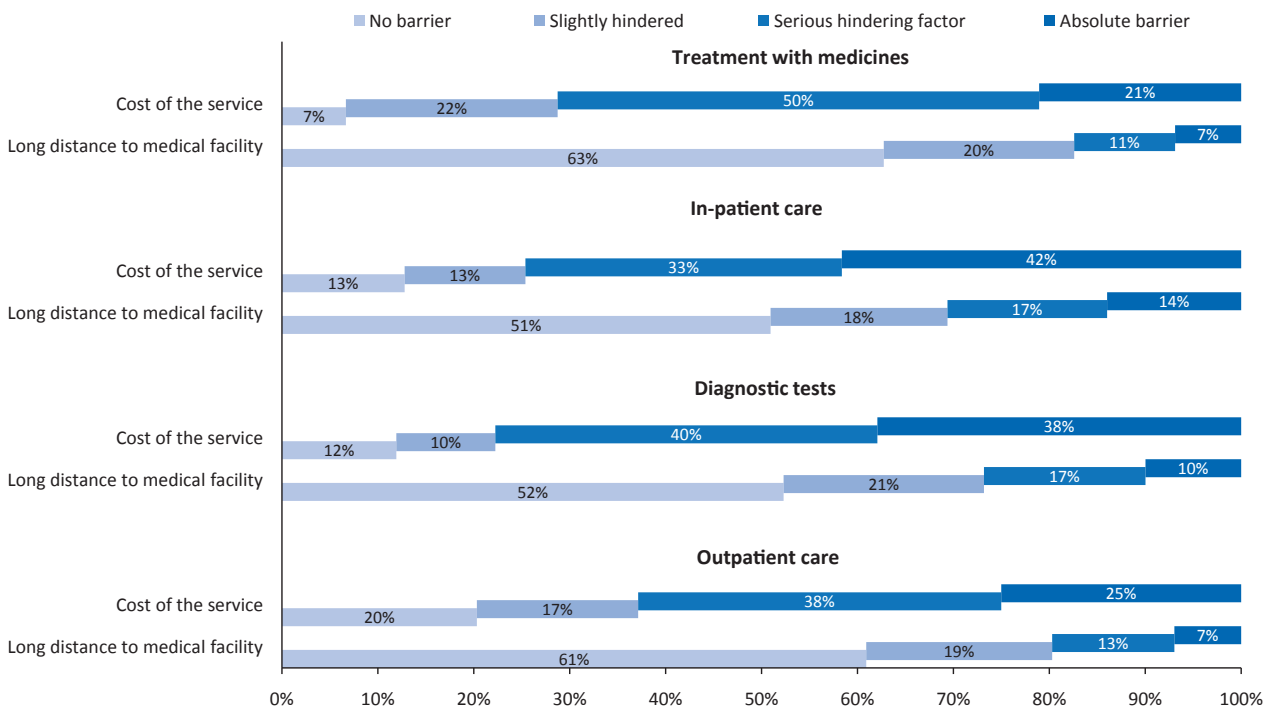
Respondents were asked to identify the level of barrier the cost and physical distance represents for them to access different health services. Respondents could classify levels of barriers to access (i) medicines; (ii) in-patient care; (iii) diagnostic tests; and (iv) outpatient treatment as follows:

- *No barrier - this factor has not hindered us at all*
- *Slightly hindering factor but in case of necessity we always managed to receive this treatment*
- *Serious hindering factor and we could use this service only in extreme necessity*
- *Absolute barrier – because of this factor we were not able to access this service at all*

The graph below shows that the cost of services is in general a major barrier for the bottom wealth quintile households, especially with regard to access *to inpatient care and diagnostic tests*. Cost is reported as an *absolute* barrier to these services by as many as 40% of families. Overall, about three quarters of families consider *cost an absolute barrier or a serious hindering factor* with regard to inpatient care and diagnostic tests. Importantly, cost is considered a major barrier to accessing *outpatient care* as well, reported as an absolute barrier or serious hindering-factor by 25% bottom wealth quintile families

Financial and Geographic Barriers

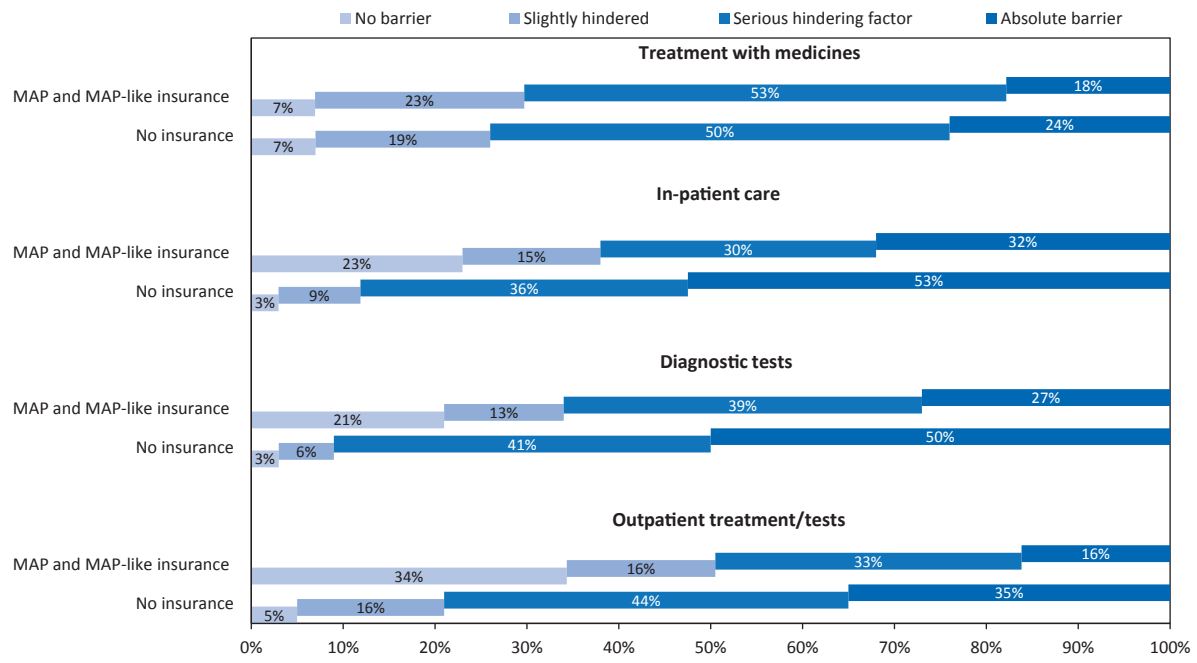
Cost and distance as hindering factors for accessing various types of care during 12 months before the survey among the bottom quintile families, Georgia 2010



Families *with* health insurance reported the costs of service as less of a burden than non-insured families. For Inpatient care and diagnostic examinations, as much as half of the uninsured families claimed that cost of these services was *an absolute barrier* for them compared to 32% and 27% among the families with MAP and MAP-like insurance (respectively). As for the outpatient care, cost is reported to be *an absolute barrier* by 16% of insured families as compared to 35% among the uninsured. Thus, for medical treatment (other than purchase of medicines), cost is twice as less- likely to represent an absolute barrier for the insured families than for families with no health insurance.

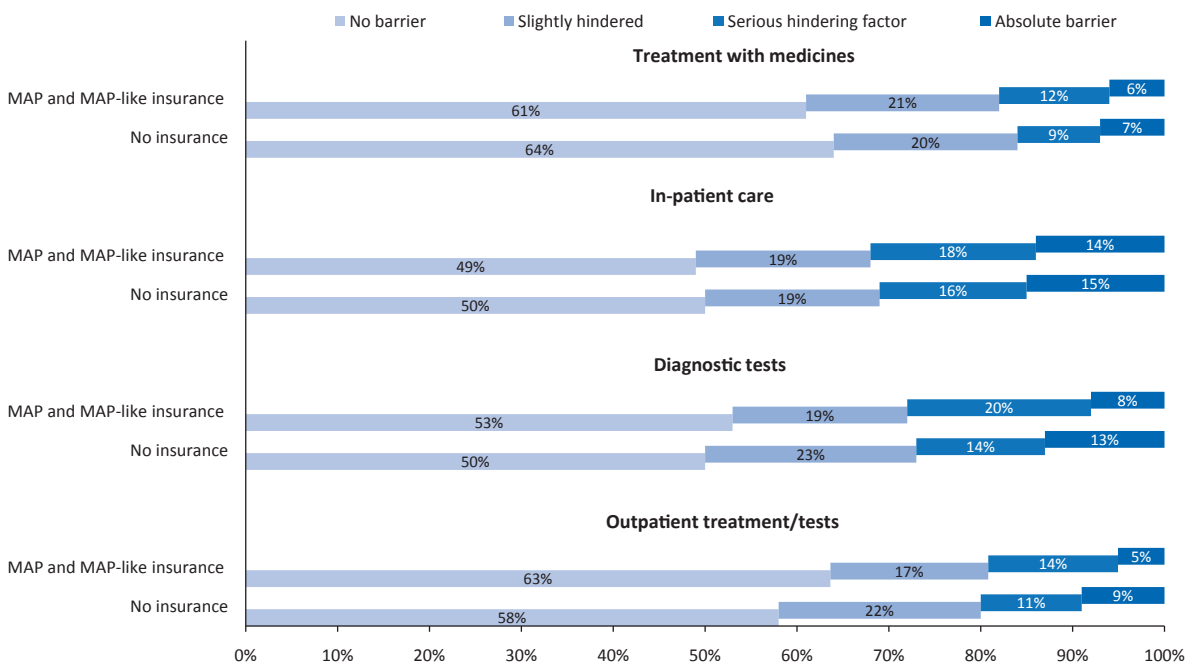
Financial Barriers to Various Types of Care

Cost as hindering factor for accessing various types of care during 12 months before the survey among the bottom quintile families by insurance status, Georgia 2010

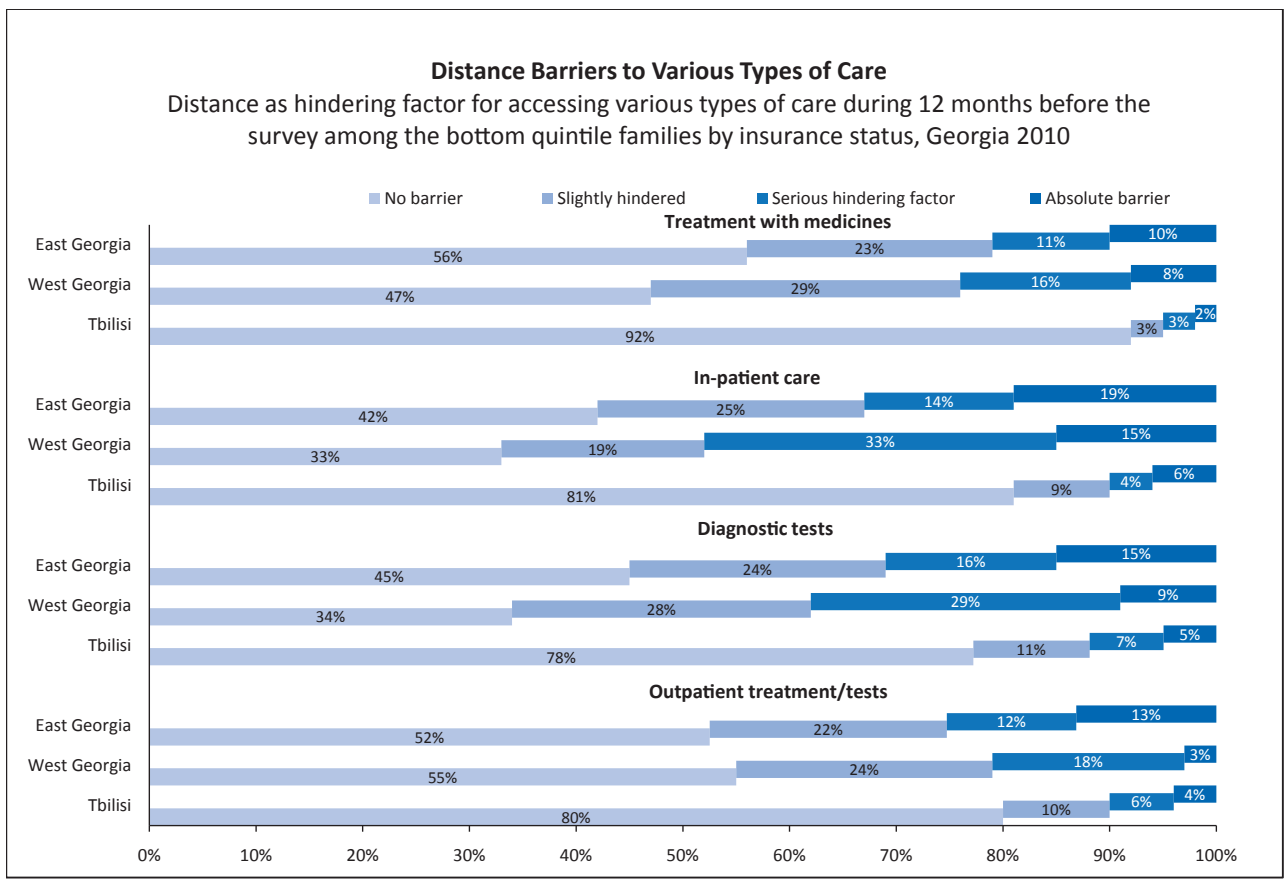


Geographical Barriers to Various Types of Care

Distance as hindering factor for accessing various types of care during 12 months before the survey among the bottom quintile families by insurance status, Georgia 2010



Geographic distance to medical facilities is much less of a barrier than cost of health services and medicines. However, it is still an issue for some parts of the rural population. Physical distance to a medical facility or pharmacy seems to be a minor barrier for families residing in Tbilisi (about 10% indicating distance as an absolute or serious barrier to facilities for inpatient care and diagnostic tests). However, outside the capital there are still challenges with geographical access. Physical distance to *inpatient facilities* is considered *an absolute barrier* by 19% of families in eastern Georgia, and 15% in western Georgia. Importantly, distance is reported as *an absolute barrier to access to outpatient services* by 13% of families living in east Georgia while these rates are negligible in west Georgia and in Tbilisi.



Assumed cost of health services and financial access

The respondents were asked if there had been a case when they or a family member did not go to the doctor or medical facility because of financial problems. About two-thirds (65%) of the respondents reported that they did not use medical services at one point in time because of financial problems. The minority of these respondents (15%) had actually found out beforehand from the medical facility/doctor precisely how much this service would have cost. Insured families were less likely to have to decide not to go to a doctor/medical facility.

Table: Percentage of families that report not going to a doctor/medical facility because of financial problems among the bottom wealth quintile families by insurance status, Georgia 2010 (n=902)

	Families with MAP & MAP-like insurance (n=432)	Families with no insurance (n=435)	**Total**
We found out beforehand from the medical facility/doctor precisely how much this service would cost	12%	18%	**15%**
We had not found out the exact price, but we thought that we would not be able to cover the cost of treatment	48%	52%	**50%**
There has been no such case	40%	30%	**35%**

As for the barriers other than distance to a medical facility and financial problems, about half of the respondents report they face no other major barriers. Some additional reasons and practices when respondents decide not to refer to a medical facility in the case of health problems include: practicing self-treatment, seeking advice from pharmacies, seeking advice from friends and relatives with or without a medical background.

Other reasons for not visiting a doctor/health facility aside from 'distance' and 'financial problems' (n=902)
▪ **We have not had any other reason (apart from distance to medical facility and financial problems) - 46%**
▪ **We are self-treating based on our knowledge although none of our family members has a medical background - 21%**
▪ **We have always sought medical assistance in case of health problems - 13%**
▪ **We seek advice from pharmacies - 8%**
▪ **We go to our friends/relatives who are doctors(s) and treat us or provide consultation free of charge - 6%**
▪ **We ask advice from friends/relatives who are not doctors/nurses - 6%**
▪ **We have a family member with medical education who takes care of our health issues - 2%**
▪ **He/she is not able physically – 0.3%**
▪ **Because of work – 0.2%**
▪ **We have other, more important family matters – 0.2%**
▪ **There are long lines in medical facilities and we have to wait for long – 0.1%**
▪ **Usually we use the service of traditional healers – 0.1%**

A significant proportion of people that required health services depended on informal advice from a doctor who is a family member or friend (8%); seek advice from a pharmacy (8%) or friends/relatives without a medical background (6%). 21% reported that they resorted to self-treatment.

Out-of-pocket payment of health services (Formal/Informal)

Among all respondents who had visited a doctor or health facility during the 12 months prior to the survey, the majority either paid only officially at the counter and got a receipt for the payment (45%) or did not have to pay anything (45%). Insured families are less likely to pay out of pocket for services than uninsured: 60% of the families with MAP and MAP-like insurance reported they had not paid anything as opposed to 28% among the uninsured. The need for making unofficial payment for received services does not seem to be a significant issue, although about one in ten respondents reported paying at least partly unofficially directly to the doctor/nurse in cash or in the form of a present. Overall, among the families that had to make a payment for the received health services, 18% made part of the payment under the counter in the form of cash or a present.

Payment for Health Services

Type of payment for last visit to doctor/health facility during the past 12 months before the survey among bottom quintile families, Georgia 2010

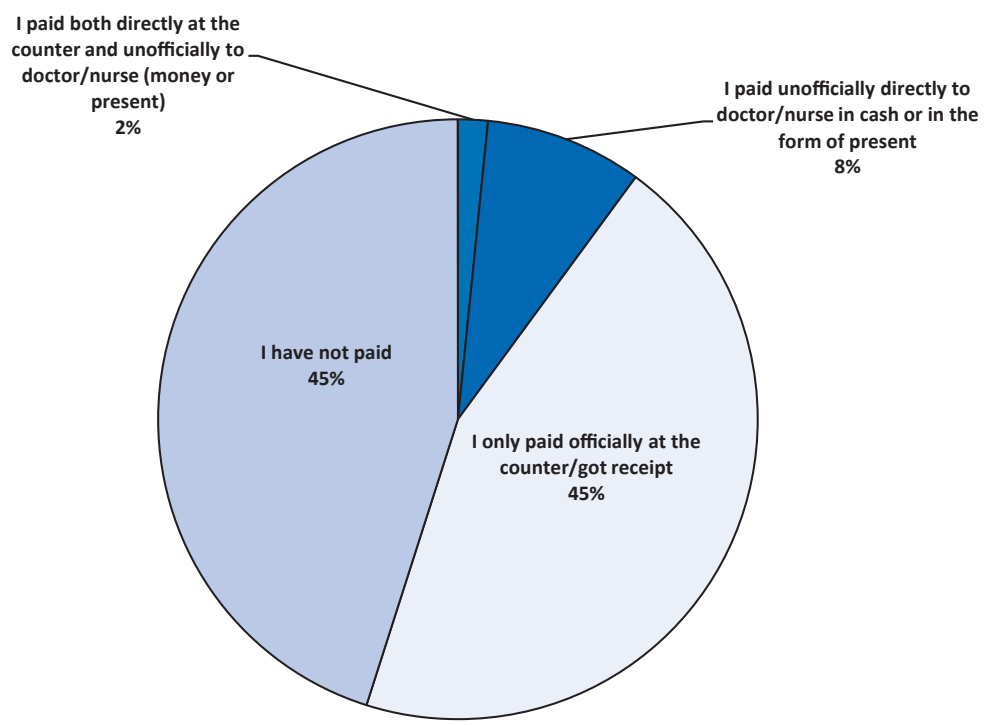
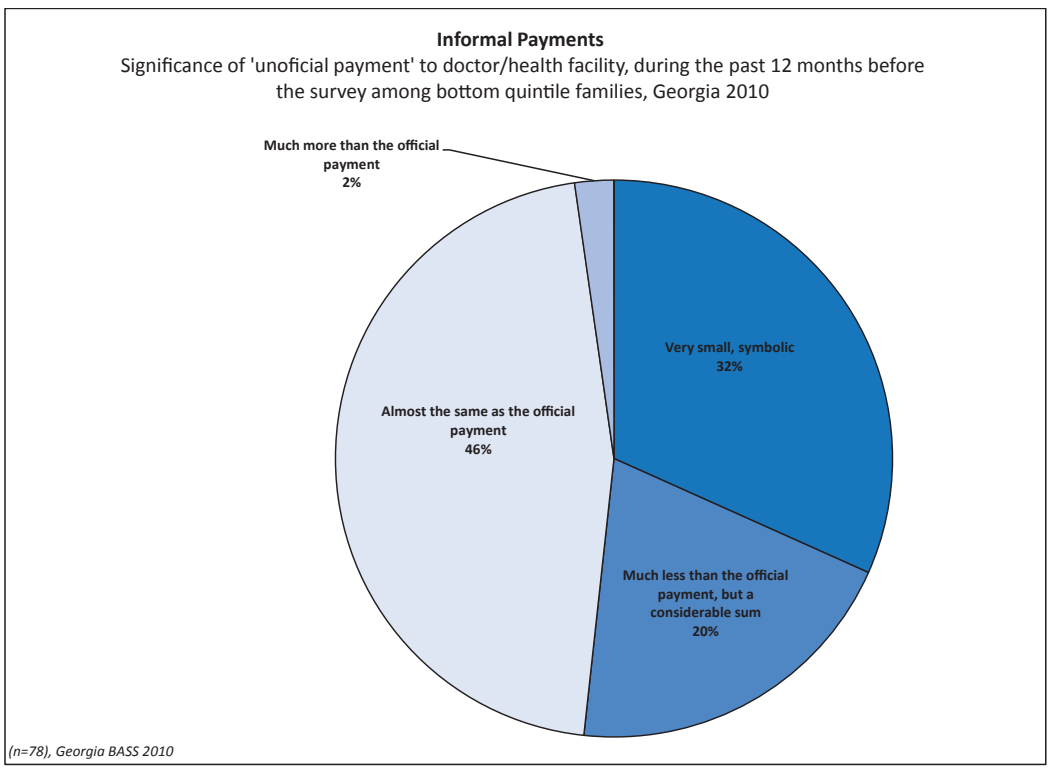


Table: Type of payment method for last visit to doctor/medical facility among bottom wealth quintile by insurance status, 12 months before the survey, Georgia 2010 (n=902)

	Families with MAP & MAP-like insurance (n=432)	Families with no insurance (n=435)	Total
I only paid officially at the counter/ got receipt	32%	59%	45%
I paid unofficially directly to doctor/nurse in cash or in the form of a present	7%	11%	8%
I paid both directly at the counter and unofficially to doctor/nurse (money or present)	1%	2%	2%
I have not paid anything	60%	28%	45%

About half of the respondents who made a payment 'under the counter' reported that the payment was almost the same (46%) or much more (2%) than the official 'over the counter' payment.



3.5 FAMILY ASSISTANCE

INTRODUCTION

Family assistance was the main type of social assistance before the introduction of TSA. Since 2006, it is closed for new entrants and is expected to be phased-out gradually. Currently, family assistance is provided to the following categories: a) single pensioner; b) pensioner couple; c) disabled child; d) person with 1st category disability; e) families with seven or more children. As of November 2010, 20, 586 people were receiving it.

RESULTS FROM THE SURVEY

4% of the households reported that they receive family assistance. The support is for single pensioners, disabled and vulnerable children.

Type of family assistance received among bottom quintile, Georgia 2010 (n=38)
▪ **Social assistance for a single pensioner - 30%**
▪ **Social assistance for multiple single pensioners - 8%**
▪ **Social assistance for blind persons with the first category disability - 26%**
▪ **Social assistance for disabled children - 19%**
▪ **Social assistance for children without parents - 16%**
▪ **Social assistance for families with many children - 2%**

3.6 SOCIAL WORKER

INTRODUCTION

Professional social work in Georgia is in its early stages of development. Although the SSA has posted social workers to every region, they are more concentrated in regional centres and the capital. These government social workers have received 3 months social work certificate training. There are now graduate social work and master's courses at universities in Georgia, but these are recent developments and only one or two groups of students have so far graduated. The graduate students are usually employed by NGOs who offer more rewarding terms and conditions.

The last 3 years has seen rapid development of social services for children, there is the provision of day care and targeted social assistance to very poor families. Social workers with the SSA have limited experience and few resources for work that seeks to prevent family breakdown or working with parents to enable children to return to live with families. Although there is now a system of referral for child abuse cases, in reality social workers have a limited but growing knowledge of handling these cases.

RESULTS FROM THE SURVEY

Familiarity with Social Worker

Respondents were asked about their awareness and knowledge of social workers. It was elaborated in the question that these are representatives of the government who provide support to families, whose problems cannot be solved only through financial support. It was also explained that the function of social workers is different from the social agents of the SSA. Nearly one in ten of the respondents had heard of social workers (9%).

The majority of people who have heard of social workers are not clear about the kind of specific services a social worker does provide (62%). The percentage of households who report different types of services provided by social workers to families

Type of services social workers provide to families according to respondents who are aware of the social work profession among the bottom quintile, Georgia 2010 (n=82)
▪ **Don't know – 62%**
▪ **Helping to solve family conflicts - 18%**
▪ **Preventing family from taking child to institution (children's home) – 7%**
▪ **Supporting adoptions – 9%**
▪ **Help children with clothes – 2%**
▪ **Bringing all inventory for disabled – 1%**
▪ **Helping to bring children from institutions back to family environment – 0%**
▪ **Preparing convicts for probation – 0%**

The majority of respondents who have heard of social workers do not know where to apply in case they need a social worker's support 53%.

Knowledge where to apply for social worker's support in case of need among respondents who are aware of social work profession among bottom quintile, Georgia 2010 (n=82)
▪ Don't know - 53%
▪ Social Services Agency - 33%
▪ Local authorities - 14%

Those who have ever requested services from a Social Worker

9% of the people who have heard of social workers have ever requested services from a social worker (8.8%). Of the entire sample, less than one per cent (0.8%) has ever requested services from a social worker.

The level of satisfaction with the Social Worker was assessed by asking the respondent to rate the social worker on a scale 1 (very good) to 5 (very bad).

Rating of social worker's work among respondents who received support from a social worker among bottom quintile, Georgia 2010 (n=8)
▪ Very Good – 1 families
▪ Good – 4 families
▪ Average – 2 families
▪ Bad – 1 families
▪ Very Bad – 0 families

In most cases was the social worker able to solve the problem the family requested help with? (79% [Yes fully - 44%/ Yes partly – 35%]).

3.7 PROGRAMS FOR PEOPLE WITH DISABILITIES

INTRODUCTION

Currently, the Ministry of Labour, Health and Social Affairs administers and/or funds several programs for disabled people[14]. The programs provide disabled people (including children) with the following services:

- Children's homes for disabled children
- Day care services for disabled children
- Psychosomatic rehabilitation of disabled children
- Community-based services for disabled children
- Institutional support for people with mental health disorders
- Foster care for disabled children
- Early rehabilitation and prevention of stagnated physical and mental development among children
- Provision of supporting equipment (hearing devices, wheelchairs, etc) for the disabled

[14] By the end of 2009, around 140,000 people with disabilities (living in 120,000 families) were registered in the data-base of socially vulnerable families and received a state pension. 10,000 of this group have IDP status. 74% of people with disabilities registered in the database have access to medical insurance. 12% of children under 17 who receive support for Prevention-Reintegration are disabled. 15% of the children in the 'foster care' programme are living with a disability. 3,653 children under 18 with disabilities received family assistance in December 2009.

In addition to these, there are small-scale disability programs and services funded and administered by local and international charities in different parts of the country.

RESULTS FROM THE SURVEY

Prevalence of children with a disability

Nearly one-in-seven households (15%) report that they have one or more family members who have a physical, sensory or mental limitation living in the family.

Awareness of assistance for disabled provided by the SSA

The majority of respondents with one or more family members who have a physical, sensory or mental limitation living in the family (n=138) had not heard of assistance for the disabled provided by the SSA (62%). The respondents who had heard of assistance for the disabled provided by the SSA mainly identified cash assistance.

Type of assistance identified among families with person with disability in household that are familiar with support from SSA among bottom quintile, Georgia 2010 (n=57)
▪ **Cash assistance for disabled persons - 73%**
▪ **Medical assistance for disabled persons - 16%**
▪ **Supporting appliances for disabled persons - 5%**
▪ **Food aid - 5%**
▪ **Difficult to answer - 13%**

⌦ In 1.5% of the households there was a child living with disabilities (13 out of 902 households).

Services for child with disability solicited

Families with one or more children in their family who has a physical, sensory or mental limitation were asked for each of the services below if the family had tried to receive support during the past 12 months before the survey.

Type of assistance families with a child living with disabilities tried to receive during the past 12 months, among the bottom quintile, Georgia 2010 (n=13)
▪ **Medical treatment – 5 families**
▪ **General education – 3 families**
▪ **Psychiatrist's consultations, treatment – 2 families**
▪ **Transport service – 2 families**
▪ **Special therapy for disabled (speaking, physical therapy, etc) – 1 family**
▪ **Day care service – 0**
▪ **Vocational education – 0**
▪ **Supporting equipment for physical disability (wheelchair, hearing device, etc) – 0**
▪ **Rehabilitation treatment – 0**

Support received for child with disabilities

The majority of families with children with disabilities (62%) had received some kind of assistance from the government or any other organization during the past 12 months. The main provider of support was the SSA:

- Social Services Agency - 77%
- Local authorities/municipality - 26%
- Non-governmental organisation - 10%

Financial support (cash) – Of the families with children with disabilities that reported to have received some kind of assistance from the government or any other organization during the past 12 months sixty seven per cent (67%) received financial assistance. This means that of all the families containing children with disabilities forty two percent (42%) received cash assistance.

Voucher - Of the families with children with disabilities that reported to have received some kind of assistance from the government or any other organization during the past 12 months, nine per cent (9%) received a voucher. This means that of all families with children with disabilities (3%) received a voucher.

Different types of support received

For a series of different types of support the respondent was asked if the child with disability received assistance during the last 12 months before the survey:

Type of assistance families with child living with disabilities received during the past 12 months, among bottom quintile, Georgia 2010 (n=9)
▪ **Medical treatment – 4 families**
▪ **General education – 2 families**
▪ **Transport service – 1 family**
▪ **Day care service – 0**
▪ **Vocational education – 0**
▪ **Supporting equipment for physical disability (Wheelchair, hearing device, etc) – 0**
▪ **Special therapy for disabled – 0**
▪ **Psychiatrist's consultation, treatment – 0**
▪ **Rehabilitation treatment – 0**

Barriers to access support for children with disabilities

Nine out of the 13 families with children with disabilities report that during the past 12 months there has been a case when the disabled child needed specific service, but was not able to receive it.
The reasons for not receiving the specific services included:

- We do not know how to apply for assistance - 7
- We are expecting the assistance in near future -1
- Lack of documents - 2

3.8 EARLY CHILDHOOD DEVELOPMENT

INTRODUCTION

Pre-school services are a critical investment in the long term development of Georgia. Unleashing the cognitive development potential of children early on in the life cycle is key to maximizing the development opportunities for every child. International research has found that well-organized pre-school education results in long-term improvements in school success for children, including; higher grades; lower rates of repeaters; and higher educational attainment (more go to university). But the positive impact of pre-school education goes far beyond school performance. Economic calculations have indicated that it is one of the best investments a country can make. It has one of the highest economic returns to society. International research, mainly from the US and Europe, shows that pre-school education will result in: reduced unemployment; reduction of dependency on state social services; reduced delinquency; improved health outcomes; increase in incomes; and subsequently increased tax revenues.

In the broader South Caucasus region, enrollment in pre-school education was always lower than that in Central and Eastern Europe or Russia. In the immediate post-Soviet period, the Net Enrollment Ratio (NER) in Kindergartens fell from an already low figure of 45% to 23% amongst 3-5 year olds and the number of kindergartens was halved. According to the Reproductive Health Survey (RHS) of 2011, the number has increased to 41.2% in recent years. However, this increase comes with significant disparity of 31.1% of rural children against 51.5% of urban children and 25.8% of children from the poorest quintile compared to 53.5% of children from the wealthiest quintile attending pre-school.

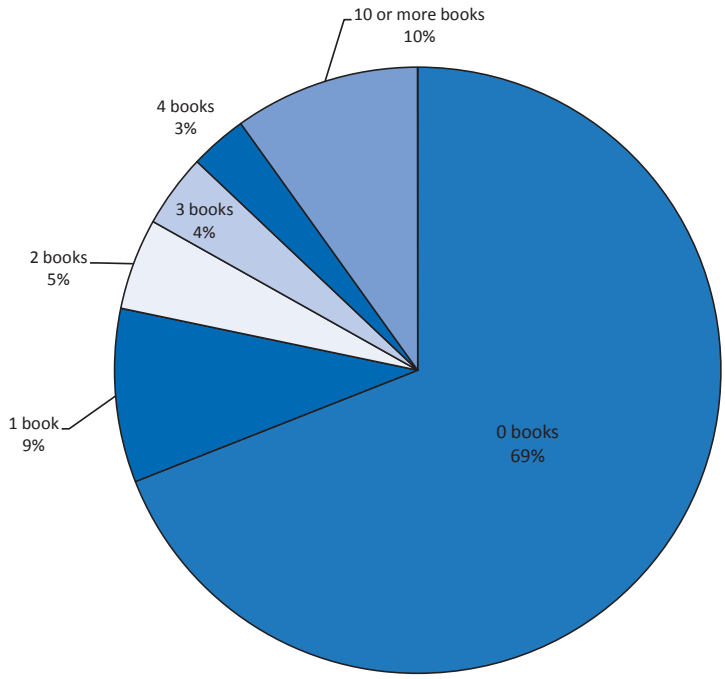
A review of research carried out on both the availability of services and parental attitudes between 2005 and 2007 revealed two consistent causal factors in low pre-school NER. The first was the inability of parents to pay the fees for kindergarten enrollment which correlated strongly with the disparity related to poverty mentioned above. The second was a perception amongst many parents that pre-school was not necessary because an adult was always at home to care for the child-thus equating kindergartens with “child sitting” and not placing much value on the cognitive and developmental aspects kindergartens promote.

RESULTS FROM THE SURVEY

Learning materials

In order to assess if children have a supportive learning environment, families were asked if children had children’s books or book’s with pictures for their children aged 3-5 years old. This excludes school books. The majority of children do not have access to children’s books (69%). Only 18% of the children have access to three or more children’s books.

Learning Materials: Children's Books
Percentage of children 3-5 years old who have 3 or more children's books among families in the bottom quintile, Georgia 2010



(n=130), Georgia BASS 2010

Inadequate care

Caregivers' care and support includes making sure that child is protected from physical danger. Leaving a child alone or in the care of another child exposes the child to an increased risk of injury, abuse and neglect. During the last seven days before the survey, 13% of the respondents who needed to leave the house for shopping or other needs reported that it had left a child home alone for more than an hour (12%) and/or left it under the guardianship of a child in a car for more than an hour (0.8%).

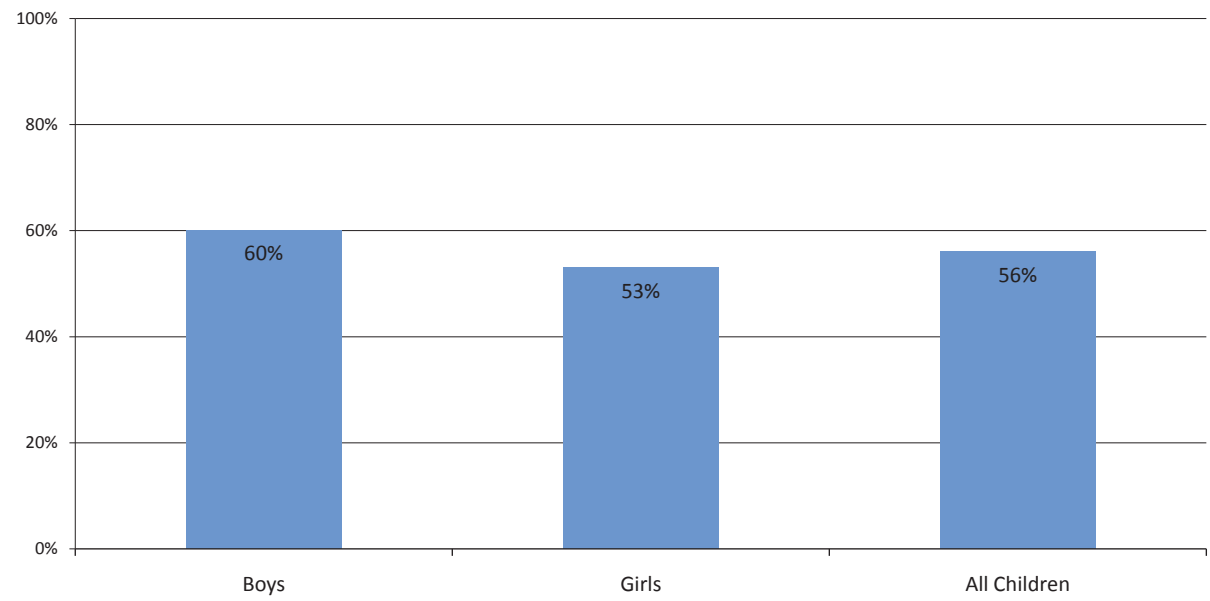
Attendance to early childhood education

Early childhood care and learning is the foundation of quality basic education. Expanding and improving comprehensive early childhood education, especially for the most disadvantaged children, is one of the major strategies to enable all children to realize their right to learn. A variety of early learning programs exist worldwide: community based centres, day care centres, kindergarten, and pre-schools, which can be organized by the state, private, or by different community based organizations (including religious groups). The bottom line is that the child is participating in an organized early learning program.

Slightly more than half of all children 3-5 years old (56%) are engaged in some kind of organised learning or educational program, such as private or public kindergarten or similar institution. Boys (60%) are more likely to engage in organized learning than girls (53%).

Early Childhood Education Attendance

Percentage of children 3-5 attending kindergarten among bottom quintile families, Georgia 2010



(n=130), Georgia BASS 2010

- The majority of children attend a public kindergarten (87%).
- Three quarter of the families report that the facility is close to their home (75%).

Satisfaction with kindergarten

The large majority are satisfied with the kindergarten their child attends (88%).

Level of satisfaction with kindergarten among families with child attending the service, among bottom quintile, Georgia 2010 (n=65)
▪ **Very satisfied - 55%**
▪ **More or less satisfied - 34%**
▪ **Neither satisfied, nor dissatisfied - 7%**
▪ **More or less dissatisfied - 5%**
▪ **Very dissatisfied – 0%**

- All families are satisfied with the teachers of the kindergarten (100%).
- About three-quarter of the families are satisfied with the nutrition provided at the kindergarten (Yes: 77%/ No: 7%/ Difficult to answer: 16%)
- Four out of five families are satisfied with the building of the kindergarten (Yes: 79%/ No: 15%/ Difficult to answer: 6%)

Payment of kindergarten

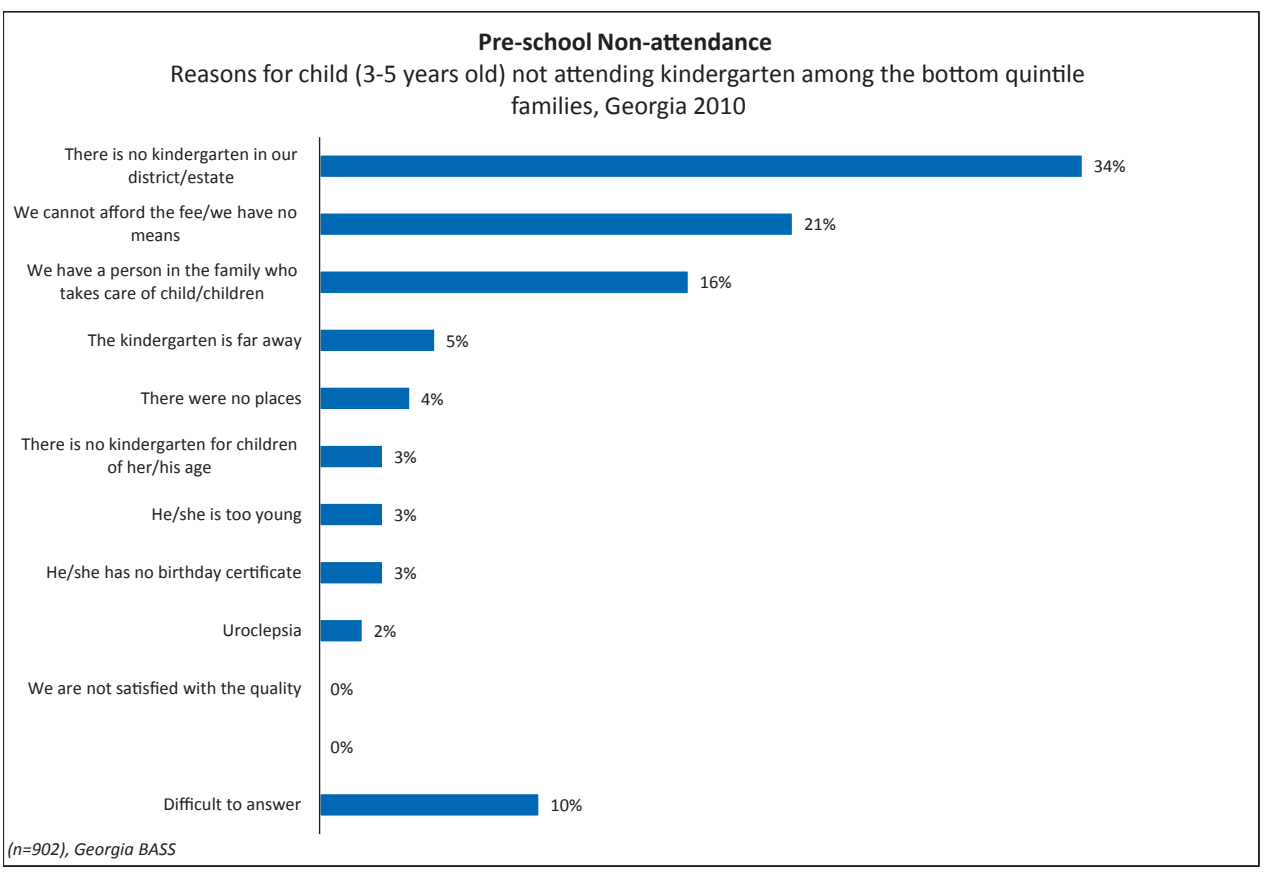
Two-thirds of the families that have a child in kindergarten pay at least partly for the education.

Responsible for covering the fee of child attending kindergarten, among bottom quintile, Georgia 2010 (n=65)
▪ **Fully funded by family - 48%**
▪ **Co-funded by family - 14%**
▪ **It is free (we are exempted from fees/we are funded by the state) – 13%**
▪ **It is free for all children – 26%**

- A large majority of the families report that they are having difficulties in covering the fees of different circles/sections (83%).
- About half of the respondents (56%) report that different unofficial fees (presents, other fees) are a barrier for them from financial point of view.

Non-attendance

Reasons for not accessing early childhood education are the absence of a kindergarten close to the family home (33%) and the cost of the kindergarten (21%).



The families where a child aged 3-6 years was not attending kindergarten were asked if they would be financially able to afford to take the child to kindergarten. 61% said they could not afford it. Nearly a quarter could afford it (24%) and 15% found it difficult to answer.

Early Child Development Index (ECDI)

All children should be physically healthy, mentally alert, socially competent, emotionally sound and ready to learn. Internationally, a new tool has been developed in order to assess the different child development domains: *language/cognitive, social/emotional and physical approaches to learning*. Development is a process of change where the child masters more and more levels of moving, thinking, feeling, and interacting with people and objects in their environment. An Early Child Development Index (ECDI) is prepared based on a series of questions. The primary purpose of the ECDI is to inform public policy regarding the collective wellbeing of children within a given nation, population subgroup, gender, and economic class. It is based on the caregiver's report on four developmental domains of the child: Literacy & Numeracy Domain, Physical Domain, Learning Domain, and the Social and Emotional Domain. The questions included in the survey specify some benchmarks that children would be expected to have if they are developing like the majority of children in that age group.

Literacy and Numeracy Domain - Language/cognitive development is assessed through a set of three questions, assessing the ability of the child to recognize letters, recognize numbers from 1 to 10, and read simple words. This means that they can do two of the following three exercises:

Literacy & Numeracy Domain - % of children 3-5 year old among bottom quintile developmentally on target, Georgia 2010 (n=130)
▪ **Can identify/name at least 10 letters of alphabet (24%)**
▪ **Can read at least four simple popular words (19%)**
▪ **Knows the name and recognizes the symbol of all numbers from 1 to 10 (40%)**

⌦ Twenty two percent (22%) of the 3-5 year olds are developmentally on target.

Physical domain is assessed by looking at whether the child is prone to frequent illnesses, and child's fine motor skills. The child is physically on target if one or both of the following is true:

Physical Domain - % of children 3-5 year old among bottom quintile developmentally on target, Georgia 2010 (n=130)
▪ **Can pick up a small object with two fingers (87%)**
▪ **Does not get tired from playing (69%)**

⌦ Ninety-two percent (95%) of the 3-5 year old children their physical development is on target.

Learning Domain is assessed by looking at a child's ability to follow simple directions, and he/she's ability to occupy himself/herself independently. The child is developmentally on target if one or both of the following is true:

Learning Domain - % of children 3-5 year old among bottom quintile developmentally on target, Georgia 2010 (n=130)
▪ **Follows simple directions on how to do something correctly (76%)**
▪ **When given something to do, is able to do it independently (86%)**

⌦ In ninety percent (90%) of 3-5 year olds, their learning development is on target.

Social and Emotional Domain is assessed by looking at a child's ability to get along with other children, their ability not to be aggressive with other children, and their ability to focus and concentrate without becoming easily distracted. The child is developmentally on target if at least two of the following are true:

Social & Emotional Domain - % of children 3-5 year old among bottom quintile developmentally on target, Georgia 2010 (n=130)
▪ **Gets along well with other children (88%)**
▪ **Does not kick, bite, or hit other children (62%)**
▪ **Does not get easily angry (49%)**

⌦ In sixty-seven percent (67%) of the 3-5 year old children, their social and emotional development is on target.

ECDI is the percentage of children who are developmentally on target in at least three of the four component domains above.

⌦ **Seventy percent of children age 36-59 months are developmentally on track in the literacy-numeracy, physical, social-emotional, and learning domains.**

3.8 ACCESS TO SCHOOL EDUCATION

Since access to education and especially school attendance has been covered by other surveys (Reproductive Health Survey 2010) the focus was limited to reasons for non-attendance. The survey shows that 8.7% of school-aged children (36 cases) do not go to an educational institution. Some of the reasons are not linked with school dropouts. The number of like cases is 11. These are broken down as follows: (i) he/he is still too young, will go to school next year (3 cases); (ii) She/he already finished the school (6 cases); (iii) She/he is learning a vocational skill (1 case); and (iv) He/she is engaged in sport activities (1 case). If we exclude these cases, the percentage of dropouts for the surveyed school children will be 6.5%. Although it is not possible to make generalizations due to the small number of cases, it is noteworthy that 16 dropouts out of 25 are from Kvemo Kartli. More investigation is required.

3.9 DOCUMENTATION SERVICES / BIRTH REGISTRATION

INTRODUCTION

A lack of documentation can lead to exclusion from state provided services and transfers, including pre-school and primary education, health care and various forms of social transfers. Over the recent years, the government of Georgia has undertaken significant efforts to ensure that all citizens of Georgia, including ethnic minorities, have ID documentation and birth certificates. Survey data indicate that these efforts have further reduced the share of children without birth certificates from 7% in 2005 to 0.1% in 2009.[15]

[15] UNICEF (2007) Georgia Multiple Indicator Cluster Survey 2005, p. , UNICEF (2010) Welfare Monitoring Survey

RESULTS FROM THE SURVEY

During the survey, 14% of the respondents reported that a member of their family tried to obtain a birth certificate or personal ID during the past 12 months before the survey.

Among the families that tried to get a birth certificate or personal ID during the past 12 months before the survey (n=113), one in seven (14%) could not get the documentation despite their attempts. The main reason for not getting the documentation was their inability to pay the fees related to the documentation.

The people that received the documentation all got it within a month (100%). Seven out of eight families (87%) got it within 10 days of the request.

Time it takes to receive a birth certificate/ID among bottom quintile during past 12 months, Georgia 2010 (n=93)
▪ **1 - 5 days - 27%**
▪ **6 - 10 days - 60%**
▪ **11 -20 days - 8%**
▪ **21 days - 1 month - 4%**
▪ **More than a month - 0%**
▪ **Difficult to answer - 0.6%**

Less than 2% of the families that obtained a birth certificate or personal ID during the past 12 months before the survey reported that they had to pay, apart from the official fee, another fee.

Difficulties or delays during the process of getting the birth certificate/ID were encountered by 6% of the respondents who were successful in getting the requested documentation. The four difficulties reported were:

- They could not explain what documents they needed so they had to go there several times - 1
- They did not prepare the ID by the time they promised - 2
- Old ID card was not fixed and it took a lot time - 2
- The child did not have a photo - 1

In 7% of the families there is a member who wants to get a birth certificate or ID but has not yet got it. The main reasons for not having the missing documentation are:

Reasons for not yet having received a birth certificate/ID among bottom quintile during past 12 months, Georgia 2010 (n=57)
▪ **We have not needed one yet. We will get it once we need - 25%**
▪ **No barriers. We will get it - 17%**
▪ **We do not have necessary documents - 11%**
▪ **We have difficulties with going to the civil registry because of physical conditions - 4%**
▪ **We have difficulties with going to the civil registry because of long distance - 13%**
▪ **We do not know where to go to - 0%**
▪ **Lack of money - 21%**
▪ **Lack of address - 3%**
▪ **Difficult to answer - 7%**

Chapter 4 - SUMMARY AND CONCLUSION

The Barriers to Access to Social Services Survey was developed to gain a better understanding of why significant shares of poor households in Georgia are not accessing their entitlements. The study is particularly important for understanding child poverty and well-being, as families are the primary source of support and care for children.

Awareness of SSA and its United Database of Socially Unprotected Families is very high. The application and review function of the database is implemented efficiently by the SSA. However, a quarter of the poor have not applied. Families from Tbilisi and ethnic minorities are less-likely to have applied. The main reasons for not applying are related to a negative attitude towards the application system as well as ignorance. The majority of these families have limited knowledge on how to apply while a large share has the intention to apply. Additional informational campaigns are needed to inform these vulnerable families in order to allow them to request assistance. Poor families from Tbilisi and ethnic minority groups require specific attention in customized communication messaging.

The socio-economic situation in the majority of the families that applied to the database was rated too high to receive cash assistance (about 50-60%) and a third did not qualify for health insurance for the vulnerable (MAP). An elevation of the 'cut-off score' for the two forms of assistance should be considered in order to increase its reach and impact. Outreach from SSA offices in regions where the distance to the nearest SSA office is an issue should also be strongly considered.

Cost is the number one barrier to accessing health services, including medicines. Health insurance has a positive impact on the health of the poor families that participate in the health insurance for vulnerable families (MAP) program. They are more likely to use health services and cost is less likely to be a barrier compared to uninsured poor families. However, more than four out of ten families are not insured. Families in west Georgia are nearly twice as likely to be insured compared to families from minority groups. Since these groups are less likely to have applied for the database, they are also less likely to receive health insurance. The main reasons for not having insurance are a combination of 'not applying for the database', 'not qualifying for the MAP' and 'lack of money to purchase a private insurance policy'. The purchase of medicines remains a barrier for the insured families as well.

Early childhood development is lacking in Georgia. Only half of pre-school aged children attend pre-school. And while the field of social work is growing, awareness about social work amongst the general population is low and the outreach of social workers in communities is limited.

Recommendations

- Intensive and targeted information campaigns to clearly inform vulnerable families about their rights to entitlements (TSA, Cash Assistance, Health Insurance, etc.), and the process of application. Television should be the main mode of disseminating this information. Minority groups require a special communication strategy.
- Informational material and application forms for the database should be translated into minority languages.
- Qualitative study (focus groups) among minority groups to understand specific barriers to apply for the database. Low application level in Tbilisi also needs additional investigation.
- Outreach from SSA offices in particularly hard to reach areas should be considered.
- In order to increase the reach and impact of TSA & MAP health insurance, an elevation of the 'cut-off score' should be considered for both entitlements.
- The respective 'weight' of children in the TSA assessment should be re-considered, so that poor families with more children are included in social assistance programs.
- A separate assessment tool for children should be considered, so that the holistic needs (disability, school attendance, pre-school, day care, etc.) of the child are examined within applying households.
- Consider expansion of existing drug benefits - costs of medication pose high financial burden on the poorest population
- Increase insurance literacy - what it covers, co-payment system. E.g. Design user-friendly health insurance guides, establish information hotlines.
- Clear communication regarding the content of health insurance policies (especially related to medicines) should be improved.
- Raise health awareness and financial access to - primary healthcare/family doctors/ preventive examinations; Discourage over use of self-treatment
- Help overcoming financial and geographical barriers to access pre-school among the poorest families
- The continued monitoring of the impact and barriers of social assistance programs for poor families should be considered.

ANNEX: Confidence intervals of key indicators

B1 - Family member receives any type of pension

	Estimate	Standard Error	95% Confidence Interval	
			Lower	Upper
Tbilisi	62.8%	4.8%	53.0%	71.6%
West Georgia	66.2%	2.5%	61.0%	70.9%
East Georgia	57.2%	2.5%	52.3%	62.0%
Georgian	62.6%	2.1%	58.5%	66.6%
Azeri	51.7%	5.3%	41.4%	62.0%
Armenian	69.0%	9.9%	47.3%	84.7%
MAP and MAP like Insurance	65.9%	2.9%	60.0%	71.2%
other Insurance	60.9%	9.6%	41.3%	77.4%
Uninsured	58.7%	2.7%	53.2%	63.9%

B13.1 Please answer whether one needs to be in the database to receive these types of assistance? - Cash assistance

	Estimate	Standard Error	95% Confidence Interval	
			Lower	Upper
Georgian	92.7%	1.4%	89.4%	94.9%
Azeri	92.2%	2.9%	84.5%	96.3%
Armenian	67.0%	11.0%	43.4%	84.4%
Tbilisi	84.8%	4.1%	74.9%	91.2%
West Georgia	98.4%	0.6%	96.5%	99.3%
East Georgia	89.4%	1.6%	85.8%	92.2%
MAP and MAP like Insurance	94.8%	1.2%	91.9%	96.7%
other Insurance	100.0%	0.0%	0.0%	100.0%
Uninsured	87.3%	2.3%	82.1%	91.2%

B16. Have you applied to be registered at the database of socially unprotected families?

	Estimate	Standard Error	95% Confidence Interval	
			Lower	Upper
Georgian	76.9%	2.1%	72.4%	80.8%
Azeri	66.6%	5.0%	56.2%	75.6%
Armenian	63.8%	14.6%	33.8%	85.8%
Tbilisi	58.2%	6.0%	46.2%	69.3%
West Georgia	83.0%	2.0%	78.6%	86.6%
East Georgia	80.4%	2.2%	75.7%	84.3%
MAP and MAP like Insurance	91.2%	2.1%	86.0%	94.6%
other Insurance	37.0%	9.2%	21.3%	55.9%
Uninsured	61.6%	3.0%	55.7%	67.2%

C1. During the past 12 months have you or your family members received any kind of monetary social assistance (pensions, social assistance, utilities subsidy, etc)?

	Estimate	Standard Error	95% Confidence Interval	
			Lower	Upper
Tbilisi	70.0%	4.4%	60.8%	77.9%
West Georgia	79.1%	2.2%	74.5%	83.0%
East Georgia	66.4%	2.6%	61.2%	71.3%
Georgian	74.0%	1.9%	70.1%	77.5%
Azeri	54.7%	5.3%	44.3%	64.8%
Armenian	72.9%	9.4%	51.3%	87.3%
MAP and MAP like Insurance	85.1%	2.2%	80.4%	88.9%
other Insurance	57.3%	9.7%	38.2%	74.5%
Uninsured	60.6%	2.7%	55.2%	65.8%

C2.1. During the past 12 months have you or your family members received - Pension

	Estimate	Standard Error	95% Confidence Interval	
			Lower	Upper
Tbilisi	60.9%	4.8%	51.2%	69.8%
West Georgia	66.6%	2.5%	61.5%	71.3%
East Georgia	55.3%	2.5%	50.4%	60.2%
Georgian	61.9%	2.1%	57.8%	65.9%
Azeri	48.7%	5.3%	38.4%	59.1%
Armenian	67.4%	10.1%	45.6%	83.6%
MAP and MAP like Insurance	65.9%	2.8%	60.1%	71.3%
other Insurance	57.3%	9.7%	38.2%	74.5%
Uninsured	56.8%	2.7%	51.4%	62.1%

C2.2. During the past 12 months have you or your family members received - Targeted Social Assistance

	Estimate	Standard Error	95% Confidence Interval	
			Lower	Upper
Tbilisi	16.4%	4.6%	9.2%	27.5%
West Georgia	34.1%	2.4%	29.5%	39.0%
East Georgia	22.6%	2.2%	18.5%	27.2%
Georgian	27.9%	2.0%	24.2%	31.9%
Azeri	10.7%	3.5%	5.5%	19.8%
Armenian	1.5%	1.6%	0.2%	10.5%
MAP and MAP like Insurance	47.9%	3.0%	42.1%	53.8%
other Insurance	4.7%	3.3%	1.2%	17.4%
Uninsured	4.1%	0.9%	2.7%	6.2%

E5. During the past 12 months, how did you cover the costs of received medical treatment (except medicine)?

From the regular incomes of our family	Estimate	Standard Error	95% Confidence Interval	
			Lower	Upper
Tbilisi	31.4%	5.8%	21.2%	43.6%
West Georgia	45.1%	3.1%	39.1%	51.2%
East Georgia	42.7%	3.2%	36.6%	49.0%
Georgian	38.7%	2.4%	34.1%	43.6%
Azeri	68.2%	7.0%	53.3%	80.1%
Armenian	47.7%	18.7%	17.4%	79.8%
MAP and MAP like Insurance	24.6%	2.6%	19.9%	30.1%
other Insurance	43.0%	10.0%	25.3%	62.7%
Uninsured	60.3%	3.5%	53.3%	66.8%

From family savings	Estimate	Standard Error	95% Confidence Interval	
			Lower	Upper
Tbilisi	20.8%	4.8%	12.8%	31.8%
West Georgia	4.3%	1.3%	2.4%	7.6%
East Georgia	6.1%	1.5%	3.7%	10.0%
Georgian	10.2%	1.8%	7.2%	14.2%
Azeri	1.9%	1.8%	0.3%	12.1%
Armenian	11.5%	10.9%	1.5%	51.8%
MAP and MAP like Insurance	8.4%	2.4%	4.7%	14.6%
other Insurance	6.6%	6.3%	0.9%	34.3%
Uninsured	11.2%	2.2%	7.6%	16.4%

Insurance company covered the costs	Estimate	Standard Error	95% Confidence Interval	
			Lower	Upper
Tbilisi	28.3%	5.7%	18.6%	40.6%
West Georgia	39.0%	3.0%	33.3%	45.1%
East Georgia	33.2%	3.0%	27.6%	39.4%
Georgian	35.6%	2.4%	31.0%	40.4%
Azeri	14.9%	5.2%	7.2%	28.2%
Armenian	21.0%	10.8%	6.8%	48.9%
MAP and MAP like Insurance	62.0%	3.2%	55.6%	68.0%
other Insurance	18.4%	7.3%	8.0%	37.0%
Uninsured	1.2%	0.6%	0.4%	3.1%

E15. Is there a member in your family who is not insured?

		Estimate	Standard Error	95% Confidence Interval	
				Lower	Upper
Tbilisi	None of the family members are insured	44.4%	5.6%	33.9%	55.4%
	Some members of the family are not insured	18.9%	4.2%	12.0%	28.5%
	All members of the family are insured	36.7%	5.2%	27.1%	47.5%
West Georgia	None of the family members are insured	41.1%	2.6%	36.2%	46.2%
	Some members of the family are not insured	8.1%	1.5%	5.6%	11.5%
	All members of the family are insured	50.8%	2.6%	45.7%	55.9%
East Georgia	None of the family members are insured	56.1%	2.4%	51.3%	60.7%
	Some members of the family are not insured	8.8%	1.1%	6.7%	11.3%
	All members of the family are insured	35.2%	2.4%	30.7%	39.9%
Georgian	None of the family members are insured	43.9%	2.2%	39.6%	48.3%
	Some members of the family are not insured	12.4%	1.5%	9.7%	15.8%
	All members of the family are insuredx	43.7%	2.1%	39.6%	48.0%
Azeri	None of the family members are insured	68.3%	4.9%	58.1%	77.0%
	Some members of the family are not insured	4.0%	2.0%	1.5%	10.3%
	All members of the family are insured	27.6%	4.7%	19.3%	37.8%
Armenian	None of the family members are insured	71.6%	9.7%	49.6%	86.5%
	Some members of the family are not insured	5.2%	3.9%	1.1%	20.6%
	All members of the family are insured	23.3%	9.0%	10.1%	45.0%