Impact of the COVID-19 pandemic on the health sector

Impact of COVID-19 on the labor rights of health care workers and the conditions under which medical staff work

Tbilisi 2021

Content

Author of the research: Giorgi Tchanturidze

COVID-19 and Georgia

Georgia handled the pandemic quite well in the initial period. Restrictions effectively ensured that the spread of the virus was arrested. The Authorities and health officials mentioned from the very beginning that ending of the first wave did not mean defeating the epidemic, and that this could only be achieved through the joint efforts of all countries of the world.

During the pandemic, in order to prevent the spread of Covid-19 in the workplace, detailed recommendations and instructions were developed for almost all areas of activity, the implementation and monitoring of which was ongoing. As of December 28, 20,798 inspections had been conducted to verify compliance with the coronavirus recommendations. These controls have helped slow the spread of the virus and manage the epidemic without a complete cessation of the economy.

Georgia introduced innovation and was the first to use hotels as quarantine spaces. In 3 big cities, multi-profile clinics were transformed into Covid clinics. **Online clinics, fever centers, quarantine and fever hotels** were set up where primary patient triage was performed.

With the declaration of a state of emergency and strict restrictive measures, the country has gained considerable time to make the health sector better prepared to meet the post-epidemic waves. It was important to strengthen the laboratory sector during this period. If the laboratory sector could conduct 400 tests a day in the spring, by the end of December that number had risen to 20,000 (including 12,000 PCR tests) as a result of an increase in the number of laboratories prepared for testing. By the end of December, testing was already being conducted across 250 laboratories and primary care centers across the country. It is worth noting the important role of the Lugar Laboratory in the testing process, especially in the early stages of the pandemic, when other laboratories could not do such research. At the initial stage of the pandemic, it was possible to get a test answer from anywhere in Georgia in no more than 6 hours.

The second wave of the epidemic turned out to be much more difficult than the first one, the increase in patients caused significant overoaded of the hospitals, increased the number of deaths and the share of the total infected individuals. At the end of November, it became necessary to introduce a new package of restrictive measures and social assistance.

Online Clinic:

From April 2, to strengthen the primary health care system, at the initiative of the Ministry of Health, an online clinic platform was set up, which initially involved 25 online clinics. By the end of December, about 700 physicians from 65 online clinics were involved in remote patient management.

228 people were employed in 2 central online clinics created based on the Ministry of Health. The online clinic service, which involves remotely managing patients at home, in addition to the main online clinics of the Ministry of Health, also provides patients with family doctors attached to them through a universal health care program and private insurance.

Between April 2 and December 28, doctors at online clinics consulted 250,000 patients.

A total of 13,300 people from the medical staff were involved in the fight against Covid by December. The Ministry of Health has launched a program to increase the pay of all staff involved in the fight against Covid, which was initially 2-months, but as officials say the program will be extended. The salaries of doctors involved in the management of the Covid pandemic have increased by 50%. This difference is financed from the state budget, for which 5 million GEL was allocated. As the Independent Trade Unions of Medicine, Pharmacy and Social Security Workers of Georgia told us - "Part of the clinics decided for themselves who would be paid, which created some problems. Deficiencies were also observed in the administration process, which is why many doctors could not receive increased salary at the initial stage. There were medical institutions where there was no payment of 50% supplement in the lower echelon of the medical staff from the employer. "

It should be noted that the receipt of salaries by medical staff is often a problematic issue that is related to the participation of clinics in the universal health care program. As the employees note, "the funds provided by the universal health care program in the clinics are transferred with a delay of several months. Due to that, the employers are late in paying their salaries. "50% of the salaries that the medical staff should have received in October, some of them had not received at the end of November.

The state has fully covered the costs of treating the patients. As for testing, priority groups were identified for which testing should have taken place in the first place. However, the approach to testing has changed over time. During the second wave of the pandemic, when the number of infections in Georgia increased significantly, the problem of the number of tests became acute.

Expenditures - In 2020, the budget related to the coronavirus amounted to 236.5 million. GEL. Which includes costs for treatment, testing, equipment and quarantine services.

Cost per patient: light case - 1200 GEL; Severe patient over 3000 GEL.

Bed occupancy - If at the beginning of March the bed occupancy mobilized for COVID-19 was 826 beds in 15 clinics, this figure increased almost 10 times by the end of December and amounted to more than 7,400 beds in 95 clinics.

During COVID-19 management standard clinical beds were later supplemented by clinical hotels. At the beginning of the year, hotels were used only for quarantine and patients with fever.

By December, the hotel already had clinical status and was an intermediate link between the home and the hospital treatment. At the clinical hotels, there are provided the medical equipment needed to treat coronavirus-related complications. However, all such hotels have a group of doctors who manage the condition of patients at the hotels. It should be noted that clinical hotels were an innovation of Georgia, and they are considered an alternative to the field hospital. By the

end of December, up to 9,500 beds had been mobilized in clinical hotels. While Covid Clinics were operating at almost 95% workload, clinical hotels played an important role in unloading of clinics.

In September 2020, a home management and treatment regime was launched to avoid overcrowding of the hospital sector. In December, when the number of cases reached a peak, more than 60% of patients were mostly held at home. Home treatment services are provided by the population through the universal health care program and private insurance with the help of family doctors that were responsible for them.

Selective contracting was conducted in Tbilisi, Kutaisi and Batumi in the primary health care sector. Out of 150 primary health care facilities, 87 facilities remained in the program. The government plans to do the same in the hospital sector in the future. Issues covered by selective contracting include: infrastructure, quality of service, volume of the provided service.

Emergency and Coordination Emergency Assistance Center

Transformation of the structure of emergency medical care On January 1, 2020, the ambulance service of Tbilisi and the regions was merged. Brigades, referral crews. Up to 3,000 village doctors and nurses. From 1st of August, ambulance brigades were transfered from 112 to the center under the Ministry of Health.

There were 24-hour shifts across the country - 332 medical crews, 1149 doctors, 1330 nurses, 1276 drivers, 89 paramedics, 1206 village doctors and 1442 nurses.

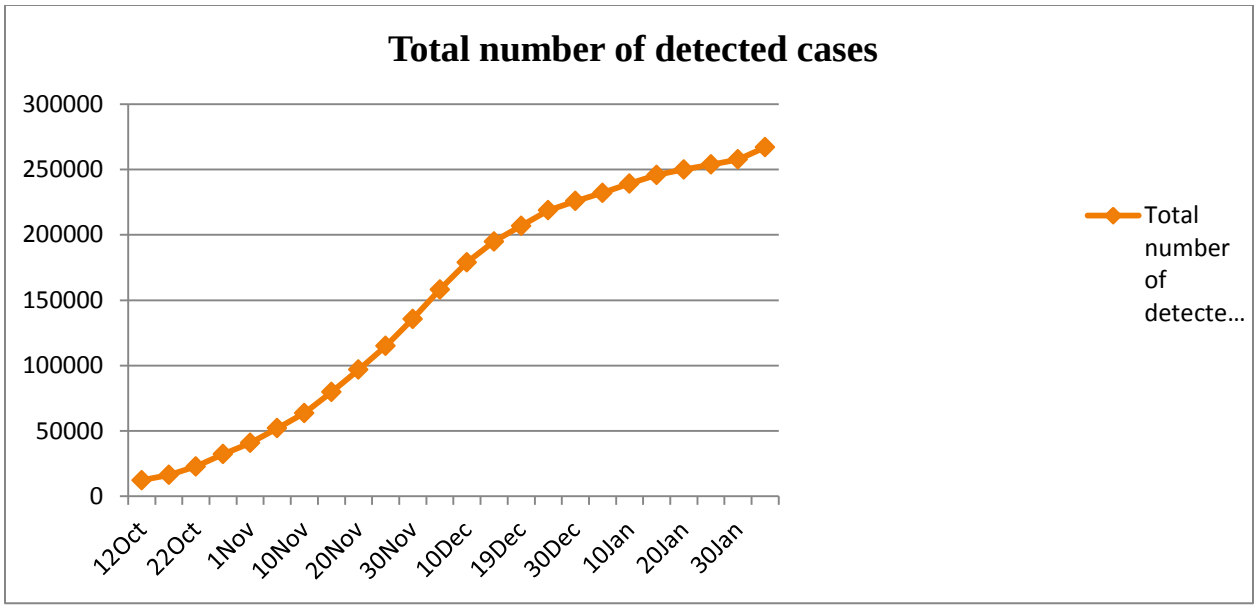
During the year, emergency medical care was provided to 1,200,000 citizens.

Statistical data

The total number of beds in the country was 19,260 as of February 5; Controlled breathing apparatus - 2795. Free controlled breathing apparatus - 864.;[1] 7400 beds were vacated for the Covid-infected patients. Controlled breathing apparatus - 2795. Free controlled breathing apparatus - 864.

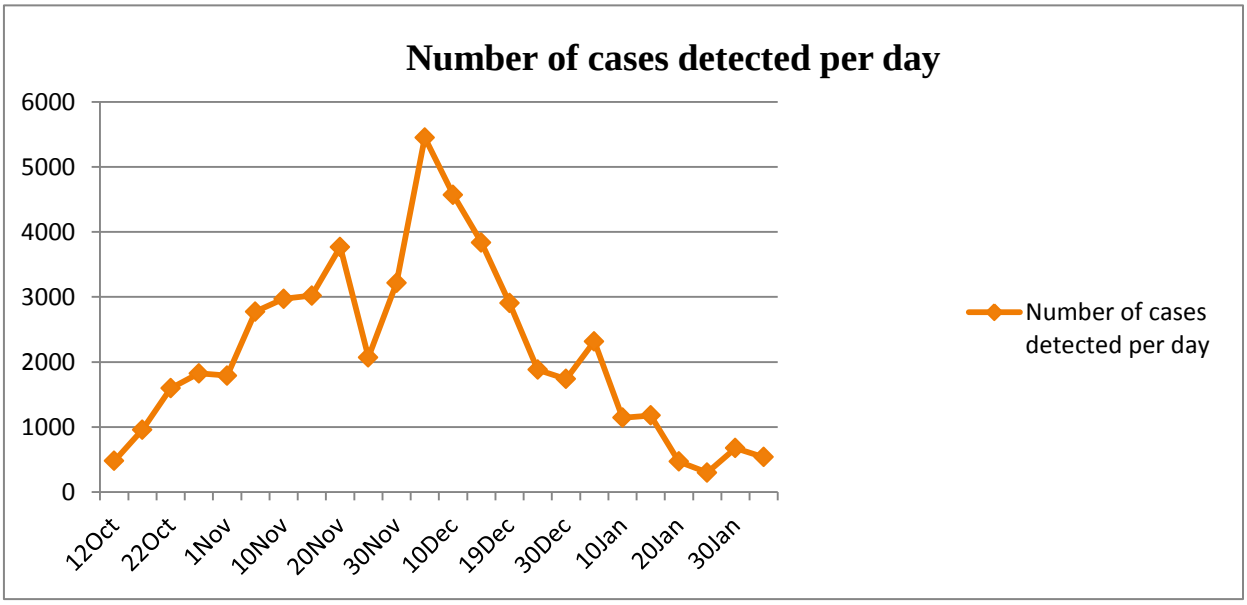
A significant increase in the number of Covid-infected people in the country has been observed since October (the so-called second wave). If as of October 12, the total number of infected people was 12,272, a month later the number increased fivefold to 63,650.

[1] Information Portal of the Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs of Georgia



Source: International Health Organization. Diagram of the author.

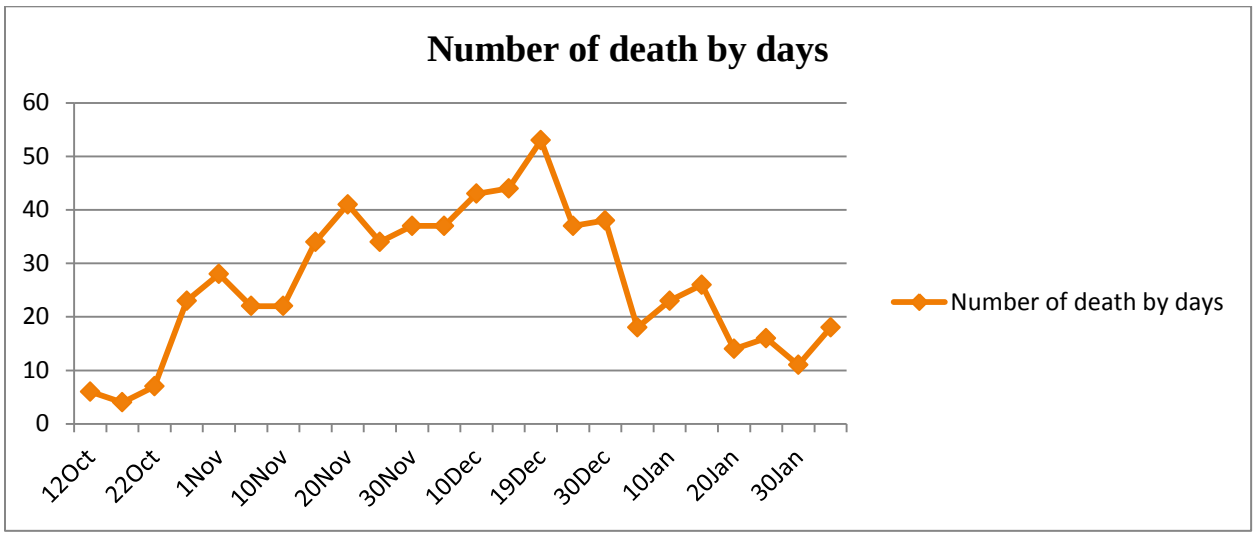
The maximum number of newcases of infections detected daily was recorded on 5th of December. Restrictions on the second wave of the epidemic were imposed by the authorities on 28th of November. Due to the fact that the virus has an incubation period of several days, the number of infected people continued to increase for the perof of 1 week. From the 5th of December, it was characterized by a significant downward trend.



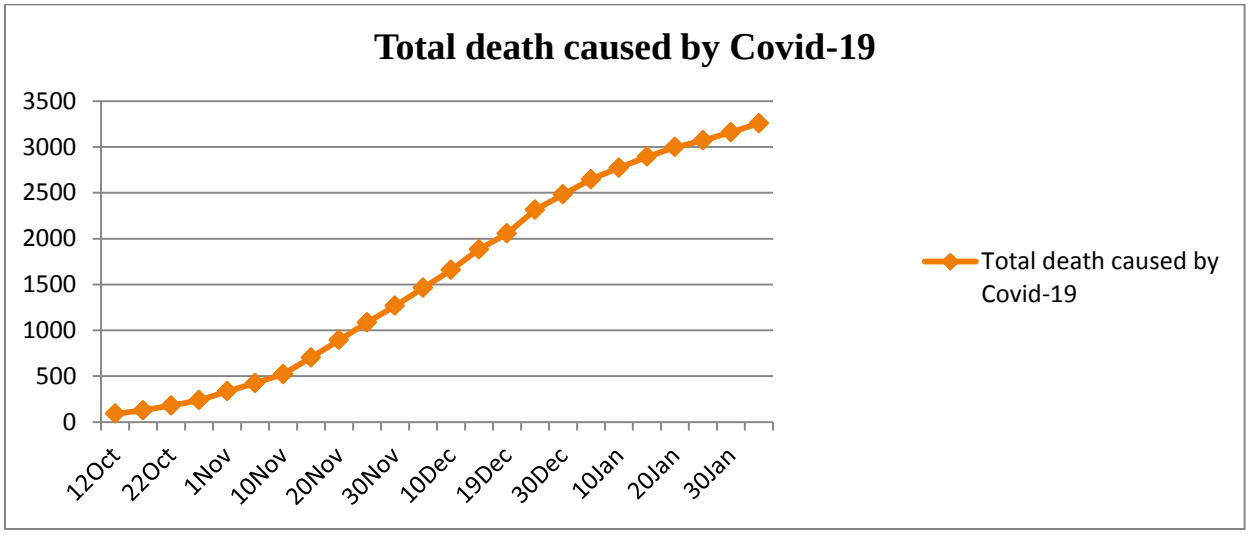
Source: International Health Organization. Diagram of the author.

A similar downward trend has been observed in terms of deaths since 19th of December. The maximum number of deaths per day was recorded on December 19, exactly 2 weeks after the

peak of the number of infected people (December 5). This is explained by the duration of infection characteristic for the Coronavirus.



Source: International Health Organization. Diagram of the author.



Source: International Health Organization. Author Schedule.

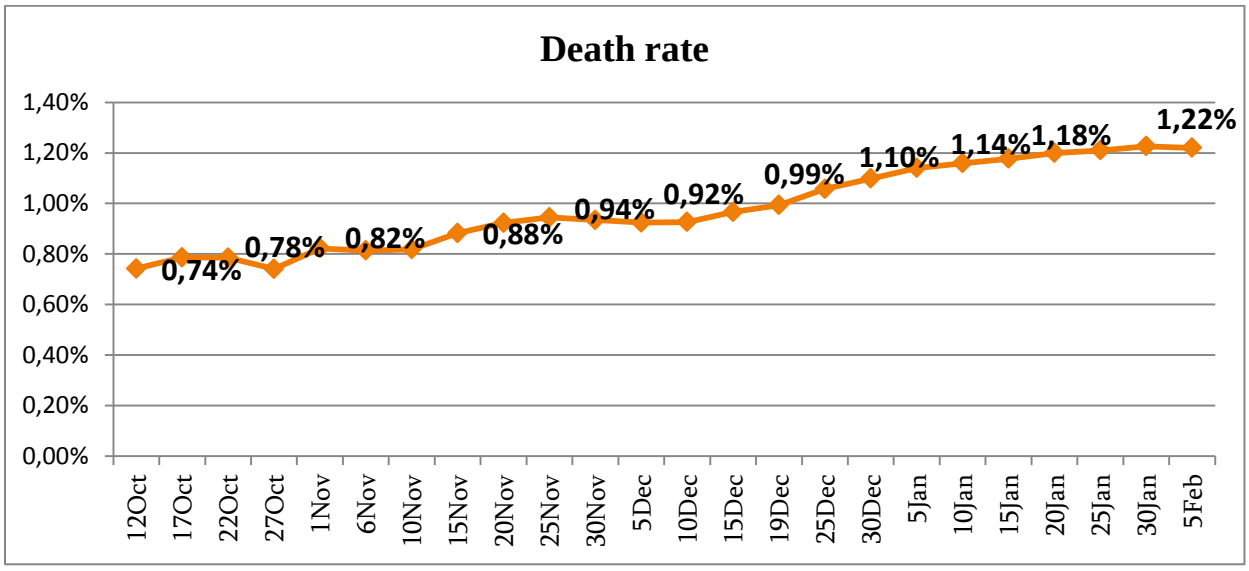
At the beginning of February, the share of deaths among the total number of infected people in Georgia was 1.24%. A similar rate was 2.17% worldwide. Therefore, it can be said that the epidemic in Georgia was managed more efficiently than in the rest of world average.

This should take into account the number of tests performed per day and how well the test reveals all infected people. If in the part of the patients can not be detected infection, this may lead to the fact that the statistics reflect only the data of relatively severe patients and

consequently the number of deaths among the identified infected people will be higher. As of December 19, when the country had the highest number of deaths from coronavirus, the death toll among the total number of infected people was 1%.[2] This figure increased in the following period. However, the number of people tested also increased, while the percentage of infected people among those tested decreased.

The overload of the health care system has gradually led to an increase in the death rate among those infected. If in the beginning of October it was 0.74%, in the beginning of February - it increased to 1.22%.

Although the maximum incidence of infections was recorded on December 5, the death rate curve continued to increase until 30th of January. This can be explained by the fact that in the given period there were more previously infected patients who were still being treated. At first glance, reduction of the rate of infection could release more physicians for existing patients. However, the significant increase in the number of infections in the previous period led to more delays in managemement/responding to these cases, which prolonged the high workload of physicians.



Source: International Health Organization. Diagram of the author.

Accordingly, delayed referrals in the post-peak period were likely to result in more severe patients than before. The further increase in mortality is in part evidence that post-treatment of severely infected patients infected with COVID-19 is less effective and preventive measures should be given priority.Decrease of the healthcare system overload and responding to cases in a timely manner is vital.

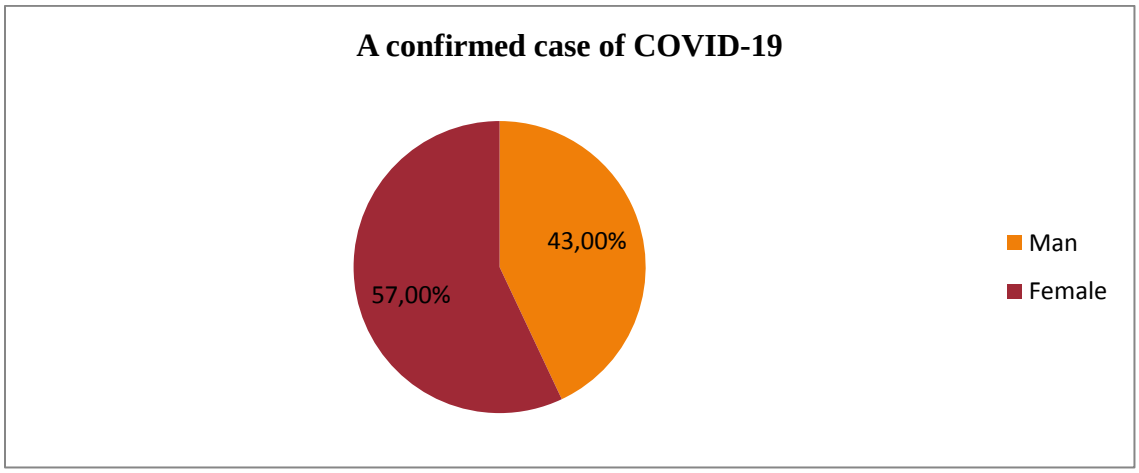
[2] World Health Organization data

The government taget was 4% decrease of the infection rate in the tested population for lifting the restrictions. This indicator was used to remove restrictions locally, by cities.

By the end of December, 60% of those infected were managed at home, which in turn meant less communication between the doctor and the patient.

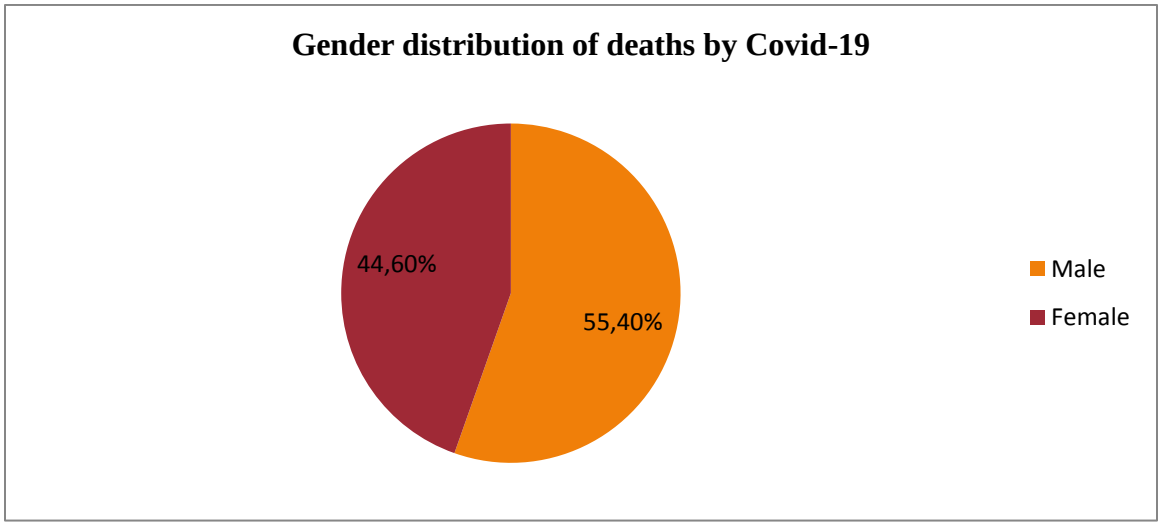
132,232 people completed COVID-19 treatment at home under the supervision of the family physicians.

Most of the confirmed cases of COVID-19 were detected in women.



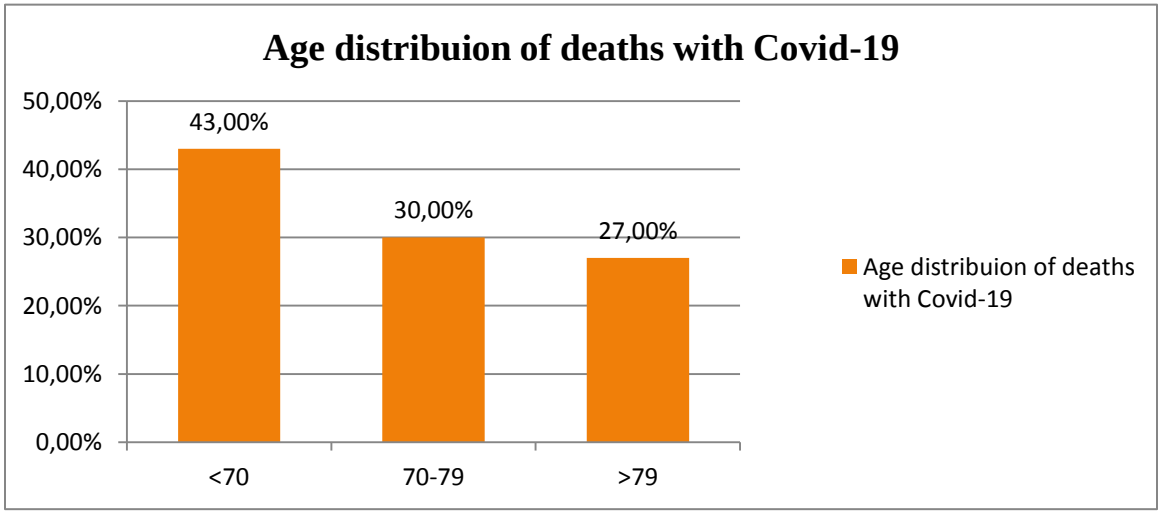
Source: report of National Center for Disease Control and Public Health, 5th revision

Although women predominate among the infected people, more men have died from the virus. The gender distribution of the dead looks like this:



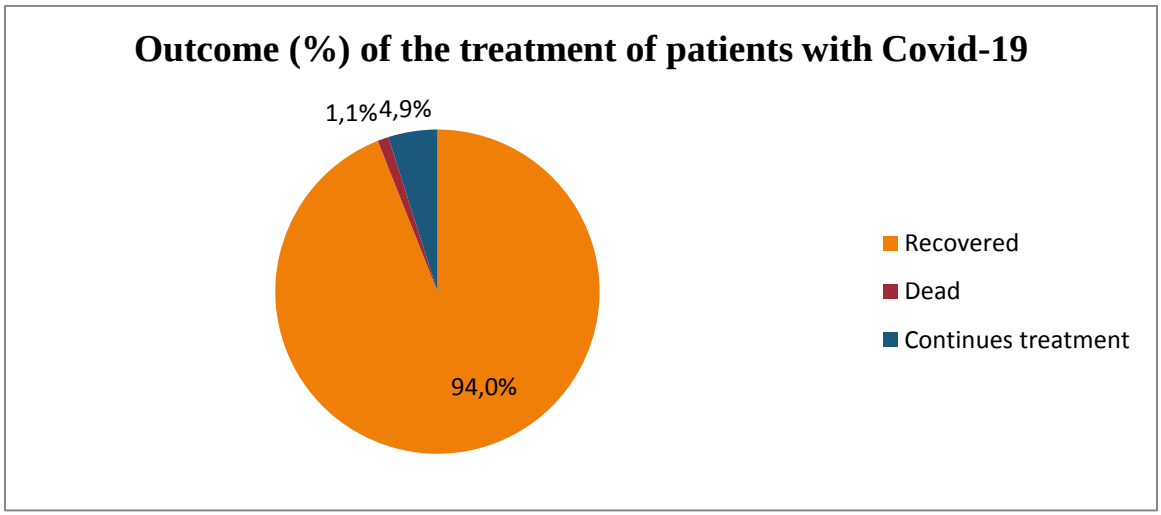
Source: report of National Center for Disease Control and Public Health, 5th revision

As for the age distribution of the dead people, most of them are over 70 years old. At the same time, 62.2% of those who died of COVID-19 had various concomitant chronic diseases.



Source: report of National Center for Disease Control and Public Health, 5th revision

Outcome of the treatment of patients with Covid-19 (%) as of December 31, 2020:



Source: report of National Center for Disease Control and Public Health, 5th revision

Epidemic management in Georgia

In the 10 months since the pandemic has began, the government has enacted up to 200 regulations related to the management of COVID-19, which can be divided into 4 categories: measures to prevent the spread of the virus; state social assistance measures for the population; recommendations regarding safety rules at workplace and recommendations/protocols related to medical activities.

In the initial period of the pandemic, Covid-infected patients were managed in an infectious hospital, as only this hospital had boxes. The hospital has repeatedly been criticized for infrastructural malfunctions. The country's main hospital for management of infectious diaereses has met with a pandemic situation in a ill-conditioned state. This was due to the fact that the hospital area was sold years ago and transferred to the ownership of a private clinic. Therefore, the infectious diseases hospital is located on the territory of another clinic and because of this the Ministry of Health has not been renovated the building.

Shortly after the pandemic began, the government set up an information platform[3] to inform the public about protection measures against the virus, preventive measures taken by the state, statistics on the spread of the virus, as well as government-approved restrictions and economic assistance measures

A portal has been launched where it is possible for citizens to search for the primary health care facility accoridng to their registrtion place.

It should be noted that all costs related to the treatment of Corona-infected people were borne by the state.

Nursing staff

Georgia's healthcare system, despite the progress made in recent years, still lags significantly behind the healthcare systems of developed countries. The employment rate in the health and social care sector in OECD countries has reached 10%.[4] The similar index in Georgia is only 4.6%.[5] In the fight against the Coronavirus, Georgia was forced to focus on prompt and effective response, as it was clear that the weak health care system would make it difficult for the country to manage large numbers of patients, especially since from the very beginning it appeared that even countries with developed medical systems were facing significant problems.

According to the statistics of the International Labor Organization, by 2030 there will be 18 million fewer doctors in the world than needed. At the same time, in 2014, 23% of the population with upper middle-income countries (including Georgia) did not have access to medical services due to the lack of doctors. A similar index was 55% for lower middle-income countries.[66]

[3] https://stopcov.ge/

[4] Health Workforce Policies in OECD Countries 2016

[5] National Statistics Office of Georgia

[6] ILOSTAT, COVID-19: Are there enough health workers?

One of the most significant problems in the healthcare system is the insufficient number of nurses.

The number of nurses employed in the healthcare sector of Georgia is asymmetric compared to European countries. According to a research conducted by the International Foundation Curatio, Georgia has twice as many doctors per 100,000 population compared to average European country. Accordingly, Georgia has a total of 10,000 more doctors and 12,500 fewer nurses than it should have. The number of nurses per 100,000 population is 509, which is significantly lower than in other countries.[7] According to the World Health Organization database, Georgia ranks last among the 53 countries in the European region in regards of number of nurses per 100,000 population.[8]

According to the same base, the ratio of nurses and doctors in Georgia is 0.8, while the same rate is 3.3 in Germany and 2.2 in Ukraine, for example, the recommended ratio of the World Health Organization is 4: 1. For comparison, in Finland, which leads the EU in the number of nurses per 100,000 population, this figure is 1426, in Germany - 1322, in Ireland - 1288, and so on.[9]

Complicating matters is the fact that 20% of the nurses employed in the system in 2014 have already reached retirement age. Which means we should not at least expect an increase in the number of nurses in the nearest future.

In developed countries, 60-70% of the cost of medical facilities comes from the salaries of employees. Which means that Georgia uses expensive staff in the form of doctors instead of nurses. This significantly increases the cost of services. In addition, there are specialties where Georgia almost has no doctor. An important problem is the unequal geographical distribution of staff in the country. Tbilisi, where leaves 30% of the population, is served by approximately 15,000 physicians and the rest of the population - by only 8,000.[10]

It should be noted that the ratio of nurses and doctors by regions is especially lowest in Tbilisi, where there are 2 doctors per nurse.

The productivity of doctors is low in Georgia, where a hospital doctor treats an average of 42 patients per year, while the similar index for Germany is 116, for example. This difference may be due to the imbalance between doctors and nurses.

---

[7] Resolution of the Government of Georgia №334 "Nursing Development Strategy On approval. "

[8] World Health Organization Database "Health for All", 2014

[9] Eurostat, number of nurses per 100,000 population in EU countries

[10] Curatio International Foundation, Health Barometer Wave 10, "Human Resources in the Health Sector"

The number of doctors in Georgia is 2 times more than the number of nurses. While according to the recommendation of the World Health Organization, the number of nurses should exceed the number of doctors by 4 times. Therefore, if we follow the recommendation of the World Health Organization, Georgia needs 8 times more nurses than it has today.

It should be noted that the demand for nursing education in the country is low. Nursing education in Georgia is conducted in the format of higher academic and vocational education.[11] The nursing bachelor's programs are implemented by 5 universities, and the bachelor's program in midwifery is implemented only by 1. Only 99 students graduated from these programs in 2011-2019 (Table 1). Even more alarming is the fact that after the start of their studies, most of the students mobility switch to other medical programs. This may be due to the low quality of teaching of nursing/midwife programs.

As for the graduates of vocational schools, their number in 2013-2019 was 1881. Therefore, the staffing of nursing personal is performed almost entirely from vocational schools. But neither is the number of nurses trained by vocational schools sufficient for the country.

It should be noted that the regulatory environment for health services provides for a nurse/ patient ratio only within the scope of obstetric-neonatal and neonatal intensive care services. There are no such requirements for other services. There is no requirement regarding the ratio of doctors to nurses. Therefore the demand for nurses in the country is low.

The Nursing Development Strategy, adopted by the Government of Georgia in 2019 as a resolution[12][12], states that the Ministry of Health is working to introduce a standard of nurse-patient ratio within various services, Which should be reflected in the demand for nursing staff resources.

According to this strategy, one of the important reasons for the lack of nursing staff is that this profession is non-prestigious. The strategy states that 54% (n = 2860) of physicians, nurses and managers consider nursing to be non-prestigious. At the same time, the strategy emphasizes the lack of knowledge about the nature and functions of the nursing profession, both in the non-medical part of the society, as well as in the medical and nursing staff.

Financial access is also one of the reasons for the shortage of nursing staff. Due to the fact that the bachelor's degree program in nursing is not included in the list of priority fields for the

[11] Resolution of the Government of Georgia №334 "On Approval of the Nursing Development Strategy".

[12] Resolution of the Government of Georgia №334 regarding the approval of the Nursing Development Strategy.

country,[1313] there are no free tuition programs in this area and the student must obtain funding by receiving a state grant. In addition to the fact that nursing staff today receives mainly vocational education, the ways of obtaining funding in vocational schools are important. In addition to the fact that nursing staff today receive mainly vocational education, the ways of obtaining funding in vocational schools are important. The problem in this regard was the fact that the state grant allowed only students from state vocational schools to receive grants. This has changed recently and today it is possible to obtain funding in private vocational schools.

Another problem is the lack of young nursing staff. Lack of formal education/specialization system for nurses; Absence of a sharp line between the profession of nurse and doctor and etc.

One of the main reasons for the nursing to be non-prestious is the low salary in this field. As the nurses themselves say, their salary is several times lower than the doctor's salary.

The impact of the pandemic on the activity of dentists

The spread of COVID-19 and the state's response to it have put dental clinics in a difficult position. From the very beginning of the pandemic, dental activities were considered a high-risk activity.

According to the dentists' labour union, "the state has banned planned work in dental clinics as a high-risk activity. With this fact, the lack of information and identification with the dentists with the beauty salons's staff has led to complete uncertainty, the closure of clinics. Representatives of the Revenue Service, patrol and City Hall staff visited clinics and requested closures, leaving acutely ill patients without treatment. This was partially eliminated by the active work of the labour union, but it still remains a difficult problem."

Dentists name the following problems as the main problems caused by the pandemic:

1. Prohibition of planned works as high risk activities;

2. Thegrowing prices of personal's protective equipment and materials;

3. Suspension of medical tourism;

4. Unemployed dentists;

5. Being out of the scope of PSR-testing program;

[13] Order of the Minister of Education, Science, Culture and Sports of Georgia №175/n "On the Approval of the Rules and Conditions for Issuing Program Funding for Higher Education Institutions by the Ministry of Education, Science, Culture and Sports of Georgia in the 2019-2020 academic year"

6. The problem of waste disposal.

Leaving patients without treatment has complicated their condition, which is a much higher financial cost for both patients as well as for insurance companies.

The problem has also arisen in clinics that were dependent on the medical tourism, virtually closed all clinics that were working on implantology and in orthopedics and orthodontics, because all these three specializations have been considered as planned work, which is debatable as some physicians consider these fields to be less dangerous than ophthalmology or any other field of medicine.

In March 2020, 99% of the dental staff of dental clinics were left unemployed due to increased prices of personal protective equipment and reduced patient flow and bans.

The right to resume planned work is granted to the clinic only after monitoring conducted by the Agency for Regulation of Medical and Pharmaceutical Activities and the Labor Inspection, which also runs at a very slow pace over time and the questionnaire, used to examine the clinics, in the opinion of the representatives of the clinics, does not meet the real need and does not reflect the reality that should be crucial for high-risk activities.

As of December, only 25% of clinics registered in Georgia were inspected. Consequently, the remaining 75% of the employed medical staff remained unemployed for months.

Dentists also consider the issue of waste disposal to be a difficult unsolved problem, which is the responsibility of clinics to be reported electronically on a daily basis.

Treatment at Covid Hotel

Calls for the establishment of field hospitals in the country have been repeatedly heard in the community. A similar hospital was set up at the beginning of the pandemic in the city of Marneuli. Then, with the improvement of the epidemiological situation, the calls for the field hospital disappeared. However, after the beginning of the so-called second wave of the pandemic in the country, the talk about it intensified again. Instead of setting up field hospitals, the government has used the experience it has gained from using hotels as quarantine spaces, and has added another innovation to the hotels that were used as quarantine - the “Covid-Hotel”, which accommodates mild patients if they do not have conditions for isolation at home. At the same time, Covid-Hotel is under the supervision of a group of doctors, therefore, unlike home treatment, the condition of the patients is assessed by doctors onsite.

The arrangement of a field hospital can have two main purposes - patients are isolated from those around them, thus preventing the spread of the virus, and they receive qualified help from doctors. Since the disease is mild in most Covid patients, there is no need to hospitalize them.

For those patients who do not have adequate facilities at home, Covid-Hotel is the best solution as staying in a hotel is much more comfortable than in a specially arranged field hospital. In the case of a decision to treat/supervise patients with COVID-19 at the Covid-Hotel, the patient's condition is managed through Covid Hotel-based on-duty medical teams (doctor, nurse) who are also in close contact with infectious disease specialists and public health professionals.

Covid-Hotel which works for 20 patients - employees 1 team of doctor and nurse, with increasing number of patients, 1 more nurse is added for every additional 30 patients and 2 full teams if number of patients exceeds 50.

In case of deterioration of the patient's condition at home/hotel - the patient is subject to hospitalization (including re-hospitalization) - according to the decision of the doctor. In this case, the doctor informs "112" about the mentioned patient, on the basis of which "112" ensures the involvement of the emergency medical service.

Labor rights of the medical staff

Healthcare workers are at the forefront of the COVID-19 pandemic containment process, so they belong to the infection risk group and work in hazardous conditions.

The International Labor Organization, together with the World Health Organization, has published a guideline on the corona virus pandemic and labor rights and responsibilities.[14]

According to the guideline, hazardous working conditions include the following factors: contact with the source of infection, long working hours, psychological stress, occupational fatigue, stigmatization, physical and psychological pressure.

As for the rights of healthcare workers, the guideline assesses these rights more broadly than standardized, by adding measures to prevent the dangers posed by the spread of the corona virus. According to the guideline, in addition to the labor rights provided by labor law, the rights of health care workers include the expectation that employers in medical facilities will:

- Undertake the responsibility to provide the necessary protective and preventive measures to minimize health risks in the workplace;
- Provides employees with information, instructions and training on occupational health and safety, including the rules for wearing and making protective equipment;

[14] Coronavirus disease (COVID-19) outbreak: rights, roles and responsibilities of health workers, including key considerations for occupational safety and health: interim guidance, 19 March 2020

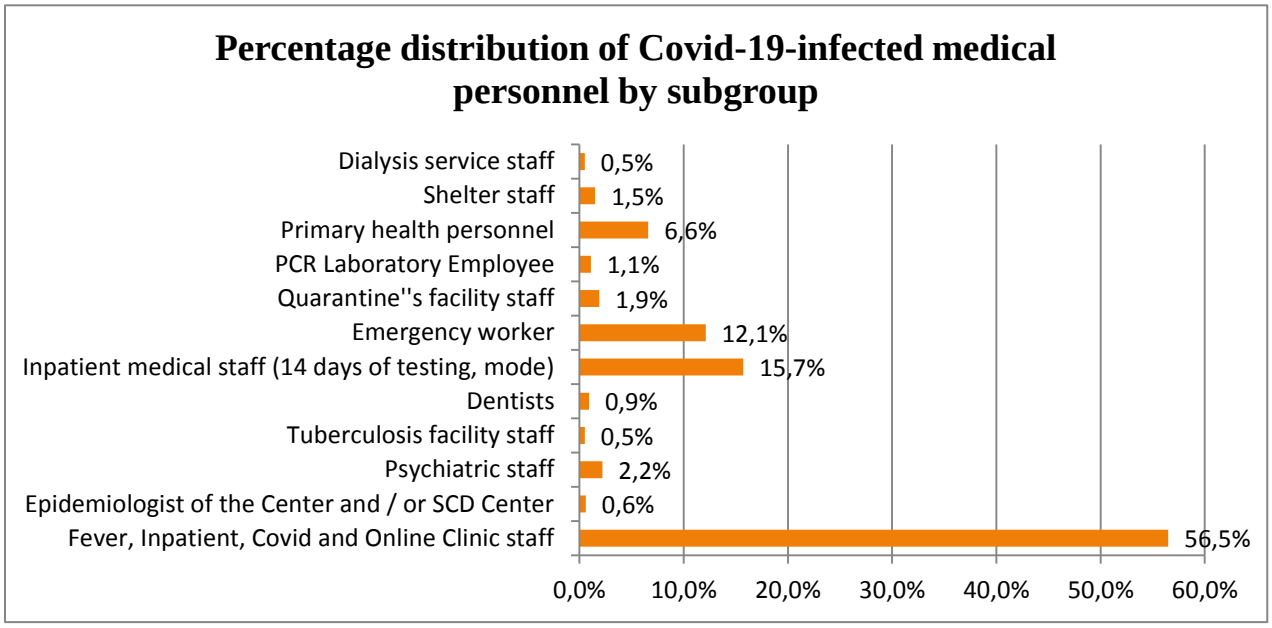
- Provide staff with an adequate amount of protective equipment (masks; goggles; hand sanitizers; soap and water; cleaning products);
- Provides staff with information on issues such as triage, testing, patient care and infection prevention and control issues for patients and the public;
- Ensures the safety of staff;
- Provides an environment free from judgment (for example due to contact of staff with blood or respiratory system fluids), as well as develops a procedure for immediate investigation of cases of violence;
- Advises health workers to assess their own health, report symptoms, and stay home during illness;
- Provides appropriate working hours with breaks;
- Consult health care workers on aspects of occupational safety at work and notify the labor inspectorate of occupational diseases;
- Healthy workers are allowed to leave work if they believe there is a compelling reason to do so, due to the imminent and serious threat to their health;
- Do not require health care professionals to return to work if there is a serious health hazard until appropriate action has been taken;
- Recognize the right of compensation, rehabilitation and treatment for health care professionals who have become infected in the workplace - consider infection as a work-related illness;
- Provides access to mental health and counseling;
- Provides cooperation between management and healthcare professionals as well as their representatives.

Working conditions / environment of medical staff

The rapid spread of COVID-19 has doubled the importance of healthcare professionals. Healthcare professionals are the backbone of the healthcare system in fighting the pandemic. They try to help others at the risk of their own lives and health. For this, these people deserve at least decent working conditions.

As of December 31, 6% of the Covid-infected individuals were medical personnel. A total of 15,500 healthcare professionals were infected with COVID-19 during 2020.

The distribution of infected personnel according to subgroups of activity is as follows:



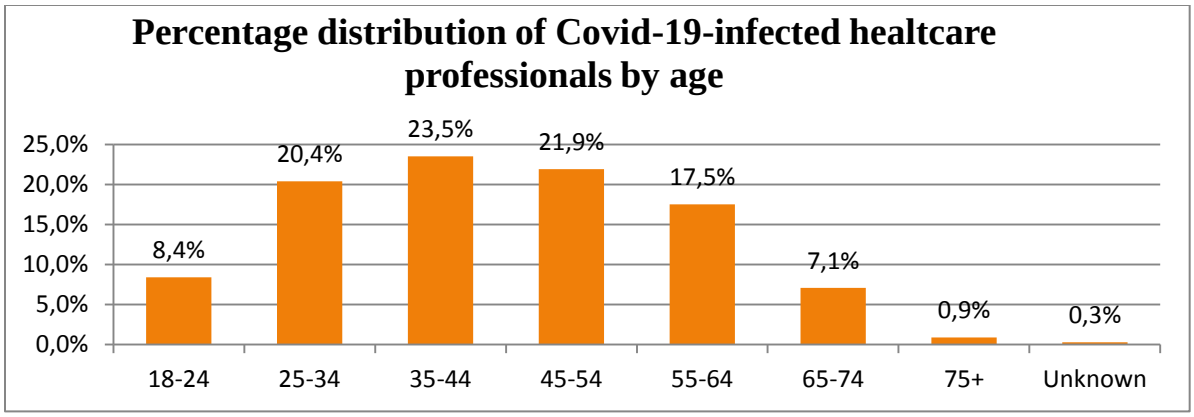
Source: Report of National Center for Disease Control and Public Health, 5th revision. The data reflects the results of December medical testing.

As can be seen from the diagram, more than half of the cases of infection of medical staff were reported in the staff of fever, inpatient, hospital and online clinics.

In addition to doctors having to work in stressful environments and busy schedules, the psychological pressure is exacerbated by the fear that they will become infected and then infect their own family members and friends. A study conducted at China COVID-19 Infectious Diseases Hospital showed that 23% of the 230 healthcare professionals had anxiety and 27% had stress disorder. [15]

In Georgia, 80% of the infected medical staff were women and 20% were men. By age groups, 80% of the infected medical staff were between the ages of 30 and 70 years.

[15] J. Z. Huang et al.: Mental health survey of 230 medical staff in a tertiary infectious disease hospital for COVID-19, (2020) [accessed 9 April 2020].



Source: Report of National Center for Disease Control and Public Health, 5th revision

By the end of 2020, 62 death cases from COVID-19 had been reported among medical personnel, which is 0.4% of the total infected healthcare professionals. Nationwide, the death rate was 1.1% at the end of December. This difference can be explained by the fact that the population of retirement age employed in the medical field as well as in the economy in general is small. The ratio of dead women to men among healthcare professionals is 50%/50%.[16]

Distribution of deaths by medical staff by age:

Age group		%
30-39	2	3,2
40-49	3	4,8
50-59	9	14,5
60-69	30	48,4
70+	18	29
Total	62	100

Source: Report of National Center for Disease Control and Public Health, 5th revision

Occupational safety issues

Each infected doctor means that fewer patients can get qualified help from a doctor. During the pandemic, the number of infectious disease specialists and resuscitators is particularly significant. There are a total of 488 resuscitators and 256 infectious disease specialists in Georgia.[17] In total they can treat about 2000 patients at a time. During the peak period of the pandemic, there were consistently more than 7,000 patients in the hospital. This is the number of patients with moderate to severe (mild patients staying at home or moving to a Covid-hotel).

[16] Report of the National Center for Disease Control and Public Health 5th Review "One Year with COVID-19"

[17] Source: Statement by the Prime Minister

Accordingly, one resuscitator received 14.3 hospitalized patients, which is 5.8 times the amount that can be treated by this number of resuscitators. We should not forget also the fact that a large part of the beds in Covid-hospitals are occupied by other types of patients and they also need the help of resuscitators. Consequently, the country does not have a sufficient number of doctors, and in case of their infection, the already unfavorable ratio of doctors and patients worsens.

Therefore, providing the necessary equipment for the safety of healthcare professionals is vitally important. No less important than the equipment are also the working conditions of the doctors. Fatigue is why doctors are not infrequently infected. A tense schedule, constant contact with severe patients, and the stress caused by patient's death put doctors in a difficult psychological state. Under such conditions, the risk of making a mistake increases. It is therefore necessary for the government to take measures that will relieve hospitals and reduce the workload of doctors.

A study by Wuhan University[18] suggests that long shift hours increase the risk of the virus spreading in healthcare professionals.

Timely and continuous training of doctors is also important in terms of occupational safety. Dialogue and timely exchange of information between healthcare professionals and their employers also helps to improve the situation in the workplace and serves to better protect the safety of employees. It is important that staff receive timely information about the clinic protocol, guidelines, measures taken and decisions made.[19]

Short-term employees

Due to the lack of medical staff, many countries have resorted to mobilizing various types of support staff in the short term period. In Ireland, for example, a call was made to all health professionals who are not working at the moment to register and return to active work if necessary.[20] Germany provides quick registration for foreign medical workers who are in the country and awaiting registration documents.[21][22]

Return of retired medical staff to hospitals in Georgia was actively considered. Eventually, however, choices were made for undergraduate medical students. Students on the one hand do not have enough experience, however they have taken basic courses in medicine and can perform the functions of support staff. This prevented older doctors from returning to the workplace who were at risk for the virus. Students, in addition to being transferred directly to clinics, were also employed in online clinics, from where they monitored patients online.

[18] Risk Factors of Healthcare Workers With Coronavirus Disease 2019: A Retrospective Cohort Study in a Designated Hospital of Wuhan in China

[19] ILO Sectoral Brief COVID-19 and the health sector

[20] Be on call for Ireland, Government of Ireland, 2020.

[21] Ausländische Pflegekräfte schnell zulassen, Federal Government of Germany, 18 Mar. 2020 [accessed 9 April 2020] 22 C. Dyer:

[22] ILO Monitor: COVID-19 and the world of work. Second edition

In such a situation, it is important that the students who participated in this campaign have appropriate working conditions. Some of them volunteer for this activity, some of them have an employment contract and receive remuneration. In the case of such unplanned employment, it is advisable for the government to discuss these issues with the social partners so as not to infringe on the rights of these individuals. According to the recent amendments to the Labor Code, the maximum period of internship should not exceed 6 months. In the case of volunteering, this norm will not work, although it is important for the social partners to know what kind of relationship students have with employers and how well all their rights are protected.

Authorities should also pay attention to the fact that such emergency workers were trained to work in pandemic conditions.

Women in the health care system

Women make up more than 70% of the world's healthcare workers.[23] There are a total of 31,746 doctors and 19,613 nurses in Georgia (Table 2). There are 20,084 women and 11,662 men among doctors[24]Women make up 63.2% of doctors. Statistical information on the gender of nurses is not available, although here, as in the case of doctors, it is likely that women predominate.

It is noteworthy that the number of doctors has increased by 3889 compared to 2010, which corresponds to a 31% increase. During the same period, the number of nurses increased by only 300 (1.5%).

Traditionally, women perform unpaid work in addition to their main job, and are involved in caring activities. Women are often employed in low-skilled and low-paid jobs, leading to gender gaps in wages. This difference is -26% in high-income countries and 29% in upper-middle-income countries.[25] In Georgia, this difference is higher than in other upper-middle-income countries and it is 36.2%.

Closure of schools and public institutions is another factor affecting the psychological state. This is especially true for women who have to do housework while caring for children and the elderly. The work of women doctors has become even more difficult during this period, which is compounded by the increased concern for family affairs.

[23] ILO Monitor: COVID-19 and the world of work. Second edition

[24] Geostat Gender Portal

[25] ILO:Improving Employment and Working Conditions in Health Services: Report for discussion at the Tripartite Meeting on impoving Employment and Working Conditions in Health Services (Geneva, 2017).

Experience from years ago, such as the Ebola epidemic in 2014, shows that health care workers may face violence, discrimination and stigma from the public because the public is afraid of coming into contact with the source of the disease.[26]

In hospitals, doctors and nurses who had direct contact with patients infected with the corona virus did not leave hospitals for 2 weeks at the beginning of the pandemic and then spent 2 weeks in the quarantine zone. After quarantine, they returned to the hospitals. This means that they literally could not see their own families.

Social dialogue in times of crisis

Many labour unions around the world have been involved in responding to COVID-19 results. This response is manifested in informing its members, in dialogue with employers' organizations and the government, and in mobilizing its members in a pandemic to help those in need.[27]The Georgian Labour Union Confederation, along with all of the above, was involved in providing personal protective equipment to employees and also contributed to the fund set up to combat COVID-19.

All issues related to labor rights are particularly important in the social dialogue process, be it the involvement of retirees or students in the management of COVID-19, or the review of the labor rights of existing medical staff through dialogue with the social partners.

The importance of this dialogue increases especially in times of crisis, when doctors have to work in a non-standard mode, and the protection of the rights of employees for a short period of time is less predictable. The Independent Labour Union of Medicine, Pharmacy and Social Security Workers of Georgia was actively involved in the process of increasing salaries for medical staff by 50%. In this process, the unions revealed a number of cases where the clinic did not raise salaries for lower-level staff. They informed the relevant authorities and made similar facts available to the public. During the first wave of the pandemic, when the country and medical staff successfully dealt with the pandemic, the public expressed its gratitude in various ways, including applause. However, as the Georgian Independent Labour Unions of Medicine, Pharmacy and Social Welfare Workers have said, applause is not enough for nursing staff, and in a situation where part of the nursing staff even has a subsistence minimum, the government should do more for their well-being. "The public applauded the respect for the medical staff, but for the medical staff of our country, who have obligations, including bank liabilities, they can not pay applause, so the slogan of the medical unions was “salary instead of applause”. The call was preceded by a 50% salary rise for nursing staff. In addition, we demanded an increase in the

[26] Mental health and psychosocial considerations during the COVID-19 outbreak, WHO, 2020 [accessed 9 April2020].

[27] ILO Sectoral Brief ILO brief Key points COVID-19 and the health sector

salaries of nurses employed in the municipalities, the improvement of the labor rights and conditions of the nurses in general, and the remuneration of overtime hours."

The Trade Labour of Medical Workers has written a letter to the Ministry of Internally Displaced Persons from the Occupied Territories, Labor Health and Social Affairs of Georgia about the need to complete the renovation work at the Oncology Hospital, as the hospital staff remained unemployed due to the government announcing the renovation work. According to the trade union of medical workers, the repair work has not actually started, and the doctors, when there is a great demand for them all over the world, can no longer continue to work.

In the conditions of the pandemic, a collective agreement was signed between the employer and the medical workers' unions in the clinic named after Academician Nikoloz Kipshidze (former Republican Hospital). The collective agreement reflected the increase in the salary rate, the adjustment of the payroll network and the improvement of the working conditions of the medical staff, which is related to the COVID-19 pandemic.

The union of medical workers draws attention to the lack of salaries in the medical field - "In the first line of health care, where salaries are below the subsistence level, we demand an increase of at least 50% in salaries for nurses, nursing assistants and family doctors. This is the medical staff whose salaries range from 150 to 250 GEL. In the regions, the salary of the lower echelon is estimated at 80 to 150 GEL. There are several outpatient clinics in Tbilisi where salaries are similar. ”The labour union continues its campaign on salary issues with the slogan“ Salary instead of applause ”.

While rapid changes in working conditions in the field of emergencies, including for medical workers, may have been necessary, in the long run it is necessary to consider the protection of the labor rights of employees in such fields. The Georgian government has not discussed the employment status of healthcare workers with social partners even 1 year after the start of the pandemic. Which threatens the realization of the labor rights of the employees themselves, as well as the process of development of social dialogue in general.

Working hours

In response to Covid-19, many medical workers face increased working hours and shorter break periods. Emergency workers have to work in atypical and stressful environments.

The International Labor Organization's Guidelines[28] for Decent Work in **Emergency Services** (hereinafter referred to as the ES) set out the criteria that such services must meet in regards to employees.

International Labor Organization Guidelines for Decent Work in Public Emergency Services:

„26. The work schedule should be designed to provide sufficient staff for all periods of time, including night and weekend, as well as to provide rest periods for PES employees, including for the performance of their family responsibilities. Where general law emergency services do not consider maximum working hours per week, minimum daily rest hours, break hours, special legislation, regulations or agreements should be adopted to protect employees from excessive working hours.

27. Given that persons employed in emergency services may work atypical and non-standard working hours, as well as they should respond to emergencies, the following principles should be observed when determining working hours:

a) The legislation should provide for maximum working hours per week, minimum daily and weekly continuous rest periods, except in unusual situations, such as when it is necessary to protect human life and health, property or the environment. In such cases, the employer must provide a compensatory leave period. If the crisis continues for a long time, the government should take measures to return them to standard conditions as soon as possible.

b) break hours used during shifts shall be considered as working hours.

c) In shifts or any other period not included in normal working hours during which the employer requires the employee to be on standby due to specific service requirements or at a specific location, such waiting time shall be deemed to be working hours unless otherwise compensated. The employer is responsible for informing the employee if such a policy exists. ”

[28] ILO Guidelines on decent work in public emergency services 2018

In addition, the International Labor Organization Convention on Nursing Staff (№149) and its accompanying Recommendation (№157) set standards for decent working time, especially for nursing staff.

The terms of employment covered by the Convention are partly related to the difficulties associated with the pandemic: working hours, including the regulation and compensation of overtime hours, inconvenient work schedules, weekly rest, maternity leave, hospital sheets and social security. Exemption from standard working hours according to Recommendation (No. 157) is possible only during special emergencies. According to the annex to the recommendation, overtime work should be done only voluntarily, unless it is needed while caring for a patient and sufficient volunteers cannot be found.[29]

Providing income for healthcare professionals

Meeting the needs of healthcare professionals is of particular importance during a pandemic crisis. Healthcare professionals are at high risk to get infected. In case of getting infected they miss some time at work. During this period it is important that they receive income. From the very beginning of the pandemic, the Georgian Trade Union Confederation called for the authorities to automatically consider the period of Coronavirus infection as an honorable reason for employees to miss their jobs. Authorities responded in a timely manner and employees were given a hospital sheet in case of infection. Such an approach is important because, on the one hand, it retains the income needed by employees to cover the costs of subsistence and increased costs during the infection, and on the other hand, the employee goes to a medical facility at an early stage of infection and thus reduces the risk of spreading the virus. It should also be noted that this principle applies only to hired employees. For the self-employed, who, according to the new methodology used by Geostat, make up 30.7% of the employees, the source of income is the amount they earn, therefore their income is not secured during the period of infection. The government imposed compensations in parallel with economic restrictions to help employees. However, these compensations apply only to those who lost their jobs during the pandemic period due to government restrictions (in case of self-employment - income). Even the self-employed who do not have the opportunity to earn an income during the period of infection remain out of focus. Consequently the motivation of these people not to be left without income increases the risks of spreading the virus. At the same time, official employers have an obligation to control the condition of their employees, by measuring the temperature or other means, which is not controlled in the case of self-employed.

[29] ILO Guidelines on decent work in public emergency services 2018

Public and private health sector

The commercialization of the healthcare sector has over time generated some dissatisfaction in the community. The International Organization of Employers has launched a discussion on the topic - Challenges and Opportunities in Private-Public Cooperation,[30] which addresses this issues.

As in 1998 at the PES's tripartite meeting on employment and working conditions stated, **healthcare is not a property and should be in the public interest. However, health care should be organized and implemented through the provision of public services, although it can also be provided by the private sector.**

Some countries are integrating private hospitals into the public health system, thus increasing the number of beds for the Covid -infected people.[31]Georgia has mastered the beds of both state and private clinics for the treatment of patients. Up to 8,000 beds have been vacated to receive Covid-patients across the country. While the number of non-specialized beds in the whole country is not more than 10 thousand.

However, according to representatives of the healthcare professionals' union, several multidisciplinary clinics refused to convert it to a Covid-clinic and the reason for this was the fact that the clinic would lose its profit. Consequently, the privatization of the medical sector increases the risk that the state will not be able to fully use the resources of the existing healthcare system when it is necessary. The full privatization of the hospital sector in Georgia took place in 2007-2012. In the hospital sector in the country, the share of state hospitals in the total number does not exceed 15%. A similar index in European countries ranges from 60 to 75%. Most of the state-owned specialized medical institutions (psychiatric, phthisiological, narcological and other services) are owned.[32]

Georgia met the pandemic with a weak primary health care system. As stated in the study of the "Open Society Georgia Foundation" - "Primary health care development was not given the highest priority. **The focus of the healthcare system is mainly shifted to the inpatient sector, which is almost entirely profit-oriented.** Internationally recognized evidence even shows that

[30] IOE: "Private sector contributions in health emergencies" (2020) [accessed 9 April 2020]

[31] "Private hospitals will be made public for duration of coronavirus pandemic", the journal ie, 24 Mar. 2020[accessed 9 April 2020].

[32] Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs of Georgia, "Brief Overview of the Georgian Healthcare System", 2017.

the commercialization of the health care system jeopardizes access to and equity services for the primary health care system.“[33]

In 2016, the rate of medical care provision in Georgia was 3.7 per 1000 population. The bed occupancyrate was quite low - 51.8%, and the bed rest period was 5.0 days. [34]

According to 2016 data, government expenditures on healthcarewith respect to the gross domestic product is 3.0%, and the share of state expenditures on healthcare in relation to the state budget is 8.6%. Despite the decline, the share of out-of-pocket payments (OOP) in total healthcare spending remains high and it is 57%, placing a heavy burden on domestic economy.

The introduction of the universal healthcare program has somewhat increased the use of health services:

	Outpatient appeals per person	Hospitalization per 100 inhabitants
2012	2,6	8
2016	4	13,3

Source: "Brief overview of the Georgian healthcare system", 2017

Consequently more people were given access to medical services.

Underdeveloped primary health care system, however, leads to inefficient use of hospital resources. The ratio of the number of active cases and hospitalization in the country is 30%. While the same rate in Europe is 4-5%, and in America is 1%. There is a misuse of expensive hospital resources, and for the first time less workload falls on healthcare. Most patients do not know who their family doctor is.

Georgia knows only the system of private and public hospitals, while 70-80% of Europe and 48.3% of the US clinical sectors are noncommercial (non-profit) hospitals. These are privately owned hospitals that are charitable in nature and not profit-oriented. As a rule, such hospitals are exempt from taxes. However, the existence of such hospitals does not preclude the existence of profit. This profit is simply used not for the interests of the owners, but for the hospital itself - to improve the quality of medical services, to arrange new equipment and infrastructure, to pay for the work of medical staff, for research activities and other purposes.Such "public" hospitals take

[33] OSFG, Mikava N., Gabrichidze S. "Weak primary health care - the main barrier to universal access to health care", 2019.

[34] Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs of Georgia, “Brief Overview of the Georgian Health Care System” 2017.

better care of citizens' interests than any other form, are not profit-oriented, and are more efficient in terms of governance than state-owned hospitals.

During the pandemic, the primary health care system acquired special importance, as the primary health care system through family doctors is the first link where the patient and the doctor make contact. It is the family doctor who detects the infectious disease and directs the patient to the doctor of the appropriate profile. In addition to the function of the primary health care system is constant patient supervision, the family physician knows the patient history best and is therefore best able to manage the patient. In addition, **primary healthcare not only manages the patient, but also prevents disease.**During the pandemic, constant contact with patients and the population prevents the spread of the virus through the provision of information, while on the other hand, the infection is detected at an earlier stage and delayed referral and possible complications are avoided.

Universal Healthcare

The health sector is not a standard sector of the economy and it needs strict regulation from the state. Among them, regulations should affect the prices set by clinics, as most clinics receive funding from the universal health care system, and these costs are also reflected in budget funds. More efficient redistribution of budget funds will enable more people to receive the benefits provided by the universal health care program. In addition, price stability is important for the population, which has to co-pay for the services provided.

The reform implemented by the state in 2019, which regulated prices to some extent, proved painful for many clinics as the clinics differ in size, leading to differences in their costs. Regardless of the size of the clinic, it has to incur constant costs, such as - maintenance of buildings, purchase of medical equipment, etc. Therefore, before equalizing the costs in the universal healthcare program, it was necessary to make changes in the rules of licensing clinics,through selective contracting. Selective contracting[35] is a healthcare practice where the insurer limits the choice of providers that the patient may visit. By selective contracting, the insurer can exclude inefficient clinics from the network, thereby reducing costs. In the case of universal health care, the state represents the insurer as well as the insurer. The cost-effectiveness of the program increases after the exclusion of ineffective clinics. Accordingly, the next stage - which is reflected in the equalization of tariffs - is relatively painless for the remaining clinics, as the clinics with which the state has a contract are characterized by more or less equal costs.

[35] Jan Boone and Christoph Schottmuller „Do health insurers contract the best providers? Provider networks, quality and costs? "2016

In selective contracting, the state can essentially determine many factors, including the quality of service and price. At the same time, however, the contract may reflect the labor rights and remuneration of employees.

Rough cuts in funding for clinics within universal health care could lead to a reduction in the quality of service. Selective contracting puts clinics in similar conditions.[36] Reduces the difference caused by economies of scope as much as possible, so after the use of selective contracting it becomes easier to equalize the tariffs for health services provided by clinics participating in universal health care.

Unequal tariffs encouraged many small clinics to get involved in the universal health care program, because even though they had to spend more than other clinics and used the money less cost-effectively, the state still reimbursed those costs.

The state should use selective contracting to ensure that the equalization of tariffs on health services does not lead to a **reduction in both the quality** of medical services and the **remuneration** of medical staff.

Recommendations

Policy aimed at increasing the number of nursing staff. Determining the nurse/patient ratio.

Georgia ranks last in Europe in the number of nurses per 100,000 population. The number of nurses is twice less than in European countries. According to the World Health Organization, the ratio of nurses and doctors in Georgia is 0.8, while in Germany, for example, it is 3.3, and in Ukraine it is 2.2, and the ratio recommended by the World Health Organization is 4/1. An increase in the number of nursing staff will lead to an increase in the quality of health care. At the same time, doctors will have less to combine the functions of a nurse, thus increasing their labor productivity. The normative definition of nurse/patient ratio is an accepted practice in many countries. The number of nurses has a direct impact on patient care.

Ratification of the International Labor Organization №149 - Convention on the Conditions of Work and Employment of Nursing Staff (1977).

The International Labor Organization Convention on Nursing Personnel (№149) and its accompanying Recommendation (№157) set standards for decent working time, especially for nursing staff. The terms of employment covered by the Convention are partly related to the

[36] J Zwanziger, G A Melnick, and A Bamezai, "The effect of selective contracting on hospital costs and revenues."

difficulties associated with the pandemic: working hours, including the regulation and compensation of overtime hours, inconvenient work schedules, weekly rest, maternity leave, hospital sheets and social security. Exemption from standard working hours under Recommendation (№157) is possible only during special emergencies. According to the annex to the recommendation, overtime work should be done only voluntarily, unless it is needed while caring for a patient and not enough volunteers can be found.

Employers should take into account the rights provided for in the guidelines jointly developed by the International Labor Organization and the World Health Organization, which are intended for healthcare workers, including the employer:

- Takes the responsibility to provide the necessary protective and preventive measures to minimize health risks in the workplace.
- Provides employees with information, instructions and training on occupational health and safety.
- Provides a free environment for adjudication on issues such as contact with blood or respiratory fluids, or cases of violence, and develops a procedure for immediate investigation of the matter;
- Provides appropriate working hours with breaks;
- Will consult with healthcare professionals on aspects of occupational safety at work and report to the Labor Inspectorate on occupational diseases;
- Allow healthcare professionals to leave work if they believe there is a compelling reason for the imminent and serious threat to their health;
- Provides cooperation between management and healthcare workers, as well as their representatives (trade unions).

The labor legislation should reflect the important guarantees of protection of employees in public emergency services, which are defined by the guideline of the International Labor Organization"on decent work in public emergency services", including:

- Where general law emergency services do not provide for maximum working hours per week, minimum daily rest hours, break hours, special legislation, regulations or agreements should be adopted to protect employees from excessive working hours..
- Given that people working in emergency services may have to work atypical and non-standard working hours, as well as they have to respond to emergencies, the following principles should be observed when determining working hours:
- a) The legislation should provide for maximum working hours per week, minimum daily and weekly continuous rest periods, except in unusual situations, such as when it is necessary to protect human life and health, property or the environment. In such cases, the employer must provide a compensatory leave period. If the crisis continues for a long

time, the government should take measures to return to normal conditions as soon as possible.

- b) Break hours used during shifts should be considered as working hours.
- c) In shifts or any other period not included in normal working hours during which the employer requires the employee to be on standby due to specific service requirements or at a specific location, such waiting time shall be deemed to be working hours unless otherwise compensated. The employer is responsible for notifying the employee if such a policy exists.

The labor inspectorate will look into issues related to overtime hours in hospitals.

Due to the fact that in the conditions of the pandemic, many doctors work with increased workload and overtime, the probability of violating the labor rights of medical staff increases. Healthcare professionals play a crucial role in pandemic crisis management, so it is important that the enforcement of their labor rights is guaranteed. For this, the labor inspectorate needs to periodically check the state of protection of labor rights of employees in the field of health.

To discuss the issues related to the healthcare issues that are important for the persons working in the healthcare system with social partners.

In order for social dialogue to be successful, dialogue needs to be encouraged, at the sectoral and organizational levels. Today, the Tripartite Social Partnership Commission exists only at the national level and many issues related to any particular sector remain beyond attention. Therefore, it is important to establish a tripartite social partnership platform at the sectoral level as well, and the parties should be represented in it - the relevant department of the Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs, the Georgian Independent Trade Union of Medicine, Pharmacy and Social Workers.

In a pandemic, students involved in the fight against COVID-19 must have appropriate working conditions. Some of them volunteer for this activity, some of them have an employment contract and receive remuneration. In the case of such unplanned employment, it is advisable for the government to discuss these issues with the social partners so as not to infringe on the rights of these individuals. It is important for the social partners to know what kind of relationship students have with employers and to what extent all their rights are protected. In addition, the increased workload of medical workers, which is associated with many risks, should be considered by the social partners, which on the one hand will reduce the risks of violating the rights of employees, and on the other hand will help increase their awareness.

Improving the funding system of the universal health care system. Selective contracting.

Selective contracting is a healthcare practice where the insurer limits the choice of providers that the patient may visit. By selective contracting, the insurer can exclude inefficient clinics from the network, thereby reducing costs. In the case of universal health care, the insurer is the same as

the insured state. The cost-effectiveness of the program increases after the exclusion of ineffective clinics. Accordingly, the next stage - which is reflected in the **equalization of tariffs** - is relatively painless for the remaining clinics, as the clinics with which the state has a contract are characterized by more or less equal costs.

In selective contracting, the state can essentially determine many factors, including the quality of service and price. At the same time, however, the contract may reflect the **labor rights and remuneration of employees**.

Separation of physicians' remuneration and universal health care system. Remuneration of employees in many clinics is directly related to transfers within the universal health care system. Which in turn leads to salary delays for several months. It is important for clinics to have a reserve that ensures salary continuity and eliminates salary delays. One way to achieve this is through selective contracting, which excludes inefficient clinics, most of which rely solely on universal health care funds and spend these funds inefficiently, from the universal health care system.

Accelerate the pace of monitoring of dental clinics by the Agency for Regulation of Medical and Pharmaceutical Activities and the Labor Inspectorate.

The restoration of the activities of dental clinics depends on the mentioned monitoring. The slow pace of this process leaves many dentists unemployed for months. It is therefore necessary to speed up monitoring so that dentists can still receive revenue months later.

Encourage organizational form of hospitals such as noncommercial (nonprofit) hospitals in addition to private and public hospitals.

Georgia met the pandemic with a weak primary health care system. The focus of the healthcare system in the country is mainly shifted to the inpatient sector, which is almost entirely profit-oriented. This is due to the almost complete commercialization of the healthcare system in recent years. Internationally recognized evidence shows that the commercialization of the health care system jeopardizes access to primary health care system services.

Georgia is familiar only with the system of private and public hospitals, while in Europe 70-80% are noncommercial (non-profit) hospitals. These are privately owned hospitals that are charitable in nature and not profit-oriented. As a rule, such hospitals are exempt from taxes. However, the existence of such hospitals does not preclude the existence of profit. This profit is simply used not for the interests of the owners, but for the hospital itself - to improve the quality of medical services, to arrange new equipment and infrastructure, to pay for the work of medical staff, for research activities and other purposes. Such "public" hospitals take better care of the interests of the citizens than any other form, are not profit-oriented and are more efficient in terms of governance than state-owned hospitals.

Further development of the primary health care system and increase of the population's access to health care.

During the pandemic period, the primary health care system acquired special importance, as the primary health care system through family doctors is the first link where the patient and the doctor make contact. It is the family doctor who detects the infectious disease and directs the patient to the doctor of the appropriate profile. In addition to the function of the primary health care system is constant patient supervision, the family physician knows the patient history best and is therefore best able to manage the patient. In addition, primary health care not only manages the patient, but also prevents disease. During a pandemic, constant with patients and the general public helps to prevent the spread of the virus by providing information, while on the other hand, the infection is detected at an earlier stage and delayed referral and possible complications are avoided. Further development of the primary health care system is therefore crucial, both in terms of tackling the pandemic and in improving the overall health care system and increasing access to health care programs for the population.

Bibliography:

1. Health Workforce Policies in OECD Countries 2016;
2. ILOSTAT, COVID-19:Are there enough health workers?;
3. J. Z. Huang et al.: Mental health survey of 230 medical staff in a tertiary infectious disease hospital for COVID-19,(2020) [accessed 9 April 2020];
4. ILO Guidelines on decent work in public emergency services(Geneva, April 2018);
5. ILO Sectoral BriefCOVID-19 and the health sector;
6. Risk Factors of Healthcare Workers With Coronavirus Disease 2019: A Retrospective Cohort Study in a Designated Hospital of Wuhan in China ;
7. Be on call for Ireland, Government of Ireland, 2020;
8. Ausländische Pflegekräfte schnell zulassen, Federal Government of Germany, 18 Mar. 2020 [accessed 9 April 2020];
9. C. Dyer: ”Covid-19: 15 000 deregistered doctors are told “your NHS needs you”, BMJ (2020) [accessed 9 April 2020];
10. C149 - Nursing Personnel Convention, 1977 (No. 149)
11. ILO Monitor: COVID-19 and the world of work. Second edition;
12. ILO:Improving Employment and Working Conditions in Health Services: Report for discussion at the Tripartite Meeting on impoving Employment and Working Conditions in Health Services (Geneva, 2017);
13. Mental health and psychosocial considerations during the COVID-19 outbreak, WHO, 2020 [accessed 9 April 2020];
14. ILO Sectoral Brief ILO brief Key points COVID-19 and the health sector;
15. “Private hospitals will be made public for duration of coronavirus pandemic”, the journal ie, 24 Mar. 2020 [accessed 9 April 2020];
16. IOE: “Private sector contributions in health emergencies” (2020) [accessed 9 April 2020];
17. Nursing skill mix in European hospitals: cross-sectional study of the association with mortality, patient ratings, and quality of care;
18. WHO, Global strategy on human resources for health: Workforce 2030;
19. Resolution Towards a sustainable health workforce in the WHO European Region: framework for action. Regional Committee for Europe, 67th session, EUR/RC67/R5, Budapest, Hungary, 11–14 September 2017;
20. Coronavirus disease (COVID-19) outbreak: rights, roles and responsibilities of health workers, including key considerations for occupational safety and health: interim guidance, 19 March 2020
21. State Concept of the Georgian Healthcare System for 2014-2020 "Universal Health Care and Quality Management to Protect Patients' Rights";

22. Report of the National Center for Disease Control and Public Health, 5th revision "One year with COVID-19";
23. Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs of Georgia, "Brief Overview of the Healthcare System of Georgia" 2017;
24. Georgia Socio-Economic Development Strategy "Georgia 2020";
25. Law of Georgia on Health Care;
26. Law of Georgia on Public Health";
27. Law of Georgia on Patients' Rights" ;
28. Order №01-91/N of Minister of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs of Georgia, August 18, 2020 on the approval of the Statute of the National Health Agency;
29. Management of post-acute COVID-19 and hospitalized patients after discharge at home State Standard for the Management of Clinical Conditions in General Practice - (Protocol);
30. Order № 01-528/O of Minister of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs of Georgia "On the Approval of the Algorithm for Medical Supervision in the Isolation of Patients with Slightly Current COVID-19" Annex 1;
31. Order №150/O of of Minister of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs of Georgia on the Approval of the State Health Care Programs, dated 4th of April, 2020,the bill "On Change to the Resolution №674 of the Government of Georgia of December 31, 2019 on the Approval of the State Health Care Programs for 2020";
32. Resolution of the Government of Georgia №334 "On Approval of the Nursing Development Strategy";
33. Curatio International Foundation, Healthcare Barometer Wave 10, "Human Resources in the Healthcare Sector";
34. Minister of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs of Georgia, "Brief Overview of the Health Care System of Georgia", 2017;
35. OSFG, Mikava N., Gabrichidze S. "Weak primary health care - the main barrier to universal access to health care", 2019;
36. The Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs of Georgia, "Brief Overview of the Georgian Health Care System" 2017;
37. World Health Organization Database "Health for All", 2014;
38. Information portal of the Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs of Georgia;
39. World Health Organization website;

40. National Statistics Office of Georgia;
41. Geostat Gender Portal;
42. https://stopcov.ge/;
43. https://www.ncdc.ge/;
44. http://rama.moh.gov.ge/;
45. https://bm.ge/ka/video/ra-ujdeba-dges-jandacvis-sistemas-erti-kovid-inficirebulis-mkurnaloba/21726/;
46. https://bm.ge/ka/article/saxelmwifom-reforma-tarifebis-gatanabrebit-daiwyo-rac-seriozul-shecdomad-mimachnia---profesori/44559/.
47. Eurostat, number of nurses per 100,000 population in EU countries

Appendix 1.

Work instructions for the staff of the clinics involved in the 112 system during the emergency period

1. The medical clinic receives the relevant cases through the software of 112;
2. No more than 10 minutes through 112 software, the clinic is required to confirm receipt of the relevant case;
3. The clinic ensures that cases are received 24 hours a day;
4. In accordance with the protocol defined by the Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs, the clinic conducts telephone consultations with the initiators;
5. Telephone consultation should start no later than 1 hour after receiving the case;
6. In case the authorized family doctor of the clinic determines that the patient needs urgent medical assistance, he / she shall inform the 112 operator (telephone number 112) by phone;
7. The initiators who do not require emergency medical care by the decision of the authorized family doctor of the clinic are registered in the result form of 112 software;
8. Subsequent telephone communication with significant patients (who have not been referred to the ambulance) includes a 14-day cycle, namely, the second communication is made no later than the 3rd day after the receipt of the case, the third communication is made no later than the 6th day, the fourth communication is made no later than the 10th day later. -14 today;
9. After each telephone communication, the information should be reflected in the output form of 112 software;
10. In case at any stage the doctor considers that telephone communication with the patient is no longer necessary, the result form of 112 software is filled in;
11. In case of additional telephone communication, the need for the involvement of the emergency medical service is identified, the family doctor informs 112 about the mentioned patient, on the basis of which 112 ensures the involvement of the emergency medical service;
12. The main purpose of telephone consultation is for all citizens to receive qualified medical advice and to feel the maximum care of the state for their health;

Table 1.

Nursing / midwife program	Number of students (2019)	Number of course graduates
A(A)IP - New Vision University	2	
Medical Rehabilitation and Nursing (English)	2	
A(A)IP -St. Tbel Abuseridze Teaching University of the Georgian Patriarchate		5
Nursing		5
A(A)IP - St. Tamar Mepe University of the Georgian Patriarchate	1	2
Nursing	1	2
LEPL - Tbilisi State Medical University	70	62
Nursing (midwife)	20	11
Georgian-Austrian Bachelor's Degree educational Program (Nurse)	50	51
Ltd. - University of Georgia	29	30
Nursing	4	
Nursing (English)	25	30
Total	102	99

Source: Resolution of the Government of Georgia №334

Table 2.

Statistics of doctors

Doctors, Total	**31 746**
Including:	
Internal medicine physicians (Therapists)	1 248
Surgeons	2 648
Obstetricians and gynecologists	1 812
Pediatricians	1 563
Ophthalmologists	689
Otolaryngologists	578
Neurologists	1 178
Psychiatrists and narcologists	375
Phthisiologists	246
Dermatovenerologists	448

Radiologists	2 026
Medical Rehabilitation and Sports	93
Physicians of medicine	
Dentists	2 435
Other	16 407

Source: National Statistics Office of Georgia

Table 3. Number of nurses per 100,000 population

Year	Number of nurses per 100,000 population
1996	488
1997	505
1998	502
1999	500
2000	464
2001	422
2002	417
2003	414
2004	408
2005	400
2006	381
2007	371
2008	450
2009	445
2010	455
2011	424
2012	389
2013	402
2014	398
2015	418
2016	502
2017	509

Source: National Statistics Office of Georgia

Table 4. Distribution of employees by economic activity

Distribution of employees by types of economic activity (Nace rev. 2), 2018-2019		
		A thousand men
	2018	**2019**
Total	**1 296,2**	**1 295,9**
Rural, forestry and fish farming	253,9	247,4
Industry	153,9	147,0
Construction	98,8	101,4
Wholesale and retail trade; Repair of cars and motorcycles	185,0	195,9
Transport and warehousing	78,2	82,0
Accommodation and food delivery activities	44,3	48,8
Information and communication	20,9	19,0
Financial and insurance activities	33,7	30,7
Real estate activities	4,4	3,9
Professional, scientific and technical activities	21,2	19,0
Administrative and support service activities	21,3	22,4
State governance and defense; Mandatory social security	91,3	93,2
Education	155,1	153,4
Health and social services activities	65,3	60,2
Art, fun and leasure activities	28,4	29,9
Other services	20,0	22,0
Activities of domestic economics as employers; Production of undifferentiated goods and services by households for their own consumption	19,4	17,9
Activities of extraterritorial organizations and bodies	1,1	1,4
Unidentified	-	0,4

Source: Geostat - Labor Force Survey.