

Health Systems in Transition

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Georgia

Health system review

Erica Richardson • Nino Berdzuli

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Health Systems in Transition

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Georgia:

Health System Review 2017



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Preface

The Health Systems in Transition (HiT) series consists of country-based reviews that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a specific country. Each review is produced by country experts in collaboration with the Observatory's staff. In order to facilitate comparisons between countries, reviews are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a report.

HiTs seek to provide relevant information to support policy-makers and analysts in the development of health systems in Europe. They are building blocks that can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems;
- to describe the institutional framework, the process, content and implementation of health reform programmes;
- to highlight challenges and areas that require more in-depth analysis;
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries; and
- to assist other researchers in more in-depth comparative health policy analysis.

Compiling the reviews poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including

the World Health Organization (WHO) Regional Office for Europe's European Health for All database, data from national statistical offices, Eurostat, the Organisation for Economic Co-operation and Development (OECD) Health Data, data from the International Monetary Fund (IMF), the World Bank's World Development Indicators and any other relevant sources considered useful by the authors. Data collection methods and definitions sometimes vary, but typically are consistent within each separate review.

A standardized review has certain disadvantages because the financing and delivery of health care differ across countries. However, it also offers advantages, because it raises similar issues and questions. HiTs can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analysis of health systems. This series is an ongoing initiative and material is updated at regular intervals.

Comments and suggestions for the further development and improvement of the HiT series are most welcome and can be sent to info@obs.euro.who.int.

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Switzerland, the United Kingdom, and the Veneto Region of Italy; the European Commission; the World Bank; UNCAM (French National Union of Health Insurance Funds); the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. The European Observatory has a secretariat in Brussels and hubs in London (at LSE and LSHTM) and at the Berlin University of Technology.

The Observatory team working on HiTs is led by Josep Figueras, Director, Elias Mossialos, Martin McKee, Reinhard Busse (Co-directors), Ewout van Ginneken, Ellen Nolte and Suszy Lessof. The Country Monitoring Programme of the Observatory and the HiT series are coordinated by Anna Maresso. The production and copy-editing process of this HiT was coordinated by Jonathan North, with the support of Caroline White, Alison Chapman (copy-editing) and Pat Hinsley (typesetting).

List of abbreviations

CHE	current health expenditure
CI	confidence interval
CPD	continuing professional development
DALY	disability adjusted life year
DRG	diagnosis-related group
EIDSS	Electronic Integrated Disease Surveillance System
EmSC	Emergency Situations Coordination and Urgent Assistance Centre of Georgia
EU	European Union
FCTC	Framework Convention on Tobacco Control
FFS	fee for service
GDP	gross domestic product
GEL	Georgian lari
GGE	General Government Expenditure
GHC	Georgia Healthcare Group
GHED	Global Health Expenditure Database
GMP	good manufacturing practice
Hep C	hepatitis C
HMIS	health management information system
HTA	health technology assessment
HUES	Health Utilization and Expenditure Survey
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th revision
IDP	internally displaced person
IHR	International Health Regulations
MAP	Medical Assistance for the Poor
MDR-TB	multi-drug resistant TB
MoES	Ministry of Education and Science
MoF	Ministry of Finance
MoLHSA	Ministry of Labour, Health and Social Affairs
NCD	noncommunicable disease
NCDC	National Centre for Disease Control and Public Health

NHA	national health account
OECD	Organisation for Economic Co-operation and Development
OOP	out of pocket
PPP	purchasing power parity
PROM	patient reported outcome measure
PWID	people who inject drugs
SDR	standardized death rate
SHI	social health insurance
SRAMA	State Regulation Agency for Medical Activities
SSA	Social Services Agency
TB	tuberculosis
THE	total health expenditure
UHCP	Universal Health Care Programme
UNCAM	French National Union of Health Insurance Funds
USCE	Unified State Certification Exams
VAT	value added tax
VHI	voluntary health insurance
VFA	voluntary financing arrangement
WHO	World Health Organization
ZDL	Zonal Diagnostic Laboratories

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Abstract

This analysis of the Georgian health system reviews developments in its organization and governance, health financing, health care provision, health reforms and health system performance. Since 2012, political commitment to improving access to health care, to protecting the population from the financial risks of health care costs and to reducing inequalities has led to the introduction of reforms to provide universal health coverage. Considerable progress has been made.

Over 90% of the resident population became entitled to a tightly defined package of state-funded benefits in 2013; previously, only 45% of the population had been eligible. The package of services has variable depth of coverage depending on the groups covered, with the lowest income groups enjoying the most comprehensive benefits. To finance the broader coverage, the government increased health spending significantly, although this remains low in international comparisons. Out-of-pocket (OOP) payments have fallen as public spending has increased. Nevertheless, current health expenditure (CHE) is still dominated by OOP payments (57% in 2015), two thirds of which are for outpatient pharmaceuticals. For this reason, in July 2017, the package of benefits was expanded for the most vulnerable households to cover essential medicines for four common chronic conditions.

The system has retained extensive infrastructure with strong geographical coverage. Georgia also has a large number of doctors per capita, but an acute shortage of nurses. Incentives in the system for patients and providers favour emergency and inpatient care over primary care. There are also limited financial incentives to improve the quality of care and a lack of disincentives to inhibit poor quality care. Future reform plans focus on ensuring universal access to high-quality medical services, strengthening primary care and public health services, and increasing financial protection.

Executive summary

Georgia has undergone a profound demographic transformation since independence from the Soviet Union. The population has shrunk by around 25% since independence (to 3.7 million in 2014), largely due to intense out-migration. There is also a large number of internally displaced persons (IDPs) following conflicts in Abkhazia and South Ossetia. These two regions are now *de facto* beyond the jurisdiction of the central Georgian authorities. The country is divided into nine regions, two autonomous republics and the capital city, Tbilisi. Within the regions there is also a single-level system of local self-government (municipalities).

Economic growth has not benefited all sections of the population and poverty remains the key economic and social issue. Civil war, rapid marketization and hyperinflation following independence left Georgia in a state of economic collapse, but since 1994 the economic situation has improved rapidly. Nevertheless, a large proportion of the population (20.6% in 2016) is still living in relative poverty (under 60% of the median consumption).

Life expectancy at birth was 68.8 years for males and 77.3 years for females in 2014. This is lower than in previous years after decades of Georgia having one of the highest levels of life expectancy in the CIS. The reduction of life expectancy at birth in 2014 was due to changes in the denominator. Following the 2014 census, population estimates were revised sharply downwards and all life expectancy-related indicators were affected. Recalculation of the population in the inter-census period is ongoing. Much of the gender gap in life expectancy can be attributed to lifestyle factors. For example, smoking prevalence rates are 55.5% for men and only 4.8% for women. While still above the European Union (EU) average, maternal and infant mortality rates have fallen. The government has invested in electronic data recording and strengthening registration structures that had collapsed in order to improve the accuracy of mortality reporting to support decision-making in public health.

The Georgian health system has moved strongly away from the Semashko model it inherited at independence. The system is now highly decentralized and was extensively privatized under reforms introduced from 2007 to 2012. These reforms were characterized by deregulation and trust in market mechanisms. During this period, most government spending on health was channelled through private health insurance companies, which were paid to provide a standard package of benefits for households living below the poverty line. In 2010, health insurance companies bid to be the sole provider of health insurance for families below the poverty line in a specific region. In exchange for this monopoly provision for a fixed term, the companies were required to invest in upgrading the hospital and primary care facilities in their region. This created a number of vertically integrated for-profit purchaser–providers at the regional level.

Infrastructure and capital planning are driven by concerns for equitable geographical access to services, but planning in the health system is made much more complex by the dominance of private for-profit providers. Following extensive privatization and decentralization, most providers are independent of government in terms of ownership, governance and management. The pattern of vertical integration of pharmaceutical companies, private insurance companies and medical service providers is unusual in the European context and these companies are influential in the system.

Georgia also has a large number of doctors per capita, but an acute shortage of nurses. Furthermore, there are three times as many doctors in Tbilisi than there are in other regions, and recruiting and retaining staff to work in rural areas is a significant challenge. The oversupply of doctors and intense shortage of nursing staff also makes changing the skill-mix extremely challenging. Certification of doctors has been reintroduced, but nurses are not certified.

Since 2013, the government has been striving to provide universal coverage through a tightly defined package of publicly funded benefits and has made considerable progress. One of the key financing issues faced by the Georgian health system since independence has been the lack of political will to prioritize health for national development and fund the health sector accordingly. The introduction of the Universal Health Coverage Programme (UHCP) extended the breadth of coverage to almost the whole population, most of whom had no health coverage before 2013. In this new approach, market mechanisms and private insurance companies play a less prominent role. The Social Services Agency (SSA), which conducts means testing and access to social assistance programmes, such as disability payments, is now the single payer in the health system for different levels of government-funded cover under the UHCP.

Within the package of benefits under the UHCP, the depth of coverage is greater for lower income households. More comprehensive cover is provided to pensioners, children aged 0–5 years and households registered as living below the poverty line. Basic primary care and some diagnostic services, as well as urgent outpatient and inpatient care (with a cost ceiling), elective surgery (with 10–30% co-payments), oncological services and obstetric care, are available for those above the poverty line but earning less than the highest income bracket.

Under the UHCP, financial access to care has improved by reducing OOP spending on health services. This is evidenced by the surge in utilization as the system was able to meet pent-up demand for medical services among patients who previously did not have health care coverage. Georgia still has some of the lowest utilization rates for outpatient care in Europe, but utilization of outpatient and inpatient care has more than doubled since the introduction of the UHCP (from 2.1 outpatient contacts per year in 2010 to 4 in 2015). Utilization of inpatient care is relatively high, but this is indicative of a strong preference in the system for care-seeking and treatment at more specialized levels of the system at the expense of primary care, as well as incentives in the system that encourage hospital care. Despite primary care being made free at the point of use for all, most of the UHCP budget is spent on inpatient services.

The expansion of coverage was made possible by a substantial increase in budgetary funding for health, even though government health expenditure remains low in international comparisons. The increase in government health expenditure is consistent with the experience of other countries when they have moved towards universal coverage from less equitable systems, as it goes hand-in-hand with reducing the financial barriers to care. Since 2014, the UHCP has consistently overspent its budgeted amount. This was largely due to the rapidly growing demand for health services among those who were previously uninsured or lacked coverage for certain interventions.

Alongside cover provided under the UHCP, the health budget also finances 23 vertical programmes for priority diseases and conditions. These vertical programmes seek to provide access to services for the whole population, but with varying depth of coverage. The vertical programmes include: mental health, diabetes management, child leukaemia services, dialysis and kidney transplantation, palliative care, and a range of public health protection programmes including tuberculosis control, vaccination programmes and the innovative hepatitis C (Hep C) programme, which aims to achieve a 90% reduction in prevalence by 2020. Georgia has a high prevalence of Hep C infection, mainly due to inadequate infection control in health care settings and

unsafe injections among persons who inject drugs (PWID). In 2015, 7.7% of the adult population was living with Hep C. By 2017, ~30% of the estimated population living with Hep C in Georgia had received treatment, with cure rates of 82% and 98% depending on the regimen.

An ongoing priority for the Ministry of Labour, Health and Social Affairs (MoLHSA) is ensuring and improving the quality and safety of care provided. Currently, there are limited mechanisms to reward good performance and use of available clinical decision support tools, such as national guidelines and protocols; care pathways are not used. Volumes of care in some hospitals are too low to ensure quality of care. From 2007–12, the system was intended to be self-regulating and medical quality was considered the responsibility of professional medical and provider organizations, but there was a lack of financial incentives to improve the quality of care and a lack of disincentives to inhibit poor quality. MoLHSA is now seeking to counter this through: strengthening the role of the SSA as a selective purchaser of medical services; medical facility licensing requirements; continuing professional development (CPD) for health professionals; and certification mechanisms.

The role of the SSA as a single purchaser has significantly reduced fragmentation in the system and improved efficiency. In 2016, the UHCP was spending less per person than the Medical Assistance for the Poor programme (MAP) – approximately 166 Georgian lari (GEL) compared with 180 GEL, even though the benefits offered were more extensive. This demonstrates a big decline in spending on administration; prior to 2013, Georgia's public spending on health administration was considerably higher than most Organisation for Economic Co-operation and Development (OECD) countries, including Switzerland.

However, incentives in the system for patients and providers still strongly favour emergency and inpatient care. Even though the per capita cost of coverage has fallen with the implementation of the UHCP, more than half of UHCP funding went on emergency inpatient care. The very detailed and complex payment system for hospitals makes it difficult for the SSA to control costs, and incentives in place encourage providers to treat patients as urgent cases. The SSA introduced standardization of tariff-rule setting, which has already led to cost savings at the system level. However, currently, any savings in health expenditure are accrued to the central government budget rather than the health system.

MoLHSA and the SSA are introducing quality assurance measures as part of reforms to reorganize maternity and neonatal care. The 'regionalization' of maternity and neonatal health services since 2015 has been part of a data-driven

package of reforms to improve maternal and infant health outcomes by strengthening the collection of health data and using reimbursement mechanisms to try to ensure quality of care. The reform aimed to create a comprehensive, coordinated and geographically structured system of designating where infants should be delivered to ensure that risk-appropriate perinatal care is available for all mothers and infants.

Despite a notable decrease in OOP health expenditure, health system financing in Georgia is still dominated by OOP payments. OOP payments fell from 73% of current health expenditure (CHE) in 2012 to 57% in 2015. Outpatient pharmaceuticals represent one of the biggest gaps in coverage and pharmaceutical costs can be impoverishing for low-income households. This has serious implications for equity and financial protection in the system. A small share of OOP payments also comes from private expenditure on voluntary health insurance (2.2% of voluntary financing arrangements in 2015), which has a substitutive role.

The high cost of outpatient pharmaceuticals is widely seen as the biggest barrier to accessing care. There are co-payments in the system for some less vulnerable groups, but the depth of cover appears less of an issue than the scope of cover as around two thirds of OOP spending in Georgia is for outpatient pharmaceuticals. Overall, pharmaceutical care in Georgia is highly inefficient, as evidenced by the high price of pharmaceuticals locally and the very high level of spending per capita on pharmaceuticals. In 2015, 38% of CHE (3.0% of gross domestic product (GDP)) was spent on pharmaceuticals in Georgia. The take-up of generic pharmaceutical products is weak as they are not well trusted by patients or professionals, and cost-effectiveness guidelines are not used. To cover the most vulnerable households, in July 2017, the government introduced essential medicines coverage for four common types of chronic disease – cardiovascular (including hypertension), chronic obstructive pulmonary disease, type 2 diabetes and thyroid conditions.

Under the UHCP, patients have almost unlimited choice of provider for emergency, elective treatment and primary care. Patients can access the hospital of their choice for planned surgery if they have prior authorization from the SSA. This free choice of medical facilities and physicians has been rated the most positive aspect of the UHCP. However, the provision of patient information to inform such choice of provider is limited. Primary care doctors only act as gatekeepers for patients covered under relevant parts of the UHCP or private insurance. Other patients, and those not registered with a primary care provider, are free to self-refer to inpatient services as they pay OOP. For

many patients, this is the preferred option as the quality of primary health care services is still perceived to be low. Self-treatment is also a common feature of health care in Georgia, despite the recent drive to reintroduce prescriptions for many medicines, such as antibiotics.

Overall satisfaction with the health system has increased and grown since the introduction of the UHCP in 2013. Survey data show that patients appreciate the level of choice in the system and the improved access to specialist services, but dislike making co-payments and the limitations on the services covered – particularly for pharmaceuticals and dental care.

1. Introduction

Chapter summary

- Social and economic upheaval since independence, as well as armed conflict, have displaced populations and led to significant out-migration of the working-age population.
- Georgia is a parliamentary democracy and elections have been conducted in line with internationally recognized democratic standards.
- Despite economic growth, poverty remains the key economic and social issue.
- The disease burden is dominated by noncommunicable diseases (NCD), but communicable diseases continue to pose a significant challenge for the health system.
- The government has invested in electronic data recording and strengthening registration structures, which has significantly improved coverage of death registration, although the accuracy of causes of death reporting remains a challenge.

1.1 Geography and sociodemography

Georgia is situated in the South Caucasus and is on the Black Sea; it borders the Russian Federation to the north and Turkey, Armenia and Azerbaijan to the south (Fig. 1.1). The country is divided by the Surami mountain range, which runs from north to south between the Lesser and Greater Caucasus mountains. Two administrative territorial units (Abkhazia and South Ossetia/Tskhinvali region) are beyond the jurisdiction of the Georgian authorities. As a result of conflicts in Abkhazia and South Ossetia/Tskhinvali there were 300 000 internally displaced persons (IDPs) before the conflicts once again escalated in August 2008, creating an estimated 128 000 more IDPs in Georgia (Redmond & Sunjic, 2008).

Fig. 1.1
Map of Georgia



Source: UN Cartographic Section.

Official population calculations for January 2016 reflect the findings of the 2014 population census, which found the total population of Georgia to be 3.7 million (Geostat, 2016). This is considerably lower than previously estimated because there have been challenges to basic registration in the country since independence (Badurashvili et al., 2001), but also because Abkhazia and South Ossetia/Tskhinvali could not be included in the data collection. There has also been significant out-migration of the working-age population. It has been estimated that over 0.75 million Georgians, or 16.6% of the population, have emigrated; the top destination country is the Russian Federation, followed by Ukraine and Greece (World Bank, 2016). In 2014, remittances accounted for 12% of gross domestic product (GDP), or US\$ 2bn (World Bank, 2015). Economic recession in the Russian Federation since 2014 has meant a sharp drop in remittances to Georgia, which were US\$ 1.15bn, or 8% of GDP, in 2016 (National Bank of Georgia, 2018). With high levels of out-migration of the working age population, the Georgian population is aging despite a relatively high birth rate in the European context (see Table 1.1).

Table 1.1

Trends in population demographic indicators, selected years

	1995	2000	2005	2010	2015	2016
Total population (millions)	4.7	4.4	4.2	3.9	3.7	3.7
Population ages 0–14 (% of total)	24.5	22.6	19.5	18.0	18.7	18.9
Population ages 65 and above (% of total)	11.4	12.4	14.3	14.3	14.6	14.7
Population density (people per km ²)	82.8	77.3	73.3	68.7	65.0	65.0
Population growth (annual growth rate %)	–2.7	–0.8	–1.3	–1.3	–0.3	0.1
Fertility rate, total (births per woman)	1.9	1.6	1.7	1.9	2.0	–
Distribution of population (% population living in rural areas)	46.2	47.4	47.5	47.1	46.4	46.2

Source: World Bank, 2018.

1.2 Economic context

In 2017, Georgia was classified a lower-middle-income country. The economy bounced back following the global financial crisis in 2008 and experienced robust growth from 2010 to 2014 (see Table 1.2). Growth averaged 5.6% of GDP a year, which allowed for increased government spending. However, the Georgian economy is vulnerable to external shocks and weakening external demand since the end of 2014 has rapidly slowed Georgia's economic growth. The country is now in a challenging fiscal position and large budget overruns have widened the current account deficit (World Bank, 2017).

Table 1.2

Macroeconomic indicators, selected years

	1995	2000	2005	2010	2015	2016
GDP per capita (current US\$)	569	692	1 530	2 964	3 765	3 866
GDP per capita, PPP (current int'l US\$)	1 673	2 587	4 365	6 598	9 611	10 005
GDP growth (annual %)	2.6	1.8	9.6	6.2	2.9	2.8
General government final consumption expenditure (%GDP)	10.9	8.5	17.3	21.1	17.9	18.4
Current account balance (%GDP)	–	–5.8	–10.9	–10.3	–12.0	–12.8
Central government debts (%GDP)	–	69.9	35.1	36.8	41.3	44.4
Unemployment, total (% labour force, modelled ILO estimate)	12.1	10.8	13.8	16.3	12.0	11.7
Poverty headcount ratio at national poverty lines (% of population)	–	–	33.2	36.1	20.8	21.3
Income inequality (Gini coefficient)	–	40.5	40.3	42.1	38.5	–

Source: World Bank, 2018.

Notes: GDP: gross domestic product; ILO: International Labour Organization; PPP: purchasing power parity.

Poverty has been a pervasive problem for Georgia and its reduction has been a key target for both national governments and international partners. The poverty headcount ratio at the national poverty line was 21.3% of the population in 2016 (Table 1.2). Poverty indicators based on the consumption patterns of households are central to the proxy means testing approach to awarding social and health benefits that was introduced in 2006, whereby households are scored and categorized for the targeting of benefits, including health care benefits.

1.3 Political context

Georgia is a semi-presidential republic, in that the president governs alongside a cabinet and prime minister. The period immediately following independence from the Soviet Union was marked by civil war and instability in Georgia. However, in 1995, Eduard Shevardnadze, who had been an influential politician in the Soviet Union, was elected president and presided over a programme of reform which brought stability and some economic growth to the country, but it also saw increasing levels of poverty, crime and corruption. This led to a series of popular protests challenging the official results of elections held at the end of 2003 and pushing for fresh elections to be held. Mikheil Saakashvili was elected president in January 2004 and re-elected in January 2008. However, Saakashvili's bloc (United National Movement) lost control of parliament following elections in 2012. The elections were won by the Georgian Dream coalition. Georgian Dream won a second term in the most recent elections of October 2016, led by the Prime Minister Giorgi Kvirikashvili.

Georgia is divided into nine regions and two autonomous republics (Adjara and Abkhazia) plus the capital city, Tbilisi. Within the regions there is a one-level system of local self-government at the municipal level (*rayon sakrebulo*). There are also several self-governing towns, with a municipal government independent from the national authorities.

1.4 Health status

After independence, challenging socioeconomic conditions made it very difficult to maintain reporting structures. The share of ill-defined causes of death among all mortality in Georgia increased steadily from 2007, reaching 55% in 2010 (WHO Europe, 2017). Research has shown that once the proportion of deaths from ill-defined causes is greater than 20% of total mortality, then mortality

data must be viewed as unreliable (Mathers et al., 2005). To improve the quality of death certification, the main institution responsible for health statistics, the National Centre for Disease Control and Public Health (NCDC) conducted a secondary investigation of ill-defined causes of death across Georgia. ICD-10 validation of diagnosis for age, gender and special codes restrictions were built into the reporting software and facility-level comparisons with previous years are now made. The proportion of deaths attributed to ill-defined causes has subsequently improved, falling to 28.4% in 2014, and 27.3% in 2015, but the mortality data are still unreliable at this level; there is no other country in the European region where the proportion is above 15% (WHO Europe, 2017). There was a wide gap between reported infant, maternal and under-5 mortality rates and estimated rates in the past. For example, the Reproductive Age Mortality Survey (RAMOS) 2008 found a maternal mortality ratio of 44 deaths per 100 000 live births, which was almost twice as high as the maternal mortality ratio of 23/100 000 officially reported (Table 1.3). Significant improvements in the systems for registering the deaths of women of reproductive age have reduced this gap as now 98% of such deaths are captured and differences between the reported and estimated rates are now minimal (WHO, 2018b). The infant mortality rate in Georgia has also declined over the past decade; nevertheless, maternal and infant mortality rates remain a challenge (WHO Europe, 2017). Since 2016, an electronic surveillance system for pregnant women registers all

Table 1.3

Mortality and health indicators, selected years

	1995	2000	2005	2010	2014	2015	2016
Life expectancy at birth, total**	70.3	71.3	74.0	74.4	73.1	72.9	72.9
Life expectancy at birth, male**	66.3	67.5	70.0	70.0	68.8	68.6	68.6
Life expectancy at birth, female**	74.2	75.0	76.6	78.7	77.3	77.2	77.2
Estimated life expectancy at birth		71.8	73.9	73.8	74.5		
Mortality, SDR per 100 000 population							
Circulatory diseases	624.3	682.4	578.8	476*			
Malignant neoplasms	75.2	96.6	95.8	102.8*			
Communicable diseases	11.8	9.3	7.3	7.0*			
External causes of death	45.2	28.0	28.0	35.7*			
All causes	866.1	949.3	880.0	894.4*			
Infant mortality rate***	28.2	21.1	18.1	12.0	9.5	8.6	9.0
Estimated infant mortality rate	38.1	31.2	21.9	14.9	11.3		
Maternal mortality rate***	55.1	49.2	23.4	19.4	31.5	32.2	23.0
Estimated maternal mortality rate		37.0				36.0	

Source: WHO Europe, 2017.

Notes: SDR: standardized death rate; *2009 data as last reliable year; **Geostat; ***NCDC.

information about antenatal and obstetric care provided for all women, as well as their newborn's health status. This will enable policy-makers to examine the issue in more detail to inform policy solutions.

It is also important to note that the 2014 census found that the population was smaller than had previously been thought. This change to the denominator caused a significant increase in per capita rates and measures. This change in population size has been taken into account in data for 2014 and onwards; the Georgian National Statistics Office is in the process of retrospectively recalculating population sizes in the inter-census period, and all health-related indicators will also be recalculated as part of this process.

Health data for 2009 (the last year available for which the proportion of deaths attributed to ill-defined causes was below 20%) showed that cardiovascular diseases were by far the most common causes of death in Georgia, accounting for 53.2% of total mortality (WHO Europe, 2017). All other evidence shows that mortality in Georgia remains dominated by NCD, in particular cardiovascular disease. Recent national cancer morbidity data show a sharp jump in the incidence of malignant neoplasms in 2015, almost doubling to 285 per 100 000 population (2016: 249.7). This was due to the introduction of the Cancer Population Registry on 1 January 2015, as the specialist cancer clinic (dispensary) registration system had collapsed many years previously. Until 2015, there was a lack of statistical data on malignant neoplasms, so rates prior to this time are likely to substantially underestimate the burden of disease attributable to cancer. The further development of other planned NCD registries will make it possible to improve the overall quality of health data in the country.

In Georgia, there are no regularly conducted population surveys to assess the spread of risk factors such as tobacco and alcohol consumption. A representative population survey conducted in Georgia in 2016 found that 57% of men and 7% of women are smokers (although nicotine tests found a female prevalence rate of 12.2%), and these levels are higher than those found in the previous survey conducted in 2010 (NCDC, 2018).

The FCTC (Framework Convention on Tobacco Control) Global Report (2016) put smoking prevalence at 55.5% of men and 4.8% of women in 2011, and youth prevalence of 9.9% for young men and 3.8% for young women in 2014; this represents a reduction in the male rate but an increase in the female rate since 2008. The report also highlighted the challenge of full implementation of tobacco control in Georgia where smoking harms are not widely recognized outside the health sector (WHO, 2016). However, the Parliament of Georgia

still managed to pass strong new legislation on tobacco control on 17 May 2017. The law introduces a comprehensive smoking ban in enclosed public spaces, workplaces and public transport, an extensive ban on the display of tobacco products at point of sale, and standardized packaging to be rolled out in stages from 1 May 2018.

Drinking rates have changed more over time, with a decline in reported abstinence (from 27.4% in 2001 to 6.6% in 2010 for men, and 70.1% to 41.1% for women over the same period) and a commensurate increase in light drinking (once a month or less frequently), from 44.5% to 59.6% for men and 26.1% to 55.2% for women (Stickley, Roberts & McKee, 2012). It was also found that 28.2% of respondents had been diagnosed with hypertension, of whom 55.7% [CI: 52–59.5%] did not take daily medication (Roberts et al., 2012). According to the STEPS-2016, 37.7% of the population suffers from hypertension and only 53.3% of people with arterial hypertension were on medication for raised blood pressure in 2016 (NCDC, 2018).

The Global Burden of Disease study has found that disability adjusted life years (DALYs) in Georgia remain quite low in international comparison and they have stayed relatively stable over time. In 2015, there were 35 700 DALYs per 100 000 population for all causes (IHME, 2016).

Communicable diseases continue to pose a considerable challenge for the health system. Tuberculosis (TB), for example, remains a pressing public health issue. Despite a marked fall, from 254 cases per 100 000 in 2000 to 132 cases in 2009 and 92 cases in 2016, Georgia has one of the highest incidences of TB in the WHO European Region (WHO, 2017). TB drug resistance is a key challenge for the national TB programme and the main obstacle to effective TB control in the country. In 2009, routine surveillance showed that 10.6% of new TB cases and 32.5% of previously treated cases were multi-drug resistant (MDR-TB) (Furin et al., 2012); the latest data (2016) show MDR prevalence of 11% and 31% in new and previously treated cases respectively (WHO, 2017).

Georgia is a high prevalence country for hepatitis C (Hep C) infection; in 2015, NCDC estimated that 7.7% of the adult population were living with Hep C. By contrast, Georgia is a low prevalence country for HIV. Until 2014 the epidemic was concentrated in people who inject drugs (PWID) and their sexual partners, and men who have sex with men, but since then there has been a rapid increase with a clear shift towards heterosexual transmission routes (50% of new cases in 2015) (Gamkrelidze et al., 2017). Vertical programmes which deal with TB, HIV and Hep C are detailed in section 5.1.

For vaccine-preventable diseases, current immunization rates are quite high. In 2016, 85% of children were fully immunized against measles (i.e. had received both doses of the measles, mumps, rubella vaccines); 97% of infants were immunized against diphtheria, pertussis and tetanus; and 97% of infants were immunized against polio (UNICEF, 2017).

However, rates in previous years were substantially lower and herd immunity has not been assured. Historic weaknesses in the immunization programme through the 1980s and 1990s left a cohort of young people with little immunity to vaccine-preventable diseases (Khetsuriani et al., 2010). There have been outbreaks of measles (peaking in 2004) and diphtheria (peaking in 1995) with adolescents and young adults being particularly affected. A supplementary immunization campaign targeting this group encountered difficulties in achieving good coverage rates due to unfounded vaccine safety concerns fuelled by media panics (Khetsuriani et al., 2010; Topuridze et al., 2010). This allowed another outbreak to take hold in 2013, when infections were concentrated among infants (aged under 12 months) and 15–30 year olds (Gamkrelidze et al., 2017). There was also a resurgence of malaria following independence and civil war in the early 1990s, peaking at 472 cases in 2002. However, since 2010, there have been no cases of mosquito-borne malaria transmission and Georgia is close to regaining malaria-free certification having moved into the prevention of reintroduction phase (Kandelaki et al., 2012; Newby et al., 2016; WHO Europe, 2016).

Box 1.1

Equity in health outcomes

The introduction of the Universal Health Care Programme (UHCP) improved equity overall in the system as many households near the poverty line could access necessary health services for which they were previously not covered. However, geographical variation in outpatient contacts indicate that there may be serious inequalities in access to care across the country, with huge discrepancies between rural areas and Tbilisi (World Bank, 2017).

2. Organization and governance

Chapter summary

- The Georgian health system has moved strongly away from the Semashko model it inherited at independence.
- The system is now highly decentralized and was extensively privatized under reforms implemented from 2007 to 2012.
- As part of this reform programme, the system was also heavily deregulated and the Ministry of Labour, Health and Social Affairs (MoLHSA) is now working to strengthen the quality management system to ensure that the quality of care provided is adequate.
- Since 2012, Georgia has been striving to provide universal health coverage through a tightly defined package of publicly funded benefits.

2.1 Organization

In 2012, a change of government brought a significant change of direction in health policy. While the previous model had sought to harness market mechanisms to improve efficiency in the health system, from 2013, the approach has been to try and implement universal health coverage. Previous extensive privatization means the vast majority of medical service providers are autonomous. Whereas providers previously contracted with competing private insurance companies (Box 2.1), the Social Services Agency (SSA) now purchases all the services covered under the Universal Health Care Programme (UHCP) (Fig. 2.1). However, out-of-pocket (OOP) spending on health is still high.

Ministry of Labour, Health and Social Affairs (MoLHSA)

MoLHSA is formally accountable for the health of the population, oversight of the health system, the quality of health services and equity in relation to access to health care throughout the country. Its responsibilities have been

Box 2.1**Historical background**

The Semashko system set the original context for the health system in Georgia, although waves of fundamental reforms have transformed it over the past 25 years. From 1995 to 2004, a social health insurance (SHI) system operated in Georgia, but, overall, the introduction of SHI was not successful in delivering a basic package of services to be made accessible to the population in the light of scarce resources – because the system remained chronically underfunded.

The Saakashvili government (in power 2004–2012) strongly believed that marketization and liberalization should be undertaken in all sectors to be consistent with the country's overall development. Thus, health care reform was considered a continuation of changes already undertaken in other sectors as part of the national development policy, rather than as separate or specific health reforms. The reform objectives intended to transform almost all components of the system from service provision to financing, purchasing, regulation and supervision. The main principles were to transition towards complete marketization of the health sector: private provision, private purchasing, liberal regulation and minimum supervision. From 2008 to 2012, most government spending on health was channelled through private health insurance companies, which were paid to provide a standard package of benefits for households living below the poverty line – the Medical Assistance for the Poor (MAP) programme (Chanturidze et al., 2009).

In 2010, health insurance companies were invited to bid to be the sole provider of health insurance for families below the poverty line, children aged 0–5 years old, pensioners, teachers, students, disabled persons (the 'target population') in 26 medical regions. In exchange for this monopoly provision for a fixed term, the companies were required to invest in upgrading the hospital and primary care facilities in their regions. This created a number of vertically integrated purchaser–providers at the regional level. Until 2013, the SSA channelled funds to the insurance companies for the MAP programme. There was a change of government in December 2012 and reforms since February 2013 (see section 6.1) have sought to bring universal health coverage to Georgia and the SSA is now the single payer in the health system. The SSA also conducts means testing and access to social assistance programmes such as disability payments.

substantially reduced since Soviet times, especially concerning direct service provision, direct purchasing, and regulation. Different waves of decentralization by deconcentration and privatization over a number of years mean that MoLHSA now controls only a handful of specialized hospitals (Box 2.1).

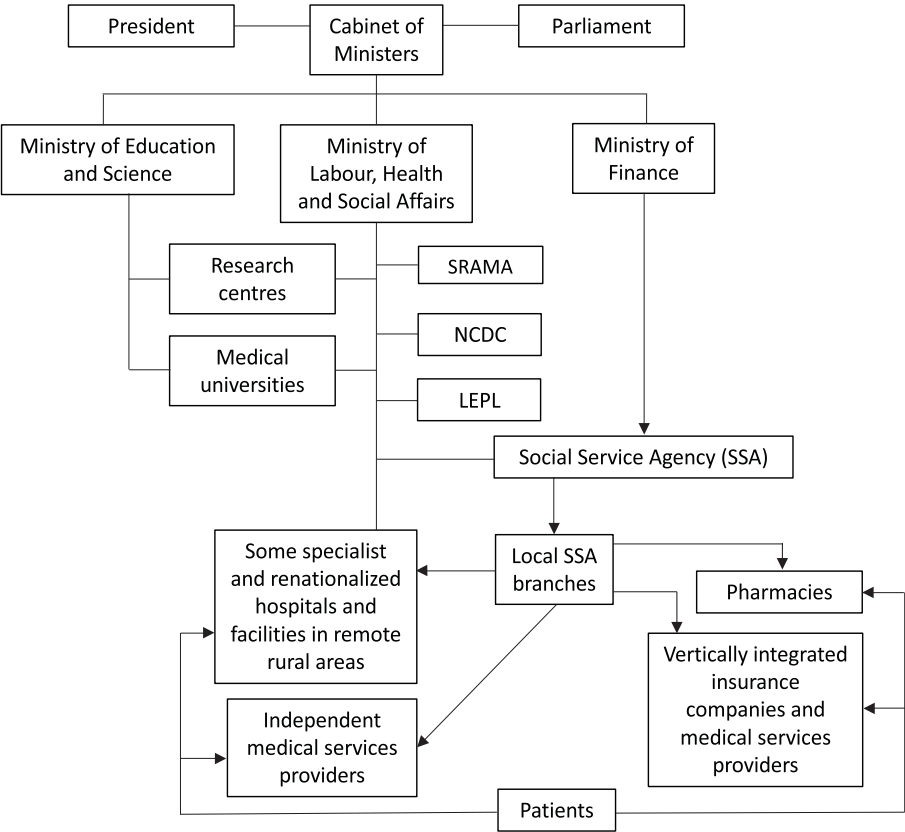
Ministry of Finance (MoF)

The MoF fulfils two main functions: routine oversight of the spending processes of all ministries, including MoLHSA, to ensure compliance with the pre-defined plan; and leading the annual budget preparation process.

The Social Services Agency (SSA)

The SSA is a state subordinated institution under the administration of MoLHSA and, among other roles, it administers service purchasing in accordance with the UHCP and 23 other health programmes by purchasing services according to a fixed price list.

Fig. 2.1
Organization of the health system in Georgia, December 2017



NCDC: National Centre for Disease Control
SRAMA: State Agency for the Regulation of Medical Activities
LEPL: Emergency Situations Coordination and Urgent Assistance Centre of Georgia
Source: Authors' own.

State Regulation Agency for Medical Activities (SRAMA)

SRAMA is part of MoLHSA and is formally responsible for issuing the licences for medical activities and permits for health care facilities and pharmacies, as well as regulating medical professionals, pharmaceuticals and medical devices. However, its role is made difficult by the lack of a clear legal framework for regulating the health system and limited resources.

National Centre for Disease Control and Public Health (NCDC)

As part of large-scale reforms of the Sanitary–Epidemiological Service, NCDC was established in 1996 from the epidemiological divisions of the Republican Sanitary–Epidemiological Station. In 2003, the Medical Statistics

and Information Centre and, then in 2007, the Public Health Department, were integrated into the NCDC, which is responsible for public health in Georgia, including immunization, surveillance, disease prevention, health promotion and the laboratory system.

Professional representation

Since 2005, the major activity for professional associations has nominally been to support MoLHSA in its endeavour to elaborate national clinical practice guidelines and protocols. MoLHSA brings together funds for this initiative from budget sources and various international partners, and invites professional associations to work on specific areas of expertise. Yet, few professional associations have been stewards of quality – setting and maintaining standards in specialties and shaping practice expectations. Only a few of the professional associations have high membership as the value or benefits offered do not resonate with physicians.

Private insurance companies

From 2007, private insurance companies were key stakeholders in the health system and their market grew exponentially as they were the main purchasers of the government-funded package of benefits (Box 2.1). From 2010, they became vertically integrated purchaser–providers for whole regions but, in 2013, the purchasing role was passed back to the SSA, although many employees still have private health insurance as an employment ‘perk’. Since April 2017, the highest income households have been excluded from the government-funded package of benefits and are expected to have private health insurance.

International partners

Numerous international partners have strongly supported the health sector in Georgia. Many have permanent offices in the country, largely supporting developments in health and social sectors. However, since 2015, international funding has reduced.

2.2 Decentralization and centralization

The decentralization process has been ongoing in Georgia since independence (Chanturidze et al., 2009). Health service providers are generally independent of the state, although some providers have been renationalized since 2013 when they have got into financial difficulties (see section 6.1). Most health facilities have been autonomous state-owned joint-stock companies or limited liability companies since 1997, rather than being the responsibility of local government or the MoLHSA.

2.3 Intersectorality

Intersectorality is not a dominant feature of governance and there is no formal mechanism to take health into account by other ministries and agencies at all levels of government. For example, health impact assessments are not a standard part of policy-making in order to ensure health in all policies. There are some mechanisms for cross-sectoral planning and implementation of health policies (such as the intersectoral ministerial board on tobacco control) but health is not routinely taken into account in policy-making. Similarly, there are no procedures or mechanisms for formal engagement with civil society or the private sector.

2.4 Regulation and planning

Under reforms introduced by the previous government, from 2007 planning and regulation of the health system was left to the market. Currently, infrastructure and capital planning are driven by concerns for equitable geographical access to services but, given the decentralization of the system (see section 2.2), planning in the health system is severely constrained. There is no active planning of health personnel.

Box 2.2

Evaluating priority setting and planning

It is not clear that there are any formal mechanisms for setting priorities in the health system. The Georgia 2020 strategy outlines plans for the health system and priorities for reform, but the scope for planning in the system is greatly complicated by the significant role played by for-profit private actors as providers of medical care, insurance and pharmaceuticals (Government of Georgia, 2013).

Regulation of third-party payers

The SSA, under MoLHSA, was given the administration of the UHCP rather than continuing to use private insurance companies because the profit margins enjoyed by the private insurers were extremely high (30–40% in earlier years and around 18% by 2012). Regulating the private insurance industry is the responsibility of the Insurance State Supervision Service (previously the National Bank of Georgia), which issues licences for insurance companies and, in return, companies are obliged to provide annual reports (Insurance State Supervision Service, 2017). In order to ensure that the insurance companies had sufficient reserves and liquidity, there has been a considerable consolidation since 2008 and there are now six major players in the health insurance market (Imedi L, PSP Insurance, ARDI, IRAO, GPIH and Alpha).

Regulation and governance of providers

Following extensive privatization and decentralization, most providers are independent of government in terms of ownership, governance and management. Private for-profit providers predominate and currently face very light regulation (Hawkins, 2017). Both primary and secondary care providers are often vertically integrated with private health insurance providers and pharmaceutical companies (see also section 5.5). For example, PSP Insurance is a part of PSP Group, which are dominant players in pharmaceutical import and retail in Georgia as well as owning a subsidiary network of service providers; the founders of PSP both sit as MPs. Alpha is owned by Aversi Pharma, which is one of the main pharmaceutical importers and retailers in Georgia and the second biggest domestic manufacturer; its subsidiary, Medalpha health care services, was sold in 2016 (Insurance State Supervision Service, 2017). Imedi L is owned by the Georgia Healthcare Group (GHC), which is one of the largest health care providers in Georgia (23.4% of total hospital bed capacity in the country in 2016) and the largest pharmaceuticals retailer and wholesaler, with approximately 29% market share by revenue in 2016 (Bank of Georgia, 2017). GHC is part of the private Bank of Georgia, which launched on the London Stock Exchange in 2006. These highly integrated ownership patterns are unusual in the European context.

SRAMA is the regulatory agency under MoLHSA, which is nominally responsible for licensing providers according to the Law on the Issuing of Licences and Permits for Business Activities (2005). An overview of the regulation of providers is provided in Table 2.1. From 2008 to 2013, the system was meant to be self-regulating and medical quality was considered the responsibility of professional medical and provider organizations (Gabrichidze, Kechinashvili & Baker, 2011). The Georgian Hospital Association was created in 2009, and was theoretically to be responsible for hospital accreditation; however, it never took on this role. The licensing of all medical providers is the formal responsibility of SRAMA. There was a lack of financial incentives to improve the quality of care and a lack of disincentives to inhibit poor quality (Gabrichidze, Kechinashvili & Baker, 2011). This was also a barrier to the development of evidence-based medical practice in the country. Private insurance companies, in particular, were not inclined to use their power to influence service quality through changes to provider payment mechanisms. While 124 clinical guidelines and protocols were developed and approved by MoLHSA by 2012, there was no mechanism for these to be implemented. It has been one of the areas in the health system where Georgia has been keen to collaborate with international partners to build capacity to regulate the quality of care. As the role of the SSA as an active purchaser develops, there will be

more scope for purchasing decisions to drive improvements in quality of care. For example, as of 2017, new regulations around the monitoring and assessment of quality in perinatal care and regulations in infection prevention and control will allow for selective purchasing of perinatal care and other health services covered under the UHCP.

Table 2.1

Overview of the regulation of providers

	Planning	Accreditation/ licensing	Pricing	Quality assurance	Financing
Public health services	NCDC	–	–	NCDC/MoLHSA	MoLHSA
Primary care	–	SRAMA	SSA	SRAMA	SSA
Secondary care	–	SRAMA	SSA	SRAMA	SSA
Dental care	–	SRAMA	Providers	SRAMA	OOP/VHI
Outpatient pharmaceuticals	–	SRAMA	SSA/suppliers	SRAMA	SHI/OOP
Long-term care	MoLHSA	SRAMA	–	SRAMA	MoLHSA
Health workforce training		MoES	MoES	SRAMA	MoES MoLHSA

Notes: MoES: Ministry of Education and Science; MoLHSA: Ministry of Labour, Health and Social Affairs; NCDC: National Centre for Disease Control and Public Health; OOP: out of pocket; SRAMA: State Regulation Agency for Medical Activities; SSA: Social Services Agency.

Regulation of services and goods

Health technology assessment (HTA) is the systematic evaluation of the effectiveness, costs and impact of health care technology with the aim of informing policy-making. As such, HTA has not been practised in Georgia. The use of assessments developed in other countries is being considered. Decisions on what to include under the UHCP are based on existing entitlements under vertical programmes and affordability.

Regulation and governance of pharmaceuticals

The legislative framework for the regulation and governance of pharmaceuticals consists of the Law on Drugs and Pharmaceutical Activities (1997) and the Law on the Licensing of Medical and Pharmaceutical Activities (2009), which was amended in 2012, 2013 and 2015. Since 2007, SRAMA has been responsible for regulating the quality of pharmaceuticals on the market. The main task is ensuring that pharmaceutical products registered in Georgia meet the criteria for quality, safety and efficacy. SRAMA is also responsible for ensuring that the market is free of counterfeit pharmaceutical products and that physical conditions in manufacturing facilities and retail pharmacies are operating in conformity with established standards. This includes regulating the import, manufacture and export of pharmaceuticals, pharmaceutical registration and the authorization of clinical trials.

It is not clear how effective quality assurance mechanisms are in Georgia given that SRAMA rarely if ever identifies any counterfeit drugs on the market – most checks they conduct are on the conformity of packaging (Tokhadze, 2016). SRAMA received notifications for up to 300 adverse drug reactions (ADRs) in 2016, but the pharmacovigilance system needs refining for it to support the registration process. Records of medication error reporting are unavailable. In essence, the deregulation of the health sector in 2008 included the deregulation of pharmaceuticals and, since 2014, this is one area where MoLHSA has been focusing efforts to improve regulation and governance in the system.

The Law on Drugs and Pharmaceutical Regulation (2009) introduced a ‘recognition policy’, which means that brand name and generic pharmaceuticals that have been accepted by an approved pharmaceutical regulatory body (such as the European Medicines Agency or the national bodies for most European countries as well as the United States of America, Japan, Australia and New Zealand) can be registered in Georgia automatically and do not need extra quality certificates from the producer (Transparency International Georgia, 2012). This has given new import opportunities and allowed importers and wholesalers to access much cheaper medicines directly, while also saving resources in Georgia through the simplified registration process. However, the opening up of the import market has also seen its deregulation and some have expressed concerns about the removal of requirements for traceability and quality standards for importers (Tokhadze, 2016).

Prices for pharmaceuticals are not controlled and ‘clawback’ or ‘reference pricing’ systems are not used. Pharmaceutical costs in Georgia are very high. All drugs are profitable and the wholesale and retail mark-ups are as high as can be borne by the market; consequently, for example, even locally produced generics have a mark-up of close to 100% (Transparency International Georgia, 2012). The average mark-up for medicines in Georgia is 102%, which is considerably higher than elsewhere in the WHO European Region (Gotsadze, 2011). Another issue for pharmaceutical cost-containment and quality of care is that hospitals are free to develop their own clinical guidelines; where the hospital owner is also a pharmaceutical company (as is often the case), treatment protocols will most often give preference to their own products.

Measures to influence the behaviour of those prescribing or dispensing pharmaceuticals did not promote the most cost-effective use of pharmaceuticals (Transparency International Georgia, 2012). For this reason, MoLHSA has been pushing to reintroduce prescriptions for outpatient pharmaceuticals since 1 September 2014, despite very strong resistance from patients who are well

accustomed to freely self-treating with most drugs available on the market without the need to consult a doctor first. It is hoped that stronger prescription enforcement will also support generic substitution to reduce costs, and the provisions for e-prescriptions will be helpful in this regard. E-prescriptions were introduced in Tbilisi in 2016 but they are not compulsory and are not used on a large scale. From 2018, MoLHSA plans to introduce e-prescriptions as criteria for hospitals and polyclinics/family medicine centres if they want to be UHCP providers, gradually making it mandatory across the country by 2020, but many rural pharmacies lack the necessary access to computers. There were some concerns about new ‘pharmacy doctors’ hired to sit in pharmacies and write prescriptions for customers (without examining them first) and other subverting practices that developed in response (Article 42 of the Constitution, Civil Development Agency (CiDA) et al., 2015). But fortunately these practices did not take root.

2.5 Patient empowerment

Patient information

Information on the UHCP has been made widely available, as was information on the MAP programme that preceded it, but research has shown that many households were unaware of their full entitlements (USAID, 2014). This low awareness among the population of entitlements and administrative procedures slowed initial uptake of the UHCP. Entitlements under the UHCP are complex and there is scope for some confusion (see section 3.3). The types of patient information available are summarized in Table 2.2.

Table 2.2
Patient information

Type of information	Is it easily available? (Y/N)	Comments
Information about statutory benefits	Y	It is easily available, but gaps in knowledge persist
Information on hospital clinical outcomes	N	
Information on hospital waiting times	N	
Comparative information about the quality of other providers (e.g. GPs)	N	
Patient access to own medical record	N	
Interactive web or 24/7 telephone information	Y	
Information on patient satisfaction collected (systematically or occasionally)	Y	Occasionally collected
Information on medical errors	Y	For certain cases, such as maternal deaths

Patient choice

Under the UHCP, patients have a lot of choice when it comes to choosing a provider for elective treatment and primary care (Table 2.3). An evaluation of the UHCP found that the free choice of medical facilities and physicians was rated the most positive aspect of the programme by more than half of the respondents (USAID, 2014). However, the mechanisms to provide sufficient patient information to inform such choice are not in place (see Table 2.2 above).

Table 2.3
Patient choice

Type of choice	Is it available? (Y/N)	Do people exercise choice? Are there any constraints (e.g. choice in the region but not country-wide)? Other comments?
Choices around coverage		
Choice of being covered or not	Y	The UHCP is not 'compulsory' – to get the benefit you need to apply for it and prove eligibility.
Choice of public or private coverage	Y	
Choice of purchasing organization	Y	
Choice of provider		
Choice of primary care practitioner	Y	
Direct access to specialists	Y	Where patients pay out of pocket, referrals from primary care are needed under the UHCP
Choice of hospital	Y	
Choice to have treatment abroad	Y	Much of this choice is made possible because such a high proportion is paid out of pocket
Choice of treatment		
Participation in treatment decisions	?	This has not been sufficiently researched to say
Right to informed consent	Y	In theory, but it is not clear if it is realized in practice
Right to request a second opinion	Y	If paying out of pocket this is always an option – less so if covered under UHCP or VHI
Right to information about alternative treatment options	?	This has not been sufficiently researched to say

Notes: UHCP: universal health care programme; VHI: voluntary health insurance.

Patient rights

Patient rights in Georgia are enshrined in law, but there has been little institutional development in this area and, overall, patient rights remain a theoretical concept developed centrally and enshrined in law, but as yet lacking effective implementation mechanisms (Table 2.4).

Table 2.4
Patient rights

	Y/N	Comments
Protection of patient rights		
Does a formal definition of patient rights exist at national level?	Y	Since 2003
Are patient rights included in specific legislation or in more than one law?	Y	
Does the legislation conform with the WHO patient rights framework?	Y	
Patient complaint avenues		
Are hospitals required to have a designated desk responsible for collecting and resolving patient complaints?	N	
Is a health-specific Ombudsman responsible for investigating and resolving patient complaints about health services?	Y	
Other complaint avenues?	Y	Most commonly patients complain directly to MoLHSA
Liability/compensation		
Is liability insurance required for physicians and/or other medical professionals?	N	
Can legal redress be sought through the courts in the case of medical error?	Y	
Is there a basis for no-fault compensation?	N	
If a tort system exists, can patients obtain damage awards for economic and non-economic losses?	N/A	

3. Financing

Chapter summary

- Since 2013, there has been a radical change of direction in health financing policy as a new government embraced the move towards universal health coverage.
- Eligibility for the UHCP is near universal, but within the package of benefits the depth of coverage is greater for lower income households.
- Georgia has made significant progress in improving financial access to health services under the UHCP by reducing OOP spending on services.
- Government health spending has increased significantly under the UHCP, but OOP payments continue to dominate total health expenditure (THE), mainly to cover outpatient pharmaceutical costs.
- Fragmentation in the system has been reduced as the SSA is now the sole purchaser for services provided under the UHCP.

3.1 Health expenditure

It should be noted that there are differences between the national health account (NHA) data for Georgia produced in the country, and those given in the Global Health Expenditure Database (GHED). Health expenditure data in the GHED reflect current expenditure with capital expenditure excluded, so the figures represent different things, but for international comparisons GHED data are used here as they have been similarly adjusted for all countries. Where the discrepancy is large, Georgian NHA figures have also been included. However, per capita rates in the GHED use a denominator (population size) that does not reflect the findings of the 2014 census in Georgia – this means that they are likely to be underestimates.

According to GHED data, current health expenditure (CHE) as a proportion of GDP has fluctuated around 8% since 2000, peaking at 9.8% in 2009 (Table 3.1; Fig. 3.1). CHE as a proportion of GDP in Georgia was 7.9% in 2015, which is slightly lower than most countries of the European Union but substantially higher than most countries of the CIS (Fig. 3.2). However, in terms of PPP, according to GHED data for 2015, CHE in Georgia was relatively low for countries of the WHO European Region at US\$ 718 per capita (Fig. 3.3).

Table 3.1

Trends in health expenditure in Georgia, selected years

	2000	2005	2010	2011	2012	2013	2014	2015
CHE per capita in PPP	179	339	584	570	626	669	726	718
CHE as % GDP	7.4	8.3	9.5	8.4	8.4	8.4	8.4	7.9
Current public expenditure on health as % CHE	15.0	16.3	22.2	18.5	19.6	23.6	28.2	39.5
Current public expenditure on health per Capita in PPP Int\$	27	55	130	105	123	158	205	283
Voluntary Financing Arrangements (VFA) as % CHE	85.0	83.7	77.8	81.5	80.4	76.4	71.8	60.5
Current public expenditure on health as % of General Government Expenditure (GGE)	6.4	6.1	6.4	5.3	5.6	6.9	8.0	10.7
General government expenditure as % GDP	17.4	22.2	33.1	29.1	29.6	28.9	29.9	29.4
OOP payments as % CHE	77.4	79.6	72.7	75.6	73.4	69.1	66.0	57.3
OOP payments as % VFA	91.1	95.0	93.5	92.7	91.4	90.5	92.0	94.8
Private insurance as % VFA	0.5	1.5	3.1	4.3	4.6	5.7	5.5	2.2

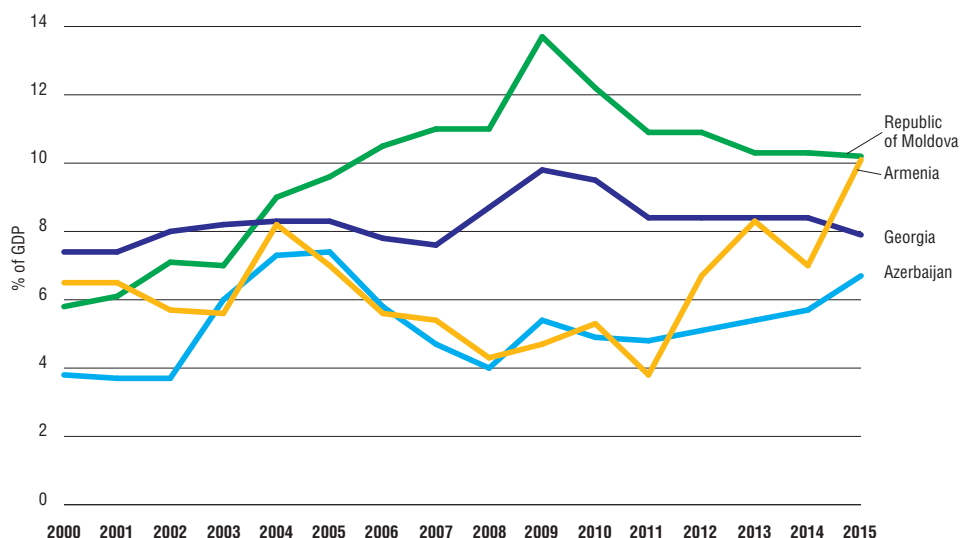
Source: WHO, 2018a.

Notes: CHE: current health expenditure; GDP: gross domestic product; GGE: General Government Expenditure; OOP: out of pocket; PPP: purchasing power parity; VFA: voluntary financing arrangements.

From 2012 to 2015, the health budget almost doubled (from 5.6% to 10.7% of general government expenditure (Fig. 3.5), which is consistent with the international experience of moving towards universal health coverage (World Bank, 2017). This was a significant rate of increase which reflected shifting political priorities towards social spending. Nevertheless, current public expenditure on health as a share of CHE was 22.2% in 2010 and 39.5% in 2015, which was one of the lowest in the WHO European Region (Fig. 3.4). Until 2012, with the introduction of the UHCP, increasing CHE as a proportion of GDP reflected the increasing cost of medical care in Georgia rather than increasing state investment in health care. It is likely that this increase is linked to the financial crisis, which drastically increased the cost of pharmaceuticals; these are predominantly imported and purchased OOP by patients (Mladovsky et al.,

Fig. 3.1

Trends in health expenditure as % GDP in Georgia and selected other countries, 2000 to latest available year



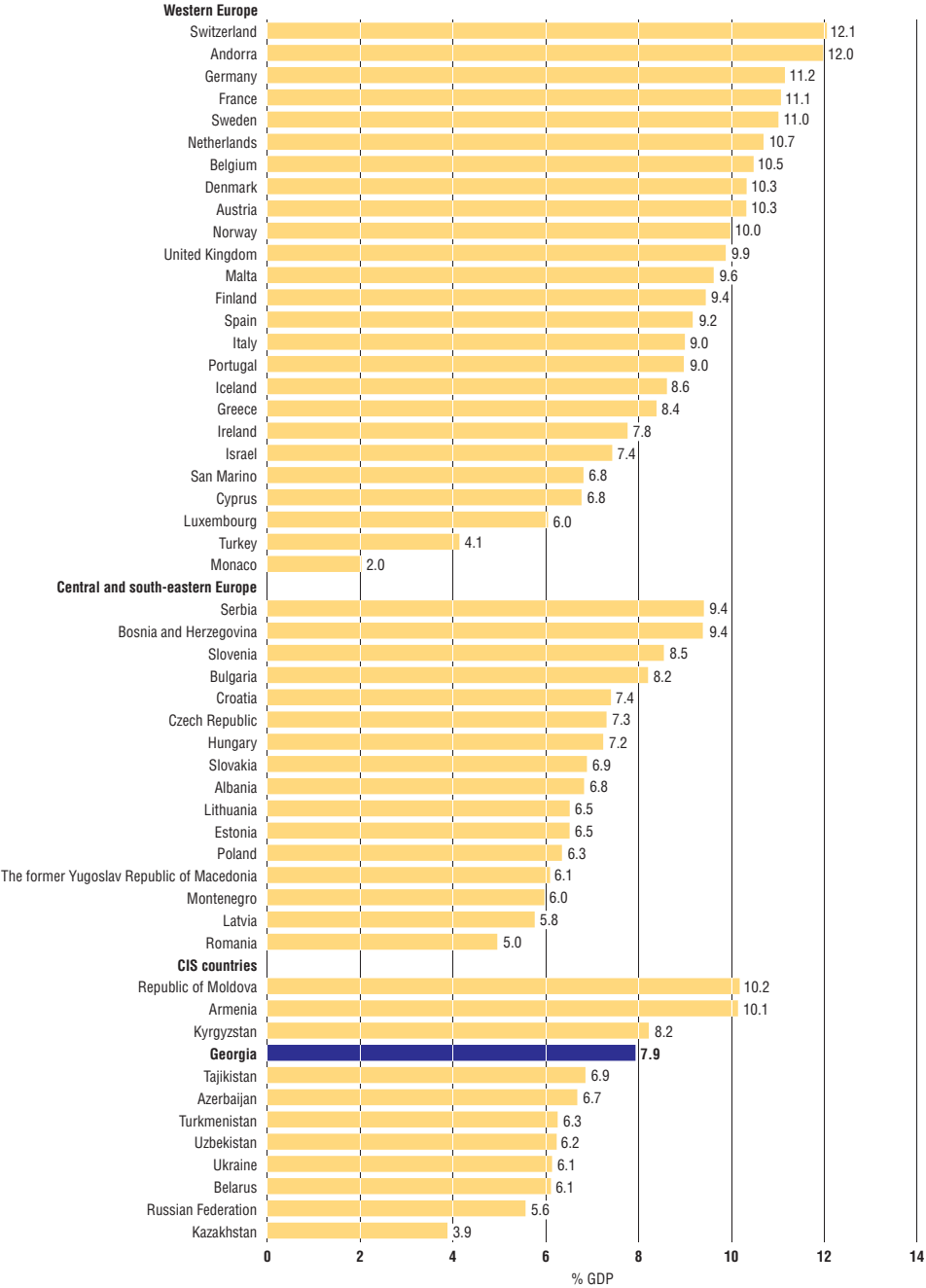
Source: WHO, 2018a.

2012). By contrast, the jump in current public expenditure on health between 2012 and 2013 reflects the rapid extension of health cover by the government as part of a commitment to achieving universal health coverage (Habicht & Thomson, 2016).

In 2013, the UHCP budget execution was much lower than planned (69%), because the UHCP was extended from July but, by 2014, UHCP spending was one third higher than planned. The planned budget was increased by 39% in 2015, but spending was still higher than planned. For 2016, the planned budget was kept at the same level as in 2015 as the fiscal environment was challenging (see section 1.2) (World Bank, 2017). Much of the overspend was due to unanticipated increases in the demand for health care among those who previously lacked cover.

The fiscal context for health expenditure between 2003 and 2012 improved more rapidly than the fall in public health spending may imply. The economy saw relatively strong growth (see section 3.2), and reforms to simplify the tax system increased the government's capacity to collect all taxes, but particularly payroll taxes in the formal economy. Since 2012, the fiscal space has not increased (see section 1.2), but government spending priorities have changed expenditure patterns.

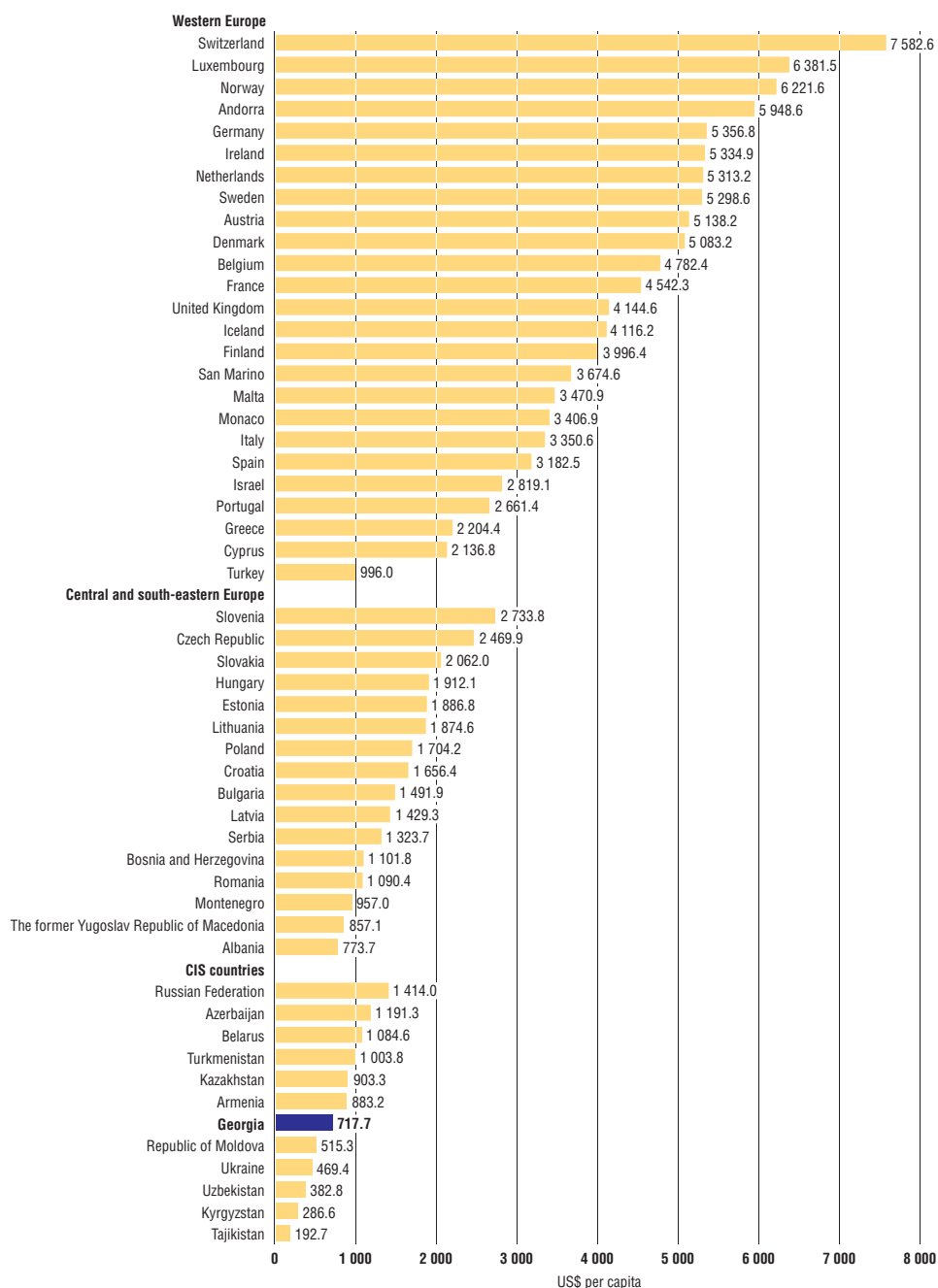
Fig. 3.2
Current health expenditure (CHE) as % Gross Domestic Product (GDP) in the WHO European Region, 2015



Source: WHO, 2018a.
Note: CIS: Commonwealth of Independent States.

Fig. 3.3

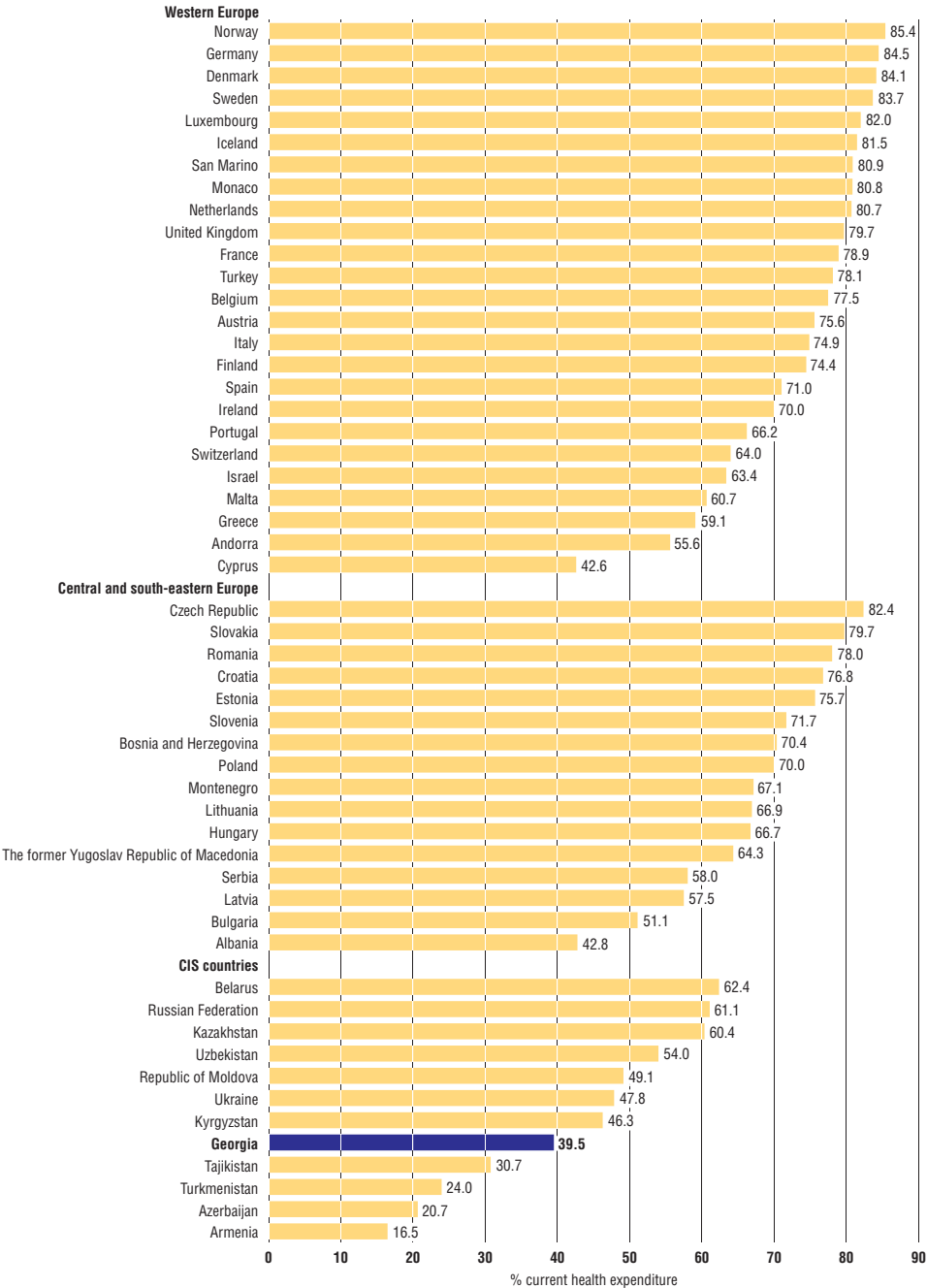
Current health expenditure (CHE) per capita in PPP in the WHO European Region, 2015



Source: WHO, 2018a.

Note: CIS: Commonwealth of Independent States.

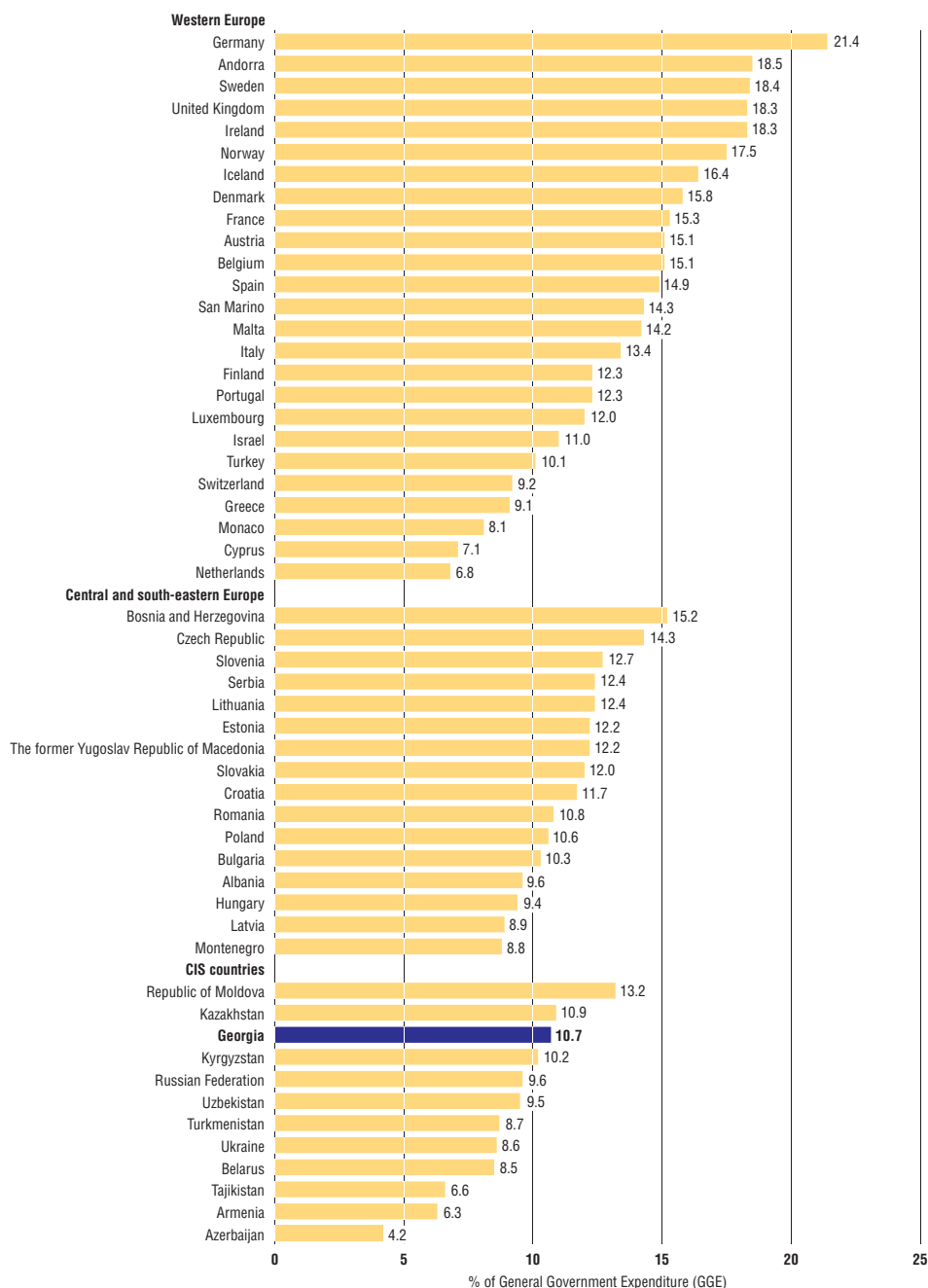
Fig. 3.4
Current public health expenditure as % of Current health expenditure (CHE) in the WHO European Region, 2015



Source: WHO, 2018a.
Note: CIS: Commonwealth of Independent States.

Fig. 3.5

Current public health expenditure as % general government expenditure in the WHO European Region, 2015



Source: WHO, 2018a.

Note: CIS: Commonwealth of Independent States.

Health expenditure by service input is dominated by expenditure on pharmaceuticals, which was 38% of THE by 2015 (MoLHSA, 2018). The UHCP dominates public expenditure on health, accounting for 75% of public spending on health in 2016. Of public spending on health, 67% was on hospital services, while 25% went to primary care providers (World Bank, 2017). With the introduction of the UHCP, there was a fall of 49% in spending on medical goods (mainly pharmaceuticals), which is partly related to generous inpatient care coverage which includes necessary medicines, while benefits for outpatient pharmaceuticals are limited. There was also a 79% fall in administration costs, which were calculated differently to exclude profits from the administration costs of private insurance companies as the system moved to one with a single payer (World Bank, 2017).

3.2 Sources of revenue and financial flows

Although current public expenditure on health as a share of CHE has increased since 2000, it is still low in international comparison, and OOP payments remain the dominant funding mode (57.3% of CHE in 2015), although the share has fallen markedly since the introduction of the UHCP in 2013. A small share of expenditure is on VHI (2.2% of voluntary financing arrangements in 2015) (Table 3.1). The share of VHI in CHE grew as a result of specific policies to boost the market up to 2012, but with the introduction of the UHCP its role in the system was curtailed. In May 2017, the most affluent households (about 43 000 people, whose annual income is above 40 000 Georgian lari (GEL)) were excluded from the UHCP on the understanding that they would purchase VHI (see section 3.5).

Since 2013, state financing for health has grown (from 5.6% of general government expenditure in 2012 to 10.7% in 2015).

Box 3.1

Assessing allocative efficiency

Before the introduction of the UHCP, allocative decisions were left to the market to resolve. Now with government funding for health care increasing, there is renewed focus on encouraging gatekeeping and the utilization of primary care services in favour of specialist care. Nevertheless, the system still incentivizes providers to treat patients at the most specialized levels of the system or in emergency care (see section 5.3). Pharmaceutical policies reintroducing prescription requirements support more rational pharmaceutical consumption, but these policies have faced fierce resistance from patients and pharmaceutical companies.

3.3 Overview of the statutory financing system

Coverage

The Georgian Parliament adopted amendments to the Constitution in October 2017, Article 28 of which now guarantees the right to affordable and quality health care by law. In 2004, the limited social insurance scheme in Georgia, which had been in place since 1995, was abandoned and from 2007 the Georgian government started to introduce an alternative model of financing: purchasing private health insurance using budgetary funds in order to cover the target population (poorest households). The Medical Assistance for the Poor (MAP) programme was rolled out nationwide in 2008 and remained the main statutory funding mechanism for health services until 2013, accounting for 45% of the health budget in 2011 (UNICEF Georgia and University of York, 2012). From 2013, a tightly defined package of benefits was made available to the uninsured population, but this was administered through the SSA rather than private insurance companies. This signalled a fundamental shift in the approach to health system financing. The Basic Package of Benefits introduced in 2013 was subsequently expanded to cover more services under the UHCP. As of May 2017, it is open to all citizens and asylum-seekers who can show they are uninsured and earn less than 40 000 GEL (US\$ 16 000). However, despite recent downward trends, OOP payments remain the dominant funding mode.

Statutory cover in Georgia is strictly defined – in terms of its breadth, scope and depth (Table 3.2). From 2008–2012 comprehensive statutory coverage of services with no co-payments was means-tested and targeted to those households registered as living below the poverty line under MAP. The government also purchased comprehensive private insurance cover for certain other groups (children in care, government workers, teachers and recent IDPs), but the majority of the population had no insurance cover. There were also a number of vertical state-funded health programmes which covered specific services, for example, psychiatric care or HIV/hepatitis/TB treatment, without co-payments. Some other services were part-funded through state health programmes, with patients paying a variable co-payment for specific operations or costs above a certain ceiling (with annual limits). The full list of state programmes was updated annually and the depth of cover fluctuated depending on the resources available and political considerations. From 2010, individuals covered under MAP had the cost of outpatient drugs on the Essential Medicines List covered, but only up to an annual limit of 50 GEL (US\$ 30, about €22).

From September 2012, in the run-up to elections, MAP was expanded to cover all pensioners, children under 6 years old, students and people with a registered disability (about an extra 800 000 people) and this extended coverage to around 45% of the population, but this expansion to other categories of the resident population included greater annual limits on essential drugs benefits and user charges of 10–20% for emergency hospital care, elective surgery, oncology services and obstetric care.

After the elections, from February 2013, the new government signalled a change of direction in health financing policy, introducing a bold programme with the explicit aim of bringing universal health coverage to Georgia. A minimal Basic Package of Benefits covering basic primary care and some diagnostic services (with 20–30% co-payments) as well as emergency care (up to 15 000 GEL or about €6600) was made available for the uninsured population. From 1 July 2013, the Basic Package for the uninsured was expanded to cover elective surgery, oncological services and obstetric care –the UHCP. Initially those with VHI were not eligible for the UHCP, but before May 2017 anyone could apply if they could prove to the SSA that they were not covered by VHI or that their policy did not cover the emergency treatment needed. There is no formal mechanism to detect whether people no longer have VHI because the private insurance companies do not have to report to MoLHSA, but a change in legislation to require such reporting is being discussed to avoid the misuse of public funds (Habicht & Thomson, 2016). By May 2017, the UHCP covered more than 95% of the population, based on the number of persons registered with a primary care provider. From May 2017, the highest earners (around 1.2% of the population) were explicitly excluded from the UHCP and expected to purchase VHI. This reduction in coverage was counterbalanced by an expansion in the package of benefits for those living below the poverty line to cover essential outpatient pharmaceuticals for four chronic conditions (see section 5.5). The package of benefits is currently differentiated by the following population categories, some of which are guided by proxy means testing scores for the targeting of benefits:

1. The target group: households registered as living under the poverty line (<70 000 rating score), artistic laureates and teachers.
2. Other priority groups: people registered as disabled, children under 5 years old, students and pensioners.
3. Uninsured veterans.
4. Citizens with low incomes (70 000–100 000 rating score): those living just above the poverty line, and children aged 6–18 years (1.2 million people ≈ 33% of the population).

5. Other citizens with higher incomes, but below pension age:
 - a) Those earning less than 1000 GEL (\approx US\$ 400) a month or with irregular income/self-employed.
 - b) Those earning less than 40 000 GEL (\approx US\$ 16 500) a year, but over 1000 GEL a month.
 - c) Those earning over 40 000 GEL a year.

The highest income group (5c – earning over 40 000 GEL) constitute around 1.2% of the population and is excluded from the UHCP (Table 3.2). If citizens with higher incomes (5a and 5b) are covered by private corporate or individual health insurance they in essence ‘opt out’ of the UHCP, but they are still covered for emergency care and cancer treatment with variable co-payments (Table 3.2).

Box 3.2

Assessing coverage

From 2013 to May 2017, the Georgian population was covered by a package of services under the UHCP with variable depth of coverage, with around 500 000 people having private health insurance. From July 2017, 43 000 people (around 1.2% of the population) with high incomes have been excluded from the UHCP. While this might not have a big impact on coverage, it has serious implications for solidarity in health care financing.

More comprehensive cover is provided to households living in poverty, as well as some other priority groups including children aged 0–5 years, pensioners and people with disabilities. For the rest, there are no user fees for the primary care or maternity services covered, but patients pay a variable proportion of the costs for inpatient care services (10–30%). Different regions were slower to roll out the UHCP and, in 2015, the number of beneficiaries, as registered with primary care providers, varied from 47% of the population in Racha-Lechkhumi to 94% in Tbilisi and Imereti (Habicht & Thomson, 2016). However, by May 2017, the UHCP had radically increased the breadth of coverage to over 95% of the population, improving access to services and increasing utilization – both for outpatient and inpatient services.

Nevertheless, health system financing in Georgia is still dominated by OOP payments (57% in 2015), two thirds of which are for outpatient pharmaceuticals. Outpatient pharmaceuticals represent one of the biggest gaps in coverage, and pharmaceutical costs can cause impoverishing and catastrophic expenditure for low-income households. Outpatient pharmaceuticals are recognized as being the main gap in coverage, which is why, in July 2017, essential medicines for four chronic conditions were included in the benefits package for the target group (the lowest income households), with a view to expanding this to other groups and diseases as funds become available. This staged roll-out is necessary to ensure the sustainability of the scheme.

As well as the UHCP, the health budget also finances 23 state (‘vertical’) programmes for public health protection (see section 5.1) and programmes for priority diseases and conditions, which seek to provide access to services for the whole population, but with varying depth of coverage. The vertical

Table 3.2
Summary table of UHCP benefits and user charges, December 2017

Service area	Type of user charge	Level of user charge	Coverage categories	Cap on amount the state covers
Planned outpatient care	None	n/a	All groups except 5c	No
	None	n/a	1, 2, 3	No
Outpatient specialist visits	Co-payment	30% of service price	4, 5a	No
	Not covered	n/a	5b, 5c	No
Essential drugs (around 50)	Co-payment	50%	1, 2, 3	50 GEL per year for Group 1 (200 GEL for pensioners under poverty line) and Group 3; 100 GEL per year for pensioners; 50 GEL for children 0–5 years old. Also Group 1 eligible for a package of free essential medicines for four chronic conditions with no co-payments.
	Not covered	n/a	4, 5a, 5b, 5c	No
Diagnostic tests (basic lab tests)	None	n/a	1, 2, 3	No
	Co-payment	30% of service price	4, 5a	No
Diagnostic tests (ultrasound, ECG, x-ray)	Not covered	n/a	5b, 5c	No
	None	n/a	1, 3	No
	Co-payment	Free for most; 10–20% of service price for CT scans	2	No
	Not covered	30% of service price	4, 5a	No
Childbirth	None	n/a	5b, 5c	No
	None	n/a	For all groups	500 GEL per vaginal delivery; 800 GEL per caesarean section
Elective surgery	Co-payment	10% of service price (pensioners)	1, 3	15 000 GEL per case
	Co-payment	20% of service price (children 0–5, students, people with disabilities)	2	15 000 GEL per case
	Co-payment	30% of service price	4	15 000 GEL per case
	Co-payment	500 GEL or 30% of service price	5a	15 000 GEL per case
	Co-payment	1000 GEL or 30% of service price	5b	
	Not covered	n/a	5c	No

Chemo-, hormone and radio therapy	None	n/a	1, 3	12 000 GEL per year
	Co-payment	10% of service price (pensioners) 20% of service price (children 0–5, students, teachers, disabled people)	2	15 000 GEL per year
	Co-payment	20% of service price	4, 5a, 5b	12 000 GEL per year
	Not covered	n/a	5c	No
Emergency outpatient care	None	n/a	1, 2, 3, 4	No
	Co-payment	50% of service price	5a	No
	Not covered	n/a	5b, 5c	No
	None	n/a	1, 3	No
Emergency inpatient care	Co-payment	10% of service price (pensioners) 20% of service price, (excluding intensive care costs) (children 0–5, students, teachers, disabled people)	2	
	Co-payment	30% of service price	4	15 000 GEL per case
	Co-payment	500 GEL or 30% of service price (excluding intensive care costs) 1000 GEL or 30% of service price (excluding intensive care costs) – 10% of service price	5a 5b	15 000 GEL per case
	Not covered	n/a	5c	No

Source: Authors own compilation based on information from MOLHSA.
Note: Here, co-payment means that the user pays a percentage of the service or treatment price, as well as any charges above the cap and charges for services not covered.

programmes include: mental health, diabetes management, child leukaemia services, maternal and child health, dialysis and kidney transplantation, palliative care, and the village doctor programmes. More details on the vertical programmes for communicable diseases (such as HIV, TB and the innovative Hep C programme) are covered in section 5.1.

Collection

In late 2004, a new Tax Code was passed by the parliament to initiate tax reforms promoted by the government. The new Code eliminated a large number of small taxes which were by their nature more nuisance taxes than major revenue-raising instruments. One of the main objectives of the Tax Code reform was to simplify the tax system, making it easier to administer and enforce. Georgia now has only six taxes which all have a flat rate: personal income tax (20%); corporate income tax (15%, but replaced by a dividend tax from 1 January 2017); value added tax (VAT) – 18%; excise duties (on alcohol, tobacco, petroleum products and automobiles); import taxes levied at 0%, 5% or 12% depending on how imports are categorized; and property taxes (up to 1%) levied at the local level. In 2015, VAT was the biggest source of fiscal revenue, providing 40% of the budget, personal income tax provided 25%, corporate income tax 12%, and excise duties 10%. Tax administration has been computerized and electronic filing is now the norm. As a result of these changes, central government tax revenues more than tripled between 2004 and 2007 (Schueth, 2012). The simplified taxation system radically improved compliance, but because they are all ‘flat rate’ taxes, the progressivity of the tax burden is limited. However, a referendum for the introduction of new taxes or tax rate increases on all but customs duties and property taxes is now required under the Liberty Act (adopted in 2009, enacted 2014). This limits the government’s options for raising revenues in times of fiscal constraint. Moreover, the new dividend tax introduced in 2016 to replace corporate income tax is projected to result in tax revenue losses of 1.5% of GDP from 2017 (World Bank, 2017).

Box 3.3

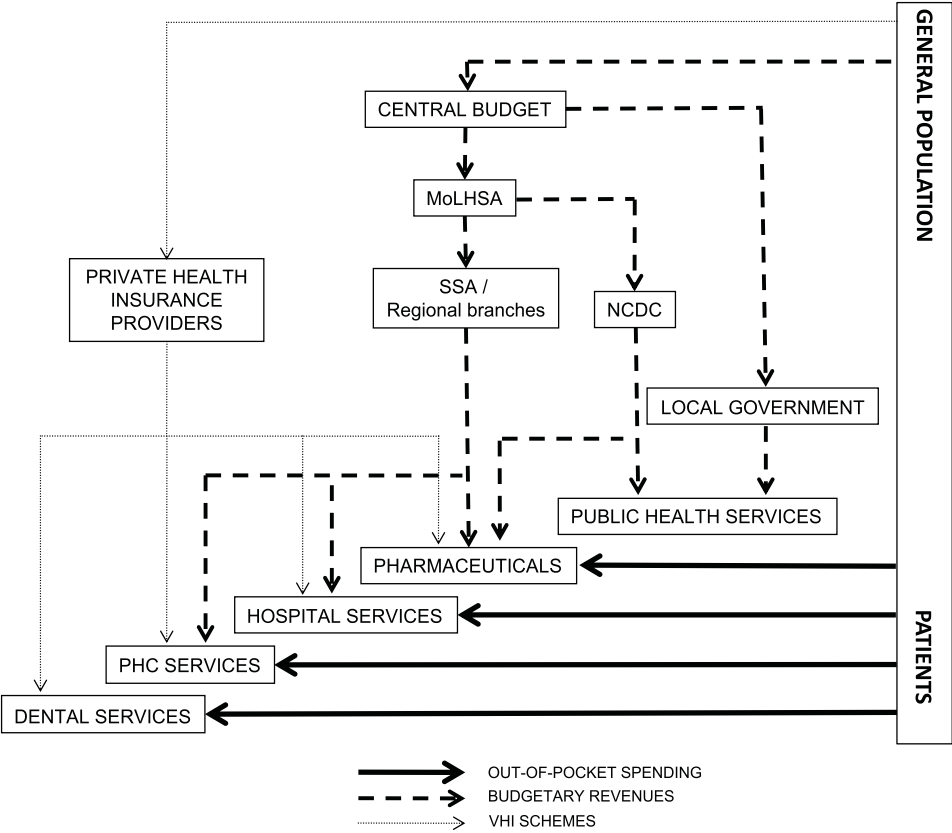
Assessing progressivity and equity of health financing

With the introduction of the UHCP in 2013, health financing has been made more progressive, especially for low-income households that scored slightly too high on proxy means testing to be covered under MAP. However, OOP payments still predominate in THE and these are highly regressive by their very nature. Spending on pharmaceuticals dominates OOP expenditure in both poorer and richer households. This reduces the overall progressivity of health financing in Georgia even though the proportion of OOP health spending fell rapidly after 2013. This is why coverage of essential medicines costs for four chronic conditions was extended to the lowest income group (the target group) in July 2017.

Pooling and allocation of funds

Public funding for personal health services is pooled via the SSA. Government funding for public health services (health surveillance, immunization, etc.) is pooled by NCDC. OOP payments, which accounted for 57% of CHE in 2015, are by definition not pooled. There is also multiple pooling through private health insurance companies, which provide more comprehensive commercial cover for employees in some sectors/enterprises (Fig. 3.6).

Fig. 3.6
Financial flows in the Georgian health system, 2017



Source: author's own compilation.

Revenues from general taxation are brought together in the accounts of the State Treasury of Georgia. The distribution of collected funds to the central and municipal budgets is regulated by the Law on Local Self-Government Budgets (2005) and the Law on Budgetary Distribution of Tax, Non-Tax and Capital Revenues (2007). MoLHSA prepares the budget on an annual basis for publicly

funded health services. As there are no earmarked funds for health, the entire budget has to be negotiated between the MoF and MoLHSA annually. The final decision on the budgetary allocation to MoLHSA lies with the Parliament. Local governments are free to allocate additional funding for health services if such resources are available – historically this happened in Tbilisi and Adjara where the local government extended coverage of the MAP scheme to more households. Local governments may also have special hardship funds to cover some of the health care costs for citizens facing financial hardship.

Priorities for services to be included in the UHCP and vertical programmes are decided by the government in consultation with MoLHSA, and each programme has its own budget. Budgets are set annually. Reallocation of resources between the sectors almost never happens within the budget year. If the government changes its priorities, it is reflected in the next year's budget. Since 2014, the budget allocation for the UHCP is based on the claims reports and expenditures of the previous year adjusted for inflation. Since September 2014, for services purchased under the UHCP, the money is allocated to the SSA, which then reimburses service providers directly. Previously, the premiums were transferred to the relevant private health insurance provider according to place of residence.

Purchasing and purchaser–provider relations

The organizational relationship between purchasers and providers has been shifting from one based on an integrated model to a contracting model. Health workers are not employed by the state but by the health facilities where they work and all health facilities are independent actors. Private health insurance companies purchase services for those with VHI. The most common payment mechanism is 'fee-for-service'. Any services outside the UHCP or VHI cover are purchased by the population from the service provider of their choice in an open market, in most cases through OOP payments.

SSA purchases health care services from service providers; neither legal status, nor the form of ownership matters in the process, so that private and public institutions are considered on an equal basis. The SSA provides a list of prices for hospital services based on nosological groups and per capita rates for primary care services covered under the UHCP. Prices are generally pegged to those reimbursed by private insurance companies. Any provider can apply to provide services under the UHCP to be reimbursed by the SSA at the fixed price. For planned hospital services, patients choose any facility which provides the given procedure (e.g. bypass surgery) and which has agreed to the reimbursement procedures of the SSA (in practice, nearly all facilities do)

in order to benefit from the UHCP. Patients take all necessary documentation to the SSA and receive approval for the service to be performed at the given health care facility.

MoLHSA defines a set of necessary medical interventions and the prices for reimbursement by SSA to service providers under the UHCP. The SSA is not yet an active health service purchaser using selective contracting throughout the system, but more an administrator of budgetary funds. However, in March 2017, the SSA initiated selective contracting for obstetric and neonatal care services based on pre-defined criteria and contractual agreements, which also includes mandatory reporting of quality indicators, with health care facilities providing these services. Selective contracting of health care providers in other clinical areas (e.g. cardiac surgery) is due to be introduced in 2018.

3.4 Out-of-pocket payments

Rising public spending on health under the UHCP has succeeded in reducing OOP spending in the system (from 73% in 2010 to 57% in 2015), but OOP payments still constitute the main source of revenue for health care in Georgia. Since independence, the health sector has been allocated a relatively small budget as a share of GDP. From 2008 to 2012, the emphasis was on targeting these limited resources to the poorest segment of the population. From 2013, the emphasis has shifted to providing universal health coverage, while trying to ensure that the package of benefits fits with the budgetary resources allocated. High OOP spending is incompatible with the goals of universal health coverage because: it creates barriers to accessing necessary health services; absorbs resources, which could be spent more productively; and potentially impoverishes households (World Bank, 2017).

Cost sharing (user charges)

The SSA determines the level of cost sharing for services where patients are expected to co-pay and the annual cap on benefits. The level and amount of co-payment for different services provided under the UHCP is made widely available, but the benefits are not clearly defined or well understood by the general population, which creates an opportunity for facilities to charge the patient for services which should be covered under the statutory package or ‘reclassifying’ a procedure (Smith, 2013). For beneficiaries in the main target group there are no formal co-payments for accessing services. There are no explicit objectives for user charges in the system beyond resource constraint. The cap on benefits (and the requirement of patients to pay the difference

between what the SSA will reimburse for a procedure and what the hospital charges) limits the system's capacity to provide adequate depth of coverage – there is no cap imposed on the level of co-payment patients are expected to pay.

Direct payments

Direct payments are most significant in relation to the cost of prescription pharmaceuticals, particularly in outpatient care, as these have only limited cover under the UHCP, so generally need to be purchased at full price by the patient. In 2015, about 64% of OOP spending was on outpatient pharmaceuticals (equivalent to about 40% of THE) (Habicht & Thomson, 2016). Inpatient pharmaceuticals are covered under the UHCP, but this actually distorts incentives in the system, encouraging patients to use emergency inpatient care rather than primary care services.

Health facilities have established rates for services that are not covered by the UHCP or VHI. The price list for services is called the 'internal standards'. Prices for additional services differ from provider to provider and are mainly based on the perceived purchasing ability of the population served. Direct payments also include payments to private medical professionals providing services out of medical facilities owned by another legal subject.

Informal payments

Following the introduction of MAP and then the UHCP, there is less space in the system for informal payments to occur. There were reports of MAP beneficiaries being charged for services which were officially included in their package of benefits (Smith, 2013).

3.5 Voluntary health insurance

VHI in Georgia has grown as substitutive insurance. The market emerged in 2007/08 as a result of government policy to reduce the role of the state in public life and policies around the targeting of social benefits. The introduction of MAP was a key policy for achieving both these goals and the result was a rapid expansion in the private health insurance industry; prior to this, the VHI market was tiny. In 2011, 69.9% of the population had no insurance cover, while 19.5% were covered under MAP, 3.1% were covered as government employees and 7.5% had VHI, which was either purchased by an employer or self-financed (UNICEF Georgia and University of York, 2012). In 2017, 238 590 people were VHI beneficiaries as employees of the Ministry of Defence and the Ministry of Internal Affairs and other state institutions; around 311 000 were privately

insured, usually through corporate schemes (Insurance State Supervision Service, 2017). Consequently, around 14% of the Georgian population held a VHI policy in 2017. Initially, with the introduction of the UHCP, there was a strong contraction in spending on private health insurance, but from late 2015, there has been some growth in the popularity of supplementary policies in addition to the UHCP to cover gaps such as, for example, dental care.

Under MAP, eligible vulnerable households were initially given a voucher with which they could purchase a comprehensive annual health insurance policy from their choice of competing private health insurance providers (Chanturidze et al., 2009). However, the system was changed in 2010 so that the different regions were each covered by a private insurance company that had won the tender to provide cover for the whole eligible population in that territory. Once a household was registered as falling below a pre-defined income level, they received a one-year insurance policy as part of their welfare benefits package. Because of the MAP programme, until September 2014, most money for commercial insurance companies came from the government budget. However, cover for the target group is now purchased through the SSA and the role of private insurance companies in health financing is once again more marginal.

The private health insurance industry became extremely profitable following the introduction of MAP; profit margins were 18% in 2012, but as high as 30–40% in previous years (World Bank, 2017). This is a key reason why the government of Georgia sought to ‘claw back’ some of the money by obliging insurance companies to become the key investors in infrastructure projects for the regions they covered under MAP (see section 4.1). It was also behind the decision to use the SSA as the main purchaser of services under the UHCP in order to contain costs.

From 2007 to 2013, public policy towards VHI was very supportive as the aim was to develop private health insurance as the backbone of health care financing in the country. Consequently, regulation of the insurance sector and the VHI market was very ‘light touch’ and focused on setting financial standards for entry and operation in the market. For example, insurers are not required to have specific accreditation to provide health insurance. The current legislation does not require open enrolment or guaranteed renewal of contracts. This limits protection for consumers.

3.6 Other financing

Parallel health systems are no longer a significant feature of the health system in Georgia, contributing less than 1% to total health expenditure. Spending on parallel health services is included in government health expenditure figures. External sources contribute more, but the level ebbs and flows depending on the reform projects underway. Since 2010, external sources have ranged from 2–3% of THE. More details on external funding for vertical programmes are given in section 5.1.

3.7 Payment mechanisms

Paying for health services

For services covered under the UHCP, payments are made retrospectively according to the agreements between the SSA and specific facilities. Providers who want to participate in the UHCP have to submit an expression of interest to the SSA to accept the conditions of the Programme. In the UHCP, the money follows the patient, who may freely choose their service provider – this means the SSA does not sign pre-agreed contracts with certain providers and does not negotiate service content or volume but reimburses providers according to agreed tariffs. In future, the SSA will ‘shop around’ to find the best prices for different procedures and contract with facilities according to agreed prices for specific procedures, but it is currently more of a passive purchaser. Private insurance companies generally offer their beneficiaries less choice as they contract with preferred providers. Payments are retrospective except where particular private insurance companies are known to be unreliable; in such cases, facilities expect payment ‘upfront’. Patients can go for treatment at a hospital not covered under their insurance or the UHCP package of benefits, but if the procedure costs more, the patient must pay the difference in price.

Payment for hospital care is case-based and payment rules vary depending on provider characteristics and the type of care provided. The general rule is that if a provider participated in MAP, the SSA tariff does not exceed that paid under MAP by more than 10%. However, new providers can submit their own prices, which has led some legal entities to close and reopen as a new entity in order to charge higher prices. Emergency care can be urgent or non-urgent, and the tariffs are concluded differently; critical and intensive care are on a separate tariff (World Bank, 2017).

A patient awaiting planned surgery must apply to the SSA for prior authorization for it to be covered, at least in part, under the UHCP. This application should contain the hospital documentation, initial diagnosis and expected costs. The SSA then assesses the application (by hand) and issues a voucher guaranteeing payment for the chosen provider. Once the patient goes in for surgery, the provider has to electronically notify the SSA within 24 hours that the patient has started treatment. This notification should include the patient ID, initial diagnosis, case code and expected length of treatment. The providers can modify the case code if necessary after the treatment has been completed, if an additional notification is made. Once the case is closed, the provider submits the bill and a detailed case summary to the SSA for processing. Each notification is hand-checked by a claims adjuster (who is also a medical doctor) to ensure the voucher, notification, costing and case summary all align. In practice, nearly all claims are reimbursed. Providers prefer this system to the one used by private insurers as it uses electronic data exchange and prompt reimbursement (Habicht & Thomson, 2016).

Primary care services funded by the state are prospective at a fixed annual per capita rate, and the individual providers contract with the SSA and private insurance companies to provide services. However, in the statutory system there is a difference in the way urban and rural primary care providers are financed where rural services fall under the Rural Doctors' Programme (see section 5.3). The SSA contracts with primary care facilities rather than individual doctors on the basis of capitation; capitation payments for primary care are not weighted by region, age or any other patient characteristic. Under the Rural Doctors' Programme, doctors receive their payment as a salary. However, no payment of any primary care provider is linked to performance.

Where the patient pays full price out of pocket for treatment, the payment mechanism is quite straightforward. For planned hospitalization and primary care visits the patient pays upfront for the services to be provided according to the price list which is decided at the facility level. For emergency care, hospitals treat first and then invoice patients. Hospital staff are available to meet with the families of patients to explore payment options, such as applying for hardship funds, and major banks have branches in hospitals to process payments. Officially, patients should pay their bills before discharge, but this is not always possible. Individual hospitals are responsible for any budgetary deficits accrued.

Table 3.3
Provider payment mechanisms

<div>Providers</div>	Payers	Planning	Accreditation/ licensing	Pricing	Quality assurance	Financing
Primary care			C, S		OOP	C, FFS
Secondary care			CBF, GB		OOP	FFS
Dentists					OOP	FFS
Pharmacies		FFS	FFS		OOP	FFS
Public health services		S, HI, FFS		HI		

Notes: C: capitation; CBF: case-based financing; FFS: fee-for-service; GB: global budget; HI: historical incrementalism; OOP: out-of-pocket payment; S: salary.

Paying health workers

In general, salaries for health care personnel are not determined by the government or MoLHSA but by their employers – the managers of the health care facilities where they work. Payment is negotiated on an individual basis between health care personnel and facility managers and can be based on workload or an agreed salary, or have elements of both. The SSA defines the price of the service to be paid to the medical facility. The management of medical facilities determines remuneration rates for staff and monthly rates for primary care staff in urban areas. Primary care doctors working under the Rural Doctors’ Programme are salaried at a fixed rate by the SSA.

4. Physical and human resources

Chapter summary

- Georgia still has extensive infrastructure with strong geographical coverage.
- Extensive privatization in the system has had a mixed impact on capital investment.
- Georgia has a large number of doctors per capita, but an acute shortage of nurses.
- The licensing of doctors has been reintroduced, but nurses are not registered.
- CPD is not a mandatory requirement for medical professionals and MoLHSA is working to develop effective CPD systems.

4.1 Physical resources

Capital stock and investments

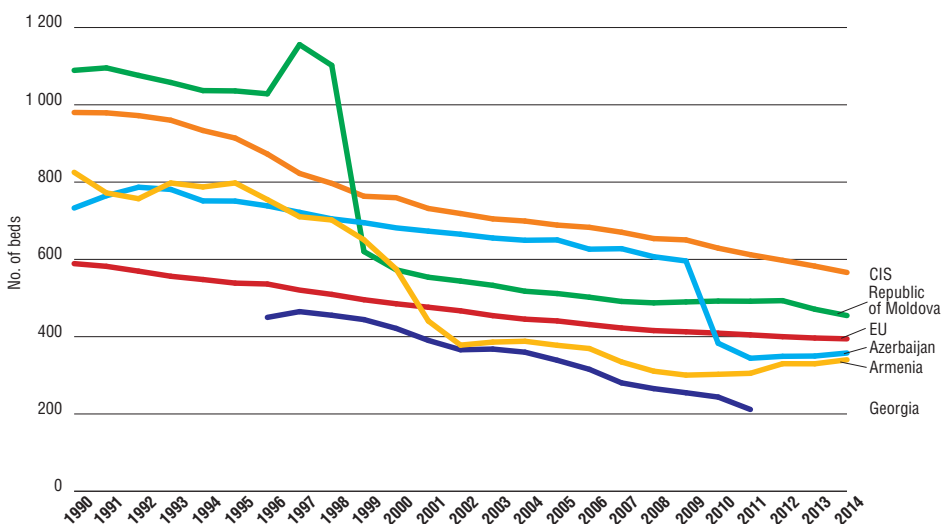
In 2010, the private insurance companies which won the tenders to provide insurance under MAP in the 26 medical regions were mandated to upgrade or construct hospitals and medical centres in their respective territories. The aim was to ensure access to quality health services for the MAP beneficiaries, but it was also in response to what was seen as the significant profits that had been made by the companies through MAP (see section 3.5). As of 2012, 40% of hospitals in Georgia were owned by insurance companies (Patsuria, 2012); other major investors were pharmaceutical companies and real estate developers (see section 6.1). This policy has in effect completed the privatization process which began in 2008, but which stalled as the global financial crisis hit (Chanturidze et al., 2009). About 80% of all hospital beds are private, primary care and outpatient specialists are essentially private, and only a handful of single-profile hospitals (such as emergency care, psychiatry, TB, HIV and the immunology

national centre) remained in the public sector (Smith, 2013). However, ongoing privatizations were halted when the new government was elected in October 2012 and, since 2013, some of the privatized hospitals have been, in effect, ‘renationalized’ as the companies which won the tender to renovate them have failed to deliver on their contract (Nikuradze, 2013). There has also been some de facto nationalization of providers in remote and mountainous areas to ensure access in areas where for-profit private providers would not operate (World Bank, 2017).

Infrastructure For many years, Georgia had a relatively low number of hospital beds in international comparison (see Fig. 4.1). However, since 2011 capacity has grown substantially, from 229 per 100 000 population in 2011 to 310 per 100 000 in 2016 (NCDC, 2017). In 2011, the bed occupancy rate in acute care hospitals was very low. In many post-Soviet countries low occupancy rates can be taken as an indication of remaining excess capacity in the system (Rechel, Richardson & McKee, 2014), but in Georgia in 2011 it was likely indicative of barriers to care. The bed occupancy rate has increased since 2011, from 35.7% to 52% in 2016 (NCDC, 2017). The average length of stay has also been falling and is now among the lowest in Europe, but given that occupancy rates are still low in international comparisons this is unlikely to reflect more efficient bed use as there has not been a parallel rapid improvement in the relevant medical technologies.

Fig. 4.1

Beds in acute hospitals per 100 000 population in Georgia and selected countries, 1990 to latest available year



Source: WHO Europe, 2017.

Existing regulations oblige health care facilities to report health information and medical statistics data. However, the mechanisms for enforcing mandatory reporting are limited. Basic indicators for hospital bed utilization are given in Table 4.1.

Table 4.1

Hospital bed utilization, Georgia, 2006–2016

	Number of hospital beds	Number of beds per 100 000 population	Bed occupancy rate (in days)	Average length of stay	Bed turnover
2006	16 455	374.1	127.8	7.4	17.1
2007	14 565	331.9	146.3	7.3	20.1
2008	14 069	320.9	79.2	3.0	26.2
2009	13 633	309.1	148.2	6.3	23.4
2010	13 378	299.3	160.0	6.4	25.2
2011	12 599	281.0	173.6	7.0	24.8
2012	11 348	252.7	228.9	7.0	32.7
2013	11 600	258.5	181.4	5.4	33.6
2014	11 675	313.3	188.3	5.2	36.3
2015	12 830	345.1	193.3	5.3	36.4
2016	13 840	372.1	189.3	5.0	37.8

Source: NCDC, 2017.

Medical equipment

The purchase of medical equipment is the responsibility of hospital managers and policy-makers and is not limited. The decision is mostly linked to the availability of finances as most hospitals are private enterprises. Current regulations do not set a national ceiling of units per population for high-technology equipment. As a result, there is a significant proliferation, particularly of CT and MRI scanners, in urban areas.

Information technology and eHealth

In the health sector, computer use is much more common in Tbilisi than elsewhere in the country but there is no exact information on the utilization of information technology (IT) at different levels of health care. Deregulation, decentralization and privatization have meant that private insurers and private providers have developed a mix of health information solutions that may not communicate easily with each other (Gabrichidze, Kechinashvili & Baker, 2011). The development and use of integrated IT systems within the health sector is a priority for MoLHSA, and these strategies focus on the services purchased through the SSA. International partners have played a key role in developing the health management information system (HMIS) in place, although the focus of this was on limiting opportunities for fraud in the purchasing process rather than collecting data to improve system performance. More detailed

health services utilization data have been collected since the introduction of the UHCP. Between 2014 and 2016, new technologies of data reporting have been gradually introduced in Georgia. Electronic reporting systems were launched for all in- and outpatient health facilities providing services countrywide, including under the UHCP and vertical programmes. In 2015, a population cancer registry was developed to improve the surveillance of cancer. In 2016, an electronic system for antenatal and obstetric services, the ‘Georgian Birth Registry’, which provides continuous monitoring of pregnant women from the first antenatal visit up until childbirth and discharge from the maternity facility, was launched nationwide. In 2018, the birth registry will be expanded to cover monitoring of children’s health from 0–5 years. This system should allow the SSA to selectively contract with providers on the basis of quality of service delivery as performance indicators can be used.

Electronic data collection has, therefore, improved, but there is a shortage of analytical tools and staff skills for data analysis. eHealth solutions such as clinical decision support systems are not widely used. Tools such as electronic medical records have been developed and piloted in a few hospitals in Tbilisi but have not yet been fully implemented.

Box 4.1

Assessing the geographical distribution of resources

Although there are a large number of trained doctors in the country, they are very unevenly distributed. There is a concentration of doctors in Tbilisi where there are approximately three times as many doctors as in other regions.

4.2 Human resources

Planning and registration of human resources

Since June 2001, in order to attain the right to practise independently, on satisfactory completion of the residency programme, doctors have to sit the Unified State Certification Exams (USCE). The state certificate for independent medical practice is granted in 57 medical specialties. This is an individual certificate that effectively allows doctors to undertake independent medical practice within specialist boundaries as defined by the residency programme. The certificate is valid indefinitely as re-certification was abandoned in 2008. MoLHSA has been discussing new mechanisms for the re-certification of medical professionals. There is a centrally managed register of all doctors with SRAMA. Doctors can lose certification for malpractice and this information is reflected in the register.

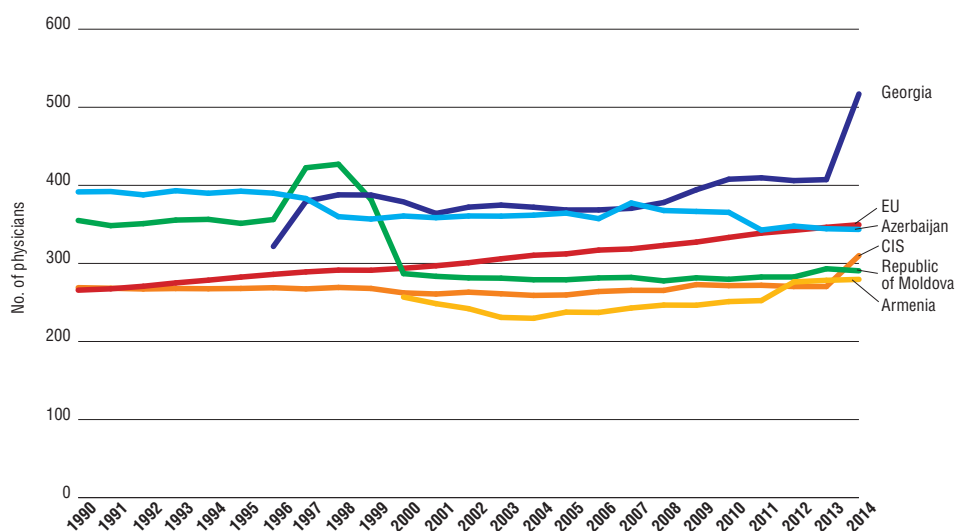
Certification exams are held twice a year (in spring and in autumn). An applicant who fails the exam can take it again at the next sitting. There is no limit on the number of times a candidate may sit the examination. There are no numerical entry restrictions or quotas for this exam, which is very much a memory test rather than a test of whether a doctor's competence or skills are 'fit for purpose'. Ensuring the quality of human resources in the Georgian health system poses significant challenges to the health sector and is a priority in the work of MoLHSA/SRAMA.

Trends in the health workforce

Georgia traditionally had high levels of medical staffing, particularly doctors, even compared with other states of the former Soviet Union, a trend that has continued since independence (Fig. 4.2). By contrast, the number of nurses has decreased dramatically since independence; by 2012, there were just 0.3 nurses per 1000 population (Fig. 4.3), which is the lowest level for all the post-Soviet countries. In 2016, according to national health statistics, it was 0.5, but the denominator was smaller. The increase in the number of doctors, nurses and dentists per capita working in the Georgian health system between 2013 and 2014 is also an artefact of the denominator (population size) being revised downwards in the light of findings from the 2014 census (Figs. 4.2–4.4). The number of nurses in Georgia is low, reflecting the very low status of nursing

Fig. 4.2

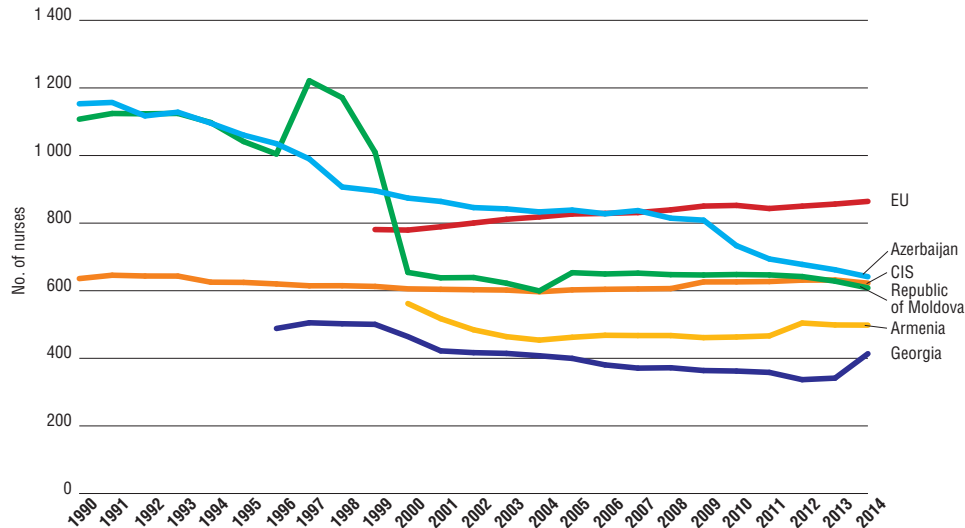
Number of physicians per 100 000 population in Georgia and selected other countries, 1990 to latest available year



Source: WHO Europe, 2017.

Fig. 4.3

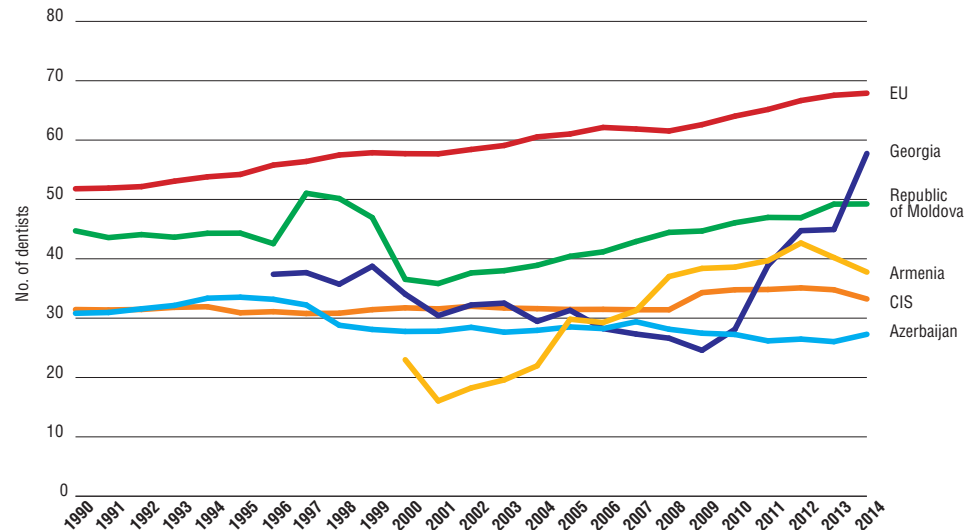
Number of nurses per 100 000 population in Georgia and selected other countries, 1990 to latest available year



Source: WHO Europe, 2017.

Fig. 4.4

Dentists (PP) per 100 000 population



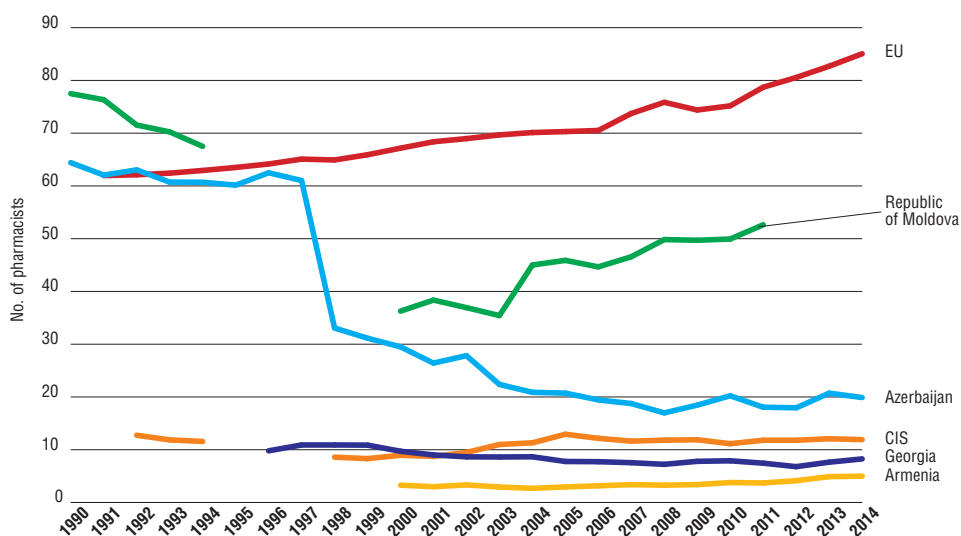
Source: WHO Europe, 2017.

as a career. Indeed, in 2016, there were more doctors working in Georgia than nurses, which has significant implications for human resources planning and policy. In comparison with western European countries, the balance between the number of doctors and nurses is reversed.

The number of pharmacists counted as working in the system is likely to be an underestimate of the true number as most work in the private sector and these are not counted in the official statistics (Fig. 4.5). The number of pharmacists working in the private sector is underreported. In 2016, there were only 315 pharmacists recorded as working in the system, but 488 pharmacists graduated in that year alone.

Fig. 4.5

Pharmacists (PP) per 100 000 population



Source: WHO Europe, 2017.

Professional mobility of health workers

The professional mobility of health workers is not something which has been monitored closely, particularly as there is a considerable oversupply of medical graduates annually.

Training of health personnel

Undergraduate education involves studying general medicine as a foundation for further, more specialized, study. The period of study is 6 years. Historically there have been problems with quality assurance in medical education in

Georgia (Chanturidze et al., 2009), and there is still a need for strict accreditation of faculty programmes and basic standard setting in medical education. Unified national university entry exams have been in place since 2006. The successful candidates are granted higher education vouchers. Depending on examination results, the state covers 100%, 75% or 50% of the cost of study. The number of fully or partially financed places depends on the availability of budget funds. There is no evidence of any manpower planning process in terms of defining the future numbers of graduate doctors needed (as cohort output numbers) and then planning the required cohort input numbers to be funded by the state.

Specialized medical training in Georgia is primarily organized through residency programmes for each medical specialty and the number of years for residency training varies across specialties. The state has not provided general financial support for residency education since 2005. However, in 2015, state funding for residency programmes in priority medical specialties for medical doctors to serve in high-mountainous and border territories for a defined period of time was introduced. The number of residency places is determined by accreditation of medical universities/medical facilities for postgraduate medical education programmes. The number of postgraduate medical education places is determined through accreditation. The selection of candidates for residency programmes is undertaken competitively through an entrance examination.

Continuing professional development (CPD) is not a requirement for doctors practising in Georgia and the government has not funded any CPD from about 2004. In the absence of government-funded CPD, doctors themselves or their employers paid to attend short courses, conferences, etc. However, attendance at such events is most often funded by pharmaceutical companies (Gotsadze, 2011).

Nurses in Georgia are trained in vocational schools across the country. Entry to these programmes can be from class 9 (age 15), when students follow a 3-year programme, or from class 11 (age 17), in which case the programme is 2 years. Since 2011, nursing education has also been provided as a baccalaureate programme in universities. However, the status of nursing is very low and is not regarded as a profession in the Georgian context (Nishiyama, Wold & Partskhlaze, 2008). There is no specialization, licensing or continuous medical education for nurses in Georgia. Overall, nursing education lacks standardization, there is no accreditation for nursing schools, and minimum training requirements vary widely (Kurth et al., 2016).

5. Provision of services

Chapter summary

- Public health services have been strengthened in recent years, particularly with regard to communicable disease control.
- Georgia is the only real-world setting where a comprehensive HepC elimination programme has been implemented with steady progress.
- Primary care is still weak and there is a strong patient preference for accessing the system at more specialized levels of care.
- There are concerns about the quality of care provided in hospitals.
- The pharmacy network is extensive but the supply of pharmaceuticals is expensive.

5.1 Public health

The government health budget covers the public health protection programmes. Administration of these programmes is a core function of the National Centre for Disease Control and Public Health (NCDC). The NCDC is a network of nine regional Centres for Public Health, employing around 400 personnel; it is also the body with primary responsibility for biosecurity and meeting the requirements of International Health Regulations (IHR) (Bakanidze, Imnadze & Perkins, 2010). As part of the Cooperative Biological Threat Reduction Programme (2004–2012), the regional laboratory network (biosafety level 2) started operation – with two Zonal Diagnostic Laboratories (ZDL) and seven Laboratory Support Stations. These are the regional part of the NCDC that provide support to municipal centres (61 centres subordinated to local government with 1020 staff in total). In line with the ‘One Health’ principle, they also cooperate closely with 11 veterinary labs under the Ministry of Agriculture. The R. Lugar Centre for Public Health Research also plays a key role, as it has the only Biosafety Level 3 laboratory in the South Caucasus Region.

The NCDC implements 10 vertical state programmes for public health protection and health promotion, covering:

- early detection and screening for diseases
- immunization
- surveillance
- blood safety
- prevention of occupational diseases
- TB management
- HIV/AIDS management
- mother and child health
- health promotion
- hepatitis C management.

Since 2009, there have been focused efforts to improve the surveillance system for communicable diseases. The primary instrument for disease surveillance is now the national guidelines, which outline how to identify and register, confirm and classify, notify and report communicable diseases; how to analyse data; how to investigate outbreaks; and how to use available information for making decisions to prevent and control infectious diseases. The NCDC determines and updates the list of notifiable diseases annually on the basis of the current epidemiological situation. The operational information on 72 notifiable diseases and conditions through the Electronic Integrated Disease Surveillance System (EIDSS) accumulates in the NCDC. Individual health care facilities are formally responsible for notifying public health centres of any clinically diagnosed or laboratory-confirmed cases. Pandemic preparedness planning has been shown to be effective in Georgia following significant international donor support in the wake of the 2006 avian influenza pandemic (World Bank, 2011). It is extremely likely that the emphasis on strengthening pandemic influenza preparedness also strengthened disease surveillance more broadly.

The Global Health Security Agenda (GHSa) was launched in February 2014 to advance worldwide safety and security measures to protect nations from infectious disease threats. Georgia is actively involved in support of the 11 Action Package objectives, ‘Real Time Surveillance’ (as a leading country), ‘National Laboratory System’ and ‘Zoonotic Diseases’ (as a contributing country). NCDC is also accessible at all times for communications with the WHO IHR contact points and with the national surveillance and response

system. A 24/7 duty officer system is in place. A communication list with contact details for all relevant institutions, organizations and persons at national, regional and local levels is prepared and updated regularly.

In 2014, the Georgian government paid for the vaccine ‘cold chain’ to be fully updated to improve the efficacy and safety of the immunization programme; having graduated from Gavi, the Georgian government is now financing its immunization programme independently. All vaccinations and immunizations included in the national vaccination calendar are free for the population. Vaccines are purchased centrally to guarantee their quality and safety. In Georgia, measles registration and epidemiological surveillance are obligatory. In 2004 and 2013, there were outbreaks of registered measles cases. The peak in 2013 was caused by the failure of a mass immunization campaign in 2008, which left particular cohorts unimmunized. The subsequent measles outbreak was concentrated among the under-1 and 15–30 years age groups. Since 2013, additional campaigns have been implemented to halt the epidemic including the completion of the anti-measles vaccination course for children aged 14, and additional vaccination for the population aged 15–30, health professionals and some other specific groups. In 2013–2014, about 150 000 people were vaccinated and the number of measles cases in the country significantly decreased.

Continuous provision of the anti-rabies serum (immunoglobulin) and rabies vaccines provided a good foundation for reaching zero incidence of rabies in humans. In 2015, this happened for the first time since 1990.

Since April 2015, in collaboration with the US Centers for Disease Control and Prevention (CDC), WHO, pharmaceutical manufacturers and other international partners, the country has implemented an elimination of hepatitis C (Hep C) vertical programme. The aim is to achieve a 90% reduction in prevalence by 2020 (Gvinjilia et al., 2016). Georgia has a high prevalence of Hep C resulting from inadequate infection control in health care settings and unsafe injection practices among PWID. In 2015, NCDC determined through the population-based survey that 7.7% of the adult population were living with Hep C. The Hep C vertical programme was the fourth biggest by spending in 2016 (World Bank, 2017). Most of the high-cost pharmaceuticals used to treat the condition were donated by the manufacturer, but additional drugs were purchased by the Georgian government and provided free of charge as clinically indicated. By December 2016, there were 27 treatment centres across Georgia, employing over 100 clinicians to oversee the treatment programme (Nasrullah

et al., 2017b). A sliding scale of co-payments was used for diagnostics and clinical monitoring, with local government or MoLHSA paying the balance. The screening programme began in January 2015 and Hep C antibody testing is provided free of charge; confirmatory testing is subject to user fees.

The Hep C programme has made determined progress towards its goal (by 2017 ~30% of the estimated population living with Hep C in Georgia had received treatment), but challenges remain, as noted in the MoHLSA Strategic Plan for Elimination of Hep C in Georgia (2017). The first tier of people who know they have Hep C and are motivated to treat it have been through the system, so now it is necessary to identify those unaware of their status and reach out to the most at-risk populations (Nasrullah et al., 2017a). The comprehensive strategy also highlights the need to prevent new infections from occurring by improving the safety of the blood supply, ensuring infection control in health care settings and providing harm-reduction services for PWID. Georgia is the only real-world setting where a comprehensive Hep C elimination programme has been launched (Nasrullah et al., 2017a).

Other communicable diseases are also dealt with through vertical programmes, which are often conducted with support from international partners. The TB programme ensures broad access to diagnosis and treatment, with support from international donors particularly for the control of MDR-TB. The UHCP opened up new opportunities for developing an integrated model for TB service delivery to promote sustainability and improved health outcomes. The prevention, detection and treatment of HIV is similarly funded through a vertical programme and antiretroviral (ARV) treatments have been made available to all registered patients. The difficulty is that almost a third of new cases are identified at a late stage when the person has already developed AIDS. The TB and HIV programmes have benefited from significant support from the Global Fund but, from 2015, Georgia has started transitioning to government funding for the procurement of first-line TB and HIV medicines.

As regards NCD, a tobacco control strategy with an action plan for 2013–2018, plus the Georgian Tobacco Control Law, which passed in the Parliament in 2017, fully implement the Framework Convention on Tobacco Control (FCTC) and have started a large-scale anti-tobacco campaign. A national health promotion strategy for 2014–2019 and a health promotion programme (with a tobacco control component) had also been developed by 2017 (see section 1.4).

Box 5.1**Assessing the effectiveness of public health interventions**

Most recent efforts in public health have focused on strengthening preventive care and treatment for communicable diseases, most notably Hep C, HIV and TB. For vaccine-preventable diseases, official immunization rates were 85% for measles and above 90% for diphtheria, tetanus and pertussis in 2015. As is the case in many countries of Europe, vaccine services have had to deal with public trust issues but in Georgia they have also had to overcome systemic weaknesses in the basic infrastructure (see section 1.4).

Interventions that address risk factors for NCD have received less attention, but full implementation of the Framework Convention on Tobacco Control is now a political priority. This is important because Georgia has some of the highest smoking rates in the world.

5.2 Patient pathways

In essence, there are three patient pathways in Georgia: the route for those covered under the UHCP and some vertical programmes; the route covered by VHI; and the private ‘out-of-pocket’ route. The route taken also depends on the condition (i.e. whether or not the condition is covered under the particular insurance package or under the UHCP – or other – programme). Patients can access inpatient treatment covered under the UHCP while bypassing primary care. For inpatient services under VHI, a referral from a registered primary care provider is needed. The bypassing of primary care entirely is common and there is a strong patient preference for accessing care at more specialized levels (Smith, 2013). Access to essential medicines is also cheaper in emergency and inpatient care settings.

Under the UHCP, in order to get a planned hospital service, the patient chooses the provider and they or the medical facility are required to submit the necessary documentation to the SSA for authorization. Once authorized, the patient is issued with a voucher that also indicates what proportion of the costs will be covered by the government and how much the patient is expected to pay (generally between 10% and 30%). Previously, patients under VHI had more choice of provider, but now many providers are integrated with private insurance companies and these tend to have preferred providers, thus limiting patient choice. Some primary care doctors are also employed or subcontracted by inpatient care providers and they do proforma referrals to their allied hospitals. As with the UHCP, many VHI packages and vertical programmes are not totally comprehensive, and many interventions are still not covered.

Patients are free to self-refer to any service provider but the patients then bear the full cost of care themselves. The scope for self-referral makes it difficult for primary care physicians to coordinate care.

Box 5.2

Patient pathway, example from Georgia

In Georgia, under the UHCP, a woman in need of a hip replacement because of arthritis would take the following steps:

- During a free visit to the GP with whom she is registered, the GP refers her to a hospital orthopaedic department or the patient goes direct to a hospital orthopaedic department.
- She has a free choice of any hospital that contracts with the SSA for treatment. Her choice of provider is shaped by the advice of peers/family and the primary care doctor.
- After choosing the medical facility, all necessary documentation is submitted to the SSA by the hospital or the patient for approval under the UHCP. If it is approved, she is issued with a voucher to cover all, or a predetermined proportion, of the costs – up to a specified ceiling (15 000 GEL). Any charges above this level are uncapped and the user pays.
- She is very unlikely to have to join a waiting list for her operation or for an appointment with a specialist.
- The cost of diagnostic tests such as x-rays are mostly free of charge for all. State coverage of such diagnostic tests is also not capped.
- If she is registered as living in poverty, the full cost of surgery is covered up to 15 000 GEL; if she is a pensioner, the required co-payment is 10% of surgical costs; and if she falls into another category of universal health coverage recipients, the co-payment is 30% of service price plus any charges above the reimbursement ceiling.
- Following surgery and primary rehabilitation at the hospital, the patient goes home to the care of her family.
- A follow-up hospital visit is likely to take place to check the treatment's outcome.

5.3 Primary/ambulatory care

From 1997, all health service providers were incorporated under commercial law, including primary care facilities. A few registered as limited liability or joint stock companies as separate entities, but most grouped together to create one legal entity (e.g. polyclinic–ambulatory unions, hospital–polyclinic unions, etc.). As a result, there is a variety of primary care service providers across the country. For example, in the Kakheti region, as in many other regions, the village ambulatories within rayons were grouped around the rayon polyclinic,

forming polyclinic–ambulatory unions, or sometimes ambulatories were grouped around the rayon hospital, forming a hospital–polyclinic–ambulatory union. By contrast, in the Imereti region, even the small village ambulatories were registered as independent legal entities. Since 2012, many primary care service providers have been integrated with private insurance companies and are now essentially ‘owned’ by the local hospital. This has created perverse incentives as the way primary care is funded (capitation) relative to hospitals (fee-for-service) means that the integrated purchaser/providers make more money through treating patients in hospital rather than in primary care.

From 2009, in rural regions, individual doctors became budget holders and the SSA started to contract with them directly rather than working through the rayon polyclinics under the Rural Doctors’ Programme. This has been highlighted as one factor in the deterioration of mortality data in Georgia as these doctors are no longer ‘controlled’ (audited) locally (MoLHSA, 2011). The Rural Doctors’ Programme was set up in 2008 to upgrade facilities and health workforce skills in primary care facilities in about 900 villages; it covers around 1.1 million people living in rural areas. However, as a vertical programme, it runs in parallel with the rest of the primary care system and this has caused some administrative challenges.

Under the UHCP, all beneficiaries have to register with a primary care provider somewhere in the country. This does not apply to those covered by VHI and about 80% of the Georgian population is registered with a primary care provider (Habicht & Thomson, 2016). Registration involves a signed agreement and patients can change their primary care provider once every two months, which is unusually frequent. The patient lists are held electronically and used by the SSA to recalculate the monthly capitation payment, unless the provider is an individual doctor covered by the Rural Doctors’ Programme as they are salaried. The salary level is quite high relative to the number of patients these doctors have on their lists and they are paid more than doctors working elsewhere in primary care.

People living in rural areas are also registered with the rayon polyclinics to get access to outpatient prescriptions reimbursed under the UHCP, because prescriptions from clinicians under the Rural Doctors’ Programme are not covered by the UHCP. This administrative anomaly means that patients have to bypass their rural doctor and pay OOP to visit the rayon polyclinic to ensure the prescription costs can be reimbursed under the UHCP. For people living in rural areas, this presents a major geographical and financial barrier to

accessing essential medicines and helps to explain why less than 0.5% of the UHCP budget has been spent on essential medicines since 2013 (Habicht & Thomson, 2016).

Family medicine was recognized as a specialty in 1998 and an exam for primary care specialists was introduced in 1999. This also explains why the staffing of primary care facilities is diverse with a mixture of family doctors, district internists/paediatricians and narrow specialists. Most facilities with family doctors are in various pilot regions for international aid programmes and these are the ‘new’ facilities which are most recently refurbished. Apart from these centres with upgraded facilities, the rest of Georgia has services provided by the ‘old’ primary care polyclinics. There is no explicit definition of the services to be provided at the primary care level. Overall, patients have little faith in the primary care system and there is a strong preference for seeking care at more specialized levels of the system.

Services which fall outside the UHCP or VHI cover are provided by the same staff in the same institutional settings on a fee-for-service basis. Managers are free to charge uninsured patients for non-state funded services according to an internally determined price list. The OOP cost of seeking care led to a serious decrease in the uptake of all kinds of medical services, and even the uptake of services which, by definition, should have been provided for free has declined since independence. Utilization increased from 2.1 outpatient contacts per year in 2010 to 4 contacts per year in 2015 according to data collected by NCDC. Some of this increase is due to the inclusion in the UHCP of primary care without co-payments for all but the highest income group (see section 3.3), but most influential has been the enforcement of prescription-only regulations in the dispensing of medicines since 2014. Nevertheless, primary care utilization rates remain low in comparison with other countries in the WHO European Region (WHO Europe, 2017).

Box 5.3

Assessing the integration of care

Integration of care is on the reform agenda in Georgia and there have been some efforts to integrate care through, for example, the perinatal regionalization programme. A diabetes management pathway is currently under development with assistance from WHO.

Box 5.4**Assessing the strength of primary care**

The weakness of primary care can be seen in the relative utilization of primary care and inpatient services – the number of outpatient visits per capita is low and well below the European Union (EU) average, while the number of inpatient procedures is high and well above the EU average (World Bank, 2017). Although most primary care services are now covered under the UHCP, quality is a factor determining the low utilization of primary care in the Georgian health system. The quality of services provided at the primary care level is perceived to be low and there are concerns about perverse incentives with regard to referrals and prescriptions by primary care providers. These perceptions limit the gatekeeping capacity of primary care doctors, despite a referral for specialist care being a requirement under the UHCP. Further strengthening of primary care is a core necessity in order for the country to better meet the health needs of the population in view of the growing burden of non-communicable diseases (World Bank, 2017).

5.4 Specialized ambulatory care/inpatient care

Specialized care in Georgia is provided by secondary and tertiary care institutions – general multi-profile and referral hospitals, scientific-research institutes, specialized hospitals and specialized clinics (dispensaries). Very few hospitals are in public ownership as successive waves of reforms have increased the autonomy of hospitals, with full-scale privatization occurring between 2008 and 2012 (see sections 4.1 and 6.1). There is relatively good geographical coverage of specialized services, but tertiary services are concentrated in the big cities.

It is hard to assess the quality of specialized care because the nature and availability of data on hospital performance are so limited; for example, no standard patient safety indicators are collected. Waiting times for treatment are not an issue. Utilization of inpatient care is high relative to the utilization of primary care. As the UHCP increased access to services, there was a jump in utilization because the system had to cope with a lot of previously unmet need. According to NCDC data, in 2015, there were 11.9 hospitalizations per 100 population, which is low in comparison with other European countries (NCDC, 2017).

Box 5.5**Assessing appropriateness of care**

Incentives in the system under MAP meant that it was likely that there was over-provision of care for patients paying OOP, but there was also some evidence of under-provision of care for MAP beneficiaries as hospitals sought to contain costs by discharging patients early or by choosing not to perform expensive diagnostic tests even when clinically indicated (Zoidze et al., 2012). More research is needed to assess the appropriateness of care under the UHCP.

Box 5.6**Patient evaluations of the care they receive**

Patient reported outcome measures (PROMs) are not in general use in Georgia, and user experience surveys have not been collected routinely as part of health system monitoring, but survey data have shown that between 2001 and 2010, overall satisfaction with the health system increased from 8% to 44.1% (Footman et al., 2013). Although most people were dissatisfied with the health system, there was a marked improvement. It would appear that satisfaction with the health system has grown further since the introduction of the UHCP in 2013 (USAID, 2014). Survey data show that patients appreciate the level of choice in the system and improved access to specialist services, but dislike making co-payments and the limitations on the services covered – particularly for pharmaceuticals and dental care (Verulava, Jorbenadze & Barkalaia, 2017).

5.5 Pharmaceutical care

Pharmaceutical care is mainly provided on a commercial basis. Pharmaceuticals are an important part of the Georgian economy, and the pharmaceutical sector is one of the largest private employers in Georgia. In 2014, over 13 000 people were employed in pharmaceutical retail and wholesale, and the annual wholesale and retail turnover of pharmaceutical products was nearly 2 billion GEL. The whole pharmaceutical sector in Georgia remains highly profitable and is growing. The import of pharmaceuticals used to be dominated by just two companies, but regulatory changes have brought other companies into the field, and with the expansion of the Hep C programme, the state is now the biggest importer by value – in 2015, the share of state imports in total imports was 63%, having previously been no more than 2% (Tokhadze, 2016). The SSA is the main importer of pharmaceuticals among state actors.

As of January 2017, the retail pharmaceutical market is dominated by four main players (down from five in 2016), which control around 70% of the total market (GEPHA (part of GPC), PSP Pharma, Aversi Pharma and GlobalPharmi). Aversi, PSP and GPC are also major investors in the hospital network following privatization, as well as being major providers in the private health insurance market (see section 2.4).

There are 78 domestic drugs manufacturers in Georgia, but Aversi and PSP (under its manufacturing brand GM Pharmaceuticals) account for over 90% of all pharmaceutical production by value (Tokhadze, 2016). Of the pharmaceuticals manufactured in Georgia, 60% are exported, mainly to Azerbaijan, Armenia and Uzbekistan. Locally manufactured medicines account for just 10% of medicines sold. Both Aversi- and PSP-owned manufacturers are ‘good manufacturing practice’ (GMP) compliant, but they receive their GMP certificates from a private auditor as there is no state GMP-certifying agency in Georgia. The creation of an international GMP standards inspection body has been discussed for many years. MoLHSA is in the process of developing a detailed implementation plan for GMP, including the creation of a GMP inspectorate within SRAMA. The plan is to have a fully functional GMP-certifying agency by 1 January 2022. In import and distribution, PSP had 22.3% market share in 2015; Aversi had 14.5%; while GPC and ABC Pharmacy (which merged as GEPHA in 2017) had 25.1% of the market together. There are approximately 2400 retail pharmacies in Georgia, 46 of which have two or more outlets, and there are five pharmacy ‘chains’ with 30 or more outlets. The biggest chains belong to Aversi, PSP and, now, GEPHA.

All pharmaceuticals prescribed as part of outpatient care are purchased by patients at full cost unless they are covered by health insurance or under the UHCP. From 2010, individuals covered under MAP had 50% of the cost of outpatient drugs on the Essential Medicines List covered up to a limit of 50 GEL (US\$ 30) annually; this was increased to 200 GEL (US\$ 120) in September 2012 (prior to the election). These benefits were sustained with the introduction of the UHCP. Under the UHCP, benefits vary depending on whether beneficiaries fall under MAP; if they do, the benefits are more generous. Around 50 essential medicines are covered under the UHCP for outpatients and for the target group the cost of these is covered up to 50 GEL per year (200 GEL for pensioners) with a 50% co-payment. Other pensioners are covered up to 100 GEL per year and other children aged 0–5 years are covered up to 50 GEL per year with a 50% co-payment. Veterans are covered up to 50 GEL per year. Any other outpatient medicines are not covered and must be purchased at cost price. Other

UHCP beneficiaries (the previously uninsured who are not pensioners, veterans or children aged 0–5 years) pay in full for all outpatient medicines. In July 2017, pharmaceutical coverage under the UHCP was extended for people with chronic conditions and registered as living below the poverty line in response to research showing access problems caused by the high OOP costs for this group. This extension covers the full cost of essential medicines for four chronic conditions: cardiovascular disease (including hypertension), COPD, diabetes, and thyroid diseases.

Box 5.7**Evaluating efficiency in pharmaceutical care**

Overall, pharmaceutical care in Georgia is highly inefficient, as evidenced by the high price of pharmaceuticals locally, and the very high level of spending per capita on pharmaceuticals, which can be catastrophic for households. In 2015, 38% of THE (3% of GDP) was spent on pharmaceuticals in Georgia (MoLHSA, 2018). Access to medicines has increased since 2010, but improvement has mainly been experienced by urban residents.

The take-up of generic pharmaceutical products is weak as they are not well trusted by patients or professionals, and cost-effectiveness guidelines are not used in most branches of medicine. The lack of unified protocols and standards in most areas is a significant barrier to the development and implementation of cost-effectiveness guidelines (Tokhadze, 2016).

The cost of outpatient pharmaceuticals is widely seen as the biggest barrier to accessing care, which is why coverage of the major chronic conditions was included in the UHCP from July 2017.

Pharmaceutical prices in Georgia are vulnerable to external economic shocks as 90% are imported; for example, the depreciation of the Georgian lari in 2015 caused a drastic rise in pharmaceutical prices. The relatively high cost of pharmaceuticals is one of the major issues in access to care in Georgia and they constitute a significant share – around two thirds – of OOP payments and 40% of THE. The price of pharmaceuticals is therefore of real political importance. This is also a source of inefficiency in the system as the cost of outpatient pharmaceuticals provides strong incentives for patients to seek care in an inpatient or emergency care setting where the full cost of medicines prescribed are covered. Moreover, low-cost generic medicines are generally less available in retail pharmacies, compared to more expensive brand-name products. This may influence purchasing decisions, skewing consumption towards higher-priced medicines. Policies to improve the cost-effective and safe use of pharmaceuticals (such as prescribing policies) are covered in section 2.4.

5.6 Long-term care

For cultural reasons the provision of formal long-term care is limited as families are expected to care for their elderly or disabled relatives, but high rates of unemployment and poverty make it very difficult for many families to uphold this tradition.

MoLHSA is responsible for funding institutions for people with learning disabilities, while financing for supplementary special schools for children with learning disabilities, as well as for children's homes, is administered by the Ministry of Education. Georgia has made significant progress towards the deinstitutionalization of care for children and the number of children living in institutions since independence had halved by 2011 (Dunn, 2011). Foster care has been expanded and strengthened, and small group homes housing no more than 8–10 children are replacing large institutions. Additionally, 250 trained state social workers were in place working with children in care as of 2011 and this number was growing (Dunn, 2011). There are similar moves by civil society groups to deinstitutionalize adults with disabilities so that they can live supported in the community (Liparishvili, 2017). Some adults with disabilities stay in institutions for years because they have nowhere else to go as there is so little community-based supported housing in the country.

In 2016, there were 205 people with disabilities living in four state institutions, meaning these are over their capacity and overcrowded (Public Defender of Georgia, 2016). One of the most serious challenges faced in meeting the needs of the residents is ensuring that these institutions are adequately staffed by appropriately qualified professionals. Staff shortages can mean that existing staff are having to provide care for too many residents at once. Residents with very different physical and mental needs are also having to be housed together.

5.7 Mental health care

Formally, mental health care services are provided free of charge at the primary and specialist care levels, and mental health services absorbed 2.1% (US\$ 7.3 million) of the total state health budget in 2017 (MoLHSA, 2018). However, although gradually increasing, budget allocations have been barely enough to cover salaries, heating and food. There has also been a gradual diversification of the package of services that is offered to people with mental health problems, but there is a continued priority for funding inpatient services (72% in 2017), with just 23% for outpatient services and 2% for

community-based and rehabilitation services. There are 12 psychiatric hospitals in Georgia, with about 1300 beds in total, as well as 18 outpatient psychiatric clinics (dispensaries); however, resources are not distributed evenly across the country (NCDC, 2017). There is less access and a lower quality of services in poorer and more remote regions; more than half (55%) of all the active psychiatrists work in the capital, Tbilisi (NCDC, 2017).

A significant step towards the deinstitutionalization of mental health care services occurred in mid-2011 when the vast dilapidated Asatiani Psychiatric Hospital in central Tbilisi was closed. Acute psychiatric units with 30 beds were relocated to newly opened general hospitals. A separate mental health centre was established in Tbilisi with a variety of services: an acute ward, a long-term treatment department, and an outpatient service, including a crisis intervention centre with a mobile team. Long-term residential facilities were opened in several towns (each with 40 beds), and crisis teams started to function in some other cities. Since 2015, a community-based mobile team has started to operate in the Tbilisi Mental Health Centre and the funding of more mobile teams began in 2016.

These reforms immediately resulted in a reduced average length of stay for patients with acute mental illness (i.e. from initial hospitalization to discharge or transfer to long-term care facility), from an average of two to three months before the reforms to an average of 21 days in 2012 (Makhashvili & van Voren, 2013).

6. Principal health reforms

Chapter summary

- In 2013, there was a significant change of direction away from targeting benefits for the poorest households to embracing universal health coverage.
- Transferring responsibility for purchasing publicly financed services from private insurance companies to the SSA created a single-payer system, reducing the high administrative costs of the previous model and establishing a platform for the 'active' purchasing of health services.
- The stalled hospital privatization programme was again pushed forward in 2010 but it was not without problems and no more privatizations have taken place since 2012.
- The reintroduction of prescriptions for outpatient pharmaceuticals has not been popular, but it is a very important development for rationalizing pharmaceutical consumption in the country.
- Future plans will necessarily focus on: strengthening regulation of the health system; further improving data quality; and ensuring quality of care.
- Developing effective continuous professional development systems for medical professionals.
- Building on the perinatal regionalization programme to develop a coordinated health system at the regional level.

6.1 Analysis of recent reforms

Hospital privatization

The Hospital Development Master Plan of January 2007 called for the complete replacement of the existing hospital infrastructure within a three-year period (2007–2009) by transferring full ownership rights from the state to the private

sector through a tendering process (Chanturidze et al., 2009). However, hospital privatization plans had to be put on hold when the global financial crisis took hold, and international investors had to withdraw their bids to take over and run hospitals. To push forward the privatization agenda, new investors had to be found and, in 2010, the Government of Georgia requested that the private insurance companies involved in MAP bid for contracts to cover all the eligible population in a given region for three years, thereby guaranteeing them a steady income in return for taking on responsibility for the state-owned health facilities in the territory. This reduced competition between private insurance providers, but it was also a means of clawing back some of the big profits they had been making under MAP and investing these revenues in the health system. The government also hoped to rationalize hospital stock through the closure of under-utilized facilities.

The private insurance companies that won these bids were obliged to renovate or build and operate hospitals in their territories by the end of 2011. Most of these works were completed between 2010 and 2012, but some companies failed to deliver on their investment commitments and, in these cases, the government has been forced to step in and suspend the management contracts for the privatized properties and resume responsibility. In these cases, staff had often gone unpaid for many months, the management had not employed cleaning staff, and the buildings were left either unrenovated or only part-renovated, with no new equipment (Patsuria, 2012; Nikuradze, 2013). These contract terminations have necessarily continued since the change of government in 2012, but all ongoing privatizations were halted as of October 2012 when the new government came to power.

At the end of 2012, as part of the Hospital Sector Development Programme, 102 multi-profile medical centres opened in Tbilisi and the regions, with up to 4000 beds providing outpatient and hospital services.

In 2014–2015, MoLHSA bought out medical centres operated and owned by the private insurance companies in several mountainous and remote areas. As the previous owners of the medical centres in these areas had lacked the interest/incentive to sustain and develop them, this decision by the government was very important for ensuring geographical access to essential medical services for the local populations.

Universal health coverage

The previous edition of the Health System Review for Georgia was published in 2009, when the MAP programme had just been scaled up and it was too early to assess the full impact of the scheme (Chanturidze et al., 2009). Since then,

the MAP programme has been evaluated widely and the findings have shaped subsequent health financing policies. Studies have shown that the targeting of MAP was robust in that it did cover the most vulnerable population with very little ‘leakage’ to higher-income groups (Hou & Chao, 2011). MAP also improved access to inpatient services (Bauhoff, Hotchkiss & Smith, 2011). However, while studies have shown that access to and utilization of acute care improved for those covered by MAP, there was no improvement in access and utilization for those with chronic conditions (Gotsadze et al., 2015). This is important because the disease burden in Georgia is dominated by NCD. This also highlighted a very significant gap in the scope of coverage – outpatient pharmaceuticals – which had the potential to improve health outcomes significantly (Smith, 2013). The limitations of the MAP programme meant that OOP payments were still 72.7% of CHE in 2010 (WHO, 2018a). The narrow targeting of MAP also meant that the leading causes of household impoverishment in Georgia were related to health care costs (World Bank, 2016). In 2010, only 27% of the population had health insurance (UNICEF, 2013), and households on the cusp of eligibility for MAP were at most risk of being pushed into poverty by catastrophic health spending.

Between 2008 and 2010, the scope of MAP coverage remained unchanged. As it became clear there was a need to include outpatient pharmaceutical costs in the package of benefits, 50% cover for 50 essential medicines with an annual limit of 50 GEL (later increased to 200 GEL) was added, but this was still insufficient to protect households from the high cost of pharmaceuticals in Georgia (Smith, 2013). As elections approached in 2012, access to health care became an increasingly important political issue and the government of the time committed to quite radical expansions of the MAP programme in September 2012 to cover all pensioners, people with disabilities, children aged 6 years of age and under, and students. This expansion had similar benefits to the original MAP, but with a reduced annual limit of 100 GEL for the 50% pharmaceutical cover and a new user charge of 10–20% for emergency hospital care, elective surgery, oncology services and childbirth (up to a limit of 500 GEL; 800 GEL for a caesarean delivery). With these changes, coverage was extended to around half of the population, but the elections in October 2012 ushered in a new government which was committed to much higher social spending and universal health coverage.

The state budget for health in 2013 increased dramatically (from 388 million to 662 million GEL) as the new government sought to refocus on spending in the social sphere (Maresso et al., 2015). All citizens were to receive a universal basic package of high-quality health services, protection from financial

risks, prevention of diseases and basic coverage of emergency care using globally approved mechanisms. The move to universal health coverage was a political commitment of the new government, influenced by the findings of research on the impact of MAP and the contemporary situation with regard to financial protection.

The reform priorities for the UHCP were outlined in the Georgia 2020 Strategy (Government of Georgia, 2013) as:

- improving public health care spending systems;
- improving the quality of health care;
- increasing the affordability of pharmaceutical products; and
- strengthening primary health care.

The ultimate aim of the steps taken to reform Georgia's health care sector is to increase the population's life expectancy and improve its overall health. Georgia's population will also be better protected from high OOP payments and the consequent risk of impoverishment; access to high-quality medical services and medicines will be improved; and the efficiency of public spending on health care will be increased through improved administration and by placing greater emphasis on preventive measures. These measures will have a positive impact on the country's human capital development, economic growth and poverty rates (Government of Georgia, 2013).

The first phase introduced the Basic Package of Benefits in February 2013; all those uninsured as of February 2013 were eligible. The package of benefits covered primary care services (including many basic diagnostic tests) and emergency medical care – both inpatient and outpatient services. This was then expanded in July 2013, when the UHCP was implemented, to include elective surgery, oncology and childbirth (all with variable limits and co-payments – see Table 3.2). All those uninsured in July 2013 could apply for cover under the UHCP, but there was no outpatient pharmaceutical cover for this group. In March 2017, the next wave of health care reforms was announced and this brought further differentiated packages for those covered under the UHCP (section 3.3). The most striking feature of this set of reforms was that the highest income group of around 43 000 people was excluded from the UHCP from July 2017, as they are expected to purchase VHI. The savings from no longer covering this group are intended to be used to cover an expanded package of drug benefits for the lowest income 'target' group. The impact of this policy on solidarity and risk pooling in health financing is yet to be seen.

Under the UHCP, the purchasing function has been consolidated to the SSA and moved from the private health insurance industry in order to improve efficiency and reduce the high administrative costs of the previous model. The vertical programme covering high-risk maternal and newborn care was integrated into the UHCP to be purchased by the SSA following the regionalization of perinatal health services. MoLHSA is currently working on the integration of the diabetes programme. The gradual incorporation of vertical programmes should help to reduce fragmentation in the system and consolidate funding flows.

This approach to achieving universal health coverage in Georgia has not been without its detractors. Some have argued that, rather than providing a limited package of benefits to all citizens, a more prudent approach would be to continue targeting comprehensive benefits to the lowest income groups (Kukava, 2013; Bendukidze et al., 2014). However, there is growing evidence that the universal limited package approach is the more effective, efficient and equitable way to achieve universal health coverage (Heymann, 2014). The provision of a Basic Package of Benefits to all citizens as the basis for achieving universal health coverage also has the support of the major donors in Georgia (the World Bank and USAID) as well as WHO. It has required a significant commitment to increased budget funding for health, which has thus far been forthcoming, although at 3% of GDP, government funding for health remains low in international comparisons (WHO, 2018a).

Pharmaceutical prescriptions

In a move towards greater regulation of the health system, and in order to lay the foundations for a more rational pharmaceutical policy, from 1 September 2014, MoLHSA tightened the regulation of outpatient prescription medicines. SRAMA is responsible for implementing the new law, which splits medicines into three categories (I, II, III) with a doctor's prescription required for Categories I and II; Category III comprises medicines that are all available over the counter. Category I covers the dispensing of psychotropic medications and their precursors, which was already strictly controlled. However, the newly restricted access to Category II medications created quite a backlash from the general public, who were accustomed to freely purchasing medicines (including antidepressants, sedatives, immunomodulators, antibiotics and drugs used for treating cancer and heart disease) without a prescription (DFWatch, 2014). Thus far there has been some occasional undermining of the new law with pharmacies hiring resident 'pharmacy doctors' to write prescriptions for

customers on demand (without a consultation), but hopefully the regulation of prescription pharmaceuticals will be fully realized to contain the irrational consumption of pharmaceuticals, dangerous self-treatment and contain costs.

To enhance the safety and quality of how medicines are prescribed by doctors and address the issue of irrational consumption of pharmaceuticals, Georgia is taking a step into the future by launching an electronic prescription system for Category II medications. The e-prescription (a method of sending and receiving electronic prescriptions) was launched in September 2016 as a pilot in Tbilisi. Involvement in the electronic prescription system is currently voluntary but, starting in 2018, it will become mandatory and, step by step, all medical facilities and pharmacies in Georgia will be introduced to the new process and asked to incorporate it into their daily operations. MoLHSA plans to gradually make e-prescriptions mandatory across the country by 2020.

Regionalization of maternal and newborn health services

Regionalization of maternal and newborn health services, or so-called perinatal regionalization, was a key reform initiated by MoLHSA in 2015. The reform aimed to create a comprehensive, coordinated and geographically structured system of designating where infants should be delivered in order to ensure that risk-appropriate care is available for all mothers and infants.

MoLHSA developed and adopted regulations that set up a three-level system of perinatal care. The regulations established detailed standards and qualifications for Level 1, 2 and 3 obstetric and neonatal care facilities, in terms of required infrastructure, services, equipment, supplies, staffing, and the degree of complexity of births and comorbid conditions the service providers were expected to handle. Following these new regulations, a nationwide assessment of all maternal and neonatal hospital resources and staff was carried out, with 105 facilities assessed. Modernization of health care facilities involved procuring additional equipment, adding the necessary services and staff, and organizing the obstetric and neonatal care units/facilities in compliance with the requirements for the given level of care. In total, 82 facilities were designated a level of care after strengthening their capacity with infrastructure/equipment and competencies of health care workers in line with the requirements.

Many hospitals were delivering babies, however very few could provide specialized care for critically ill mothers, newborns or premature babies, or risk-appropriate care. This gap was particularly clear in the regions, where most critically ill babies and mothers were being transported to the capital city, Tbilisi. The regionalization policy strengthened capacity in regional centres

and concentrated high-risk pregnant women and preterm babies at designated Level 3 perinatal centres in the regions, thus improving geographical access to risk-appropriate care.

Regionalization has also included organizing a referral system under which pregnant women are assigned to hospitals at the appropriate level of care based on the level of risk to themselves and their baby. Issues with the transport of newborns have also largely been resolved.

Other issues that still needed to be resolved included closing down facilities with very few births per year. Given that this was a highly sensitivity issue, this was partially accomplished by closing facilities in several places where geographical access and proximity to the closest Level 2 facility was not an issue. However, there are still some facilities with very few births that need to be closed.

Regionalization of perinatal care is a complex process requiring high levels of coordination and monitoring of level of care compliance. A set of key indicators (early neonatal mortality by level of care; distribution of preterm births by level of care; maternal and neonatal transportation index and causes) have been defined, collected and used to assess the regionalization process. A set of measures was developed to monitor the quality of care in hospitals providing maternal and newborn health services, such as 30-day obstetric readmission, caesarean section in low-risk pregnant women, term newborn admissions to intensive care, and others. MoLHSA mandates electronic reporting of these indicators. It will be important to maintain this mechanism to provide regular feedback to health care providers to facilitate continuous improvement.

Perinatal care regionalization can serve as a model for the reorganization and staging of other health services within each region of Georgia and the development of integrated health care networks.

6.2 Future developments

Health policy challenges which are currently under discussion include: ways of improving financial access to outpatient pharmaceuticals (potentially through price controls or government subsidy); the need to further improve the quality of essential mortality and morbidity data; the need to strengthen the quality management system to improve the quality of care provided; the introduction of diagnosis related-groups (DRGs); and ways to improve the strategic purchasing capacity of the SSA.

Much of the research analysing the impact of MAP was made possible by the Health Utilization and Expenditure Survey (HUES), which was undertaken in 2007 and then again in 2010. The most recent HUES was undertaken at the end of 2014. Early results show that the government's decision to back universal health coverage and invest in health care has been successful in increasing utilization to address previously unmet needs. The big reform challenge now is looking at how services are purchased in order to contain costs and thereby ensure the sustainability of the system. In particular, rational prescribing policies based on sound clinical guidelines are needed (including policies to support and promote the use of generics) to contain costs. There is also a need for greater incentives in the system for patients to be treated at the primary care level in preference to more specialized providers, as this is the best way to meet the needs of patients with the sorts of chronic conditions that are dominating the disease burden in the country. Other measures, such as continuing professional development, are needed to strengthen human resources capacity and enhance quality of care. Some of these changes may be unpopular at first, but a notable feature of the reforms undertaken since 2013 is that policy-makers have not shied away from taking the more rational path even in the face of opposition from the general population or vested interests.

7. Assessment of the health system

Chapter summary

- Georgia has made significant progress in improving access to health services under the UHCP, particularly in decreasing previously unmet medical needs.
- Financial protection has also improved and fewer households face financial hardship from having to pay for health services, but OOP payments still dominate health expenditure despite the rapid increase in public expenditure.
- Recent budget overruns highlight the challenge that the government faces in ensuring the sustainability of the UHCP while meeting the health needs of the population.
- In spite of progress on key indicators for universal health coverage, health system performance outcomes in Georgia still lag behind other countries in the European region.
- Transparency in the system is improving but it remains a problem – particularly in the pharmaceutical sector.

7.1 Monitoring health system performance

Information systems

There is no systematic collection of data on patient satisfaction or adverse events. There are also weak incentives in the system for providers to collect and share such data and related processes. This means that assessments of the health system in Georgia are necessarily more limited. The quality of vital statistics has improved greatly over the past couple of years, but it is not possible to examine trends using such data, as the gaps for previous years are profound

(see section 1.4). Similarly, the development of disease registries will greatly increase the capacity of information systems and the NCDC to monitor health system performance, but it is too early to identify any trends over time.

The stated objectives of the health system

The new government elected in 2012 pledged to move towards universal health coverage and this became a flagship policy. Universal health coverage includes financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. Fundamentally, no household should be pushed into poverty through ill health by accessing the health services and medications they need. The UHCP is regulated by Government Decree No. 36 and its aims are to:

- ensure access to medical services for people who do not have private health insurance
- enhance geographical and financial access to primary health care
- increase outpatient services in order to rationalize costly and high-technology hospital services
- improve population health through better access to emergency and planned inpatient and outpatient services.

7.2 Health system impact on population health

Problems with the collection of mortality data in Georgia mean that, while most deaths are now registered (see section 1.4), the cause of death is unknown for more than a quarter of the deaths. The data gaps – both in breadth and level of detail available – mean it is difficult to draw conclusions about the contribution of the health system to population health using indicators such as amenable mortality or even selected causes of avoidable deaths. It is also too limited to explore the equity of outcomes for different population groups.

According to the most recent Georgian Reproductive Health Survey (2010), data show that the infant mortality rate fell from 41.6 infant deaths per 1000 live births in 1995–1999 to 21.1 per 1000 in 2000–2004 and 14.1 per 1000 in 2005–2009 (Serbanescu et al., 2011). The neonatal mortality rate fell from 25.4 per 1000 live births in 1990–1999 to 16.8 per 1000 in 2000–2004 and 9.5 per 1000 in 2005–2009 (Serbanescu et al., 2011). In 2016, NCDC found the infant mortality rate to be 9.0 (the estimates used by WHO were 10.6; WHO Europe, 2017) and the neonatal mortality rate was 6.3, which would indicate strong

improvements over the past 25 years, but rates are still high in the European context (NCDC, 2016). Maternal mortality rates have fluctuated widely over the past decades. WHO estimates for 2015 show that the maternal mortality rate was 36 per 100 000 live births, while in the official statistics it was 32. Active surveillance of maternal mortality introduced by MoLHSA significantly improved the registration of maternal deaths in Georgia, as demonstrated by narrowing the gaps between WHO estimates and official statistics. The rate decreased to 23 per 100 000 live births in 2016 and preliminary data for 2017 show a similar decreasing trend (NCDC, 2016).

Overall, there is progress in maternal and child mortality indicators; however, despite the decreasing trend, Georgia's maternal and infant mortality rates are higher than the average for countries of the EU (WHO Europe, 2017). Consequently, maternal and infant mortality is a high priority for the country and, from 2016, the system of continuous monitoring of the health of pregnant women, the 'Birth Registry', maternal and perinatal death audits and near-miss case reviews have been introduced to monitor the quality of antenatal, obstetric and neonatal health services more closely (see section 4.1).

Data for 2006–2008 cited in the Georgian National Program for Palliative Care (Action Plan for 2011–2015) found that 47.2% of cervical cancer cases were identified at Stage III or IV; for breast cancer it was 49.4%; and overall more than half of patients newly diagnosed with cancer die within a year. In 2016, 31.6% of cervical cancer cases and 38% of breast cancer cases were identified at Stage III or IV (NCDC, 2016). Late cancer diagnosis in Georgia is likely to reflect financial or other barriers in access to screening and/or treatment services rather than being simply a reflection of poor-quality care. A central cancer registry was introduced in 2015, but it is too early to calculate reliable five-year survival rates for cancer diagnoses.

7.3 Access

By far the most significant barriers to accessing care in Georgia are financial – while financial access for inpatient care has significantly improved, access to outpatient medicines is still challenging for many households. Waiting times for hospital care are not a significant barrier to access, but there is some evidence that waiting times can be a barrier to accessing primary care services (USAID, 2014). In a patient survey, respondents mentioned the following barriers to receiving care: 40% were told the service they needed was not covered in the package of benefits; 23% forewent primary care because

they knew the service they needed was not covered; and 20% said they were unable to make an appointment with a doctor (USAID, 2014). Most respondents (62.5%) also reported not visiting hospitals when needed because they knew in advance that providers would tell them their treatment was not covered (USAID, 2014).

However, even though this survey was taken so soon after the introduction of the Basic Package of Benefits in 2013, more than a third of beneficiaries considered that the increased availability of medical services was already a major achievement of the programme, with 77% thinking it had significantly improved the affordability and accessibility of primary care services (USAID, 2014). Current problems of access therefore need to be viewed in the context of quite significant improvements since 2012; previously, the uninsured (69.9% of the population in 2011) had to pay in full, out of pocket, for primary care services. Improved access to hospital care has been strongest for the poorest sections of society, so that the level of unmet need for the poorest quintile was equal to that of the richest (World Bank, 2017). The distribution of public spending on health for outpatient care was also considerably more pro-poor in 2014 than in 2010.

In a nationally representative survey conducted in 2001 and 2010, the proportion of respondents who were constantly foregoing medicines increased from 8.8% to 22.5% (Footman et al., 2014). Access to medicines became a key concern at the time of the election in 2012, and inclusion of a tightly defined range of essential medicines in the UHCP has sought to continue the benefits granted to MAP beneficiaries just prior to the election, but also in recognition of their importance in achieving universal health coverage. The limited nature of outpatient pharmaceuticals benefits, as well as the administrative barriers to claiming them (particularly in rural areas under the Rural Doctors' Programme), nevertheless remain important barriers to accessing care. In 2014, less than 0.5% of UHCP spending was on outpatient pharmaceuticals nationwide, which shows that it was not contributing to making essential medicines affordable for the most vulnerable households (Habicht & Thomson, 2016).

7.4 Financial protection

Out-of-pocket spending in health in Georgia is high when compared with OOP spending across the European region, but it fell following the introduction of the UHCP, even though government expenditure on health increased 126%

from 2012 to 2016. The UHCP extended the breadth of cover to nearly the whole population. There are co-payments in the system for some less vulnerable groups, but the depth of cover appears less of an issue than the scope of cover, as most OOP spending on health (around two thirds) in Georgia is for outpatient pharmaceuticals. This cuts across income groups as the coverage of outpatient pharmaceuticals in the UHCP is so limited and, for patients in rural areas, hard to realize because prescriptions written by doctors employed under the Rural Doctors' Programme (which covers 1.1 million citizens) cannot be reimbursed under the UHCP (see section 5.3). Household survey data from 2015 showed that OOP payments for health were impoverishing (at a \$2.50/day international poverty line) for an additional 6.6% of Georgian households (World Bank, 2017), a level which is unchanged since 2010. The overall proportion of households facing catastrophic costs is similarly unaffected by the implementation of the UHCP.

Average catastrophic OOP spending on inpatient care has halved since the introduction of the UHCP, but average OOP spending on outpatient pharmaceuticals has almost doubled (World Bank, 2017). This is not due to any change in coverage but because pharmaceuticals in Georgia are relatively expensive, generics are not always available, and the reliance on imports makes pharmaceutical prices vulnerable to economic shocks such as the depreciation of the lari in 2015 (see section 5.5). The burden falls particularly hard on the lowest income households, where the cost of medicines for 90% of those in the poorest quintile pushed them into poverty or experiencing catastrophic expenditure, while for the richest quintile this was 21% (World Bank, 2017).

The proxy means testing for low-income households used for identifying the households eligible for MAP was criticized for being onerous and overly narrow as many low-income families were excluded from cover and faced catastrophic health care costs as a result (UNICEF Georgia and University of York, 2012). The introduction of the UHCP to cover the uninsured population should have removed this hard 'cliff edge' for catastrophic spending but, as has been shown elsewhere, in the absence of meaningful cover for essential outpatient medicines, chronic illnesses can push households into poverty (Murphy et al., 2013; Murphy et al., 2016). To improve coverage and reduce catastrophic spending on outpatient pharmaceuticals, in July 2017, a package of benefits for people with chronic conditions living in households below the poverty line was introduced as the first step towards comprehensive cover for essential medicines.

7.5 Health system efficiency

Efforts to improve the overall efficiency of the health system aim to increase the emphasis on the most vulnerable and generally improve the management of claims to help reduce the health spend and so the overall budget deficit (World Bank, 2017).

Allocative efficiency

In allocative efficiency, the most important shift has been from implementation of MAP to the UHCP. In 2016, the UHCP was spending less per person than MAP (approximately 166 GEL compared with 180 GEL), even though the benefits offered were more extensive (Habicht & Thomson, 2016). This demonstrates a big decline in spending on administration as the single-payer system has much lower administrative costs than the previous multi-payer system. Prior to 2013, Georgia's public spending on health administration was considerably higher than most Organisation for Economic Co-operation and Development (OECD) countries, including Switzerland (World Bank, 2017).

Nevertheless, there is still a strong incentive to treat patients as inpatients, particularly as emergency cases, due to the incentives in the way inpatient and emergency care is reimbursed. In 2013, more than half the UHCP funding was spent on emergency inpatient care. The incentives in the system for patients and providers strongly favour emergency and inpatient care (Table 7.1).

The very detailed and complex payment system for hospitals makes it difficult for the SSA to control costs, and incentives in place encourage providers to treat patients as urgent cases. Standardizing tariff-rule setting has already led to cost savings at the system level. Another source of inefficiency in the system is the persistence of vertical programmes, which create conflicting priorities and fragment resources. However, currently, any savings in health expenditure are accrued to the central government budget rather than to the health system. If the SSA were able to use the money they saved, this might provide a stronger incentive to pursue greater efficiency.

Table 7.1

Incentives for patients and providers by type of care

	Patient incentives	Provider incentives
First contact care		
Ambulance care	<ul style="list-style-type: none"> • easy access • free of charge • quick solution to health problems • entry point for hospital care 	<ul style="list-style-type: none"> • more patients mean more revenue • refer patients to hospital to minimize risk
Rural doctor	<ul style="list-style-type: none"> • easy access • limited scope of services • low trust • free of charge • entry point to the next level of care 	<ul style="list-style-type: none"> • narrow scope of care • easy to refer patients to the next level • good performance is not rewarded • blurred role with primary care doctors in polyclinics
Polyclinics	<ul style="list-style-type: none"> • easy access • mostly free of charge • entry point to specialists • limited scope of services • services unclear • low trust • relatively low cost for patients who have to pay OOP 	<ul style="list-style-type: none"> • limited care delivery options • easy to refer to the next level or to specialists in primary care (in some cases this increases income) • good performance is not rewarded • blurred role with rural doctors • very limited options to prescribe
Hospital emergency department	<ul style="list-style-type: none"> • easy access • wide scope of care • high trust • emergency cases are free of charge • easy access to inpatient care • free medicines 	<ul style="list-style-type: none"> • more patients mean more revenue • easy and reasonable to refer to inpatient settings
Specialized services		
Specialist outpatient and inpatient care	<ul style="list-style-type: none"> • wide scope of care • high trust • complicated to navigate • co-payment varies based on patient • UHCP and provider characteristics • free medicines 	<ul style="list-style-type: none"> • more patients mean more revenue from the SSA and from co-payments • good performance is not rewarded • revenue is gained by hospitalizing patients, categorizing patients as emergency cases and treating private patients
Vertical programmes	<ul style="list-style-type: none"> • targeted service package • free of charge • free medicines 	<ul style="list-style-type: none"> • more patients mean more revenue, but providers have fewer opportunities to increase prices or collect co-payments

Source: adapted from Habicht & Thomson, 2016.

Technical efficiency

Overall, the technical efficiency of the health system as measured in terms of outputs is relatively low. Although utilization increased rapidly after the introduction of the UHCP (as the health system dealt with a surge of unmet demand), utilization of primary care services has remained relatively low. At the same time, data on the number of hospitals and beds per hospital suggest most hospitals operate with fewer than 100 beds. It is questionable whether multi-profile hospitals can function efficiently with so few beds or ensure the quality of care when volumes are so low (World Bank, 2017). The systemic

emphasis on inpatient care over primary care also means the system is poorly suited to meeting the health needs of an aging population with a large burden of NCD.

The situation as regards human resources in Georgia is widely acknowledged as being highly inefficient. The oversupply of doctors and intense shortage of nursing staff make changing the skill-mix extremely challenging (see section 4.2). The oversupply of doctors also has serious implications for productivity given that utilization rates are relatively low.

In pharmaceutical care there is also clear scope for efficiency gains to be made. There is under-use of generics and over-pricing of pharmaceuticals, meaning retail prices in Georgia are some of the highest in the European region. Recent policies seeking to re-regulate the pharmaceuticals market by controlling prices and implementing prescribing regulations have been unpopular but are essential first steps to addressing the irrational use of drugs. Broadening the benefits package to judiciously cover essential outpatient medicines may also help to refocus the system as these are a vital part of primary care and may help patients with chronic conditions avert the need to access inpatient services.

7.6 Health care quality and safety

There are no statutory mechanisms in place to monitor the quality of care provided at the national or regional levels; some quality assurance mechanisms are in place at the provider level through a pilot scheme using a process of self-assessment. However, it is not possible to discuss the quality of care in Georgia using indicators such as those used by the OECD in their report on patient safety indicators (Drösler, Romano & Wei, 2009). The quality of morbidity statistics and data collected at the hospital level similarly do not allow for the use of process indicators such as avoidable hospital admission rates. The first step towards putting a quality assurance mechanism in place was the use of selective contracting for health care facilities providing maternal and newborn care services based on pre-defined quality indicators (introduced in March 2017). The ‘Birth Registry’ for maternity care allows quality and safety control monitoring, which will enable the SSA to strengthen selective contracting for obstetric and neonatal services further.

The main instruments available to the SSA in monitoring whether services are being delivered appropriately are prior authorization for planned surgery and the routine scrutiny of claims information submitted by providers (Habicht

& Thomson, 2016). Both processes are time-consuming and it is not clear that either procedure is effective in influencing quality of care. At present there is no mechanism to reward good performance and encourage the use of clinical decision support tools such as national guidelines and protocols; care pathways are not used. National guidelines and protocols are needed to encourage the introduction of more widely used selective contracting.

7.7 Transparency and accountability

The complexity of the co-payment rules under the UHCP, with different entitlements for different groups of people and different types of service, is confusing and may undermine transparency in the system. Where there is confusion over the scope of the benefits package, there is greater space for informal practices. Provider payment rules are similarly open to manipulation, thereby having the potential to limit transparency in the system. However, overall, transparency in the system is increasing, and even in those areas with a reputation for opaque practices, such as the pharmaceutical sector, transparency in the wider economic system allows for ownership patterns, for example, to be traced. This is important because the unusual vertical ownership patterns for pharmaceutical, medical services and health insurance companies lead to inherent conflicts of interest.

Beyond the standard electoral processes, there is not so much opportunity for popular participation in decision-making or to contribute to accountability arrangements; for example, there is no lay representation on the SSA board or any other decision-making boards.

8. Conclusions

Since 2013, Georgia has made significant progress towards achieving universal health coverage. One of the key financing issues faced by the Georgian health system since independence has been the lack of political will to prioritize health for national development and fund the health sector accordingly. The UHCP has extended entitlements to almost all the population, most of whom had no health coverage before 2012. This was made possible by a substantial increase in budgetary funding for health, even though it remains low in international comparisons.

To sustain recent achievements, the government is focusing on how publicly financed health services are purchased. Unifying purchasing functions by transferring responsibility from competing private insurance companies to the SSA has established a strong platform for the development of more active purchasing. Selective contracting should allow for greater cost containment but also enable the SSA to purchase the highest quality services. More active purchasing also means working to eliminate the use of ineffective (and not cost-effective) services and medicines to ensure selective purchasing can deliver value for money. However, moving from passive to active purchasing takes time and requires a stable political environment. There is no end point – it is a constant process of monitoring and refining mechanisms to ensure the system best meets the needs of the population. In this way, the current weaknesses and perverse incentives in the way services are paid for serve as useful learning points. However, even if purchasing were made more efficient, improving overall health system performance will still require additional government funding.

Incentives in the system strongly favour the utilization of inpatient and emergency care over primary care services. This has been shaped by the legacies of previous reforms, but also reflects strong patient preferences for seeking care at more specialized levels of the system. The limited cover for

outpatient pharmaceuticals also makes primary care less attractive. There is a lack of trust in primary care providers and the quality of care they provide, but in order to best meet the needs of the population, most care needs to be provided in the community at this level. It is most cost-efficient to provide care at the lowest appropriate level, but it is also more effective at meeting the needs of patients with noncommunicable diseases, who require support in managing and monitoring their conditions over the long term – and this means access to essential medicines. This will require a shift in financing, but also a shift in thinking about the most efficient – and effective – ways of delivering services.

9. Appendices

9.1 References

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9.2 HiT methodology and production process

HiTs are produced by country experts in collaboration with the Observatory's research directors and staff. They are based on a template that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources and examples needed to compile reviews. While

the template offers a comprehensive set of questions, it is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context. This HiT has used a revised version of the template that is being piloted during 2016–2017 and will be available on the Observatory web site once it has been finalized. The previous (2010) version of the template is available online at: <http://www.euro.who.int/en/home/projects/observatory/publications/health-system-profiles-hits/hit-template-2010>.

Authors draw on multiple data sources for the compilation of HiTs, ranging from national statistics, national and regional policy documents to published literature. Furthermore, international data sources may be incorporated, such as those of the OECD and the World Bank. The OECD Health Data contain over 1200 indicators for the 34 OECD countries. Data are drawn from information collected by national statistical bureaux and health ministries. The World Bank provides World Development Indicators, which also rely on official sources.

In addition to the information and data provided by the country experts, the Observatory supplies quantitative data in the form of a set of standard comparative figures for each country, drawing on the European Health for All database. The Health for All database contains more than 600 indicators defined by the WHO Regional Office for Europe for the purpose of monitoring Health in All Policies in Europe. It is updated for distribution twice a year from various sources, relying largely upon official figures provided by governments as well as health statistics collected by the technical units of the WHO Regional Office for Europe. The standard Health for All data have been officially approved by national governments.

HiT authors are encouraged to discuss the data in the text in detail, including the standard figures prepared by the Observatory staff, especially if there are concerns about discrepancies between the data available from different sources.

A typical HiT consists of nine chapters.

1. Introduction: outlines the broader context of the health system, including geography and sociodemography, economic and political context, and population health.
2. Organization and governance: provides an overview of how the health system in the country is organized, governed, planned and regulated, as well as the historical background of the system; outlines the main actors and their decision-making powers; and describes the level of patient empowerment in the areas of information, choice, rights and cross-border health care.

3. **Financing:** provides information on the level of expenditure and the distribution of health spending across different service areas, sources of revenue, how resources are pooled and allocated, who is covered, what benefits are covered, the extent of user charges and other out-of-pocket payments, voluntary health insurance and how providers and health workers are paid.
4. **Physical and human resources:** deals with the planning and distribution of capital stock and investments, infrastructure and medical equipment; the context in which information technology systems operate; and human resource input into the health system, including information on workforce trends, professional mobility, training and career paths.
5. **Provision of services:** concentrates on the organization and delivery of services and patient flows, addressing public health, primary care, secondary and tertiary care, day care, emergency care, pharmaceutical care, rehabilitation, long-term care, services for informal carers, palliative care, mental health care and dental care.
6. **Principal health reforms:** reviews reforms, policies and organizational changes; and provides an overview of future developments.
7. **Assessment of the health system:** provides an assessment of systems for monitoring health system performance, the impact of the health system on population health, access to health services, financial protection, health system efficiency, health care quality and safety, and transparency and accountability.
8. **Conclusions:** identifies key findings, highlights the lessons learned from health system changes; and summarizes remaining challenges and future prospects.
9. **Appendices:** includes references and useful web sites.

The quality of HiTs is of real importance since they inform policy-making and meta-analysis. HiTs are the subject of wide consultation throughout the writing and editing process, which involves multiple iterations. They are then subject to the following:

- A rigorous review process.
- There are further efforts to ensure quality while the report is finalized that focus on copy-editing and proofreading.
- HiTs are disseminated (hard copies, electronic publication, translations and launches).

The editor supports the authors throughout the production process and in close consultation with the authors ensures that all stages of the process are taken forward as effectively as possible. One of the authors is also a member of the Observatory staff team and they are responsible for supporting the other authors throughout the writing and production process. They consult closely with each other to ensure that all stages of the process are as effective as possible and that HiTs meet the series standard and can support both national decision-making and comparisons across countries.

9.3 The review process

This consists of three stages. Initially the text of the HiT is checked, reviewed and approved by the series editors of the European Observatory. It is then sent for review to two independent academic experts, and their comments and amendments are incorporated into the text, and modifications are made accordingly. The text is then submitted to the relevant ministry of health, or appropriate authority, and policy-makers within those bodies are restricted to checking for factual errors within the HiT.

9.4 About the authors

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The Health Systems in Transition reviews

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The Health Systems in Transition (HiT) country reviews provide an analytical description of each health system and of reform initiatives in progress or under development. They aim to provide relevant comparative information to support policy-makers and analysts in the development of health systems and reforms in the countries of the WHO European Region and beyond. The HiT reviews are building blocks that can be used:

- to learn in detail about different approaches to the financing, organization and delivery of health services;
- to describe accurately the process, content and implementation of health reform programmes;
- to highlight common challenges and areas that require more in-depth analysis; and
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in countries of the WHO European Region.

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Australia (2002, 2006)
Austria (2001^e, 2006^e, 2013^e)
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Belarus (2008^g, 2013)
Belgium (2000, 2007, 2010)
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Bulgaria (1999, 2003^b, 2007^g, 2012)
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Tajikistan (2000, 2010^g, 2016)
The former Yugoslav Republic of Macedonia (2000, 2006, 2017)
Turkey (2002^{gi}, 2011^h)
Turkmenistan (2000)
Ukraine (2004^g, 2010^g, 2015)
United Kingdom of Great Britain and Northern Ireland (1999^g, 2015)
United Kingdom (England) (2011)
United Kingdom (Northern Ireland) (2012)
United Kingdom (Scotland) (2012)
United Kingdom (Wales) (2012)
United States of America (2013)
Uzbekistan (2001^g, 2007^g, 2014^g)
Veneto Region, Italy (2012)

Key

All HiTs are available in English. When noted, they are also available in other languages:	
a	Albanian
b	Bulgarian
j	Estonian
c	French
d	Georgian
e	German
k	Polish
f	Romanian
g	Russian
h	Spanish
i	Turkish

* More recent versions are available from the Asia Pacific Observatory.



The European Observatory on Health Systems and Policies is a partnership, hosted by the WHO Regional Office for Europe, which includes the Governments of Austria, Belgium, Finland, Ireland, Norway, Slovenia, Sweden, Switzerland, the United Kingdom and the Veneto Region of Italy; the European Commission; the World Bank; UNCAM (French National Union of Health Insurance Funds); the London School of Economics and Political Science; and the London School of Hygiene & Tropical Medicine. The European Observatory has a secretariat in Brussels and it has hubs in London (at LSE and LSH TM) and at the Technical University of Berlin.

HiTs are in-depth profiles of health systems and policies, produced using a standardized approach that allows comparison across countries. They provide facts, figures and analysis and highlight reform initiatives in progress.