GEORGIA HEALTH UTILIZATION AND EXPENDITURE SURVEY 2017

October 2018

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1 Acknowledgements

This report was prepared by Volkan Cetinkaya (Senior Economist), Iryna Postolovska (Young Professional), and Alessia Thiebaud (Analyst) at the World Bank. The support of Enis Baris (Practice Manager, World Bank) is gratefully acknowledged. The World Health Organization Regional Office for Europe funded the 2017 Health Utilization and Expenditure Survey, and the team would like to thank Marjian Ivanusa, Sarah Thomson, and Triin Habicht at the WHO Regional Office for Europe for providing comments on the report. Most importantly, the team would like to extend their appreciation to the Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health, and Social Affairs of Georgia.

2 Executive Summary

Overview of Georgia's Health System

Georgia has made substantial progress in improving health outcomes over the last two decades, but changing lifestyles and the aging of the population are presenting new challenges. Non-communicable diseases account for the lion's share of disability-adjusted life years and deaths (81.2 percent and 92.2 percent in 2016, respectively). Prevalence of risk factors is high: 28 percent of the adult population is hypertensive, 21 percent is obese, and almost 58 percent of men smoke.

To ensure universal access to quality care for the entire population, in 2013 Georgia introduced the Universal Health Coverage Program (UHCP), shifting to a single payer model. The program is administered by the Social Service Agency (SSA) – a single purchasing agency in the Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health, and Social Affairs. The benefits package covers a range of primary and secondary care services, including planned ambulatory care, emergency outpatient and inpatient services (), elective surgery, oncological services, obstetric care, and some essential drugs (with 20-30 percent co-payment and up to 15,000 GEL or approximately 5580 USD). The depth of coverage differs and is greater for lower income households (those below the poverty line), pensioners, and children aged 0-5 years. In May 2017, individuals earning more than 40,000 GEL (or approximately 14,900 USD) were excluded from the UHCP. This affected about 30,000 individuals (or approximately 0.8 percent of the population) of the population, who were expected to purchase voluntary health insurance.

The UHCP was backed by substantial increases in government budget allocations for health, which rose from 5.2 percent of government spending in 2012 to 10.3 percent in 2016. As a result, OOP spending as a share of current health spending declined from 73.4 percent in 2012 to 55.6 percent in 2016. Despite the decline, OOP spending remains above global averages for countries with a similar level of income. Given that almost two-thirds of OOP spending are for outpatient pharmaceuticals, in July 2017, the government expanded the benefits package for the most vulnerable households, pensioners, and disabled persons to cover essential medicines for four common chronic conditions (WHO, 2017). The health system is still largely oriented towards curative care. Spending on inpatient care represents 67 percent of public health spending, while 25 percent is allocated towards primary care.

Health Utilization and Expenditure Survey (HUES)

To monitor progress in utilization of and expenditures on health services, since 2007 Georgia has been conducting the Health Expenditure and Utilization Survey (HUES). The HUES is a nationally representative household survey that tracks self-reported health status, utilization of outpatient and inpatient services, and out-of-pocket spending on health. The sample is largely drawn from the Integrated Household Survey (IHS) conducted by Geostat. This allows for the analysis to be disaggregated by consumption quintile.

This report presents findings from the latest round of the HUES conducted in 2017 and compares the results from the previous rounds (2007, 2010, and 2014). It is important to note that the 2017 HUES was conducted in June and July 2017, following the establishment of the UHCP high-income exclusion and coinciding with the expansion of the benefits package for the most vulnerable households in July 2017. The survey therefore does not capture the changes associated with the recent reforms.

Key Findings from HUES 2017

Health status

Almost 37 percent of the population in 2017 suffered from a chronic illness – a slight increase from 35 percent in 2014. About 13.3 percent reported suffering from more than one chronic illness. The proportion of people reporting an acute sickness in the preceding 30 days (8.7 percent) has not changed significantly since 2014 (8.5 percent), and the share of population suffering from more than one acute illness has remained below 1 percent since 2010.

Health service use, access, and satisfaction

Use has increased, especially in rural areas and among the poorest households, narrowing the gap between rich and poor. In 2017, almost 82 percent of the population sought care if ill in the 6 months preceding the survey compared to 79 percent in 2014. Most notable improvements in access were observed among the poor. Among the poorest quintile, the share of those seeking care when ill rose from 70.9 percent in 2014 to 77.8 percent in 2017 (Table 2.1). The difference between the poorest and the richest quintile in seeking health care also narrowed substantially since 2014, from 12.8 to 6.6 percentage points in 2017. The average number of consultations per person increased from 0.9 in 2014 to 1.5 in 2017 (0.9 to 1.2 outpatient consultations, respectively). The number of consultations per person among the poorest quintile increased from 0.9 in 2014 to 1.3 in 2017 and among the richest quintile from 1.3 to 1.6 visits, respectively. Yet a large share of the population continues to seek outpatient care directly from hospitals (almost 32 percent in 2017 compared to 31 percent in 2014) rather than through primary care.

Increased use can be attributed to improvements in access (rather than greater need for health care). Physical access to care has improved since 2014. Almost 56 percent of the population can reach a facility within 15 minutes in 2017 compared to 49 percent in 2014. For comparison, only 37.6 percent of the population had access to a facility within 15 minutes in 2007. Importantly, the share of rural population that can access a health facility has increased from 29.3 percent in 2007 to 48.0 percent in 2017. The share of population reporting access to a health facility within 30 minutes has not changed since 2014 and was around 86 percent in 2017 (up from 81 percent in 2007).

Financial barriers to access have fallen, especially among the poorest households, but access to medicines has not improved. Affordability of care has also improved somewhat, and the immediate gains that were achieved in 2014 have been sustained. The share of individuals not seeking care for an acute illness due to cost fell from 10 percent in 2014 to 7 percent in 2017. The largest declines were observed among the poorest quintile, where the share fell from 19 percent to 12 percent. Access to medicines and inpatient care also appears to have improved slightly (Table 2.1). In addition, the share of respondents who said that they expected to pay for a consultation has remained around 35 percent (in 2014 and 2017) – a significant decline from 74 percent in 2010.

Table 2.1 Financial access to health services, 2007-2017

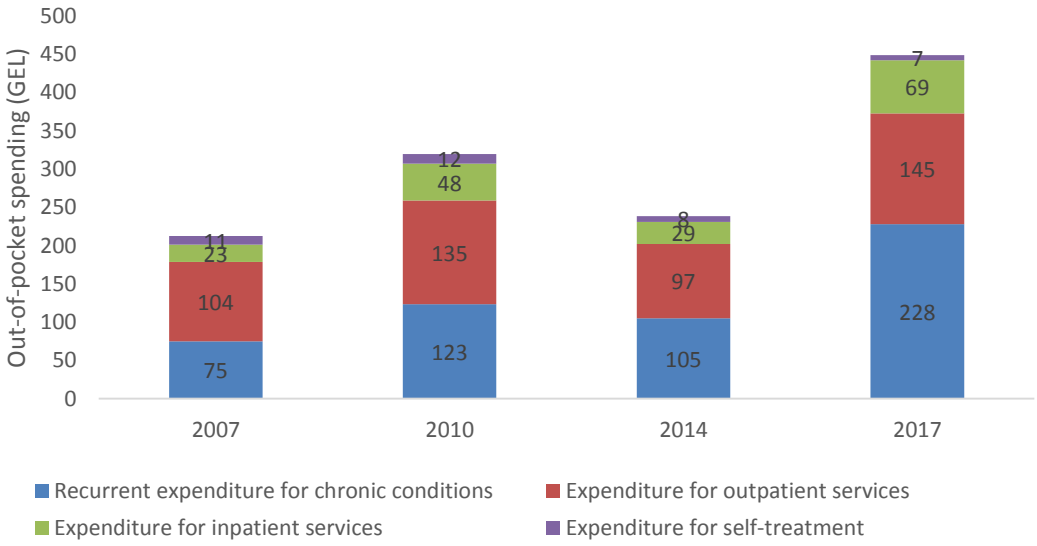
	Year	Q1 (poorest)	Q2	Q3	Q4	Q5 (richest)	**Total**
Percentage of occurrences of	2007	21.5	18.7	23.7	15.2	11.3	**16.1**
acute sickness in last 30 days,	2010	27.7**	21.9	21.6	20.5*	7.3**	**16.7**
where no consultation was	2014	18.7	10.8	6.2***	9.9	4.9	**10*** **
undertaken because it was too expensive	2017	12.3***	5.9***	6.1	5.9**	2.7	**6.8*** **

Percentage of consultations where medicine was prescribed but not purchased because it was too expensive	2007	16.4	11.6	11.6	12.2	7.3	**11.8**
	2010	21.7**	14.2	11.1	9.4*	10.3*	**13.1**
	2014	18.6	11.9	9.7	7.6	5.6***	**10.2**
	2017	15.2***	9.9*	9.5	7.8	5.5	**9.6**
Percentage of total population who reported needing hospitalization in the last year but were not hospitalized because it was too expensive	2007	4.7	3.9	3.3	4.7	3.4	**3.9**
	2010	3.5	1.8	2.3	2.8	2.6	**2.6*** **
	2014	1.4***	1.4	1.1***	0.7***	1.2**	**1.2**
	2017	0.7***	0.9***	0.5***	0.8	0.5***	**0.7*** **

Household spending on health

With increased access has come increased financial burden through out-of-pocket (OOP) payments. Household spending has increased, reversing the trend seen between 2010 and 2014. The rate of increase between 2014 and 2017 is greater than the rate of increase between 2007 and 2010. In 2017, individuals on average spent 449 GEL – almost double the amount spent in 2014. The significant rise in the total OOP amount appears to come from a substantial increase in recurrent expenditure for chronic conditions (rising from 105 GEL in 2014 to 228 GEL in 2017) (Figure 2.1). The growth in total spending by households on chronic conditions is likely driven by both the increase in the reported prevalence of chronic conditions and the increase in the mean cost per chronic patient. OOP spending among chronic patients was 616 GEL in 2017 (compared to 338 GEL in 2014).

Figure 2.1 Annualized per capita expenditure (current GEL), 2007-2017



Implications for Policy

Overall, substantial improvements have been achieved since the introduction of the UHC program, particularly among the poor and rural populations. The gap between the rich and poor and those residing in urban versus rural areas has narrowed on most indicators. The results from the 2017 HUES confirm the positive trends on most indicators. The substantial increase in OOP spending, however, raises concerns about the future affordability of care. The high OOP spending for chronic conditions confirms the need for benefits package expansion to cover the cost of pharmaceuticals

implemented in July 2017. Moving forward, it would be important to monitor whether the reform has resulted in reductions in OOP spending.

3 Background

3.1 Overview of Georgia's health system

Georgia is a lower middle-income country with a GNI per capita of 3810 US$ in 2016. The country has a population of 3.7 million, almost 42 percent of which reside in rural areas. Between 2007 and 2014, real GDP per capita grew on average by 6.8 percent annually, but modest growth of 3.1 percent and 2.7 percent has been observed in 2015 and 2016, respectively. Almost 21 percent of the population lives below the national monthly poverty line.

The country has made progress in improving health system performance and outcomes, but the increasing burden of non-communicable diseases (NCDs) and high prevalence of risk factors presents challenges. Between 1990 and 2015, life expectancy increased from 70 years to 73 years. While life expectancy increased by 3.4 years for women (from 73.9 to 77.3, respectively), men's life expectancy rose by only 2.5 years (from 66.3 to 68.8 years) (WDI, 2017). In 2016, NCDs accounted for 81.2 percent of disability-adjusted life years (DALYs) and 92.2 percent of deaths (IHME, 2017). The top cause of DALYs is ischemic heart disease, followed by cerebrovascular disease and low back and neck pain. Almost 28 percent of the adult population is hypertensive (systolic blood pressure of 140 mm Hg or higher), and 21 percent of the adult population is obese (i.e. BMI of 30 or higher). Prevalence of smoking is high and almost exclusively concentrated among men: 58 percent of men smoke compared to 6 percent of women (WDI, 2017).

In February 2013, the Government of Georgia launched the Universal Health Coverage Program (UHCP), ensuring access to a defined benefits package to the entire population. The following year all state-funded health insurance programs were pooled together and administered by the Social Services Agency (SSA). The benefits package covers a range of primary and secondary care services, including planned ambulatory care, emergency outpatient and inpatient services, (with), elective surgery, oncological services, obstetric care, and some essential drugs (20-30 percent co-payment and up to 15,000 GEL or approximately 5580 USD). The depth of coverage differs and is greater for lower income households (those below the poverty line), pensioners, and children aged 0-5 years. In May 2017, individuals earning more than 40,000 GEL (or approximately 14,900 USD) were excluded from the UHCP. This affected about 30,000 individuals (or approximately 0.8 percent of the population), who were expected to purchase voluntary health insurance.

The UHCP was backed by substantial increases in government budget allocations for health, which rose from 5.2 percent of government spending in 2012 to 10.3 percent in 2016. As a result, OOP spending as a share of current health spending declined from 73.4 percent in 2012 to 55.6 percent in 2016 (Table 3.1). Despite the decline, OOP spending remains above global averages for countries with a similar level of income. Financial access has improved for inpatient care, but limited coverage of medicines under the UHC program hinders financial risk protection. Only selected groups are eligible for 50 percent reimbursement, and the annual claim limit per person is low. In addition, the annual cap on benefits does not provide individuals with adequate depth of coverage. For those beneficiaries who are not entitled for free care, the copayment amount is calculated as 20-30 percent of the hospital price or SSA tariff (whichever is lower), but patients are also required to pay hospitals any differences between the SSA tariff and the hospital's price. The complexity of copayment calculations causes confusion and undermines transparency. Given that almost two-thirds of OOP spending are for outpatient pharmaceuticals, in July 2017, the government expanded the benefits package for the most vulnerable households, pensioners, and disabled persons to cover essential medicines for four common chronic conditions (WHO, 2017).

Table 3.1 Key health financing indicators, 2007-2017

	2007	2008	2009	2010	2011	2012	2013	2014	2015
Current health spending percent of GDP	7.6	8.7	9.8	9.5	8.4	8.4	8.4	8.4	7.9
Government spending percent current health spending	14.8	18.4	21.1	21.3	17.6	18.5	22.9	27.7	38.8
Out-of-pocket spending percent of current health spending	75.6	66.5	68.9	72.7	75.6	73.4	69.1	66.0	57.3
Government spending percent of general government expenditures	4.0	4.9	5.8	6.1	5.1	5.2	6.7	7.8	10.5

Source: World Health Organization Global Health Expenditure Database (2018).

This report presents findings from the 2017 Health Expenditure and Utilization Survey. While changes in health outcomes are manifested over a longer time horizon, monitoring service utilization and out-of-pocket spending allows to assess progress in achieving UHC.

3.2 Health Utilization and Expenditure Survey (HUES)

The first, baseline Health Utilization and Expenditure Survey (HUES) was conducted in May and June 2007. Follow-up surveys were conducted in 2010, 2014, and 2017. This report presents the results from the 2017 survey and compares them to results from previous rounds.

The objectives of the HUES survey are to:

- provide information on reported health status, use of services and satisfaction with services;
- provide information on changes in these measures, both at the national level and for specific population groups;
- estimate household health expenditure.

The survey is based on a nationally representative sample of households. More than 3,000 households were analysed in each round of the survey, from initial samples of around 3,500 households (Table 8.1). The samples are largely drawn from households that have already been interviewed in the Integrated Household Survey (IHS) conducted by Geostat. For these households, information on household consumption and expenditure is available from the IHS, allowing for analysis of sickness, utilization and health expenditure data by household consumption level.

The HUES questionnaire is structured into seven main sections (Table 8.2). All household members are asked about current and past illnesses, including chronic diseases. Information on sickness and use of services is also collected. This includes information on all illnesses and use of services in the last thirty days; last use of services for anyone who sought care in the last six months; and information on hospitalization in the previous 12 months. It is important to note that conditions and complaints for both chronic and acute conditions are self-reported. While they may sometimes be based on diagnoses given by doctors to the respondents, in other cases they may not be. They are nevertheless informative, particularly since they include conditions for which the individual may not have had any contact with health services. To ensure comparability, the questionnaire used in the follow-up surveys has remained similar to the baseline survey.

It is important to note that the 2017 HUES was conducted in June and July 2017, following the establishment of the UHCP high-income exclusion and coinciding with the expansion of the benefits package for the most vulnerable households in July 2017. The survey therefore does not capture the changes associated with the recent reforms.

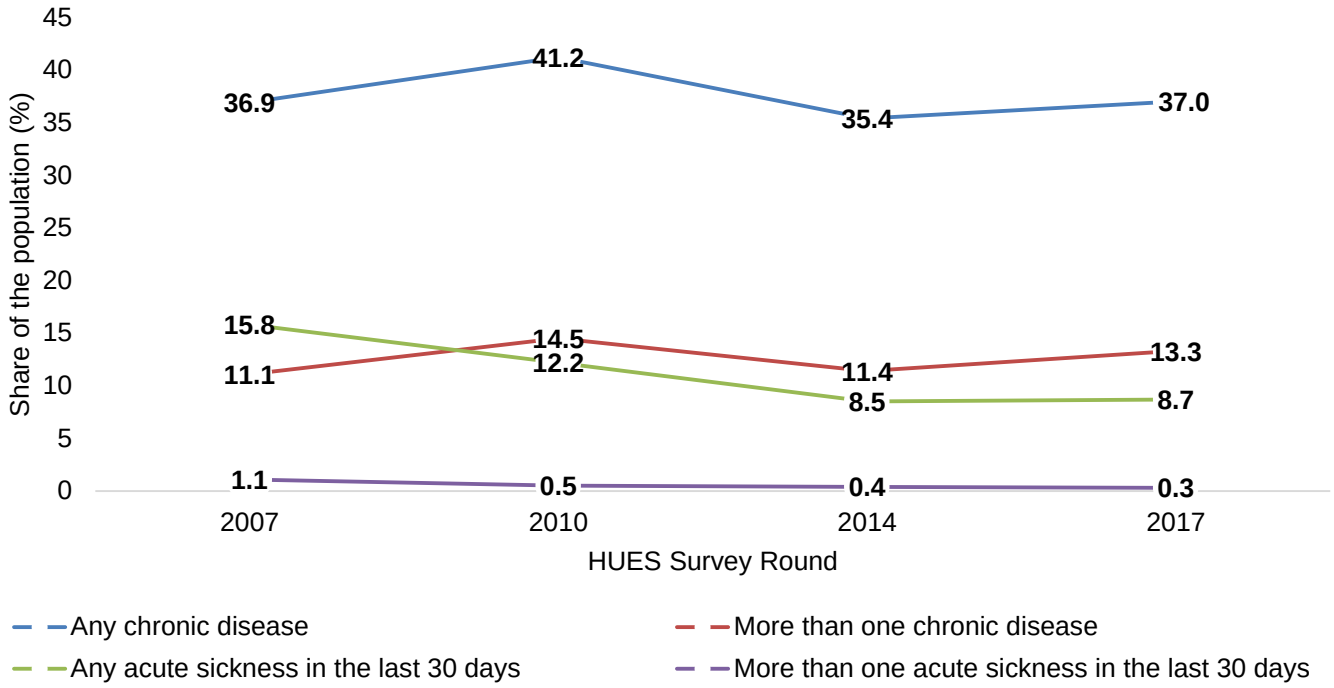
The body of this report is divided into four chapters. Chapter 4 presents information on health status; Chapter 5 reports findings on health service use, access, and satisfaction; and Chapter 6 focuses on household spending on health.

4 Health status

This chapter presents survey findings on self-reported illness. Respondents were asked about their health status and whether they suffered from any chronic illness (lasting or expected to last more than a year). They were also asked whether, in addition to those conditions, they had been ill in the last thirty days – these were considered to be acute conditions.

Almost 37.0 percent of the population in 2017 suffered from a chronic illness – a small increase from 35.4 percent in 2014. About 13.3 percent reported suffering from more than one chronic illness, which also represents a slight increase from 11.4 percent in 2014. The proportion of people reporting an acute sickness in the preceding 30 days (8.7 percent) has not changed significantly since 2014 (8.5 percent), and the share of population suffering from more than one acute illness has remained below 1 percent (Figure 4.1).

Figure 4.1 Proportion of individuals reporting illness, 2007-2017



Differences between the urban and rural populations have remained small. Chronic diseases are slightly more prevalent in rural areas – affecting 37.3 percent of the rural population and 36.6 percent of the urban population. Meanwhile, incidence of acute illness seems to have increased slightly in urban areas and decreased in rural areas. In urban areas, the proportion of the population reporting at least one acute illness in the previous 30 days rose from 8.9 percent in 2014 to 10.5 percent in 2017, while in rural areas it dropped from 8.2 percent to 7.1 percent (Table 4.2).

Table 4.2 Proportion of individuals reporting sickness, 2007-2017

	Year	Urban	Rural	Total
Individuals with any chronic disease (percent)	2007	37.8	36.2	36.9
	2010	41.6***	40.7***	41.2***
	2014	34.7***	36.1***	35.4***
	2017	36.6***	37.3*	37.0***
Individuals with more than one chronic disease (percent)	2007	12.2	10.0	11.1
	2010	15***	14***	14.5***
	2014	11.4***	11.3***	11.4***
	2017	13.4***	13.2***	13.3***
Individuals with one acute sickness last 30 days (percent)	2007	18.7	13.1	15.8
	2010	11.8***	12.7	12.2***
	2014	8.9***	8.2***	8.5***
	2017	10.5***	7.1***	8.7
Individuals with more than one acute sickness during the last 30 days (percent)	2007	1.5	0.7	1.1
	2010	0.4***	0.6	0.5***
	2014	0.6	0.3**	0.4
	2017	0.3***	0.3	0.3*

Note: Statistical significance of difference with previous survey: *** p<0.01; ** p<0.05; * p<0.1.

The overall distribution of chronic condition has remained similar between 2014 and 2017. The most common chronic diseases continue to be hypertension and other heart or circulatory diseases, accounting for about 37.6 percent of occurrences in 2017 (up from 34.1 percent in 2014). In 2017, approximately 22.9 percent of the population was hypertensive. Since 2007, the prevalence of diabetes, hypertension, and other heart of circulatory system diseases has been increasing. The prevalence of diabetes, for example, almost doubled since 2007, increasing from 3.6 percent to 6.9 percent.

Figure 4.2 Prevalence of the top five chronic conditions, 2007-2017

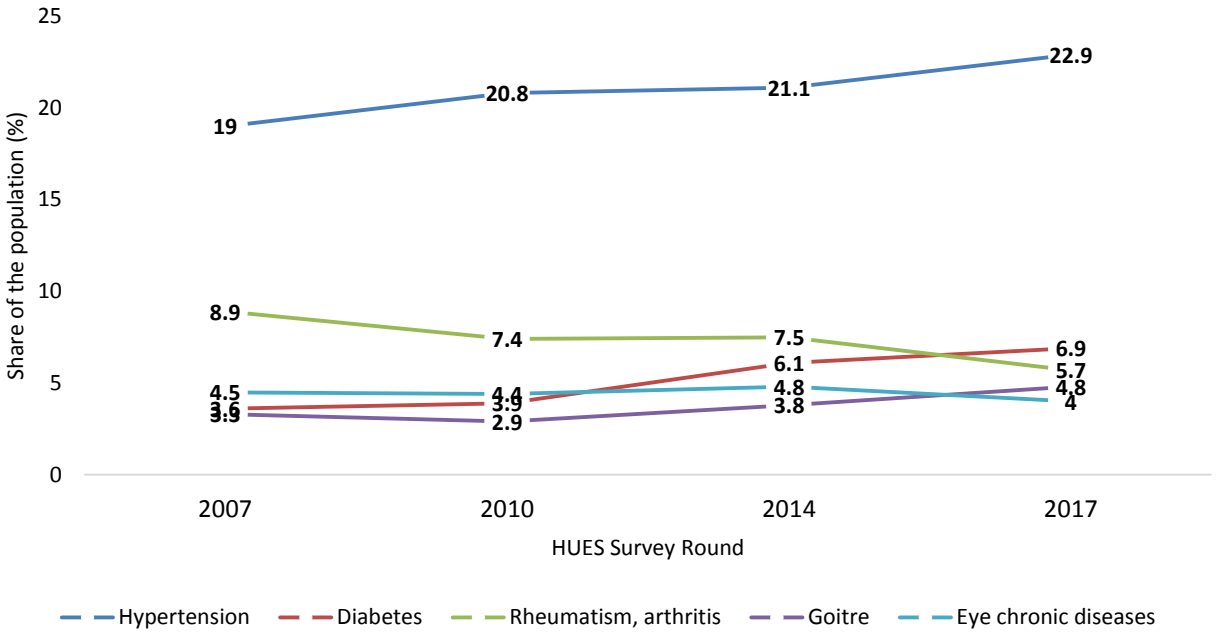


Table 4.3 Distribution of chronic conditions, 2010 and 2017

percent of occurrences	2007			2010			2014			2017		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Hypertension	18.2	19.9	**19**	20.5	21.1	**20.8**	21.5	20.7	**21.1**	22.3	23.4	**22.9**
Diabetes	4.2	3.1	**3.6**	4.5	3.4	**3.9**	7	5.3	**6.1**	7.7	6.2	**6.9**
Rheumatism, arthritis	6.9	10.9	**8.9**	6.5	8.3	**7.4**	5.6	9.3	**7.5**	5	6.4	**5.7**
Goiter	3.5	3.1	**3.3**	3.1	2.8	**2.9**	4.9	2.9	**3.8**	5.8	4	**4.8**
Eye chronic diseases	4	5	**4.5**	4.2	4.6	**4.4**	4.6	4.9	**4.8**	4	3.9	**4**
Neurological disorder	4.6	5.2	**4.9**	5.1	4.8	**4.9**	3.8	4.6	**4.2**	3.6	3.6	**3.6**
Allergy	2.2	1.6	**1.9**	2.9	1.8	**2.3**	2.4	1.7	**2**	3.4	1.8	**2.6**
Asthma	1.9	2.3	**2.1**	2	2.1	**2**	1.5	1.5	**1.5**	1.6	2.6	**2.1**
Gallstones	1.8	1.7	**1.8**	1	1.6	**1.3**	1.3	0.9	**1.1**	1.6	2.2	**1.9**
Psycho-emotional disorders	0.9	1.4	**1.1**	1	1.3	**1.1**	1.1	1.7	**1.4**	1.7	1.8	**1.7**
Cancer	1.3	1.1	**1.2**	1.4	1.1	**1.2**	1	1.5	**1.3**	2	1.3	**1.7**
Gynecological	2.9	2.6	**2.7**	3.2	2	**2.6**	1.7	1.7	**1.7**	1.8	1.5	**1.6**
Ulcers	2	1.8	**1.9**	0.9	1.2	**1.1**	1.1	1.3	**1.2**	1.3	1.8	**1.5**
Tuberculosis	0.2	0.7	**0.5**	0.3	0.6	**0.4**	0.3	0.6	**0.4**	0.1	0.3	**0.2**
Other heart or circulatory system	13.7	12.1	**12.9**	13.1	14.6	**13.8**	13	14.9	**14**	14.5	14.9	**14.7**
Other chronic diseases	11.4	8.8	**10.1**	12	10.3	**11.2**	9.4	7.8	**8.6**	8.9	7.9	**8.4**
Other musculo-skeletal	6.6	7.3	**6.9**	5.7	6.9	**6.3**	8.4	9.1	**8.7**	7.3	8.7	**8**
Other gastrointestinal	5.8	5.6	**5.7**	5.6	5.4	**5.5**	5.7	4.5	**5.1**	4.1	4.9	**4.5**
Other hepatic, biliary	5.7	3.8	**4.7**	5.1	4.2	**4.7**	3.3	3.6	**3.5**	1.9	1.9	**1.9**
Other respiratory	2.4	1.9	**2.2**	2	2	**2**	2.4	1.4	**1.9**	1.4	1	**1.2**

The distribution of acute conditions has not changed substantially since 2014. Respiratory diseases are the most common acute illness, with 30.4 percent of the population reporting

occurrence of respiratory disease in 2017, and cardiovascular diseases are the second most common acute illness (13.6 percent) (Figure 4.3 and Table 4.4).

Figure 4.3 Prevalence of the top five acute conditions in the past 30 days, 2007-2017

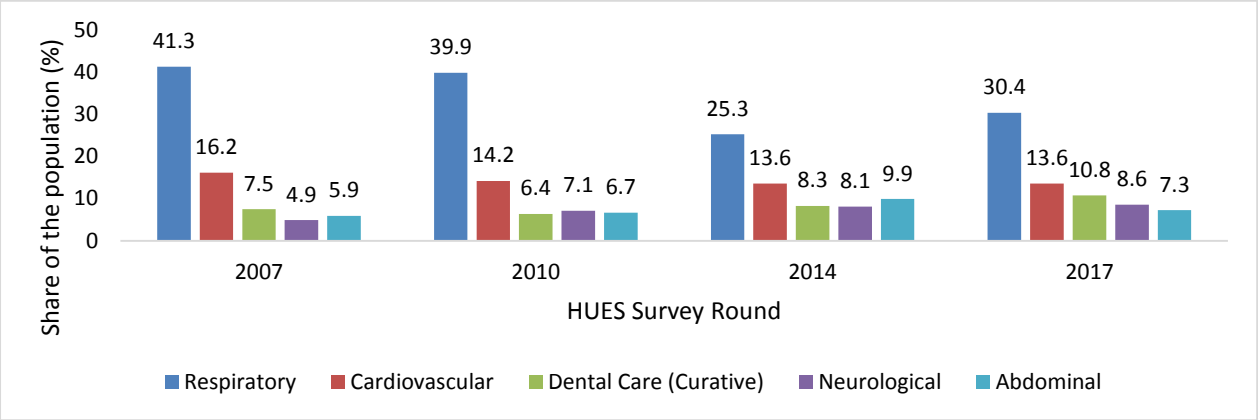


Table 4.4 Acute conditions during last 30 days, 2010

percent of occurrences	2007			2010			2014			2017		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Respiratory	41.6	41	**41.3**	41.6	38.3	**39.9**	25.2	25.4	**25.3**	28.9	32.4	**30.4**
Cardiovascular	15.2	17.4	**16.2**	14.2	14.1	**14.2**	13.1	14.3	**13.6**	11.8	16	**13.6**
Dental Care (Curative)	9.1	5.4	**7.5**	8.2	4.8	**6.4**	8.4	8.2	**8.3**	14.1	6.3	**10.8**
Neurological	4.6	5.3	**4.9**	5.9	8.3	**7.1**	6.4	10.1	**8.1**	7	10.7	**8.6**
Abdominal	5.2	6.7	**5.9**	4.6	8.6	**6.7**	8.2	11.7	**9.9**	7.4	7.1	**7.3**
Urogenital	4	8	**5.7**	4.1	7.1	**5.7**	5.9	10.1	**7.9**	4.1	5.7	**4.8**
Skin Problems	2.2	1.3	**1.8**	1.7	1.5	**1.6**	4.7	2.1	**3.5**	3.7	2.8	**3.3**
Poisoning/Intoxication	0.9	1.1	**1**	0.6	1.1	**0.9**	2.6	2.4	**2.5**	1.5	1.5	**1.5**
Psychological/Mental Problems	2.4	0.5	**1.6**	0.9	0.8	**0.8**	1.3	0.4	**0.9**	0.9	1.6	**1.2**
Pregnancy-Related Problems	0	0.8	**0.3**	0	0.3	**0.2**	0.2	0.3	**0.3**	0.2	0.7	**0.5**
Car Accident	0.2	0.1	**0.2**	0.1	0.1	**0.1**	0	0.2	**0.1**	0	0.3	**0.1**
Harm Purposely Inflicted by Others	0.1	0	**0**	0	0.2	**0.1**	0	0	**0**	0	0.2	**0.1**
Other Acute Illness	9.6	7.5	**8.7**	13.8	9.6	**11.6**	17.1	9.8	**13.6**	12.7	10.1	**11.6**
Other Trauma/Injury	3.2	4.7	**3.8**	3.5	4.4	**4**	6.6	4.8	**5.7**	5.6	4	**4.9**
Other Infectious Diseases	1.6	0	**0.9**	0.9	0.9	**0.9**	0.3	0.2	**0.3**	2	0.6	**1.4**

In 2017, over half of the population (52.6 percent) rated their health as good or better over the last four weeks. The share of population rating their health as good or better was slightly lower in rural areas than in urban areas (51.5 percent and 53.8 percent, respectively). However, individuals in urban areas were more likely to report an illness in the past 6 months than in rural areas in 2017 (44.4 percent in urban areas compared to 37.8 percent in rural areas).

As expected, chronic illnesses are particularly prevalent among older people. In 2017, 70.4 percent of men and 82.5 percent of women over 60 years of age reported a chronic illness – comparable to estimates from 2014 (Table 4.5).

Table 4.5 Age and sex differences in reported illness, 2017

Indicator			0-4 years	5-14 years	15-40 years	41-60 years	60+ years	Total
Share of the population with an acute illness in the last 30 days by age and gender	2007	Male	19.6	15.7	9.9	15.4	19.2	**14.2**
		Female	20.3	11.9	14.5	19.3	21.8	**17.3**
	2010	Male	21.2	10.0	9.2	11.4	15.2	**11.8**
		Female	15.7	9.0	9.2	12.8	18.5	**12.7**
	2014	Male	10.1	6.7	5.1	8.5	9.9	**7.4**
		Female	12.5	7.7	6.8	9.7	12.8	**9.5**
	2017	Male	12.8	9.5	5.9	7.6	10.8	**8.3**
		Female	11.6	6.9	6.9	9.0	11.9	**9.1**
Share of the population with a chronic illness by age and gender	2007	Male	9.0	9.3	17.3	42.6	71.3	**31.2**
		Female	6.9	9.9	20.6	59.3	81.3	**42.1**
	2010	Male	9.0	11.3	20.1	51.2	74.5	**36.0**
		Female	4.5	12.7	21.4	63.4	85.6	**45.8**
	2014	Male	5.4	8.5	14.0	39.7	69.4	**30.1**
		Female	5.5	6.7	15.9	48.9	82.2	**40.2**
	2017	Male	5.6	9.6	13.3	40.7	70.4	**31.2**
		Female	3.0	5.7	17.2	50.0	82.5	**42.3**

5 Health service use, access, and satisfaction

5.1 Use of services

The information on the use of all health services in the preceding 30 days can be used to estimate the total number of consultations by place of consultation on an annual basis, although it does not allow to measure seasonal changes in utilization. The overall level of utilization of health care, considering contact with any type of provider, appears to have increased significantly since 2014, with 1.5 contacts per person per year in 2017, compared with 0.9 in 2014 (Table 5.1). Utilization remains higher in urban areas, with 1.8 yearly contacts per capita, as opposed to just 1.2 in rural areas in 2017. Looking at outpatient consultations, similar trends are observed (a statistically significant increase from 0.9 outpatient consultations per capita in 2014 to 1.2 in 2017 and more pronounced in urban areas than in rural areas).

Overall utilization levels depend substantially on the frequency with which individuals fall sick and their propensity to consult with a provider when they are sick. The proportion of individuals having consulted a health care provider when sick (with any condition) rose from 78.9 percent in 2014 to 82.0 percent in 2017. In the case of acute illnesses, the share of individuals consulting a healthcare has remained broadly stable since 2010, slightly under 80 percent (Table 5.1).

Table 5.1 Utilization of services when sick

Indicator	Year	Urban	Rural	Total
Average number of consultations/contacts per person per annum (all sources of care)	2007	1.8	1.3	1.6
	2010	1.4***	1.4	1.4*
	2014	1.0***	0.8***	0.9***
	2017	1.8***	1.2***	1.5***
Average number of outpatient consultations (all types) per person per annum	2007	1.8	1.2	1.5
	2010	1.4***	1.3	1.4*
	2014	0.9***	0.8***	0.9***
	2017	1.5***	0.9***	1.2***
Percentage of total population who reported being sick with any condition in last 6 months and consulted a health care provider	2007	71.5	71.1	71.3
	2010	75.9**	73.3	74.6***
	2014	81.5***	76.3**	78.9***
	2017	82.5	81.4***	82.0***
Percentage of occurrences of acute illness in the past 30 days where a healthcare provider was consulted	2007	70.4	72.3	71.2
	2010	77.4**	76.9*	77.1***
	2014	80.1	77.8	79.0
	2017	77.4	80.5	78.7

Note: Statistical significance of difference with previous survey: *** p<0.01; ** p<0.05; * p<0.1.

For consultations undertaken in the preceding six months, over half of all first consultations (50.5 percent) in 2017 took place at the primary level (Figure 5.1 and Table 5.2)[1]. The main sources of consultation are hospitals (as an outpatient), providing about 31.9 percent of consultations, and polyclinics, providing another 29.6 percent. Even in rural areas, hospitals and polyclinics account

[1] This refers to the most recent consultations by any individual who reported being sick in the preceding six months. The places of treatment are considered to be primary level care are: home visits, village ambulatory centres, polyclinics, women's consultation clinics, dental clinics, and ambulances (if only treated there).

for more than half of first consultations (54.1 percent). Village ambulatories are the third most important source of consultations in rural areas, accounting for 16.4 percent in 2017 (down from 20.2 percent in 2014).

Figure 5.1 First place of consultation reported for the last use of services in the preceding six months, 2017

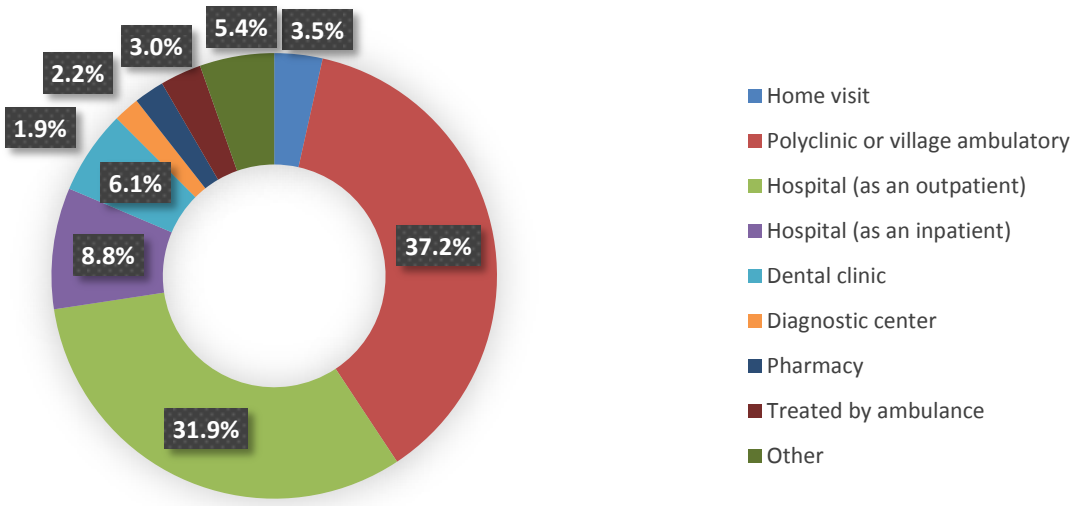


Table 5.2 First place of consultation reported for the last use of services in the preceding six months

Place of consultation (last 6 months)	2007			2010			2014			2017		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Home visit	10.2	7.2	**8.7**	8.9	5.1	**7.0**	4.1	5.0	**4.5**	3.0	4.2	**3.5**
Village Ambulatory Centre	0.5	18.9	**9.5**	0.2	17.6	**8.9**	0.2	20.2	**9.7**	0.0	16.4	**7.6**
Polyclinic	29.1	19.2	**24.2**	27.4	20.2	**23.8**	37.8	18.0	**28.4**	39.8	17.6	**29.6**
Dispensary	0.5	0.5	**0.5**	0.5	0.5	**0.5**	0.3	0.3	**0.3**	0.4	0.4	**0.4**
Women's consultation clinic	1.3	1.2	**1.3**	1.5	1.5	**1.5**	0.7	1.0	**0.9**	0.8	0.5	**0.7**
Hospital (as an outpatient)	27.2	30.0	**28.6**	28.5	30.5	**29.5**	28.7	34.3	**31.3**	28.0	36.5	**31.9**
Hospital (as an inpatient)	3.5	5.3	**4.4**	4.7	5.7	**5.2**	7.9	6.7	**7.3**	7.8	10.0	**8.8**
Dental clinic	6.9	3.5	**5.2**	6.2	2.2	**4.2**	7.1	3.8	**5.5**	9.2	2.5	**6.1**
Diagnostic center	2.7	1.1	**1.9**	3.8	1.8	**2.8**	2.7	1.3	**2.0**	2.3	1.4	**1.9**
Private office/professional's home	6.8	3.4	**5.1**	4.8	5.4	**5.1**	3.8	3.5	**3.7**	2.4	4.2	**3.2**
Pharmacy	4.6	5.2	**4.9**	5.0	3.0	**4.0**	2.0	1.7	**1.9**	2.0	2.4	**2.2**
Abroad	0.2	0.3	**0.2**	0.3	0.4	**0.4**	0.1	0.2	**0.2**	0.0	0.4	**0.2**
Ambulance - treated only there	4.4	3.0	**3.7**	5.7	4.7	**5.2**	3.3	3.2	**3.2**	2.9	3.2	**3.0**
Other	1.9	1.5	**1.7**	2.3	1.0	**1.7**	1.0	1.0	**1.0**	1.1	0.5	**0.9**
Don't know/Refuse to answer	0.1	0.0	**0.1**	0.1	0.3	**0.2**	0.2	0.0	**0.1**	0.0	0.0	**0.0**
Total	100.0	100.0	**100.0**	100.0	100.0	**100.0**	100.0	100.0	**100.0**	100.0	100.0	**100.0**

Additional results on the type of provider most frequently consulted at the first place of treatment reflect these findings (Table 5.3). The proportion of first consultations with district and family doctors has decreased slightly, from 24.1 percent in 2014 to 22.3 percent in 2017. Consultations with specialist and hospital doctors still account for about two thirds (65.0 percent) of first consultations.[2]

Table 5.3 Person consulted in the last use of services in the preceding six months (first place of treatment only)

Main person consulted for a sickness during the last 6 months	2007			2010			2014			2017		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
District (and family) doctor	15.4	21.7	**18.5**	16.7	20.5	**18.6**	24.0	24.1	**24.1**	22.6	22.1	**22.3**
Specialist (incl. hospital) doctor	70.0	65.8	**67.9**	64.9	69.5	**67.2**	64.9	68.1	**66.4**	61.9	68.7	**65.0**
Nurse	0.1	2.1	**1.1**	0.2	0.7	**0.4**	0.1	0.5	**0.3**	0.1	0.3	**0.2**
Pharmacist	4.6	5.3	**5.0**	4.9	3.0	**3.9**	2.0	1.7	**1.9**	2.1	2.4	**2.2**
Dentist/dental technician	7.5	3.6	**5.6**	6.9	2.3	**4.6**	7.4	4.5	**6.0**	9.7	3.1	**6.7**
Lab/diagnostic technician	0.5	0.1	**0.3**	0.5	0.2	**0.4**	0.2	0.0	**0.1**	0.2	0.0	**0.1**
Alternative provider	0.8	0.2	**0.5**	0.4	0.4	**0.4**	0.3	0.2	**0.3**	0.0	0.0	**0.0**
Other	0.9	1.2	**1.0**	5.4	3.4	**4.4**	0.9	0.8	**0.9**	3.4	3.3	**3.4**
Don't know/Refuses to answer	0.1	0.1	**0.1**	0.1	0.0	**0.0**	0.2	0.0	**0.1**	0.0	0.0	**0.0**
Total	100.0	100.0	**100.0**	100.0	100.0	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

5.2 Access to services

Most people have access to a health facility within 30 minutes by their usual means of transport. In most cases, this refers to taking the bus or walking. Even in rural areas, about 81.4 percent of the population live within 30 minutes of the health facility that is the nearest and/or normally visited.[3] The proportion of households that report using a facility accessible within 30 minutes has increased considerably between 2007 and 2017, both in rural areas and for the population as a whole (Figure 5.2 and Table 5.4).

[2] This is consistent with the statement that around half of consultations take place at primary care level because consultations at polyclinics, including those with specialist doctors at polyclinics, were treated as primary care level for this analysis.

[3] The survey asked respondents about the health facility that they would normally visit to see a doctor, (not necessarily the one nearest to them).

Figure 5.2 Access to and availability of services, 2017

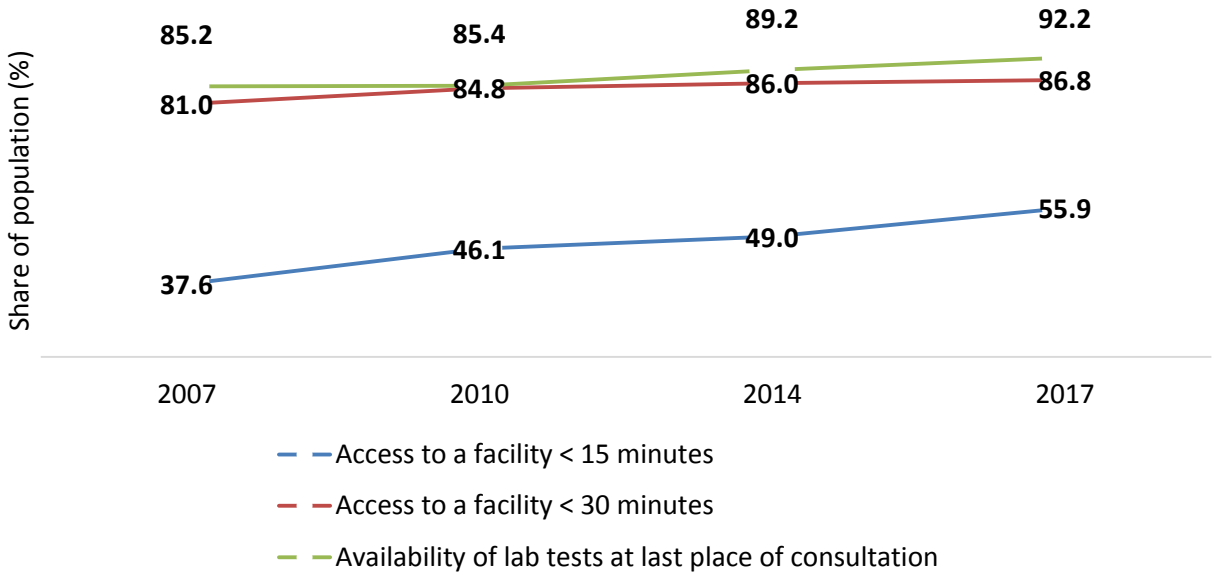


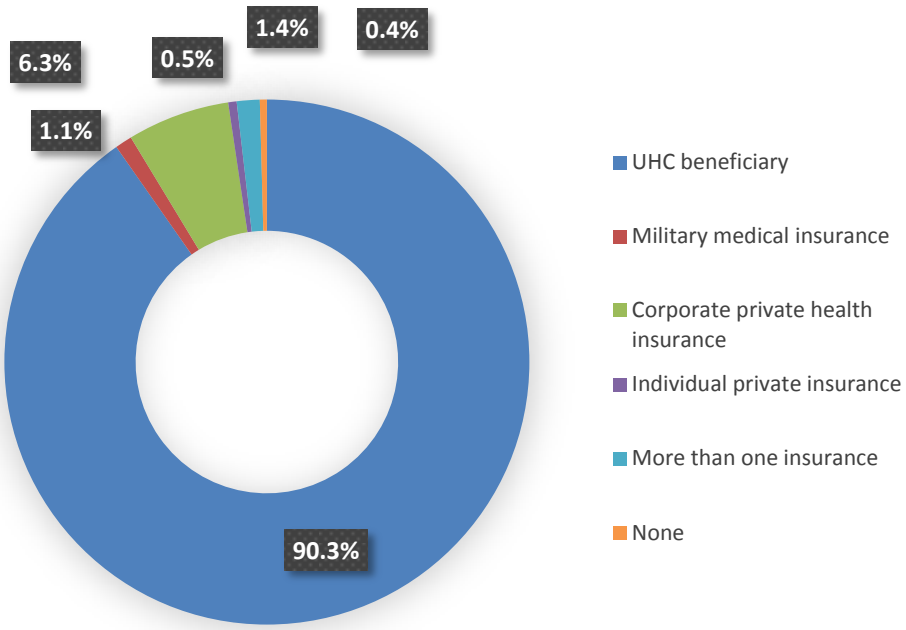
Table 5.4 Indicators of physical access and service availability

Indicator	Year	Urban	Rural	Total
Percentage of total population with access within 15 minutes by normal means of travel to a facility where they would normally see a doctor	2007	46.6	29.3	37.6
	2010	57***	35.5**	46.1***
	2014	53.3	44.9***	49.0
	2017	63.8***	48.0***	55.9***
Percentage of total population with access within 30 minutes by normal means of travel to a facility where they would normally see a doctor	2007	93.2	70.9	81
	2010	92.7	77.4**	84.8**
	2014	91.1	81.2	86.0
	2017	92.3	81.4	86.8
Mean number of days per week a doctor is reported to be present at polyclinics.	2007	5.1	5.0	5.0
	2010	5.1	5.2**	5.2**
	2014	5.2	5.5	5.3
	2017	5.3***	5.2***	5.3
Percent of health facilities (other than ambulatory) where a doctor is reported to be present for 5 or more days a week.	2007	100	98	98.9
	2010	100	98.2	99
	2014	97.7	99.2	98.5
	2017	98.9*	98.6	98.8
Percentage of patients who were able to obtain medications prescribed by doctor during last consultation	2007	83.2	84.8	84
	2010	81.5	82.6	82.1
	2014	86.7***	83.9	85.3**
	2017	88.4*	84.8	86.7**
Percentage of patients who were able to get needed lab tests at the same place they went for last consultation.	2007	88.1	82.3	85.2
	2010	88.5	82.4	85.4
	2014	91.9**	85.6	89.2***
	2017	93.5**	90.6***	92.2***

Note: Statistical significance of difference with previous survey: *** p<0.01; ** p<0.05; * p<0.1.

Georgia has achieved near universal health coverage, with less than 1 percent of the population not covered by any health schemes. The UHC Program accounts for the vast majority of coverage (90.3 percent of the population in 2017). It has the highest share in rural areas, where it covers about 95.4 percent of the population (Figure 5.3).[4]

Figure 5.3 Health insurance coverage, 2017



Services have become more affordable since 2007. In 2017, 6.8 percent of individuals with acute illnesses in the preceding 30 days did not undertake a medical consultation due to cost considerations, down from 10.0 percent in 2014 and 16.7 percent in 2010. However, the percentage of cases in which medicine was prescribed but not purchased because it was too expensive has remained relatively high: 9.6 percent in 2017 and 10.2 percent in 2014 (and the difference is not statistically significant). Medicine was prescribed in slightly less than 80 percent of consultations in both 2014 and 2017 (Table 5.5).

The proportion of individuals reporting that they required hospitalization but were not hospitalized is small and has declined in recent years (from 2.0 percent in 2014 to 1.5 percent in 2017).[5] The proportion reporting that they required hospitalization but could not afford it has also declined significantly over the past decade, from about 4.0 percent in 2007 to 0.7 percent in 2017 (Table 5.5).

[4] This information is based on coverage reported by each individual.

[5] Note that this was the self-reported need for hospital care and was not necessarily based on referral by a doctor.

Table 5.5 Insurance coverage, payments and affordability

Indicator	Year	Urban	Rural	Total
Percentage of occurrences of acute sickness in last 30 days, where no consultation was undertaken because it was too expensive/not enough money (percent of all reasons)	2007	14.2	16.4	15.1
	2010	14.3	18.9	16.7
	2014	9.6*	10.4***	10.0***
	2017	6.0***	7.8**	6.8***
Percentage of consultations where medicine was prescribed	2007	78	86.1	81.9
	2010	75.4	85.4	80.4
	2014	77.1	81.8***	79.3
	2017	75.6	82.8	78.9
Percentage of consultations where medicine was prescribed but not purchased because it was too expensive (base: all consultations)	2007	11.4	11.4	11.4
	2010	12.6	13.6*	13.1*
	2014	8.5***	12.1	10.2***
	2017	7.8	11.7	9.6
Percentage of consultations where a lab test was prescribed	2007	42.9	44.7	43.8
	2010	44.7	45.5	45.1
	2014	54.8***	47.5	51.4***
	2017	53.6	53.4***	53.0**
Percentage of consultations where a lab test was prescribed but not done because it was too expensive (base: all consultations)	2007	3.1	5.2	4.1
	2010	3.6	4.8	4.2
	2014	2.3**	3.6*	2.9***
	2017	2.1	2.8**	2.4**
Percentage of population who reported requiring hospitalization in the last year but were not hospitalized	2007	3.7	5.3	4.5
	2010	3.2	3.6**	3.4**
	2014	1.8***	2.2***	2.0***
	2017	1.3**	1.7***	1.5***
Percentage of total population who reported requiring hospitalization in the last year but were not hospitalized because it was too expensive/they did not have enough money	2007	3.3	4.6	4.0
	2010	2.6	2.5***	2.6***
	2014	1.1***	1.3***	1.2***
	2017	0.6***	0.8***	0.7***
Percentage of respondents who expect to pay for a consultation with a doctor at the nearest facility	2007	76.7	63.3	69.4
	2010	86.7***	61	73.7*
	2014	36.7***	34.8***	35.6***
	2017	39.4*	29.8***	34.5
Percentage of consultations where users received a receipt for all payments made	2007	42.1	28	35.7
	2010	52.8**	37.4**	44.5**
	2014	79.0***	71.4***	75.5***
	2017	82.6*	77.9***	80.8***

Note: Statistical significance of difference with previous survey: *** p<0.01; ** p<0.05; * p<0.1.

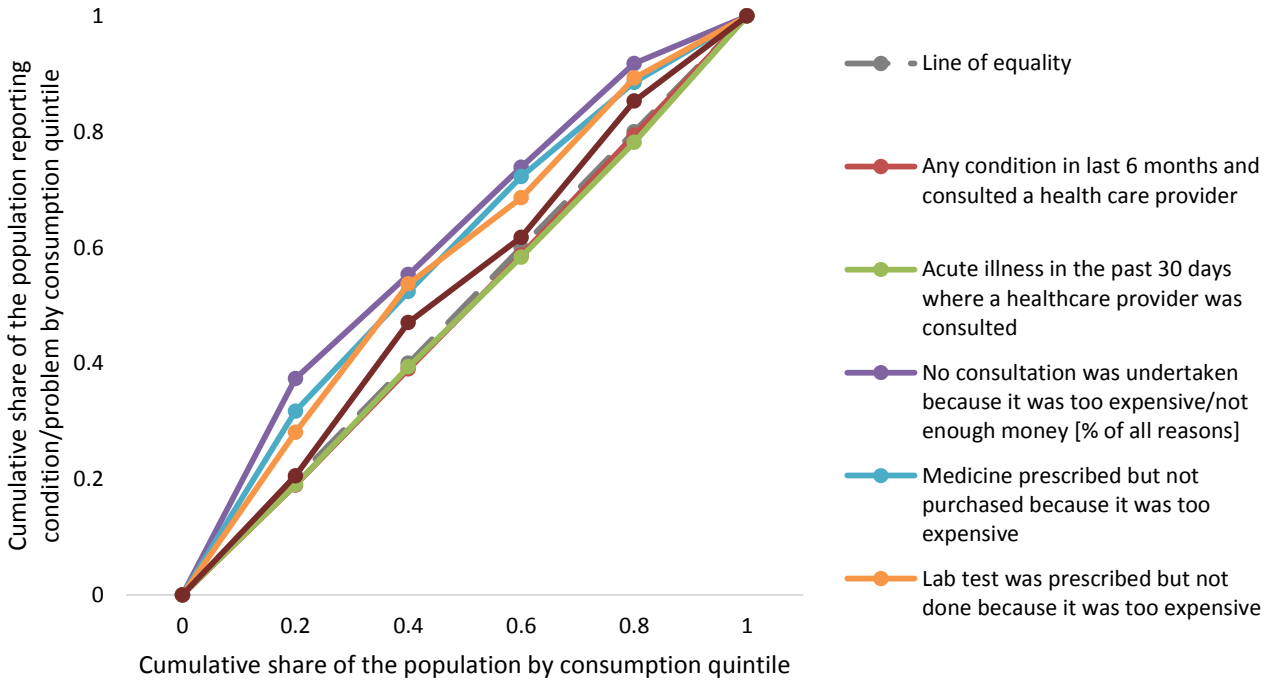
The proportion of users expecting to pay for a consultation at their nearest facility has decreased dramatically over the past decade, from 69.4 percent in 2007 to 36.7 percent in 2014 and 34.5 percent in 2017. It remains higher in urban areas (39.4 percent) than in rural areas (29.8 percent). There has also been a substantial increase in the proportion of consultations where users received

a receipt for all payments made – from 35.7 percent in 2007 and 44.5 percent in 2010 to 75.5 percent in 2014 and 80.8 percent in 2017. The increase was observed in both urban and rural areas (Table 5.5).

Table 5.6 shows a range of key indicators by household income (adult-equivalent consumption expenditure quintile). The quintiles divide the population into five equally-sized groups based on the level of consumption expenditure reported in their household over the preceding quarter. These consumption data are also used by Geostat to produce official statistics on consumption and poverty levels.

A complete picture of the distribution of health conditions or problems encountered in the health system by consumption quintile can be provided using a concentration curve, which displays the share of health indicators accounted for by cumulative proportions of individuals in the population ranked from poorest to richest. The concentration curve plots the cumulative percentage of the health variable (y-axis) against the cumulative percentage of the population, from poorest to richest (x-axis). If everyone, irrespective of living standards, experiences the same health problem, the concentration curve will be a 45-degree line (i.e. line of equality). If, however, the health sector variable is more (less) common among the poor, the concentration curve will lie above (below) the line of equality. As illustrated in Figure 5.4, the incidence of medical conditions or acute illnesses does not appear to be concentrated among the poor and is fairly uniform across consumption quintiles in 2017. As expected, however, the poorer quintiles are more likely not to seek care, undertake labs, or purchase prescribed medicines due to cost considerations (Figure 5.4).

Figure 5.4 Concentration curve of key indicators, 2017



While several indicators have improved across all quintiles, differentials between the richest and poorest quintiles have tended to increase between 2007 and 2017.

The likelihood of consulting a health provider when sick has increased for all quintiles, but it remains higher for individuals in the top quintile than for those in the bottom quintile. About 84.4

percent of individuals in the top quintile consulted a health care provider when sick, as opposed to 77.8 percent of those in the bottom quintile.

For acute illnesses in the past 30 days, the likelihood of consulting a health care provider has not increased in a statistically significant since 2014, but the differential between top and bottom quintiles has been increasing. The proportion of people consulting health services for an acute illness is 11.0 percentage points higher for the top quintile than the bottom quintile (as opposed to only 2.9 percentage points higher in 2007).

Despite improvements since 2014, differentials in the proportion of people who did not seek care or did not purchase prescribed medicines because too expensive remain high. In 2017, among those who did not undertake a consultation for an acute sickness, 12.3 percent of those in the bottom quintile mentioned cost as the main reason. This was the case for only 2.7 percent of those in the top quintile. Similarly, 15.2 percent of individuals in the bottom quintile cited cost as the main reason they did not purchase prescribed medicine, as opposed to only 5.5 percent in the top quintile.

The percentage of individuals who report not having been hospitalized despite need is declining across quintiles, but the biggest declines are observed in the top quintile. The proportion dropped from 2.2 percent in 2014 to 1.2 percent in 2017 for the top quintile, and from 2.1 percent to 1.6 percent for the bottom quintile. These changes were statistically significant.

Table 5.6 Key indicators by consumption quintile

Indicator	Year	Bottom	Second	Middle	Fourth	Top
Percentage of total population who reported being sick with any condition in last 6 months and consulted a health care provider	2007	69	68.7	72	73	73.7
	2010	70	71.1	74.1	75.4	81.9***
	2014	70.9	79.0***	78.4*	81.7***	83.7
	2017	77.8***	82.1**	80.7*	84.9**	84.4
Percentage of occurrences of acute illness in the past 30 days where a healthcare provider was consulted	2007	69.3	69.4	74	70.8	72.2
	2010	73.2	74.2	75.5	78.2	85.1***
	2014	72.5	79.4	74.0	87.0**	82.6
	2017	75.2	80.3	74.8	78.3***	86.2
Average number of consultations/contacts per person per annum (all sources of care)	2007	1.3	1.4	1.6	1.6	1.8
	2010	1.2	1.3	1.4	1.5	1.6
	2014	0.9***	0.8***	0.9***	0.8***	1.4
	2017	1.3***	1.3***	1.4***	1.8***	1.6**
Percentage of occurrences of acute sickness in last 30 days, where no consultation was undertaken because it was too expensive/not enough money [percent of all reasons]	2007	18.2	14.1	19.8	11.2	11.8
	2010	25.3*	17.7	17.3	16.7	5.3**
	2014	18.7	10.8	6.2***	9.9	4.9
	2017	12.3***	5.9***	6.1	5.9**	2.7
Percentage of consultations where medicine was prescribed but not purchased because it was too expensive [base: all consultations]	2007	15.7	10.4	12.6	11.9	7.2
	2010	21.7**	14.2*	11.1	9.4	10.3*
	2014	18.6	11.9	9.7	7.6	5.6***
	2017	15.2***	9.9*	9.5	7.8	5.5
Percentage of consultations where a lab test was prescribed but not done because it was too expensive [base: all consultations]	2007	5	3.9	4.8	3.3	3.9
	2010	6.3	4.0	4.2	4.2	2.9
	2014	5.1	3.6	3.2	1.3***	1.9
	2017	3.4***	3.1	1.8***	2.5**	1.3

Percentage of population who were reported to need hospitalization in the last year but were not hospitalized	2007	5.3	4.3	4.3	4.7	4
	2010	4.5	2.3***	2.9*	3.8	3.6
	2014	2.1***	2.3	2.0	1.4***	2.2**
	2017	1.6*	1.7**	1.4**	1.5	1.2***
Percentage of total population who reported needing hospitalization in the last year but were not hospitalized because it was too expensive/they did not have enough money	2007	4.6	3.9	3.7	4.2	3.5
	2010	3.4	1.8***	2.3**	2.8*	2.6
	2014	1.4***	1.4	1.1***	0.7***	1.2**
	2017	0.7***	0.9***	0.5***	0.8	0.5***

Note: Statistical significance of difference with previous survey: *** p<0.01; ** p<0.05; * p<0.1.

5.3 Satisfaction with health services

As was found in the previous surveys, most respondents in 2017 report being broadly happy with the health services that they received. About 96.3 percent of individuals report that they have high trust in the nearest or most frequently used health facility, an improvement from the already relatively high result of 92.6 percent in 2014. About 78.6 percent feel that they were properly involved in their care. About 98.4 percent found the health care facilities they last visited to be clean or very clean, and 93.5 percent reported spending more than 12 minutes with the main medical professional they saw. Similar results are observed in both rural and urban areas (Table 5.7).

Table 5.7 User satisfaction with services

Indicator	Year	Urban	Rural	Total
Percentage of consultations where patients report that doctor/nurse completely explained reasons of treatment	2007	80.5	85.9	83.1
	2010	75.9**	80.8***	78.4***
	2014	82.6***	85.6***	84.0***
	2017	77.1***	82.5***	79.6***
Percentage of patients reporting that they were involved as much as they wanted to be in decisions about their care and treatment	2007	83.9	80.9	82.4
	2010	74.6***	76***	75.3***
	2014	84.8***	74.3	79.8***
	2017	80.6***	76.5**	78.6*
Percentage of patients reporting that they spent more than 12 minutes with the main medical professional they saw	2007	90.7	90.1	90.4
	2010	89.3	91.3	90.3
	2014	93.7***	94.2***	94.0***
	2017	93.6	93.4	93.5
Percentage of population reporting that the health care facility they last visited was clean or very clean.	2007	92.6	92.8	92.7
	2010	94.8*	95.2**	95***
	2014	97.7***	98.5***	98.1***
	2017	98.3*	98.5	98.4
Percentage of respondents reporting trust in services for nearest / usual clinic	2007	93.4	94.7	94.1
	2010	90.2**	94	92.1***
	2014	90.7	94.4	92.6
	2017	94.7***	97.8***	96.3***
Percentage of respondents reporting that services at their nearest / usual clinic are better or much better than three years previously	2007	42.3	52.5	48
	2010	58.8***	75.4***	67.4***
	2014	54.1*	59.6***	56.9***
	2017	45.7***	49.5***	47.6***

Note: Statistical significance of difference with previous survey: *** p<0.01; ** p<0.05; * p<0.1.

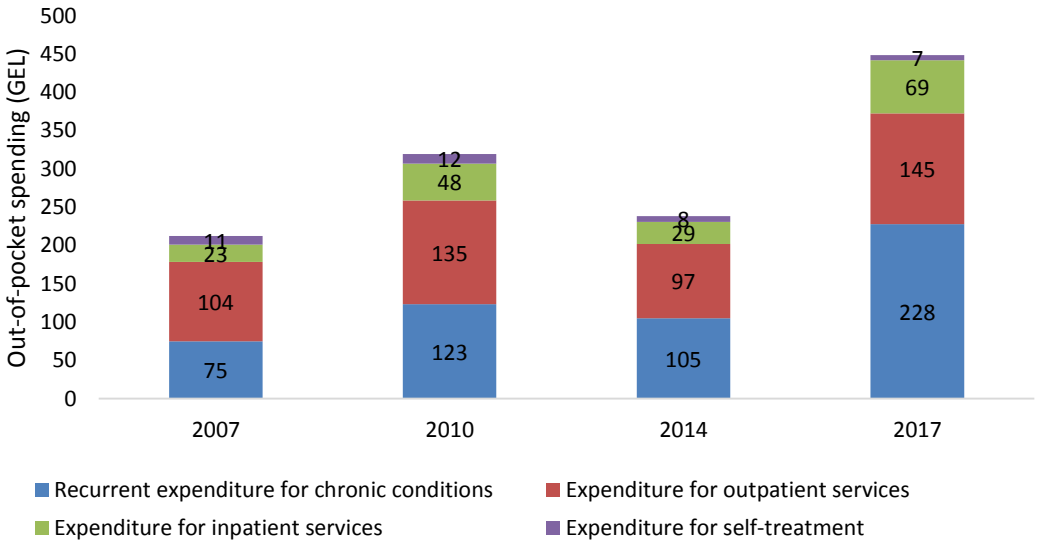
6 Health expenditure and finances

This section describes household out-of-pocket health expenditure captured by the HUES. It provides annualized per-capita estimates for various services in 2017 (in current prices) and compares them with similar estimates derived from 2007, 2010, and 2014[6]. It also compares mean expenditures between different population groups. The survey instrument recorded expenditures related to hospitalizations during the 30-day period prior to the survey as well as during the last 12 months, expenditures related to chronic diseases (monthly and annual recurrent costs), to self-treatment, and to acute illnesses occurring during last 30 days prior to survey. The estimates are based on the number of cases shown in Table 8.3.

6.1 Total household spending on health

Annualized per capita health expenditure estimates for 2017 and previous rounds are detailed in Figure 6.1 and Table 6.1. In nominal terms, household health expenditure over the period of three years increased by 88.3 percent in nominal terms – an average annual growth of 29.4 percent. This is significantly higher than general price inflation observed in the Georgian economy during 2014-2017 (approximately 12.4 percent over the period). In addition, the average annual growth rate in OOP between 2014 and 2017 is much faster than between the rate of 16.4 percent observed between 2007 and 2010.

Figure 6.1 Annualized per capita expenditure (current GEL), 2007-2017



[6] Because expenditure estimates are presented in current prices, the significance of the means difference with respect to previous rounds is not tested.

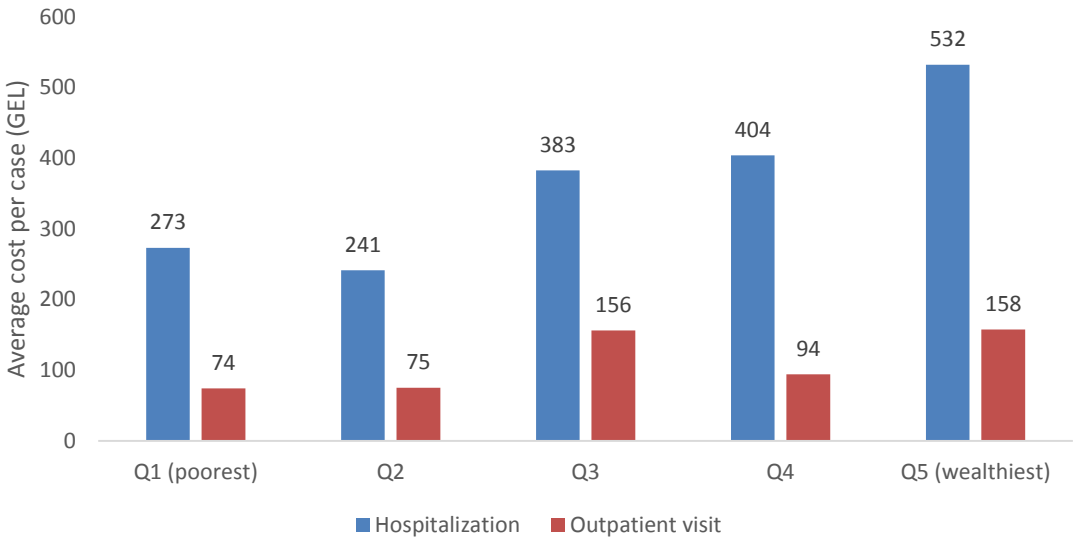
Table 6.1 Annualized per capita expenditure (current GEL), 2007-2017

Annual out-of-pocket payments per capita (GEL)	Year	in current GEL		
		Total per capita expenditure	Out of total, on drugs	Out of total, on diagnostics
Recurrent expenditure for chronic conditions	2007	74.7	56.9	0.0
Expenditure for self-treatment		11.0	10.0	0.2
Expenditure for outpatient services		103.6	49.9	18.1
Expenditure for inpatient services		22.9	4.3	1.9
Total per capita expenditure		**212.2**	**121.0**	**20.2**
Recurrent expenditure for chronic conditions	2010	123.4	112.3	0.0
Expenditure for self-treatment		12.5	11.0	0.5
Expenditure for outpatient services		135.1	65.5	23.9
Expenditure for inpatient services		48.2	9.8	3.8
Total per capita expenditure		**319.2**	**198.6**	**28.3**
Recurrent expenditure for chronic conditions	2014	105.0	97.7	0.0
Expenditure for self-treatment		7.6	7.0	0.4
Expenditure for outpatient services		96.9	46.0	15.5
Expenditure for inpatient services		28.7	6.5	3.8
Total per capita expenditure		**238.2**	**157.2**	**19.8**
Recurrent expenditure for chronic conditions	2017	227.6	194.3	16.4
Expenditure for self-treatment		6.9	6.6	0.3
Expenditure for outpatient services		144.9	35.4	26.1
Expenditure for inpatient services		69.1	2.6	3.4
Total per capita expenditure		**448.6**	**239.0**	**46.2**

Expenditure has increased at a different pace for various services. For inpatient care, the average expenditure per head of population grew by 144.9 percent between 2014 and 2017, while for outpatient services the increase was 49.5 percent. Per capita spending increased from 238 Gel to 449 Gel in current terms (Table 6.1).

As expected, out-of-pocket (OOP) spending is higher among the wealthier quintiles. In 2017, average OOP spending for a hospitalization and an outpatient visit was almost twice as high in the wealthiest quintile as compared to the poorest quintile.

Figure 6.2 Mean cost per hospitalization and outpatient visit (current GEL) by consumption quintile, 2017



6.2 Household spending on inpatient services

Overall household expenditure for inpatient services across the population as a whole increased slightly compared to 2014, driven by increased hospitalizations and a small increase in the mean cost per case of hospitalization from 362 Gel to 365 Gel. The increase was larger in rural areas, from 317 to 386 Gel (Table 6.2).

Table 6.2 Mean cost per case of hospitalization in current prices

	Mean cost per case of hospitalization (Current GEL)			
Population Groups	**2007**	**2010**	**2014**	**2017**
Urban	670.3	686.9	395.6	345.1
Rural	511.2	486.4	316.8	386.3
Bottom quintile	534.4	338.2	286.9	273.1
Second quintile	465.3	636.6	408.2	241.4
Third quintile	565.6	473.7	221.1	382.8
Fourth quintile	572.9	723.3	327.6	404.3
Top quintile	839.8	668.3	516.8	532.2
General hospital	534.0	565.4	347.8	368.2
Maternity hospital	405.8	574.1	234.9	311.7
Children's hospital	328.7	324.8	259.9	157.9
TB/infection dis. hospital				337.9
Abroad				3200.0
Other specialist hospital	975.1	803.3	570.6	477.8
Total for the sample	**598.5**	**582.8**	**362.0**	**365.3**

6.3 Household spending on outpatient services

The mean amount paid for outpatient services has increased between 2014 and 2017. Expenditure has risen faster for mean provider fees (37.7 percent) than for the mean amount paid for drugs purchased outside the facility (21.9 percent). Increases were observed for almost all population groups (Table 6.3 and Table 6.4). These increases in mean costs per consultation have resulted in a proportional growth in household level expenditure for drugs and services (measured in current per capita terms) (Table 6.1).

Table 6.3 Mean cost per outpatient visit in current prices

	Mean per outpatient visit (Current GEL)			
Population Groups	**2007**	**2010**	**2014**	**2017**
Urban	57.5	72.4	80.7	121.6
Rural	58.7	77.1	79.6	94.0
Bottom quintile	43.8	46.1	50.8	74.2
Second quintile	53.1	64.6	60.9	75.2
Third quintile	57.0	78.8	87.1	156.3
Fourth quintile	58.4	80.1	84.1	94.3
Top quintile	72.8	95.3	105.7	157.8
Home visit	43.5	72.5	91.3	59.0
Village ambulatory center	30.6	29.5	33.1	31.1
Polyclinic	47.9	62.2	56.8	59.5
Dispensary	47.3	74.8	139.1	244.9
Women's consultation clinic	50.1	119.6	102.4	98.0
General hospital (outpatient)	80.8	108.1	94.1	141.0
Maternity hospital (outpatient)	90.1	70.9	102.0	163.8
Children's hospital (outpatient)	71.7	50.7	36.3	83.2
TB or infectious disease hospital (outpatient)	32.1	58.7	170.0	206.3
Other specialist hospital (outpatient)	139.7	195.1	209.4	191.6
Dentist or dental technician	82.6	55.8	122.6	153.2
Diagnostic center	78.4	183.9	199.7	110.5
Private office or professional's home	43.2	77.0	95.6	137.6
Pharmacy	11.0	17.4	22.1	14.0
Abroad				20,000.0
Ambulance (treatment there only)	9.1	14.6	12.4	10.2
Total for the sample	**58.0**	**74.9**	**80.1**	**110.3**

Table 6.4 Mean cost per prescribed drugs purchased elsewhere in current prices

	Mean per prescription (Current GEL)			
Population Groups	**2007**	**2010**	**2014**	**2017**
Urban	25.1	35.1	36.4	40.4
Rural	28.7	37.1	38.7	53.1
Bottom quintile	25.1	23.8	32.3	39.7
Second quintile	25.7	33.2	31.4	48.0
Third quintile	27.2	35.3	45.2	42.7
Fourth quintile	24.8	38.9	34.4	41.6
Top quintile	29.8	45.9	41.4	58.6
Male	26.1	34.0	39.6	53.2
Female	27.0	37.7	36.3	40.3
Total for the sample	**26.7**	**36.2**	**37.5**	**45.7**

6.4 Household spending on chronic conditions

During the three-year period since 2014, the mean annual recurrent expenditure for a chronic patient grew by 82.4 percent. The growth in total spending by households on chronic conditions was driven by both the increase in the reported prevalence of chronic conditions and the increase in the mean cost per chronic patient. The latter rose from 338 Gel per capita in 2014 to 614 Gel per capita in 2017.

Table 6.5 Annualized expenditure per chronic patient in current prices

	Mean per individual with chronic condition per annum (Current GEL)			
Population Groups	**2007**	**2010**	**2014**	**2017**
Urban	267.8	373.7	346.6	548.6
Rural	245.8	281.1	329.9	679.6
Bottom quintile	146.4	203.5	227.7	512.8
Second quintile	176.0	273.0	296.3	554.6
Third quintile	285.7	280.6	343.7	639.2
Fourth quintile	292.8	431.3	391.7	640.5
Top quintile	380.7	441.4	421.9	764.8
Total for the sample	**256.7**	**327.2**	**338.0**	**616.4**

6.5 Household spending on self-treatment

The number of cases of self-treatment[7] captured by the HUES was lower in 2017 than in 2014. In current prices, the mean amount spent by a self-treating individual was 23 Gel in 2017, slightly higher than the amount observed in 2014 of 19 Gel (Table 6.6). Mean expenditure for self-treatment in current prices has increased slightly for all categories of the population, but the increase may not be significant in real terms.

The total household expenditure on self-treatment in current per capita terms has decreased slightly between 2014 and 2017 (reflecting the decrease in the number of cases observed) and it stood at around 7 Gel in both years (Table 6.1).

Table 6.6 Mean expenditure per case of self-treatment in current prices

	Mean per individual with chronic condition per annum (Current GEL)			
Population Groups	**2007**	**2010**	**2014**	**2017**
Urban	15.0	19.9	17.3*	21.1
Rural	11.3	17.0	20.8***	24.7
Bottom quintile	8.6	12.6	15.9**	21.2
Second quintile	11.6	16.6	15.2**	13.9
Third quintile	13.3	18.6	24.3*	21.4
Fourth quintile	14.5	17.6	17.8	24.7
Top quintile	18.4	27.8	20.7	35.2
Total for the sample	**13.4**	**18.3**	**19.1**	**22.6**

6.6 Household spending on ambulance services

The survey captured 432 cases of ambulance service utilization among the surveyed population or 39.2 per 1,000 individual in the sample (a decrease from 47.3 cases per 1,000 in 2014). The mean amount paid per event amounted to 1.5 Gel and in current per capita terms 0.1 Gel was spent when averaged across the population as a whole, although this may not adequately reflect national level spending estimates on ambulance services.

[7] All individuals reporting, “Yes” on the question “F14. Did you take any medicine or treatment for this problem based only on your own knowledge and not based on consulting a health care provider in the last 30 days?” were included as self-treating.

7 Conclusion

This report presents findings from the 2017 HUES and compares them to the results from the previous three rounds of the survey. The findings point to sustained positive trends in use of, access, to, and satisfaction with health services. Use has increased, especially in rural areas and among the poorest households, narrowing the gap between rich and poor. Increased use can be attributed to improvements in access (rather than greater need for health care). Physical access to care has improved since 2014, and financial barriers to access have fallen, especially among the poorest households. Affordability of care has also improved somewhat, and the immediate gains that were achieved in 2014 have been sustained. The share of individuals not seeking care for an acute illness due to cost fell from 10 percent in 2014 to 7 percent in 2017. Access to medicines and inpatient care also appears to have improved slightly.

With increased access has come increased financial burden through out-of-pocket (OOP) payments. Household spending has increased, reversing the trend seen between 2010 and 2014. The rate of increase between 2014 and 2017 is greater than the rate of increase between 2007 and 2010. In 2017, individuals on average spent 449 GEL – almost double the amount spent in 2014. The significant rise in the total OOP amount appears to come from a substantial increase in recurrent expenditure for chronic conditions, likely driven by both the increase in the reported prevalence of chronic conditions and the increase in the mean cost per chronic patient. OOP spending among chronic patients was 616 GEL in 2017 (compared to 338 GEL in 2014).

Substantial improvements have been achieved since the introduction of the UHC program, particularly among the poor and rural populations. The gap between the rich and poor and those residing in urban versus rural areas has narrowed on most indicators. The results from the 2017 HUES confirm the positive trends on most indicators. The substantial increase in OOP spending, however, raises concerns about the future affordability of care. The high OOP spending for chronic conditions confirms the need for benefits package expansion to cover the cost of pharmaceuticals implemented in July 2017. Moving forward, it would be important to monitor whether the reform has resulted in reductions in OOP spending.

8 Annex

Table 8.1 Number of households sampled and interviewed

	2007		2010		2014		2017	
	Freq.	**Percent**	**Freq.**	**Percent**	**Freq.**	**Percent**	**Freq.**	**Percent**
Interviewed and analyzed	3,218	94.8 percent	3,127	89.3 percent	3,168	90.5 percent	3,094	88.4 percent
Ineligible for interview	65	1.9 percent	41	1.2 percent	152	4.3 percent	38	1.1 percent
Non-response	112	3.3 percent	332	9.5 percent	180	5.1 percent	368	10.5 percent
Total	**3,395**	**100**	**3,500**	**100**	**3,500**	**100.0 percent**	**3,500**	**100.0 percent**

Table 8.2 Questionnaire sections

Section of questionnaire	**Unit covered**
A. Control information	
B. General information about the household and its members	Each household member
C. Health of household members	Each household member
D. Household's local health facilities and insurance status	Each household
E. Last medical services used in last 6 months	Completed for each household member who had a medical consultation (including preventive service) in the last six months
F. Illness, services and expenditures on health in the last 30 days	Completed for each person who has been sick, has used health services or has spent any money on health care in the last 30 days.
G. Hospitalization in the last year	Completed for anyone who has been hospitalized within the last year but not in the past 30 days
H. Occasions when individuals were not hospitalized but should have been	Each occasion

Table 8.3 Total number of cases captured by the survey

Type of care received	HUES 2007		HUES 2010		HUES 2014		HUES 2017	
	Unweighted cases	per 1,000 pop.	Unweighted cases	per 1,000 pop.	Unweighted cases	per 1,000 pop.	Unweighted cases	per 1,000 pop.
All hospitalizations in the last 12 months	670	55.3	743	63.2	688	65.1	920	83.5
Use of outpatient services in the last 30 days	1774	147.2	1758	148.0	1088	98.1	1140	103.4
Use of dental care in the last 30 days	131	12.6	98	8.8	112	10.0	115	10.4
Ambulance use in the last 12 months	1115	72.1	1389	104.5	786	47.3	432	39.2
Chronic conditions with out-of-pocket payments	3014	234.6	3539	304.2	3357	296.9	5,426	492.3
Self-treatment episodes in the last 30 days	955	73.0	694	59.7	400	34.7	352	31.9