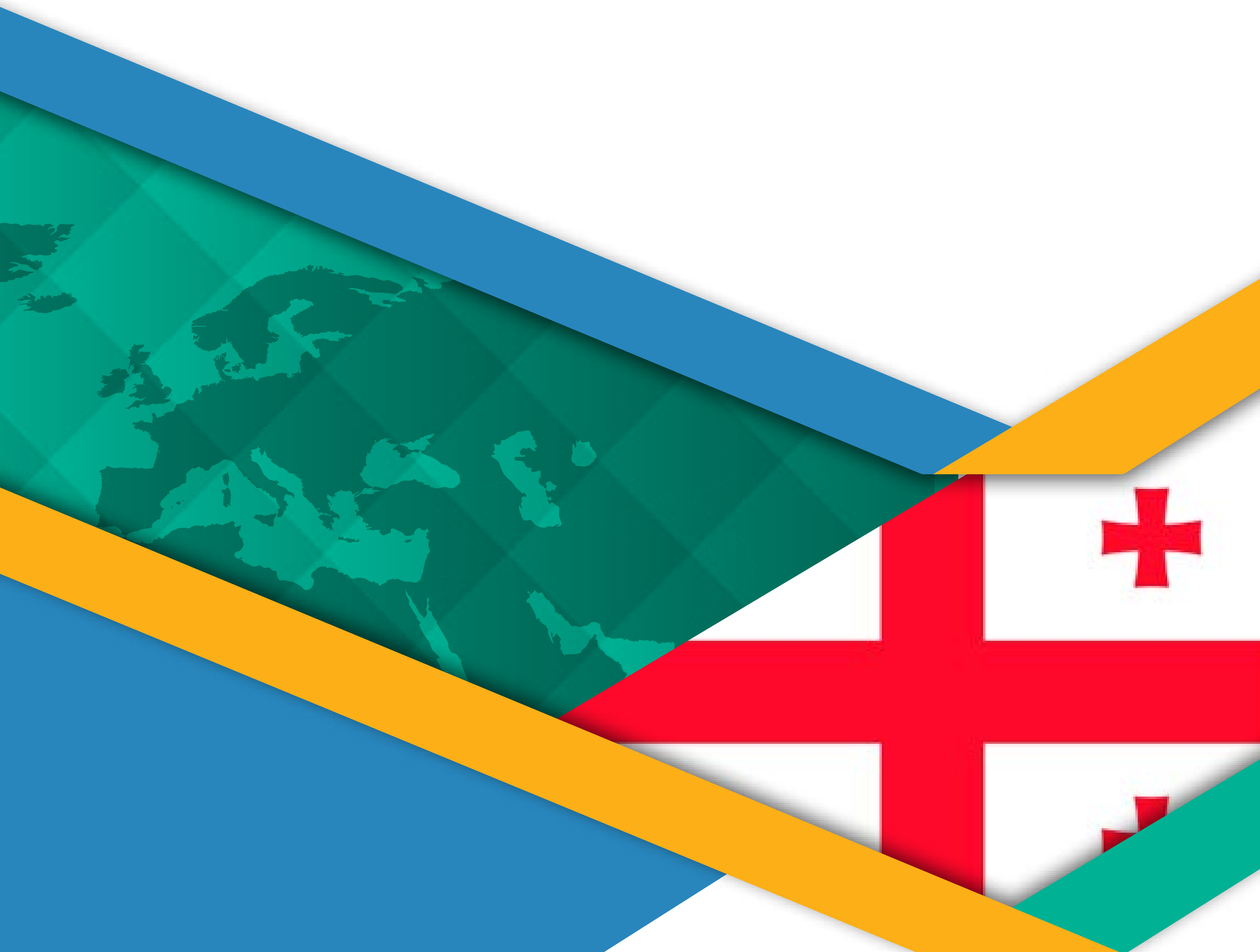
PRIMARY HEALTH CARE SYSTEMS (PRIMASYS)

Case study from Georgia



Alliance for Health Policy and Systems Research

World Health Organization

PRIMARY HEALTH CARE SYSTEMS (PRIMASYS)

Case study from Georgia

Ivdity Chikovani, Lela Sulaberidze

Curatio International Foundation

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Abbreviations

CEE/CIS	Central and Eastern Europe and the Commonwealth of Independent States
DFID	Department for International Development
DOTS	directly observed treatment, short course
GDP	gross domestic product
HUES	Health Utilization and Expenditure Survey
ICD-10	International Classification of Diseases and Related Health Problems, 10th Revision
IGME	United Nations Interagency Group for Child Mortality Estimation
MDG	Millennium Development Goal
MIP	Medical Insurance Programme
NCD	noncommunicable disease
NCDC	National Centre for Disease Control and Public Health
PHC	primary health care
PPP	purchasing power parity
TB	tuberculosis
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Background to PRIMASYS case studies

Health systems around the globe still fall short of providing accessible, good-quality, comprehensive and integrated care. As the global health community is setting ambitious goals of universal health coverage and health equity in line with the 2030 Agenda for Sustainable Development, there is increasing interest in access to and utilization of primary health care in low- and middle-income countries. A wide array of stakeholders, including development agencies, global health funders, policy planners and health system decision-makers, require a better understanding of primary health care systems in order to plan and support complex health system interventions. There is thus a need to fill the knowledge gaps concerning strategic information on front-line primary health care systems at national and subnational levels in low- and middle-income settings.

The Alliance for Health Policy and Systems Research, in collaboration with the Bill & Melinda Gates Foundation, is developing a set of 20 case studies of primary health care systems in selected low- and middle-income countries as part of an initiative entitled Primary Care Systems Profiles and Performance (PRIMASYS). PRIMASYS aims to advance the science of primary health care in low- and middle-income countries in order to support efforts to strengthen primary health care systems and improve the implementation, effectiveness and efficiency of primary health care interventions worldwide. The PRIMASYS case studies cover key aspects of primary health care systems, including policy development and implementation, financing, integration of primary health care into comprehensive health systems, scope, quality and coverage of care, governance and organization, and monitoring and evaluation of system performance.

The Alliance has developed full and abridged versions of the 20 PRIMASYS case studies. The abridged version provides an overview of the primary health care system, tailored to a primary audience of policy-makers and global health stakeholders interested in understanding the key entry points to strengthen primary health care systems. The comprehensive case study provides an in-depth assessment of the system for an audience of researchers and stakeholders who wish to gain deeper insight into the determinants and performance of primary health care systems in selected low- and middle-income countries. Furthermore, the case studies will serve as the basis for a multicountry analysis of primary health care systems, focusing on the implementation of policies and programmes, and the barriers to and facilitators of primary health care system reform. Evidence from the case studies and the multi-country analysis will in turn provide strategic evidence to enhance the performance and responsiveness of primary health care systems in low- and middle-income countries.

1. Methods

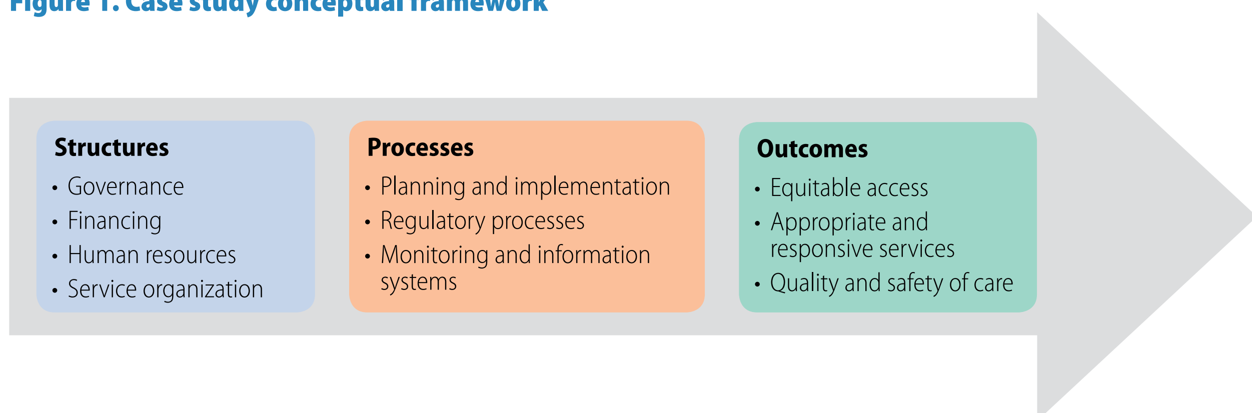
The case study was prepared based on a mixed methods approach. A thorough desk review of the documents related to health system reforms and an assessment of health care programmes in Georgia were conducted, along with in-depth interviews with key informants and stakeholders. The research team followed the proposed case study framework to describe how the primary health care (PHC) system works and what factors (both contextual and related to policy changes) have influenced access to and performance of primary care in Georgia since 1994 (Figure 1).

The desk review considered laws and regulations, ministerial decrees, organizational policies and instructions, grey literature (reports, case studies, conference materials) and peer-reviewed publications.

Quantitative data were gathered from national and international data sources, including data on key demographic and microeconomic indicators of the country from the National Statistics Office of Georgia, a statistical yearbook reporting core health indicators and distribution of health personnel and PHC facilities throughout the country released by the National Centre for Disease Control and Public Health (NCDC), and the National Health Accounts describing changes in the health expenditure in the country, provided by the Ministry of Labour, Health and Social Affairs of Georgia. For some health expenditure and microeconomic indicators, national data were supported by international data sources such as the World Bank database and the World Health Organization (WHO) Health For All database. Maternal and child health indicators were supplemented by the United Nations Children's Fund (UNICEF) TransMonEE database, the United Nations Interagency Group for Child Mortality Estimation (IGME), and the Institute for Health Metrics and Evaluation database for the burden of disease in the country.

Qualitative data were generated from in-depth interviews with key informants and stakeholders, selected based on their expertise and experience in PHC system reforms, and from focus group discussions with PHC facility managers and service providers. In order to obtain representative information, a diverse profile of interview respondents was gathered, including former and current health policy-makers

Figure 1. Case study conceptual framework



and health care experts as well as representatives of the Family Medicine Association and PHC service providers. In total, seven interviews were conducted with key informants and nine in-depth interviews with key stakeholders. The core characteristics of respondents are presented in Annex 1.

Following the in-depth interviews, three focus group discussions were held with PHC service providers. The first focus group discussion included managers of private and public PHC facilities from different regions in Georgia. The other two focus group discussions were conducted with family doctors from urban PHC facilities and rural doctors. In total, 25 participants took part in the focus group discussions.

The interviews and the focus group discussions were conducted by researchers, then recorded and transcribed verbatim by research assistants, and subsequently validated by the interviewers. Written or verbal consent was sought from all participants at the time of the interview. Transcribed data were analysed using NVivo software (version 10.4). The main findings of the qualitative data were validated with the stakeholders during the workshop conducted at the final stage of data triangulation.

2. Overview of health care in Georgia

Georgia is located in the South Caucasus region at the crossroads between Western Asia and Eastern Europe, and borders Armenia, Azerbaijan, the Russian Federation and Turkey. Georgia has a multiethnic population of 3.73 million, with 57.4% living in urban areas. The country is divided into 71 municipalities, including those within the two autonomous regions of Abkhazia and Adjara, and 12 cities.[1] In addition, the country is divided into 11 administrative territorial units, around which the health care system is organized.

Georgia is a democratic state with a republican form of government. Over the last 20 years the country has achieved significant economic growth, with the gross domestic product (GDP) per capita rising from $2590 PPP (purchasing power parity) in 2000 to $9599 PPP in 2015 *(1)*. The Georgian economy is characterized by a high level of total external debt and dollarization, and has been hit by large external shocks that have made the economy more vulnerable. Throughout 2015 and 2016 the local currency (the Georgian lari) depreciated by 42% against the United States dollar *(2, 3)*. In 2015 the country moved to the upper middle-income group with an estimated gross national income (GNI) of US$ 4160 per capita. However in 2016 GNI per capita decreased at US$ 3810 and according to this change Georgia moved back to the lower middle income countries group *(1)*.

Poverty and unemployment remain among Georgia's key challenges. There has been progress in relative poverty reduction, which fell from 24.6% in 2004 to 20.1% in 2015. However, poverty remains at higher levels in rural areas (25.3% in 2015).[2]

Table 1 summarizes the key demographic, macroeconomic and health indicators for Georgia.

2.1 Demographic and health profile

Life expectancy at birth increased for both sexes over the period 1990–2015, with a larger increase observed among females *(5)*.

Significant progress has been made in some aspects of maternal, child and newborn health in recent decades. The country reached the Millennium Development Goal (MDG) target for under-5 mortality (reduction by two thirds from 35.3 per 1000 live births between 2000 and 2015) *(6)*. Despite the documented progress, child mortality in Georgia is still the fourth highest in Europe *(7)*. The largest share of child mortality is still attributed to infant and, specifically, neonatal mortality. Under-5 mortality reduction is a result of the significant decrease in preventable deaths in the post-neonatal period and among children aged 1–4 years. The mortality rate in that age group fell twofold in the period 2004–2014, with an 85% reduction in deaths due to infectious diseases and a 48% reduction due to respiratory diseases *(8)*, which could be partially attributed to improved management of childhood illnesses at the outpatient level. The country sustains high immunization coverage rates for routine vaccines and has recently introduced new vaccines in the immunization calendar *(4)*. An improvement has been observed with regard to maternal health indicators, such as an increase in timely initiation of antenatal visits (from 54% to 82.7%) and accomplishment of all four antenatal visits (from 53% to 88%) during 2010–2015. The majority of deliveries (99.8%) are institutional, which is a common practice in Georgia. With regard to maternal mortality, although a reduction has been observed over the years, the MDG target for this indicator (reduction by three quarters from 49.2 per 100 000 live births between 2000 and 2015) was not reached *(4)*.

1 National Statistics Office of Georgia (based on the General Population Census in November 2014); not including separated regions of Abkhazia and South Ossetia.

2 National Statistics Office of Georgia (share of population under 60% of the median consumption).

3 Interviews with key stakeholders.

Table 1. Key demographic, macroeconomic and health indicators, Georgia

Indicator	Results	Source of information
Total population of country	3 720 400	National Statistics Office of Georgia, 2016
Sex ratio: male/female	0.9/1	National Statistics Office of Georgia, 2016
Population growth rate per 1000 population	1.6	National Statistics Office of Georgia, 2016
Population density (people/sq km)	64.96	World Bank, 2016
Distribution of population (rural/urban)	42.79% / 57.21%	National Statistics Office of Georgia, 2016
GDP per capita (PPP, $)	$9599	World Bank, 2015
Income or wealth inequality (Gini coefficient)	0.40	National Statistics Office of Georgia, 2016
Life expectancy at birth	72.7 years	National Statistics Office of Georgia, 2016
Top five main causes of death (ICD-10 classification)	Ischaemic heart disease (I20–I25) Cerebrovascular disease (I60–I69) Hypertensive heart disease (I10–I15) COPD (J44) Alzheimer's disease (G30)	Institute for Health Metrics and Evaluation, 2015 data
Infant mortality rate	8.6 per 1000 live births	NCDC, 2015 *(4)*
Under-5 mortality rate	10.2 per 1000 live births	NCDC, 2015
	11.9 per 1000 live births	IGME, 2015
Maternal mortality ratio	32.1 per 100 000 live births	NCDC, 2015
	36 per 100 000 live births	IGME, 2015
Immunization coverage under 1 year (including pneumococcal and rotavirus)	BCG 92.5% DTP3 93.7% Polio3 91.3% Rota2 72.4% Pneum2 89.6% Measles1 96.0%	NCDC, 2015
Total health expenditure as proportion of GDP	6% 8.5%	For 2014, WHO European Health for All database For 2015, National Health Accounts, 2015
PHC expenditure as % of total health expenditure	26.3%	For 2015, National Health Accounts
% total public sector expenditure on PHC	2%	For 2015, National Health Accounts
Per capita public sector expenditure on PHC (current $)	$25.57	For 2015, National Health Accounts
Public expenditure on health as proportion of total expenditure on health	20.9%	For 2014, World Bank
Out-of-pocket payments as proportion of total expenditure on health	57.3%	For 2015, National Health Accounts
Voluntary health insurance as proportion of total expenditure on health	6%	For 2015, National Health Accounts
Proportion of households experiencing catastrophic health expenditure: above 10% of total expenditure above 25% of total expenditure	34% 10%	For 2015, Georgia Public Expenditure Review, 2017 *(3)*

Noncommunicable diseases (NCDs) are increasing, with ischaemic heart disease, cerebrovascular disease and hypertensive heart disease among the leading causes of death. Road injuries are the third leading cause of premature death, after ischaemic heart disease and cerebrovascular disease *(5)*. The trend over the last decade shows that 10% and 13% fewer premature deaths are attributed to ischaemic heart disease and cerebrovascular disease, respectively, while 100% and 50% more deaths are caused by hypertensive heart disease and diabetes, which occupy fifth and seventh place respectively among the diseases that cause premature death *(5)*. Fewer premature deaths due to ischaemic heart disease could be associated with the improved availability of and access to invasive cardiology interventions in the country. At the same time, the increase in the recorded deaths due to hypertensive heart disease could be explained both by procedural factors – such as improved registration of cases due to increased access to services – and by health-related factors – such as suboptimal management of the condition at the primary care level *(9)*.

Georgia is a low HIV prevalence country, with an estimated adult prevalence of 0.4%, but with an increasing trend of new infections *(10)*. The HIV epidemic is largely concentrated among key populations: men who have sex with men, and people who inject drugs. Georgia is one of the first countries in the region of Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS) to have achieved and maintained universal access to antiretroviral treatment *(11)*. Though there is universal access to tuberculosis (TB) diagnosis and treatment, TB remains a significant public health problem in the country. A decreasing incidence trend has been observed over the past several years, though treatment outcomes remain unfavourable due to challenges with cases lost to follow-up and high prevalence of drug-resistant TB. Treatment completion rates among patients registered in 2014 are 83% among new and relapsed cases and 43% among multidrug-resistant cases *(12)*.

2.2 Broad characteristics of health system

Over the last two decades, the Government of Georgia has initiated several reforms in the health sector to move away from the highly centralized Semashko model inherited from the Soviet Union. The initial reform agenda included changes in health care financing, such as the separation of health care financing and provision functions, the removal of all health care personnel from the State payroll, and the decentralization of the provider network by granting autonomy to providers, followed by privatization of the service providers *(13, 14)*. The next reform wave in 2007 aimed at offering increased financial protection to the poor, promoting private insurance to reduce out-of-pocket payments and increasing investments (mainly private) in infrastructure. In 2013, a newly elected government initiated the flagship Universal Health Coverage Programme to provide basic outpatient, inpatient and emergency services to all uninsured citizens.

Table 2 provides some indicators related to PHC services according to the 2014 Health Utilization and Expenditure Survey (HUES) *(15)*. The results of some recent policy changes could not be reflected in these figures.

Geographical availability of PHC facilities is good (4.3 per 10 000 population) *(16)* and population access to a primary care provider within 30 minutes is ensured for 81.2% of the rural population *(17)*. Outpatient visits have increased since 2012 and reached 3.9 visits per capita in 2016, although this number remains lower than the European Union average. Affordability of PHC services improved between 2010 and 2014, as shown by a reduction from 17% to 10% in the proportion of illness episodes for which patients could not afford outpatient care due to cost *(17)*. More information on outpatient service utilization is given in section 7, on planning and implementation.

The pharmaceutical market is well developed in Georgia, with a fair supply of pharmaceutical products. The market is primarily controlled by two or three pharmaceutical companies. However, lower-cost generic medicines are generally less available in retail pharmacies, which skews consumption towards higher-priced originator medicine and increases the cost of purchase of pharmaceuticals *(3, 18)*. The 2014 Health Utilization and Expenditure Survey found that pharmaceuticals comprised over 65% of out-of-pocket expenditure. The study indicates that there has been no change in affordability of pharmaceutical products since 2010, and significant gaps between income level groups existed in 2014, with the poorest 3 times less likely to purchase prescribed drugs compared to the richest quintile *(17)*.

Table 2. PHC profile, Georgia

Indicators	Results	Source of information
Geographical availability of PHC facilities per 10 000 population	4.3	NCDC, 2016 (preliminary data)
Per 10 000 rural population	7.9	
Per 10 000 urban population	1.6	
PHC visits per capita	3.5	NCDC, 2016 (preliminary data)
% of rural population with access to PHC facility within 30 minutes	81.2%	World Bank, HUES, 2014 *(15)*
% of illness episodes when patient could not afford outpatient care due to cost	10%	World Bank, HUES, 2014 *(15)*
Poorest quintile	18.4%	
Richest quintile	4.9%	
Pharmaceuticals as a share of out-of-pocket expenditure	> 65%	World Bank, HUES, 2014 *(15)*
Pharmaceuticals as a share of total health spending	40%	World Bank, HUES, 2014 *(15)*
% of patients who were not able to purchase prescribed drugs due to cost	10.2%	World Bank, HUES, 2014 *(15)*
Poorest quintile	18.6%	
Richest quintile	6.6%	

3. Timeline of PHC reforms

PHC reforms have been an integral part of health sector reforms, which in turn have been greatly influenced by the political developments that have taken place in Georgia. These reforms can be divided into four distinct periods: 1994–1999, 2000–2006, 2007–2012 and from 2013 to the present. A graphical illustration of major reforms, and a brief description of barriers to and enablers of their implementation, are given in Figure 2 and Table 3.

After gaining independence in 1991 following the collapse of the Soviet Union, Georgia underwent a period of civil unrest and economic disruption. Between 1989 and 1994 GDP fell by almost three quarters, annual inflation reached 15 600%, and industrial output fell by more than half *(19)*. These disruptions led to a breakdown in the health system. There was a drastic reduction of public allocations to health, with real per capita public expenditure on health declining from US$ 10 to less than US$ 1 over the period 1991–1994. The physical condition of health facilities deteriorated, people had to pay out of pocket for health services, and health personnel were underpaid and demotivated *(20)*.

Political stabilization, commencing in 1994, enabled the country to receive international development assistance. The economic context played a catalytic role in initiating urgently needed reforms. This involved decisions on how to reallocate scarce resources most effectively, and what kind of health care system should be introduced by defining who pays for what. International development assistance was crucial in guiding and helping the government to implement structural reforms and designing the initial reform programme. However, donor assistance could not bring about reforms without the government's commitment. As key informants suggested, strong leadership was one of the factors that enabled major changes to materialize. To deal with existing challenges in 1994/1995, the government issued policies that removed constitutional guarantees on free health care and formalized official user fees. The new policies led to the decentralization of the health system, introduced new payment mechanisms for services, removed health personnel from the State payroll and opened up space to privatize health facilities *(13, 21, 22)*.

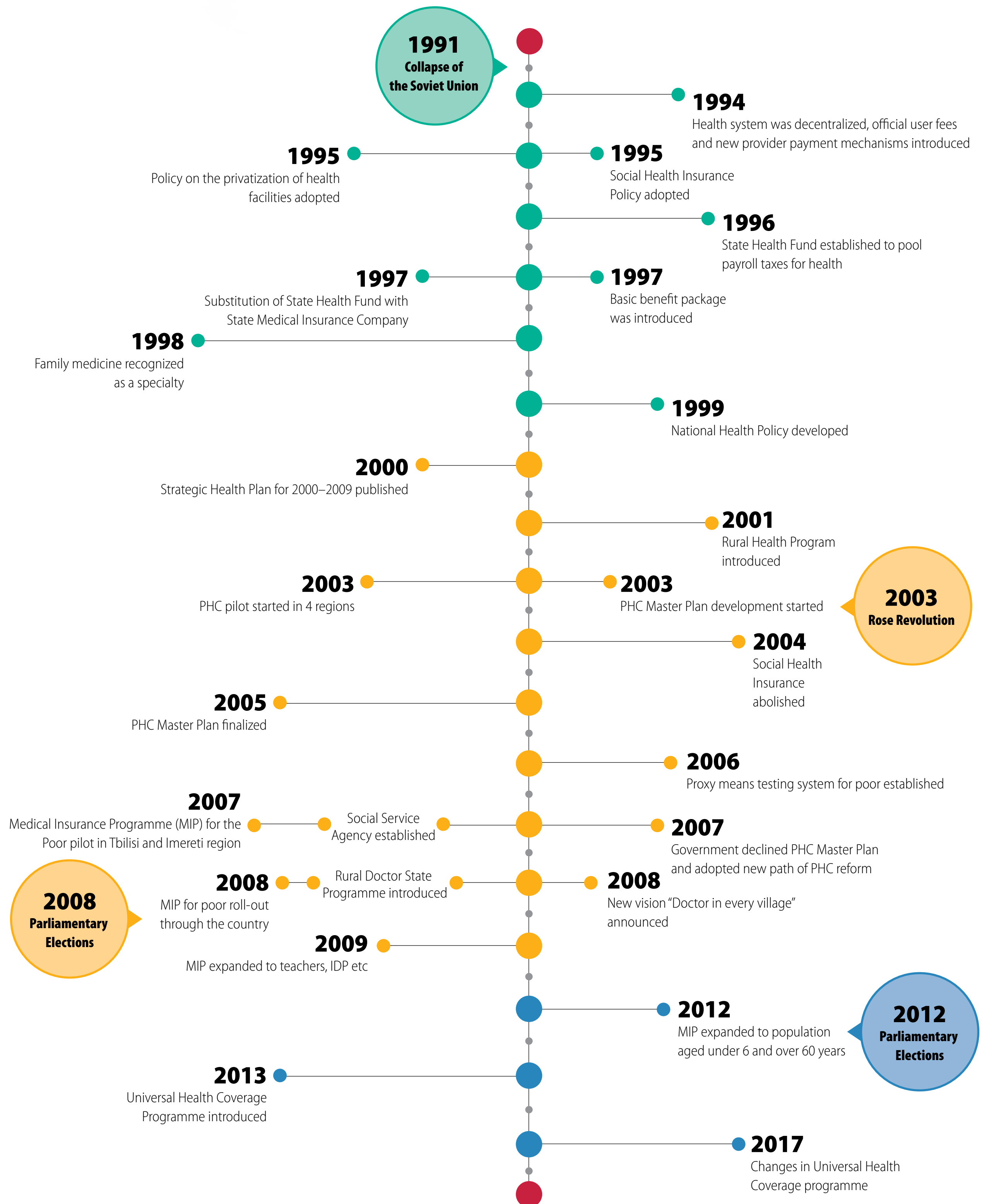
In an attempt to maintain principles of solidarity and equity, the Government of Georgia introduced a social insurance model in 1995. Earmarked mandatory payroll taxes included a 3% contribution from employers and a 1% contribution from employees. Contributions for the unemployed, pensioners, and children were covered from transfers by the central government. Public and private sources were combined through social insurance, central and local budgets and formal out-of-pocket payments.

Following the granting of autonomy to service providers, the PHC facilities underwent a structural reorganization. Most of the facilities at the district level were grouped into single legal entities such as district-level policlinic ambulatory unions or hospital policlinic unions covering the catchment population. In one pilot region (Imereti), all of the PHC providers, including village-level ambulatory services, gained independent status.

In 1997 the government defined a basic benefits package that included a range of preventive, primary care and curative services. Payments for certain health services not covered under the basic benefits package were legalized, and co-payments were introduced for different services. The basic benefits package reflected one of the major objectives of the new National Health Policy (1999), which refocused from secondary care towards public health and primary care *(13)*.

Figure 2 provides a timeline of key developments in the Georgian health system.

Figure 2. Timeline of key developments in the Georgian PHC system



Decentralization implied granting decision-making power and funding responsibilities to the regional level. Municipalities became responsible for contributing to health care on a per capita basis. To resolve the inequity between municipalities, funds were pooled at the regional level and redistributed back to the municipalities to finance part of the basic benefits package. The basic benefits package gradually expanded without a targeting approach or sufficient funding, widening the gap between the State liabilities and available resources *(22)*.

After 1995 the economic situation improved rapidly, with an average GDP per capita growth rate of 9% per year *(1)*. However, low employment in the formal sector did not allow for sufficient generation of payroll taxes, in addition to which tax compliance was low. Structural and legal reforms in public financial management did not result in improvements, due to poor governance and weak enforcement *(19)*. As a result, health programmes were continuously underfunded.

As a consequence, out-of-pocket payments for services became widespread and resulted in an economic access barrier for most of the population *(20)*. On top of the financial barriers associated with service use and medicines, other challenges included low use of preventive and primary care services, obsolete infrastructure, demotivated health personnel and the low quality of services *(23)*. Most of the population tended to bypass the health system and self-treat on the basis of drugs purchased over the counter in pharmacies, and only sought professional help for emergency care. Preventive and PHC-seeking behaviours were largely absent in the vast majority of the population. Outpatient visits numbered less than three per capita annually *(20)*.

Due to economic reasons, significant barriers to accessing care emerged for the rural population *(22)*. The majority of local municipalities, which were responsible for financing primary care services for the local population, were unable to allocate adequate funding. Due to insufficient economic capacity and weak local tax systems, poorer municipalities failed to collect sufficient revenues, while wealthier municipalities perceived that it was unfair to subsidize the health services of their neighbouring municipalities from their own budgets.[3] This led to poor fiscal performance by the regional health funds. In the period 1994–2000, significant numbers of nurses and doctors left villages and moved to urban areas to improve their lifestyles. As a result, the rural population was unable to receive the most basic medical services *(13)*.

A new period in PHC reform began in 2000, when the government recognized strengthening of the PHC system as a key priority that was articulated in the Strategic Health Plan *(24)*. Responding to inadequate access to PHC services primarily for rural residents caused by the challenges with risk pooling at the subnational level, the Government of Georgia partially reversed the decentralization process in financing of primary care. The Rural Health Programme was launched in 2001, later evolving into the Primary Health Care Programme in 2003. The programme provided funding from a single, central pool to contracted PHC providers throughout the country, with the exception of two big cities that remained the responsibility of the local municipalities. A per capita-based payment scheme was used, which implied provision of approximately US$ 1 per capita to the PHC team per 1500–2000 population in the catchment area *(13)*. However, while the policy change improved access to care for rural residents, it also led to inequity between rural and urban residents: a 2005 study showed that access to PHC providers was higher and self-treatment practices were lower among rural residents compared to the urban population *(13)*.

The Government of Georgia received substantial support from the international donor community to reform the PHC system during this time. A United Kingdom family medicine-centred PHC model was suggested to ensure equity, efficiency, effectiveness and responsiveness of the health system. Family medicine training programmes were started with

4 Additional information from interviews with key stakeholders.

the support of the United Kingdom Department for International Development (DFID) in the late 1990s, followed by the development of a PHC Master Plan in 2003–2005 with support from a World Bank grant. The Master Plan was comprehensive, feasible and tailored to needs in terms of the rationalization and refurbishment of facilities, the training of personnel and the introduction of family medicine practices. The plan envisioned the creation of a network of facilities that would ensure access to PHC centres within 15–20 minutes for the entire population of Georgia. The Master Plan was approved by the Ministry of Health, Labour and Social Affairs and was piloted in four regions from 2003. The PHC Master Plan was followed until the end of 2006. With financial and technical support from the World Bank and the European Union, a significant number of PHC facilities in rural areas were rehabilitated countrywide, health personnel were retrained as family doctors, and clinical practice guidelines were developed *(20)*.

The late 1990s and early 2000s were a time of political and economic stagnation. The initial success and the restoration of sustained economic growth were overshadowed by growing corruption and economic mismanagement. Public expenditure on health remained low and there was little improvement in health indicators and the quality of services. Health expenditure largely relied on out-of-pocket payments. A deepening political crisis put the State on the verge of collapse. A peaceful Rose Revolution in 2003 brought a new, reforming government to power *(19)*.

The new government, which had a solid public mandate, brought new libertarian and neoliberal ideologies and a political will to carry out reforms. The government managed to boost the economy through radical institutional and economic reforms that favoured the free market and deregulation *(14, 19)*. However, the poverty level remained high (one fifth of the population was considered to be under the poverty line) despite the economic recovery. The fight against poverty became a key political priority. The government chose to concentrate its efforts and resources on the most vulnerable populations. One of the major changes was the rejection of health insurance and social taxation in 2005 *(14)*. The social insurance model had failed to increase the overall levels of health funding in Georgia. The feasibility of social insurance was questioned as a way to bring about desired results in countries such as Georgia, with its large informal sector, slowly growing economy, weak regulatory and administrative capacity to raise revenues and poor tax compliance *(25, 26)*.[4] In addition, the Georgian economy was transitioning from a State-run system to a market-led system, creating additional challenges.

Overall health policy was altered in relation to these radical changes. A new wave of health reforms started with a "targeting" approach. Instead of delivering publicly subsidized services to all, the government decided to redistribute better services to those in need. In 2005, a proxy means-testing system was created to reveal poor households that should receive social and health benefits *(14)*.

Another important change was the shift from a decentralized to a more centralized approach. In 2006, the new Organic Law of Georgia on Local Self-Government consolidated the 1000+ local self-governance bodies that had previously existed into 69 municipalities, and significantly reduced local government obligations in health care. This decision was taken considering the weak capacities of local governments in planning, budgeting and management, as well as the limited budgetary revenues (with the exception of Tbilisi), which had led to the failed implementation of certain competencies provided by the legislation *(27)*. During this period, the political and economic context did not trigger any additional major changes in PHC until 2007.

The next period for PHC changes was 2007–2012, when the government continued its strategy to target those most in need. In 2007, the government launched an ambitious health financing reform with the overall goal of improving equity and financial access to essential services for the poor

5 National Statistics Office of Georgia.

(14). A comprehensive health benefits package was introduced to the poorest segment of the population through the Medical Insurance Programme (MIP), which was piloted in Tbilisi and Imereti regions. Poor households were identified through a proxy means-tested system. The MIP covered outpatient and inpatient services. The government contracted out the delivery of MIP benefits to private insurance companies, which assumed responsibility for programme administration.

The programme was rolled out nationally in 2008 without assessment of the pilot results and gradually expanded to other target groups (including internally displaced persons, children aged 0–5 years, students, pensioners and teachers). The poor population received the most comprehensive package of outpatient and inpatient care, exempted from co-payments. In terms of outpatient care, the MIP package for the poor included unlimited visits to family doctors and visits to specialists, with limited diagnostic and laboratory tests prescribed by a family doctor. Outpatient prescription drug benefits were added to this package from 2010 and included pharmaceuticals from the predefined essential list of medicines, with an annual financial limit of 50 Georgian lari, subject to a 50% co-payment by the patient. For other MIP beneficiaries, co-payments were required for diagnostic tests and specialist consultation *(28, 29)*. The MIP had covered a total of 1 635 217 beneficiaries (36% of the population) by the end of 2012. In addition, 535 662 individuals, or 11% of the population, received PHC services through individual or corporate private insurance schemes *(30)*. For the rest of the uninsured population (either through the government or private schemes), children aged under 6 years, elderly people aged over 60 years, incurable patients and patients with diabetes aged 6–60 years, basic PHC services were offered through the State PHC programme, which was administered by the State purchaser, the Social Service Agency.

In this period, there was a further shift of emphasis between primary and secondary care, with more emphasis placed on the hospital sector in order to protect the population from catastrophic financial health risks *(23)*. In March 2007, the government rejected the PHC Master Plan and introduced a revised vision for PHC reform, which differentiated between urban and rural models of PHC provision.

The government intended to terminate further investments in rural PHC infrastructure and to sell PHC buildings to rural doctors for a nominal price. In places where ambulatory service centres were not rehabilitated, primary care doctors were given lump sum grants amounting to the equivalent of US$ 1340 to rehabilitate their PHC premises *(20)*. In addition, all rural doctors were given the basic medical equipment (worth US$ 3400) that was necessary for their practice. The primary motive for this policy change was to save costs associated with further rehabilitation and maintenance of facilities and to retain PHC services in rural areas. There was a scarcity of doctors in rural areas and this intervention was intended to encourage rural doctors to retain their practices. As key informants stated, policy-makers considered this to be a more efficient way to provide PHC services in the resource-constrained environment at that time. Though international donors did not favour this decision, as refurbishment of PHC facilities was one of the core elements of their strategies, the government was firm in its decision. In general, decision-making in that period was characterized by bold decisions that were made without lengthy deliberations and technical preparations.

This initiative was also influenced by political motives to favour the rural population prior to the parliamentary elections of 2008. In his inaugural speech for his second term in office, the President of Georgia described a 50-day programme to eliminate poverty, which included having a doctor in every village equipped with new and necessary medical equipment *(31)*.

Rural primary care doctors acquired a new legal status as individual entrepreneurs and were authorized to manage their own PHC budgets. To increase basic managerial skills, special trainings were provided for them. However, as stakeholders stated, rural

doctors still face challenges due to poor managerial skills and unfinished work in terms of the ownership of PHC facilities in rural areas. Moreover, the rural doctors' legal status does not allow them to solve various administrative issues. As service providers participating in the focus group discussions put it, even if the financial resources were available they would still face problems, for example with regard to repairing ambulatory service centres, due to administrative challenges.

On the one hand, rural doctors facilitated rural outreach for the Ministry of Labour, Health and Social Affairs (for example, to reach rural MIP beneficiaries). On the other hand, managing 1200 individual rural doctors from the central level was a large administrative burden, according to the stakeholders in charge of the programme at that time.

Private insurance companies also relied on rural doctors to attract rural MIP beneficiaries to their facilities. Private insurance companies tended to contract rural doctors and encourage them to refer patients to their services. This practice discouraged rural doctors from performing a gatekeeping role between primary and secondary care, which, as key stakeholders and service providers stated, is a broader failure of primary care. Existing programme design and financial mechanisms were not and are still not suited to encourage such an approach.

Key stakeholders stated that 60–80% of rural doctors targeted by the 2008 intervention are still in place. Others have left the geographical area or medical practice along with the grants and equipment given to them, as the government did not have the leverage to retain the goods for replacement personnel.

With regard to urban areas, the previous PHC Master Plan also failed. The plan suggested removing 217 facilities and adding 16 facilities where there were none. This required strong government regulation as PHC providers were private entities and, as such, the State had much less flexibility in closing providers that were surplus to requirements or in moving providers to underserved regions. It was decided to sell PHC facilities in urban areas by auction to investors, giving preference to local medical personnel *(23)*. By 2011, almost all PHC facilities were privatized.

Interventions implemented during 2007–2012 had no significant effect on outpatient service use *(32)*, which remained at an average level of 2.1 visits annually per capita *(4)*. No reduction in expenditure on outpatient drugs and provider fees was found among chronic disease patients, while some increase in service use and reduction of ambulatory costs were found among MIP beneficiaries with acute illness *(32, 33)*. The MIP failed to cover drug benefits to the chronically ill, which was one of the drivers of health spending. Expenditure on drugs accounted for up to 60% of a household's health care costs and 86% of annualized recurrent expenditure for chronic patients *(34)*.

The next phase of PHC reforms started in 2013 in line with political changes. In 2013, the newly elected government initiated the Universal Health Coverage Programme for the whole population that was not covered by private insurance schemes. This was part of a pre-election government campaign that proclaimed accessible and affordable health care to be a key priority. This was a significant change from a targeted to a universal approach.

Another change was the reversion to centralized administration of State programmes, as the participation of private insurance companies was not considered to be cost-effective. As a result, the administration of all State-funded programmes became the responsibility of the State purchaser – the Social Service Agency. The Universal Health Coverage Programme diminished the role of private insurance companies, as the government funds flow directly to health care providers.

In mid-2017 the government introduced a differentiated approach for Universal Health Coverage Programme benefits, including improved drug benefits for chronic disease management among the poor population.

Table 3. Brief history of PHC reforms

Reform directions	Barriers	Enablers	Remarks	Source of information
1994–1999 Transition from Semashko model: • Decentralization of health system • Introduction of basic benefit package • Introduction of social insurance • Introduction of user fees and co-payments • Privatization of providers • Prioritization of PHC	Barriers to social insurance: • Large informal sector • Weak economy • Lack of regulatory and administrative capacity • Low tax compliance Other barriers: • Gradual expansion of basic benefit package due to political trade-offs and without appreciation of local resources • Municipalities' inadequate contribution to health programmes due to limited local economic capacity and resistance to participate in risk sharing • Lack of communication of basic benefit package entitlements to beneficiaries	Economic crises played a catalytic role in reform initiation Enablers were: • Donor assistance • High political commitment of government to initiate reforms • Strong leadership	Failure of social insurance resulted in poor fiscal performance of central and local governments Inadequate basic benefit package financing resulted in: • High out-of-pocket payments • Access and affordability barriers, especially for rural population	• Gamkrelidze et al. *(22)* • Gotsadze, Zoidze, and Vasadze *(13)* • Gotsadze et al. *(35)* • World Bank, IFC, MIGA *(19)* • Key informant and key stakeholder interviews; validation workshop
2000–2003 Dedicated primary health care programmes (Rural Health Programme, 2001; Primary Health Care Programme, 2003)	Poor fiscal performance of central and local government Local governments in two large cities remain responsible for PHC	• Centralization of pooling from regional to national level • Earmarked funds for PHC enabled relatively steady funding for rural providers during 2001/2002	As a result of dedicated PHC programmes and PHC financing reforms, access to PHC services improved among rural residents but led to inequity between rural and urban populations	• Gotsadze, Zoidze, and Vasadze *(13)*
2003–2005: PHC Master Plan developed 2007: Government rejected and revised Master Plan	• Priority shifting from PHC to hospital care (2007) • Lack of differentiated approach for rural and urban settings resulted in failure of Master Plan implementation in urban areas (2007) • No mechanisms in place to regulate excessive number of providers in urban settings (2007) • Restricted health resources leading to more cost-effective policy options for PHC design in rural areas	2003–2005 • Support from international donor community in PHC Master Plan development and initial implementation		• Chanturidze et al. *(23)* • Key informant and key stakeholder interviews; validation workshop

Reform directions	Barriers	Enablers	Remarks	Source of information
2008 to current: State Rural Doctors Programme	2008 • Decision made without thorough deliberations and technical preparation • Lack of needs-based approach (excessive number of doctors in relation to population) • Limited capacity at Ministry of Labour, Health and Social Affairs to adequately administer programme (2008–2011) • Low leverage of government to intervene (e.g. when grants and equipment recipients left the practice) Current: • Unfinished agenda with regard to ownership of rural ambulatory service centres • Lack of managerial capacity among rural doctors • Legal status of rural doctor prevents execution of administrative decisions • Lack of programme monitoring and evaluation • Inadequate remuneration of rural doctors and nurses resulting in them seeking additional job opportunities	2008 • Politically driven decision (doctor to every village) before the parliamentary elections • Strong leadership at State minister level in charge of health reforms in the country • Grants and basic equipment given to rural doctors at initial stage to maintain their practice • Fixed stable remuneration to rural doctors motivated them to retain practice	Programme is still in place, without major changes since its initial design	• Chanturidze et al. *(23)* • Key informant and key stakeholder interviews; validation workshop
2007–2012 Medical Insurance Programme	• Emphasis on hospital care • Limited outpatient coverage • Limited drug benefits for chronically ill • Programme design and financing mechanism of outpatient and inpatient components discourage gatekeeping role of primary care	• Strong leadership at State minister level in charge of health reforms in the country • Targeted approach • State administrative systems operational for MIP implementation (e.g. proxy means-tested system)	MIP did not increase PHC utilization for chronically ill, and drugs for chronic disease management remained major drivers of out-of-pocket expenditure	• Gotsadze et al. *(32)* • Gotsadze et al. *(33)* • Ministry of Labour, Health and Social Affairs *(34)* • Interviews with key stakeholders
2013 Universal Health Coverage Programme introduced	• Poor communication of programme entitlements to population at initial stages • Limited administrative capacity of Social Service Agency to handle necessary administrative issues for successful programme implementation • Poor financial resources for PHC (per capita cost rate does not reflect real service costs and remains at same level as 2001) • Inefficient programme design preventing PHC gatekeeping role and discouraging patients using PHC services • Low use of preventive services • Lack of monitoring and evaluation of programme • Poor access to public survey results for researchers to draw sound scientific evidence to inform policy	• Policy-driven decision with high political commitment • Increased public allocations for Universal Health Coverage Programme • Improved drug benefits for chronically ill from July 2017	Universal Health Coverage Programme increased PHC utilization especially among previously uninsured population, but failed to reduce financial risks due to uncovered drug benefits for chronically ill prior to July 2017	• Curatio International Foundation Barometer, VI, VII, VIII waves (http://curatiofoundation.org/ge/hsb8) • Somanathan, Buisman and Lavado *(36)* • World Bank *(3)* • Key informant and key stakeholder interviews; validation workshop

4. Governance

The Parliament of Georgia is the highest legislative body responsible for defining the main political directions of the health and social sectors in the country. Parliament approves the State Budget Law that defines the annual budget allocation to State programmes. The Health Care and Social Issues Committee of Parliament, which includes 17 members and is headed by the committee chair, has lawmaking and government oversight authority.

The Cabinet of Ministers, which is headed by the Prime Minister, is an executive council mandated to implement State policies. The Prime Minister approves government resolutions on the implementation of annual State programmes. The Ministry of Health, Labour and Social Affairs is responsible for policy and regulation development for the sector, and develops and oversees the implementation of State health programmes. The Ministry of Finance fulfils two main functions: leading the annual budget preparation process, and routine oversight of State budget spending to ensure compliance with predefined plans and laws. The Social Service Agency is the main health service purchasing body under the Ministry of Health, Labour and Social Affairs. The Medical Service Regulation Agency is responsible for issuing the licences and permits for health care providers and facilities, and for the certification of medical professionals. The National Centre for Disease Control and Public Health (NCDC) is responsible for planning and overseeing public health activities in the country, providing technical guidance, monitoring and supervision, surveillance and national-level reporting.

Service provision underwent significant structural and financial reorganizations as a result of the waves of reform. The Semashko model was characterized by a centralized delivery system based on territorial networks of policlinics with rural ambulatory centres and first-aid posts at the lowest level, all of which were operational subunits of the district hospital, which managed all financing for the district. From 1997, the PHC facilities in a district centre (that is, policlinics) became free-standing independent legal entities with responsibility for management and contracting for all PHC and outpatient specialized services. Most facilities were under State ownership, but they were privatized after the 2007 reform wave. In rural areas, individual doctors became entrepreneurs responsible for their own PHC budgets, and the State purchaser contracted them directly *(23)*.

Almost all PHC facilities were privatized by 2011. As a result of the reform initiatives in the period 2007–2010, when private insurance companies were implementing State-subsidized programmes for the poor, a considerable share of the health provider network became owned by private insurance companies. Currently, the majority of health providers are private for-profit entities owned by private insurance companies, medical corporations or stand-alone private facilities. Few PHC facilities remain under public ownership.

Specialized clinics such as dispensaries for TB care, mental health care units, clinics for HIV and hepatitis C treatment, and antenatal clinics provide services under the respective vertical State programmes. There is a process of structural integration of specialized services with general primary care services: for example, TB specialists (doctors and nurses) are contracted by primary care centres to perform their duties as part of the TB State programme. As a result, in recent years the number of old, separately standing dispensaries has been reduced.

At present, PHC services are provided by 304 primary care centres (policlinics and policlinic-ambulatory unions that include ambulatory services under their subordination), 35 independent rural ambulatory centres, 29 antenatal clinics, 18 specialized dispensaries and 1258 rural doctors (individual entrepreneurs) *(16)*.

The national average of PHC facilities (including rural doctors and excluding antenatal clinics and specialized dispensaries) is 4.3 per 10 000 people, with marked urban–rural variations (Table 4):[5] in rural areas on average 8 rural doctors serve a population of 10 000, while in urban settings on average 1.6 PHC facilities serve the same number of people.

Local governments have a limited role in PHC. Central government delegates certain responsibilities to local governments under the Public Health Law, including storage of vaccines and consumables and their distribution to health care providers within the national immunization calendar, vaccination against rabies, preventive and control measures in case of epidemic threats, and primary epidemiological investigation of communicable disease cases *(37)*. The role of local governments in health care is vague and undefined: according to the Organic Law on Local Self-Government, municipalities may carry out activities to promote health care and the cultivation of healthy lifestyles *(38)*. Currently, the capital city and other selected municipalities supplement some vertical programmes from their budgets.

The locus of policy-making power has changed over the course of the health reforms. At the beginning of the reforms, policy-making power was concentrated within the Ministry of Health, Labour and Social Affairs. International donors were involved in the policy dialogue and their influence on policy decisions was significant during this period.

Despite the government change in 2003, and the frequent turnover of health ministers, policy-making power remained at that ministry until the 2007 reforms. In October 2006, following the rejection of the health reform concept developed by the Ministry of Labour, Health and Social Affairs, the President called on the government to change the health policy-making process. The Prime Minister and the State Minister of Public Reforms were asked to take responsibility for health care reform. Major reforms during that time were elaborated under the leadership of the State Minister, who was the "father" of Georgian public sector and economic reforms. The role of the Ministry of Labour, Health and Social Affairs in policy decisions became more prominent when the State Minister left the post in 2009. In

Table 4. Geographical distribution of PHC facilities

	Number of urban PHC facilities / rural doctors	PHC facilities / rural doctors per 10 000 population	Rural doctors per 10 000 rural population	Urban PHC facilities per 10 000 urban population
Georgia	**1597**	**4.3**	**7.9**	**1.6**
Racha-Lechkhumi	62	19.4	24.8	
Kakheti	226	7.1	8.5	2.4
Mtskheta-Mtianeti	67	7.1	7.5	5.7
Guria	80	7.1	9.2	1.6
Samegrelo-Zemo Svaneti	190	5.7	8.0	2.2
Samtskhe-Javakheti	87	5.4	7.9	0.5
Shida Kartli	140	5.3	8.3	0.9
Imereti	248	4.6	7.8	1.3
Kvemo Kartli	181	4.3	6.6	1.2
Adjara	129	3.9	7.2	1.2
Tbilisi	174	1.6		1.6

6 Georgia Law on State Budget, 2012–2016.

general, during the period after the Rose Revolution, policy decisions were taken by key figures without thorough deliberations and technical discussions. International donor support continued to the health sector, though policy dialogue was reduced and policy advice given by donors to the government did not have much impact, as the government lost interest in following donor advice *(19)*.

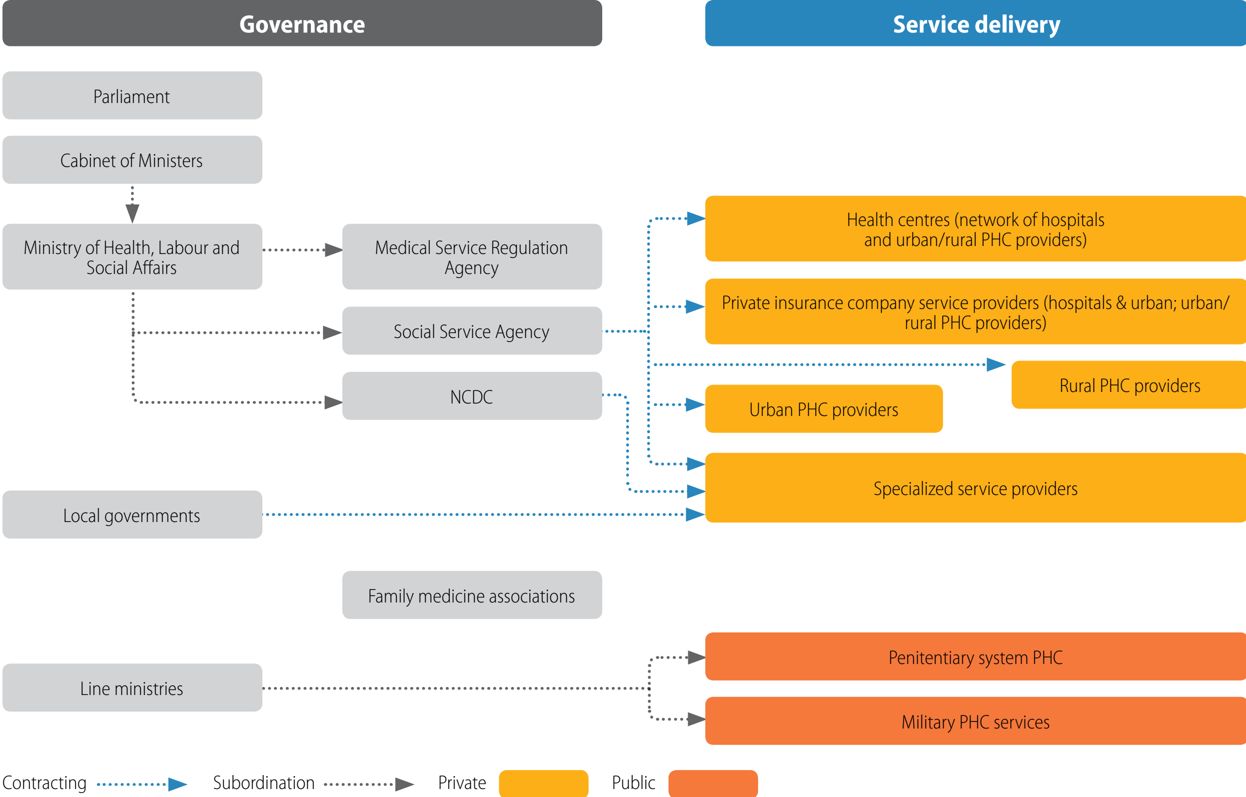
Following the change of government in 2012, major policy decisions have been made at the Ministry of Health, Labour and Social Affairs, including the substitution of multiple private insurance companies with a single public purchaser to administer State-funded health benefits. In general, policy-making during this period, especially at the initial stages, was done "behind closed doors", according to key stakeholders. For example, during the development of the Universal Health Coverage Programme there were no open hearings on policies or consultative decision-making processes. Therefore, individuals or interest groups proactively attempted to influence policy decisions. For example, the initially calculated per capita tariff for PHC services was much lower; however, after the active participation of interested parties, the tariff was revisited and partially increased, although not to the desired level. The directions of the Universal Health Coverage Programme were declared in a concept paper that serves as the main policy document guiding the Government of Georgia's actions *(39)*. Among other activities, the concept paper mentions the development and gradual implementation of a primary health care development strategy, although that has not yet materialized.

The Primary Health Care Coordination Council that was functional during the period 2003–2012 was re-established at the Ministry of Labour, Health and Social Affairs in 2013 with renewed functions and composition. The objective was to expand the representation of service providers in the discussions about State programme implementation. One rural doctor representing each region was included in the council's work. Several meetings of the council have been held since its establishment. According to key stakeholders, the council has not had any major influence on primary health care policy formulation.

The role of the Parliamentary Health Care and Social Issues Committee was not as prominent and visible prior to 2016. After the 2016 parliamentary elections, a newly elected Parliamentary Committee, which has a new composition and leadership, aims to strengthen the committee's role in national policy-making by facilitating an inclusive process for developing a 10-year strategy that defines the vision, overall objectives, key priorities and strategic goals for improving health care services, social protection and labour relations in Georgia.

Figure 3 provides a summary of the governance and current architecture of the PHC system in Georgia.

Figure 3. Governance and architecture of the PHC system



5. Financing

Currently, health revenues in Georgia are derived from out-of-pocket expenditure, general taxation and private insurance schemes. Out-of-pocket expenditure remains the largest portion of health revenues. Public funds from general taxation are spent on State health programmes, including the Universal Health Coverage Programme, the Rural Doctors Programme and other vertical programmes. A small percentage of the general population (8%) purchases private health insurance for themselves either through corporate or individual packages *(40)*.

According to the National Health Accounts, total health expenditure was 8.5% of GDP in 2015. Total health expenditure on health, according to WHO, constituted $627.7 PPP per capita in 2014, which is 2 times and 6 times lower than the CIS and European Union averages, respectively. The share of public sources of total health expenditure increased from 12% in 2001 to 36% in 2015; correspondingly, private sources decreased from 81% to 62% but still remain at a high level *(40)*.

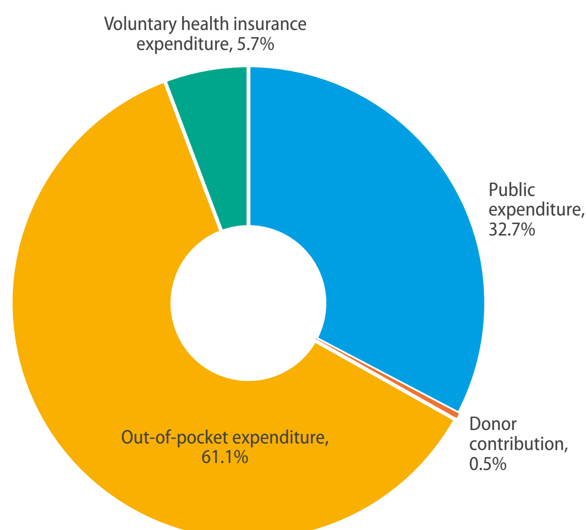
The share of PHC expenditure reached 26.3% of total health expenditure in 2015, according to National Health Accounts data. Public sector expenditure on PHC accounted for 32.7% in 2015. At the same time, private spending on PHC amounted to 66.8% of total expenditure on PHC. The donor contribution to total PHC expenditure equalled 0.5% in 2015 (Figure 4).

Since 2013 access to outpatient services has been increased through publicly financed services within the Universal Health Coverage Programme. The government's political commitment to universal health coverage has been supported by significant public budget allocations to health. During the period 2012–2016, State budget allocations for health increased more than 2.5 times, albeit from a low base of 1.7% of GDP, and reached 2.7% of GDP or 8.9% of government expenditure.[6] Overspending of the Universal Health Coverage Programme budget occurring for the last two years, however, highlighted concerns with the programme financial sustainability and uncovered challenges with the programme administration by the State purchaser *(3)*.

Although the government has introduced numerous health finance reforms over the past two decades, high out-of-pocket payments remain a key challenge for the government (57.3% of total health expenditure in 2015, according to the National Health Accounts). Out-of-pocket payments in Georgia are primarily spent on pharmaceuticals, followed by official co-payments, direct formal payments to health facilities and informal payments to health care providers.

Introduction of the MIP in 2007 targeting priority groups, including the poor, had an impact on out-of-pocket health expenditure, as revealed by the 2007–2010 Health Utilization and Expenditure Surveys. It reduced the cost of accessing services, especially among the poorest: out-of-pocket payments for outpatient visits reduced by 26.8 Georgian lari (US$ 15.7) and monthly health care

Figure 4. Distribution of total health expenditure on PHC, 2015



costs decreased by 68.7 lari (US$ 40.4) *(41)*. Another study showed that the MIP improved utilization and reduced costs incurred by patients with acute health needs, though it did not affect either health service utilization or expenditure on outpatient drugs and reduction in provider fees among patients with chronic illnesses *(32)*. Outpatient drugs were subsidized from the limited essential drugs list in the annual amount of US$ 21 for the poor since 2010, and no other outpatient drug benefits were covered by the Universal Health Coverage Programme until July 2017, when the new policy change became effective. Nevertheless, pharmaceuticals remained a major cause of out-of-pocket payments.

The Health Utilization and Expenditure Survey of 2014 found that pharmaceuticals still comprised the major share (two thirds) of out-of-pocket payments. Although 85.3% of patients were able to purchase prescribed drugs in 2014, there was a significant gap between income groups: the poorest were 3 times less likely to purchase prescribed pharmaceuticals compared to the richest quintile *(36)*. The Universal Health Coverage Programme resulted in a reduction of the financial barrier in accessing outpatient care, with the proportion of illness episodes when patients could not afford outpatient care because of the cost falling from 16.7% in 2010 to 10% in 2014, though gaps remained between different income groups – patients in the poorest quintile were not able to afford outpatient health care services 3 times more frequently compared to those in the richest quintile *(17)*.

Thus the Universal Health Coverage Programme has not yet succeeded in protecting the population from financial risks due to high spending on outpatient drugs, benefit limits under the programme and co-payments. According to the Household Budget Survey, 2015, the incidence of catastrophic health payments has increased in Georgia since 2012. At the lower threshold of 10% of total expenditure, the share of households experiencing catastrophic spending increased from 28% (2012) to 34% (2015) *(3)*.

Consideration of the evidence on the existing financial burden and the inefficient design of the Universal Health Coverage Programme, as well as concerns about financial sustainability, led the government to make respective policy changes. The programme has been criticized from its early stages by political leaders from opposition parties and various experts. The programme approach, with similar benefits offered to all (with the exception of the poor, who already received the best coverage), was a major subject of criticism, along with the limited drug benefits for chronic disease management and high spending on inpatient services. Key informants suggested that the country income and level of public spending on health does not allow "such a luxury".

The government faced State budget overspending in 2015/2016, with half of this overrun attributable to health expenditure. To respond to the risk to fiscal sustainability, the government developed a Fiscal Sustainability Programme at the end of 2016 after the parliamentary elections, when the ruling coalition was elected for a second term. The commitments articulated in the Fiscal Sustainability Programme served as a basis for the International Monetary Fund-supported programme. The government commits to increase the efficiency of State health programmes through focusing on the most vulnerable and improving programme administration *(3)*.

The recent changes (2017) introduced drug benefits for chronic disease management for the poor. Other policy changes differentiated publicly subsidized health services for certain groups of the population under the Universal Health Coverage Programme: households with a monthly income less than 1000 Georgian lari (US$ 418) and other target groups (for example children aged under 6 years, pensioners and students) are eligible for free visits to family doctors and for specialized services under a co-payment system; households with a monthly income above 1000 lari can receive family doctor services for free, while diagnostic tests and specialist consultations are subject to payment;

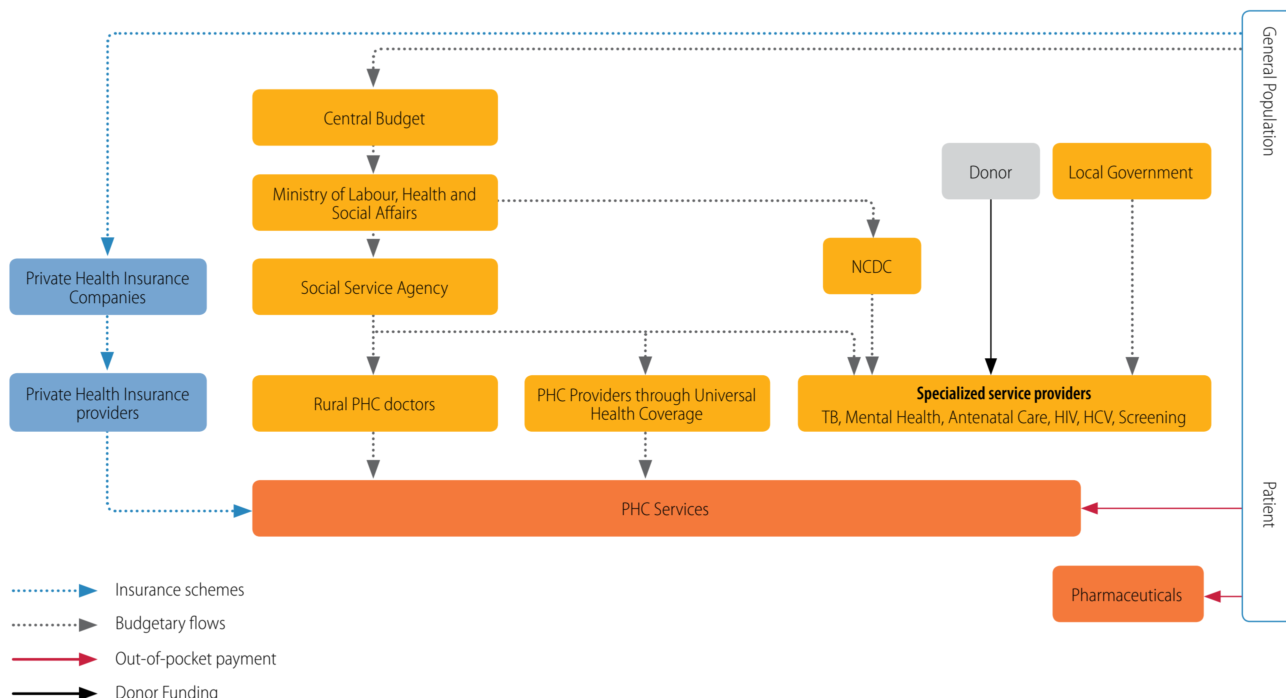
and households with an annual income of 40 000 lari (US$ 16 735) and above are no longer eligible for benefits under the programme. The poor population has the same access to the full package of outpatient and inpatient services without co-payments.

Figure 5 summarizes current financial flows for the PHC system in Georgia.

PHC services are delivered to the population through the Universal Health Coverage Programme, the Rural Doctors Programme and numerous vertical programmes, such as the maternal and child health programme, immunization, TB care, mental health care, diabetes care, HIV, hepatitis C and screening programmes.

The Universal Health Coverage Programme service providers are funded at a fixed per capita rate for PHC services of less than US$ 1 (that per capita payment for PHC services was introduced in 2001, when the Rural Health Programme was launched). The monthly budget for PHC facilities is formulated according to the catchment population size. In 2014, the Universal Health Coverage Programme budget was mainly spent on emergency outpatient and inpatient services, which constituted 70% of the total programme budget, while 13% was spent on planned outpatient services *(42)*. The Rural Doctors Programme is financed through a global budget model. Doctors and nurses are reimbursed at fixed amounts of the service fee without any additional funding linked to performance. In general, at present there are no performance-based financing mechanisms in the State-funded programmes, although there are plans to pilot provider-side performance-based financing schemes for chronic disease management and TB outpatient services. One Tbilisi-based private PHC provider has designed and is currently implementing a performance-based financing scheme that includes selected indicators on immunization coverage and chronic disease management. Vertical programmes are financed either through global budgets or on a fee-for-service basis.

Figure 5. Current financial flows for PHC system in Georgia



6. Human resources

General PHC services in Georgia are delivered by family doctors, who are graduates of the full residency programme in family medicine, or by doctors who are certified in internal medicine and paediatrics or in other medical specialties related to family medicine (gastroenterology, nephrology, pulmonology, cardiology and rheumatology) and gained family medicine as a second specialty after a short-term residency programme. In the period 2006–2016, the rate of generalists (family doctors and internal medicine doctors) increased from 50 to 126.1 per 100 000 people *(16)*. At the same time, the number of nurses per 100 000 people decreased from 1998 and reached 0.8 nurses to 1 doctor in 2014. This ratio is the lowest among the post-Soviet countries *(7)*, probably due to the overproduction of physicians and the underproduction of nurses in Georgian society, where the nursing profession is considered a far less prestigious career choice than that of physician. Nurses in Georgia are trained in vocational schools. In 2006, a nursing higher education school was established at the Tbilisi State Medical University. There is no national certification or licensing of nurses *(23)*. One of the biggest private medical corporations has established a nursing continuous education programme for its own nursing staff. There are no community health workers in Georgia.

In response to the overproduction of doctors, the administration of the Tbilisi State Medical University (one of the biggest medical universities in Georgia) has been gradually restricting the number of places at the Faculty of Medicine for Georgian citizens and substituting a cohort of students from foreign applicants since 2015.

Family medicine was recognized as a specialty in 1998. With donor support, health personnel were retrained in six-month-long family doctor training programmes during the period 2003–2012. In total, 916 doctors and 1073 nurses were trained *(20)*.

Currently, free training programmes are no longer available for medical personnel. The leading private providers offer in-service training for their staff on a regular basis.

7. Planning and implementation

Primary care services from the State-funded programmes are provided through the Universal Health Coverage Programme, the Rural Doctors Programme and other vertical programmes. Programme beneficiaries and benefit packages are given in Tables 5 and 6.

The only difference between services under the Universal Health Coverage Programme and those under the Rural Doctors Programme is that the latter covers diagnostic and laboratory tests at a minimal level and does not cover specialist consultations (Table 6). When needed, a rural patient is referred to a district PHC facility, where the patient receives the required services under the Universal Health Coverage Programme. In addition, the Rural Doctors Programme incorporates DOTS (directly observed treatment, short course) for rural TB patients, while in other areas DOTS is part of the TB care programme.

Services under vertical programmes are implemented by either separate standing specialized service providers or in some areas by PHC clinics that have involved these specialists among their service providers.

The regulation on deployment of primary care providers exists only for rural doctors. The ministerial decree of 2013 defined rural areas where doctors should be deployed, as well as a list of equipment and medications to be in place in the rural PHC premises where the rural doctor operates. The Universal Health Coverage Programme introduced free choice of doctors and abolished catchment boundaries. This was in line with a patient-centred care system that allowed patients to decide where to register, though it created challenges in some areas, for example defining catchment populations for immunization and tracking immunization coverage rates.

After the introduction of the Universal Health Coverage Programme, the number of visits to PHC facilities per capita per year increased from 2.3 in 2012 to 3.5 in 2016 in Georgia (Figure 6). The Health Expenditure and Utilization Survey of 2014 found that utilization of outpatient services increased, especially among the previously uninsured population *(17)*. The increase could be partly attributed to the introduction of the Outpatient Drug Prescriptions Policy in 2014. According to the policy, the majority of outpatient drugs should be purchased through prescriptions from GPs, which naturally resulted in an increase in outpatient visits in 2014/2015. Nevertheless, this estimate is lower than the European Union average of 6.3 consultations per capita per year *(43)*. The rise in PHC visits is partly attributable to the population decrease found by the 2014 census, which has not been adjusted for in the previous years. Figure 6 also shows the number of visits per capita if the population decrease is not considered. In this case, the increase in visits to PHC facilities is less prominent.

Although the Universal Health Coverage Programme encouraged utilization of PHC services, there are deficiencies in the adequacy and quality of those services.

The insufficient level of outpatient visits could be explained by out-of-pocket payments associated with the purchase of drugs for chronic disease management. Due to the inadequate drug benefits, patients refrain from using outpatient services and refer themselves directly to emergency and hospital services, where essential medicines are freely provided.

Another major shortcoming is the failure to fulfil the gatekeeping role of PHC. There are high referral rates from family doctors to specialists (40% instead of a more typical international range of 10–15%) *(44)*. Specialist visits are subject to co-payments, so excessive referral to specialists leads to out-of-pocket expenditure, with the exception of the poor, who are exempted from co-payments. The financial mechanisms for funding outpatient and inpatient services under the Universal Health

Table 5. Coverage of State-funded programmes

Beneficiaries	Universal Health Coverage	Rural Doctors	Maternal and child health	Immuni-zation	TB care	Mental health	Diabetes	HIV	Hepatitis C	Screening
Children 0–5	✓									
Pensioners	✓									
Teachers	✓									
Poor	✓									
Uninsured[a]	✓									
Rural residents		✓								
All citizens			✓	✓	✓	✓	✓	✓	✓	✓

a. Below 40 000 Georgian lari annual income.

Table 6. Benefit packages of State-funded programmes

Services	Universal Health Coverage	Rural Doctors	Maternal and child health	TB care	Mental health	Diabetes	HIV	Hepatitis C	Screening
Visits to doctor/nurse	✓	✓							
Immunization	✓	✓							
Home visits	✓	✓							
Chronic and acute disease diagnosis, management, and referral as necessary	✓	✓							
Emergency medical assistance	✓	✓							
Limited specialist consultation	✓								
Limited diagnostics and laboratory tests	✓								
Minimal diagnostics and laboratory tests		✓							
23 essential drugs for the poor and chronic conditions[a]	✓	✓							
Four antenatal visits			✓						
TB case management				✓					
DOTS for TB patients		✓		✓					
Management of mental disorders, counselling, free drug provision					✓				
Free insulin provision						✓			
Antiretroviral treatment							✓		
Hepatitis C treatment								✓	
Screening for breast, cervical and prostatic cancer									✓

a. Including cardiovascular, chronic lung, thyroid gland diseases and diabetes type 2, subject to 10% co-payment (not more than 1 Georgian lari).

Coverage Programme and lack of cost containment mechanisms lead to failure of the PHC system to prevent use of costly hospital services. Primary care is fragmented and offers little value for money for patients relative to specialist and hospital care. Although PHC acts as a patient's first point of contact with the health care system, there is no incentive for PHC facilities to retain the patient at the outpatient level, as PHC providers are paid at a fixed rate per patient, while hospitals are paid based on activities undertaken, which creates an incentive to pull patients towards inpatient care *(3)*.

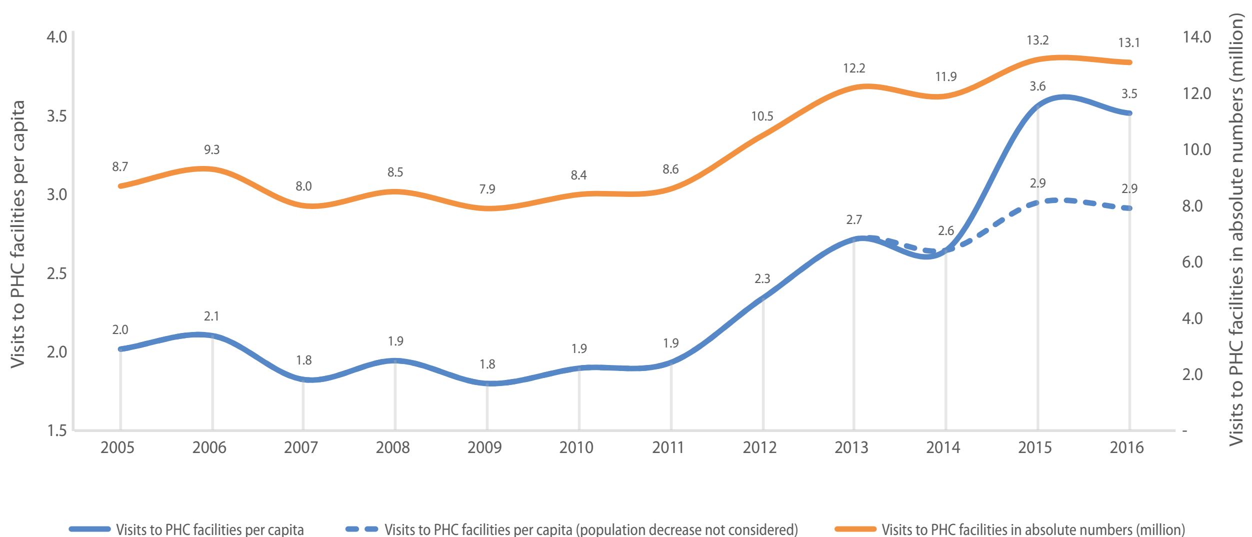
Fragmentation of services is also an issue for general primary care and specialized care. Despite structural integration of specialized services (for example TB or mental health) in primary care facilities there is no horizontal linkage between the programmes (Universal Health Coverage, TB and Mental Health Programmes). As PHC providers, focus group discussion participants mentioned that there was no information sharing between specialized programme providers and GPs, as the patient is commonly viewed as a beneficiary of vertical programmes and the management is not usually interested in providing integrated services due to the lack of financial motivation. Consequently, a patient-oriented approach is still lacking in most cases.

Limited administrative capacity of the single public purchaser (Social Service Agency) has been identified as one of the shortcomings in efficient implementation of the programme. Key stakeholders underlined limited technical capacity and shortage of human resources at the Social Service Agency to undertake analysis of the performance of State programmes.

There are no mechanisms is place – such as monitoring of ambulatory care sensitive conditions – to manifest poor and best practices in the health system as a basis for effective application of the State financial resources. One of the barriers, along with the lack of technical capacity, is the failure of the information system to provide necessary data for such analysis.

Weaknesses exist with regard to performance, health personnel qualifications, programme planning and monitoring. The per capita tariff for PHC services was calculated in 2012 and has not been revised since then to adjust for increased costs and inflation. Among other challenges is the lack of financing mechanisms to stimulate health workers' performance.

Figure 6. Visits to PHC facilities (2005–2016)



8. Regulatory processes

Under current legislation PHC market entry is straightforward, and commencement of PHC service provision requires only medical personnel certification. For high-risk PHC services such as infectious diseases, radiology, dermatology, sexually transmitted diseases, TB, and interventions with anaesthetics, specific technical requirements have been established *(45)*.

In 2006, the Government of Georgia introduced an aggressive privatization policy and applied market-regulated principles to the health sector, characterized by liberal regulations and minimum supervision. In the framework of this policy many regulations were abolished, and medical facilities and quality of services were no longer controlled by the State.

In terms of professional education standards, family doctors receive their education through a three-year residency programme accredited by the Ministry of Labour, Health and Social Affairs. The programme was developed within the donor-supported project in 2007. The quality of the medical education system is not satisfactory, according to field specialists. This has prompted private providers to establish their own residency programmes to ensure higher quality amongst the workforce.

To promote the family medicine residency programme among medical students in resource-limited areas, the Ministry of Labour, Health and Social Affairs decided to provide scholarships covering tuition fees for students from remote areas in 2014. However, due to the inadequacy of the promotional campaign, the budget was not fully utilized, and relatively few applications were received from prospective students.

The PHC medical personnel core competencies are regulated through a Minister of Health order *(46)* that is only a normative act to standardize their professional activity. Medical practice is also partially regulated by national practice guidelines and protocols. The guidelines set recommended (not mandatory) standards of care against which patients' complaints are judged. The Ministry of Labour, Health and Social Affairs, in close collaboration with professional associations, has elaborated more than 20 national clinical practice guidelines and protocols of care for PHC.

The quality of care is controlled by the Medical Service Regulation Agency under the Ministry of Labour, Health and Social Affairs. The Medical Service Regulation Agency investigates cases, including patients' complaints, and in instances of professional misconduct can issue a written notice to health personnel or suspend their medical activity through temporary or permanent revocation of a certificate.

As mentioned, there are no regulations to appraise service providers' clinical practice. The instrument for health personnel performance appraisal was developed by the Family Medicine Association in 2006 and applied under the donor-supported programme; however, it has not been institutionalized in the system, due to the absence of a body that would assume this responsibility. Private medical corporations and service providers have attempted to introduce their own quality appraisal methods in their facilities.

Immunization is the only field where appraisal of the clinical practice is undertaken on a regular basis. The NCDC carries out assessment of the quality and safety of the immunization practices of primary care providers under the broader immunization programme review exercise. This is done every second year and is supported by donors (including WHO and UNICEF).

9. Monitoring and information systems

Health reporting starts from the lowest level of service provision (rural doctor, ambulatory) and follows the established forms, frequency and hierarchy of reporting. The Medical Statistics Department at the NCDC is responsible for monitoring, evaluation and analysis of the population health status. The medical statistics yearbook is produced on an annual basis and provides descriptive and some analytical information derived from the routine Health Information System and surveys.

In recent years significant resources have been invested to strengthen communicable disease surveillance and response systems in the country, and an effective system is operational to identify and respond to epidemics.

Numerous donor-funded projects have dealt with reforming and strengthening the Health Information System at primary care level over the last two decades in Georgia. Some changes have been institutionalized across the system countrywide, while others did not extend beyond the piloting stage.

The Ministry of Health, Labour and Social Affairs recently introduced "E-Health" – an innovative, comprehensive electronic information system to capture information on all aspects of health care in Georgia. The system is built around a citizen's ID number; different modules are created to gather information from various programmes, including those in the areas of universal health coverage, rural doctors, maternal and child health, immunization, TB care and mental health. Currently, paper-based reporting is still in place, while E-Health is mainly used to control programmes from a financial perspective, and there is limited use of the data for service volume or quality monitoring purposes. A number of factors are behind this weakness: limited human resources at the Ministry of Health, Labour and Social Affairs to analyse the data, lack of an established culture to monitor programme performance according to a monitoring and evaluation framework, and the failure of E-Health to provide some useful information. Currently, separate health information systems are functional for specific areas, such as HIV/AIDS, TB, immunization, hepatitis C, and communicable diseases, although the data collection forms are integrated into the routine Health Information System.

The quality of data may vary across different areas, depending on the intensity of monitoring and supervision and data use for analysis. As health care providers and key stakeholders stated, data for maternal and child death, immunization, vaccine-preventable diseases, TB, and some other key areas are accurate and reliable. In general, reliance on paper reporting, inadequate use of data for critical analysis, and inefficient feedback and correction measures negatively affect the quality of data.

Satisfaction with primary care services was evaluated a year after introduction of the Universal Health Coverage Programme. The survey of 431 beneficiaries found that 80% were satisfied with outpatient services. Financial protection and free choice of doctors were identified as positive aspects *(47)*. The Universal Health Coverage Programme has not been further evaluated.

10. Ways forward

Primary care is the cornerstone of a strong health care system. Georgia's health care system has undergone radical reform processes over the last two decades, significantly influenced by external drivers such as political dynamics, macroeconomic factors, international partners' involvement and internal processes. As an integral part of the health care system, primary care has been the subject of several reforms, during which it has been accorded different levels of prioritization during different time periods, each with their own achievements and failures.

The current PHC system in Georgia offers accessible and affordable services to the population, with differentiated benefits to those in greater need. However, the system still requires significant improvements to achieve its ultimate goal of delivering comprehensive, continuous and people-centred care.

Low utilization of PHC services and inadequate gatekeeping at the PHC level should be addressed by creating mechanisms to motivate both health care providers and patients to use the system. Cost containment mechanisms should be incorporated in the payment models of primary and secondary care to stimulate use of low-cost services. Introduction of patient-centred practices will also increase demand for PHC.

In order to address the challenges of fragmentation of care, vertical programmes should be gradually integrated into the Universal Health Coverage Programme. This will create the basis for comprehensive, coordinated and efficient services.

NCDs account for more than 80% of the disease burden in the country. Primary care should contribute to NCD prevention and control through primary prevention and management of risk factors and the provision of care, including medications. Out-of-pocket payments associated with the drugs for NCD management are a significant barrier in using PHC services in Georgia and constitute the largest share of health expenditure. In response to this, in mid-2017 the Ministry of Health, Labour and Social Affairs introduced outpatient drug benefits for four chronic conditions to the poor in the context of the Universal Health Coverage Programme. This benefit is expected to boost the role of PHC in chronic disease management through increased referrals to PHC doctors, who will be responsible for prescription of the subsidized drugs.

In order to improve accountability, quality, and appropriate use of resources, programme performance should be measured on a regular basis. Monitoring of hospitalization for ambulatory care sensitive conditions could be considered to assess the effectiveness of primary care interventions. This will help reduced the costs associated with unnecessary hospitalization and emergency admissions.

The postgraduate and continuous education system for medical personnel requires major improvements to ensure production and maintenance of a qualified workforce.

Finally, strengthening the role of PHC in the country will not be achieved without adequate funding. Although public health spending has increased over the last year, it remains at a low level (2.7% of GDP). But what is more worrying is that public health resources are still disproportionally allocated to inpatient care, and consequently the health system fails to get the best health outcomes from the available funding.

Although strengthening primary care has been on the agenda of policy-makers, no concrete actions have been taken until recently. In 2017, the Parliamentary Health Care and Social Issues Committee started to define a long-term (2017–2035) vision and action plan for social protection and health, which identifies PHC as one of the core areas on the way to achieving universal health coverage.

Annex 1. Characteristics of key informants and stakeholders

Type of respondent	Descriptor	Main areas of expertise	Period of expertise or involvement in PHC reforms
Key informant	Expert	Health research, policy and systems, health financing	Since 1991
Key informant	Current and former policy-maker, expert	Health policy and systems	Since 1995
Key informant	Former policy-maker	Public health and PHC	Since 1994
Key informant	Policy-maker, expert	Health policy and systems	Since 1991
Key informant	Former representative of State purchaser	Health programmes and management	2003–2007
Key informant	Former policy-maker	Health policy and systems	2008–2010
Key informant	Former policy-maker	Health policy and systems	2005–2012
Key stakeholder	Former representative of Programme Implementation Unit, current official of NCDC	Health programme administration, PHC	Since 2003
Key stakeholder	Former official of Ministry of Labour, Health and Social Affairs	Health programme administration	2005–2007
Key stakeholder	Representative of Family Medicine Association, expert	PHC, patient rights	Since 2000
Key stakeholder	Representative of Family Medicine Association, service provider	PHC service delivery, management	Since 1994
Key stakeholder	Former PHC service provider	PHC service delivery, management	1999–2007
Key stakeholder	Current official of Ministry of Labour, Health and Social Affairs	Health system administration, universal health coverage, PHC, Rural Doctors Programme	Since 2007
Key stakeholder	Current official of Ministry of Labour, Health and Social Affairs	Health programme administration, PHC, Rural Doctors Programme	Since 2008
Key stakeholder	Former representative of Ministry of Labour, Health and Social Affairs, current PHC service provider	Health programme administration, PHC, facility management	Since 2003
Key stakeholder	Representative of network of private health providers	PHC, management	Since 2014

Annex 2. State programmes, including PHC component, beneficiaries and funding

<table>
<tr><th>YY</th><th>1997–2000</th><th>2001–2002</th><th>2003–2005</th><th>2006</th><th>2007</th><th>2008</th><th>2009–2011</th><th>2012</th><th>2013</th><th>2017</th></tr>
<tr><td rowspan="5">Programmes</td><td colspan="3">Social Health Insurance Programme: basic benefit package</td><td></td><td></td><td></td><td></td><td></td><td colspan="2">Universal Health Coverage Programme</td></tr>
<tr><td></td><td>Rural Health Programme</td><td>State PHC Programme</td><td colspan="4">State PHC Programme, including family medicine component</td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td colspan="4">Medical Insurance Programme for target groups</td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td colspan="5">Rural Doctors Programme</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td colspan="5">Separate State programmes for mental health, maternal and child health, immunization, diabetes, oncology, tuberculosis, HIV, screening</td></tr>
<tr><td>Beneficiaries</td><td>Entire population</td><td>Rural Health Programme: entire population except Tbilisi and Poti
Municipal programmes in the frame of basic benefit package: Tbilisi and Poti residents</td><td>PHC programme: entire population except Tbilisi and Batumi residents 3+
Municipal programmes in the frame of basic benefit package</td><td>Entire population</td><td>PHC: entire population except MIP beneficiaries
MIP: pilot
Poor households from Tbilisi and Imereti region</td><td>PHC: entire population except MIP beneficiaries
MIP: national roll-out
Poor households of Georgia
Rural Doctors Programme: rural population</td><td>PHC: entire population except MIP beneficiaries
MIP: expanded to internally displaced persons, teachers, etc.
Rural Doctors Programme: rural population</td><td>MIP: expanded to children under 6 years, people over 65, students, etc.
Rural Doctors Programme: rural population</td><td>Entire population except privately insured individuals</td><td>Entire population except privately insured individuals, and individuals having income more than 40 000 lari per year</td></tr>
</table>

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YY	1997–2000	2001–2002	2003–2005	2006	2007	2008	2009–2011	2012	2013	2017
	Outpatient services covered:			State PHC programme services:	State PHC programme services:				PHC component of Universal Health Coverage Programme	
Services	• Health promotion • Preventive services • Outpatient visits • Immunization • Diagnostic services • Laboratory investigations • Chronic disease management • Maternal and child health services • Emergency care and ambulance • Specialist consultations: ∘ Endocrinologist ∘ Oncologist ∘ Gynaecologist ∘ TB doctor			• - • + • + • + • + • + • + • + • + • + ∘ + ∘ + ∘ + ∘ + ∘ Radiologist ∘ Surgeon ∘ Ophthalmologist ∘ Otorhino-laryngology ∘ Psychiatrist	• - • + • + • + • + • + • + • + • + • + ∘ + ∘ + ∘ + ∘ + ∘ + ∘ + ∘ + ∘ + ∘ +				• - • + • + • + • + • + • + • + • + • + ∘ + ∘ + ∘ + ∘ + ∘ - ∘ - ∘ + ∘ + ∘ + ∘ Cardiologist ∘ Neurologist ∘ Urologist	
	Drug supply for terminal oncology patients			• DOTS for TB patients • + Outpatient services restricted for population aged 15–65; they are only receiving chronic disease management service	• DOTS for TB patients • + MIP beneficiaries are not restricted in specialist consultations; they can visit any doctor based on family doctor's decision				• DOTS for TB patients • + Since April 2017, services covered through the Universal Health Coverage Programme have been differentiated for different population groups based on their income	

YY	1997–2000	2001–2002	2003–2005	2006	2007	2008	2009–2011	2012	2013	2017
Financial sources	1. Central budget 2. Social insurance premium (3+1) collected by State Medical Insurance Company 3. Local municipal budgets 4. Out-of-pocket expenditure			1. Central budget 2. Local municipal budgets for only maintenance of health facilities 3. Out-of-pocket expenditure						
Payment mechanisms		Capitation US$ 1 per capita		Capitation Global budget	Capitation Global budget	Capitation Service fee for Rural Doctors Programme			Capitation US$ 1.16 per capita Service fee for Rural Doctors Programme	Capitation US$ 0.72 per capita Service fee for Rural Doctors Programme
Depth of public subsidies	Fully covered / no co-payments				PHC • Fully covered general outpatient care MIP • Fully covered general outpatient care + specialist consultations for poor				PHC through Universal Health Coverage Programme • Fully covered outpatient care for poor • Family doctor for all beneficiaries • Specialist consultations subject to co-payment • Drug benefits for chronic disease management for poor (fully covered from essential list from 2017)	
Programme administration	State Medical Insurance Company and municipal health funds			Health and Social Protection Agency	PHC and Rural Doctors Programmes: administered by Social Service Agency MIP: administered by Social Service Agency through private insurance companies				Universal Health Coverage and Rural Doctors Programmes: administered by Social Service Agency	

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