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Challenges of Primary Health Care Reforms in Georgia (1995-2018)

After the restoration of independence in Georgia, the political and socio-economic crises lead the health system to the complete collapse. The lack of financial means practically ruled out comprehensive medical care, which used to be the feature of the Soviet System. As a result, it became necessary to balance government obligations with its capacity in the health care, to implement fundamental reorientation in health care system, by creating a new model formanagement and organization. Democratic mechanisms in state administration had to be actively used to achieve this goal.

In order to overcome the deep crisis of health care system, Government of Georgia initiated painful and multistage reorientation process in health care system in August 10, 1995. The main objective of ongoing reforms was to establish qualitatively new relations, corresponding to the requirements of the state's political and economic development[11]. The Georgian National Health Policy goals were directed towards improving health, providing health care and mobilizing social resources in accordance with priorities for health and human development, creating a legal basis for the new health system, giving priority to primary care, converting principles of health insurance, ensuring social security, reforming pharmaceutical policies, reforming medical education, medical science and health information services[12].

Primary Health Care (PHC) reforms have been an integral part of health sector reforms in Georgia.For most patients, primary care is the first point of contact with the health service. Equity in the availability of health care has been an underlying principle of primary health care, a keystone of the health-for-all strategy and thus a critical element in monitoring progress of countries in the implementation of the strategy[13].

The broad principles of primary health care systematically defined in the Declaration of Alma-Ata in 1978, have helped develop a new health culture. Over the last years primary health care has advanced considerably in taking on new roles

[11] Verulava T., Maglakelidze T. (2017). Health Financing Policy in the South Caucasus: Georgia, Armenia, Azerbaijan.Bulletin of the Georgian National Academy of Sciences, 11 (2): 143-150.

[12] იქვე.

[13] იქვე.

and functions. The four strategic elements of primary health care, as defined in the Declaration of Alma- Ata, may be summarized as follows[14]:

- The need to reorient health services so that primary health care is at the core of the health care system, while secondary and tertiary care act as supporting, referral levels;
- A concept of health policy that includes lifestyle and the environmental determinants of health, i.e. an intersectional approach to health policy;
- Community and individual involvement, both in terms of participation in the decision-making process and of greater individual responsibility for one's own health;
- Appropriate technology and cost-effectiveness, including the efficient allocation of resources and their redistribution away from hospitals and towards primary health care.

Primary health care is a system-wide approach to designing health services based on primary care, which is regarded as a means to help reduce medical expenditures and provide more effective and equitable care for thepopulation[15]. Equitable distribution of primary care serviceshas been investigated in industrialized countries[16]. As developingcountries are more likely to have inequitable access tohealth services, it is important to assess the extent towhich new health policies improve the situation.

Primary Health Care (PHC) reforms have been an integral part of health sector reforms in Georgia. These reforms can be divided into four distinct periods: 1994–1999, 2000–2006, 2007–2012 and from 2013 to the present.

1994-1999 period

During 1994-1995, the government issued policies that led tothe decentralization of the health system, by introducingnew payment mechanisms for services, removinghealth personnel from the State payroll and openingup space to privatize health facilities.

In an attempt to maintain principles of solidarity andequality, the Government of Georgiaintroduced a socialinsurance model in 1995.

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[14] Ivdity Chikovani, Lela Sulaberidze. Primary Health Care Systems, Case Study from Georgia. Geneva: World HealthOrganization; 2017.Starfield B, Shi L: Policy relevant determinants of health: aninternational perspective. Health Policy 2002, 60(3):201-218.

[15] Ivdity Chikovani, Lela Sulaberidze. Primary Health Care Systems, Case Study from Georgia. Geneva: World HealthOrganization; 2017.Starfield B, Shi L: Policy relevant determinants of health: aninternational perspective. Health Policy 2002, 60(3):201-218.

[16] Starfield B, Shi L, Macinko J: Contribution of primary care tohealth systems and health. The Milbank quarterly 2005,83(3):457-502.

The PHC facilities underwent a structuralreorganization. Most of the facilities at the districtlevel were grouped into single legal entities such asdistrict-level policlinic ambulatory unions covering the catchment population.Primary health care service providers are differently configured in eachregion depending on how they were incorporated under commercial law in 1997. A few were registered as limited liability or joint stock companies as separateentities, but most grouped together to create one legal entity (e.g. polyclinicambulatoryunions, hospital-polyclinic unions, etc.) covering the population ofthe district. As a result there is a variety of PHC service providers across thecountry[17].

A Society of General Practitioners and Family Medicinewas established in December 1995. Georgia was one of the first countries inthe former Soviet Union to recognize family medicine as a specialty in 1998. A licensing exam for the primary care specialists was introduced in 1999. Adepartment of primary care was established within the MoLHSA in 2000. In2001, this was merged with Public Health Department.

The many ofthe primary care services are staffed by general practitioners offering a broader rangeof services, but some are staffed by generalist physicians, general paediatriciansand narrow specialists. Primary care doctors only act as gatekeepers for patientscovered under relevant private health insurance schemes, because patientsmostly pay out of pocket for services and are free to self-refer to inpatient-services. For many patients, this is the preferred option, as the quality of primary careservices is still perceived to be low.

In 1999, the Georgian National Health Policy was developed and adopted bythe government. The declared main objectives of the policy were to improve theequity, accessibility and affordability of health care services for the populationof Georgia. Thirty-eight objectives were outlined in the policy paper. The vision

for the future health care system was that it should be (1) financed by the state aswell as through social insurance, while maintaining the principles of solidarityand equity, and (2) led by primary health care, with a major emphasis on healthpromotion and disease prevention. The document was followed by the StrategicHealth Plan for Georgia 2000–2009, which attempted to set the frameworkfor utilization of public resources, indicating the areas of intervention throughadditional funding.

Under the new nationalhealth strategy, it is intended that primary health care be given additionalemphasis, and it is planned that resources will be shifted from the

[17] Doorslaer E, Masseria C, Koolman X, Group OHER: Inequalitiesin access to medical care by income in developed countries.CMAJ: Canadian Medical Association journal = journal del'Association medicale canadienne 2006, 174(2):177-183.

hospitalsector. The strategy sets targets to establish national and regional centres forfamily medicine by 2003, financing mechanisms by 2005 and completion of anational network of primary care centres staffed by trained primary care teams by 2008. Since 1996, a number of pilot projects that focus on strengthening primary care have begun, and expansion of successful initiatives is envisioned.

Sixteen family medicine trainers and 48 family medicine specialists have been trained under the Family Physicians Training programme since it began in 1997. These trainings were funded by the United Kingdom Department for International Development (DFID). Under a second DFID Project, a further cohort of family medicine specialist trainers, as well as specialist trainers of primary care nursing and management, are being trained. The establishment of five family medicine demonstration sites, including a National Family Medicine Training Centre, is also being funded under the initiative. A rural primary care development is funded by United States Agency for International Development (USAID) and implemented by the American International Health Alliance (AIHA) and International Medical Corps (IMC) program. A second AIHA program is training health system managers. The British nongovernmental organization, OXFAM, is also supporting a pilot primary health care project in both urban and rural areas. The next round of World Bank financing, scheduled for 2002–2007, is planned to support further reform of the primary sector, although the final model that will be used is not yet finalized. Further training and refurbishment of PHC facilities is planned. Policies on rational and cost-effective drug prescription are being established with support of DFID and WHO as part of strengthening primary care.

In 1997 the government defined a basic benefitspackage that included a range of primarycare services. Payments for certainhealth services not covered under the basic benefitspackage were legalized, and co-payments wereintroduced for different services. The basic benefitspackage reflected one of the major objectives of thenew National Health Policy, which refocusedfrom secondary care towards primary care.

Low employment in the formalsector did not allow for sufficient generation ofpayroll taxes. In addition, tax compliance waslow. Structural and legal reforms in public financialmanagement did not result in improvements, dueto poor governance and weak enforcement.

As a result, health programmes were underfunded. As a consequence, out-of-pocket payments forservices became widespread and resulted in aneconomic access barrier for most of the population.

Due to economic reasons, the majority of local municipalities, which were-responsible for financing primary care services for thelocal population, were unable to allocate adequatefunding.

2000-2006 period

A new period in PHC reform began in 2000. Responding to inadequateaccess to PHC services primarily for rural residentsthe Rural Health Programme waslaunched in 2001.The programprovided funding from a single, central pool tocontracted PHC providers throughout thecountry.

A per capitabasedpayment scheme was used, which impliedprovision of approximately US$ 1 per capita to the PHCteam per 2000 population in the catchmentarea. However, while the policy change improvedaccess to care for rural residents, it also led to inequitybetween rural and urban residents.

The Government of Georgia received substantialsupport from the international donor communityto reform the PHC system. A UnitedKingdom family medicine-centred PHC model wassuggested to ensure equity, efficiency, effectivenessand responsiveness of the health system.Familymedicine training programmes were started with the support of the United Kingdom Department forInternational Development, followed by the development of a PHC Master Planin 2003–2005 with support from a World Bank grant. The development of the Primary Health Care Master Plan began in 2003 with support from the international aid sources. According to the official records and literature review, the plan was outlined to consolidate the 750 existing primary health care facilities outside of Tbilisi into 549 facilities that would serve approximately 30,000 people each.

In 2005, 674 primary health care facilities were reporting to the NationalCentre for Disease Control and Health Care. These included 180 independentpolyclinics, 51 medical centres, 100 independent dental clinics, 19 women'sconsultation centres, 77 dispensaries and 247 independent ambulatories. Therewere 437 dependent ambulatories and 385 dependent nurse-midwife points inthe form of ambulatory-polyclinic associations. From the totalnumber of 81 ambulance stations (in charge of providing emergency care oncall), only 72 were independent, and 9 were dependent, functioning togetherwith other health providers. However, since 2005, when the mandatory licensingof most health services was abolished, Ministry of Health has not been able to monitor the number of functioning health service providers[18].

In 2006, the State Agency for Social Assistance was created, along with the Governmental Commission for Health and Social Reforms, which became the decision-making body for health care reforms. As a fact, the first policy created, en-

titled Main Directions in Health 2007–2009, and outlined four main health objectives for the government to address: affordability of basic health services and protection of the public from serious financial health risks, quality of services, accessibility of services by continued development of infrastructure, and efficiency of the health system.

The Master Plan was comprehensive andtailored to needs in terms of the rationalization of facilities, the training of personneland the introduction of family medicine practices.The plan envisioned the creation of a network offacilities that would ensure access to PHC centreswithin 15–20 minutes for the entire populationof Georgia. The Master Plan was piloted in four regions from 2003 to 2006. significant number of PHCfacilities in rural areas were rehabilitated,health personnel were retrained as family doctors,and clinical practice guidelines were developed.

2007-2012 period

The next period for PHC changes was 2007–2012,when the government continued its strategy totarget those most in need. In 2007, the governmentlaunched an ambitious health financing reformwith the overall goal of improving equity andfinancial access to essential services for the poor. In 2006 The Ministry of Labour, Health and Social Affairs of Georgia has launched implementation of "Health Insurance Program for Socially Vulnerable Families". Its aim was to ensure medical service for the population below the poverty line. In 2012 the Health insurance program was extended to children aged 0-5, pensioner women above 60 years and men above 65 years, students and people with severe disabilities. In 2007 Health Insurance program covered only 4.1% of the population, in 2012 it increased up to 37.9%, together with persons covered under private and corporate Health insurance (12.9%), overall amounting to 50.8% insured individuals[19].

The government contracted out the delivery of benefits to private insurance companies, which assumed responsibility for programme administration.

In 2006, the Government of Georgia introducedan aggressive privatization policy and appliedmarket-regulated principles to the health sector,characterized by liberal regulations and minimumsupervision. In the framework of this policy manyregulations were abolished, and medical facilitiesand quality of services were no longer controlled bythe State.By 2011,almost all PHC facilities were privatized.

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[18] Verulava T. Health Care System in Georgia. Metsniereba. Tbilisi. 2001.

[19] Chanturidze T, Ugulava T, Durán A, Ensor T and Richardson E.Georgia: Health system review. Health Systems in Transition, 2009;11(8):1-116.

In March 2007, the governmentintroduced arevised vision for PHC reform, which differentiatedbetween urban and rural models of PHC provision.The government intended to sell PHC buildings to rural doctors for a nominal price.

Inplaces where ambulatory service centres were notrehabilitated, primary care doctors were given lumpsum grants to rehabilitate their PHC premises. In addition, allrural doctors were given the basic medical equipment that was necessary for their practice.

There was a scarcity of doctors inrural areas and this intervention was intended toencourage rural doctors to retain their practices. Rural primary care doctors acquired a new legal statusas individual entrepreneurs and were authorized tomanage their own PHC budgets. To increase basicmanagerial skills, special trainings were providedfor them.

Interventions implemented during 2007–2012 hadno significant effect on outpatient service use,which remained at an average level of 2.1 visitsannually per capita. Expenditure on drugs accountedfor up to 60% of a household's health care costs and86% of annualized recurrent expenditure for chronicpatients.

2013 to the present

The next phase of PHC reforms started in 2013 in linewith political changes. In 2013, the newly electedgovernment initiated the Universal Health Coverage Programme for the whole population that was notcovered by private insurance schemes. This was a significant change from atargeted to a universal approach.The goals of Universal Health CoverageProgramme are: to increase geographic and financial access to primary health care; to rationalize expensive and high-tech hospital services by increasing PHC utilization; and to increase financial access to urgent hospital and outpatient services[20].

First time in the history of the country the state program extends to citizens of the country, as well as holders of neutral identification cards/neutral travel documents and individuals without citizenship status. The state money allocated for healthcare almost doubled from 2012 to 2013 and increased from 365 million to 634 million GEL. Universal health care program covers ambulatory consultations of a family physician, planned and urgent out-patient service, urgent in-patient treatment, planned surgical operation (including daycare inpatient) and related examinations in specified limit. According to the survey, the affordability of health services has significantly increased as a result of the implementation of the Universal Healthcare Program; In 2015-2017, the percentage of households who did not have access to health services decreased from 43.1% to 22.3%.

After introduction of Universal Health program, the visits of population for medical services have significantly increased. According to the studies, the visits to family doctors has increased by 43%, specialized doctors – 18%, program beneficiaries took laboratory analysis by more that 17% prior to introduction of the programme, number of instrumental examinations increased by 9%.

Another change was the reversion to centralizedadministration of State programmes, as theparticipation of private insurance companies wasnot considered to be cost-effective. As a result, theadministration of all State-funded programmesbecame the responsibility of the State purchaser– the Social Service Agency. The Universal HealthCoverage Programme diminished the role of privateinsurance companies, as the government funds flewdirectly to health care providers.

In mid-2017 the government introduced adifferentiated approach for Universal HealthCoverage Programme benefits.From July 2017, the Program for Providing Medicine for the Chronic Diseases (PPMCD) has been launched. Socially Vulnerable individuals of any age who have the following chronic diseases: Cardiovascular diseases, Chronic lung diseases, Thyroid gland diseases, Diabetes Type 2 (Non-insulin-dependent), can be the beneficiaries of this program. PPMCD does not apply to the chronic patients of pension age, which are not registered in the unified database of socially vulnerable families, accordingly, the expenses may often be catastrophic for them. and consequently, result in their impoverishment. In order to take advantage of the benefits when purchasing medication included in the list, citizens should contact a family (rural) doctor or a specialist physician who writes a form of confirmation for the patient diagnosed with the chronic disease. The doctor writes down the diagnosis of the disease and prescribes the daily dose of the medicine. Furthermore, beneficiary with the prescription will need to be submitted to any branch of the Social Services Agency and registered with the program. After registration in the Social Service Agency, the beneficiary is able to address the relevant Pharmacy. The beneficiary can at once take medicine that will be enough for three months. In the case of taking each medicine, a person pays 10% of the medicines value, which does not exceed 1 GEL ($0.4). The program will facilitate affordability of medical services for socially vulnerable patients. However, the program applies only to those pensioners who are registered in the unified database of socially vulnerable families.

According to one study conducted in 2018, most of the respondents (57%) buy medicine without visiting family doctor and 37% self-medicate; The out-off pocket spending on medicines is still high for most respondents; 31% could not fully

[20] MoLHSA (2009a). Georgia health system performance assessment. Tbilisi, MoLHSA.

purchase the medicines prescribed by the doctor, and 15% did not purchase them at all due to the high cost. Significant amount of the respondents (36%) do not know about PPMDC.

In terms of professional education standards, familydoctors receive their education through a three-yearresidency programme accredited by the Ministry of-Labour, Health and Social Affairs. The quality of the medical education systemis not satisfactory. Thishas prompted private providers to establish theirown residency programmes to ensure higher qualityamongst the workforce.

The PHC medical personnel core competencies areregulated through a Minister of Health order that is only a normative act to standardize theirprofessional activity. Medical practice is also partiallyregulated by national practice guidelines andprotocols. The Ministry of Labour,Health and Social Affairs, in close collaboration withprofessional associations, has elaborated more than 20 national clinical practice guidelines and protocolsof care for PHC.

The weakness of primary care can be seen in the relative utilization of primary care and inpatientservices – the number of outpatient visits per capita is low and well below the European Union(EU) average, while the number of inpatient procedures is high and well above the EU average. Although most primary care services are now covered under the UHCP,quality is a factor determining the low utilization of primary care in the Georgian health system.The quality of services provided at the primary care level is perceived to be low and there areconcerns about perverse incentives with regard to referrals and prescriptions by primary carereproviders[21]. These perceptions limit the gatekeeping capacity of primary care doctors, despite areferral for specialist care being a requirement under the UHCP. Further strengthening of primarycare is a core necessity in order for the country to better meet the health needs of the populationin view of the growing burden of non-communicable diseases.

[21] World Bank (2017). Georgia Public Expenditure Review: Building a Sustainable Future. Report No:114062-GE. Washington DC, World Bank Group.