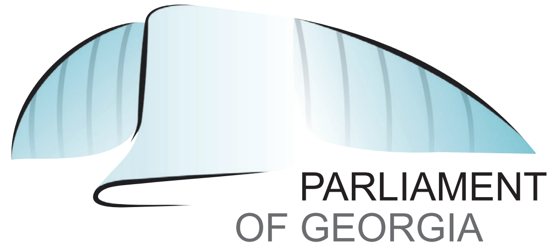
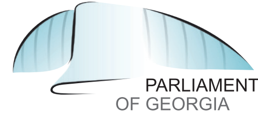



# VISION FOR DEVELOPING THE HEALTHCARE SYSTEM IN GEORGIA BY 2030

2017

ევროკავშირი
საქართველოსთვის
The European Union for Georgia



Empowered lives.
Resilient nations.

Prepared by the Healthcare and Social Issues Committee of the Parliament of Georgia with the support of the European Union and the United Nations Development Programme (UNDP). The opinions presented in this publication are those of the author and do not necessarily reflect the position of the donor organisations.

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## Acronyms and Abbreviations

| | |
|---|---|
| ACSCs | Ambulatory Care Sensitive Conditions |
| BMJ | British Medical Journal |
| CPD | Continuing Professional Development |
| DTRA | US Defense Threat Reduction Agency |
| GDP | Gross Domestic Product |
| GEOSTAT | National Statistics Office of Georgia |
| EMS | Emergency Medical Services |
| NCDC & PH | L. Sakvarelidze National Center for Disease Control and Public Health |
| PHC | Primary Health Centers |
| SDGs | United Nations Sustainable Development Goals |
| STEP | Non-communicable Diseases Risk Factor Surveillance |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children’s Fund |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |
| WHR | World Health Report by the World Health Organization |
| WHS | World Health Statistics Report by the World Health Organization |

## Foreword

According to the World Bank Classification in 2017, Georgia belongs to the group of lower middle-income countries. In 2016, the gross domestic product (GDP) per capita was USD 3,853. In the same year, the relative poverty rate was at 20.6% against 60% of the median consumption while the unemployment rate was 11.8%.

Despite a significant increase in health expenditures in recent years, existing data show that Georgia still holds one of the last places in terms of the share of state healthcare expenditure in total health care expenditures (36% in 2015) as well as in GDP (2.9% in 2015) and in the state budget (8.6% in 2015) among the countries of the European region.

Since the second half of the 1990s, life expectancy at birth has significantly improved and reached 72.7 years in 2016. There is significant progress in terms of reducing maternal and child mortality: the mortality rate of children under the age of five was 24.9 per one thousand live births in 2000 and 10.7 in 2016 while the maternal mortality rate was 49.2 per one thousand live births in 2000 and 17.8 in 2016.

Non-communicable diseases are leading among mortality factors: in 2016, 35% of deaths were caused by cardiovascular system diseases and 13% by cancers. Additionally, respiratory system diseases have a significant share in the total number of incidents of diseases in the country: 38%-40% of all of the incidents.

In terms of increasing access to healthcare, the most important achievement was the implementation of the universal healthcare program in 2013 which led to the universal coverage of the population with state-funded healthcare services. The WHO Regional Office for Europe (WHO/Europe) has recognized the universal healthcare program as a successful project in the European Health Report for 2015.

Despite the above noted, significant steps have to be taken to increase the efficiency of the healthcare system as well as the accessibility of a full range of health services and improve the quality of medical services.

The initiative of the Healthcare and Social Issues Committee of the Parliament of Georgia to develop a long-term vision vis-à-vis the development of the healthcare sector in the country as well as a Committee action plan was implemented with the support of the European Union and the United Nations Development Programme (UNDP) joint project entitled “Strengthening the System of Parliamentary Democracy in Georgia”.

## Goal and Basic Principles

According to the WHO's definition, a healthcare system is a joint effort of all organizations, institutions and resources whose goal is to promote and improve the health of the population (WHR-2000). This definition was specified at a conference in Tallinn in 2008. According to the specified definition, the healthcare system consists of the following: providing healthcare services (individual and public), primary and secondary prevention, treatment, care and rehabilitation; actions to deliver healthcare services, especially, funding, resource generation and management functions, and administrative activities to influence relevant interventions in various sectors that are related to health, whether or not their primary purpose is to improve health.

The best possible health condition is very important for the well-being of the population and the socio-economic development of the country. In order to achieve this, it is essential for the six so-called "system building blocks" of the healthcare system to function properly and efficiently. These blocks are: healthcare service delivery; human resources, medication, drugs and technologies; health financing; health information systems; leadership and governance.

This document describes the objectives and the actions according to each systemic block. Each of them should serve the main purpose of the healthcare system of Georgia which can be defined as follows: **To realize the fundamental right to health by means of the efficient health care system so that every citizen of Georgia can afford quality health care services and products without facing financial hardship.**

Basic Principles

- Protection of human rights in healthcare and the inviolability of honor and dignity in both civilian and penitentiary systems
- Fair distribution of lifelong healthcare risk management between an individual, the market and the government
- Compatibility with the country's economic and demographic development trends and the general vision of social policy
- Focus on primary healthcare, integrated service-based approaches and declaring disease prevention and primary healthcare as the fields of priority
- Exclusive responsibility of the state for public health and public health programs
- Common rules on the healthcare market: equal coexistence of public and private sector representatives under general, homogenous regulations.

**Major Target Indicators of the Healthcare System in Georgia (according to several target indicators of the UN Sustainable Development Goal (SDG) 3):**

| Indicator | Baseline | Target 2030 |
|---|---|---|
| Life expectancy at birth | 72.7 (2016, GEOSTAT) | At least 76 |
| Healthy life expectancy on average | 66.4 (2015, WHO) | At least 70 |
| Mortality rate for children from 0 to 5 per 1,000 live births | 10.2 (2015, NCDC & PH) | 6 |
| Neonatal mortality per 1,000 live births | 6.1 (2015, NCDC & PH) | 5 |
| Maternal mortality rate per 100,000 live births | 32 (2015, NCDC & PH) | 12 |
| Birth rate per 1,000 adolescent females aged 15-19 | 51.0 (2015, NCDC & PH) | Reduce by 40% |
| HIV incidence per 100,000 inhabitants | 19.2 (2015, NCDC & PH) | 1.25 |
| Tuberculosis incidence per 100,000 inhabitants | 74.7 (2015, NCDC & PH) | 15 |
| Prevalence of Hepatitis C (HCV) | Anti-HCV+ 7.7%<br>HCV RNA +<br>5.4% (Hepatitis seroprevalence survey, 2015) | Anti-HCV+ 7.0%<br>HCV RNA+ 0.5% |
| Mortality rate caused by cardiovascular diseases per 100,000 inhabitants | 562.7 (2015, NCDC & PH) | Reduce by 1/3 |
| Mortality rate due to cancer per 100,000 persons | 168.0 (2015, NCDC & PH) | Reduce by 1/3 |
| Mortality rate due to diabetes per 100,000 persons | 26.8 (2015, NCDC & PH) | Reduce by 1/3 |
| Spread of lower respiratory tract diseases | 2669.9 (2015, NCDC & PH) | Reduce significantly |
| Age-standardized indicator for current tobacco use among persons aged 15+ | 31.0% (STEPS 2016) | <20% |

| | | |
|---|---|---|
| Annual consumption of pure alcohol in liters per person aged 18 and older | 6.4 liters of pure alcohol (STEPS 2010) | Reduce by 10% |
| Mortality rate attributed to household and ambient air pollution | 292.3 (2012, WHS 2016) | 65 |
| Mortality rate due to unsafe water, sanitary conditions and lack of hygiene (services for unsafe water, sanitary conditions and hygiene (WASH) for all persons) | 0.2 (2012, WHS 2016) | 0.2 |

## 1. High Quality Medical Service

The implementation of the universal healthcare program led to universal accessibility to medical services in the country and significantly increased their utilization (ambulatory visits per capita in 2012 – 2.3; in 2015 – 4.0; hospitalization per 100 persons in 2012 – 8.0; in 2015 – 12.6).

Despite the above noted, the current legal regulations of the healthcare sector fail to adequately ensure the quality, continuity, consistency and effectiveness of medical service. A document classifying medical institutions was developed; however, links and feedback between the various levels of medical services have not yet been defined. Regulation tools have to be developed for a number of professional activities (for example, primary healthcare). The mechanisms for acquiring the right (license/permit, technical regulations) to undertake medical activities have to be revised; first of all, in terms of infrastructure and human resources so that they are compatible with the international criteria of the integrated model of medical service.

The assessment of the quality of medical services and the process of evidence-based decision-making are not comprehensive at the level of medical institutions. The mechanisms for evaluating the efficiency and quality of medical services have to be revised. Specific financial or other (non-financial) types of motivating factors have not been developed which would encourage the medical institutions to constantly supervise and improve the quality of the service.

In terms of improving the quality of the service, the plan for the regionalization of perinatal services developed in cooperation with international organizations (United States Agency for International Development (USAID/SUSTAIN), United Nations Children’s Fund (UNICEF), United Nations Population Fund (UNFPA)), as well as the definition of clear criteria for the system of referral for high risk pregnant women and infants, is a step forward.

It is noteworthy that the definition of primary healthcare, an organizational model and a regulatory framework for the system, weak mechanisms of feedback between primary healthcare institutions and hospitals, fragmented services and less focus on prevention, early diagnosis and management of diseases still remain as significant challenges.

The quality of the infrastructure and equipment in primary healthcare varies across the country. An inventory of primary healthcare units has not been performed for a decade.

Attention also has to be paid to the excessive utilization of emergency medical services as well as to the insufficient functional and informational cooperation between emergency medical services and primary healthcare services.

**Objective:** Preserving the geographic accessibility of healthcare services and ensuring their continuity with the primary focus on the development of preventive and primary healthcare; in addition, steadily improving the quality of medical services through the regulation of medical infrastructure and the qualification of staff and the development of efficient quality management systems.

**Activities:**

1.1. Improve the mechanism of regulation of medical institutions, including internal audits, conditions for obtaining a license/permit, technical regulations and mechanisms of accreditation for high risk medical activities

1.2. Develop/implement quality management systems for medical services within both ambulatory and hospital settings. This includes the development of quality indicators, their systematic monitoring and integration into reporting forms and the healthcare information system as well as mechanisms for internal and external (independent) audit and accreditation

1.3. Create a state plan for supporting the development of healthcare infrastructure which will outline mechanisms for the proper planning of the share of state and private sectors as well as the mechanisms for regulating obligations. Special focus will be made on the needs of the population of high-mountainous regions and territories adjacent to conflict zones as well as persons with disabilities

1.4. Complete the work on the strategic plan for developing primary healthcare and gradually implement the plan on the basis of an inventory of the relevant institutional or staff capacities

1.5. Develop the criteria for contacts and referrals between primary healthcare, emergency assistance and other levels of healthcare services

1.6. Gradually integrate “vertical programs” (for example, antenatal care, infectious diseases, village doctor) into the universal healthcare program and regionalize the services

1.7. Introduce the mechanism of “a certificate of need” regarding basic services and develop a system of evaluating technologies based on which the issue of the inclusion of a particular service into the standardized basic package will be decided

1.8. Develop/implement a new mechanism in close cooperation with professional associations to adapt and regularly revise the national recommendations (guidelines) and state standards (protocols) for disease management

1.9. Ensure the quality of services of prevention, early diagnosis, treatment and management of major communicable and non-communicable diseases as well as the geographic and financial accessibility of these services

1.10. Develop services of acute, post-acute, rehabilitation and long-term care (including home care) services

1.11. Support the development of community services.

**Target Indicators:**

| Indicator | Baseline | Target 2030 |
|---|---|---|
| Total number of primary healthcare visits per capita | 4.0 (2015) | Not less than 8 |
| Share of residents who can get to a medical institution where they usually visit a doctor in 30 minutes using their usual means of transportation | Total: 85.5%;<br>In cities/towns: 93.6%<br>In villages: 77.8%<br>(2014) | In cities/towns: 100%<br>In villages: 100% |
| % of medical institutions where the quality of healthcare is evaluated with the help of quality indicators | There are no baseline data | 100% |
| Standardized indicator of mortality per 100,000 inhabitants | 984 (2014, WHO/EURO) | Reduce by 1/3 |
| 30-day obstetric re-hospitalization | There are no baseline data; the data will be available in 2017 | <20% |

| Cases of hospitalization due to the diagnosis of complications of diabetes (**ACSCs) per 100,000 inhabitants** | 42.6 | <5% |
|---|---|---|
| Cases of hospitalization due to the diagnosis of chronic hypertension (**ACSCs) per 100,000 inhabitants** | 93.8 | <5% |

## 2. Highly Qualified Medical Personnel

Lack of qualified human resources and their unequal geographic distribution still remain important barriers for the provision of high quality medical services. The imbalanced ratio of doctors and nurses has reached a critical level (1:0.67); by these data, Georgia is significantly behind the average indicators of the European region. The indicator showing the number of doctors providing medical services to the population (573.3 doctors per 100,000 inhabitants - 2015) is significantly higher than in European countries (322). There is a lack of nurses both in towns and villages; additionally, there is a lack of general practitioners, there are trends of ageing among staff in the medical specialties which are in deficit and, in general, medical staff lacks adequate qualification. The situation is exacerbated by a sharp imbalance between production and the demand for human resources. Further, the existing voluntary system of continuing professional development is not efficient as it lacks all proper mechanisms for motivating staff and cannot provide them with the opportunity to develop adequate theoretical knowledge or clinical skills which exacerbates the problem of human resources.

**Objective:** Provide the healthcare system with the needed number of motivated and qualified medical staff.

**Activities:**

2.1. Develop a strategic plan for human resources development and management, including the following:

- 2.1.1. Build capacities in terms of human resources planning and gradually develop these resources
- 2.1.2. Introduce tools for “needs assessment”
- 2.1.3. Based on the needs of the country, balance the new inflow of doctors and increase the number of nurses to achieve an adequate balance of medical staff.

2.2. Support education for nurses, including the following:

2.2.1. Subsidize/stimulate education for nurses from the side of the state

2.2.2. Due to the lack of nurses, support the system of re-training nurses at the transitional stage

2.2.3. Support the development of bachelor and master programs in nursing as well as the science of nursing.

2.3. Develop and implement tools for regulating nursing activities with active engagement of professional organizations in the field:

2.3.1. Define competencies for nurses and develop the tools for assessing their professional knowledge and skills

2.3.2. Gradually introduce/implement the process of registration/certification for nurses

2.3.3. Ensure the functioning of a formalized system of continuing professional development for nurses and support the sustainability of the system.

2.4. Improve the mechanisms for the certification of doctors, including the development of tools to assess their skills for the analysis of clinical cases and problem solving

2.5. Gradually elaborate a continuing professional development system for doctors in close cooperation with professional organizations in the field:

2.5.1. Introduce a system of the recognition of providers of continuing professional development opportunities with the goal to elaborate mechanisms for recognizing/evaluating (accrediting) the continuing professional development programs

2.5.2. Support the development of various forms of continuing professional development activities (distance learning, electronic platforms for independent learning, etc.)

2.5.3. Develop efficient mechanisms (including financial) to raise the motivation and the qualification of medical staff; for example: a targeted bonus system of which a part can only be used for continuing professional development.

2.6. Support the development of university clinics as educational centers

2.7. Improve the continuity of medical services as well as coordination among various types of services at the primary healthcare and hospital levels with the goal to create a cohort of specialist doctors with a wide range of specializations.

**Target Indicators:**

| Indicator | Baseline | Target 2030 |
|---|---|---|
| Ratio of doctors and nurses | 1:0.7 (2016) | 1:2 (SDG 3. c.) |
| Ratio of referrals to primary healthcare to the number of doctors in primary healthcare (in a day) | 3.8 (2014) | 12 |
| Ratio of the number of hospitalizations to the number of doctors in the hospital network (in a year) | 42 (2014) | 80 |
| Ratio of medical professionals with certificates or diplomas from educational institutions and the number of students accepted at the educational programs for nurses | 6:1 (2012) | 1:2 |
| Share of medical specialties in which certification exams take place with the use of renewed tools | | 80% |
| Share of the nurses employed in the system who have undergone registration/certification | 0% | 50% |
| Share of the doctors employed in the system who take part in the system of continuing professional development | N/A | 60% |

## 3. Medication, Drugs and Technologies

Irrational pharmacotherapy, self-medication and prescription drug abuse represented systemic problems. A number of legislative amendments were made to address these problems and ensure patient safety, including an amendment which has prohibited the sale of pharmaceutical products of the second category without a prescription beginning from September 1, 2014. So-called “electronic prescriptions” were also introduced. In the future, it is important to improve the quality control and the monitoring mechanisms of pharmaceutical products.

In the pharmaceutical sector, the liberal regulation of this area is problematic, including a simple registration rule for pharmaceutical products as well as requirements for pharmacies. The state regulation of clinical trials on pharmaceutical products needs to be improved. The current legislation and

limited institutional and financial resources do not allow for the full control and the monitoring of the quality of pharmaceuticals. In order to protect patients, the following systemic problems in the direction of the regulation of pharmaceutical products have to be addressed: irrational pharmacotherapy, less use of generic medications by patients and doctors, insufficient use of the prescription mechanism, high costs of medications and the “aggressive” marketing of the pharmaceutical industry.

The high cost of medications is a heavy burden on the population; the costs have been increasing steadily for the past 10 years and constitute almost half of the population’s expenses on healthcare.

**Objective:** Ensure access to basic and quality pharmaceutical products through the rational policy on pharmaceutical industry.

**Activities:**

3.1. Harmonize regulations in the pharmaceutical field, including registration rules of pharmaceutical products with European Union legislation

3.2. Promote the implementation of “electronic prescriptions” throughout the country for the purpose of the rational use of medications

3.3. Increase access to essential medications

3.4. Improve and implement quality control mechanisms, prepare the basis for establishing a quality control laboratory and review the possibilities of using private-public partnership (PPP) mechanisms in this regard

3.5. Increase legislative control and impose stricter sanctions on medication marketing, advertising, sponsorship, gifts for doctors, etc.

3.6. Develop and implement GMP standards in the pharmaceutical industry

3.7. Develop state funding schemes on essential pharmaceuticals and products to treat major diseases causing death

3.8. Raise public awareness regarding the problems of excessive use of medications

3.9. Encourage use of generic medications.

**Target Indicators:**

| Indicator | Baseline | Target 2030 |
|---|---|---|
| Indicator of the use of “electronic prescriptions” throughout the country | Tbilisi | All regions of Georgia |
| Share of out-of-pocket expenses on outpatient medications | 66% (2015) | <30% |
| Share of pharmaceutical manufacturing that meets the GMP standards | N/A | 90% |

## 4. Healthcare Funding System

The main priority of the Government of Georgia is to ensure a universal accessibility to quality health-care services which was reflected in an unprecedented increase in the volume of state appropriations allocated to the healthcare sector (GEL 450 million in 2012, GEL 1 billion in 2017). However, Georgia’s indicators are still low when compared to the internationally recognized data on the efficiency of the healthcare funding system. According to 2015 data, the share of state expenditures on healthcare in GDP was 2.9% (the average rate in Europe is 5.7%) while the share of state expenditures on health-care in the state budget was 8.6%. Despite the decrease, the share of out-of-pocket payments (OOP) (57.3%) in the total expenses for healthcare is still considerably high, imposing a heavy burden on households.

The share of expenditures on ambulatory medications (38%) is critically high in national expendi-tures on healthcare and it is mainly made up of out-of-pocket expenses. Expenses on preventive and primary healthcare services (19%) are still limited and volatile when compared to hospital expenses (31%).

**Objective:** Improve the efficiency of the system of healthcare funding considering universal health-care principles.

**Activities:**

4.1. Gradually increase and optimize state expenditures on healthcare

4.2. Introduce a general standardized package which will be fully funded by the state for low-in-come groups and partially funded for middle-income groups while the high-income population will be covered by the private insurance industry

4.3. Transition to the global budget financing mechanism for hospital and emergency services (in-patient) whose cost will be calculated using the diagnosis-related group (DRG) method

4.4. Transition from capitation/fixed funding of preventive and primary healthcare services to the outcome focused funding; a mixed mechanism may be used during the transitional period

4.5. Provide state funding for ambulatory medications for chronic diseases (gradually increase the coverage of vulnerable groups)

4.6. Establish and improve mechanisms of active procurement and selective outsourcing

4.7. Provide state financial resources for the responsibilities assumed by the state through the transitional plan of the Global Fund.

**Target Indicators:**

| Indicator | Baseline | Target 2030 |
|---|---|---|
| Share of state expenditure on healthcare from GDP | 2.9% (2015) | >5% |
| Share of out-of-pocket payments out of the total expenditure on healthcare | 57% (2015) | <30% |
| Share of inpatient cases which are compensated by DRG method | 0% | 100% |
| Share of expenditure on primary healthcare and prevention out of the total expenditure on healthcare | 19.3% | 40% |
| Universal coverage with standard package | There are no baseline data | 100% |

## 5. Governance and Electronic Healthcare System

Georgia has an established practice of coordinated interagency cooperation with regard to particular serious problems in healthcare such as the Country Coordinating Mechanism (CCM) on HIV infection/AIDS, tuberculosis and malaria. However, the efforts of various state, donor and non-governmental organizations are still fragmented and less harmonized in the process of developing and implementing the healthcare policy.

A general electronic healthcare system was established in 2013. Since 2016, cancer and birth registers and an electronic prescription system have been functioning and work has been ongoing on the system of electronic medical records. Despite the above noted, the existing healthcare information system is still not comprehensive in terms of data collection, quality, standardization and evidence generation. Overall, it is necessary to develop the electronic healthcare policy and strategy in a way that this field, together with the efficient management of the healthcare system, becomes a modern mechanism for rapid implementation of integrated healthcare and personalized medicine.

In order to develop numerous other components of electronic healthcare in Georgia – telemedicine, mobile healthcare, distance learning – it is necessary to implement legislative and technological changes and to develop an interoperable system harmonized with similar systems in the European Union.

With the financial support of the US Defense Threat Reduction Agency (DTRA), work is under way on establishing an online platform of the British Medical Journal (BMJ) within the frames of which it will be possible to implement the teaching modules of continuing medical education of BMJ in Georgia.

Mechanisms for developing evidence-based healthcare policy still need to be introduced in this sector. Current state programs and the financial resources allocated for their implementation are mainly defined by the system of precedential planning. In order to implement the evidence-based healthcare policy cycle, work is already ongoing on over three important documents: Evaluation of the Efficiency of the Healthcare System of Georgia, National Presentation on the Health Condition of the Population of Georgia and National Healthcare Reports. However, a systemic analysis and use of the existing information in the process of a constant review and revision of the healthcare policy are still fragmented.

In addition, it is impossible to systematically generate reliable evidence to develop policy in a timely manner with the help of the healthcare information system; additionally, almost no studies are conducted with the goal to assess the quality of provided services or the level of satisfaction of patients at the level of individual medical institutions.

LEPL State Regulation Agency of Medical Activities ensures protection of patients' rights in terms of the quality of medical services as per the existing legislation.

At this stage, there is limited availability of data as well as a limited number of indicators for assessing patients' safety for which the data can be gathered.

Apart from exceptions, the process of developing clinical administration guidelines and protocols as well as the versions of these for patients is conducted in a fragmented way.

**Objective:** Develop an efficient system of administration in the healthcare field and improve the general electronic system of healthcare and develop a general state multi-sector "Health in all polices" approach.

**Activities:**

5.1. Improve coordinated interagency cooperation with the goal to support the "Health in all policies" approach

5.2. Support electronic and mobile health and healthcare information systems and healthcare research and develop the relevant normative base

5.3. Support electronic platforms and mobile applications for modern continuing professional development models – namely, distance learning, teaching and self-assessment as well as electronic portfolio and other innovative approaches; implement successful models and ensure the efficient functioning of the process of continuing development

5.4. Strengthen municipal responsibilities and authorities in terms of the provision and funding of healthcare services (including public and primary healthcare) within the framework of local self-governance reform

5.5. Support the proper functioning of the process of the evaluation of mechanisms for ensuring patients' safety and the quality of service in medical institutions

5.6. Raise the level of awareness of patients when providing services and publish and disseminate patients' versions of clinical practice guidelines and protocols

5.7. Develop alternative mechanisms for systemic management of medical errors and discussion of disputes which will increase the level of patients' safety and protection of their rights

5.8. Support the development of personalized medicine based on innovations and genome.

**Target Indicators:**

| Indicator | Baseline | Target 2030 |
| --- | --- | --- |
| % of state funds assigned to healthcare during the financial year which is not considered in the Medium Term Expenditure Frameworks (MTEF) | % | 0% |
| % of medical institutions which use electronic medical records | | |
| Indicator for the use of mobile applications in medical specialties (% of specialties) | Currently <5% | >30% |

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