PRIMARY HEALTH CARE SYSTEMS (PRIMASYS)

Case study from Georgia
Overview

Georgia is located in the South Caucasus region at the crossroads between Western Asia and Eastern Europe, and borders Armenia, Azerbaijan, Russian Federation and Turkey. Georgia has a multiethnic population of 3.73 million, 57.4% of whom live 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 – regions around which health care 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 gross domestic product (GDP) per capita rising from $2590 PPP (purchasing power parity) in 2000 to $9599 PPP in 2015.\(^2\) Despite a number of large and potentially long-lasting economic shocks that have made the Georgian economy more vulnerable,\(^3\) the country moved to the upper middle-income group with an estimated gross national income of US$ 4160 per capita in 2015.\(^4\)

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).\(^5\)

During 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 the privatization of the service provider network.\(^6,7\) 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. 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.\(^8\) Among other activities, the concept paper mentions the development of a primary health care (PHC) development strategy and its gradual implementation, though that has not yet materialized. 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 has reached 2.7% of GDP or 8.9% of government expenditure.\(^9\)

Significant progress has been made in some aspects of maternal, child and newborn health in recent decades.

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1. National Statistics Office of Georgia (based on the General Population Census in November 2014); not including separated regions of Abkhazia and South Ossetia.
The country reached the Millennium Development Goal target for under-5 mortality (reduction by two thirds from 35.3 per 1000 live births between 2000 and 2015), but it failed to attain the maternal mortality reduction target (reduction by three quarters from 49.2 per 100 000 live births between 2000 and 2015). Despite the documented progress, child mortality in Georgia is the fourth highest in Europe. The largest share of child mortality is still attributed to infant mortality. The country sustains high immunization coverage rates for routine vaccines.

Life expectancy at birth increased for both sexes over the period 1990–2015, with a larger improvement observed among females. Noncommunicable diseases such as ischaemic heart disease, cerebrovascular disease and hypertensive heart disease are three leading causes of death. Among causes that lead to premature death, road injuries feature in the top three leading causes, after ischaemic heart disease and cerebrovascular disease.

Table 1 summarizes key demographic and health indicators for Georgia.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Results</th>
<th>Source of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population of country</td>
<td>3 720 400</td>
<td>National Statistics Office of Georgia, 2016</td>
</tr>
<tr>
<td>Distribution of population (rural/urban)</td>
<td>42.79% / 57.21%</td>
<td>National Statistics Office of Georgia, 2016</td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td>72.9 years</td>
<td>National Statistics Office of Georgia, 2015</td>
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<tr>
<td>Infant mortality rate</td>
<td>8.6 per 1000 live births</td>
<td>NCDC, 2015</td>
</tr>
<tr>
<td>Under-5 mortality rate</td>
<td>10.2 per 1000 live births</td>
<td>NCDC, 2015</td>
</tr>
<tr>
<td>Maternal mortality ratio</td>
<td>32.1 per 100 000 live births</td>
<td>NCDC, 2015</td>
</tr>
<tr>
<td>Immunization coverage under 1 year (including pneumococcal and rotavirus)</td>
<td>BCG 92.5%, DTP3 93.7%, Polio3 91.3%, Rota2 72.4%, Pneum2 89.6%, Measles1 96%</td>
<td>NCDC, 2015</td>
</tr>
<tr>
<td>Income or wealth inequality (Gini coefficient)</td>
<td>0.42</td>
<td>National Statistics Office of Georgia, 2015</td>
</tr>
<tr>
<td>Total health expenditure as proportion of GDP</td>
<td>6%</td>
<td>WHO European health for all database, 2014</td>
</tr>
<tr>
<td></td>
<td>8.5%</td>
<td>National Health Accounts, 2015</td>
</tr>
</tbody>
</table>

The PHC reforms were an integral part of the health sector reforms, greatly influenced by political developments that took place in Georgia. Four distinct periods can be recognized: 1994–1999, 2000–2006, 2007–2012 and from 2013 to present. Health care reforms began in Georgia from the mid-1990s in response to the economic crises after the collapse of the Soviet Union in 1991. In 1994/1995 the government issued policies that removed constitutional guarantees on free health care and formalized official user fees. The new policies also led to the decentralization of the health system, introduced new payment mechanisms for services, removed health personnel from the State payroll and opened space for the privatization of health facilities.

In an attempt to combine public and private sources for health care financing, the Government of Georgia introduced a social insurance model in 1995. Figure 1 provides a timeline of key developments in the Georgian health system.

In 1997 the government defined a basic benefits package that included a range of preventive, primary 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 a new National Health Policy (1999) that refocused from secondary care towards public health and primary care. The basic benefits package gradually expanded, but it was not accompanied by sufficient funding, as a consequence of which the health market largely relied on informal and formal payments. Due to economic reasons, significant barriers to accessing care emerged for the rural population. Other challenges included the low use of preventive and primary care services, financial barriers associated with service use and medicines, obsolete infrastructure, demotivated health personnel and the low quality of services. To respond to these challenges, the government recognized strengthening of the PHC system as a key priority, as defined by a Strategic Health Plan in 2000.

The Government of Georgia received substantial support from the international donor community to reform the PHC system, starting from the Family Medicine Training Programme in the late 1990s, followed by the development of a PHC Master Plan in 2003–2005. 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 Master Plan was approved by the Ministry of Health, Labour and Social Affairs and was piloted in four regions from 2003. The plan was followed until the end of 2006. In March 2007, the government rejected the PHC Master Plan and introduced a revised

### Timeline of PHC reforms

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Results</th>
<th>Source of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHC expenditure as % of total health expenditure</td>
<td>26.8%</td>
<td>National Health Accounts, 2015</td>
</tr>
<tr>
<td>% total public sector expenditure on PHC</td>
<td>1.3%</td>
<td>National Health Accounts, 2015</td>
</tr>
<tr>
<td>Per capita public sector expenditure on PHC (current $)</td>
<td>$25.57</td>
<td>National Health Accounts, 2015</td>
</tr>
<tr>
<td>Out-of-pocket payments as proportion of total expenditure on health</td>
<td>57.3%</td>
<td>National Health Accounts, 2015</td>
</tr>
</tbody>
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Figure 1. Timeline of key developments in the Georgia PHC system

- **1991** Collapse of the Soviet Union
- **1994** Health system was decentralized; official user fees and new provider payment mechanisms introduced
- **1995** Policy on the privatization of health facilities adopted
- **1997** Substitution of State Health Fund with State Medical Insurance Company
- **1998** Family medicine recognized as a specialty
- **1996** State Health Fund established to pool payroll taxes for health
- **1999** Social Health Insurance Policy adopted
- **2000** Basic benefit package was introduced
- **2001** National Health Policy developed
- **2003** PHC Master Plan development started
- **2004** Strategic Health Plan for 2000–2009 published
- **2005** PHC Master Plan finalized
- **2006** Proxy means testing system for poor established
- **2007** Medical Insurance Programme (MIP) for the Poor pilot in Tbilisi and Imereti region
- **2008** MIP for poor roll-out through the country
- **2009** MIP expanded to teachers, IDP etc.
- **2010** New vision “Doctor in every village” announced
- **2012** Government declined PHC Master Plan and adopted new path of PHC reform
- **2012** MIP expanded to population aged under 6 and over 60 years
- **2013** Universal Health Coverage Programme introduced
- **2017** Changes in Universal Health Coverage programme
vision for PHC reform. This entailed the termination of further investments in PHC infrastructure. Individual primary care doctors working in some rural areas were given grants (in the amount of US$ 1340 equivalent) to renovate their practices, and all rural primary care doctors were authorized to manage their own PHC budgets. This was considered to be a more efficient way to provide PHC services in the resource-constrained environment at that time. This initiative was also influenced by political motives to favour the rural population prior to the parliamentary elections of 2008.

The Government of Georgia introduced the Medical Insurance Programme in 2007. The first targeted group was poor households, which were identified through a proxy means-tested system. The Medical Insurance Programme for the poor started as a pilot in the capital city and in Imereti, one of the largest regions in the country, and covered outpatient and inpatient services.

The government contracted out the delivery of Medical Insurance Programme benefits to private insurance companies, which became responsible for programme administration. The programme was gradually expanded to other target groups (including internally displaced persons, children aged 0–5 years, pensioners and teachers). Part of the population received PHC services under individual or corporate private insurance schemes. For the rest of the uninsured population (either through the government or private schemes), basic PHC services were offered through the State PHC programme administered by the State purchaser – the Social Service Agency.

In 2013, the government initiated the Universal Health Coverage Programme for the whole population not covered by private insurance schemes. The administration of all State-funded programmes became the responsibility of the State purchaser – the Social Service Agency.

Governance and architecture

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. The 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 comprises 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 the State budget spending to ensure compliance with the 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. Since 2013, the NCDC is also formally responsible for the organization of PHC in the country.

Service provision underwent significant structural and financial reorganizations as a result of the reform waves. The Semashko model was characterized by a centralized delivery system based on territorial networks of polyclinics 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. Currently the majority of health providers are private for profit, with a few public providers remaining. In rural areas individual doctors became individual entrepreneurs responsible for their PHC budgets, and the State purchaser contracted them directly.

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, over recent years the number of old, separately standing dispensaries has been reduced.

At present, PHC services are provided by 367 primary care centres (policlinics, policlinic-ambulatory unions), 36 independent rural ambulatory centres, 29 antenatal clinics, 31 specialized dispensaries and 1270 rural doctors (individual entrepreneurs). Local governments have a limited role in PHC. Only selected municipalities supplement some vertical programmes.

During the development of the Universal Health Coverage Programme there were no open hearings on policies and consultative decision-making processes. Therefore, individuals or interest groups were proactively attempting to influence policy decisions. For example, the initially calculated per capita tariff for PHC services was much lower; however, after active participation of interested groups, the tariff was revisited and increased.

The locus of policy-making power 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. Despite the government change in 2003, and the frequent turnover of ministers, it remained at that ministry until the 2007 reforms. Thereafter the Prime Minister and the State Minister of Public Reforms took responsibility for health care reform. Following the government change in 2012, major policy decisions have been made at the Ministry of Health, Labour and Social Affairs, including substitution of multiple private insurance companies with a single public purchaser to administer State-funded health benefits. 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 2 provides a summary of the governance and current architecture of the PHC system in Georgia.
Financing

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.

According to the National Health Accounts, total health expenditure was 8.5% of GDP in 2015. 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.27

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%. The donor contribution to total PHC expenditure equalled 0.5% in 2015.

Although the government has introduced numerous health financing reforms over the past two decades, high out-of-pocket payments remain a key challenge for the Government (67.3% according to the National Health Accounts in 2015). 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. Outpatient drugs are not subsidized by the Universal Health Coverage Programme in the country, and only limited essential drugs up to an amount of US$ 21 annually are covered for the poor population. Although public sources of health financing have increased, households continue to be the major source of health financing in Georgia, through out-of-pocket spending.

Figure 3 summarizes current financial flows for the PHC system in Georgia.

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PHC services are delivered to the population through the Universal Health Coverage Programme, the Rural Doctor 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. Their PHC monthly budget is formed 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 Universal Health Coverage Programme budget, while 13% was spent on planned outpatient services.28 The Rural Doctors Programme is financed through a global budget financing model. Doctors and nurses are reimbursed at fixed amounts of monthly salaries without any additional funding linked to performance. In general, there are currently no performance-based financing mechanisms in the State-funded programmes. Vertical programmes are financed either through global budgets or on a fee-for-service basis.

Human resources

General PHC services in Georgia are delivered by family doctors and by doctors who are already practising and certified in internal medicine and paediatrics or in other medical specialties related to family medicine (gastroenterology, nephrology, pulmonology, cardiology and rheumatology), and who have gained family medicine as a second specialty. In the period 2006–2015, the number of generalists (family doctors and internal medicine doctors) increased from 50 to 138.3 per 100 000 people.29 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,30 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.

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.31 After the introduction of the Medical Insurance Programme, which was implemented through private insurance companies, many of the trained workforce shifted to the private insurance sector. Since the design of the Medical Insurance Programme did not stimulate the use of PHC services, family doctors did not act as gatekeepers to prevent the use of secondary services. According to field specialists, the quality of services provided at the PHC level is low.

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Regulations

Under the current PHC legislation, PHC market entry is easy, and the start 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 are established.32

Since 2006, when the Government of Georgia introduced an aggressive privatization policy and applied market-regulated principles to the health sector, neither medical facilities nor the quality of services have been monitored, and many regulations have been abolished.

In terms of professional education standards, family doctors receive their education through a three-year residency programme accredited by the Ministry of Health, Labour and Social Affairs. The quality of the medical education system is not satisfactory, according to the field specialists. This has prompted private providers to establish their own residency programmes to ensure higher quality amongst the workforce. There is no national certification or licensing of nurses.33

The PHC medical personnel core competences are regulated through a Minister of Health order34 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 would be judged. The Ministry of Health, Labour and Social Affairs, with close collaboration with professional associations, 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 Health, Labour and Social Affairs, through investigating patients’ complaints. As a response measure the Medical Service Regulation Agency could issue a written notice to health personnel or deprive 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 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 attempt to introduce their own quality appraisal methods in their facilities. In addition, there are no mechanisms in place to monitor State programme performance.

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 2 and 3.

The only difference between services under the Universal Health Coverage Programme and the Rural Doctors Programme is that the latter covers diagnostic and laboratory tests at a minimal level and does not cover specialist consultations (Table 3). When needed, a rural patient may be 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 existence of different financing sources and mechanisms in PHC leads to administrative challenges, including inefficiency of programme management and fragmentation of services.

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 3.7 in 2015 in Georgia. This could be partly attributed to the introduction of the Drug Prescriptions Policy in 2014. Nevertheless, this estimate is lower than the European Union average of 6.3 consultations per capita per year.

One of the major deficiencies of the Universal Health Coverage Programme is the failure to fulfill a gatekeeping role – there are high referrals from family doctors to specialists (40% instead of a more typical international range of 10–15%) leading to out-of-pocket expenditure. 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 to adjust for increased costs and inflation. Among other challenges is lack of financing mechanisms to stimulate health workers' performance.

Table 2. Coverage of State-funded programmes

<table>
<thead>
<tr>
<th>Beneficiaries</th>
<th>Universal Health Coverage</th>
<th>Rural Doctors</th>
<th>Maternal and child health</th>
<th>Immunization</th>
<th>TB care</th>
<th>Mental health</th>
<th>Diabetes</th>
<th>HIV</th>
<th>Hepatitis C</th>
<th>Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children 0–5</td>
<td>✓</td>
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<tr>
<td>Pensioners</td>
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<tr>
<td>Teachers</td>
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<tr>
<td>Poor</td>
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<td>Uninsured</td>
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<tr>
<td>Rural residents</td>
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<td>All citizens</td>
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<td>✓</td>
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</tbody>
</table>

Monitoring and evaluation

Health reporting starts from the lowest level of service provision (ambulatory) and follows the established forms and frequency of reporting. 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.

### Table 3. Benefit packages of State-funded programmes

<table>
<thead>
<tr>
<th>Services</th>
<th>Universal Health Coverage</th>
<th>Rural Doctors</th>
<th>Maternal and child health</th>
<th>TB care</th>
<th>Mental health</th>
<th>HIV</th>
<th>Hepatitis C</th>
<th>Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits to doctor/nurse</td>
<td>✓</td>
<td>✓</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Immunization</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Home visits</td>
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<td>✓</td>
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<td></td>
<td></td>
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<td></td>
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<tr>
<td>Chronic and acute disease diagnosis, management, and referral as necessary</td>
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<td>✓</td>
<td></td>
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<tr>
<td>Emergency medical assistance</td>
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<tr>
<td>Limited specialist consultation</td>
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<tr>
<td>Limited diagnostics and laboratory tests</td>
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<td></td>
<td></td>
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<tr>
<td>Minimal diagnostics and laboratory tests</td>
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<td>✓</td>
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<tr>
<td>Limited essential drugs for poor</td>
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<td>✓</td>
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<tr>
<td>Four antenatal visits</td>
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<td>✓</td>
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<tr>
<td>TB case management</td>
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<td></td>
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<td>✓</td>
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<tr>
<td>DOTS for TB patients</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Management of mental disorders, counselling, free drug provision</td>
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<td></td>
<td>✓</td>
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<tr>
<td>Antiretroviral treatment</td>
<td></td>
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<td>✓</td>
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<tr>
<td>Hepatitis C treatment</td>
<td></td>
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<td></td>
<td></td>
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<td>✓</td>
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Ways forward

In order to address the challenges that arise from the multiple sources of financing of PHC services and the fragmentation of care, vertical programmes should be gradually integrated into the Universal Health Coverage Programme. This will create the grounds for comprehensive, coordinated and efficient care.

The low utilization of PHC services and inadequate gatekeeping at PHC level should be addressed by creating an incentive-driven approach. The use of patient-centred practices will also increase demand for PHC services.

The introduction of drug benefits for the management of chronic conditions is a key way to reduce out-of-pocket expenditure, which constitutes the largest share of health expenditure. In March 2017, the Ministry of Health, Labour and Social Affairs announced plans to introduce outpatient drug benefits to the targeted population in the context of universal health coverage for four chronic conditions that account for more than 80% of the disease burden in the country from July 2017. 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 the 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 policy-makers to identify poor and best practices in the PHC system and argue for effective application of limited financial resources.

And finally, strengthening of the PHC role in the country will not be achieved without adequate funding.

The Health Care and Social Issues Committee of Parliament has begun to define a long-term strategy and action plan for social protection and health care. The action plan should include legislative initiatives for implementation of strategic tasks, as well as parliamentary oversight and all the activities related to European Union integration. Primary care will be one of the core areas to be elaborated in the strategy.

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