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STRATEGY FOR UNIVERSAL HEALTH INSURANCE IMPLEMENTATION IN GEORGIA

Draft Recommendations

FRIEDRICH EBERT STIFTUNG

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GEORGIAN DEVELOPMENT PLATFORM

Strategy for Universal Health Insurance Implementation in Georgia

Draft Recommendations

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PREFACE

In post-Soviet Georgia, after the complete collapse of the economic and social systems, the problems in the field of health care were constantly relevant during different governments of the country.During this period, based on different approaches and concepts, several reforms or attempts to carry out a reform took place. Despite some progress in certain areas, both in terms of the emergence of new medical services and introduction of modern medical technologies, there are still many problems in the healthcare sector.These problems are even more acute and visible in the context of permanently high levels of poverty and severe social problems.

The group, formed within the framework of GEORGIAN DEVELOPMENT PLATFORM with the participation of health policy, economists and insurance specialists, aimed to prepare a strategic document on health care reform based on a detailed analysis.

It should be emphasized that the study was particularly focused on the issues related to health insurance on the basis of which the strategic document was developed.

The analytical work was preceded by the search for extensive material that reflects the state of health and the health care system of the population of Georgia in accordance with the aims and objectives of the research.Information required for analysis was requested from various public agencies in accordance with the established procedure.In-depth interviews were conducted with public and private sector representatives. In this regard, we are especially grateful to Georgian Insurance Association for their assistance in the development of the project. Emphasis was also placed on the review of successful experience in the development of the healthcare sector in the EU and other countries.

After systematizing and analyzing the material, important and key issues for the strategic document were identified. Accordingly, the need for health care reform and its specific direction were pointed out - specifically the need to move to a universal health insurance model. A draft recommendations on Strategy for Universal Health Insurance Implementation in Georgia, focused on specific priorities and mechanisms, rather than general one has been prepared, detailing the conceptual and strategic issues needed to implement the reform.

During the elaboration of the draft recommendations on the strategy, the principles of the Resolution # 629 of the Government of Georgia (December 20, 2019) "On Approval of the Rules for Development, Monitoring and Evaluation of Policy Documents" were mainly taken into account. However, the text of the strategy is not accompanied by the annexes provided by the resolution in the form of a logical framework and action plan. The group of authors believes that at the initial stage it is more appropriate to have a discussion around the conceptual part of the strategic document, while discussing the issues related to implementation is the next stage.

The present publication consists of two parts.The first part presents the draft recommendations on Strategy for Universal Health Insurance Implementation in Georgia, and the second part introduces the analytical material that was used to develop the draft strategy.

The experts involved in the project were given the opportunity to carry out this important activity in the framework of the project "Development of a universal health insurance policy", which was implemented by GEORGIAN DEVELOPMET PLATFORM with the support of the Friedrich-Ebert-Stiftung. We particularly acknowledge the role of the Friedrich-Ebert-Stiftung for its fruitful cooperation and hope that in the future we will have the opportunity and honor of productive cooperation on health, as well as other socially relevant issues.

Part I - Strategy for Universal Health Insurance Implementation in Georgia (draft recommendations)

Introduction

Every change of government since the country's independence has been accompanied by a radical overhaul of the health care system. The previous strategy and positive experience were unconditionally ignored. Three such periods of thorough reform of the field can be conditionally distinguished: The first - 1995-2003, the second - 2004-2012 and the third - from 2013 to the present.

Despite the fundamentally different approaches in different periods and the positive moments inherent in each period, it was essentially impossible to form a financially sustainable, high-quality health care system. At a time when living standards and the social background are improving at a slow pace amid Georgia's economic development problems, health care, access to related services and the financial burden remain a challenge for many groups.

The increase in state budget funding for health care has reduced the catastrophic spending of certain groups on medical services. However, it failed to provide every citizen with financially sustainable, full access to basic health care services. Along with financial, institutional and geographical problems, access to quality medical services in the country remains problematic, with some exceptions. The model based on state policy in the health sector maintains significant challenges and failures in the segments of preventive medicine and primary health care, especially in peripheral cities and villages.

These factors contribute to the low level of indicators reflecting the overall picture of the country's health care and inadequate dynamics of improvement.

Accordingly, a systematic analysis of the current health sector was conducted, the positive and negative experiences of previous periods were studied, and problems and challenges were identified.

Based on the analytical work, the draft recommendations on **Strategy for Universal Health Insurance Implementation in Georgia** was developed. The strategy envisages the fundamental transformation of the healthcare sector as a basic financial-institutional model, as well as strategic goals and objectives related to certain important components of this sector.

1. Prerequisites

In the very first year (1995) of the transition from the Soviet model of healthcare (the so-called "Semashko model") to health program funding, the State Health Fund was established. The minimum guarantees of the state in the field of health, the sources of financing its provision were defined - In the form of targeted taxes, accumulation mechanisms and financial management institution.

State health programs have been in place since August 1995 (treatment of children under 1 year of age, supervision of pregnant women, mental health, tuberculosis control, emergency care for war veterans and the homeless, etc.).

Since 1996, the State Medical Insurance Company has been established with 12 regional branches. In financial, managerial and contractual terms, the state-owned company was to be independent, with its supreme advisory body being, by law, a supervisory board. The source of income for the State Medical Insurance Company was a social insurance contribution of 4%, of which 3% was paid by the employer and 1% by the employee. By legalizing medical "tax" and then "insurance premium" created so-called Insurance risk. Insurance premiums were accumulate to the state health insurance company. In addition to health insurance contributions, the state health insurance company's source of income was a central budget transfer generated by general state revenues. The central budget transfer was mainly intended to fund state programs for those who were not employed (unemployed, persons with disabilities, the homeless, pensioners, children).

Budget execution for this period should be considered as one of the main problems. Execution of 90 percent or more of the annual budget for eight years was only possible in 1996 and 2001. The situation has relatively improved since 2000 (2000 - 90%, 2001 - 80%). However, in 2003 the sequestered budget was funded by only 62%. Despite episodic successes, the main reason for the failure of health care reform in 1995-2003 was the weak economic and financial institutions of the newly created state. As a result, Georgia has failed to make consistent and systemic changes in the sector - Failed to introduce an adequate model of health policy management; Failed to carry out fundamental economic reforms and,

as a matter of principle, proved powerless in the face of total corruption.

In 2004, after a change of government, work on reforming the healthcare system resumed with the involvement of international partners. The Government Commission for Health and Social Reform, established at the end of 2006, defined the basic principles for the implementation of reforms in the health sector and developed a conceptual model of reform, which included four strategic directions: (i) Providing financial access to essential medical care and protecting the public from financial risks associated with medical care; (ii) Providing high quality medical services - creating and enforcing an appropriate regulatory environment; (iii) Ensuring physical access to quality medical services for the population - developing medical infrastructure and training of competent staff; and (iv) Improving the efficiency of the health care system - building the capacity of the Ministry and its subordinate organizations and introducing the principles of good governance.

The main goal in changing health care funding since 2006 was to improve financial access to essential medical care. In order to better manage the financial risks associated with deteriorating health, the government, instead of purchasing medical services, made a choice in favor of purchasing health insurance.

The concept of reform envisaged two main principles: First - creating a targeted system of state funding for the provision of medical services to the most vulnerable sections of the population; Second - the management of state funds to promote the development of private insurance.

According to the reform, the existing state health programs (including outpatient programs) should be gradually replaced by insurance products - the purchase of medical services should be replaced by insurance services; Budget resources would be redistributed in favor of the socially vulnerable; Financial access to insurance services for vulnerable groups was provided by an insurance voucher; The government would facilitate the implementation of insurance programs for soldiers, police officers, and civil servants; The citizen himself must choose the insurance company he/she prefers; All insurance companies licensed in Georgia should have an equal right to become a participant in the program and a provider of insurance services; Short-term (one-year) insurance contracts should have been replaced by a permanent insurance contract.

The first state pilot program to provide health insurance to the population living below the poverty line was developed in 2007 and provided medical services to 196,000 citizens living below the poverty line in Tbilisi and the Imereti region. Since 2008, insurance vouchers have been issued to families living in Georgia who are registered in the "Unified Database of Socially Vulnerable Families" and the rating score of their families did not exceed 70,000. The Social Services Agency handed over a voucher to the citizen to finance medical insurance.

Until 2010, a citizen or beneficiary family holding a voucher had the right to freely choose an insurance company. The citizen himself signed a contract with the selected insurance company, received an insurance policy with a voucher, on the basis of which he was provided with medical services defined by the program and financed. Following the piloting of a health insurance program for people living below the poverty line, the state began providing medical insurance to public school teachers the same year.

As a result of the amendments made in 2010, the rules in the state programs of health financing were significantly changed. Specifically: the right of a state program beneficiary to freely choose an insurance company has been replaced by a mandatory relationship with a particular company; The territory of Georgia was conditionally divided into 26 medical districts. Based on the insurance voucher, the insured entered into an insurance contract with the insurance company (insurer) that won the tender, which, based on the results of the tender, was identified as the winner in the relevant medical (one of 26) districts of the insured; Since 2010, the contract between the insured and the insurer has become 3 years (instead of one year); The establishment of new medical facilities by insurance companies has somewhat improved the environment for medical services, there has also been territorial accessibility, however, on the other hand, the reduction of premiums and increased liabilities have worsened the financial condition for insurance companies.

As of April 2010, approximately 1,104,785 people were covered by state health care programs. Outside the state programs were the population, which was divided into three groups: (i) Formal sector employees and their family members, only a small proportion of whom have benefited from corporate or government health insurance programs; (ii) Retirees of non-poor age - population over 60, high-risk group, for which, at the initiative of the state, 4 service programs were established at the end of 2008: emergency, cardiac surgery, oncology and primary health care; (iii) Self-employed - the most problematic and difficult to mobilize group. When purchasing medical services, these people actually had to pay out of pocket. They could not join the insurance system due to anti-selection and would face some difficulties in getting the insurance product in installments.

In 2009, the Georgian government created a new model of health insurance, which is known as "cheap insurance" - any citizen between the ages of 3 and 60 could purchase a "cheap insurance package" for GEL 19.80 (with 33% co-payment of a 60 GEL package purchased by the state) and receive primary health care and emergency inpatient and outpatient

medical services for GEL 8,000 for one year, as well as medical assistance in the event of an accident. However, despite the insurance expectations of 300,000 - 500,000 citizens, for some reason, the policy was purchased by only 122,000 citizens.

As of December 2011, more than 960,000 people were insured under state programs. In particular, the population below the poverty line, compactly resettled IDPs, orphans, People's Artists, People's Painters and Rustaveli Prize winners, beneficiaries of homes for the disabled and the elderly, beneficiaries of boarding schools, teachers, population living in the vicinity of occupied Autonomous Republic of Abkhazia, beneficiaries of community organizations and the population insured by the budget of Tbilisi City Hall (with 70 000-100 000 rating points).

According to 2012 data, more than 2 million people in Georgia did not have health insurance. In order to insure this segment, according to the decree of the Government of Georgia, about 800 000 citizens have been involved in the state insurance program since September 2012: Children aged 0 to 5 years; Old-age pensioners; students; Children with disabilities and severe disabilities. According to the Ministry of Labor, Health and Social Affairs of Georgia, by the end of 2012, the number of beneficiaries of the state insurance program exceeded 1,600,000 people. The rest of the population, which included the main employed population, could only benefit from the so-called vertical state programs, which in fact meant that they were not insured by the state in terms of managing emergency and planned somatic conditions.

This period of health care reform, despite the promising strategy declared at the beginning and some correct steps taken, proved unsuccessful. Reform very soon deviated from the main strategic line, it was very often accompanied by populist and irrational decisions, it was not consistent. Of the four models developed by the Government Commission for Health and Social Reform, practically none of the strategic directions has been properly developed - despite improvements in sector funding, the population has not been fully provided with essential health services; As in the first phase of the reform, the health insurance system was not properly developed; Proper place was still not given to public health, and the primary health care system was still underdeveloped and very weak; The field again found itself without a modern system of quality assurance of medical services.

Since 2013, the new government has radically changed its health policy, introducing a bold program with the clear goal of establishing a universal healthcare approach in Georgia. The goal of the universal health care program was to provide health insurance to all those citizens of Georgia who, as of July 1, 2013, did not have existing state insurance and did not have private insurance. In 2014, all state health insurance programs were abolished and citizens benefiting from them also joined the universal health care program. Consequently, private insurance companies no longer participate in state projects from this period. By 2014, the number of insured persons in private companies had decreased to 510,000.

In 2013, the Government of Georgia identified universal health care as the main focus of the country's health policy, which was accompanied by an unprecedented increase in the volume of state allocations to the health sector (2012 - 424 million GEL, 2018 - 1 056 million GEL, 2021 - 1 600 million GEL) and the process of introducing and further expanding the universal health care program.

The so-called minimum package of the universal health care program was made available to the population, which included basic primary health care and some diagnostic outpatient services (co-financed from 20-30%), as well as emergency care (within 15,000 GEL).

Medical services were administered first by the LEPL Social Service Agency (2013–2020) and then by the LEPL National Health Agency, not by private insurance companies. All of this has led to a fundamental change in the approach to financing the health care system. At the initial stage of implementation, the beneficiaries of the universal healthcare program became persons with a Georgian citizenship document, a neutral ID card, a neutral travel document. Also, stateless persons in Georgia, stateless persons seeking refugee or humanitarian status and seeking asylum. The minimum package, introduced in 2013, was further expanded to include more services under the Universal Health Care Program.

In 2013, the budget for the universal health care program was much lower than planned (69%) as the program expanded from July this year. Already by 2014, program costs were one-third higher than planned. In 2015, the budget plan increased by 39%, but the expenditures still exceeded the planned ones. The budget planned for 2016 was maintained at the same level as in 2015 because of the difficult fiscal environment. These overspending was largely due to a sudden increase in demand for health care from those who had not previously participated in the program. The trend of overspending on the universal health care program continued in the following years. As a result, State spending on health care is constantly increasing and uncontrollable. The budget overspending of the universal health care program for 7 years (2014-2020) totaled about 560 million GEL, or 13% more than the approved budget[1].

The ever-increasing costs of the universal health care program have put on the agenda the need to reduce the number of categories covered by the program and the amount of paid services provided for them. As of May 2017, the highest

1 Ministry of Internally Displaced Persons from the Occupied Territories of Georgia, Labor, Health and Social Affairs, Adapted from Georgian Healthcare Barometer XIV Wave.

income portion was excluded from the Universal Health Care Program on the grounds that they could purchase voluntary health insurance. As of today, the program is open to all citizens and asylum seekers who are not insured and earn less than 40,000 GEL per year. Also, the package of persons with incomes above 1000 GEL per month was reduced, which was left without any planned outpatient (specialized) services.

According to official statistics, universal health care program services cover more than 95% of the population, based on the number of people registered with primary health care providers. The package of benefits is differentiated according to the following categories of the population, some of which are based on the rating score given by the Social Service Agency: 1. Families living below the poverty line (with a rating score <70,000), People's Artists, teachers, children in foster care, IDPs; 2. Persons with disabilities, children under 5, students and pensioners; 3. Uninsured veterans; 4. Low-income citizens (with a rating score of 70,000-100,000) and children aged 6-18; 5. Other citizens below retirement age with higher income: a. Those who earn less than 1000 GEL per month or have irregular income / self-employed; b. Those who earn less than GEL 40,000 a year but more than GEL 1,000 a month; c. Who earns more than 40,000 GEL a year. Individuals with an income of more than 40,000 GEL use only selected services, which are covered by services provided by universal health care and vertical programs, subject to co-payment.

Currently, the state budget for healthcare is funded through the following schemes: (i) universal health care program; (ii) public health and other public health (vertical) programs; and (iii)Programs for priority diseases and conditions aimed at improving access to health care and characterized by different coverage rates (more than 20 public programs in total).

2. Main problems and challenges

Models of the Georgian healthcare system, as in the previous periods, as well as the current system, reveal many fundamental problems, as well as problems expressed in specific details of the system. There are several major issues to be addressed that still raise the need for fundamental changes in the healthcare sector.

Universal Health Care - Achieving real universality remains a major problem in the health care system. To define the universality of health care, it is advisable to use the definition of the World Health Organization[2], according to which, "Universal health coverage means that all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care".

Given the socio-economic background, low fiscal and institutional discipline in the period 1995-2003, the health insurance system based on the state insurance company not only failed to provide full coverage of the population, but also failed to provide adequate medical services to existing beneficiaries.

Reforms from 2004-2006 were part of the economic visions cultivated by the government of that period. According to these views, health care, as well as many other areas in which the experience of European practice has a high role for social systems provided by public authorities, was considered to be a matter of individual responsibility in the case of Georgia. In this context, the purchase of insurance packages from private insurance companies for vulnerable families since 2006, despite the general positivity of the move, should have been seen primarily as an instrument of social assistance to poor families and not as part of a unified health policy.

Against the background of acute and visible problems related to access to health services for a large part of the citizens and given the political turmoil, the government from 2007 to 2012 had to gradually expand the population categories included in state programs. Against this background, the number of insured persons in private insurance companies has been steadily increasing (reaching 1.6 million by 2012). Despite some positive trends, by the end of this period there was still a large part (more than half) of the population receiving medical services mainly through out-of-pocket payments. Against a difficult social background, this made large numbers of families even more vulnerable. The imperfection of insurance packages was obvious even in the case of citizens insured under state programs. Also, the increase in financial problems of insurance companies, which was especially complicated by the end of this period, due to the imposition of additional obligations on insurance companies (e.g. construction-rehabilitation of hospitals). Overall, the principle of universal health care was not the goal of health policy in this period, in the sense of universality as defined by the WHO.

The new government in 2012 set an ambitious task of creating a universal health care system so that no citizen would be left out of the system. At the same time, the tool to ensure this was not the development of a citizen insurance system in private insurance companies, which was started under the previous government, but on the contrary, the number of insured persons was sharply reduced and a state program of universal health care was introduced, which implied a direct financial relationship between the state and the medical service providers. There were flaws in this system from

2 https://www.who.int/health-topics/universal-health-coverage#tab=tab_1

the beginning. There is a sharp informational asymmetry between the patient and the health care provider when there is virtually no intermediate link between the patient and the provider (e.g. as an insurance company).

A large part of the cost of medical services is reimbursed by the state on the basis of the submitted documents. The amount of reimbursable expenses is increasing more and more, because the patient's ability to control the necessity of the provided medical services and the related expenses is sharply limited, and the motivation is insufficient. However, the capacity of public authorities to control services and costs in this scale system is limited.

Of course, compared to previous periods, the universal health care program has substantially improved the functioning of the social security cushion for health problems of a broad group of the population, especially in the early years of the reform. Due to both natural causes (e.g., a sharp increase in referrals) and a weak cost control system, this program requires more and more budget expenditures from year to year. Amid increased budget spending, the universal health care program was restricted in 2017. In particular, persons with an annual income of more than GEL 40,000 were excluded from the program, and for certain categories (especially those with a monthly income of more than GEL 1,000) the "minimum package" reimbursed by the program was reduced.

In the end, such picture is created - in 2003-2012 the government was not a universal task, but the social reality, political and other goals in the society gradually pushed it to go more and more covered by state programs. The new government has been declaring the universality of healthcare since 2012, but the inefficiency and problematic nature of the operating system is pushing the system to either reduce its universality, or to constantly increase budget expenditures and overspending.

Finally, despite the differences in approaches and practical realities, the coverage of the population with certain basic medical services could not be provided in the described periods. This implies that in both periods the formation of "basic" (universal or minimal) medical services under both models was driven by the practice of using differentiated packages for different community groups. However, it was not possible to establish a system that would fully provide the population with a universal package in quantitative terms.

Although the share of out-of-pocket payments has dropped significantly since the introduction of the universal healthcare program in 2013, it remains the most important source of funding (accounting for 48% of total current healthcare spending in 2018).

Primary Health Care and Outpatient Sector

The universal health care program has significantly improved funding for the health care sector and beneficiaries. From 2011 to 2016, the health budget, as a share of the state budget, doubled (increased from 5 to 10%) and then remained at around ten percent. The number of referrals to both outpatient and inpatient facilities has increased dramatically since the launch of the program. The number of referrals for outpatient services per capita increased from 2.1 to 3.4 in 2012-2015. Progress in subsequent years was insignificant, reaching only 3.6 in 2020 (for example, the average for European countries is 6). This rate of outpatient referrals in the rural doctor program is even lower (on average not more than 1), which indicates the low provision of primary health care services to the relevant population.

Although public spending on outpatient services doubled between 2013 and 2016, the share of outpatient spending on public health care has not actually changed since 2016, accounting for only 1/4 of total public health spending. This is at a time when spending on hospital services has been rising and since 2015 has accounted for about 2/3 of total public spending on healthcare. In 2013-2017, the share of the state in total expenditures on outpatient services, prevention and public health was 43.3%, and on inpatient services in total expenditures - 71%[3]. Despite a solid increase in state funding for health care, out-of-pocket payments by the population for outpatient services are still in excess (48.4%)[4], which is a heavy financial burden.

The surge in current spending on health care in 2013 was the result of the state covering a significantly increased portion of the population through relevant services. Since this period, the universal health program has consistently dominated in public spending on health. The share of this program in 2016 was 3/4 of public spending on health. 67% of public spending on health came from hospital services and 25% from primary care[5]. These ratios did not change substantially in the following years.

The current system of primary health care in Georgia does not fulfill the most important function of a "gatekeeper". The scanty utilization of primary health care services is facilitated by unhealthy incentives in the health care system that motivate primary care providers to refer patients to their hospital instead of holding them at PHC levels. This is due to the

3 The International Foundation Curatio, Healthcare Challenge - Georgian Healthcare Barometer XII Wave, http://curatiofoundation.org/ge/projects-and-publications-ge/

4 Ibid

5 The World Bank, 2017

shortcomings of the existing system of payment services. The main reason for the low utilization of planned outpatient component services is the inpatient support of the program, another manifestation of which is the modest assortment of instrumental and clinical-laboratory examinations as a whole.

It should be noted that the situation is completely different in the structure of losses of private insurance companies, where on average 35-40% of outpatient services, 30-35% of medicines and 25% of inpatient services.

Medicines

Adequate medicamentous treatment is a very serious and still unresolved healthcare problem in Georgia. The share of drug treatment in the outpatient component of the universal health care program, especially in the early stages of its introduction, was meager. To compensate for this serious backlog, a state program for the provision of medicines for chronic diseases was launched in April 2017. However, the potential of this program is quite limited and it is designed for groups of beneficiaries with specific diseases. All this means that a very large proportion of the beneficiaries of the universal health care program are deprived of adequate medical treatment in terms of planned outpatient services.

From 2014 until today, the increase in prices for both outpatient and inpatient services has been permanent. This primarily concerns medicines and outpatient care, which is a heavy burden for the population, as the largest share of these types of expenses comes from out-of-pocket payments. About 14% of the population suffers catastrophic expenditures on health care, while the leading place in the structure of out-of-pocket payments (60%) is occupied by funds paid for medicines. According to the National Health Report, the expenditure on medicines of the population in 2016 was 687 million GEL, and in the following years it increased and reached almost 1 billion GEL. Depending on the type of expenditure, spending on pharmaceuticals are high in health costs. On average, 36.9% of the total national health expenditure in 2014-2020 is net pharmaceutical costs, which is mainly paid by the population out of pocket (96%).

The most important part of direct payments comes from pharmaceuticals, especially in the outpatient treatment phase, as such costs are covered to a limited extent under the universal health care program. On pharmaceuticals, the patient usually has to pay the full price. In 2015, about 64% of out-of-pocket expenses came from outpatient medications, which accounted for about 40% of total health care spending[6]. These proportions changed very slightly in 2016-2018[7]. The cost of pharmaceuticals in the hospital is covered by the universal health care program. However, this actually distorts the incentives in the system, forcing patients to use inpatient emergency care rather than primary health care services.

In addition to financial accessibility, a very serious problem is the poor management of medicines (evidence-free and irrational treatment regimens, self-medication, etc.), the scale of which, both in terms of financial and public health, is growing immeasurably due to mental or technical reasons, prescription failure and underdeveloped primary health care.

A proper quality compliance system for imported and locally produced medicines on the market is not provided. Not all generic medications prescribed to a patient guarantee its appropriate quality, composition, and effectiveness.

Health Care Financing and Sustainability

The volume of public finances for health is significantly lower than the European average, both in absolute terms and in terms of share of total national expenditure.

As a result of the increase in health expenditures by the state under the universal health care program, it has become possible to reduce out-of-pocket costs in the system (from 73% in 2010 to 48% in 2018). However, despite the downward trend in recent years, out-of-pocket payments remain the dominant source of healthcare funding in the country.

Overall, from 2008 to 2012, the focus was on directing public resources to the poorest segment of the population. Since 2013, the focus has shifted to universal health care, as the state seeks to align the benefits package with the allocated budgetary resources. Georgia has a fairly high level of poverty and catastrophically high spending on healthcare compared to other European countries. Catastrophic costs are mainly due to out-of-pocket payments for outpatient medications as well as inpatient and outpatient services[8]. The catastrophic ex penditures of the population on healthcare were increasing and amounted to 34% by 2017. It is expected that this figure will increase even more[9].

At the end of 2020, the state set limits on payable tariffs for providers. The resulting loss was probably offset by some medical facilities providing redundant or unnecessary services, which leads to an increase in out-of-pocket payments and places a heavy burden on patients. The National Health Agency determines the level of co-payment for the cost of

6 Habicht & Thomson, 2016
7 How much can people in Georgia pay for health care services? WHO, 2021
8 WHO-EURO-2021-2532-42288-58479-geo.pdf
9 Georgian Healthcare Barometer XIV Wave

services provided by patients and the annual upper limit of the benefits to be received by it. Information on the level and amount of co-financing for various services provided under the universal health program is available, but the benefits provided by the program are not sufficiently clearly defined and well understood by the population, which makes it possible to oblige patients to pay for services covered by a universal package or may have the procedure reclassified for the same purpose. There is no official co-financing required to access the services for the main target groupbeneficiaries. Unfortunately, there are no clear goals or principles for establishing co-financing in the system beyond the cause of limited public resources. Existence of an upper limit of eligible benefits and the obligation to pay the difference between the agency's remuneration and the hospital fee for the patient limits the ability of the system to provide adequate depth of coverage - there is no limit to the level of co-payment to determine in advance the amount to be paid by the patient.

The share of private health insurance in the health care system is small. In 2017, its share was 6% of current healthcare expenditures and 9% of private healthcare expenditures[10]. Private medical insurance is provided by private insurance companies and it covers 9% of the population (438,302 people in 2020). Most are voluntary and apply to employees and their families. The share of health insurance in current health care expenditures increased as a result of relevant policies until 2012, but with the introduction of the universal health care program, its role in the system has been significantly reduced[11].

Health Indicators

The previous periods and the current situation in the healthcare sector are directly reflected in various indicators, which are used both to assess the dynamics of improvement, as well as for comparison with different countries. There is a marked improvement in some indicators, including: Maternal mortality rate; Neonatal mortality rate; Mortality rate under 5 years. Despite this progress, the indicators show a number of negative trends in the social sphere of the country and specifically in healthcare.

The mortality rate for adults aged 30-70 due to cardiovascular and chronic respiratory diseases, cancer and diabetes, often referred to as "death that should not occur", is unfortunately quite high - 24.9. It is noteworthy that this parameter of Georgia is better than only Turkmenistan, Russia and Tajikistan in the WHO Eurasian region.

Despite years of progress in TB control, the incidence of these communicable diseases is still high (74.0). Due to this, Georgia ranks 45th in the WHO Eurasian Region Register. Georgia is among the 18 countries in the region that carry 99% of the burden of combating resistant forms of tuberculosis (MDR). All this is an unmistakable proof of the inadequacy of the public and primary health care sectors as a whole.

The declared universal coverage is not fully confirmed by the value of the coverage indicator by health services (66.0). According to this index, Georgia is only ahead of Serbia and Bosnia and Herzegovina in the WHO Eurasian region.

Georgia is ahead of only 4 countries in the region in terms of life expectancy at birth. It is noteworthy that at the end of the 90s these figures of Georgia and Estonia were slightly different from each other. However, 20 years later, in Estonia, which is the leader in the region in terms of social policy, the growth of this weighty indicator, unlike our country, is very impressive.

Human Resources and Medical Service Quality

In the first years of independence (1991–1995)[12] the number of doctors in Georgia sharply decreased (3.2 per 1,000 population). However, an upward trend was soon observed[13]. The number of doctors has been growing sharply since 2006 and currently significantly exceeds similar indicators in EU countries (compared to 1000 inhabitants, Georgia - 5.94 [2020][14], France - 3.3, Netherlands - 2.4, Estonia - 3.47, Slovakia - 3.2 - [2019])[15]. For several years now, due to the surplus of doctors, the distribution in their country has been unequal - Tbilisi, where about 30% of the country's population lives, has about 15,000 doctors, and the rest of the country - about 8,000. Against the background of an abundance of doctors and the low consumption of outpatient services by the population, the productivity of physicians is low in both the hospital and outpatient sectors[16]. One hospital doctor treats an average of 42 patients a year (2016), which is 2.5-3 times

10 WHO, 2020
11 Health Systems in Transition, Georgia, 2017 მიხედვით.
12 National Center for Disease Control and Public Health, Health Care, Georgia, Statistical Reference,1996
13 National Center for Disease Control and Public Health, Health Care, Georgia, Statistical Reference, 2010–2019
14 National Center for Disease Control and Public Health, Health Care, Georgia, Statistical Reference, 2020 https://www.ncdc.ge/#/pages/file/ebe72ea5-5087-4dc3-aaf1-c94cda232ad2
15 European Health Information Gateway :https://gateway.euro.who.int/en/
16 The International Foundation Curatio, Healthcare Challenge - Georgian Healthcare Barometer X Wave. 21.06.2019 http://curatiofoundation.org/wp-content/uploads/2018/03/HRH_Barometer-10.pdf

less than in EU countries (2017). In the outpatient sector, one physician serves an average of 1,062 patients per year (an average of four per day). For comparison, 104 in Hungary and 116 in Germany[17]. In the health care system, as of today, there is a shortage of doctors as a whole, although we have a shortage of certain specialties in different municipalities.

The Ministries of Education and Health are responsible for the coordination and quality of undergraduate and postgraduate medical education. 15 institutions participate in the implementation of the 6-year training program for certified physicians, and in the field of postgraduate medical education - state / private educational and private medical institutions. 684 Georgian students graduated from the 6-year graduate program in 2016, which means that the number of new graduates per 100,000 population is twice the average of EU countries.

Professional development, which is a systemic component of quality assurance of medical services[18], is complete if there are adequate tools and mechanisms for objective monitoring / evaluation of the professional activity of the physician and professional development. At present, it can be said that there is practically no system of continuous development of doctors in the country[19], because there are many inconsistencies in the legal framework related to the issue - doctor who obtains a certificate of independent medical practice for the rest of his/her life, only voluntarily engages in continuous professional development activities, which the law considers an integral part of the doctor's activity, however, the law does not impose any sanctions for non-fulfillment of this obligation. Continuous professional development standard is vague - there are no specific requirements for continuing professional development providers and the list of continuing education programs is narrow.

The country's healthcare system suffers from an acute shortage of qualified nurses relevant to the modern concept of nursing. More than 20% of the nurses employed in the field have already reached retirement age in 2015[20]. The already small number of nurses in the 1990s declined dramatically in the following years (1996–2007)[21] and despite the recent growth trend, their number is still low (22,126, or 5.94 nurses per 1,000 population [2020]) and lags significantly behind similar figures in EU countries. For comparison, in the Netherlands, the Czech Republic, Estonia and France respectively 7.8; 8.56; 6.2 and 11.1 thousand inhabitants (2019)[22].

The health care of a country with a similar population of Georgia, taking into account age seeding and biological losses, needs to be replenished with about 1,200 nurses each year. An imbalance is also noted in the geographical distribution of nursing human resources. The main mass of nurses is gathered in the capital, where 2 doctors per 1 nurse. In some municipalities (Racha-Lechkhumi-Kvemo Svaneti; Mtskheta-Mtianeti) the nurse / doctor ratio is higher than the Georgian average (0.8 [2016])[23]. According to 2020 data, this proportion is 0.87. For comparison, the average rate in European countries is 2.4 (2018).

One of the most important reasons for the reduction in the number of nursing staff is the lack of financial motivation (with some exceptions), which primarily concerns the primary health care ring. Continuous and growing migration from rural to urban areas[24] and a number of problems with the primary health care system (including the rural doctor program) are exacerbating the shortage of nurses in the regions. Low financial access to undergraduate degree programs in nursing also plays an important role in reducing the number of nursing staff[25]. The scarcity of qualified nurses and the unequal geographical distribution of physicians have a serious negative impact on the quality of medical care.

3. Strategy Vision

As a result of systemic reforms in the field of health care, the state, through its legislative framework and other operational instruments, provides a health care system based on the principle of universality, in which the population of Georgia will be fully involved. The universality of health care means that every person has access to state-defined basic medical care without significant financial complications. The population should be provided with high quality, both basic and additional, a wider range of medical and health services. The health care system as a whole must be financially stable, and in terms of institutional and operational management - effective. According to the vision of the strategy:

17 Organisation for Economic Co-operation and Development (OECD) iLibrary https://www.oecd-ilibrary.org/statistics

18 Accriditation Council for Continuing Medical Education https://www.accme.org/ Continuing Medical Education in Europe: Evolution or Revolution? Published by MedEd Global Solutions, May 2010 [www.continuingmedicaleducation-europe.com]

19 G. Beria, V. Surguladze, T. Giorgadze, Health Policy, Economics and Sociology 2019; 5 (2) (used in Georgian)

20 The International Foundation Curatio, Healthcare Challenge - Georgian Healthcare Barometer X Wave. 21.06.2019 http://curatiofoundation.org/wp-content/uploads/2018/03/HRH_Barometer-10.pdf

21 National Center for Disease Control and Public Health, Health Care, Georgia, Statistical Reference, 2010–2019

22 European Health Information Gateway :https://gateway.euro.who.int/en/

23 The International Foundation Curatio, Healthcare Challenge - Georgian Healthcare Barometer X Wave. 21.06.2019 http://curatiofoundation.org/wp-content/uploads/2018/03/HRH_Barometer-10.pdf

24 Government Commission on Migration Issues, Georgia Migration Profile 2019, 2020

25 https://matsne.gov.ge/ka/document/view/4617071?publication=0

1. Frameworks and systems established by the state that provide basic health services to the entire population (this is the competence of public authorities);
2. Provision of basic preventive, primary health care, outpatient and inpatient medical services to the entire population (operational support and the role of mediator between the beneficiary and the medical service providers are provided by private insurance organizations within the framework of the package of universal health insurance);
3. Provision of medical services within the package of universal health insurance (provided by health care providers in such a way that the primary gatekeepe role of the beneficiary organization for the beneficiary is played by the primary care (family) physician); and
4. Financing the provision of medical services and products to the beneficiaries (based on the universal package of insurance, which is the same for everyone. Only the insurance premium payment / co-payment system is differentiated for different groups of the society. The sustainable financial model of the health care system is directly related to the fiscal policy of the state and provides for the preferential support of socially vulnerable groups, equity, fiscal incentives for sectoral tasks of health policy).

The strategy, in addition to the transition to a universal health insurance system, addresses the strategic goals and tasks of the reform in relation to other components of the health care system, which together should ensure the improvement of the health status of the entire population.

4. Strategic Goals and Tasks

Strategic goal 1 - Ensuring Universality of Health Care

The strategic goal is to create a legislative-systemic framework by the state that will fully involve the population of the country in a system of efficiently operated, differentiated and sustainable health care, provided with basic funding.

Task 1.1. Prepare and adopt legislative changes on universal health insurance.

The introduction of the universal health insurance model as a key model of the health care system is a substantial reform, taking into account the goals and objectives set out in this strategy. Consequently, in contrast to past practice, when many of the most important issues of this type were regulated by Georgian government decrees, they will be replaced by legislation. All this, as a result of the formation of a stable and predictable system, will create long-term guarantees for the parties involved in the system. At the same time, in its content, this reform is non-partisan. Accordingly, the wide participation of various political parties, interested organizations, insurance companies, medical service providers and experts will be ensured in the process of reviewing and adopting legislative changes. The Law on Universal Health Insurance will be prepared and adopted. The social part of the new model will also be reflected in the Social Code of Georgia, which the Georgian government plans to develop and adopt.

Task 1.2. Determining and approving the amount of the health insurance package and insurance premiums within the Universal Health Insurance System.

In previous periods, when the practice of purchasing insurance products was established (2004-2012) and with the approaches established during the universal health care program in force from 2013 to the present, different service packages were and are provided for different community groups. Such an approach was based on a kind of artificial adjustment of the state budget capacity to the health needs of certain public groups. The content of the packages of services offered was the result of this.

In line with the present strategy, the approach changes substantially. The proposed approach assumes that the state will legislate and therefore have a defined universal insurance package for all categories of the population, regardless of age, social category, income, etc. To date, the following social tools are widely used in state health policy: The state provides wider service packages to the socially vulnerable, certain age or occupational groups, and more modestly to other groups. According to the strategy approach, the introduction of a universal health insurance package is an expression of the state's undifferentiated attitude towards each member of society in terms of health insurance guarantees and, consequently, social/public responsibilities, regardless of belonging to any of its groups/categories.

This approach will use not differentiated packages as a tool to address social policy objectives, but differentiated approaches to insurance premium payment support, including different mechanisms of co-payment and fiscal benefits for different groups of the population to achieve universal package services for all individuals.

Universal health insurance package includes: first level outpatient services; Second level (specialized) outpatient services; Prescribing medications and medical treatment (outpatient); Emergency outpatient services; Emergency inpatient services; Planned inpatient services; Oncology services; Obstetric services.

The services for the insured are presented in detail in the Universal Health Insurance package. Also, the percentage of the co-payment for each expected service and the monetary limit for covering the costs. In addition, the insurance package will be accompanied by a complete and comprehensive list of patented and generic medicines to be reimbursed under compulsory insurance, as well as other positive lists specified in a separate article of the package (universal health insurance package The model version is attached to the document. See Appendix).

The review and adjustment of the universal health insurance package and insurance conditions will be allowed at regular intervals (for example, 2 or 3 years). It is not allowed to make any changes in the insurance package or conditions that will worsen the condition of the insured.

The state will approve the amount of insurance premium(s) for the purchase of a universal health insurance package from private insurance companies in monetary terms. The state approves the monthly insurance premium. The Basic Insurance Premium provides the amount of a monthly individual insurance premium for individuals between the ages of 18 and 60 (except for persons who, according to the established list, belong to special groups due to diseases) in cash over a specific budget year. The state also determines the coefficients according to which the amount of the basic premium can be increased or decreased for a specific category of persons. The basic insurance premium ratio will be 1 and the range of premium increase or decrease ratios will be set from 0.8 to 1.3. Different rates are defined for age groups (for example, for 0-18 years old or when buying a family insurance product, when insuring a second, third, etc. family member will be less than 1 and over 60, or for people with special group diagnoses - more than 1).

The state can use other (vertical) health care programs to provide an increased range of ratios. For example, for individuals aged 60 and over and those belonging to special groups, the state will develop a list and conditions of long-term essential medicines and approve a state program that reimburses the purchase of listed medicines for these groups from the state budget. Such consideration of the medication component serves to ensure that the inclusion of 60-year-olds and older, as well as other special groups, in insurance schemes does not significantly increase the amount of the basic insurance premium or the insurance premium ratio.

Anyone involved in the system will be able to purchase an improved product/coverage in addition to the basic universal health insurance package at any insurance company. The insurance company has the right to offer improved coverage/add-on products to the person insured by him or another company. The fact that mandatory basic/universal package and add-on/enhanced coverage are purchased from various insurance companies does not relieve insurers from meeting their obligations. In addition, the insurance contract and the relevant documentation must provide for the possibility of clear separation and identification of the products covered by the universal insurance package and the products add-on it, and, consequently, the insurance premium and the amount of the added insurance premium established by the state.

Task 1.3. Defining the criteria and conditions for the participation of insurance organizations in the universal health insurance system.

The state obliges all categories of the population to be insured with one of the private insurance companies involved in the universal health insurance scheme.

The state shall determine the following criteria for the inclusion of licensed insurance companies in the universal health insurance scheme:

1. The insurance company wishing to participate in the universal health insurance scheme of the population of Georgia must submit a solid financial guarantee in the form of a high investment. The state will determine the amount of the financial guarantee above the mandatory minimum capital;
2. The insurance company is obliged to have a total premium in the form of health insurance from direct insurance activities for the last 3 years with a specific minimum amount set by the state;
3. For the system to function smoothly, it is important for the insurance company to introduce a structured management mechanism at the initial stage, based on its portfolio;
4. The insurance company must provide information on the ability to meet other conditions set by the state (e.g. geographical standards of primary health care, provision of human resources, etc).

State law sets deadlines for insurance companies to record in writing their desire to be included in a universal health insurance scheme and to submit relevant documentation to meet the criteria. Based on the submitted information, the list of companies involved in the universal health insurance scheme will be approved. Insurance companies wishing to be additionally involved in the scheme will be able to submit a wish to join the scheme and relevant documentation at any time. If the criteria are met and the company is included in the approved list, they will be able to join the scheme from the next budget year.

Task 1.4. Establish financially sustainable, equitable and operational funding mechanisms for the universal health insurance system.

The insurance premium of each insured person will play the role of the main instrument in the universal health insurance financing system, which will be received by its insurer insurance organization. There are different mechanisms for insurance premiums for different categories.

The following categories of insured persons and the mechanisms for payment of relevant insurance premiums are allocated for universal health insurance.

	Categories of insured	Insurance premium payment mechanism
1.	Persons whose average monthly income (gross) during the last 12 calendar months does not exceed 1200 GEL	Pays the insurance premium from its own income. The insurance premium paid by him/her is excluded from his income tax. The amount remaining after the payment of the insurance premium is paid in the form of income tax. The exemption under this person in terms of family insurance also applies to the total amount of insurance premiums.
2.	Persons whose average monthly income (gross) for the last 12 calendar months exceeds 1200 GEL, but does not exceed 3300 GEL	Pays the insurance premium from its own income. The insurance premium paid by him is excluded from his total (taxable) income. The amount of insurance premium paid is deducted from the taxable base of income tax. The exemption under this person in terms of family insurance also applies to the total amount of insurance premiums. The state may impose additional fiscal incentives to stimulate family insurance packages, including when the amount of income tax payable exceeds the total insurance premium of the family package.
3.	Individuals whose average monthly income (gross) is last In the course of 12 calendar months exceeds 3300 GEL	Pays the insurance premium from its own income. Does not enjoy tax breaks. The state may impose a fiscal benefit only to stimulate family insurance packages.
4.	Individuals who are registered in the unified database of socially vulnerable families and their rating score does not exceed 200,000, regardless of age	The state will issue vouchers at the cost of the insurance premium. Such families will purchase family insurance packages with appropriate premium ratios.
5.	**Persons under 18 years of age (except for family members who are registered in the Unified Database of Socially Vulnerable Families and their rating score does not exceed 200,000), including:**	
5.1.	Persons under the age of 18 in families where one or more members receive registered income	One of the adult members of the family is obliged to include minors in the family insurance package and pay the relevant insurance premiums. It will be subject to tax breaks for the amount of the relevant income.
5.2.	Persons under 18 years of age in families where neither member receives registered income	One of the adult members of the family is obliged to include minors in the family insurance package. The state will issue vouchers in the amount of insurance premium for all insured persons.
6.	**Persons aged 60 and over (excluding family members who are not registered in the Unified Database of Socially Vulnerable Families and whose rating score does not exceed 200,000) including:**	
6.1.	Persons aged 60 and over who represent a single household or are members of a two-person household when the second member is aged 60 and over	Are required to pay the insurance premium. Do not enjoy tax breaks.
6.2.	Persons aged 60 and over whose other family members are one or more persons under the age of 60 who receive registered income	Have the choice of either paying the insurance premium themselves without tax relief or joining a family insurance package purchased by another family member in which the person paying the insurance premium will benefit from the established tax benefit.
6.3.	Persons aged 60 and over whose other family members are one or more persons under 60 who do not receive registered income	Have the choice of either paying the insurance premium themselves without tax breaks or joining a family insurance package purchased by another family member, to which the state transfers vouchers in the amount of the insurance premium.
7.	Persons who do not fall into any of the other categories listed	The state will issue vouchers in the amount of the insurance premium.

The state ensures the enrollment of beneficiaries' insurance premiums for insurance organizations, formation of a voucher reimbursement mechanism and relevant instruments, including its integration with the tax administration. This mechanism will also be integrated into a unified electronic system based on individual online beneficiary health profiles.

Based on the analysis of insurance packages available in the insurance market for the strategy development phase, the estimated volume of the total insurance premium attracted by insurance companies in the first budget year of the introduction of universal health insurance is GEL 2,250 million. Contribution from the state budget will be of two types: 1. Reimbursement of vouchers issued to different categories of policyholders, with a maximum projected budget expenditure of 900 million GEL, which is 40% of the total insurance premium; and 2. In terms of tax revenues, the projected maximum amount of revenue unacceptable by the state budget is 500 million GEL, which is 22% of the total insurance premium.

The dynamics of the macro-financial parameters of universal health insurance will be twofold: 1. In accordance with the dynamics of price increases for medical services and insurance market, the state will periodically increase the amount of the basic premium for universal health insurance. Among them will increase the amount of contribution from the state budget (reimbursement of vouchers and loss of tax revenues). The increased financial burden on the state will be offset by an increase in the state budget revenues in line with the expected inflation forecast. 2. In accordance with the current trends in the economy, the numbers of persons under the categories of insured persons will be adjusted based on the projected volumes of real economic growth. In this regard, an increase in the number of persons with registered incomes and the relocation of low-income persons from the lower groups to the upper groups is expected. Given these projections, it is expected that in the fifth budget year since the start of the reform, the total contribution of the state budget in both forms (voucher financing and loss of tax revenues) will be reduced from 62% of the basic premium to 35-40%.

The state will develop special mechanisms and measures aimed at actually employing and income recipients whose incomes are not registered with the Revenue Service, to gradually bring them into the area of taxation. To this end, the state will use state programs, including programs to support small and medium-sized businesses and agricultural activities, where additional conditions are defined as taxation. It will also use various income accounting tools for the self-employed and those with individual entrepreneurial activities.

Task 1.5. Establish, implement and operate a unified electronic system based on individual online profiles of beneficiaries' health.

The state will create a unified electronic system based on individual online profiles of beneficiaries' health. The system will be accessible to state authorities, insurance companies, medical service providers, drug and medical facilities, and insured persons. Depending on the purpose of access to the system, the degree of access to the data in the system will be differentiated, in compliance with the standards of personal information protection.

The system will have an individual profile of each insured person as well as complete data in electronic form. These include: payment of insurance premiums, including benefits, vouchers and other financial information; Data on insurance package, received medical services and medical history; Data on participation in state vertical programs; Data on insurance claims; Data on electronic referrals of personal physicians, prescription of medicines, data on subscribed electronic prescriptions, etc.

The unified electronic health system will serve as an individual service for beneficiaries, rapid electronic data exchange and document circulation, as well as an important tool for the state for accounting and statistical work on the state of health of the population and for further analysis.

Task 1.6. Ensure the transition from the existing system to the universal health insurance system and put the system into operation.

The implementation of the reform includes three stages, including the introduction of universal health insurance 1. transitional stage, 2. enactment, 3. further functioning.

The previous budget year for the introduction of universal health insurance is defined as a transitional stage and the detailed deadlines for specific processes are defined by the legislation within the transition period.

During the implementation of specific legislative, technical and technological tasks defined in „other tasks“ in the transition phase, it is important to ensure the transition phase from the current universal health care program model to universal health insurance. The process of involving the population in a universal model of health is important in this regard.

In the transition phase of the universal health insurance system, insureds in any form of private insurance companies retain insurance until the end of the insurance period, but not longer than the date of entry into force of the universal health insurance. At the end of the insurance period, they will be included in the universal health insurance scheme without changing the insurance company. Clearly, if a particular insurance company is on an approved list of companies involved in a universal health insurance scheme. Such persons will have the right to change the insurance company 12 months after joining the new scheme, within the period established by law. If the insured does not change the insurance company within the specified time, he / she will remain in the same insurance company until the end of the insurance

period. It is possible that the legislation may provide for additional restrictions for a certain period of time (not more than 24 months from the date of entry into force of the scheme). A condition for a ban on changing the insurance company may be that within one certain period of joining the scheme, within the period prescribed by law, at least one insurance case has been recorded and at least a reimbursed loss.

Persons without insurance for the transition phase (uninsured population) will join the system as soon as the system is launched. Uninsured persons will be redistributed to insurance companies on a random basis (equal number in each insurance company). In the case of redistribution of insured persons between insurance companies, the new structure of insured persons should take into account the aspect of equal redistribution of insurance risks between insurance companies.

Within 24 months from the date of enactment of the universal health insurance (the first calendar day of the defined budget year), all types of insured persons will have the right to change the insurance company. The legislation will set specific deadlines and procedures for the period from the date of entry into force to the 18th to the 22nd month, when the insured persons will have the opportunity to express a desire to change the insurance company. The redistribution of the insured among the insurance companies will take effect on the first calendar day of the 25th month after the scheme takes effect and its validity period (including the next right to change the insurance company) will be limited to a period of 36 months.

Task 1.7. Relieve the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs from its operational functions and strengthen its policy-making, standards-assurance, analytical and regulatory functions.

The introduction of universal health insurance will relieve the Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs of its operational functions, and therefore there will no longer be a need for a legal entity within the Ministry to run a universal health care program under the current system. In return, the reform requires the establishment of a universal health insurance regulatory system within the ministry. Other functions of the Ministry related to regulation and quality management will also be strengthened for the implementation of the tasks defined for the 2nd and 3rd goals of the strategy. Relevant structural changes and reorganization in the system of the Ministry will be implemented.

National Council for the Regulation of Universal Health Insurance will be established to regulate universal health insurance. The Board will be a permanent collegial body. Relevant public institutions and specialists will be represented in the Council. The subcommittees will function within the Council, including Subcommittee on Positive Lists of Universal Health Insurance Medications, Subcommittee on Positive Lists of Outpatient and Inpatient Services, Subcommittee working on the analysis and system-adjustment of accounting and statistical data on the functioning of universal health insurance indicators and the functioning of universal health insurance.The Ministry will be empowered to create additional Subcommittees as needed. The Ministry will provide organizational support for the activities of the National Council and Subcommittees.

The law will establish a mediation unit between the insured and the insurer. The rules of its staffing and functioning will take into account the participation of public authorities and private entities.

The legislation defines the mechanisms for the protection of the rights of consumers of universal health insurance.

State vertical health care programs will be aligned with the universal health insurance system as part of a unified health care policy.

Strategic Goal 2 - Strengthen Primary Health Care and Make it a Key Component of Health Care, Prioritize and Modernize the Outpatient Sector

Task 2.1. Incorporate primary health care into the universal health insurance system and ensure geographical access to its services.

The important reform of the introduction of universal health insurance is directly related to the elimination of the weaknesses of the healthcare sector of Georgia and the substantial improvement of the systems. In this regard, according to the strategic vision, the development of primary health care and the outpatient sector is a top priority.

Within the framework of the universal health insurance system, each insured person / family will be provided with a qualified personal physician. The Ministry determines the competencies of the "Personal Physician" and the certification requirements, which must be met in order to hold this position. Targeted projects and programs will train/retrain qualified doctors for the position of "Personal Physician". As a result, doctors working in the primary health care sector within the framework of state (budget) programs will be replaced by General Practitioners" contracted by insurance companies.

The state will group the settlements/geographical area of Georgia and create a list, which will reflect: 1. High density settlement; 2. Medium density settlement/group of settlements; 3. A group of low-density settlements. For each type of settlement/group of settlements, the state will establish minimum ratios between the personal physician and the number of insured persons. Also, geographical distance standards for medium and low density settlements.

In the mode of public-private partnership, the state in medium and low density zones provides the transfer of the relevant building to the insurance companies, where the work space of the personal physician and other relevant personnel will be located, and the insurance companies themselves provide the appropriate inventory and personnel activities. The state will set minimum inventory requirements.

In the medium and especially low density zones, the state will provide salary supplements for the personal physician and support medical staff hired by the insurance company (within the number specified in the norms). These supplements will be 30% of the salary set by the insurance company in the medium density zones and 70% - in the low density zones.

The state provides guidelines and protocols for personal physicians and other staff, training projects and certification within continuing medical education, at no additional cost to insurance companies.

Task 2.2. Identify a clear role for primary health care under universal health insurance (including the role of a key Gatekeeper for beneficiaries) and a significant increase in the role for the outpatient sector.

The basic insurance package approved within the framework of universal health insurance and its conditions provide for the important role of a personal doctor as a "gatekeeper". This means that the personal physician regularly holds information about the health of the insured person. If necessary, the personal doctor is the first link for the insured person, who provides referral of the insured person to the relevant specialist/medical service provider and subscribes to electronic prescriptions. Also, it is the personal doctor who gathers the information about the medical services and medical treatment received by the insured person, on the basis of which he/she manages the insurance cases.

The universal health insurance package will include first and second level as emergency as well as planned outpatient services and relevant laboratory and instrumental examinations with appropriate limits.

This approach should substantially increase referrals, equalize the sharp difference in referrals in urban and rural areas, and increase the share of outpatient services in beneficiary health care costs. In addition, the quality assurance system of outpatient medical services will be launched. Professional resources and equipment will be provided, evidence-based medicine and guideline approaches will be introduced. Also, inclusion of the beneficiary in a single preventive/curative cycle: Primary Health Care - Specialized Outpatient Services - Inpatient - Primary Health Care. All this should be reflected in the timely detection and treatment of the disease, which should ultimately lead to an improvement in the health indicators of the population.

Strategic Goal 3 - Ensure Appropriate Standards of Access and Quality in the Delivery of Medical Services to Beneficiaries

Task 3.1. Improving and introducing a system for developing, approving and updating health care guidelines and protocols.

A register of each medical service provided under the Universal Health Insurance package will be implemented. Up to the date of introduction of universal health insurance, the existing guidelines and protocols in accordance with the services and procedures provided in the register will be updated, and if necessary, new ones will be developed and approved. The system for developing guidelines and protocols, regular updating and approval will also be improved and implemented. The guidelines and protocols used in its treatment will be integrated into the profiles of the beneficiaries in the unified electronic system of universal health insurance with reference to the relevant codes.

Task 3.2. Introduce a modern model of professional resources development in the healthcare sector, including doctors and nurses, and provide its legal framework.

A new regulation of the Professional Development Council will be developed and approved, its new composition will be staffed. The board will include representatives of insurance companies along with well-known professionals and academics. The Professional Development Council is an independent advisory and recommendation body that will be closely linked to the Ministry.

A mandatory professional development system will be introduced in the field of healthcare, which will take into account the successful models of the EU and other countries.

The professional development system will use innovative tools relevant to both traditional and modern challenges - loans, rehabilitation, recertification, licensing, incentives and sanctions. E-health resources (registration and reporting, distance learning, supervision, telemedicine, etc.) will be widely used.

A fundamental distinguishing feature of the whole new, continuous medical education system is the competence-based approach, the key feature of which is the distribution of teaching not according to traditional learning elements, but according to the essence of the target competencies, which are cognitive-methodological (ie knowledge and partial skills) and effective (skills and habits).

The development system will use components such as: indicator evaluation of the quality and results of the doctor's clinical activity, introduction of the practice of recording and reviewing medical errors, sociological evaluations and more. An electronic register of professional development will be introduced.

The Professional Development Council will work closely with the European Accreditation Council for Ccontinuing Medical Education (EACCME) to improve the quality of medical care.

To address the acute shortage of highly qualified nurses in the health sector, an action plan will be developed to ensure an adequate number and quality of nurses in the health sector. The plan reflects the promotion of training programs, motivation mechanisms, advocacy of the profession, etc.

Task 3.3. Increase the effectiveness of treatment and optimize the use of medication through the widespread introduction and control of targeted and rational drug treatment approaches; Establishment of an adequate quality assurance system for medicines and other medical products.

Rational and optimal use of medicines, which is a significant problem today, will substantially improve the expansion of diagnostic services in the planned outpatient block of the universal health insurance package and the emergence of an adequate medical treatment component. However, within the framework of the package, only on the basis of guidelines and protocols, according to the positive list, the medicine will be prescribed, and it will be purchased through electronic prescriptions.

Both in and out of universal health insurance, or in the healthcare sector as a whole, medical treatment is based on commonly recommended indications, regimens or treatment regimens, with priority given to approaches based on evidence-based medicine and successful international experience. An adequate oversight system will be established across the country for drug management.

Improving drug management in the short term will dramatically reduce the risk of irrational treatment, polypharmacy, polypragmatism, and comedicity, and the risk of resistance to anti-infectives.

There will be positive changes in terms of uncontrolled purchase of medicines and self-medication, which, in general, will reduce the costs of purchasing medicines, which are mainly paid out of pocket.

At present, patented, original medicines as well as generic medicines are sold on the pharmaceutical market. Existing mechanisms for regulating pharmaceutical activities do not ensure that all medicines purchased in a pharmacy network are of appropriate quality and effectiveness. This applies to both locally produced and imported medicines. The consumer will be mistaked and choose a generic medicine with a low quality at a relatively low price.

Legislative changes will be made to address this unresolved issue, which will determine the transition period and then enact regulations. The law prohibits the sale of a drug on the pharmaceutical market that does not comply with the quality specified in its documentation. The ultimate goal of this reform is to sell on the Georgian pharmaceutical market only those medicines and medicines that have access to the pharmaceutical market of EU countries.

The legal framework for pharmaceutical activities will be analyzed in depth and changes will be made to create more guarantees for the regulation of wholesale and retail trade in the pharmaceutical market in order to minimize the risks of oligopolistic pricing.

Task 3.4. Establishment of a special fund and support tools for the introduction of high medical technologies in Georgian clinics and for studies in accordance with international standards.

Despite the development of medical technology in Georgia (especially in some areas) there are still many segments where the technology of proper treatment is not introduced in the country and patients are treated abroad, which is associated with significant costs.

Without modern technological and professional resources in medicine, it is impossible not only to treat the citizens of the country, but also to raise highly qualified professionals on the ground, and it is even more difficult to leave their country for further work.

A fund for the development of high medical technologies will be established with funds raised from the state budget and donors. The Foundation, with the involvement of highly qualified organizations selected on the basis of tender, will study in detail the problems of medical technologies in Georgia. Analyzes statistics of people who have gone abroad for treatment and types of medical services received abroad. Based on the analytical work, a special plan will be developed for the gradual introduction of new technologies in the country. The Foundation will support research projects related to medical technology development, technology introduction and related human resource development projects based on competitions, expressions of interest, as well as private-public partnerships.

5. Strategy Implementation, Monitoring and Evaluation

The implementation of the strategy will be coordinated by the National Council for the Regulation of Universal Health Insurance established within the Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs of Georgia. The Council, in addition to the representatives of the Ministry, includes representatives of other state agencies, professional organizations in the field, educational institutions and medical institutions.

The Ministry is a leading agency in the implementation of the Universal Health Insurance Strategy in Georgia, and the National Council for the Regulation of Universal Health Insurance is the deliberative body of the Ministry.

There will be subcommittees within the National Council, including the subcommittee of positive lists of universal health insurance medicines, subcommittee on Positive Lists of Outpatient and Inpatient Services, subcommittee working on the analysis and system-adjustment of accounting and statistical data on the functioning of universal health insurance indicators and the functioning of universal health insurance. The Ministry will be empowered to create additional subcommittees as needed. The Ministry will provide organizational support for the activities of the National Council and subcommittees.

For the effective implementation of the strategy, the National Council for the Regulation of Universal Health Insurance will actively cooperate with government agencies, the private sector and civil society, which is a guarantee of efficiency, transparency and accountability.

During the implementation of the strategy, a unified monitoring and evaluation system will be developed, which will provide a unified approach and evaluation of the results of the measures implemented in the direction of a specific policy, which is important for the effectiveness of the planned measures.

The integrated monitoring and evaluation system will use pre-defined indicators that reflect the initial state, the implementation of the tasks set by the strategy and the achievement of the final goals.

The implementation of the strategy is monitored by the National Council for the Regulation of Universal Health Insurance.

The relevant structural unit of the Ministry ensures the collection of data related to the implementation of the strategy and the preparation of regular monitoring reports.

Strategy Appendix: Model Version of the Universal Health Insurance Package

#	Services provided by insurance conditions:	Co-payment	limit	Short description
1	24/7 Hotline - Provides round-the-clock telephone insurance consulting to address issues related to ongoing medical insurance.	100%	Unlimited	The insured has the opportunity to call the "hot line" operator at any time of the day (24/7).
2	Scheduled outpatient services:			
2.1	Preventive Examinations - Provides medical services based on gender and age for health check-ups without medical indications (according to the defined screening table)	100%	With age and scheme at calculated intervals	The insured applies to a personal physician who provides the insured with an application on the basis of a personal physician service.
2.2.	Primary level planned outpatient services - Provides consultation with a personal physician and key specialists (endocrinologist, gynecologist, laryngologist, neurologist, surgeon, urologist, cardiologist). The following laboratory and instrumental examinations for medical indication: electrocardiography, ultrasound and X-ray examinations, general blood analysis, general urine analysis and creatine, peripheral blood glucose, hemoglobin, fecal analysis for occult bleeding;	90%	5 000 GEL	The insured is entitled to choose the licensed service provider of the medical institution, where he / she will receive the first level planned outpatient services from the list provided in advance by the insured. The insured is consulted by a specialist doctor on the basis of a personal doctor's referral. Laboratory and instrumental examinations prescribed by a physician specialist should be agreed and prescribed by a personal physician (upon referral).

2,3	Second level planned outpatient services - Provides consultation with a specialist in medical indications, instrumental and laboratory examinations, outpatient manipulations (medical manipulations when the patient does not stay in bed at the clinic) and diagnostic manipulations when the patient's stay in the clinic does not exceed 1 bed-day. Laboratory and instrumental examinations related to planned surgical hospitalization.	90%	5 000 GEL	The insured person applies to a personal doctor for second level outpatient services. The personal physician provides the insured with referrals to the company's provider clinics. Laboratory and instrumental examinations prescribed by a physician specialist should be agreed and prescribed by a personal physician (upon referral).
2,4	Care service - includes post-hospital care/ home visit of the nurse within 14 days of hospitalization	90%	5 000 GEL	The insured applies to a personal physician who provides the service to the insured.
2.5	Medication - Provides the medication needed for outpatient treatment	90%	5 000 GEL	The personal doctor prescribes the prescription of the relevant medicine electronically, thus the insured in the provider's pharmacy chains pays the share of the cost of the prescribed medicine only provided by the insurance conditions. Drug therapy is produced according to the approved and annually updated national protocol and the positive list of medicines included in it.
3	Emergency outpatient services - includes positively defined medical services for the following conditions. In addition, the service must be provided to the insured within the first 24 hours after the accident and should not exceed 1 bed-day (1 bed-day - overnight service in a hospital).	100%	unlimited	The insured or other interested person must inform the hotline of the insurance company before receiving the service. The notification must contain the following information: name of the insured, surname, ID card number, name of the medical institution, time of application to the medical institution.
4	Inpatient care - provides conservative (therapeutic) and surgical services for an insured patient in a medical facility with a relevant hospital service license, including intensive care, resuscitation, diagnostic manipulations, and medication treatment for more than 1 bed-day. (Bed-day - medical services received in a hospital-type medical facility during the patient overnight stay).			The insured is entitled to choose the licensed medical institution from the list offered to him by the insurance company.
4,1	Emergency Hospital Services - Provides for the necessary medical measures (Medications, diagnostic manipulations, therapeutic and surgical treatment) related to the deterioration of the insured's health condition, in case of which the insured's death, disability or significant deterioration of the health condition is inevitable in case of a delay of more than 24 hours; and which will be provided to the insured in the medical facility so that the patient stays in bed at the medical facility for one bed-day or more.			The insured or other interested person must inform the hotline of the insurance company before receiving the service. The notification must contain the following information: name of the insured, surname, ID card number, name of the medical institution, time of application to the medical institution.
4.1.1.	Emergency (critical) hospital services - life-saving hospital services with simultaneous resuscitation. Intervention begins within minutes of a decision being made.	100%	70 000 GEL	
4.1.2.	Urgent hospital care - Acute onset and/ or clinically deteriorating hospital care for life-threatening conditions when medical care begins no later than the first 24 hours after the occurrence of an insured event.	100%	70 000 GEL	

4,2	Scheduled Hospital Services - Provides in-hospital services (medications, diagnostic procedures, therapeutic and surgical treatment, standard, intensive (postoperative ward costs) services) as prescribed by a physician with appropriate medical indications. It is planned within a few days after the accident, at a time convenient for the patient, the doctor and/or the medical institution.	90%	50 000 GEL	The insured is entitled to choose the licensed service provider medical institution from the list offered to him by the insurance company. The insured must submit complete documentation on the planned hospitalization to the insurer at least 20 working days before the date of hospitalization; In order to receive services in the company's clinic, the insurer issues a letter of guarantee, on the basis of which the insured is exempted from paying the reimbursable share by the insurer of the amount provided by the insurance condition in the relevant service.
5	Day Hospital / One Bed-Day Hospital Services - Provides emergency and scheduled day hospital (day hospital services - services that are conducted in a licensed medical facility so that the insured stays in bed) and one-day hospital (one-day hospital service - a service conducted in a licensed medical facility so that the insured stays in bed with medical testimony for no more than 1 bed-day) services.	90%	10 000 GEL	The insured is entitled to choose the licensed service provider medical institution from the list offered to him by the insurance company. The insured must submit complete documentation on the planned hospitalization to the insurer at least 10 working days before the date of hospitalization; In order to receive services in the company's clinic, the insurer issues a letter of guarantee, on the basis of which the insured is exempted from paying the reimbursable share by the insurer of the amount provided by the insurance condition in the relevant service.
6	Oncology - provides for the reimbursement of the cost of diagnostic tests required for benign and malignant oncology and treatment services (other than surgery) at appropriate medical indications (including radiation and chemotherapy, hormone therapy, as well as examinations and treatments related to these procedures).	100%	50 000 GEL	In the case of radiation, radiotherapy, chemotherapy, adjuvant therapy, monoclonal antibody therapy and therapeutic hospital services, see. Action during scheduled hospital services; In case of hormone therapy and treatment with drugs acting on bone resorption, see Occurs during medication treatment.
7	Childbirth - includes physiological childbirth, caesarean section with medical indications, medical services for complications of childbirth and / or after bedtime complications (medications, manipulations, ward (standard, resuscitation, intensive), analgesia with medical indications). In addition to postpartum sepsis, a critical (life-saving) condition, ectopic pregnancies that include emergency hospital care.	100%	500/800 GEL	On the basis of the notification, the insurer issues a letter of guarantee to receive services at the company's clinic, on the basis of which the insured is exempted from paying the reimbursable share by the insurer for the amount provided by the insurance condition in the relevant service. The insured must submit complete documentation on the planned caesarean section to the insurer at least 3 (three) working days before the date of the planned caesarean section; In case of unplanned caesarean section - 1 day before discharge from the maternity hospital.

Part II - Basic Analytical Materials of the Draft Recommendations

Chapter 1. Current State of the Health Care System

1.1. Healthcare Strategies and Universal Healthcare

The universality of health care means that each person has access to the necessary medical care at the place and time where it is needed, without any financial difficulties. All of this covers the full range of basic medical services, from health promotion and prevention to treatment, rehabilitation and palliative care[26].

On February 21, 2013, the Government of Georgia defined universal health care as the main direction of the country's health policy[27], which was accompanied by an unprecedented increase in the volume of state allocations for the health sector (2012 - 424 million GEL, 2018 - 1 056 million GEL, 2021 – up to 1 600 million GEL) and The process of introducing and further expanding the Universal Health Care (UHC) program.

Although the legal form of the UHC program does not differ from other state health programs operating over the years, due to its political and strategic importance, special emphasis is placed on it.

The UHC program replaced the previous government's state program, which operated in the country from 2008 and remained the main major funding mechanism for health services until 2013. This program was based on the insurance model. The state subsidized the cost of the health insurance package for the priority groups by 100%, as a result of which the insured families received the services provided by the state, which were administered by private insurance companies. The program accounted for 45% of the 2011 total health budget[28].

Since September 2012, this program has expanded to include all retirees, children under the age of 6, students and people with disabilities (additional 800,000 people). The program covered about 45% of the population. This expansion was accompanied by deteriorating annual limits on drug funding, as well as the introduction of 10-20% co-financing for ambulance, hospital, elective surgery, oncology and obstetrics services. In addition, the rest of the population, which included the main employed population, could only benefit from vertical state programs, which in effect meant that they were not insured by the state in terms of managing emergency and planned somatic conditions.

As mentioned above, since February 2013, the new government has radically changed its health policy, introducing a bold program with the clear goal of establishing a universal healthcare approach in Georgia.

The so-called minimum package, which included basic primary health care and some diagnostic outpatient services (20-30% out of pocket), as well as emergency care (up to 15,000 GEL), became available to the population. Medical services were administered first by LEPL Social Services (2013-2020) and then by LEPL National Health Agencies and not by private insurance companies. All of this has led to a fundamental change in the approach to financing the health care system.

At the initial stage of implementation, the beneficiaries of the universal healthcare program became persons with a Georgian citizenship document, a neutral ID card, and a neutral travel document. Also, stateless persons with status in Georgia, persons with refugee or humanitarian status and seeking asylum.

The minimum package, introduced in 2013, was further expanded to include more services under the Universal Health Care Program.

As of May 2017, the highest-income segment (1.2% of the population) was excluded from the universal health care program on the grounds that they could purchase voluntary health insurance.

As of today, the UHC program is open to all citizens and asylum seekers who are uninsured and earn less than Rs 40,000 per year.

According to official statistics, UHC program services cover more than 95% of the population, based on the number of people registered with primary health care providers.

As of today, the benefits package is differentiated according to the following categories of the population, some of which are based on the rating score given by the Social Service Agency:

26 https://www.who.int/health-topics/universal-health-coverage#tab=tab_1
27 https://matsne.gov.ge/ka/document/view/1852448?publication=0
28 UNICEF, 2012

1. Families living below the poverty line (with a rating of <70,000), People's Artists, teachers, children in foster care, IDPs;
2. Persons with disabilities, children under 5, schoolchildren and pensioners;
3. Uninsured veterans;
4. Low-income citizens (with a rating score of 70,000-100,000) and children aged 6-18;
5. Other citizens below retirement age with higher income:
   a. Those who earn less than 1000 GEL per month or have irregular income/self-employed;
   b. Those who earn less than 40,000 GEL a year, but more than 1,000 GEL per month;
   c. Who earns more than 40,000 GEL a year.

The highest-income group (with an income of more than GEL 40,000) in 2020 was around 66,000 people and they are excluded from the Universal Health Care Program. However, they still enjoy selected services covered by universal healthcare and vertical program services, on a co-payment basis.

1.2. Effectiveness of the Universal Health Care State Program

Successful management of a health program of this scale is virtually impossible without an adequate system of monitoring and evaluation. The accounting mechanisms used under the program, in particular the number of cases, are insufficient to assess the effectiveness. Consequently, it is impossible to determine the quality of medical care provided to the population. It is also unknown how positively the increased funding from the state has affected the health of the population, except for some indicators of increased utilization. Official statistics related to the program in this regard are also very scarce. For example, the National Health Report for 2017 has not been published at all.

In such circumstances, the effectiveness of the UHC program can be assessed according to international project and mission protocols, based on unit research results, indirect approaches, and expert evaluations.

As of 2021, the UHC program covers scheduled outpatient (including certain primary care services), emergency outpatient, and scheduled surgical services. As well as oncology (chemotherapy, hormone therapy and radiation therapy and examinations and medications related to these procedures) and treatment of infectious diseases, childbirth and caesarean section.

Although outpatient services are included in the list of services, and one of the essential components of modern health care - primary health care - is prioritized by the government of the country[29], the real situation is completely different.

Beneficiaries of the program are provided with primary health care services according to the UHC and Rural Physician (see below) program.

Numerous reports on the numerous weaknesses of primary health care in Georgia, first of all, the absence of the most important function of the "gatekeeper"[30].

The WHO and other documents state that poor utilization of PHC services is facilitated by unhealthy incentives in the health care system that motivate primary care providers to refer patients to their hospital instead of PHC-level retention. The focus is on the shortcomings of existing methods of reimbursing services that are not related to outcomes and measurable indicators.

Referrals to both outpatient and inpatient settings have increased dramatically since the launch of the UHC program. In 2020, the number of referrals for outpatient services per capita did not change[31] compared to the previous year (Table 1.1.). However, this figure is still low, as the average of the countries of the European region of the WHO is 6. In addition, in EU countries where there is a successful healthcare system and strong primary health care, this indicator is even higher. From the material presented in the statistical reference, it is impossible to determine the direct share of the service of the primary health care physician, not to mention the so-called rural doctors.

Table 1.1. Outpatient Number of Doctor Visits and Ambulance Calls Per Capita, Georgia

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Visit to doctor	1.8	1.8	2.1	2.4	3.1	3.4	3.4	3.0	3.2	3.6	3.6
Call an ambulance	0.2	0.2	0.2	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.3

29 https://matsne.gov.ge/ka/document/view/2657250?publication=0

30 WHO, Quality of Primary Health Care in Georgia, 2018, გვ. 52, geo-qocphc-eng.pdf (who.int); Welfare Foundation, Georgian Open Society Foundation, Weak Primary Health Care - A Barrier to Universal Access to Health Care, 2020;44 გვ; https:// (osgf.ge);
WHO, Health system, research in Georgia, 2017, გვ. 44 https://www.who.int/alliance-hpsr/projects/primasys/en/
Georgian Healthcare Barometer XII Wave, http://curatiofoundation.org/ge/projects-and-publications-ge/

31 National Center for Disease Control and Public Health, Health Care, Georgia, Statistical Reference,,2020
https://www.ncdc.ge/#/pages/file/ebe72ea5-5087-4dc3-aaf1-c94cda232ad2

Given that the provision of PHC services to the rural population is part of the Rural Physician Program with a number of problems (see below), the situation is even more dramatic. That is, a significant portion of the country (approximately 40%) lacks full-fledged UHC services.

It should be emphasized that there is no coordination between the two programs (UHC and Rural Physician Programs), which serve a common priority - primary health care.

The main reason for the low utilization of the services of the planned outpatient component of the UHC program is the orientation to inpatient care of the program, another manifestation of which is the modest assortment of instrumental and clinical-laboratory examinations.

This issue is even more serious for those earning less than 40,000 GEL per year and 1000 GEL or more per month, as the universal health care program does not provide for their planned outpatient services (specialist consultations, instrumental and clinical-laboratory examinations) at all. This means that at least 1.5 million people under the UHC program are deprived of planned specialized outpatient services (Including persons to who receive income more than 40 000 GEL per year).

Health expenditure analysis (2012–2018) also indicates that outpatient services do not have a proper place in the UHC program. Although public spending on outpatient care has doubled during this period, the share of outpatient spending on public health care has not actually changed since 2016, accounting for only 1/4 of all public health care spending. This is at a time when spending on hospital services has been on the rise, accounting for about 2/3 of all public health spending since 2015. In the period 2013-2017, the share of the state in total expenditures on outpatient services, prevention and public health was 43.3%, and on inpatient services in total expenditures - 71%[32]. Despite a solid increase in state funding for health care, out-of-pocket payments over outpatient services still outweigh the costs (48.4%), which is a heavy financial burden.

Adequate medication treatment is a very serious and still unresolved problem in Georgian healthcare. The share of medication treatment in the outpatient component of the UHC program, especially in the early stages of its introduction, was meager. To compensate for this serious backlog, a state program for the provision of medicines for chronic diseases was launched in April 2017. However, the potential of this program is quite limited and it is designed for groups of beneficiaries with specific diseases (see below). All of this means that a very large proportion of UHC program beneficiaries lack adequate medical treatment in terms of planned outpatient services.

From 2014 to date, the increase in prices for both outpatient and inpatient services has been permanent.

This primarily concerns medicines and outpatient care, which is a heavy burden for the population, as the largest share of this type of expenses comes from out-of-pocket payments. This medication problem is addressed in a report by the World Health Organization[33].

It is true that this report is based on 2015 data, however, with later assessments the situation is even more dramatic[34]. WHO estimates that approximately 14% of the population suffers catastrophic expenditures on health care, with over 60% of out-of-pocket payments on medicines.

According to the National Health Report, the expenditure on medicines of the population is 687 million GEL (2016), Then it raised more and reached to about 1 Billion GEL.

The state program for the provision of medicines for chronic diseases, introduced in 2017, could not significantly improve the situation either. Moreover, it is known that the 13.4 million GEL allocated for this program (which is only 2% of the out-of-pocket payments for medicines) could not be fully spent in the period 2017-2018.

It is unclear what administrative costs are associated with the management of the UHC program by the state structure, how the management effectiveness is assessed and what the results are. Also, how correct is it that the management of a program of this scale and the administration of its medical services is practically done by one agency.

1.3. Vertical State Health Programs in the Context of Universal Coverage

In addition to the universal health care program, there are 23 targeted state programs and sub-programs in the country (7 in the referral service program). Some programs have an adequate component of management, monitoring and evaluation (state programs for the elimination of hepatitis C, HIV/AIDS and tuberculosis, as well as immunization). It should be noted that the vast majority of these programs are in the format of international partnerships (CDC, USAID, WHO, GFATM).

32 International Foundation Curatio, Healthcare Challenge - Georgian Healthcare Barometer XII Wave http://curatiofoundation.org/ge/projects-and-publications-ge/

33 Can people afford to pay for health care? New evidence on financial protection in Europe (2019) https://www.euro.who.int/en/publications/abstracts/can-people-afford-to-pay-for-health-care-new-evidence-on-financial-protection-in-europe-2019

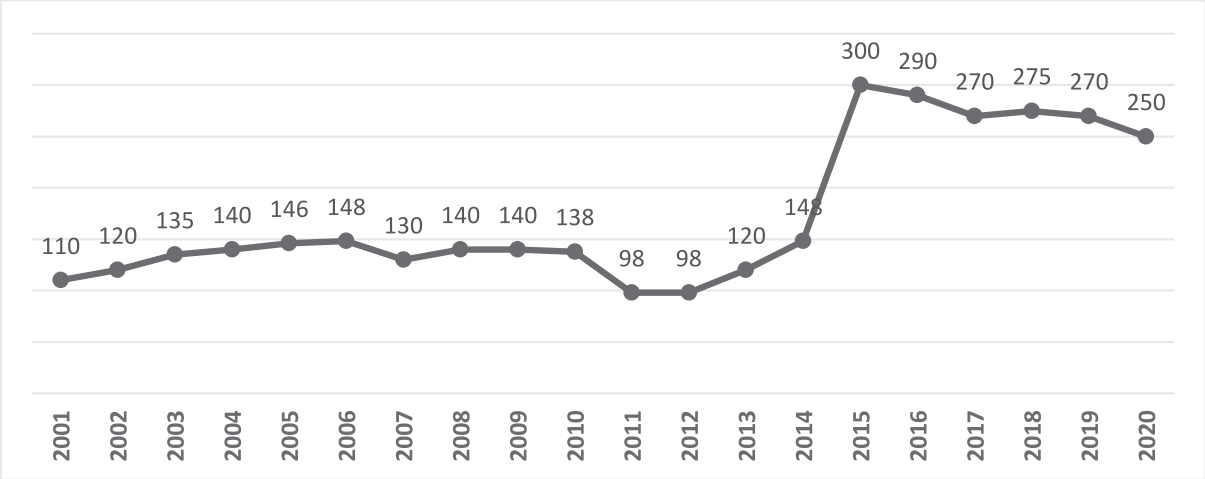
34 https://apps.who.int/iris/bitstream/handle/10665/342814/WHO-EURO-2021-2532-42288-58479-geo.pdf?sequence=1&isAllowed=y

Unfortunately, the vast majority of other programs lack the necessary components of management and especially monitoring and evaluation, which means that there is no tool for a thorough evaluation of their effectiveness, so they can only be evaluated by indirect approaches, unit surveys or evaluation mission protocols.

State Program for Early Detection and Screening

Numerous epidemiological data confirm that preventive medicine has not been given the most important place in the country's healthcare, which primarily concerns non-communicable diseases. One of the most visible examples of this is the data of the Cancer Population Register introduced in 2015 to improve the control of oncological diseases, according to which the epidemiological situation in the country is serious (Chart 1.1).

Chart 1.1. Malignant neoplasms, incidence per 100,000 population (NCDC 2020)



In 2015-2020, 41.6% of new cases of cancer of all localizations were registered in stages I and II of the disease; The share of diseases registered in stages III and IV is still high (41.4%) (Table 1.2.).

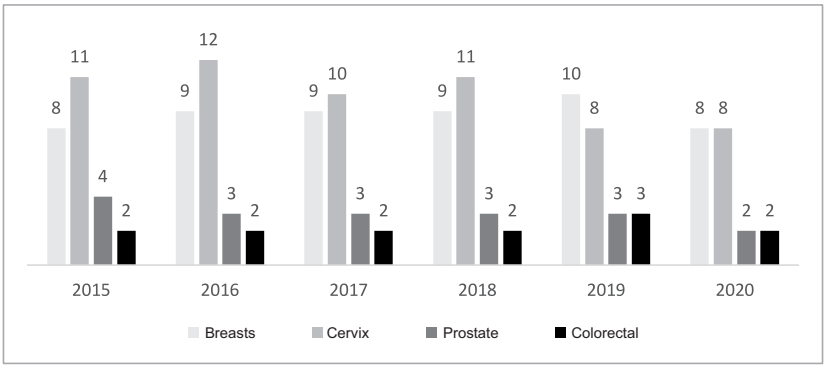
Table 1.2. Distribution of New Cancer Cases by Stages (%), Georgia (NCDC 2020)

Stage	2015	2016	2017	2018	2019	2020
I	21,1	23,9	23,6	24,4	24,7	22,1
II	20,9	18,4	18,0	16,9	18.3	19,5
III	21,5	20,0	20,0	18,7	19.7	17,9
IV	26,5	25,5	25,5	24,0	21,2	22,6
Unidentified	10,1	12,2	12,2	16,0	16,1	17,9

All of this points to the late diagnosis of cancer and the inadequacy of its early detection.

Weaknesses of the state program for early detection and screening of diseases: (Chart 1.2.)

Chart 1.2. Cancer screening rates for the target population (%), Georgia



State Program for the Provision of Medicines for the Treatment of Chronic Diseases

The state program for the provision of medicines for the treatment of chronic diseases has been operating since 2017, the implementation of which until 2021 was the LEPL Social Service Agency under the control of the Ministry, and from 2021 - the LEPL National Health Agency. The goal of the program was to improve the provision of medicines for some chronic diseases by increasing financial access. In 2017, the beneficiaries of the program were individuals who were registered in the "Unified Database of Socially Vulnerable Families" and the rating score assigned to them did not exceed 100,000.

From August 2018, the beneficiaries also became elderly retirees and children with disability status. As well as persons with severely or significantly pronounced disability status. From September 2019, the program also includes veterans of the program, who purchase medicines at a symbolic price - 1 GEL, like the population of retirement age, children with disabilities, as well as people with severe or severe disabilities and the socially vulnerable[35].

Services provided by the program included procurement of medicines and logistics services for the treatment of chronic diseases such as: chronic cardiovascular disease, chronic lung disease, diabetes (type II), epilepsy, Parkinson's disease, thyroid disease.

It should be noted that targeted and rational treatment of the vast majority of chronic diseases requires several groups of medications, which is not possible with the list of this program, not to mention the possibility of drug selection, which is a fairly common necessity of medical treatment. The list of medicines for the users of the rural doctor program is very small. And most importantly, without the actual involvement of a physician (primarily a PHC physician), the practice of “handing out drugs” is a negative experience because it involves a number of potential risks.

The State Audit Office conducted a program compliance audit (1.01.2017 –01.01. 2019 period), which identified a number of serious shortcomings[36]. In particular, the mechanisms developed by the Ministry and the Agency do not ensure the availability of medicines to the beneficiaries (only 9%), do not fully control the expiration dates of the medicines, and do not measure the outcome and evaluate the effectiveness of the program.

Since 2021, there has been a kind of integration of the state program of provision of medicines into the universal health program and the National Health Agency has become responsible for the management-coordination of these two programs. No significant changes were made to the medication component, except that the medication procedure was made easier for the beneficiaries. The list of medications and annual limits are still limited and, most importantly, due to the weak planned outpatient component of the UHC program, medication therapy still lacks the much-needed medical monitoring.

State Program of Rural Physician

The main goal of the state program of rural doctors, which was launched in 2009, was to increase the availability of primary health care services to the rural population (primarily geographical). According to official statistics, this program should cover 40.1% of the country's population with PHC services.

Until 2019, the program was managed by the LEPL Social Service Agency, which signed a contract with a natural person - a village doctor/nurse. Since 2009, rural doctors have been entrepreneurs/individuals, mostly located in state-owned dispensaries, municipal-owned buildings, and sometimes even their own homes. Polyclinics and dispensaries at the municipal level are integrated into medical centers/hospitals. However, most PHC service providers in large cities have been privatized.

According to the current model of financing rural doctors, the state will procure medical services from a natural person/ individual entrepreneur - a rural doctor. At present, part of the property of the outpatient clinic is state-owned (they are managed by the Ministry of Economy and Sustainable Development), part has been transferred to the municipalities, and part is privately owned. Several local missions and international surveys conducted in recent years have identified a number of shortcomings in terms of program design, administration, funding, and monitoring[37]. In particular:

- Narrow area of primary health care coverage due to unequal distribution of medical facilities and quantitative or functional shortage of medical staff;
- Low productivity and efficiency of medical staff;
- Inadequate program funding model;
- The practice of combining low-wage rural doctors into another service;
- Difficulties in finding local staff (nurses) and shortage of nurses in general;
- Lack of system necessary for professional development;

35 http://ssa.gov.ge/index.php?lang_id=&sec_id=1291

36 Audit report of the state program for the provision of medicines for the treatment of chronic diseases; Compliance Audit Period: 2018, 2017, https://www.sao.ge

37 WHO, Quality of primary health care in Georgia, 2018, p. 52 geo-qocphc-eng.pdf (who.int)
Welfare Foundation, Welfare Foundation, Georgian Open Society Foundation, Weak Primary Health Care - A Barrier to Universal Access to Health Care, 2020; p. 44 https:// (osgf.ge); Audit of the effectiveness of the state program of rural doctors, 2015. P. 66; Special Report of the Public Defender of Georgia Monitoring the Access to Primary Health Care for the Population within the State Program «Rural Doctor», https://www.ombudsman.ge/res/docs/202007161314214495 9.pdf;

- Lack of tools necessary to evaluate the effectiveness of the program;
- Difficulties in establishing adequate working conditions in a large number of doctor's service points;
- With rare exceptions, shortage of IT equipment and well-functioning software and lack of internet.

In the report published by the World Health Organization in 2018 - "Quality of Primary Health Care in Georgia", an extensive package of measures and regulations was offered to solve the identified problems.

From November 2019, a change was made in the Rural Physician program and its administration function was transferred to LEPL Emergency Situations Coordination and Urgent Assistance Center. The same center was tasked with purchasing essential medicines and medical supplies for outpatient clinics, a doctor's bag, medical documentation printing services, medical waste management services, and/or containers and a rural doctor/nurse uniform.

The recommendations of local organizations, some actions taken by the government to rectify the situation did not achieve the desired result, because the proposed recommendations were largely ignored, and government interventions were cosmetic and, consequently, systemic. As a result, 40% of the country's population is deprived or only partially receives the basic health care services it needs.

1.4. Healthcare Professional Resources and their Development

Systematic analytical research related to professional resources in the healthcare sector of Georgia is a unit, and the statistical information on some of the most important issues is incomplete.

In the first years of independence (1991-1995)[38] the number of doctors in Georgia sharply decreased (3.2 per 1,000 population). However, an upward trend was soon observed[39]. The number of doctors has been growing sharply since 2006 and currently significantly exceeds similar indicators in EU countries (for comparison per 1000 population: Georgia - 5.94 [2020], France - 3.3, Netherlands - 2.4, Estonia - 3.47, Slovakia - 3.2 - [2019])[40].

For several years now, due to the abundance of doctors, the distribution in their country has been unequal: Tbilisi, where about 30% of the country's population lives, has about 15,000 doctors, and the rest of the country - about 8,000. Against the background of the surplus of physicians and the low consumption of mostly outpatient services by the population, the productivity of physicians is low in both the hospital and outpatient sectors[41].

An average of one hospital doctor treats 42 patients a year (2016), which is 2.5-3 times less than in EU countries (2017). In the outpatient sector, 1 physician serves an average of 1,062 patients per year (an average of four per day). For comparison, 104 in Hungary and 116 in Germany[42], or almost three times more a day.

The country's healthcare system suffers from an acute shortage of qualified nurses with a modern concept of nursing. More than 20% of the nurses employed in the field have already reached retirement age in 2015[43].

The already small number of nurses in the 1990s declined dramatically in the following years (1996–2007), and despite a recent growth trend, their number is still low (22,126 totaling 5.94 nurses per 1,000 population [2020]) and lags significantly behind similar figures in EU countries. For comparison, in the Netherlands, the Czech Republic, Estonia and France respectively 7.8; 8.56; 6.2 and 11.1 per 1,000 population (2019)[44].

The health care of a country with a similar population of Georgia, taking into account age seeding and biological losses, needs to be replenished with about 1,200 nurses each year. An imbalance is also noted in the geographical distribution of nursing human resources. The main mass of nurses is gathered in the capital, where 2 doctors per 1 nurse. In some municipalities (Racha-Lechkhumi-Kvemo Svaneti; Mtskheta-Mtianeti) the nurse / doctor ratio is higher than the Georgian average (0,8 [2016])[45]. According to 2020 data, this proportion is 0.87. For comparison, the average rate in European countries is 2.4 (2018).

One of the most important (with a few exceptions) of the many reasons for the decline in the number of nursing staff is the lack of financial motivation, which primarily concerns the primary health care ring. Continuous and growing migration from rural to urban areas[46] and a number of problems with the primary health care system (including the rural doctor program) are exacerbating the shortage of nurses in the regions. Another important reason for the decrease in the number of nursing staff is the non-prestige of this profession. According to a sociological survey, more than half of physicians, managers, and even nurses consider nursing to be non-prestigious. However, both medical and non-medical communities in the same country have a lack of knowledge about the nature of the nursing profession and its functions.

38 National Center for Disease Control and Public Health, Health Care, Georgia, Statistical Reference,1996
39 National Center for Disease Control and Public Health, Health Care, Georgia, Statistical Reference, 2010–2019
40 European Health Information Gateway :https://gateway.euro.who.int/en/
41 International Foundation Curatio, Georgian Healthcare Barometer X Wave, 21.06.2019, http://curatiofoundation.org/wp-content/uploads/2018/03/HRH_Barometer-10.pdf
42 Organisation for Economic Co-operation and Development (OECD) iLibrary , https://www.oecd-ilibrary.org/statistics
43 International Foundation Curatio, Georgian Healthcare Barometer X Wave, 21.06.2019, http://curatiofoundation.org/wp-content/uploads/2018/03/HRH_Barometer-10.pdf
44 European Health Information Gateway :https://gateway.euro.who.int/en/
45 International Foundation Curatio, Georgian Healthcare Barometer X Wave, 21.06.2019, http://curatiofoundation.org/wp-content/uploads/2018/03/HRH_Barometer-10.pdf
46 Government Commission on Migration Issues of Georgia 2019 Migration Profile, 2020

According to research conducted in 2015-2017, nursing professions are not in demand professions. Low financial access to undergraduate degree programs in nursing also plays an important role in reducing the number of nursing staff[47].

Nursing is not a regulated profession and there is no system of continuing education for nurses, which has a negative impact on both the prestige of the profession and the qualifications of nurses. The Government of Georgia, although very late, still saw the scale of the problem and the expected risks, and in response to them approved Resolution №334 (July 16, 2019)[48].

Table 1.3. Professional Resources, Georgia, 2020

Total number of doctors (including dentists)	25 429
Doctors per 1 000 population	6,83
Doctors involved in medical practice *	20 379
Doctors involved in medical activities per 1,000 population *	5,47
Nurses	22126
Nurses per 1 000 population	5,94
Visit to the doctor	12 807 695
Doctors home visits	152706
Number of village doctor (individual)	1264

Note: Does not include: Dentists, maxillofacial surgeons, physicians working in administration and research, as well as unemployed, retired and physicians working abroad.

The goal of **the Nursing Development Strategy** is to "improve the quality and accessibility of health services by establishing a sustainable system of qualified human resources in the field of nursing and establishing a sustainable system of professional regulation." This document, which seems to have been developed by qualified professionals, is a better project than a concept, as the relevant interventions/ activities in this strategy are not sufficient to address the shortage of nurses and qualification problems in a timely manner. Moreover, there seems to be no connection with the necessary systemic changes (if the government sees it) that, even in terms of professional resources, will actually contribute to the establishment of a quality assurance system for medical services.

According to Resolution 334, the strategy is in its second year of implementation and it is interesting to see how far the target parameters set by the project monitoring and evaluation component have been achieved. However, unfortunately, there is no information about it.

Ensuring the quality of medical services in Georgia is the prerogative of the Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs. The Ministries of Education and Health are responsible for the coordination and quality of undergraduate and postgraduate medical education.

15 institutions participate in the implementation of the 6-year training program for certified physicians, and in the field of postgraduate medical education - public / private educational and private medical institutions.

According to a study by the International Foundation Curatio, 684 Georgian students graduated from the 6-year graduate program in 2016, which means that the number of new graduates per 100,000 population is twice the EU average.

Quality assurance in postgraduate medical education is ensured through institutional and program accreditation. Medical institutions and/or schools are accredited to participate in residency programs. This process is regulated by the State Agency for Regulation of Medical Activities. Based on pre-defined criteria, the readiness of the institutions is assessed and a quota is set, within which the institution will be able to provide quality education to the applicant.

The system of continuous professional (medical) development (CPD), despite numerous shortcomings, has existed in the reality of independent Georgia for only 4 years (2001-2004).

Professional development, which is a systemic component of quality assurance of medical services[49], is complete when there are adequate tools and mechanisms for objective monitoring/evaluation of the professional activity of the physician and his/her professional development.

At present, it can be said that there is practically no system of continuous development of doctors in the country[50], because:

47 https://matsne.gov.ge/ka/document/view/4617071?publication=0
48 https://matsne.gov.ge/ka/document/view/4617071?publication=0
49 Accreditation Council for Continuing Medical Education https://www.accme.org/ Continuing Medical Education in Europe: Evolution or Revolution? Published by MedEd Global Solutions, May 2010 [www.continuingmedicaleducation-europe.com]
50 G. Beria, V. Surguladze, T. Giorgadze, Health Policy, Economics and Sociology 2019; 5 (2) (used in Georgian)

- There are numerous inconsistencies in the legislative framework related to the issue;
- A doctor who obtains a certificate of independent medical practice for the rest of his / her life engages in continuous professional development activities only of his / her own free will, which is considered by the law to be an integral part of a doctor's activity. However, the law does not impose any sanctions for non-fulfillment of this obligation;
- The standard of continuing professional development is vague - there are no specific requirements for CPD providers and the list of continuing education programs is narrow;
- The continuous professional development of nurses is ignored.

There is currently a mandatory CPD system in 28 EU countries. In Georgia, the situation is as follows - the bachelor's program for nurses is implemented by 5 institutions in Georgia, and the program of practicing nurses is implemented by 20 professional colleges.

According to the research of the International Foundation Curatio, 23 Georgian students graduated from the bachelor's program in nursing in 2016. They do not include the number of vocational college graduates due to lack of access to data.

According to government sources, 99 students successfully completed the undergraduate program in 2019. According to the expert assessment of the same source, about 350 students graduate from the vocational college every year.

The rejection of personnel strategies in the health sector, and the subsequent passivity in this area, further deepened the problem that arose in the Soviet period. In the healthcare system, as of today, there is a shortage of doctors as a whole, and in the municipalities - a shortage of certain specialties. The scarcity of qualified nurses and the unequal geographical distribution of physicians have a serious negative impact on the quality of medical care. The current professional development model in the country is weak and inadequate for today's challenges, its first component - non-formal continuing education, is legally flawed. Also, to date there is no system for professional development of nurses.

1.5. Population Health and Well-being According to UN Sustainable Development (SDG) indicators

The analysis of the 14 indicators of the №3 Sustainable Development Goal, despite progress in a certain direction, shows a number of negative trends in the social sphere of the country and specifically in healthcare (Table 1.4.).

Table 1.4. Georgia - SDG №3 Indicators[51]

N	Indicators of SDG №3	Existing Rate	Long-term Target Rate
1	Maternal mortality rate (per 100 thousand live births)	25,0	3,4
2	Neonatal mortality rate (per 1000 live births)	4,9	1,1
3	Mortality rate under 5 years (per 1000 live births)	9,6	2,6
4	Tuberculosis incident (per 100 thousand population)	74,0	≤0
5	Prevalence of HIV infection (per 1000 uninfected population)	0,22	≤0
6	Age-standardized mortality rate for adults aged 30-70 years due to cardiovascular and chronic respiratory diseases, cancer and diabetes (per 100 thousand population)	24,9	9,3
7	Age-standardized mortality rate due to household and environmental air pollution (per 100 thousand population)	102,0	0
8	Road accident deaths (per 100 thousand population)	12,41	3,2
9	Life expectancy at birth (years)	73,28	83
10	Adult fertility (births per 1000 women)	45,19	2,5
11	Childbirths received by qualified personnel (%)	99,9	100
12	Number of infants, who received 2 WHO-recommended vaccinations (%)	94,0	100
13	Universal Health Coverage Index	66,0	100
14	Subjective well-being	5,1	7,6

Significant progress has been made in maternal and child health over the past decade (Table 1.4).

51 https://dashboards.sdgindex.org/

Despite years of progress in TB control, the incidence of these communicable diseases is still high (74.0). Due to this, Georgia ranks 45th in the WHO Eurasian Region Register (Table 1.4.). Georgia is among the 18 countries in the region that carry 99% of the burden of combating drug-resistant (MDR) forms of tuberculosis. All of this, as a whole, is an unequivocal proof of the inadequacy of the public and primary health care sectors.

The mortality rate for adults aged 30-70 years due to cardiovascular and chronic respiratory diseases, cancer and diabetes, often referred to as "death that should not occur", is unfortunately quite high - 24.9 (Table 1.4.). It is noteworthy that this parameter of Georgia is better than only Turkmenistan, Russia and Tajikistan in the WHO Eurasian region.

Serious problems of preventive medicine and environmental protection are indicated by the very high rate of mortality due to household and environmental air pollution (Table 1.4.).

The declared universal coverage is not fully confirmed by the value of the coverage indicator by health services (66.0) (Table 1.4.). According to this index, Georgia is only ahead of Serbia and Bosnia and Herzegovina in the WHO Eurasian region.

Although road accident mortality is only partially affected by the effectiveness of the health care system (public health, emergency medical care, etc.), its great importance (Table 1.4.) and the 45th place in the WHO list should be considered a serious challenge.

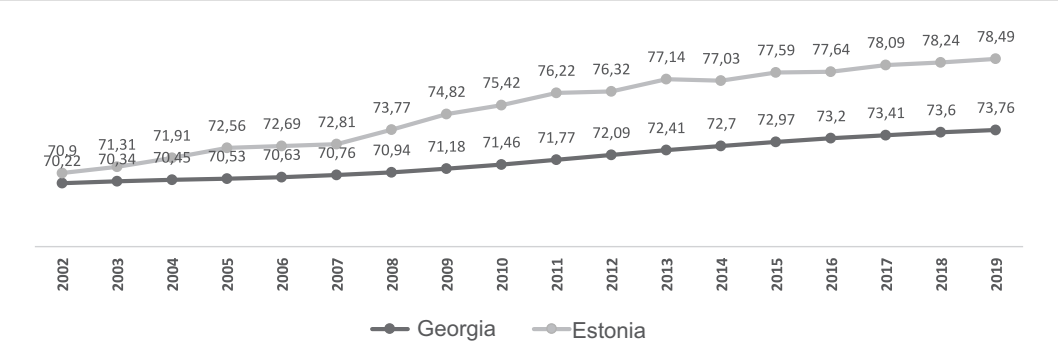
The lack of sexual culture and information of certain groups of the population is indicated by the Adult Fertility Indicator (Table 1.4.) And the 47th place in the list (the next countries are only Tajikistan and Azerbaijan).

Georgia is not in a desirable position according to the indicators of subjective well-being and life expectancy at birth (Table 1.4.). According to the Subjective Welfare Index, the country ranks second at the bottom, 48th ahead of Turkey.

Georgia is ahead of only 4 countries in the region in terms of life expectancy at birth (Table 1.4.).

It is noteworthy that at the end of the 90s these figures of Georgia and Estonia were slightly different from each other. However, 20 years later, in Estonia, which is the leader in the region in terms of social policy, the growth of this indicator is very impressive (Chart 1.3).

Chart 1.3. Life expectancy at birth in Georgia and Estonia



Data from the Institute for Health Measurement and Evaluation (IHME) of the Washington University[52] on the 10 leading causes of death in Georgia and the dynamics for 2009-2019 are presented in Table 1.5.

Table 1.5. Top 10 Causes of Death and Their Dynamics 2009-2019, Georgia

Rating	Percentage Change, 2009-2019
Ischemic heart disease	-15,30%
Stroke	-17,60%
Hypertensive heart disease	44,40%
lung cancer	10,70%
Alzheimer's disease	16,50%
Cirrhosis	-1,40%
Diabetes	22,80%
COPD	-9,70%
Breast Cancer	-5,20%
Stomach cancer	-6,60%

52 Georgia | Institute for Health Metrics and Evaluation (healthdata.org)

Chapter 2. Finances of the HealthCare System

The financial and economic viability of the existing schemes is crucial for the existence of an effective health care system and its sustainability. Over the last 30 years, the health care financing system has changed many times in the wake of reforms. In the early 1990s, state funding was virtually non-existent. Only since 1995 have real efforts been made to establish a system of medical / social insurance and, consequently, health care financing. From the first decade of the new century, steps were taken in a new direction - towards a model of mass privatization of institutions and a model focused on private insurance. At the end of the same period, the state began to provide a growing number of target groups with health services.

Since 2013, a radical change in the state's course in health care has been declared - the universal health program has been launched, which aims to fund a health package for the entire population without private health insurance. However, in recent years, there has been a problem of insufficient funding for universal coverage, which puts us in need of fundamental changes in the country's healthcare system and its funding.

2.1. Expenditures on HealthCare

Georgia's current healthcare expenditures have fluctuated between 7-8.5% of GDP each year since 2011. This figure lags slightly behind the EU average, although it is one of the highest among the countries in the region (Table 2.1.)[53].

Table. 2.1. Share of Healthcare Expenditures as GDP in Georgia and Other Countries

Countries	2011	2012	2013	2014	2015	2016	2017	2018
Armenia	9	9	10	10	10	10	10	10
Azerbaijan	2	3	3	3	4	4	4	4
Belarus	5	5	6	5	6	6	6	6
Czechia	7	7	8	8	7	7	7	8
Finland	9	10	10	10	10	9	9	9
Georgia	**8**	**8**	**8**	**8**	**8**	**8**	**7**	**7**
Germany	11	11	11	11	11	11	11	11
Netherlands	10	11	11	11	10	10	10	10
Poland	6	6	6	6	6	7	7	6
Portugal	10	9	9	9	9	9	9	9
Moldova	9	9	9	9	9	8	7	7
Russian federation	5	5	5	5	5	5	5	5
Slovakia	7	8	8	7	7	7	7	7
Switzerland	10	11	11	11	11	12	12	12
Turkey	5	4	4	4	4	4	4	4
Ukraine	7	7	7	7	8	8	7	8

Source: WHO, Global Health Expenditure Database

However, in absolute terms, Georgia's total per capita current health expenditure rate is low compared to EU countries, and close to the regional average (Table 2.2).

Table 2.2. Current Per Capita Expenditure on Health, PPP, by Country

Countries	2011	2012	2013	2014	2015	2016	2017	2018
Armenia	658	699	826	855	883	877	997	1,037
Azerbaijan	387	482	525	603	740	705	655	634
Belarus	842	939	1,047	1,026	1,121	1,076	1,095	1,132
Czechia	2,011	2,043	2,380	2,472	2,442	2,522	2,753	3,041

53 WHO, Global Health Expenditure Database.

Finland	3,773	3,917	4,069	4,084	4,099	4,212	4,340	4,457
Georgia	**583**	**637**	**660**	**707**	**693**	**778**	**735**	**796**
Germany	4,587	4,709	4,953	5,193	5,355	5,574	5,931	6,098
Netherlands	4,779	4,989	5,219	5,214	5,205	5,280	5,499	5,635
Poland	1,424	1,478	1,575	1,627	1,717	1,851	1,979	2,015
Portugal	2,549	2,467	2,529	2,587	2,659	2,972	3,084	3,242
Moldova	456	464	489	521	520	484	481	480
Russian federation	1,156	1,265	1,323	1,347	1,287	1,280	1,389	1,488
Slovakia	1,919	2,035	2,101	1,999	2,034	2,110	2,094	2,180
Switzerland	5,841	6,175	6,551	6,846	7,309	7,573	7,928	8,114
Turkey	921	923	981	1,042	1,061	1,136	1,176	1,171
Ukraine	566	605	603	597	591	597	617	683

Source: WHO, Global Health Expenditure Database

The share of health care expenditures in the state budget is characterized by an upward trend in the long run (Chart 2.1.).

Chart 2.1. Share of state expenditures on health care from total budget expenditures (%)

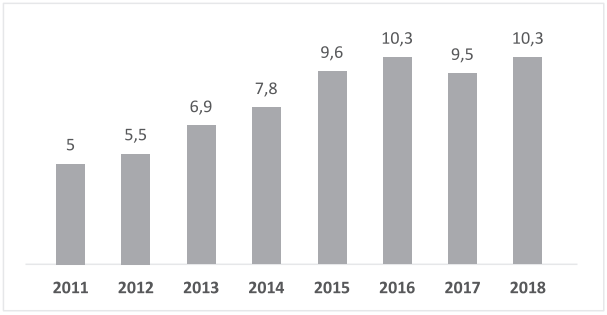
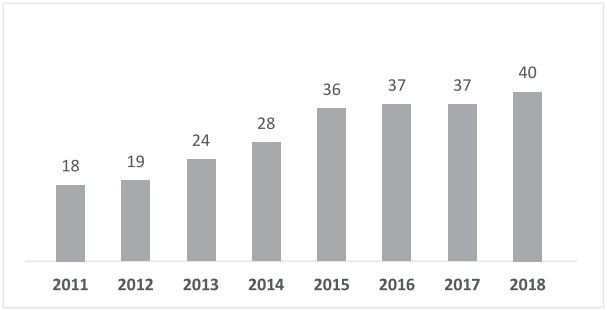


Chart 2.2 Share of government spending on health in current national health expenditure (%)



From 2011 to 2016, the health budget, as a share of the state budget, doubled (increased from 5 to 10%) and then remained at around ten percent. This significant increase was driven by a shift in overall policy priorities in favor of social spending. In addition, the low share of state expenditure as a total current expenditure on health (17.5% in 2011) has already increased to 40 percent in 2018 (chart 2.2.).

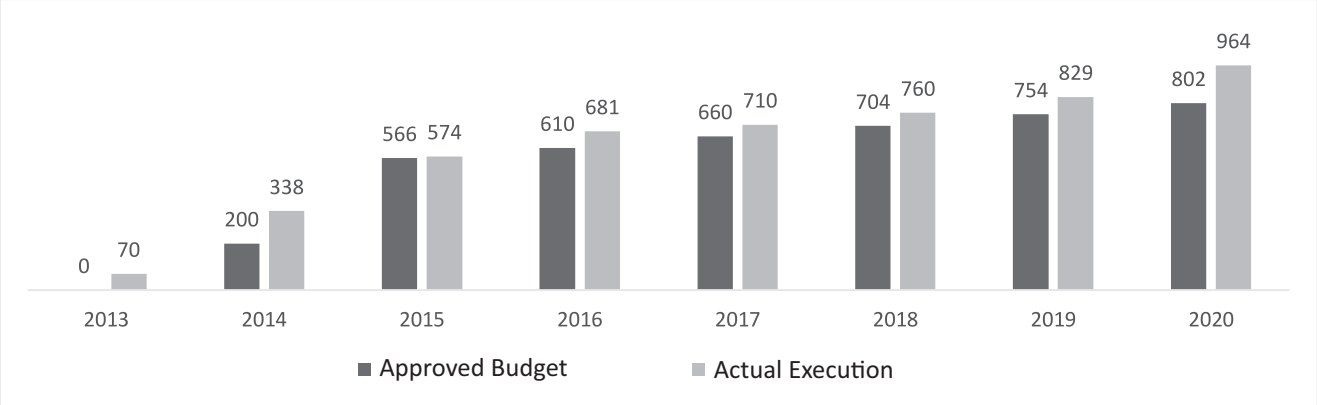
However, this achievement is still significantly lower than the WHO European Region average. It should be noted that the growth rate of this indicator has slowed down significantly since 2015. Thus, the volume of public finances for health is significantly lower than the European average, both in absolute terms and in terms of share of total national expenditure.

The surge in current spending on health care in 2013 was the result of the state covering a significantly increased portion of the population through relevant services. From this period onwards, the universal health program has been constantly dominated by public spending on health. The share of this program in 2016 was 3/4 of public spending on health. 67% of public spending on health came from hospital services and 25% from primary care[54]. These ratios did not change substantially in the following years.

It is noteworthy that in 2013 the budget execution of the universal health program was much lower than planned (69%) as the program expanded from July. Already by 2014, the costs of this program were one third higher than planned. In 2015, the budget plan increased by 39%, but the expenditures still exceeded the planned ones. The budget planned for 2016 was kept at the same level as in 2015 because of the difficult fiscal environment[55]. These overspending was largely due to a sudden increase in demand for health care from those who had not previously participated in the program. The trend of overspending on the universal health care program continued in the following years. As a result, public spending on health care is constantly increasing and uncontrollable. The budget overspending of the universal health program for 7 years (2014-2020) totaled about GEL 560 million, or 13% more than the approved budget (chart 2.3.)[56].

54 World Bank, 2017
55 Ibid
56 Ministry of Internally Displaced Persons from the Occupied Territories of Georgia, Labor, Health and Social Affairs, Adapted from Georgian Healthcare Barometer XII Wave

Chart 2.3. Budgets planned and actually spent within the framework of the universal health care program of the population (Mln GEL)



Depending on the type of expenditure, expenditures on pharmaceuticals are high in health expenditure. On average, 36.9% of the total national health expenditure in 2014-2020 is net pharmaceutical expenditure, which is mainly paid by the population out of pocket (96%). The rest is used to provide medical services, most of which is spent on hospital and outpatient services. As shown in chart X2 above, the share of state funding in the health services sector is in the range of 37-42% since 2015[57].

2.2. Funding Sources and Flows

The state budget for health care is financed through the following schemes: (i) universal health care program; (ii) more than twenty public ("vertical") public health programs; and (iii) Programs for priority diseases and conditions that seek to provide access to services for the entire population but have different rates of coverage.

Public spending on health, as a share of total current expenditure on health, has been rising since 2000, although it is still low compared to developed countries, and out-of-pocket payments remain the most important source of funding. They accounted for 48% of total current spending on healthcare in 2018.

The share of out-of-pocket payments has dropped significantly since the introduction of the universal healthcare program in 2013. In recent years, voluntary health insurance has accounted for a small share of total health care spending (only 4% in 2018). State funding for health care increased from 5.6% in 2012 and reached 10% of total government spending in 2015-2018[58].

The share of voluntary health insurance in current health care expenditures increased as a result of relevant policies until 2012, but with the introduction of the Universal Health Care Program, its role in the system has been significantly reduced[59].

Attracting and Distributing Finances

Vertical funding for public health services (health monitoring, immunization, etc.) is combined under the National Center for Disease Control and Public Health (NCDC).

The specific directions of out-of-pocket payments for health care are, of course, not pre-determined. Funds are also accumulated through private health insurance companies, which provide relatively comprehensive commercial coverage for employees in a number of sectors/enterprises. However, in 2017, these expenditures accounted for only 6% of total healthcare expenditures as a whole and 9% of private healthcare expenditures[60].

It is noteworthy that there are no pre-defined (named) funding sources for health care in the country and the total budget is agreed annually between the Ministries of Finance and Health. The final decision on the budget of the Ministry of Health belongs to the Parliament.

The local government has the right to allocate additional funding for health services if it has such a resource. Historically, this funding has been significant in Tbilisi and Adjara, where local governments are expanding state funding schemes to include more and more families. Local governments may also have emergency funds to reimburse the health care costs of financially disadvantaged citizens.

57 Ibid
58 WHO, Global Health Expenditure Database
59 Health Systems in Transition, Georgia, 2017
60 WHO, 2020

Prioritization of services in the universal health care program and vertical programs is decided by the government in consultation with the Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs of Georgia, and each program has its own budget. This budget is determined annually. The redistribution of resources between sub-sectors usually does not take place during the budget year. If the government changes its priorities, it will be reflected in next year's budget.

Since 2014, the budget of the universal health care program has been based on the previous year 's requirements of providers, which are adjusted according to inflation. From September 2014, funds for services purchased under the Universal Health Care Program would be allocated to the Social Services Agency, which would reimburse service providers directly for the services rendered. It should be noted that in 2020 this function was transferred to the National Health Agency (in the text below - the agency).

Procurement and Buyer-Provider Relationship

The organizational relationship between buyers and providers has changed from the existing integrated model to the contract model. And for those who have voluntary health insurance, private health insurance companies buy the service. The most common payment mechanism is "fee for service". Any service beyond the universal health care program or voluntary health insurance is purchased by the public from the service provider of their choice in the open market, in most cases by out-of-pocket payment. Procurement of health services from service providers is done by the agency. In this process, neither the legal status nor the form of ownership matters, private and public institutions are treated on equal terms. The agency provides service pricing lists for hospitals (by nosology groups) and per capita rates for primary health care services under the universal health care program. These reimbursable prices are usually tied to the prices of private insurance companies. Any provider can claim the price set by the agency to reimburse the services provided under the universal health care program. For scheduled hospital services, patients choose any facility that provides the prescribed manipulation and that agrees with the agency's reimbursement procedures (in practice, almost all facilities do this to benefit from the universal health care program). Patients obtain all the necessary documentation and consent from the agency to receive services at a particular health facility.

The Ministry determines the list of necessary medical interventions and the reimbursement prices for service providers by the Agency under the Universal Health Care Program. The agency should become a purchaser of health services, using selective contracts throughout the system. However, it is still more of a budget funds administrator. The Social Services Agency has been launching selective contracting in some clinical areas since 2017, based on pre-defined criteria and contractual arrangements. This relationship also provides for mandatory reporting of quality indicators by the health care providers providing these services. This selective contracting is performed according to the following criteria: Coverage of services, quality of services, volume of services, financial transparency and "compliance" with sanctions. On the other hand, no way of spending and quality control within the universal health care program is currently defined.

Out-of-pocket Payments

As a result of the increase in health expenditures by the state under the universal health care program, it has become possible to reduce out-of-pocket costs in the system (from 73% in 2010 to 48% in 2018). However, despite the downward trend in recent years, out-of-pocket payments remain the dominant source of healthcare funding in the country.

Overall, from 2008 to 2012, the focus was on focusing on the poorest segment of the existing public resource population. Since 2013, the focus has shifted to universal health care, as the state seeks to align the benefits package with the allocated budgetary resources.

Georgia has a fairly high poverty rate and catastrophically high spending on healthcare compared to other European countries. Catastrophic costs are mainly due to out-of-pocket payments for outpatient treatment as well as inpatient and outpatient treatment[61].

At the end of 2020, the state set tariff limits for reimbursing providers. Part of the loss caused by medical institutions is likely to be offset by the provision of surplus or unnecessary services, leading to an increase in out-of-pocket payments and a heavy burden on patients.

The catastrophic expenditures of the population on healthcare were increasing and amounted to 34% by 2017. It is expected that this figure will increase even more[62].

Co-payment (Customer Expenses)

The National Health Agency determines the level of co-payment for the cost of services provided by patients and the annual upper limit of the benefits to be received by it. Information on the level and amount of co-financing for the various services provided under the universal health program is widely available, but the benefits provided by the program

61 WHO-EURO-2021-2532-42288-58479-geo.pdf
62 Georgian Healthcare Barometer XIV Wave

are not sufficiently clearly defined and well understood by the general public, which makes it possible to oblige patients to pay for services covered by a universal package or may have the procedure reclassified for the same purpose. The beneficiaries of the main target group have not been formally defined as the co-financing required to access the services. Unfortunately, there are no clear goals or principles for establishing co-financing in the system beyond the cause of limited public resources.

The existence of an upper limit of eligible benefits and the obligation to pay the difference between the agency's remuneration and the hospital fee for the patient limits the system's ability to provide adequate depth of coverage - there is no limit to the level of co-payment to determine in advance the amount to be paid by the patient.

Direct Payment

The most important part of direct payments comes from drugs, especially in the outpatient treatment phase, as such costs are covered by a limited amount under the universal health care program. On pharmaceuticals, the patient usually has to pay the full price. In 2015, about 64% of out-of-pocket spending came on outpatient medications, accounting for about 40% of total health care spending[63]. These proportions changed very slightly in 2016-2018[64]. The cost of inpatient pharmacy is covered by the universal health care program, however, it actually distorts the incentives in the system, forcing patients to use emergency inpatient care rather than primary health care.

Health care providers set tariffs for services that are not covered by the universal health care program or voluntary health insurance. This list of service prices is called "Internal Standards". Prices for such services vary by provider.

Informal Payments

Since the introduction of the Medical Assistance for the Poor program in 2008 and the Universal Health Care Program in 2013, the space for informal payments has become very limited and only a small amount of money is spent in this area today.

Voluntary Health Insurance

Insureds in the health insurance market are not required to be treated only by system-only providers. There is a free choice, however, from a financial point of view, they can get services at the provider medical facility through a family doctor relatively easily, as the insured is exempted from paying the reimbursable share of the amount provided by the insured in the relevant service. Also, the insured does not have to collect medical documentation, submit it to the insurance company and wait to receive reimbursement.

There are the following types of medical services in case of insurance accident in the Georgian market: Medical services through a personal doctor, emergency hospitalization or emergency outpatient services, planned hospitalization, planned outpatient services, medication treatment, childbirth and scheduled dental (therapeutic and surgical) services.

The share of private health insurance in the health care system is small. In 2017, its share was 6% of current healthcare expenditures and 9% of private healthcare expenditures[65]. Private health insurance is provided by private insurance companies and it covers 9% of the population (438,302 people in 2020), most of which is voluntary and applies to employees and their families. Private insurance is compulsory for some groups of people (e.g. military personnel). Some private insurance policies cover services that are not covered by a universal health care program, such as dental care and some outpatient medications. It is noteworthy that the exclusion of the highest income category from the coverage of the universal health care program in 2017 did not increase the demand for private insurance[66].

Other Sources of Funding

External sources (foreign-funded healthcare initiatives) play a role in health financing. The level of such funding has varied over the last decade, depending on various reform projects. Overall, the share of funding from external sources has been steadily declining and has fluctuated between 1-2% of total healthcare spending since 2016.

2.3. Remuneration Mechanisms

Reimbursement of Health Services

Payment for medical services under the universal health care program is made retrospectively. With this program, money goes to the patient, who can freely choose the service provider - this means that the agency does not send the beneficiary to a predetermined provider and does not negotiate the content or volume of the service, but reimburses the

63 Habicht & Thomson, 2016
64 How much can people in Georgia pay for health care services? WHO, 2021
65 WHO, 2020
66 How much can people in Georgia pay for health care services? WHO, 2021

providers for the services provided in accordance with the tariffs set. As mentioned above, the agency is gradually changing its approach - in some cases, the agency itself finds the organizations that offer the best prices for various procedures and concludes relevant contracts, although, for the most part, it still remains a passive purchaser of health services.

Private insurance companies usually offer less choice to their beneficiaries as they enter into contracts with their preferred providers. Payment is mostly retrospective here as well. Patients can go for treatment to a medical facility that is not covered by their insurance or universal health plan, but if the procedure is more expensive than the insurance company has provided, the patient must pay the difference in price himself.

Hospital services are reimbursed on a case-by-case basis and payment methods vary according to the characteristics of the provider and the type of service.

Ambulances can be emergency or non-emergency and tariffs are set differently. Critical and intensive care have separate rates[67].

A patient planning a surgery should apply to the agency for authorization in advance so that the relevant costs are at least partially covered by the universal health care program. This application should include the hospital documentation, first diagnosis, and expected cost. The agency then reviews the application and issues a voucher that guarantees a refund. When a patient undergoes surgery, the provider must notify the agency electronically within 24 hours. Once the case is closed, the provider will submit a detailed case report to the agency for further processing. The agency reimburses virtually every claim.

Procurement of primary health care services by the state is done annually at a fixed rate per capita. Individual providers enter into contracts with the agency and private insurance companies to provide these types of services. However, in the universal health care system, there is a difference between urban and rural primary health care funding. In particular, in contrast to cities, primary health care in rural areas has been covered for years by the Rural Physician Program, whose staff is currently enrolled in the Emergency Situations Coordination and Urgent Assistance Center system.

The agency concludes contracts on the basis of capitation with primary health care institutions and not with individual doctors. Capitation reimbursement for primary health care does not take into account the region, age or other characteristics of the patients. Former rural physician program doctors receive remuneration in the form of a fixed salary. Like them, in the case of primary health care providers there is no remuneration related to the volume of services provided.

Where the patient pays the full cost of the treatment out of pocket, the payment mechanism is quite simple. For scheduled inpatient and outpatient services, he/she pays in advance according to the service price list, which is determined by each provider individually. In case of emergency care, hospitals first treat patients and then ask for reimbursement. Hospitals themselves are responsible for any of their budget deficits and accumulated debt.

It is noteworthy that the profitability of the health sector has been deteriorating since 2015. At the same time, the state debt to companies worsens the liquidity of the sector[68], which is offset by the fact that medical institutions:

1. Increase loan liabilities - Sector Loan/EBITDA ratio increased 3 times in 2015-19;
2. Delayed payment of trade and wage liabilities - In 2019, the turnover of trade liabilities averaged 8 months, while the turnover of wage liabilities reached 1.5 months[69].

Remuneration of Health Care Staffs

The salaries of healthcare staff are not set by the government or the ministry. Their employers - the managers of healthcare institutions, make a decision on this. Remuneration is agreed upon individually, between healthcare staff and facility managers, and may be based on workload or a fixed salary, or both contain certain elements. The agency determines the cost of services paid for the medical facility. Medical facility staff pay rates are set by management everywhere, and as for primary health care staff rates, management makes this decision only in cities. Rural primary care physicians work under the Emergency Situations Coordination and Urgent Assistance Center and their salaries are set at a fixed rate by the agency.

67 World Bank, 2017
68 Deteriorating profitability of medical facilities increases the risks to their ongoing operations and their solvency
69 Georgian Healthcare Barometer XIV Wave

Chapter 3 - Health Insurance

3.1 Developing a Health Insurance Market

1995-2006: Reforms of the Georgian Healthcare System and their Role in the Development of Health Insurance

In 1992-1996, real national income decreased by 78% compared to 1990 data, and health expenditure per capita per year was less than one US dollar. In 1995, the government began reforming the health care system.

Compulsory Social Insurance Fund (Municipal Funds in 1996) was established in 1995, where the employee was obliged to contribute 1% of the salary, and the employer - to contribute 3% of the salary to the fund.

State health care programs were funded with the money received, of which should be noted:

- Prevention of socially dangerous diseases;
- Treatment of children under one year;
- Supervision of pregnant women;
- Urgent assistance to war veterans and the needy.

These funds were also used to create reserves for disasters and epidemics and to develop medical science. These state programs provided funding (co-financing) for medical services with equal but specific, limited range for all citizens of Georgia. However, it proved ineffective due to the ambition of universal coverage of the population and, at the same time, the deficit budget, which accounted for about 20% of the annual number of actual cases of the disease. The imperfection of the programs was also reflected in the fact that the majority of the population knew nothing about these programs at all.

The Compulsory Social Insurance Fund was transformed into a state health insurance company in 1996, and the government established a basic package to cover the basic medical expenses of the population. Medical expenses were covered directly by the state medical insurance company, municipal health funds and the central government. Later, in 2002, compulsory health insurance contributions were replaced by the introduction of social tax, which was a direct tax.

In 2004-2006, the Ministry of Health started working on health system reform with the help of donor organizations, but its implementation was delayed due to the lack of a unified and established concept by decision makers. However, some positive movements were observed during this period - The primary health care program has been in place since 2003, with the aim of providing access to medical services for all citizens, regardless of their age, gender and, most importantly, social status.

A period of significant change began in the fall of 2006. A government commission on health and social reforms has been set up at the Ministry of Health, headed by the Prime Minister. Direct responsibility for developing and implementing reform plans has been entrusted to the Minister of State for Coordination of Reforms. The basic principles for the implementation of reforms in the healthcare sector have been established. The conceptual model of the reform envisaged 4 strategic directions:

I - Ensuring financial access to essential medical services and protecting the population from financial risks related to medical services;

II - Ensuring high quality of medical services - creating and enforcing a suitable regulatory environment;

III - Providing physical access to quality medical services for the population - Development of medical infrastructure and training of competent staff;

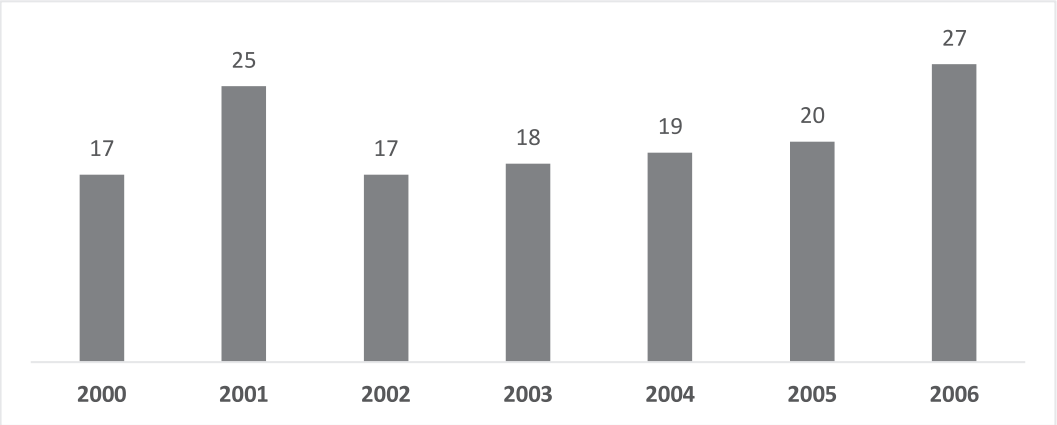
IV - Improving the efficiency of the health care system - Capacity building of the Ministry and its subordinate organizations and introduction of the principles of good governance.

As a result of considering the possibilities for changes in health care policy, two important decisions have matured in the government:

- Increasing the targeting of health programs in parallel with increasing the targeting of social assistance programs;
- Gradual replacement of existing universal programs with target group-oriented programs.

During this period, medical insurance was developing at a slow pace, though still. Its share of the total insurance market at the end of 2006 was 27%, amounting to GEL 18.7 million (Chart 3.1.).

Chart 3.1. Medical insurance market share by years (%)



The number of insured was limited mainly to 100,000 citizens living in Tbilisi, more than 80% of whom were insured through corporate rules. Insufficient coverage of the population with insurance showed that tangible results could not have been achieved without the purposeful intervention of the state in the development of the insurance market.

Activation of health insurance begins in late 2006 as a result of a new wave of health care system reforms.

When the Government of Georgia introduced a change in the health care financing system in 2006, the main goal of the health financing policy was to provide financial access to essential medical services. A state plan for the development of medical insurance was created, which aimed, on the one hand, to increase access to medical services for the socially vulnerable, and on the other hand, to promote the development of a financing model based on private medical insurance, which would protect the citizens of Georgia from financial risks related to illness and ensure the effective functioning of the medical sector.

In order to better manage the financial risks associated with deteriorating health, the government has made a choice in favor of purchasing health insurance instead of purchasing medical services and together with the Georgian Insurance Association developed a concept that provided for working in two directions simultaneously, based on two basic principles:

- The first principle - the creation of a targeted system of state funding for the provision of medical services to the most vulnerable sections of the population;
- The second principle - the management of state funds to promote the development of private insurance.

As a result of this choice:

- Existing state health programs (including outpatient programs) should be gradually replaced by insurance products - the purchase of medical services should be replaced by insurance services;
- Budget resources would be redistributed in favor of the socially vulnerable;
- Financial access to insurance services for vulnerable groups was provided by an insurance voucher;
- The government would facilitate the implementation of insurance programs for soldiers, police officers, and civil servants;
- The citizen himself must choose the insurance company he/she prefers;
- All insurance companies licensed in Georgia should have an equal right to become a participant in the program and a provider of insurance services;
- Short-term (one-year) insurance contracts should have been replaced by a permanent insurance contract.

After 2007: State-funded Health Insurance Programs

Phase I - Medical (health) insurance for the population below the poverty line

The first state pilot program to provide health insurance to the population living below the poverty line was developed in 2007 and provided medical services to 196,000 citizens living below the poverty line in Tbilisi and the Imereti region. The state health insurance program aimed to increase financial access to medical services for this group of the population.

According to the Resolution №166 of the Government of Georgia (July 31, 2007) the population was provided with the following medical services:

A. Reimbursement of outpatient costs not covered by the primary health care program:
   a.a. Emergency outpatient treatment;
   a.b. Consultation of family doctor, nurse, specialist doctors and other medical services, including home medical services, if necessary;
   a.c. Ultrasound and X-ray examinations prescribed by a doctor, laboratory and instrumental examinations related to planned hospitalization;

B. Reimbursement of inpatient services costs:
   b.a. Emergency inpatient services, including hospitalization for complicated pregnancies;
   b.b. Planned surgical operations, limit - 12 000 GEL per user;
   b.c. Co-payment costs not covered by state inpatient services programs;
   b.d. Costs of chemotherapy and radiation therapy, limit - 12 000 GEL per user;

C. Maternity expenses, limit - 400 GEL per beneficiary.

The program was valid until December 31, 2007.

The budget of the program as of December 31, 2007 was GEL 44,500,000. Among them, monitoring and management costs - 600 000 GEL.

The attracted insurance premium amounted to 15 095 400 GEL.

Phase II - Step-by-step insurance of the population throughout Georgia

Based on the Resolution №92 of the Government of Georgia of 2008, started gradually insuring the population throughout Georgia by regions.

All insurance companies licensed in Georgia had an equal right to become a program participant and a provider of insurance services. The government has set requirements for insurance companies and ensured a healthy level of competition between insurance companies.

In 2008, insurance vouchers were awarded to families living in Georgia who were registered in the "Unified Database of Socially Vulnerable Families" and as of March 31, 2008, their families' rating score did not exceed 70,000. In the process of financing medical services, a circulating financial instrument - insurance voucher was launched.

The Social Services Agency handed over a voucher to the citizen to finance medical insurance. The citizen or beneficiary family holding the voucher had the right to freely choose the insurance company. The citizen himself signed a contract with the selected insurance company, received an insurance policy with a voucher, on the basis of which he was provided with medical services defined by the program and financed.

Under the insurance contract, the government paid the premium on a monthly basis, on the principle of one twelfth of the standard value of the policy per insured and using the appropriate coefficient according to age groups:

a. 0-64 years - 12.93 GEL (c = 0.862);
b. > 65 years - 21.43 GEL (c = 1,429).

By the end of 2008, the policy had been distributed to 666,651 people living below the poverty line. According to 2008 data, the following cases were reported under the Medical Insurance Program for the population below the poverty line (Table 3.1.):

Table 3.1. Insurance cases by Types

Type of assistance	Number of cases
Acute Hospital	20 383
Obstetric Care	25 528
Childbirth with a 200 GEL voucher	30 700
Childbirth "Policy" - 400 GEL	2 579
Planned	17 620
Oncology	11 950

During this period, the following financial Indications were revealed as a result of the activities of the insurance companies participating in the program:

Table 3.2. Financial Indications of Insurance companies

Attracted Premium	77 245 088
Earned Premium	37 769 379
Paid Losses	21 991 366
Reserve of incurred but unregulated losses	3 868 402
Reserve of incurred but unreported losses	3 071 415
Administrative Costs	2 382 176
Acquisition Cost	5 132 119
Net Loss Ratio	76,6%
Combined Loss Ratio	96%
Operational Result	1 323 900

Insurance-Technical Council

On December 23, 2008, by the order of the Minister of Labor, Health and Social Affairs of Georgia, a Board for Insurance and Technical Issues was established in the Ministry.

The Insurance-Technical Council, together with stakeholders (private insurance companies and medical service providers), jointly reviewed and developed recommendations for the interpretation of technical and financial decisions. The Council consisted of representatives of the Ministry and its subordinate agencies, medical institutions and private insurance companies. The Council also included industry experts with relevant qualifications.

The tasks of the Board were:

a. Finding ways to solve problems that arise during the implementation of programs;
b. Develop recommendations to improve program conditions;
c. Interpret and specify program conditions;
d. Monitor measures for the development of voluntary health insurance and look for ways to improve them.

Due to the urgency and importance of individual issues, in order to implement certain measures, the Board was authorized to form working groups, both from the members of the Board and from invited experts and specialists.

2009 - Amendments to the Resolution

In parallel with the increase in the number of insured, the insurance conditions have been improved. As a result of the 2008 and 2009 amendments to the resolution, new clauses were added to the terms of the medical insurance financed by the insurance voucher. In particular:

a.b. Electrocardiographic, ultrasound and X-ray examinations prescribed by a doctor, laboratory and instrumental examinations related to planned surgical hospitalization;
a.c. Clinical-laboratory examinations at the outpatient level as prescribed by a doctor: General blood test, General analysis of urine and creatine, Peripheral blood glucose, Pregnancy test, Hemoglobin, The fecal occult blood test;
a.d. Examinations required for the social examination of persons with disabilities (PWDs), in particular for the granting of disability status, in addition to high-tech examinations (computed tomography and nuclear magnetic resonance imaging);
a.e. Issuance of all types of medical certificates and prescriptions at the outpatient level (except Form №IV-100/a, in connection with the start of the work, information to be submitted to the Service Agency of the Ministry of Internal Affairs for obtaining a driver's license and the right to keep / carry a weapon);
b.b. Planned surgical operations (including day hospital), insurance annual limit 15 000 GEL.

Prior to December 2009, the program budget was set at GEL 29,511,700, including monitoring and management costs of GEL 520,000.

Other State-funded Health Insurance Programs - Teacher Insurance

Following the successful piloting of a health insurance program for the population below the poverty line, the state began providing medical insurance to public school teachers the same year.

According to the Resolution N256 of November 21, 2007, they were entitled to the following services:

a. Reimbursement of outpatient costs not covered by the state primary health care program:
   a.a. Emergency outpatient services;
   a.b. Consultation of family doctor, nurse, specialists and other medical services at home, including medical services, if necessary;
   a.c. Ultrasound and X-ray examinations prescribed by a doctor, laboratory and instrumental examinations related to planned hospitalization;
b. Reimbursement of inpatient services costs;
   b.a. Emergency inpatient services, including hospitalization for complicated pregnancies;
   b.b. Planned surgical operations, insurance limit for one insured - 12 000 GEL per year;
   b.c. Co-payment costs not covered by state inpatient services programs;
   b.d. Chemotherapy and radiation therapy costs, insurance limit - 12 000 GEL;
c. Maternity expenses, insurance limit for one insured - 400 GEL.

In accordance with the terms of the medical insurance, the insurance voucher, as well as the insurance voucher and the insurance premium (premium) paid by the insurer did not reimburse the expenses incurred for the following medical services:

a. Expenses and services covered by other state health programs (including municipal) in force at the time of enactment of this ordinance;
b. Planned therapeutic hospital services;
c. Without medical indication, treatment without a doctor's prescription, self-medication;
d. Costs of medical services abroad;
e. Sanatorium-spa treatment;
f. Aesthetic surgery, cosmetic treatment;
g. Costs of sexual disorders, infertility treatment;
h. Costs of treatment of AIDS, chronic hepatitis;
i. If the need for medical care arose as a result of self-harm, involvement in terrorist acts, criminal acts or drug exposure;
j. Costs of transplantation as well as exoprosthesis.

Withdrawal of Insurance Voucher, Amount of Insurance Premium and Payment Method

The insurance voucher was cashed by the Ministry of Education and Science of Georgia within the framework of the allocations allocated from the state budget of the relevant year of the insurance period.

The insurance organization submitted the data on the insured to pay the insurance voucher within the time period and in the form specified by the Ministry of Education and Science of Georgia, and if necessary, at the request of the Ministry, also the original of the insurance voucher.

One monthly insurance premium payable by the insured for health insurance was determined by a resolution of the Government of Georgia and was fully covered by the full monthly amount (100%) of the one-year insurance voucher. The insurance voucher covered 100% of the monthly insurance premium in 2008-2009; 66.6% - in 2010-2011; 33.3% - in 2012-2013.

Health Insurance Mediation Service - With the development of insurance programs, the Health Insurance Mediation Service was launched and operated successfully from 2008 - the non-profit, non-governmental body, whose main task was to assist the subjects of the insurance relationship in resolving disputes in a non-judicial manner. The Mediation Service was initially funded by a grant from the United States Agency for International Development, and a year later by insurance companies (0.3% of revenue).

Chart 3.2. Total attracted premium of the insurance market (million GEL)

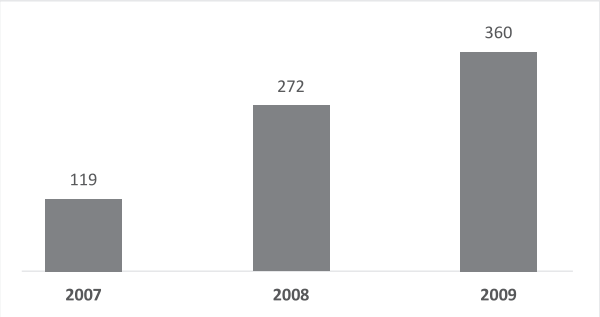
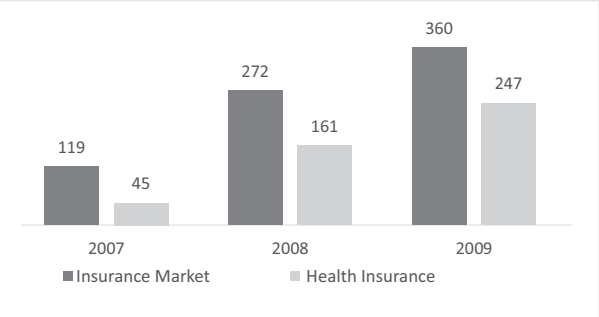


Chart 3.3. Premium attracted in the field of health insurance (million GEL)



Insurance Market in 2007-2009

The introduction of health insurance for the population below the poverty line has had a significant impact on the insurance market as a whole. In the initial phase of the program, in 2007, compared to 2006, the insurance market grew by 68%. The growth dynamics continued in the following years as well, and by the end of 2009 the total premium attracted by the insurance market was GEL 360 million (Chart 3.2.).

The premium attracted in the field of medical (health) insurance in 2007, compared to 2006, increased by 26,340,851 GEL and amounted to 45,075,751 GEL, and by the end of 2009 it exceeded 247 million GEL (Chart 3.3.).

At the end of the same year, the number of insured persons was 1,311,287.

Changes in State Programs for Health Care Financing

As a result of the amendments made by the Government of Georgia to Resolution № 218 of December 9, 2009 in 2010, the rules in the state programs for financing health care have changed significantly. Specifically:

- The right of a state program beneficiary to freely choose an insurance company has been replaced by a mandatory relationship with a particular company;
- The territory of Georgia was conditionally divided into 26 medical districts. Based on the insurance voucher, the insured entered into an insurance contract with the insurance company (insurer) that won the tender, which was identified as the winner in the relevant medical (one of 26) districts of the insured's place of residence based on the results of the tender held on April 18, 2010;
- Since 2010, the contract between the insured and the insurer has become 3 years (instead of one year);
- From 1 May 2010, the amount of the annual insurance premium for each insured person, instead of 180 GEL, was determined according to the price fixed by the winning insurer through the competition in the relevant medical district. In particular, in Tbilisi, Sachkhere and Gori 116.4 GEL, and in the other 23 districts - 132 GEL;
- Against the background of the reduced premium, it was planned to reimburse a new component of the insurance package - co-payment of 50% of medical expenses within the annual insurance limit of the policy (50 GEL);
- The reason for the termination of participation in the state programs for the company was the systematic and gross violations of the obligations of the company under the terms of the voucher and the competition, about which a written report is issued by the Health Insurance Mediation Service and / or the Ministry of Labor, Health and Social Affairs;
- According to the amendments to Resolution № 218 of 2009, the company was obliged to clearly indicate in the insurance certificate to the beneficiary information about the Health Insurance Mediation Service, which was funded by insurance companies until May 2010. Then the Mediation Service was subordinated to the Ministry of Labor, Health and Social Affairs of Georgia, and in 2014 it was abolished;
- The insurance companies participating in the state insurance programs, according to the terms of the competition, had a new and important obligation - to complete and start the construction of a hospital in the medical districts of their activities within the established time.

On the one hand, the creation of new medical facilities by insurance companies has significantly improved the medical service environment, there has also been territorial access, however, on the other hand, the reduction of the premium and the increase of the imposed duties have worsened the financial condition of the insurance companies.

Other State Programs

At the same time, since 2007, government agencies have been actively pursuing private medical insurance and, through state funding, representatives of various public organizations have been involved in the insurance system. As of April 2010, approximately 1,104,785 people were covered by state health care programs. Fully funded from:

- Population below the poverty line - 954 966;
- Internally Displaced Persons in Compact Settlements - 12 083;
- Children deprived of care - 3 053;
- People's Artists, People's Painters and Rustaveli Prize Laureates - 189;
- Teachers - 79,494;
- Population insured by the budget of Tbilisi City Hall (with 70,000-100,000 points) - 55,000.

Some state institutions are partially funded - the government has facilitated the implementation of insurance programs for soldiers, police and civil servants.

Population Without State Programs

In managing public funds for the improvement of the country's health care system, it was necessary to take into account the population without the state programs, which was divided into three groups:

- Formal sector employees and their families, only a small proportion of whom have benefited from corporate or government health insurance programs;
- Non-poor retirement pensioner - population over 60, high risk group, for which at the initiative of the state at the end of 2008 4 service programs were created: emergency, cardiac surgery, oncology and primary health care;
- Self-employed - the most problematic and difficult to mobilize group. When buying medical services, these people actually have to pay out of pocket. They are not included in the insurance system due to anti-selection and face some difficulties when taking the insurance product in installments.

In order to facilitate the integration of the self-employed in the insurance system, in 2009 the Government of Georgia created a new model of health insurance, which is known as "Cheap Insurance" - any citizen between the ages of 3 and 60 could purchase a "cheap insurance package" for GEL 19.80 (with 33% co-payment of a 60 GEL package purchased by the state) and receive primary health care and emergency inpatient and outpatient medical services for GEL 8,000 for one year, as well as medical assistance in the event of an accident. However, despite the insurance expectations of 300,000 - 500,000 citizens, for some reason, the policy was purchased by only 122,000 citizens.

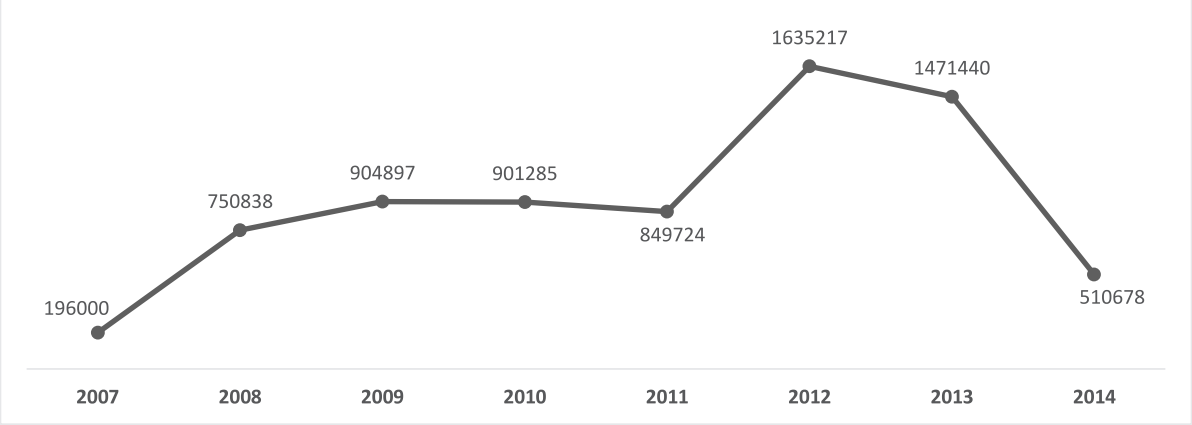
As of December 2011, more than 960,000 people were insured under state programs. In particular, the population below the poverty line, compactly resettled IDPs, children deprived of care, People's Artists, People's Painters and Rustaveli Prize Laureates, beneficiaries of homes for the disabled and the elderly, beneficiaries of boarding schools, teachers, population living in the vicinity of the Autonomous Republic of Abkhazia, beneficiaries of community organizations and the population insured by the budget of Tbilisi City Hall (with 70 000-100 000 points).

According to 2012 data, more than 2 million people in Georgia did not have health insurance. Accordingly, in order to insure this segment, the Government of Georgia issued Resolution №165 in 2012, within the framework of which approximately 800,000 citizens have been involved in the state insurance program since September 2012:

- Children aged 0 to 5 years;
- Retirement pensioners;
- Students;
- Children with disabilities and severe disabilities.

According to the Ministry of Labor, Health and Social Affairs of Georgia, by the end of 2012, the number of beneficiaries of the state insurance program under both of the above-mentioned resolutions (№218 and №165) exceeded 1,600,000 people (Chart 3.4.).

Chart 3.4. Number of the state health insurance program beneficiaries



Under Resolution №165 of 2012, the net loss ratio was 98.7% from September 2012 to September 2013, and 92% for the following year (September 2014). In 2012 (in the period from January to December) within the framework of Resolution №218 - 97.5%. 97.4% was also recorded in 2013.

In 2013, the state program of universal health care was launched in Georgia, which was implemented by the Social Service Agency. The goal of the program was to provide health insurance to all those citizens of Georgia who, as of July 1, 2013, did not benefit from the existing state insurance and did not have private insurance.

In 2014, all state health insurance programs were abolished and their beneficiary citizens also joined the universal health care program. Consequently, private insurance companies no longer participate in state projects from this period.

3.2. Infrastructure - Insurance Market Actors

There are various insurance systems that give the insured a limited, free and/or mixed choice of relevant medical facilities.

Historically, all markets have been dominated by the so-called Free choice system. Over time, the free choice system has many problems. These problems are related to the unscrupulous behavior of both the insureds and the providers and the financial inefficiency of such a system. Managed Care Plans have emerged in developed markets to address these issues, the two most common of which are HMO (Health Maintenance Organization) and PPO (Preferred Provider Organizations).

An HMO is an example of a locked system of medical services created by an HMO investor (often an insurance company, but not necessarily). Its features are:

- The HMO contracts with specific providers and oversees the service delivery process by them. In order to manage the flow of insured and to spend money efficiently, the so-called Family doctor who performs the functions of a Gatekeeper - Insured persons do not have the right to visit a doctor of a specific specialty directly until they go to a family doctor and send him or her to this or that specialist;
- Providers often receive reimbursement on a capitation basis or receive a fixed amount for each insured regardless of how much and what type of service was provided;
- Receiving medical services by the insured outside the HMO providers system is virtually unpaid.

As for the PPO system, it has the following features:

- The gatekeeper is not typically used here. PPO providers usually do not work on a capitation basis, they are paid according to the service rendered;
- Insured persons are not required to be treated only by the providers involved in the system. However, there are all kinds of financial levers (much lower co-payment shares) that push the insured to stay within the network of selected providers;
- Insured in the medical (health) insurance market are not required to be treated only by system providers. There is free choice. However, getting care from a provider's medical facility through a family doctor can be relatively financially easy. The insured is exempted from the payment of a reimbursable share by the insurer of the amount provided by the insurance condition in the relevant service. Also, the insured does not have to collect medical documentation, submit it to the insurance company and wait to receive reimbursement.

Consider specific actions in case of insurance accident according to the types of medical services:

The Insured Receives Medical Care Through a Personal Doctor - In order to make an appointment with a personal doctor, the insured connects to the company hotline and plans a visit. The insured is also registered electronically with the chosen doctor at the desired time. In case the insured is not able to register with the family doctor at the desired time or wants to receive remote service, the personal doctor will contact the insured at the indicated number at the scheduled time.

In Case of Emergency Hospitalization or Emergency Outpatient Services, the insured (insured representative) is obliged to inform the insurance company through the hotline. Expenses for medical services received without notice will not be reimbursed. At the same time, the insurer makes a direct payment to the provider clinic of the company, on the basis of which the insured is exempted from the payment of the reimbursable share by the insurer of the amount provided by the insurance condition in the relevant service. (Provider medical institution - a medical institution that, upon the occurrence of an insured event on the basis of an agreement with the insurer, provides the insured with appropriate medical care within the framework of the services specified in the insurance agreement and the card). When applying to a non-contracting clinic of the company, the insured pays the service fee in full and then applies to the insurance company (possibly electronically) for payment.

The insured must submit complete documentation of **the planned hospitalization** to the insurer at least X working days before the date of hospitalization. In case the planned hospitalization is not agreed with the insurer in advance and the relevant documentation is not submitted in advance, the service will not be reimbursed by the insurer.

In order to receive services in the company's clinic, the insurer issues a letter of guarantee, on the basis of which the insured is exempted from paying the reimbursable share by the insurer of the amount provided by the insurance condition in the relevant service. When applying to a company non-contracting clinic, the insured pays the service fee in full and then applies to the insurance company for reimbursement.

In order to receive **planned outpatient services**, the insured will contact the company's provider's personal physician. The personal doctor will provide the insured with the necessary referral to the mentioned clinic.

Upon submission of a personal doctor's application, insurance card and identity document, the insured is exempted from the payment of a reimbursable share by the insurer of the amount provided by the insurance condition in the relevant service. When receiving services without consulting a personal doctor, the insured pays the relevant services in full and applies to the insurance company for payment or sends the relevant documents electronically.

In case of **medical treatment**, the insured has the opportunity to choose the service pharmacy network. One-time reimbursement is the cost of the medication required for the treatment for not more than one month.

The personal doctor will prescribe the relevant medication on the company form or record it electronically, so that the insured in the provider's pharmacy chains pays the share of the cost of the prescribed medication only under the insurance conditions. When purchasing a medicine prescribed by a doctor-specialist (In the absence of a personal physician referral to both a provider and a non-provider pharmacy network or to a non-provider pharmacy network prescribed by a personal physician), the insured pays the relevant services in full and applies to the insurance company for payment or sends the relevant documents electronically.

During the delivery, the insured must submit complete documentation about the planned Caesarean section to the insurer at least X working days before the planned Caesarean section date. In case of childbirth or unplanned caesarean section - X days before discharge from the maternity hospital.

On the basis of the notification, the insurer issues a letter of guarantee to receive services at the company's clinic of the company, on the basis of which the insured is exempted from the payment of the reimbursable share by the insurer for the amount provided by the insurance condition in the relevant service.

Without a letter of guarantee, as well as when applying to the company's non-provider clinic, the insured pays the service fee in full and then applies to the insurance reimbursement group for payment.

In order to receive **dental services**, the insured is entitled to apply to any licensed dental clinic.

When applying to the company's clinic, the insured must present an identification card and an identity document. In such a case, the insured is exempted from the payment of the reimbursable share by the insurer of the amount provided by the insurance condition in the relevant service.

When applying to a non-provider clinic of the company, the insured pays the service fee in full and then applies to the insurance company for payment or sends the relevant documentation electronically.

Planned Dental (Therapeutic and Surgical) Services - The insured is entitled to apply to any licensed dental clinic.

When applying to the company's clinic, the insured must present an identification card and an identity document. In such a case, the insured is exempted from the payment of the reimbursable share by the insurer of the amount provided by the insurance condition in the relevant service.

When applying to a non-provider clinic of the company, the insured pays the service fee in full and then applies to the insurance company for payment or sends the relevant documentation electronically.

Dental and pregnancy-delivery coverage services have been added to all the markets in its time due to the existing competition and marketing considerations. These risks are not insurable. Over time, this resistance has appeared in all markets, which has manifested itself in the fact that these services (especially dentistry) have seriously aggravated the loss. In developed markets, dentistry is almost nowhere to be found as part of medical insurance, it is taken out separately, in the form of dental insurance. In fact, this insurance is no longer insurance in the classical sense and is more like a financial service, or lending to the insured - The total premium paid by the client in installments during the year almost coincides with the annual insurance limit.

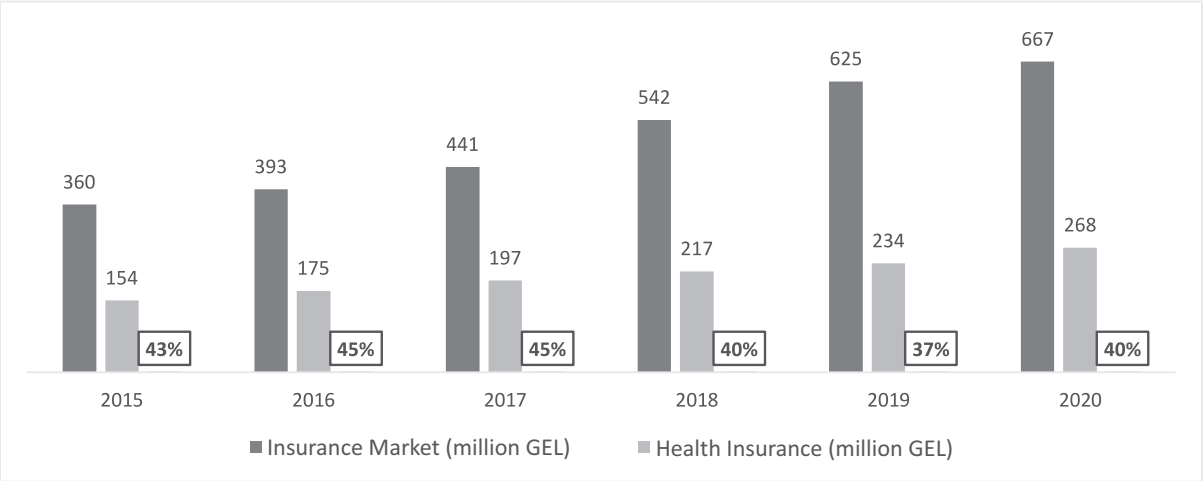
3.3 Insurance Market Overview, Quantitative and Financial Indicators 2010-2020

Prior to the introduction of the universal health care program, the share of medical (health) insurance in the insurance market (private insurance and state insurance programs combined) was 73.78%, which is mainly a result of the changes made in 2012 (Chart 3.5.).

At the same time, as of December 31, 2012, the number of insured persons was 1,915,952.

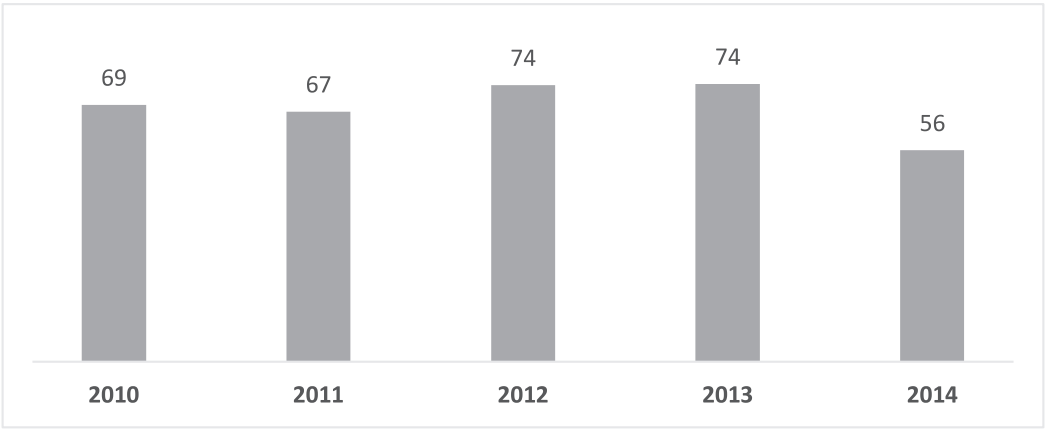
The sharp drop in premiums in the field of medical (health) insurance from 2013 to 2014 is due to the entry into force of the state program of universal health care, the first phase of which was launched in February 2013, and the second phase began in July 2013.

Chart 3.5. The share of premiums attracted in health insurance in the insurance market



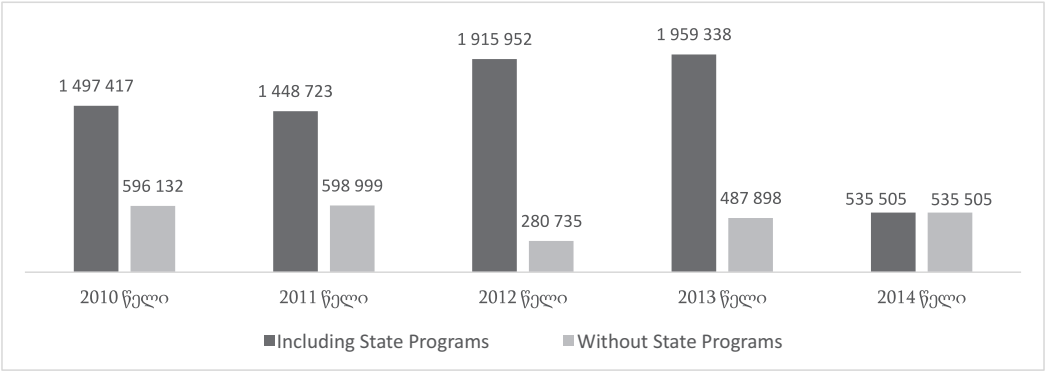
It should be noted that the premium attracted is an insurance premium, which includes insurance liabilities (including multi-year liabilities) that entered into force during the reporting period, whether the premium is paid to the insurer or not. Consequently, the dynamics of growth / decrease is reflected even more clearly in the issued premium - the part of the insurance premium that belongs to the last part of the insurance contract (Chart 3.6.).

Chart 3.6. Attracted premiums and share of health insurance (%), 2010-2014



With the launch of the universal health care program, there was a danger that it would also have a negative impact on the number of private insurance beneficiaries. According to statistics, after the insurance companies were completely excluded from the state health program, the number of insured persons decreased to 535,505 (as of December 31, 2014) (Chart 3.7.).

Chart 3.7. Number of insured



However, although part of the consumers switched from private insurance to the universal health care universal program, private insurance still did not lose its relevance and its own functions. From 2015, the growth rate is still observed - the number of insured increases from year to year. In order to increase the number of insured, the insurance sector offered customers coverage for services that were not covered by the universal health care program, including outpatient care.

The number of insured is growing mainly at the expense of insurance of corporate and state agencies. It is important that individual insurance develops at a fairly slow pace.

It is noteworthy that despite the increase in the number of insured, as of 2020, only 17% of the population of Georgia is insured (according to the National Statistics Office of Georgia, at the end of 2020 the population was 3,728,600), which indicates that the insurance culture is poorly developed. The issue of raising the insurance culture is one of the important factors to make the future in the financial sector calmer and more predictable.

As the number of insured increases, both the attracted and the generated premium increase. Health insurance still has a significant share of the insurance market (Chart 3.8.).

Chart 3.8. Premium generated in health insurance (Gross) (million GEL)

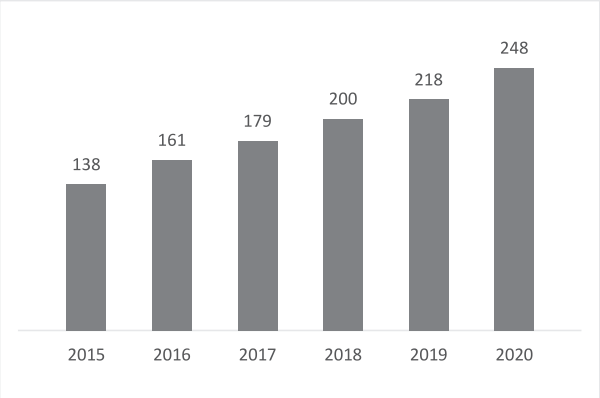
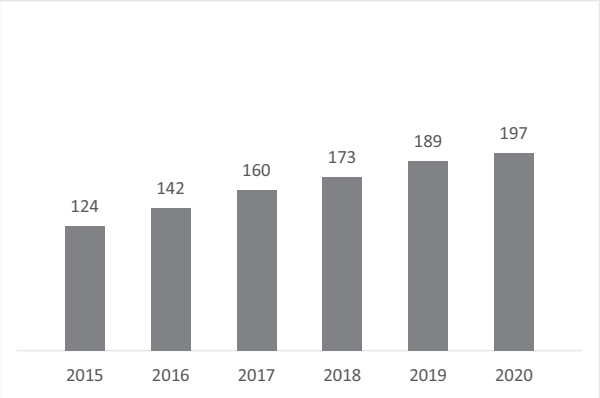


Chart 3.9. Amount of insurance losses during the reporting period (gross)

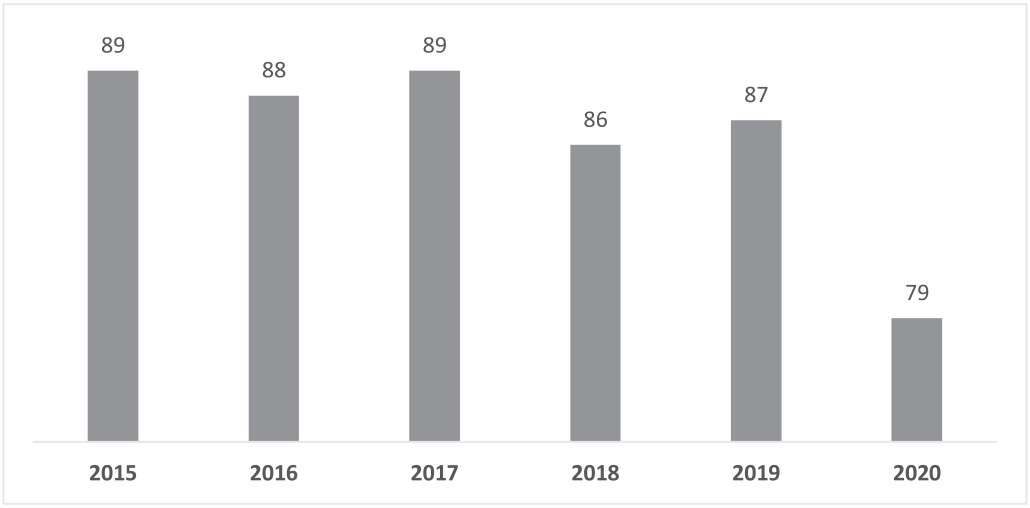


With the growth of the medical (health) insurance market, the number of losses also increases, which means that more and more insured people benefit from insurance from year to year (Chart 3.9.).

Due to the fact that medical (health) insurance is mostly service financing (especially outpatient), it is always characterized by high losses, unlike other types of insurance. Net loss varies between 86-89% over the years (Chat 3.10.).

The exception is 2020, which is likely to be caused by the declaration of a state of emergency in Georgia on March 21, 2020 as part of the fight against the new coronavirus (COVID-19).

Chart 3.8. Premium generated in health insurance (Gross) (million GEL)



3.4 Health Insurance "Geography"

As already mentioned, group insurance is the largest part of the business of medical (health) insurance. Group insurance can be considered as a group of employees employed in both private and public structures. Due to the fact that there are public structures in all regions / municipalities of Georgia, medical (health) insurance will be applied to the persons employed in the mentioned regions, in case the organization has purchased the mentioned insurance. The same can be said for private organizations that have branches in different regions and have purchased medical (health) insurance.

Determining the exact number of insured by regions and municipalities is hampered by a number of problems. First of all, the address of the insured person in case the legal and physical address of the insured person does not match. There

are quite frequent cases when the legal address is fixed differently and the physical address is different. Consequently, the distribution of the number of insured persons by legal address by regions and municipalities presents a rather inaccurate picture. It is also problematic to use a physical address in this regard. The physical address of the insured person and the address of the service / organization may also be different.

In view of all the above, in order to study the geography of insurance, it is advisable to consider the coverage of how the whole of Georgia is covered by medical (health) insurance.

An important assumption for this is the following: Due to the nature of the insurance, if the insurance company is represented by a family doctor in a particular region/municipality/city/town/village, it means that at least the minimum number (possibly less than ten) in that region/municipality/city/town/village is a person with medical (health) insurance. Conversely, if at least a minimum amount of medical (health) insurance is available in a particular region/municipality/city/town/village, a family doctor will be definitely present in the said or nearby region/municipality/city/town/village.

Accordingly, the location of family physicians shows the spread of insured throughout Georgia. There are 78 such locations, mainly cities, towns and several large rural settlements.

3.5. Types of Health Insurance

Individual Health Insurance

There are two main types of health insurance - individual and group.

Individual insurance is when a private person insures only the health of himself or his/her family members under the conditions of the insurance he/she prefers.

According to statistics, by the end of 2020, there are 40,943 policyholders (including family members) in the insurance market who enjoy individual insurance. As we have already mentioned, individual insurance is developing at a slow pace in Georgia. One of the reasons is by nature those coverages covered by individual insurance (only emergency services for a certain period, at least one year). Basically, the following coverage is valid for a certain period of time (at least one year) after purchasing individual insurance:

- 24-hour hotline - 100% unlimited;
- Personal doctor service - 100% unlimited;
- Ambulance - 100% unlimited;
- Emergency outpatient services - 40-60% coverage. It is possible to include a positive list, within which the insurance case is reimbursed unlimitedly or without a positive list, but within the established limit;
- Emergency hospitalization - covered 100%, within a certain limit;
- Hospitalization in case of an accident - covered 100%, within a certain limit.

The status of a beneficiary of a universal health care program is suspended for a person (with exceptions, including children aged 0-5, pensioners ...) who enjoys private insurance (including individual insurance). Given this choice - individual insurance or universal health plan - in most cases the decision is in favor of the universal health plan, because a person can, without paying any premiums, receive for free in some cases about the same or more benefits (in financial terms) than when buying individual insurance.

Group Health (Corporate/Government Agencies) Insurance

Group insurance is when one insurance contract provides for the insurance of a group of individuals united by a certain mark (for example, an organization insures the health of its employees). Group insurance can be considered as a group of employees employed in both private and public structures.

In addition to individuals, organizations are also interested in medical (health) insurance. On the one hand, they provide employees with an additional significant benefit, as they are insured by the employer scheme, both employees and their family members, and on the other hand, the employer protects himself from the costs caused by the employee's illness. Thus, in health insurance, the insurance interest may have both the individual himself in relation to the health of himself or his dependent family members, as well as organizations in relation to the health of their employees.

Consequently, the employer may pay the employee insurance premium in full or in part. However, the employee has the opportunity to insure his/her family members by paying an additional insurance premium and/or to improve his/her and/or family members' insurance conditions/coverage.

Generally, in the case of group insurance, there are certain requirements for the group. First, the group should not be made up of a desire to purchase insurance. In addition, the volume of the group must exceed a certain limit, which may be different in various companies and cases. Also, to prevent anti-selection within the group, there is usually a requirement that the number of insured members of the group should not be less than 70-80% of the whole group. There is also a requirement that a member of the insured group must be in an active employment position (must go to work regularly).

When group insurance underwriting, it is not the individuals but the characteristics of the whole group that are considered. Morbidity rates and tables are used to assess groups.

Typically, group contracts are concluded for one year, subject to renewal. Each year's premium covers only that year's losses. Each year a new bonus may be determined based on changes in the group.

In the case of medical (health) insurance, group insurance is the largest part of the business. Because this form of insurance is attractive for both the insurer and the insured with many features and indicators. In particular, it is much easier and preferential for policyholders to purchase medical coverage within a group than individually, and it is attractive for an insurer to insure an entire portfolio as a result of a single contract, which in itself is largely balanced.

Medical insurance policies provide for a number of exceptions that are not covered by the policy. First of all, it is related to the reimbursement of the costs of treatment of diseases that are long-term and expensive. There are usually the following exceptions in policies: Psychiatric, ophthalmological, balneological, venereal, diabetic diseases. Exceptions also include diseases that afflicted the insured prior to insurance and are ongoing in a chronic form. In addition, medical services required as a result of participation in high-risk sports, illegal or military operations. Exceptions also include medical services, the need for which is caused by the insured's intentional damage to his/her health or life (self-harm, suicide attempt, etc.).

These exceptions are present in almost all policies. However, this is not a complete list of exceptions. Exceptions vary from policy to policy, depending on the high health risk of the insured/insured group.

The insurer/organization insures the health of the employee and his/her family members with the desired insurance conditions. When finding the desired insurance conditions /coverage, the following happens:

- In case of fixed budget allocated for medical (health) insurance, receiving the most desirable coverage/ conditions offer from insurers;
- Receiving the offer of the optimal insurance premium from the insurers within the pre-defined desired coverages/ conditions.

In both cases the insurer makes a choice between several insurers. Tender or direct cooperation with insurers may be used in this selection process.

Chapter 4 - Successful International Experience in Universal Healthcare

It is necessary to share international experience to determine appropriate strategies for the improvement and development of the Georgian healthcare system. More specifically, those countries that in recent years have achieved real success in terms of universal health by thoroughly reforming their health systems.

The presented analytical overview serves to compare the systems of the EU and several other, successful countries in terms of universal health care, based on which the components are selected for the most convenient, long-rang and promising healthcare model to be introduced in Georgia.

The study relied on a description of the models and a number of characteristic parameters of these models to clearly present the health system profile of each country. As well as international health indicators. After systematizing and analyzing the obtained information, based on the data of the research component of the project, the health systems of the countries of particular concern to Georgia - the Netherlands, Israel and Switzerland - were selected, for which the second phase of the desk research was conducted, focusing on the following issues:

- Experience in health care reform and introduction of mandatory health insurance;
- Services and activities defined by mandatory health insurance and other health care projects;
- Medical service delivery system and providers;
- Strategies for quality assurance of medical services;
- Universal Health Care and Medications.

4.1. Healthcare Models in EU Countries

Information and data on models and characteristics of health systems in 26 EU countries are used from documents prepared by the European Commission, the Organization for Economic Co-operation and Development and the WHO European Health Observatory, the World Bank and the UN SDG websites.

Important characteristic information on the health care system of the EU Member States is presented in in the Annexsees 1,2,3,4. It is noteworthy that the priority health task of all 26 countries is to maximize the coverage of its population with medical services, which, if we rely on statistics, will succeed. In addition, the vast majority of these countries (19 countries) provide universal health care through various country-tailored social insurance schemes, while the rest (7 countries) use the state model of health care.

As it turns out, the social insurance model (or rather, some of its modern modifications) responds more adequately to the very serious modern challenges of health care, in terms of effective management, cost-effectiveness, quality assurance of services and, most importantly, universal coverage.

Health insurance is mandatory in social insurance models and is provided with an appropriate legal framework.

Particular attention should be paid to the competitive insurance model, which was first established in the Netherlands (1993) and then developed in one form or another in Switzerland, Israel and Slovakia. Also, several other countries are preparing health care reform to introduce this model.

4.2. Successful Models of Mandatory Health Insurance in the Perspective of Universal Health Care: The Netherlands, Israel, Switzerland

At the turn of the twentieth and twenty-first centuries, the issue of thorough health care system reform was on the agenda of the governments of many developed countries in response to the challenges of the time. The strategic goal of the reforms was to increase access to multifaceted, efficient and quality medical care for the population.

The Netherlands, Israel and Switzerland have successfully coped with this task after overcoming a number of difficulties. The population of all these countries is fully and timely provided with quality medical services, which is largely the result of a well-functioning, reformed health care system based on the model of compulsory health insurance.

The Netherlands - The model of social health insurance has been operating in the country since 1941. Prior to the reform, about 63% of the population was covered by insurance medical services. However, the wealthier strata enjoyed private insurance, while a significant portion of the population was left without insurance. The ineffectiveness of this insurance model and, consequently, the long waiting lists for service delivery, led to a market-oriented reform based on a model of managed competition by Allen Enthoven, an American economist of Dutch descent.

After almost twenty years of preparation, in 2006, a fundamental health care reform was carried out, creating new structures and governance mechanisms for the system. As a result, a unified system of mandatory health insurance has been introduced, based on the principle of competition, in which private insurance companies compete with each other to attract policyholders.

Mandatory health insurance scheme is mainly regulated by two laws (on Medical Insurance [2006] and on Exclusive Medical Expenses [2015]).

Insurers and service providers are given some opportunity to agree on the prices, volume and quality of medical services. In addition, the insurer can make a profit and pay dividends to shareholders. It is the responsibility of insurance companies to acquire new customers. They are prohibited from changing the amount of the insurance premium even if there is a risk (age, severity of comorbidities, etc.).

The government refused to intervene in the system and took on the role of guarantor of the medical care process, without directly participating in the process itself. Responsibilities were transferred to insurers, health care providers and policyholders. In this model, the state is responsible for monitoring the quality of medical services, as well as physical and economic access.

In order to avoid negative market influences on the new system, a supervisory system represented by independent organizations was established.

Increased competition among outpatient service providers in the long-term care sector has led to a number of beneficial changes in the system. The transfer of home care powers to municipalities has made it possible to create more diversified mechanisms for organizing this type of service. There were 10 insurers in 2018, but the insurance market was dominated by the four largest insurance conglomerates, accounting for 90% of enrollments. All insurers operate in a non-profit mode.

The number of uninsured in the Netherlands has been steadily declining since 2011. At the beginning of 2017, only 23,000 people were uninsured, which is 0.2 percent of the population.

Israel - Voluntary health insurance funds have played an important role in the development of the country's healthcare system over the past decades. Prior to the introduction of the state system of mandatory health insurance, these funds provided most of the medical services in the country.

In 1988, the government set up a commission to investigate national health problems, also known as the Netanyahu Commission. This commission identified such serious problems of the system as: (i) the inconsistency of the quality of medical services with the expectations of the population; (ii) inefficiency of the Ministry of Health and scarcity of resources; (iii) Simultaneous participation of the Ministry of Health in the processes of regulation and delivery of medical services; (iv) ambiguity in funding and budgeting processes; (v) poor management and lack of management leverage; (vi) Low levels of employee satisfaction and motivation.

The package of recommendations developed to address these key issues identified the main strategic directions and priorities for the reform: Develop and enact a law on compulsory health insurance; Reorganization of the Ministry of Health in order to separate the regulation and the provision of medical services; Strengthening decentralization and competition in the field; Improving centralized financing and moving to the capitation principle of remuneration; Access to private practice in state hospitals; Introduce material incentives to increase employee motivation; Development of information systems and expansion of scientific research.

The Medical Insurance Act (1995) provides health insurance for all citizens of the country. The population is free to choose one of the four competing private companies, which is obliged to register all interested parties and, through the providers, in accordance with the medical indications, to provide them with the medical services included in the basket defined by the government.

The health funds involved in this insurance scheme, the same insurance companies, are non-profit. Health funds (companies) have at their disposal an extensive network of medical facilities: clinics, hospitals, specialized diagnostic centers and clinics, women's and children's clinics, emergency rooms, pharmacies, nursing homes and geriatric centers.

The insured has the right to receive reasonable quality medical care within a reasonable period of time within a reasonable distance from the residence. However, there is no official definition of "reasonable".

Certain groups of the population are not included in the compulsory insurance scheme. These are soldiers who receive assistance from the Ministry of Defense and prisoners who are cared for by the penitentiary system. As well as registered

but undocumented foreign workers whose inclusion in the insurance program is the responsibility of their employers; Undocumented migrants; Temporary residents and tourists.

In **Switzerland**, health insurance has historically been provided by many small private insurers. After several less successful attempts to introduce a universal coverage system, in 1994 the federal government introduced a law based on the principle of compulsory health insurance that would have to: i) Strengthening equality by introducing universal coverage and subsidizing low-income families; ii) Expand the benefit basket and improve health services; and iii) Retention of the growing costs of the health care system.

The law (1996) obliges all citizens to purchase health insurance, while the cantons are required to comply with the requirements of the law. By law, a natural person acquires a personal insurance policy, and for those who are dependent with that person, it becomes necessary to purchase separate policies for them. New residents must purchase the policy within three months of arrival in Switzerland, and repayment is made retroactively, according to the date of arrival. A temporary resident-visitor pays out-of-pocket insurance or uses his/her own country insurance if he/she has one. The issue of compulsory health insurance for undocumented immigrants is still an unresolved problem.

Since 2000, a number of health care reforms have been implemented in the country, which has led to the optimization of the compulsory health insurance system - Changed hospital fundings, improved drug-related regulations, tightened control over epidemics, and harmonized human resource regulations across the country.

Further steps to reform the sector were presented in the Federal Government's Strategy Paper "Health 2020", which prioritized three areas of reform: (i) improving the use of information; (ii) improving outpatient care planning; (iii) Improving the health of people with special needs.

With the reform of the health care system and the introduction of compulsory health insurance, the coverage rate of the population with health services reached the maximum mark (99%) in a short time. However, the quality of medical care is high, long waiting lists are virtually ruled out because all providers involved in a licensed, compulsory insurance scheme have an obligation to accept all applicants.

Compulsory and Voluntary Health Insurance, Other Health Programs and General Principles of their Financing and Management

The health insurance system in **the Netherlands** has three components:

I. Compulsory basic health insurance - This insurance scheme is regulated by the Health Insurance Act (Zorgverzekeringswet, Zvw), according to which a citizen aged 18 and over must purchase an insurance package. The insured pays one part of this package (nominal, fixed) to the insurance company of his choice, and the other (depending on the amount of income) the employer pays to the Health Insurance Fund (FMS). The resources accumulated in this fund are distributed among the insurers according to the risk equalization system for the groups of insured persons. "Medical benefits" reduce the cost of health insurance to low-income groups. Children and adolescents under the age of 18 are registered with one of the parent insurance companies, and the cost of their insurance package is automatically covered by the state.

Insurance companies are obliged to accept all applicants, while policyholders have the right to change companies every year. The uninsured person will be fined and his/her insurance premium will be deducted directly from the income. Undocumented immigrants are not eligible to purchase health insurance (except for emergency care, obstetric services). Because of this, they pay for the treatment out of pocket. Individuals residing in the country for more than three months are required to purchase private insurance. Short-term visitors must also purchase visit duration insurance if they do not submit proof of insurance purchased elsewhere.

In addition to the above-mentioned contribution, the insured must pay the franchise for the insurance to take effect, the minimum and maximum amount of which is determined and made public by the government 1 year in advance. In case of non-payment of the franchise, the beneficiary is provided with only the minimum version of the basic package (see below). The amount of the monthly premium for basic medical services (Zvw) is in the range of 110 euros (with 5% variability among competing insurers). The cost of the mandatory deduction (franchise) is approximately 385 euros.

II. Compulsory long-term care/treatment insurance is governed by the Exclusive Medical Expenses Act (WRI, Algemene Wet Bijzondere Ziektekosten, AWBZ), and is funded primarily by income-dependent premiums. Insurance implies a complex cost-sharing scheme between insurers and policyholders. Assistance under this type of insurance is provided only after confirmation of the necessity of receiving it. The medical bureaus (Zorgkantoren) are responsible for organizing and providing care. They operate independently but work closely with health insurance companies.

III. Voluntary health insurance, which covers medical services that are not included in the above two compulsory insurance schemes. Public health programs and other social projects (including some types of home care) are mostly covered by the budget.

The Israeli healthcare system is represented by three main components:

I. Compulsory basic health insurance, which is regulated by the National Law on Health Insurance - Mandatory health insurance is primarily financed by the targeted health tax (5% of the income of persons aged 22 and over) and the budget, which in turn is financed by the progressive income tax of individuals. The health tax is about 4.8% of an Israeli citizen's salary. Children, married women and other special groups are exempt from the health tax. The government distributes the health insurance budget to 4 non-profit insurance companies according to capitation, which includes the sex, age, geographical distribution of the insured and five chronic, expensive diseases to treat.

II. Voluntary medical insurance, which includes medical services that are not included in the compulsory health insurance scheme. This insurance covers 14% of national health expenditures (2016). Commercial voluntary insurance is usually more comprehensive, more individually tailored, and therefore more expensive. It can be purchased by individuals and employee groups. Virtually every citizen of the country acquires voluntary insurance services from one of the four nonprofit insurance companies or commercial insurers, or both. As of 2016, 84% of the country's adult population had compulsory health insurance, while 57% were additionally involved in a commercial insurance program.

III. Public health and other social programs (immunization, vaccination, infectious disease control, infant development screening, postpartum care, long-term care / treatment, etc.) are covered by the Ministry of Health from the budget.

Compulsory health insurance in **Switzerland** has three sources of funding: 1. Insurance premiums (35.6% of total health expenditures [2016]); 2. General taxes, cantons, municipalities and federal taxes (which covered health care costs, respectively 17.3; 15.0; 1.8; 0.4% [2016]); and 3. Contributions to other social insurance schemes (including military, seniority and disability insurance) - 10% [2016].

Compulsory health insurance is the duty of non-commercial insurers competing with each other on Cantonal Exchanges. Insurers are under the supervision of the Federal Office of Public Health. Usually up to sixty (56 - 2019) insurers represent policies for three age groups (18≤, 19–25, ≥26) with a 6-level franchise on the Cantonal Exchange.

In addition to the standard model of services (for example, free choice of doctor), there are alternatives in which the choice of provider may be limited - Involvement of health promotion organizations; Family doctor models that require a primary care physician "Gatekeeper" function; Call Centers and Hotlines.

Usually, the vast majority of policyholders opt for alternative insurance. Some insurers also offer accident coverage.

The average annual premium in Switzerland in 2018 was 5,584 Swiss francs (6,085 USD). At the same time, the amount of premiums varies according to the insurance companies. The individual pays the premium through the insurer of his choice. The central fund distributes its funds according to the risk equalization scheme among insurers, which is adjusted according to the specifics of the canton, age, sex and basic expenses of the previous year (time spent in hospitals or nursing homes, pharmaceutical expenses, etc.).

Voluntary health insurance is used by people in the country to cover services not covered by a mandatory insurance package (for example, free choice of hospitals or doctors, or inpatient care in special circumstances). This type of insurance is regulated by the Swiss Financial Market Supervision Division. Insurers have the right to refuse service to the applicant based on changes to the benefit basket, premium adjustments, and medical history. Service prices are usually agreed directly between insurers and providers. Unlike mandatory insurers, voluntary insurers are for-profit organizations. However, they also often have non-profit branches that operate under a compulsory health insurance scheme. Usually, voluntary insurance covers 50% of the population. Public health programs and other social projects are covered by cantonal budgets.

The Place and Role of Governments and other Organizations in Health Insurance and other Health Strategies

The universal health care model cannot be effective and successful when the Ministry of Health is simultaneously involved in the regulation and delivery of medical services, lacks adequate resources to manage the new system, and generally is not renewable in response to modern healthcare challenges.

The governments of the countries refused to participate directly in the new insurance system and took on the role of guarantor of its functioning, while the responsibilities were transferred to insurers, health care providers and policyholders. In addition, states are responsible for monitoring the quality of medical care and the physical and economic availability of services.

In order to avoid negative market influences on the new system, a supervisory system represented by independent organizations was set up (see Annexas 6,7,8).

Medical Services Defined by Mandatory and Voluntary Health Insurance and Public Health Programs

Mandatory Health Insurance

Overall, the basic mandatory health insurance packages in all three countries are similar, and some differences can be explained by the specifics of health systems and their economic potential.

Basic package services are clearly focused on outpatient services, with a completely adequate outpatient medication component.

An important place is given to public health and, consequently, preventive medicine services, which should be said primarily about the Swiss program.

Particularly noteworthy is the large number of social treatment / care and support projects that collaborate / coordinate with Package Outside social programs.

Universal package of mandatory insurance		
The Netherlands	Israel	Switzerland
• Consult a general practitioner doctor • Consult a specialist doctor • Inpatient treatment • Consultation of a psychiatrist / psychologist • Dental care (18≤) • Prescribing medicines and reimbursing their cost • Physiotherapy Services (18≤) • Home nursing care • Health promotion programs • Outpatient psychiatric care for mild / moderate mental disorders • Outpatient and inpatient care for complicated and severe mental disorders ***Minimum version of the basic package (in case of non-payment of the franchise)*** • Dental Services (18≤) • A visit to a general practitioner doctor • Essential medicines (according to the list) • Providing medical care in outpatient facilities in the evening hours and on weekends • Provide medical care for pregnant women at home, including care during the menstrual period • Home care for the sick	• Primary health care and specialized outpatient services • Diagnostic examinations • Prescribing medications and reimbursing them • Inpatient treatment • Basic preventive services • Psychiatric care • Dental care (for people aged 18≤ and 75+) • Pregnancy care • Additional medical care (physiotherapy, occupational therapy, medical nutrition, speech therapist) • Some long-term medical equipment (wheelchairs, orthopedic devices) • Limited palliative care and hospital care	• Preferably the services of a general practitioner and medical specialists • Pharmaceutical and medical devices (extensive list) • Inpatient treatment • Home Care Services (Spitex) • Psychotherapy (with medical indications) • Some prophylactic measures, including selective vaccinations, some health tests, and screenings for high-risk patients • Patronage of pregnant women, childbirth, care of mothers and subsequent period • Outpatient management of mental illness • Long-term care with medical indication • Hospice Services (due to major illness)

Long-term care / treatment services are covered by compulsory insurance only in the Netherlands. This component is completely autonomous and is not included in the basic package. However, it is an important complement to its services.

Long-term care/treatment includes boarding life, personal care, supervision, medical care and nursing services. As well as the provision of ancillary medical facilities and transportation services.

Patients who require constant supervision or 24-hour care are given the opportunity to receive long-term care to avoid exacerbations or serious harm. The Needs Assessment Center (Centrum Indicatiestelling Zorg) is a government agency that decides to provide the above assistance only based on clinical needs.

Low-income people are offered subsidies by the Dutch government to cover the premiums for the above-mentioned component and other social security programs.

Voluntary Health Insurance

Given that there is quite successful compulsory insurance in all three countries, the commercial insurance sector is highly developed and therefore a full-fledged complement to the basic package.

The vast majority of the population in the Netherlands and Switzerland (84% and 72%, respectively) acquire additional private insurance, while in Israel the number is lower (25%).

The list of services and facilities included in the insurance packages of different sizes or contents voluntarily purchased in all three countries is practically identical - Dental services, physiotherapy procedures, certain medications, glasses (lenses), as well as home or apartment care services, long-term care / treatment (only in Switzerland, because in the Netherlands it is covered by compulsory insurance, and in Israel - from the budget with a social program).

Private insurance is also purchased to improve inpatient treatment or maternity conditions (comfortable medical facilities or wards, etc.).

Public Health Programs

Services provided by public health (immunization, screening, control of infectious diseases, etc.) are covered by budgets in all three countries and are therefore free to the population.

		The Netherlands	Israel	Switzerland
Primary care physicians	**Property**	Private	Private, nonprofit	Private
	Remuneration	Main activities according to capitation and service fees	Staffing schedule or contract, according to capitation and some service fees	Predominantly according to the service fee; Sometimes by capitation - within a managed care plan
	The function of the "Gatekeeper"	Yes	Only in the case of 1/4 of the health plans system	Only under some managed care plans
	The need for patient registration	No However, many register voluntarily	Only in the case of 1/2 of the health plans system	Not at all, with the exception of some managed care plans
Hospitals	Property	Private, non-profit	Predominantly public and non-commercial, the rest commercial	Public and private
	Remuneration	On the principle of diagnosis related groups (DRG), within the global budget	Hospital Services - On the principle of diagnosis related groups (DRG)	Inpatient services - On the principle of diagnosis related groups (DRG); Outpatient services - according to the service fee

Medical Service Delivery System and Providers

Professional Resources

In all three countries, the number of physicians is regulated at both the university and national levels.

In **the Netherlands**, the Quality Agency (Capaciteitsorgaan) and the Ministry of Health work together to develop postgraduate training programs and doctor certification to balance supply and demand and improve service quality. The scarcity of doctors and pharmacists in villages and remote regions is still an unresolved problem.

There is a shortage of doctors in **Israel**. In addition, more than half (58%) of Israeli physicians aged 65 and over have received higher medical education abroad (2015). To address the shortage of doctors across the country, and especially in remote areas, the government has increased the number of doctors in the country's hospitals since 2011 and introduced financial incentives (single bonuses and salary supplements) to motivate graduates to work in remote areas. This initiative has led to a positive trend since its introduction.

Acquisition of medical specialties in **Switzerland** is carried out according to a six-year program in public universities. Curriculum standard is defined at the federal level. After receiving a federal medical diploma, graduates move on to

the training phase as specialists. The title of "specialist" is one of the conditions for obtaining the right to participate in independent medical practice. Although training professionals in the field and increasing national capacity was a high priority of the Federal Government's Strategy 2020, some universities retained the right to limit the number of students.

Primary Health Care

As of 2017, there were 13,364 registered general practitioners (GPs) and 23,236 specialist doctors registered in **the Netherlands**. 82% of these physicians worked in groups (2-7 physicians per group) and 18% individually. The general practitioner is a central figure in healthcare in the Netherlands. The size of the full-time internship is up to 2,200 people. Often a general practitioner is assigned the function of a "gatekeeper" for this position. Chronic cases (diabete, cardiovascular disease, chronic obstructive pulmonary disease) are managed through networks of groups of physicians hired by providers (3–9 general practitioners).

As of 2018, 5,052 (13%) out of 38,523 licensed physicians in **Israel** held the position of general practitioner. The average number of doctors in the country is 0.6 doctors per 1000 population (or 1 doctor per 1 653 insured). However, this figure varies according to the specifics of the regions and the areas of action of the health funds (from 0.57 to 0.73). Most doctors are contracted by one of the companies involved in compulsory health insurance. Insurance companies (Clalit, Maccabi, Meuhedet and Leumit) have different approaches to organizing beneficiary care/treatment.

The Clalit is the largest company that owns and manages primary health care clinics. The doctors working in it are salaried employees of the same clinics. A typical clinic is multidisciplinary, with 6-6 general practitioners, several nurses, pharmacists and doctors of different specialties (cardiologist, endocrinologist, dermatologist, etc.) working in it. The Clalit also hires specialists in independent practice.

The other three health insurance companies prefer a mix of multidisciplinary clinics and independent primary care practitioners.

At the Maccabi (second largest) and the Meuhedet, primary health care is provided primarily by independent practitioners, while at the Leumit the clinical model is preferred. The insured has the right to choose a doctor from the company list. According to practice, most of the insured stay with their doctor for a long time.

In the Clalit, each beneficiary is attached to their doctor. The Clalit is the only company in the country that requires a doctor to adhere to the "Gatekeeper" standard, which means that it provides a variety of services according to its application (with the exception of dermatologist, otolaryngologist, ophthalmologist, orthopedist and gynecologist).

About one-third of Israeli nurses in the community work as salaried employees for one in four insurers. Their role has been expanding, starting with the traditional care of pregnant women and ending with the care / treatment of patients with chronic diseases.

Doctors are prohibited from taking additional fees for services rendered. The salaries of doctors working at the Clalit Clinic are determined by a collective agreement with the Medical Association of Israel. Compensation for work performed by individual practitioners under compulsory health insurance is made in accordance with the capacitive approach agreed with physicians' associations. The Clalit and the Leumit mainly use the "passive capitation" approach, ie a quarterly fee based on the number of registered patients, regardless of whether the patient has visited his or her doctor. The Maccabi and the Meuhedet use "active capitation" to cover only those insured who have visited a doctor at least once a quarter. Independent practitioners also receive a limited amount of pay for certain services. Quality-related financial incentives are not generally used.

42.9% of physicians employed in **the Swiss** outpatient sector were general practitioners (2017). The majority of the population has the opportunity to make a free choice between self-employed, private practice physicians, except when it comes to physicians involved in compulsory insurance schemes.

Primary and specialized outpatient treatment is usually physician-centered, while nurses and other health care professionals play a relatively modest role. The average number of patients per doctor in the primary health care system ranges from 1,600 to 1,900. To date, no financial initiative has been developed to increase the motivation of general practitioners to become involved in the treatment/care of chronic patients. In the compulsory insurance system, the remuneration of general practitioners is capitation. A much larger portion is produced according to a national scale called TARMED (since 2004). The TARMED fee is the subject of an annual agreement between the Insurers' Associations and the Canton Supplier Associations. In case of disagreement, it is the prerogative of the cantonal government. Payment above the established fee is not allowed.

Specialized Outpatient Services

Netherlands - The vast majority of medical professionals work in hospitals (49% - in university clinics, 39% - in group practice), with the remaining 12% practicing independently. Since 2015, physician specialist fee amounts have been openly reviewed by specialist associations and hospitals.

Integrated funding has dramatically changed the relationship between specialists and hospitals, i.e. hospitals have to allocate financial resources between their specialists.

Israel - Specialized outpatient services are mainly provided by clinics or doctors' offices owned by health insurance companies. Clinics are mainly polyprofile, while offices are monophilic. The patient is free to choose the specialist of his choice, which is contracted by the compulsory health insurance company. Services provided by specialists working outside the system should be paid out of pocket or covered by voluntary health insurance. The remuneration of most of the specialists working in the outpatient mode according to the quarterly ceiling is based on the principle of active capitation, which is supplemented by the cost of certain additional procedures. Tariffs are set by health insurance companies. The specialist does not have the right to "balance" the services included in the compulsory insurance scheme. At the same time, specialists can serve patients with both compulsory and voluntary insurance. Specialists can, at their discretion, determine the amount of the fee for voluntarily insured patients.

Switzerland - Approximately 57% of physicians practicing private practice in the outpatient sector are qualified as private “specialists” (2017). They are mostly self-employed. All citizens of the country can apply directly to a specialist, except when compulsory insurance requires the application of a "gatekeeper" of primary health care. Specialist remuneration, as in the case of general practitioners, is based on the TARMED scale. The practice of medical specialists is mainly concentrated in urban areas and in the vicinity of hospitals. The Swiss system allows specialists to serve both private and compulsory insurance beneficiaries.

Hospital Services

Netherlands - As of 2018, there were 71 inpatient facilities in the country, including 8 university clinics. All hospitals are private, but profits are distributed only to shareholders. Payments are mostly based on a case-based diagnosis-treatment (DBC) system, which is similar to the DRG approach. Doctors 'groups negotiate with hospitals on the issue of doctors' salaries. The DBC system is used in both outpatient and inpatient services. Also, in relation to the remuneration of specialist physicians, which strengthens the integration of specialized care in the hospital. Some of the inpatient treatment is covered by the expense of add-on. Add-on in health insurance are separate bills intended to purchase expensive medicines and to cover the costs of treatment in a separate intensive care unit. In addition, university medical centers receive a special subsidy for the introduction of new technologies.

Israel - 18 of the 45 hospitals in the country are owned by the Ministry of Health or municipalities, which is 40% of the national potential. 16 private, non-commercial hospitals (36%) are owned by health insurance companies or other non-profit organizations, while 11 commercial hospitals make up the remaining 24%. Typically, these are small, specialized hospitals that specialize in a specific area, and the cost of inpatient treatment is different: Emergency inpatient care - according to the service provided; Hospital treatment - daily; Hospital treatment - daily or by intervention - according to the PRG (procedure-related group) approach; Outpatient services - according to the service provided or in accordance with the PRG (procedure-related group) approach.

Maximum rates are set by the government. However, health insurance companies are involved in price reduction negotiations. The government also sets revenue parameters (minimum and maximum) that control how much each hospital’s revenue can decrease or increase from year to year. Hospital revenues cover all expenses, including the remuneration of doctors. Procedural group fees (PRG) cover all hospitalization costs (excluding rehabilitation). Any additional charges for patient severity, expensive treatment, or use of new technology are excluded. Government and non-commercial hospitals strictly adhere to the national standard of fees, while prices in commercial hospitals are unregulated. Doctors at state and non-commercial hospitals (these are mostly hired staff) receive additional pay for non-working hours on limited terms. Until 2018, there was no possibility to choose a specialist in non-profit hospitals. Patients who wished to choose, for example, an endocrinologist or surgeon had to go to a commercial hospital with out-of-pocket consultation fees or purchase voluntary health insurance.

Switzerland - As of 2016, there were 283 hospitals in the country (102 general profile and 181 specialized), a bed fund - 38 058. Hospitals are publicly or privately owned. Inpatient treatment accounted for about one-third of total health expenditures (35.3% in 2016). More than half (55%) of hospital service financing is covered by compulsory health insurance, co-insurance and co-financing. Compulsory health insurance services are covered by the Diagnostic Related Groups (DRG) system. The cantons are responsible for planning hospitals and coordinating insurance schemes with other cantons. Since 2012, patients have been able to receive services in any canton. Doctors employed in a hospital usually receive a salary, while doctors in a public hospital can receive additional remuneration. In particular, from the services of insured patients.

Medical Service Quality Assurance Strategies

In all three countries, ensuring the quality of medical services is a top priority, and the challenges that governments and health care systems are adequately addressing.

In **the Netherlands**, medical quality assurance is provided by the relevant legislation, which regulates professional activities, compliance of health care institutions with established standards, patient rights and medical technologies. The Netherlands Health Inspectorate is responsible for quality and safety monitoring. The National Institutes of Health Care based on quality improvement and accelerating the introduction of evidence-based practices (2014) and its subordinate National Quality Institute are responsible for a number of areas of quality control of medical services. The state mechanism for ensuring the quality of medical services is presented in the state register, which confirms the compulsory continuous medical education every five years with the following instruments - Powerful system of accreditation and licensing of institutions, National Quality Improvement Programs, regular on-site assessment system by professional organizations, professional clinical guidelines, monitoring and evaluation and expertise reports.

Israel has a comprehensive system for monitoring the quality of primary health care services. The quality indicators of each compulsory health insurance company have been public since 2014. Although the information published by insurance companies is presented in a national format, companies' databases also store internal data in regional, clinical and personal (physician) formats. Companies monitor the activities of their physicians and work closely with them to improve quality.

The Ministry of Health regularly publishes comparative monitoring data by hospitals and clinics. Numerous models of financial incentives have been developed to improve medical services in hospitals and maternity homes. Professional associations, mainly in collaboration with the Ministry of Health, have developed instructions, protocols, guidelines and other supporting materials for clinical areas. All general hospitals in Israel are required to be accredited by the Joint Commission International. An independent research institute annually evaluates the quality of services provided by the compulsory insurance of the population and the health system in general in terms of satisfaction. The Ministry of Health maintains a national registry of certain expensive medical devices, widespread diseases (including cancer, low weight, injuries and occupational diseases) and conditions.

Switzerland - Medical service providers must be licensed in practical medicine and are required to comply with all educational and regulatory standards. Continuing medical education of physicians is obligatory. The Swiss Institute for Continuing Medical Education is responsible for licensing doctors. Professional self-regulation in the country has been a traditional approach to quality improvement. However, this approach has more and more opponents. Quality assurance initiatives often appear on the ground at the level of medical service providers, which involve the development of new clinical approaches, groups of colleague physicians and consensus guidelines. Improving the quality of medical care is a priority of the federal initiative Health 2020, which aims to implement a national quality assurance network and programs in areas such as the safety of medical treatment and nosocomial infections. Since 2008, inpatient quality indicators have been introduced to monitor and evaluate the quality of emergency care in hospitals.

Universal Healthcare and Medicines

The Netherlands - Providing coverage for pharmaceutical needs, regardless of age and income, is a fundamental feature of Dutch healthcare. The standard insurance packages offered by private insurers definitely provide coverage of medicines included in the positive list. The decision to include medicines in an insurance package is made by the Ministry of Health, Welfare and Sports (VWS) on the recommendation of the Netherlands Health Insurance Board (CVZ). At the same time, insurance companies' offers for reimbursing a limited number of certain groups of medicines may be considered.

The National Institutes of Health (Zorginstituut Nederland [ZIN]) is responsible for evaluating medicines with health technologies and making recommendations for their reimbursement. For its part, the National Institutes of Health seeks advice and recommendations from the Scientific Advisory Committee and independent experts on value and effectiveness issues.

Positive list drugs are basically divided into three groups: (1)Therapeutically interchangeable products; (2) Unique products that cannot be grouped and (3)Medicines that are reimbursed only in the specific circumstances. Health insurance covers only registered, reimbursable medicines.

Most insurers cover the lowest cost of medication costs. Consent to cover expensive medications is given when they share the doctor's arguments about the need for a particular medication. Unregistered drugs are reimbursed only in exceptional cases.

Prior to the sale of a medicinal product in the country, its manufacturer must obtain the consent and registration certificate of the Netherlands Medicines Evaluation Board (MEB, College ter Beoordeling van Geneesmiddelen, CBG). The manufacturer of the pharmaceutical preparation is obliged to submit a dossier to the CBG, which will present all the data of chemical-pharmaceutical, pharmacological, toxicological, clinical and other research. Upon completion of the drug approval procedures, it will be filed with the Medication Information Bank (MEB) and assigned a registration number.

Since 1996, the price of medicines has been regulated by the Law on the Price of Medicines (Wet Geneesmiddelprijzen, WGP). It is noteworthy that it also includes generics, which account for 74% of all medicines used (2019). The maximum wholesale price of each drug is determined by the Ministry of Health (VWS) according to the principle of external reference prices. The external reference pricing approach is used only when consent has been obtained to reimburse the cost of the product and when it is sold in at least half of the reference countries. These prices are reviewed and verified twice a year, taking into account changes in market conditions.

In order to produce medicines locally in the Netherlands, manufacturers must follow the rules of maximum prices for medicines (Regeling maximumprijzen geneesmiddelen). The company Farmatec, which is part of the Ministry of Health, is responsible for setting these prices. In addition, it issues permits for medicinal products and devices, maintains registration.

Issues related to pharmaceutical products in **Israel** are provided by a strong legal framework and other regulations: Decree on Pharmacists (1981) - regulates the production, marketing, subscription, import and registration of medicinal products; Pharmaceutical Regulations (Medicinal Products, 1986) - Regulates the marketing, prescription, import and registration of medicines. Also contains provisions regarding the challenge of pharmacological supervision and medication; Pharmacist Regulation (GMP, 2008) - regulates the production, import and demand of medicinal products; Order on Price Supervision of Goods and Services (1996); Order on Price Supervision of Goods and Services (Maximum Prices of Prescription Drugs, 2001); Order on the Supervision of the Prices of Goods and Services (Statement on the Use of Medicines, 2001).

The regulation of pharmaceuticals in the country is entrusted to the Pharmaceutical Administration under the Ministry of Health, which is represented by the following entities: Institute for Standardization and Control of Pharmaceuticals - is responsible for the quality of medicinal products; Drug Registration Department - is responsible for the registration of medicines; Department of Import of Pharmaceuticals - is responsible for the import of medicinal products; Pharmaceutical Monitoring Division - Responsible for approving labels and packages of medicinal products; Pharmaco Supervision and Drug Information Department - Responsible for drug treatment safety.

The Pharmaceutical Administration is also responsible for the following matters: Proper functioning of the pharmaceutical service system in the country; Licensing and testing of pharmaceutical products and medical devices; Supervision clinical testing of the drug; Prevention of pharmaceutical crime. The main goal of the Pharmaceutical Administration is to ensure that all medicines sold in Israel meet safety, quality and efficacy standards.

Switzerland - The universal coverage of medicines (regardless of age and income) is one of the main strategies of the country's health policy. The basic package of compulsory insurance and the special list (SL) of reimbursable pharmaceuticals are approved simultaneously. Under compulsory insurance, beneficiaries have access to more than 250,000 medicines published in a special list.

The government's decision to include medicines in the reimbursable list is based on the following conditions: The medicinal product must be approved by Swissmedic and must meet the standards of efficacy, functionality and economic effectiveness.

Determining the maximum allowable price of a medicine is the prerogative of the Swiss Federal Office of Public Health (FOPH). The country has its own normative-legal basis for the approval of pharmaceuticals, which is basically similar to the regulations in force in the EU countries, despite the differences in certain details.

Swissmedic is the regulatory body responsible for approving medicinal products in the country. It is a public institution that is part of the Federal Department of the Interior and whose mandate is determined by the Federal Council. Nevertheless, it retains considerable organizational and managerial independence, has its own budget, which is only partially funded by state taxes. Companies wishing to submit a Marketing Authorization Application (MAA) to Swissmedic must be either registered in Switzerland or have a Swiss subsidiary.

The Swiss healthcare system provides a range of social support services to provide quality healthcare services to low-income individuals, achieved through a combination of premium regulation and subsidies, through the operation of risk-based financial redistribution schemes between insurers and cost sharing. The service of social support and certain public health programs provides full coverage, which exempts the insured from any deductions, co-insurance and co-payments. This, in turn, helps to increase access to other services and, consequently, medical treatment.

Appendices (Chapter 4)

Appendix 1

Profile of Health Care Systems in EU Countries

Country	Population (million)	Coverage of the population with universal health care (%)	Health expenditure per capita USD, 2018	Percentage of Government Expenditure on Health in Total Expenditure on Health 2018	Percentage paid out of pocket for health expenses 2018	Voluntary insurance share (%) in health care expenditure 2016	Model
Cyprus	0,8	83.0	1954,40	42,80	44,60	4.1%	State health care system
Denmark	5,7	98.2	6216,8	83,9	13,8	1.8%	
Finland	5,5	97.5	4515,7	78,6	18,4	2.0%	
Italy	60,7	98.0	2989	739	23,5	0.9%	
Latvia	2,0	97.8	1101,5	59,7	39,3	1.6%	
Malta	0,4	100.0	2753,5	63,5	34,3	1.7%	
Portugal	10,3	100.0	2215,2	61,5	29,5	5.1%	
Spain	46,4	100.0	2736,3	70,4	22,2	4.4%	
Sweden	9,9	100.0	5981,7	85,1	13,8	0.5%	
Germany	82,2	89,2	5472,2	77,7	12,6	8.9%	Social insurance system
Austria	8,7	99,9	5326,4	73,1	18,4	4.6%	
Belgium	11,3	99	4912,7	75,8	19,1	4.1%	
Bulgaria	7,2	88,2	989,9	57,6	40,5	0.3%	
Croatia	4,2	100	1014,2	83,2	10,5	6.9%	
Slovakia	5,4	100	1299,9	73,2	18,9	N/A	
Slovenia	2,1	100	2169,6	72,4	12	12.1%	
Estonia	1,3	94	1553	73,6	24,7	0.2%	
France	66,8	99,9	4690,1	73,4	9,2	13.3%	
Hungary	9,8	95	1081,8	69,1	26,9	N/A	
Lithuania	2,9	100	1249,3	65,9	31,6	<1%	
Luxembourg	0,6	95,2	6227,1	84,9	10,5	N/A	
Netherlands	17	99,9	5306,5	64,9	10,8	5.9%	
Poland	38	91	978,7	71,1	20,8	0,04	
Czechia	10,6	100	1765,6	82,7	14,2	0.2%	
Romania	19,8	86,4	687,3	79,5	19,5	0.1%	
Greece	10,8	86.0	1566,9	51,9	36,4	3.4%	

Appendix 2

Key Health Indicators

Country	Life expectancy at birth (years)		Total death rate (per 1000 population)		Cardiovascular disease mortality rate (per 1000 population)		Cancer mortality rates (per 1000 population)		Infant mortality (per 1000 live births)		Model
	2001	2020	2001	2019	2001	2019	2001	2019	2001	2019	
Cyprus	79,1	82,4	6,2	2,8	2,4	1,9	1,6	1,9	5,1	3	State health care system
Denmark	77,2	81,6	7,5	3,2	2,5	1,5	2,2	2,1	5,1	2,9	
Finland	78,2	82,2	6,8	3,3	2,7	2,4	1,5	1,7	3	2,1	
Italy	80,1	82,4	5,8	28,9	2,2	1,8	1,8	1,9	4,1	2,4	
Latvia	70,2	75,5	11,7	5,6	6,2	4,3	2	2,3	10,9	3,4	
Malta	78,9	83,2	6,7	3,1	2,9	2,2	1,6	1,9	6,9	4,1	
Portugal	77,2	81,1	7,2	3,2	2,6	2,6	1,6	1,9	4,9	3,9	
Spain	79,8	82,4	7,2	2,8	1,9	1,5	1,7	1,8	3,9	2,6	
Sweden	79,9	82,5	6,1	3,1	2,5	1,9	1,6	1,7	0,1	2,1	
Germany	78,8	81,3	6,4	3,3	3,1	2,2	1,7	1,8	5,1	2,9	Social insurance system
Austria	78,1	80,9	6,7	3,2	2,2	1,6	1,9	1,9	4,9	3,7	
Belgium	71,9	79,8	11,1	6,2	7,1	7,1	1,5	1,8	13,9	3,9	
Bulgaria	75,3	78,3	8,9	4,2	4,6	3,3	2,3	2,1	4,1	2,6	
Croatia	74,6	77,4	9,2	4,4	4,8	3,5	2,1	2,4	7,9	2,4	
Slovakia	73,6	77,1	9,9	4,4	5,4	4,1	2,2	2,5	6,2	5,1	
Slovenia	76,4	80,6	7,8	3,2	2,9	2,3	2,1	2,2	4,4	2,1	
Estonia	70,9	78,5	10,9	4,2	5,5	4,2	1,9	2,2	8,9	1,6	
France	79,3	82,3	6,1	2,9	1,6	1,3	1,8	1,9	4,9	3,5	
Hungary	81,1	81,2	6,6	3,3	2,9	2,3	1,7	1,9	3,9	3,2	
Lithuania	72,5	75,7	10,4	5,5	5,1	4,8	2,7	2,6	8,1	3,6	
Luxembourg	71,6	75,1	10,3	5,2	5,4	5,7	1,9	2,2	8,2	3,3	
Netherlands	78	81,8	6,5	3,3	2,4	1,5	1,7	1,7	6,1	4,7	
Poland	78,4	81,5	6,8	3,2	2,2	1,5	1,9	2,1	5,1	3,6	
Czechia	74,2	76,7	9,2	4,4	4,3	3,9	2,2	2,3	8,2	3,8	
Romania	71,1	74,9	10,1	5,5	6,6	5,4	1,8	2,1	18,1	4,1	
Greece	79,1	75,7	6,8	3,3	3,3	2,3	1,6	1,9	4,9	3,6	

Appendix 3

Professional Resource

Country	Number of practicing physicians per 1000 population		Number of nurses per 1000 population		Model
	2001	2019	2001	2019	
Cyprus	2,6	2,2	5,4	5,3	State health care system
Denmark	2,9	4,2	9,3	10,1	
Finland	2,5	3,8	10,7	14,1	
Italy	3,9	4,1	4,2	6,7	
Latvia	2,7	3,3	4,5	4,39	
Malta	2,3	2,9	5,2	7,8	
Portugal	3,1	5,2	4,2	7,1	
Spain	3,1	4,4	3,8	5,89	
Sweden	3,2	4,3	10,1	10,85	Social insurance system
Germany	3,9	5,4	7,2	10,4	
Austria	2,8	3,2	8,8	11,1	
Belgium	3,4	4,1	3,9	4,9	
Bulgaria	3,4	4,07	7,8	8,6	
Croatia	2,3	3,1	4,6	8,1	
Slovakia	3,2	3,6	7,4	5,7	
Slovenia	2,2	3,3	7,1	10,3	
Estonia	3,1	3,5	5,8	6,2	
France	3,3	3,4	6,7	11,1	
Hungary	3,4	4,5	10,5	14,0	
Lithuania	2,9	3,5	5,5	6,6	
Luxembourg	3,6	4,6	7,6	7,9	
Netherlands	2,2	3,0	7,5	11,7	
Poland	2,4	3,6	7,8	10,9	
Czechia	2	2,4	4,8	5,1	
Romania	1,9	3,3	5	7,4	
Greece	4,4	5,5	2,9	3,4	

Health Care Utilization

Country	Medical consultations per capita per year (frequency)		Hospital beds per 1000 population		Hospital discharge per 1000 population per year		Average length of stay in hospitals		Indicator of dissatisfaction with access to medical services due to barriers (economic [cost], geographical [distance], long waiting list)		Model
	2001	2019	2001	2019	2001	2019	2001	2019	2001	2017	
Cyprus	3,8	2,1	3,8	330,09	82,1	79,8	7,2	6,1	2,8	1,5	State health care system
Denmark	4,2	4	4,2	235,76	157,2	139,2	6,1	5,5	0,6	1,3	
Finland	7,5	4,4	7,5	284,05	209,5	163,9	12,8	6,2	0,8	4,7	
Italy	4,6	10,4	4,6	258,54	173,6	111,7	7,7	7,5	5,1	2,4	
Latvia	8,3	6,1	8,3	321,61	21,22	161,7	11,3	6,7	9,8	6,2	
Malta	7,6	7,2	7,6	319,01	171,2	150,2	8,8	7,7	0,7	0,2	
Portugal	3,6	5,7	3,6	329,16	111,1	84,2	8,9	9,3	1	2,1	
Spain	3,6	5,3	3,6	249,67	119,2	103,4	8,3	6	0,4	0,2	
Sweden	3,3	2,6	3,3	196,75	160,2	136,8	7,2	5,5	2,5	1,5	
Germany	7,8	6,6	7,8	5,3	261,4	243,1	8,4	6,3	0,7	0,1	Social insurance system
Austria	7,7	7,3	7,7	4,9	167,2	167,2	8,4	6,5	0,4	1,8	
Belgium	7,2	6,3	7,2	6,2	148,9	345,8	10,7	5,2	15,1	1,9	
Bulgaria	7,8	8,2	7,8	4,1	203,0	191,3	11,3	5,7	0,7	0,3	
Croatia	6	6,7	6	3,5	163,1	161,5	11,8	8,8	6	1,4	
Slovakia	7,7	11,1	7,7	4,8	193,2	189,1	8,3	6,6	2,3	2,4	
Slovenia	5,2	6,7	5,2	4,1	166,2	173,0	10,1	6,6	0,2	3,3	
Estonia	6,6	5,5	6,6	3,4	193,1	153,9	8,7	6,2	7,3	16,4	
France	8,1	5,9	8,1	3,1	217,0	183,0	10,9	5,4	1,9	1	
Hungary	9	9,8	9	5,9	227,4	252,5	11,6	7,5	2,2	0,3	
Lithuania	7,9	10,7	7,9	4,3	238,7	190,5	8,7	5,4	3,4	0,8	
Luxembourg	8,3	9,5	8,3	5,3	228,2	220,3	10	5,9	5,4	2,2	
Netherlands	6,4	5,5	6,4	3,7	150,2		8,4	7,4	0,6	0,4	
Poland	4,7	8,8	4,7	2,7	93,6	87,6	8,1	5	0,3	0,2	
Czechia	6,7	7,7	6,7	4,7	166,1	168,2	10,1	6,7	6	4,2	
Romania	7,7	5,2	7,7	5,3	228,2	213,1	9,9	7,3	10,3	4,9	
Greece	4,8	3,2	4,8	3,6	166,3	149,00	8,1	6,9	5,5	8,2	

Appendix 5

Insurance Payment/Co-payment Modalities

Services / cost sharing		The Netherlands	Israel	Switzerland
Visit to doctor	Primary Health Care General Practitioner	No	No	Full cost coverage before reaching the mandatory annual franchise limit; + 10% co-insurance; Average 131USD per visit
	Doctor specialist	Full cost coverage before reaching the mandatory annual franchise limit; (487 USD)	Co-payment to the quarterly limit; Compulsory insurance for health and children per visit 6,5–9,0 USD	Full cost coverage before reaching the mandatory annual franchise limit; + 10% co-insurance; Average 245 USD per visit
Hospital treatment		Full cost coverage before reaching the mandatory annual franchise limit	No, the only exception is nursing care	Full cost coverage before reaching the mandatory annual franchise limit; + 10% co-insurance and co-payment of 12 USD per day
Prescribing medications		Full cost coverage before reaching the mandatory annual franchise limit; Additional co-payment for drugs and therapeutic (by formula) substitutes defined by the «Orientation Pricing» strategy	Minimum co-insurance 4,5USD per prescription; Maximum 15% for patented and 10% for generic drugs	Full cost coverage before reaching the mandatory annual franchise limit; + 10% co-insurance and 20% if not generic
Restrictions on cost sharing		No, the annual franchise (465 USD) eliminates the need for cost sharing	There are generally no restrictions. It is valid only in case of prescribing chronic medicines and visiting a specialist at home	Yes, for adults For primary health care and specialized outpatient treatment, as well as for prescribing medicines (annual limit 2,645 USD)
Safety net/cost sharing benefits		Services for children do not require any cost sharing as well as private services	Preventive services do not require any cost sharing. Consultation of specialists - co-payment does not apply to: elderly people receiving social benefits, people with acute illness and socially disadvantaged children. Monthly contraction for chronic patients. Prescribing Medications - Holocaust Victims and Acute Diseases do not require co-payment	The distribution of taxes does not apply to obstetric care and certain preventive services; No co-payment is required for children, school-age and persons under 25 years of age. Annual limit for primary health care, specialized outpatient treatment and prescription drugs for children and persons under 18 years 785 USD

Appendix 6

Israel: Distribution of Functions in The Health Sector

National Public Health Advisory Board	Provides advice on important health policy issues
The Benefits Package Committee	Gives instructions on prioritizing new medical technologies and including their and new medicines benefits in the basket
Sectoral National Councils	Provide counseling in specific areas such as traumatology, mental health, and maternal and child health
The Ministry of Finance's Insurance and Capital Markets Division	Regulates voluntary health insurance
Ombudsman's office	Assists citizens in realizing their rights under the insurance law. In addition, there are a number of NGOs for patient advocacy, many of which focus on specific diseases
The Scientific Council of the Israel Medical Association	Together with the Ministry of Health, it is responsible for preparing special certification programs for medical service providers and conducting examinations
The Council for Higher Education	Responsible for authorizing, certifying and funding all university programs, including the training of health professionals
A joint Ministry of Health - Ministry of Finance committee	Establishes fees for hospitals, other providers and services. These ministries are also involved in spending control. However, the responsibility for cost containment is vested in different departments
Departments of the Ministry of Health	Control the quality and safety of patients in hospitals and other facilities. Provide national leadership in health information technology. Promote justice in the field of healthcare and discuss competition issues in it

Appendix 7

The Netherlands: Distribution of Functions in The Health Sector

The national government	Totally responsible for setting healthcare priorities, making legislative changes as needed, and monitoring the availability, quality, and cost of services in the country market system.
Government, Ministry of Health	The Ministry of Health conducts health policy and is not directly involved in management processes
Municipalities	Responsible for overseeing some health services, including preventive examinations and long-term outpatient services
Independent institutions	
Health Council (national level)	Advises the Government on Evidence-Based Medicine, Healthcare, Public Health and the Environment
The Medicines Evaluation Board	Controls the effectiveness, safety and quality of medications
The National Health Care Institute	Evaluates new technologies in terms of efficiency and economy, gives advice to the Ministry of Health on the inclusion of new technologies in the benefit package
The Dutch Health Care Authority (Nederlandse Zorgautoriteit)	Ensure the proper functioning of all markets in health insurance, health procurement and medical services
The Dutch Competition Authority (Authority Consument en Markt)	Ensures compliance with antitrust law by both insurers and providers
The Health Care Inspectorate	Supervises the quality, safety and availability of medical services
Health information technology (IT)	Responsible for exchanging information through IT infrastructure
Sectoral Professional Associations	Work on new registration-reporting schemes and professional guidelines, are involved in quality assurance projects for medical services

Appendix 8

Switzerland: Distribution of Functions in The Health Sector

Federal Government	Regulates system funding, ensures quality and safety of pharmaceutical and medical devices, oversees public health initiatives, and facilitates research and education The Swiss Conference of Cantonal
Health Ministers	Performs the role of a political coordinated body
Cantons	Responsible for licensing providers, coordinating hospital services, public health, and subsidizing institutions and individual premiums
Municipalities	Mainly responsible for organizing and providing long-term care (care for the elderly and the home), as well as providing assistance to vulnerable groups
The Federal Office of Public Health	Is the main national institution that: oversees the use of compulsory health insurance for compliance with the law, sanctions insurance premiums, regulates compulsory coverage and sets prices for pharmaceutical products. The agency is also responsible for national health strategies, including health promotion, disease prevention and health.
The Swiss Federal Department of Home Affairs	Determines the adequacy of Remuneration Basket services and its profitability
The Federal Office of Public Health and the Swissmedic agency	Determines the adequacy of benefit basket services and its profitability and supervises medicinal products
The nonprofit corporation SwissDRG AG	Responsible for introducing and adapting the national system of relative costs
The nonprofit organization Health Promotion Switzerland	Engaged in health promotion programs and disseminating health-related information
The Association of Swiss Patients and a national ombudsman	Participate in advocating for patients' rights

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MISSION

Based on Georgian national interest and rationalistic approach **Georgian Development Platform (Geodp)** aims to generate, promote and lobby for policies that go beyond current political agenda and affiliations; concentrating all its efforts to overcome current and future hurdles of the Georgian state, strengthening its democracy and insuring its sustainable development and prosperity.

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By setting high internal and external ethical and professional standards, the organization aims to:

- Mobilize Georgian public and institutions to achieve the necessary change we need, to ensure the modernization, progress and sustainable development of our nation.
- Define the current and strategic needs of our country and by taking into consideration the negative past experiences, assess current alternative visions, to offer public and respective interest groups adequate possible solutions and means of resolution.
- In Political, Economic, Social and other key domains, implement European type, democratic systems based on principles of efficiency and sustainability as

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In order to achieve goals and reach strategic milestones set by the organization, we aim to mobilize the intellectual capital and direct our activities in the following directions:

- **Research and Analytics –** Generate adequate policies based on rational approach and reform analysis.
- **Lobbying and Public Advocacy –** In cooperation with state institutions and the public to concentrate on implementation and reflection of formulated strategic visions and action plans into respective legal acts and state practices.
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