World Health Organization
European Region

Governance of the private health sector in Georgia

a situation analysis using WHO's Progression Pathway for Governance of Mixed Health Systems

Abstract

Since 2013, Georgia has aimed to achieve universal health coverage by progressively expanding publicly funded benefits. However, with 85% of hospital beds and most primary care clinics, outpatient facilities and pharmacies under private ownership, strong governance is essential to align profit-driven incentives with policy goals. This study examines governance in Georgia, analysing sectoral strategies, regulations, purchasing mechanisms, and public–private dialogue. It is based on a literature review, document analysis, interviews with state authorities, private sector representatives and local experts, and a validation workshop. Although a strategic framework for the health system exists, it lacks sufficient detail to inform private sector investment and resource allocation. Regulatory and purchasing gaps contribute to imbalances in provider distribution and risks to care affordability, quality and appropriateness. Weak institutional mechanisms for inclusive policy dialogue have hindered effective collaboration between stakeholders and failed to address conflicts of interest. To enhance governance, strategic planning must be supported by detailed implementation plans with full budgetary integration. Strengthening the capacity of the state purchaser is crucial to creating the right incentives and holding providers accountable. Transparent and inclusive policy processes are also needed to enhance the design of reforms, facilitate implementation and protect the public interest.

Keywords

PRIVATE SECTOR
GOVERNMENT REGULATION
FACILITY REGULATION AND CONTROL
HEALTHCARE FINANCING
DELIVERY OF HEALTH CARE
CONFLICT OF INTEREST

Document number: WHO/EURO:2025-11941-51713-79128 (PDF)

Contents

Acknowledgements ..... **iv**

List of Abbreviations ..... **v**

1. Introduction **1**

2. Situation analysis by governance behaviour **5**

2.1. Deliver strategy 5

2.2. Enable stakeholders 9

2.2.1. Regulation 9

2.2.2. Purchasing 18

2.3. Foster relation s 21

2.4. Build understanding 22

2.5. Align structures 23

2.6. Nurture trust 24

3. Recommended actions by governance behaviour **27**

3.1. Deliver strategy 27

3.2. Enable stakeholders 30

3.2.1. Regulation 30

3.2.2. Purchasing 35

3.3. Foster relations 38

3.4. Build understanding 38

3.5. Align structures 39

3.6. Nurture trust 40

4. Summary of findings and recommended actions **43**

5. References **53**

Acknowledgements

This publication was written by Mark Hellowell (Global Health Policy Unit, University of Edinburg, Scotland), Mari Tvaliashvili (Data Management Officer, WHO Country Office in Georgia), Tomas Roubal (Health Policy Adviser, WHO Country Office in Georgia) and Akaki Zoidze (Professor, Ilia State University, Georgia), with technical contributions and coordination provided by David Clarke and Anna Cocozza (Special Programme on Primary Health-care at WHO headquarters).

The WHO Regional office for Europe is grateful to the many individuals who contributed to the implementation of the WHO Progression Pathway on the Governance of Mixed Health Systems in Georgia. Thanks are also extended to Triin Habicht and Allison Ekberg (Technical officers, WHO Regional Office for Europe), Kakha Gvinianidze (Public Health Officer, WHO Country Office in Georgia) and George Gotsadze (Associate Professor, Ilia State University) for reviewing the report and providing valuable technical feedback on earlier drafts.

In the process of its development, multiple discussions took place between experts, including a consultation meeting held in Tbilisi in October 2024. Additional technical consultations were organized during 2024 with national authorities, including the Ministry of Internally Displaced Persons from the Occupied Territories, Health, Labour and Social Affairs and other agencies and representatives from the private sector. A draft of this report for consultation was shared with these stakeholders and served as the basis for collecting feedback from respective stakeholders and institutions on its content and analysis.

This policy brief has been compiled in line with the collaboration framework and strategic priorities of the WHO Country Cooperation strategy 2024-2027 between the WHO Regional Office for Europe and the Government of Georgia.

The publication was developed with financial support from the Universal Health Coverage Partnership.

List of abbreviations

CME	Continuing Medical Education
CPD	Continuing Professional Development
DRG	Diagnosis-Related Group
HE	Higher Education
HIS	Health Information System
ICU	Intensive Care Unit
IPC	Infection Prevention and Control
KIIs	Key Informant Interviews
MoIDPHLSA	Ministry of Internally Displaced Persons from the Occupied Territories, Health, Labour and Social Affairs
NCDC	National Center for Disease Control
NHA	National Health Agency
PHC	Primary Health-Care
PHI	Private Health Insurance
RAMA	State Regulation Agency for Medical Activities
UHC	Universal Health Coverage
UHCP	Universal Health Coverage Programme

1. Introduction

Since 2013, Georgia has been striving to achieve universal health coverage (UHC) through a progressively expanding (but still limited) package of publicly funded benefits – the UHC Programme (UHCP). Currently, this programme covers 95% of the population, with levels of coverage varying according to residents' income, age and other factors *(1)*. However, in the context of extensive private ownership within the health system (with 85% of hospital beds and most Primary Health Care (PHC) clinics,[1] outpatient facilities and pharmacies under private ownership) *(2)*, state authorities must establish robust and comprehensive governance functions. These authorities – including the Ministry of Internally Displaced Persons from the Occupied Territories, Health, Labour and Social Affairs (MoIDPHLSA), the State Regulation Agency for Medical Activities (RAMA) and the National Health Agency (NHA) (which functions as the single state purchaser of the UHCP) – must aim to ensure that:

- providers' incentives are aligned with key health policy objectives, such as enhanced equity of access, quality of care, and financial protection;
- providers are effectively held to account for their levels of performance against these objectives; and
- relationships between the public and private sectors (as well as within the private sector) are appropriately transparent and serve the public interest.

This report provides a situation analysis of the existing governance structure, taking into account current strategies and proposals for reform (in recognition of the dynamic nature of policy-making in this field in Georgia).[2] The analysis focuses on the governance function pertaining to entities that have direct contact with patients and other consumers, including health and medical students – and does not directly address governance of manufacturers or distributors of medical equipment

[1] Some PHC facilities remain under state ownership, while many have been opened within private hospitals, or have been newly (re)built by private entities.

[2] The report does not seek to provide a comprehensive description of evaluation of the health system in more general terms. General information on the health system, alongside identification of key concerns and challenges, can be found in the Health Systems in Action Insights series paper on Georgia (2).

or pharmaceuticals.[3] WHO's Progression Pathway for Governance of Mixed Health Systems (3) (henceforth referred to as the Progression Pathway) is used as the organizing framework for this analysis, defining governance as "what state authorities do/can do to influence the operation and performance of the private sector to support the achievement of policy goals". The assessment is organized according to six governance behaviours (outlined in Table 1), for each of which four levels of progress are identified:

- Level 1 – Nascent
- Level 2 – Developing
- Level 3 – Progressing
- Level 4 – Established.[4]

Table 1. The strategic priorities and focus areas

	Governance behaviour	Definition
1	Deliver strategy	Authorities define strategic objectives for the health system and the private sector's role in achieving these.
2	Enable stakeholders	Authorities use a combination of regulations and purchasing to shape incentives and strengthen accountability.
3	Foster relations	Authorities adopt policy processes that include the private sector, but also other social-interest stakeholders, and with transparency.
4	Build understanding	Authorities ensure they have access to, and act upon, high-quality data on the private sector's resources, activities and levels of performance.
5	Align structures	Authorities ensure effective coordination of care across the public and private sectors, and across service domains.
6	Nurture trust	Authorities employ legal, regulatory and other mechanisms to safeguard patients' rights and welfare.

This report is based on a comprehensive literature review, document analysis, and at least 20 semi-structured key informant interviews (KIIs) with Georgian state authorities, private sector entities and other stakeholders, undertaken either in person or online during mid-2024. The report has been subject to external validation by key government and private sector stakeholders, both in written

[3] That said, brief commentary is provided on conflicts of interest that arise due to the presence of companies that own businesses across the pharmaceutical supply chain and within the health-care delivery sphere.

[4] The criteria used to assess a health system's position in relation to this framework have been defined by WHO and are outlined and explained in the Progression Pathway literature *(3)*.

form and via a validation workshop. However, the final results of the assessment, and related recommended action points presented remain those of WHO alone.

The structure of the rest of this document is as follows. In section 2, the situation analysis is presented, with the main findings organized under each of the six governance behaviours. In each case, the domain is briefly defined and the assessment of the level of progress achieved is reported and explained. Following this, section 3 outlines a series of recommended actions for improving governance – similarly, organized by governance behaviour – with a focus on the specific actions required to proceed to the next level of the Progression Pathway and beyond. Finally, section 4 provides a brief summary of the main findings of the assessment and proposed next steps.

2. Situation analysis by governance behaviour

2.1. Deliver strategy

This governance behaviour is concerned with the extent to which state authorities have the following elements in place or under way: a strategy for improving health system performance with regard to a defined set of objectives; an understanding of the role of the private sector in achieving these; a plan for influencing the private sector's activities in alignment with its defined roles; and an appropriate monitoring and evaluation framework.

Current level of progress: Progressing ○○●○

In Georgia, no comprehensive health system strategy existed prior to 2022. However, in May 2022 the Government of Georgia published the National Healthcare Strategy 2022–2030 *(4)* (henceforth: "the Strategy"). This outlined a series of objectives, outcome indicators and deadlines relating to: governance, equity and efficiency of health financing; human resources development; quality of medicines and health services; health information systems (HIS); and public health capacities. One objective of the Strategy (1.5) explicitly refers to the private sector, calling for the further development of "effective models and mechanisms of public and private cooperation in the health-care system").[5] However, the important role of the private sector in the health system is implicitly acknowledged throughout, and a package of reforms that directly implicates the private sector is also outlined in the document. This package includes:

[5] While this objective appears to relate to several of the governance behaviours, the related indicators demonstrate that this is primarily concerned with the use of public–private partnerships – that is, transaction-specific contracts for physical assets and related services. Data from the KIIs on this objective indicate that this was seen as an option for expanding and improving the physical condition of public facilities owned by Georgia Medical Holding, but the objective is no longer being pursued.

- enhanced information on reporting requirements for all health-care providers;
- enriched licensing requirements, to move towards international standards;
- adoption of accreditation-based selective contracting;
- a shift to needs-based planning, organization and regulation of health-care services;
- enhancements in the role and capacity of primary care in service delivery;
- greater aggregation in the diagnosis-related groups (DRGs) payment model;
- curtailing of co-payments (including prohibition of mechanisms referred to as extra billing and balance billing);
- new regulations for continuing professional development (CPD) in the workforce; and
- strengthened regulations for prescribing and dispensing of medicines.

Despite this, some private sector stakeholders questioned the extent to which the Strategy is a reliable guide to the health system's future direction, pointing to the absence of detailed implementation plans for some commitments (e.g. needs-based planning, regulation and selective purchasing) and a lack of detailed costing for others (e.g. strengthening of PHC's status and capacity), such that related costs may not be fully captured in the Government's Basic Data and Directions document.[6] These key informants recognized, however, that certain elements of the Strategy (such as greater bundling of DRG financing, mandatory accreditation, and prohibition of both extra billing and balance billing for UHCP-financed services) have already moved to the implementation stage.

Taken as a whole, the package of reforms outlined in the Strategy signals an important change to the operating environment for private providers, particularly in comparison to that of the previous decade *(4)*. From 2013 a combination of government action and inaction elicited significant increases in market entry and capital investment; for example, acute hospital bed numbers increased from 30.6 per 10 000 population in 2013 to 49.39 per 10 000 in 2021 *(6)*. These factors included:

- large increases in public health expenditure (albeit, as noted, the real value of PHC spending has fallen over this 10-year period);
- unregulated co-payments (alongside capped government payments);
- very low market entry barriers;
- passive purchasing by the state purchaser (for example, the absence of selective purchasing, volume controls, or monitoring), enabling oversupply and supply-induced demand; and
- pricing changes that led to excessive levels of capital investment, especially in the hospital sector, and – furthermore – financial incentives to set up new and often small-scale facilities.

[6] This is equivalent to a medium-term expenditure framework, published annually and with three-year projections. The most recently published version can be found at the Ministry of Finance's website *(5)*.

Given this historical context, the Strategy's proposals to contain costs and capacity are notable. For example, there are plans for more bundled DRG payments, elimination of extra billing and balance billing for UHCP-financed care, and a new Certificate of Need process (among others) *(4)*. In the KIIs, some representatives of private providers expressed concern about their own (or their market rivals') economic sustainability in this new environment.

Such concerns are, they suggested, exacerbated by specific government actions that constrain revenues and profits. Examples cited in the interviews included:

- the decision to increase minimum salaries for doctors and nurses without corresponding adjustments to UHCP payment rates (capitation/DRGs);
- the decision to keep PHC capitation rates at the same (nominal) value over an 11-year period, resulting in a considerable erosion in their real value; and
- new licensing requirements that specify the minimum distance between intensive care unit (ICU) beds, again without corresponding adjustments to DRG rates.

With the Government of Georgia's current emphasis on enhanced technical efficiency (that is, on containing costs and capacity), while ensuring accessibility and quality of care, there is an opportunity to establish a greater degree of policy stability, helping to ensure that private sector decisions (e.g. investment decisions) are aligned to intended reforms to health financing and service delivery/models of care. The 2022–2030 Strategy represents an important foundation for this, but may not be sufficient without further action to ensure effective implementation (see section 3).


Innova

2.2. Enable stakeholders

This governance behaviour is concerned with the policy instruments used by state authorities to enable or constrain private sector activities. Under this domain, seven regulatory mechanisms are considered, alongside purchasing.[7] Individually and collectively, these mechanisms exert a powerful influence on: (i) the incentives of the private sector, and the extent to which it is held accountable for its performance; and, in turn, (ii) its structure, conduct and performance in relation to policy goals. Accordingly, the level that Georgia has achieved in the Progression Pathway is assessed for each instrument, rather than for the governance behaviour as a whole.

2.2.1. Regulation

2.2.1.1. Facility registration and licensing processes

This part of the assessment is concerned with the extent to which facility registration and licensing processes are well specified and well enforced, such that all private facilities are competent to provide safe, effective, high-quality care.

Current level of progress: Progressing ○○●○

Currently, the licensing requirements for all providers (public and private) are defined in legislation *(7)*. These requirements were very limited for many years, but have been strengthened over time in some clinical areas *(8)*: for example, in relation to hospitals, there are new Infection prevention and control (IPC)-related requirements for the distance between ICU beds.[8] In addition, the 2022–2030 Strategy proposes further enriching licensing requirements *(4)*. The rationale for these proposals is not explicitly recorded in the Strategy, but was acknowledged in the KIIs with government and private sector representatives, especially in regard to certain clinical areas. For example, several key informants identified PHC as a service domain in which current standards are outdated and inadequate to ensure quality of care.

To establish initial compliance with licensing requirements, inspectors from the RAMA visit the facility, check for compliance and make an authorization decision. If a facility fails to achieve compliance, a list of reasons is provided and the facility has the right to reapply after attempting to address the cited deficiencies. The RAMA also conducts inspections of existing licences. In general, statements from the KIIs reflected that inspections are conducted frequently and licensing requirements are

[7] It should be noted that, in the Progression Pathway, purchasing is the focus of a single domain. However, given the extent of private sector integration within the UHCP in Georgia, a more granular analysis of the current situation in, and recommendations, for the purchasing domain are required.

[8] As related costs have not been factored into DRG payments, this has – in the view of some private sector key informants – reduced the economic viability for hospitals of establishing or maintaining ICU capacity.

strictly enforced – with penalties for non-compliance being (potentially) severe. Indeed, some key informants who are facility owners/managers expressed a concern that inspectors' decisions could be unreasonable, with the penalty decisions often lacking a clear risk-based element – such that financial penalties, or penalties with financial consequences (e.g. enforced ward closures) constituted a major source of business risk. It was suggested that penalties could be imposed for infractions that did not constitute a material risk to safety or quality of care.

Starting in 2025, the licensing regime will also be accompanied by an accreditation regime, with accreditation becoming compulsory for all providers in receipt of UHCP patients/funds. In the validation workshop, representatives of the MoIDPHLSA acknowledged the importance of ensuring alignment between the licensing standards and accreditation requirements. It will be important to ensure that the two mechanisms are complementary, and that any contradictions are resolved at an early stage of implementation.

As part of the 2022–2030 Strategy, the MoIDPHLSA is also considering the introduction of a Certificate of Need process, under which new providers (or those planning to modify/extend their service offer) must seek authorization to do so through the licensing process.[9, 10] This reform is intended to curtail the market entry of small clinics and hospitals, especially in geographical and service areas with excess capacity. However, as its impact will be borne only by new providers and/or those that intend to adjust or extend their service offer, its short-to-medium term impact on the structure of the market will be limited.

2.2.1.2. Regulation of health education/training institutions

This part of the assessment is concerned with the extent to which the regulation of private health-care training/education institutions ensures that graduates are competent to provide safe, effective and high-quality health services in the professional domains/clinical areas in which they are qualified.

Current level of progress: Developing ○●○○

Multiple challenges relating to health education/training in Georgia are prevalent across the health sector (that is, not specific to the private sector). However, the nature and extent of these challenges and the solutions available to address them differ for the public and private spheres, due to differences in the policy tools available. For example, for private sector institutions, there is a lack of direct bureaucratic oversight and control, reinforcing the need for effective regulation.

Since 2018, standards for the medical education sector have based on World Federation of Medical Education Standards for Basic Medical Education. In Georgia, the National Center for Educational Quality Enhancement is responsible for implementing external quality-assurance evaluation

[9] This is one of the mandatory policy actions agreed upon with Asian Development Bank as a condition for releasing their policy loan of US$ 50 million.

[10] It is also proposed that a master plan for the future shape of the health-care network should be established; however, there is no evidence that progress on this has yet been made.

processes (Authorization and Programme Accreditation), and continuous development of medical education. It has been recognized by the World Federation of Medical Education. Accreditation of higher medical education programmes (32 programmes implemented by 22 Higher Education (HE) institutions, most of them in the private sector) is conducted regularly, with the participation of international experts.

The medical education system in Georgia is regulated by the Ministry of Education, Science, Culture and Sport, up to degree level. Although the MoIDPHLSA has sought to influence educational output in some areas (such as perinatal services, cardiac surgery, radiology and emergency services), in general there is no proactive needs-based management of the supply of health professionals. The number of medical education institutions is increasing and the number of students admitted is excessive, contributing to an excess supply of medical doctors, especially in more popular (often more remunerative) specialties.

Conversely, the educational system is failing to produce a sufficient number of other health professionals, especially nurses. According to a recent report on human resources for health by the State Audit Office, the number of nurses who completed their studies in HE continued to fall over the period 2018–2021 (61 graduates in 2021) *(9)*. In addition, as of 2021, 15.2% of active nurses in the system were of retirement age, while the rate of new graduates in the same period was 2.6% of the total number of active nurses. In Georgia, the ratio of doctors to nurses is about 1 : 1, whereas the norm in Europe is about 1 : 3 *(10)*. The overproduction of doctors contributes to this shortfall as well as to inefficiency in service delivery, with many nursing roles currently performed by doctors, who are not trained in nursing competencies. Furthermore, no midwives are currently being trained, despite the ageing of this part of the workforce.

Overseas students account for a growing proportion of students in medical education programmes in Georgia, with the highest growth found in private institutions *(10)*. In the context of finite teaching capacity, growth in the number of overseas students is contributing to a general problem of high numbers of students per educational institution/department. This raises concerns regarding the quality of training offered in such institutions – reflected by a growing number of complaints from international students to the National Center for Educational Quality Enhancement *(11)*.

According to the 2023 State Audit Office Report on human resources for health *(9)*, postgraduate medical education programmes in Georgia do not adequately promote the development of essential clinical skills. For example, the certification exam is conducted only by written tests, with multiple choice answers, while the practical skills of the examinee are not assessed. It is standard practice in many medical education programmes to include clinical placements to support development of practice and practical competencies, which appears to be lacking in Georgia. Among postgraduate students interviewed by the audit body, 46% stated that related education methods were irrelevant for obtaining the proper knowledge for future medical activities, while 44% said that the acquired knowledge would be insufficient to provide independent services to patients. Doctors receive certificates that are valid indefinitely, with no obligation for recertification or CPD in many specialties.

Despite efforts to align national residency programmes with international standards, medical diplomas issued in Georgia are still only partially recognized in European countries. It is important to further develop the national higher education system to bring it into closer alignment with European standards.

2.2.1.3. Regulation of health professionals

This part of the assessment is concerned with the extent to which there is a well-defined, comprehensive suite of regulations for health-care professionals employed in the private sector. To be comprehensive, professional regulation should encompass: registration, licensing and defined standards of practice (including standards for CPD), as well as providing for complaints and disciplinary functions.

Current level of progress: Developing ○●○○

A legislative framework for maintaining active registers of health professionals has been established. The RAMA has a database of individuals to whom they have issued a certificate. However, this information is not up to date – for instance, some registered individuals are inactive (e.g. the electronic data are not linked with other government databases, which means that the information may include records of doctors who are no longer working, including even deceased individuals). Furthermore, the National Center for Disease Control (NCDC) has taken steps to improve the data-collection tool by linking information to personal identification numbers through an electronic module. However, this system is limited – for example, it does not allow for the identification of doctors' specialties or qualification levels.

The licensing (state certification) process is linked to professional education and practice. Disciplinary procedures – including for violating certification requirements and principles of ethical behaviour – are embedded in regulations, and can be enforced if a formal complaint is filed with the MoIDPHLSA by a patient or a patient's relatives. Several gaps remain in this framework. For doctors, re-licensing is not required. For most medical specialties, neither CPD nor continuing medical education (CME) are mandatory. According to the aforementioned State Audit Office report, the involvement of professionally active doctors in CME is low throughout the country. As of 2021, only 43% of the total of 17 632 doctors had participated in CME during the audit period (2018–2021) *(9)*.

CPD includes residencies and short-term courses. Programmes in the former category are accredited by the Professional Development Council and are provided by accredited medical facilities, professional associations and educational establishments. Some short courses are also internationally accredited. However, overall, the quality of these programmes is not monitored by regulators. Many courses are not subject to any defined standards or external assessment. No system is in place to record and track all non-accredited courses. For both accredited and non-accredited courses, there is a system of credits/points – however, accumulation of credits is not a requirement for most clinical disciplines,[11] and the RAMA does not hold a record of credits obtained.

In addition, some pharmaceutical companies offer free courses, often with attractive terms and in attractive locations. These courses are not overseen by the RAMA. There have been proposals to enhance monitoring of such courses, but the resources available for this are limited. The 2022–2030 Strategy includes proposals to update the CPD system, including linking obligations for health workers to undergo CPD to professional (re)certification and licensing processes *(4)*, but these are not yet in place.

Nurses will for the first time be required to hold a licence (a state certificate) to practise from 1 January 2025. However, there are currently no CME or CPD requirements for nurses. Overall, nursing as a professional area is underdeveloped in Georgia relative to European norms.

[11] There are exceptions to this. For instance, obstetrician-gynaecologists must accumulate 30 credit points through training, among other requirements.

2.2.1.4. Regulation of clinical practice/service delivery

This part of the assessment is concerned with the extent to which evidence-based clinical practice guidelines, treatment guidelines, clinical protocols and care pathways exist and are used as key mechanisms for improving the safety, efficacy and quality of care in the private sector.

Current level of progress: Developing ○●○○

Evidence-based national standards, protocols and guidelines exist for the treatment of some health conditions exist. Compliance with standards and protocols is mandatory for both public and private providers participating in the UHCP and other publicly funded programmes, while guidelines have the status of recommendations. There is a National Council for Clinical Practice Recommendations (Guidelines) and State Standards (Protocols) for Disease Management (and the approval of their regulations). It comprises representatives from the MoIDPHLSA, the RAMA, health-care providers and professional associations. Professional associations are expected to play a growing role in regulation. However, procedures to manage potential conflicts of interest – for example, requiring clinicians to declare relationships with commercial (e.g. pharmaceutical industry) interests – do not currently exist. Currently, the RAMA and the NHA are responsible for enforcement, within the scope of their competencies. However, several key informants reported that, in practice, enforcement is irregular and inadequate, citing the absence of clear indicators, reporting frameworks or monitoring and, critically, inadequate technical capacities within the RAMA and the NHA.

2.2.1.5. Regulation of retail pharmacies

This part of the assessment is concerned with extent to which the registration and licensing regime for private retail pharmacies is well defined and well enforced, such that all private retail pharmacies must take steps to ensure that they provide safe, effective and high-quality health products.

Current level of progress: Progressing ○○●○

In 2021, amendments were made to the Law on Medical Products by local experts under WHO guidance *(12)*. This created a framework for quality assurance and price regulation of essential medicines, ensuring that the system for regulating the operation of pharmacy retailers – all of which are in the private sector (there are no public retailers) – is described in detail. The RAMA is responsible for defining and enforcing licensing requirements; for example, for storage, dispensing, and in relation to the quality, safety and effectiveness of products sold *(4)*. In addition, reference prices for subsidized medicines came into force in 2023, followed by mechanisms for managed-entry agreements for new medicines in 2024. However, the cost of medicines in Georgia remains high and out-of-pocket spending on pharmaceuticals has historically been a major factor behind catastrophic health expenditures for households (accounting for 90% of out-of-pocket payments among the poorest households with catastrophic spending in 2018) *(13)*. In addition, there are challenges with enforcement, including in relation to specific areas critical to public health. For example, although laws and regulations exist on the prescription and sale of antimicrobials for human use, key informants reported that most antibiotics can still be purchased over the counter without a prescription.

Other governance challenges relate to the high degree of market concentration in the pharmacy sector. This is due to both **horizontal integration** (with the three largest chains owning one third of all retail outlets) and also **vertical integration** (with a few large holding companies owning combinations of pharmaceutical companies, private insurance companies, health-care providers and pharmacies) *(14)*. The former issue generates upward pressure on prices, while the latter generates risks of conflicts of interest, which may in turn amplify the risk of irrational prescribing or dispensing practices. In 2021, an assessment by the Georgian Competition and Consumer Agency found that doctors generally indicated the brand name of medicines in the prescription, contributing to overprescribing of branded drugs, and underprescribing of generics *(14)*. In 2022, a prescription system for generics was introduced, which means that doctors must prescribe medicines by International Nonproprietary Name rather than by brand – although it is not clear whether the system has fully addressed the problem.

2.2.1.6. Regulation of the private health insurance (PHI) industry

This part of the assessment deals with extent to which the PHI industry is regulated to protect consumers.

Current level of progress: Progressing ○○●○

PHI accounts for 7% of total health expenditure, and 10% of private health expenditure in Georgia *(2)*. However, PHI is the only source of coverage for higher income individuals (those with an annual income of more than 40 000 Georgian lari), as they are excluded from the UHCP. In addition, PHI is provided by the Government to certain targeted groups (e.g. the military), funded by the state budget. Overall, the PHI sector covered 19% of the population in 2024 *(15)*.

In the KIIs, representatives of the Insurance State Supervision Service of Georgia (the regulator of the PHI industry) highlighted the high cost of purchasing individual insurance. Due to high premiums, some individuals who did not have access to either the UHCP or to employer-provided PHI may be left without coverage. In addition, UHCP eligibility rules prohibit many people from holding public and private insurance in parallel; however, many exceptions are made for specific groups, including teachers, public artists, children in foster care, settled internally displaced people, people in households below the poverty line, pensioners (women aged over 60 years and men over 65 years), children aged under 5 years, students and people registered as disabled, households with low incomes (70 000–100 000 points on the social assistance scale), and children aged 6–18 years *(2,16)*. Discussions are ongoing between the MoIDPHLSA and some insurance companies on potential changes to this restriction – with a focus on allowing complementary PHI products that would offer coverage for services that are not covered or only partially covered under the UHCP, such as dental care and certain medications.

Beyond this, regulation is limited to prudential matters (ensuring their financial stability) and basic consumer protections (e.g. insurers are prohibited from misrepresenting the levels of coverage their products provide). This is undertaken by the above-mentioned Insurance State Supervision Service of Georgia. There is no regulation of coverage – for example, no compulsory minimum standards for all insurance products (which could encompass essential services coverage, including PHC). Private insurance companies offer insurance packages with varying levels of coverage, based on product prices and consumers' risk status.

2.2.1.7. Regulation of the PHC market – economic regulation

This part of the assessment is concerned with the extent to which regulations protect the public against the accumulation and/or abuse of market power among private sector entities.

Current level of progress: Developing ○●○○

Inefficiency in service delivery is indicated by the average acute care hospital bed occupancy rate, which was 49% in 2019 – substantially lower than the European Union average of 77% *(17)*. Fragmentation in service delivery is indicated by the average number of beds per facility; specifically, the fact that hospitals are on average five times smaller in Georgia (average beds per facility: 58) than in other European countries (average beds per facility: 297) *(18)*. This fragmentation creates risks to *(13)*:

- quality of care (due to the lack of training opportunities for staff, as well as the relative infrequency of practice due to low volumes in or underuse of many facilities);
- technical efficiency (due to the high fixed costs of having many small facilities, without economies of scale);
- regulatory effectiveness (due to the high costs of regulating, inspecting and monitoring hundreds of facilities); and
- fiscal sustainability (due to strong provider incentives to induce demand and engage in upcoding to remain financially sustainable).

Fragmentation in service delivery is accompanied by vertical integration within some of the larger chains and networks *(18)* (created by holding companies that own health-care facilities, pharmaceutical companies, pharmacy retailers and private health insurers), which can command significant market power and generate conflicts of interest. However, there are no existing regulations to monitor,[12] prevent or reverse vertical integration, nor does the 2022–2030 Strategy propose any regulatory actions in this area. That said, the above-mentioned Certificate of Need proposal may mitigate to a certain extent the risk of further fragmentation.

Previous attempts to establish a planned network proved unsuccessful. For example, in 2007, the Hospital Development Master Plan outlined plans to constrain total hospital capacity and, at the same time, ensure universal access to inpatient facilities based on 45-minute travel times. Implementation of this plan proved impossible in the context of widespread private ownership, misaligned commercial incentives, and legal constraints.

There remains no formal mechanism for maintaining profit-making provision of services that do not make a profit.[13]

[12] Ideally, the NHA should access and use data on the financial performance of contracted companies – including revenues, profits and related ratios. Such data are available, for example from state audit authorities such as the Service for Accounting, Reporting and Audit Supervision, but are not routinely accessed or used by health authorities.

[13] Some private provider chains or networks are (under legacy contracts) obligated to provide a pre-agreed range of services in rural areas, in which some services are unprofitable (make a loss). This is to ensure that access to services is maintained in localities in which there are no alternative providers. However, the legal status of these contracts is uncertain and they depend to some degree on goodwill or relational contracts, meaning that access to some services in such settings may be at risk over the longer term.

2.2.2. Purchasing

This part of the assessment is concerned with the extent to which purchasing arrangements are well designed and effectively implemented, ensuring that the resources and activities of private providers contribute to policy goals such as equity of access, financial protection and quality of care, without detriment to the financial sustainability of public health expenditure.

Current level of progress: Developing ○●○○

The UHCP and publicly funded vertical programmes account for a significant proportion of private providers' revenues. For example, for five of the largest corporations in the health sector, the proportion of revenues from UHCP/public sources was as follows in 2022 *(19)*:

- New hospitals 33%
- Aversi 56%[14]
- Evexi hospitals 67%
- Geo hospitals 67%
- Evexi clinic 70%.

In this context, the Government has considerable opportunity to use its purchasing power to influence the structure, conduct and performance of the industry. Currently, however, the strategic use of purchasing is limited. The NHA remains a largely passive purchaser, with functions limited to managing payments to providers. The NHA does not sign pre-agreed contracts with providers, nor does it negotiate detailed service specifications or volumes. It reimburses the claims made by providers according to agreed tariffs – with the terms of engagement codified in sector-wide regulations *(20)*. Patients may freely choose their provider and providers are free to select patients. Statements from the KIIs included that NHA technical capacity was very limited; and this was also acknowledged in the interviews with NHA leadership.

2.2.2.1. Eligibility criteria

The introduction of compulsory international accreditation brings with it an element of quality-based selection in the purchasing process. In addition, some efforts have been made to use purchasing as a means of changing the structure of service delivery in Georgia. For example, to motivate urban PHC providers to merge into larger groups, clinics were obliged (in order to be eligible to participate in the UHCP) to employ at least five family doctors and nurses, and have at least 13 000 people enrolled *(21)*. In addition, selective contracting procedures for some specific specialist areas (e.g. maternity services) have been introduced. Building on these experiences, the 2022–2030 Strategy includes proposals to extend selective contracting to more services, focusing initially on PHC, specialty outpatient care, and diagnostics *(4)*. However, according to the MoIDPHLSA, the current policy direction at government level is to not pursue needs-based selective contracting. As a result, it is unclear how structural

[14] For New hospitals and Aversi, the relatively low proportions in 2022 may reflect high patient demand for services that were either not covered by the UHCP or resulted from self-referrals. As a result, private out-of-pocket spending constitutes a prominent source of revenue for these businesses.

problems – such as fragmentation and excess capacity in some localities and service domains, along with undersupply in others (e.g. many rural areas, and palliative care) – are to be addressed.

It should be noted that, in most European countries, administrative and/or regulatory mechanisms do the heavy lifting in terms of ensuring that the network is structured to meet needs efficiently, while providing adequate geographical access to patients in terms of travel time. In such cases, a system of routine (automatic) purchasing tends to be in place, but is limited to providers in the regulated network, with selective contracting used to address capacity gaps in specific localities and/or service domains. However, in Georgia, such regulations are absent, and the messaging from the KIIs indicates they are widely regarded as infeasible, from a political standpoint.[15]

2.2.2.2. Contract specifications and monitoring

As noted in the previous sections, no individual contracts exist with providers in Georgia. Service requirements are defined in regulations, rather than in the form of standardized contractual specifications, with annexes for individual providers. There is very limited monitoring of performance in relation to contractual requirements, resulting in a lack of accountability for performance. In addition, payment is not linked to quality or outcomes. Monitoring is, in reality, largely restricted to claims assessment.

2.2.2.3. Provider payment

As already described, PHC capitation payments have been fixed in nominal terms for 11 years, such that their real value has fallen considerably over this period. The KIIs with PHC providers indicated that providers are adapting to this challenge by decreasing workload and continuing to employ only those willing to accept lower salaries, and/or by reshaping services towards those that are paid for by patients.

The introduction of DRG-based tariffs, the prohibition of both extra billing and balance billing within the UHCP, as well as capping of co-payments in general are likely to have an impact on the incentives for and behaviours of providers. The DRG reforms can enable greater transparency and improvement of planning and monitoring systems, while the curtailment of (previously unregulated) co-payments can improve equity of access and enhance financial protection. However, they may not be sufficient to ensure improved budgetary control, without volume limitations. In addition, they are likely to significantly constrain provider revenues. The risk is that providers will adapt to this financial environment not by adjusting their expected rates of return, but by engaging in behaviours such as cherry-picking and cream-skimming. For example, one private sector key informant reported that inpatient care providers were increasingly refusing to accept patients from ambulances. Others may decide to refocus supply on more affluent patients, capable to paying out of pocket for services. Given the limited number of public facilities in Georgia, such behaviours constitute a major risk to equity of access and as such should be closely monitored.

[15] In some cases, the Government has obliged providers to fulfil public service (accessibility) obligations, but such rules are in need of review, to ensure that delivery continues to be aligned with need.

2.3. Foster relations

This governance behaviour is concerned with the extent to which the Government has: established platforms for serious policy dialogue with credible representatives of the private sector; ensured that such platforms provide access and voice to other stakeholders, such as patients' associations, community groups and representatives of vulnerable groups; and taken action to mitigate the po¬tential for bias, conflict of interest or corruption, to influence policy.

Current level of progress: Developing ○●○○

KIIs with government representatives highlighted a structured approach to strategy and policy development. Participants cited the existence of legislation that mandates regular consultation with all relevant social-interest stakeholders, including the private sector *(22)*. Several government stakeholders emphasized the role of private providers' representatives in the formulation of the 2022–2030 Strategy and other important policies – for example, through their participation in working groups and iterative reviews.

However, representatives of the private sector expressed some frustration that consultation often comes too late for them to exert meaningful influence on reforms. Some private sector key informants suggested that meetings with state authorities tended to focus on information provision (by authorities) rather than seeking information, with the critical decisions already having been made before private sector input is sought, limiting the scope for cross-sector deliberation and negotiation.

However, it is apparent that recent reforms have led the private sector to adopt a more proactive approach to their associations' engagement with the policy process. For example, the largest hospital association has been involved in advocating for selective contracting and accreditation as potential solutions for managing the impacts of regulatory/purchasing reform on the provider market (that is, aiming to diminish the degree of competitive pressure, and allowing more limited UHCP funds to be spread across a smaller number of providers). This association has also been involved in some aspects of implementation. For example, after its leadership emphasized the complexity of meeting accreditation requirements by the 2025 deadline (particularly for smaller facilities that lack the necessary resources and expertise), it was asked to facilitate connections with international accreditation companies and consulting groups to support training and pre-assessment processes.

Although the development of the Strategy included a broader public consultation, Georgia has yet to develop platforms for institutionalizing social participation or engaging with stakeholders (such as patients' associations, community groups, or representatives of vulnerable groups) *(23)*. This is a particular concern given the presence and influence of private sector interest groups that span multiple sectors (reflecting the vertical integration of the market). It is important that such interest groups are precluded from infringing on health authorities' integrity, impartiality and independence in exercising their functions *(24)*. In this context, actions to include a broader range of stakeholders in the policy process are – alongside efforts to enhance transparency (e.g. with full documentation of and public access to details of meetings, attendees, and decisions taken) – key to mitigating the risk of bias, conflict of interest, or corruption in policy-making with regard to the private sector.

2.4. Build understanding

This governance behaviour is concerned with the extent to which the Government acts to ensure that: (i) the private sec¬tor is integrated in all relevant facility-level public health and service delivery reporting systems; (ii) such data are organized to enable evidence-based strategic and operational decision-making; and (ii) data are actually used to inform strategic and operational decision-making in relevant policy areas.

Current level of progress: Developing ○●○○

In Georgia, there is a national HIS, and strengthening this is one of the goals of the 2022–2030 Strategy. For all licence/permit holders, regardless of ownership status, reporting into the national HIS is a mandatory requirement *(25–27)*. Efforts are being made by the Government to improve reporting. Remaining challenges in the data ecosystem that impede the use of data for analysis, planning and decision-making (e.g. by the NHA) include duplication of entries, lack of clear or uniform data-collection processes, and poor data quality.

The primary focus is on the data required to process claims or determine capitation payments, rather than on data that could enable monitoring of clinical activity or quality of care – as a result of which, there is no effective provision of feedback or information to providers that could help them to support improvements in quality of care. This means that there is limited information available to patients to inform their decisions about where/through which providers to access treatment (e.g. data are lacking and there is no methodology or platform that would allow for certain indicators (such as mortality and rehospitalization rates) to be placed in the public domain, thereby contributing to a lack of informed patient choice).

Coordination is lacking across authorities and stakeholders involved in data collection (e.g. across the MoIDPHLSA, the NCDC and the NHA, and related datasets), and there is a lack of coherence across datasets *(28,29)*.

There is also a lack of adequately trained human resources, and a shortage of financial resources, which hamper the further development of the information system.

2.5. Align structures

This governance behaviour is concerned with the extent to which the Government acts to ensure that core health policy goals are reflected in organizational structures, service delivery models and financing arrangements.

Current level of progress: Progressing ○○●○○

In Georgia, the private sector is fully integrated in organizational structures for health service delivery – including in curative health services, and also public health and preventive services (e.g. immunization, prevention of infectious diseases, and cancer screening). The private sector is also routinely included in national efforts to improve access to care. For example, the hepatitis C elimination programme in Georgia was considered by some key informants participating in the study to be a good example of a public–private partnership, with technical assistance support provided by development partners.

Some efforts have been made to align public and private health-care providers towards a PHC-oriented model of service delivery (as stipulated in both the 2022–2030 Strategy, and the MoIDPHLSA's PHC Roadmap, which has been developed with WHO support)*(30)*. Through the MoIDPHLSA, the Government has been able to establish a gatekeeping function at the PHC level, defining clinical care pathways for four prevalent noncommunicable diseases to regulate referrals from PHC providers to specialized outpatient, diagnostic and hospital services. It is intended that this will reduce patient self-referrals, although the impacts are not yet known and there are no new financial incentives to motivate, nor regulatory measures to enforce compliance with the new rules.

More generally, progress towards a PHC-oriented model of service delivery is in reality impeded by acute underfunding of PHC providers by the Government. One key informant (a senior manager of a private PHC network) stated that very low PHC capitation rates could force private providers out of the UHCP network, or encourage them to extend services in clinical areas outside of the PHC package (for which out-of-pocket payments can be charged), thus reducing the supply of government-funded PHC. Related impacts on the scale and structure of the PHC network are likely to be particularly severe outside of the country's main cities (Tbilisi, Kutaisi, Batumi), in which opportunities to generate out-of-pocket payments are comparatively limited.

Georgia Medical Holdings operates a number of rural ambulatory facilities and public clinics in locations in which commercial operations are assessed to be non-viable (often, but not always, in rural areas). That said, as discussed earlier, in many rural and small-town areas, the private sector is also represented due to contractual obligations agreed during the early phases of privatization. In relation to these obligations, government stakeholders should consider whether such arrangements are still required in all cases and/or still an efficient use of resources (for example, due to demographic changes in each area, they may no longer be reflective of current population health needs).

2.6. Nurture trust

This governance behaviour is concerned with ensuring that the Government acts to ensure that consumer pro¬tection laws are well specified and well enforced, such that they safeguard that the health, welfare and rights of patients. The Strategy has no objectives specifically focused on this issue.

Current level of progress: Developing ○●○○

Certain legal provisions allow for improvement in financial protection for patients (e.g. the limiting of co-payments under the UHCP) and these may also serve to improve pricing transparency and to nurture greater trust. However, such protections do not extend beyond the UHCP, and there are no reliable or consistent legal provisions or structures in place to ensure that citizens' and patients' voices and rights are fully respected. Civil society is generally weak in Georgia, and social accountability mechanisms are largely absent.

3. Recommended actions by governance behaviour

This section draws on the situation analysis outlined in section 2 to propose a series of actions through which governance can be strengthened, with a focus on those required to move to the next level of the Progression Pathway for each governance behaviour. In addition, a key cross-cutting recommendation is the need for the Government to define and implement a capacity development plan for the MoIDPHLSA, the RAMA and the NHA. In the former case (Ministry and the RAMA), this should focus on the knowledge and skills needed to strengthen access to and use of data (including digital health data); to upgrade and optimize regulatory frameworks, drawing on international best practice;[16] and to engage with the private sector in meaningful consultation, without detriment to the integrity, impartiality and independence of their regulatory functions. For the NHA, this means developing the knowledge and skills needed for it to fully realize its role as a strategic purchaser for the UHCP.

3.1. Deliver strategy

This assessment has concluded that Georgia is at Level 3: Progressing, in this governance behaviour.

Current level of progress: Progressing ○○●○

This designation recognizes the status of the National Healthcare Strategy 2022–2030 *(4)* as a promising foundation on which to build. To move from the Progressing level to Established (the

[16] For example, learning from the European Commission's Regulatory Scrutiny Board *(31)*, which serves as an advisory body that evaluates the quality of impact assessments and major policy proposals, including health-care regulations, to ensure consistency and coherence across European Union Member States.


ცენტრი
Centre
წერეთლის გამზ.
Tsereteli Ave.
დინამო არენა
DINAMO ARENA

highest level in the Progression Pathway), the required actions include:

- drawing on the Strategy to further develop the triannual action plans, ensuring these are fully costed (that is, taking account of all related expenditures) and aligned to the Government's Basic Data and Directions document (equivalent to a medium-term expenditure framework) *(5)*;
- for each action plan, clearly identifying the entities responsible for delivery, including specified roles for public and private sector actors; and
- ensuring that for each action plan, the monitoring and evaluation framework allows progress to be tracked on a continuous basis, including reporting to Parliament every six months, supported by public hearings and informed by the scrutiny of and reporting by the State Audit Office.[17]

The goals of enhanced public accountability are both:

- to ensure effective implementation; and
- to contribute to the policy consistency and stability that is being called for by health system stakeholders, including in the private sector.

In addition, as effective implementation of the Strategy will have a major impact on the business environment in which the private sector operates, monitoring by the MoIDPHLSA and (over time) the NHA should include a focus on providers' responses, including adverse behaviours (such as inappropriate self-referrals, risk selection of patients, rerouting of patients from publicly financed to privately financed settings, skimping on quality, and so on). The efficacy of monitoring can be facilitated by improved information flow, and strengthened analytical capabilities on the part of the MoIDPHLSA, both of which are also identified as strategic priorities in the Strategy *(4)*, but which now need renewed attention and financial support. In addition, the Government should ensure that public–private dialogue is used strategically to strengthen the monitoring framework. For example, the private sector could be enabled and encouraged to suggest relevant performance indicators, tools and information sources to strengthen such efforts.

[17] It may also be important to provide training within the State Audit Office for the people designated to perform this task, including through engagement with the International Organization of Supreme Audit Institutions. More information about capacity development is available on their website *(31)*.

3.2. Enable stakeholders

3.2.1. Regulation

3.2.1.1. Facility registration and licensing processes

This assessment has concluded that Georgia is at Level 2: Developing, in relation to this domain of the "Enable stakeholders" governance behaviour. This designation reflects current limitations but also the Government's intentions to:

- enrich the licensing regime;
- complement this with a de facto compulsory accreditation system; and
- extend its scope to include, over time, a needs-based component.

Current level of progress: Developing ○●○○

The Government should continue to upgrade licensing requirements in line with international standards. The introduction of accreditation for all UHCP providers may generate additional upward pressure on providers' quality of care – mitigating to some degree the risks posed by existing limitations in the statutory system. However, the statutory system itself should provide effective safeguards, ensuring that minimum standards are equally applied to all operating providers to ensure consumer protection. It may be possible to harness the accreditation process in the future; that is, to draw on the standards, benchmarks and enforcement procedures required to upgrade licensing requirements. In this way, accreditation can provide a long-term contribution to the creation of a more effective quality-improvement system in Georgia.

In addition, efforts should be made to ensure inspections are risk based, such that penalties (both financial and non-financial) are proportional to the impacts of non-compliance on patient safety and quality of care. Penalties should properly differentiate between providers that are or are not putting patients at risk. With successful implementation of these elements, the country can in due course move towards a designation of Level 3: Progressing in this domain.

3.2.1.2. Regulation of health education/training institutions

This assessment has concluded that Georgia is at Level 2: Developing, in relation to this domain of the "Enable stakeholders" governance behaviour.

Current level of progress: Developing ○●○○

To move towards a designation of Progressing, actions will be required to ensure that the numbers, composition and competencies of trainees/students are monitored and aligned with assessed

workforce needs, and to improve the quality of training/education. In relation to workforce planning, action is needed to address: the current oversupply of doctors, imbalance among specialists, and undersupply of nurses and midwives. This is an area where the policy tools available to public sector institutions differ from those available to private sector institutions. For those in the former category, influence can be exerted through the provision (or withholding) of grants – ensuring these are provided in the numbers, and to the students or for the courses required for the health system. For institutions in the latter category, however, the necessary actions must incorporate a strengthening of regulations to constrain admissions of local students at the undergraduate and postgraduate levels (in accordance with assessed needs).

In addition, private sector institutions are currently facing strong incentives to recruit large numbers of overseas students. In the context of limited teaching capacity, recruitment should be managed (for example, through regulations to ensure caps on the number of students per faculty) to safeguard the quality of education provided to all students (local and international) and to enable more practical (bedside) clinical training.

More generally, curricula should be enriched – including via appropriate engagement of professional associations – to ensure that doctors have sufficient practical training before they enter practice. Assessment approaches can also be upgraded to meet international standards of certification/examination – again, ensuring that they focus on practical clinical skills, with appropriate quality control, along with monitoring and evaluation of results. Such changes (e.g. in relation to nursing training) command significant buy-in and support from private health-care facilities and can provide a focus for cross-sectoral joint working and trust-building.

3.2.1.3. Regulation of health professionals

This assessment has concluded that Georgia is at Level 2: Developing, in relation to this domain of the "Enable stakeholders" governance behaviour.

Current level of progress: Developing ○●○○

Moving towards the Progressing level will require:

- improved data collection and analysis on human resources for health – including in relation to the number (by specialty) and qualifications of medical personnel, and with the Ministry of Education, Science, Culture and Sport providing the MoIDPHLSA with timely information on the number, composition and qualifications of personnel due to enter practice;
- working with private (as well as public) providers to introduce and enforce new regulations for nursing and midwifery in line with international standards; and
- updating and ensuring mandatory enforcement of CME/CPD requirements for all health professionals across all specialties in both the public and private sectors, with effective supervision of the accumulation of credit scores and effective monitoring mechanisms for all accredited programmes.

3.2.1.4. Regulation of clinical practice/service delivery

This assessment has concluded that Georgia is at Level 2: Developing, in relation to this domain of the Enable stakeholders governance behaviour.

Current level of progress: Developing ○●○○

To move from Developing to Progressing will require stronger government capacity (in both the RAMA and the NHA) to create and enforce a robust quality-management system. To achieve this, the Government should continue to support the expanded role for – and encourage capacity development of – selected professional associations (namely, those that are genuinely representative of and are assessed to be respected by the relevant professions), as outlined in the 2022–2030 Strategy. This includes ensuring support via the National Council for Clinical Practice Recommendations (Guidelines) and the State Standards (Protocols) for Disease Management, and the approval of their regulations.

Private sector investment in quality improvement may also be stimulated through government-supported efforts, including public recognition and acknowledgement of providers' progress in this area. This could include developing a process for national awards to be granted to providers that: (i) consistently achieve excellence with regard to enforcement of quality-assurance mechanisms, as revealed in external clinical audits; (ii) receive high scores in assessment of patient experience, as demonstrated in periodic patient surveys and experience/satisfaction polls; (iii) achieve consistently high standards of ethical conduct among employees and facilities, as assessed by patient representative groups; and/or (iv) make a significant contribution to addressing population-level health problems.

3.2.1.5. Regulation of retail pharmacies

This assessment has concluded that Georgia is at Level 3: Progressing, in this domain of the "Enable stakeholders" governance behaviour.

Current level of progress: Progressing ○○●○

This designation reflects the progress made in strengthening quality assurance and the price regulation of essential medicines since the introduction of the Law on Medical Products in 2021 *(12)*. However, further action is required to ensure that retail prices are controlled and the scope for irrational prescribing and dispensing are curtailed. The Government should take further steps to strengthen the RAMA's technical capacity and access to data, enabling stronger monitoring of both prescription and dispensing decisions, supported by the e-prescription system. As irrational prescribing and dispensing are likely to persist, further regulations can be considered – for example, reversing and/or mitigating the impacts of vertical integration within the pharmaceutical supply chain, in alignment with the findings of the 2021 Georgian Competition and Consumer Agency report on the pharmaceutical market *(14)*.


Ethanol 96%

3.2.1.6. Regulation of the PHI industry

This assessment has concluded that Georgia is at Level 2: Developing in relation to this domain of the "Enable stakeholders" governance behaviour.

Current level of progress: Developing ○●○○

This designation recognizes that some consumer protection arrangements are in place. However, to progress towards a designation of Established, the Government will need to define and enforce PHI regulations that:

- standardize the levels of coverage provided;
- eliminate waiting time periods (e.g. for people who have recently moved into one of the population categories eligible for subsidies); and
- ensure that dependents are covered from day one of the policy's operation.

In the context of standardized coverage, the Government should ensure that PHI products provide comprehensive coverage for preventive care, primary care and other key outpatient services, to further protect consumers from experiencing gaps in coverage and to support a broader shift away from heavy reliance on inpatient care.

3.2.1.7. Regulation of the PHC market – economic regulation

This assessment has concluded that Georgia is at Level 2: Developing, in relation to this domain of the "Enable stakeholders" governance behaviour.

Current level of progress: Developing ○●○○

Effective solutions to the problem of market fragmentation, especially in the hospital sector, will need to be implemented to enable Georgia to move from Developing level to Progressing. In fact, current plans to address this problem focus not on economic regulation per se but on a combination of:

- enrichments to licensing (e.g. new IPC requirements, and plans for a Certificate of Need element in authorization decisions);
- compulsory accreditation (for providers in the UHCP network); and
- a long-term commitment to expanding the scope of needs-based selective purchasing (on which progress has stalled, as discussed in more detail below).

It remains to be seen whether this package of reforms can lead to market consolidation and, thus, to greater efficiency; for example, by realizing economies of scale, eliminating excess capacity, and so on. Current market conditions do not favour large-scale market entry or capital investment, limiting the impact of the aforementioned Certificate of Need on market structure. A more direct approach to ensuring efficiency/accessibility would involve the use of regulations to establish a core hospital network (based on assessed needs/accessibility criteria), with routine UHCP purchasing restricted

to providers in that network. In this scenario, selective contracting (with providers selected through competitive tenders, and paid on the basis of performance-adjusted global budgets) would be used to address gaps in specific localities and/or service domains. However, the KIIs revealed that a regulated needs-based core network is widely seen as technically unfeasible in Georgia, given the extent of legal constraints and the dominance of private providers.[18]

Regulation may be used to address the extent of vertical integration – including integration due to the presence of holding companies that own combinations of health-care facilities, pharmaceutical companies, pharmacies and private insurers. As a first step, the Government should commission the Georgian Competition and Consumer Agency to carry out a market inquiry into the structure, conduct and performance of the health-care industry (including both the public and private sectors). This would extend the Georgian Competition and Consumer Agency's (impactful) 2021 work on market concentration in the pharmaceutical market *(14)*, and focus on:[19]

- examining the nature and extent of vertical integration in the health-care industry);
- identifying any impacts on competition of, and any conflicts of interest arising from, vertical integration;
- evaluating the consequences of competition constraints and conflicts of interest (if any) for patients' health and financial status; and
- propose recommendations for limiting market holdings where the evidence shows that these result in the accumulation or retention of market power and/or facilitate behaviours that harm or disadvantage patients.

3.2.2. Purchasing

This assessment has concluded that Georgia is at Level 2: Developing, in relation to this domain of the "Enable stakeholders" governance behaviour.

Current level of progress: Developing ○●○○

For the UHCP, provider eligibility criteria are minimal. Individual contracts and contract specifications are absent. Monitoring of provider performance is limited. As a result, performance pressures on UHCP-financed providers are determined by market conditions, operating within a regulatory system that is limited in scope and effectiveness.

To advance from Developing level towards a designation of Progressing, the NHA's role as a strategic

[18] This view may also be in part because of the failure of the 2007 Hospital Development Master Plan (discussed in subsection 2.2.1).

[19] The evidence base of market investigations undertaken internationally since 2014 (e.g. in Australia, Brazil, Chile, South Africa, the United Kingdom and the United States of America) can be employed to make the case for, and define the investigation focus of, this inquiry.

purchaser will need to be strengthened, alongside its capacity to realize this role in practice, including through the following actions.

- Setting and enforcing eligibility criteria involves shifting to needs-based, as well as quality-based, selective contracting (which will in turn require the current informal moratorium on selective contracting to be removed).
- Ensuring providers are held accountable for the quantity and quality of care they provide includes supporting UHCP providers to implement monitoring mechanisms, with routine digitized reporting on selected performance indicators in both the public and private sectors (further detail provided on this action area in section 3.4).
- Moving from the current reactive, supply-driven approach to a more strategic approach involves setting out expected outputs in contracts with providers, with detailed specifications and performance indicators covering access, quality and volume), together with robust monitoring and enforcement mechanisms.

With regard to payment mechanisms, for the PHC level, payment could be reformed to enable clinics to take more responsibility for patient care, particularly for patients with (multiple) chronic conditions. Potential reforms could include increased budgetary prioritization for PHC, enabling higher capitation base rates, greater risk adjustment and a performance-related element *(32)*. For hospitals, the current reform direction – moving towards reducing financial barriers to access and enhancing financial protection for the population – should be maintained. This implies resisting ongoing political pressure to relax the regulation of co-payments. In addition, to replace current informal arrangements with private providers located in rural (or otherwise perceived unprofitable) areas with more formal sustainable arrangements, competitive tenders could be employed, with selected providers paid on the basis of performance-adjusted global budgets.

3.3. Foster relations

This assessment has concluded that Georgia is at Level 2: Developing, in this governance behaviour.

Current level of progress: Developing ○●○○

Implementation of recent regulations and purchasing reforms has motivated the private sector to develop credible, well-resourced representative bodies and to engage in dialogue. However, representative bodies express concerns about the impact of such dialogue on policy decisions, and view the private sector's role in policy as largely ad hoc and reactive. The Government could consider establishing sectoral high-level dialogue platforms, with regularly scheduled meetings, in which representative bodies can propose topics for discussion and agreement. Regular dialogue on issues of pressing concern will become a critical part of the biannual/triannual action plans for implementation of the 2022–2030 Strategy, and can also make a contribution to the policy predictability that private sector stakeholders have been calling for.

At the same time, the dominance of the private sector in the health system – and the resources it can mobilize to influence activities – require Government to ensure greater openness, inclusivity and transparency in the associated processes. Therefore, to move from Developing level to a designation of Progressing, the Government must act to ensure stronger and regularized involvement in policy processes of both private sector representatives and a broader range of other social-interest stakeholders. This will help to ensure balanced representation of interests and greater transparency in decision-making – for example, by publishing meeting schedules and minutes, and establishing clear rules in relation to identification and management of conflicts of interest.

3.4. Build understanding

This assessment has concluded that Georgia is at Level 2: Developing, in this governance behaviour.

Current level of progress: Developing ○●○○

To move towards a designation of Progressing, the Government will need to address current weaknesses in the HIS. In addition, it is important to invest in the capacities of authorities engaged in data collection (the MoIDPHLSA, the NCDC and the NHA) to perform their functions effectively. Digital data reporting and analytics procedures, data (and data-exchange) standards, and forms for data collection should be coordinated and coherent across these entities. Data that must be reported by each provider should be standardized across sectors, and explicitly defined in appropriate

detail. For relevant staff within the MoIDPHLSA, the RAMA and the NHA, the ability to access and use data in policy analysis and decision-making should be seen as a core requirement, with training provided accordingly. In the longer term, eligibility to receive UHCP contracts and payments should be dependent on the extent of providers' compliance with reporting requirements. The Government should also build on previous steps *(33)* to make relevant information available to the public (for example, on the basis of a methodology that would calculate and risk-adjust certain indicators, such as mortality and re-hospitalization rates), on a platform and in a format easily accessible to the population, to enable and inform patient choices.

3.5. Align structures

This assessment has concluded that Georgia is at Level 3: Progressing, in this governance behaviour.

Current level of progress: Progressing ○○●○

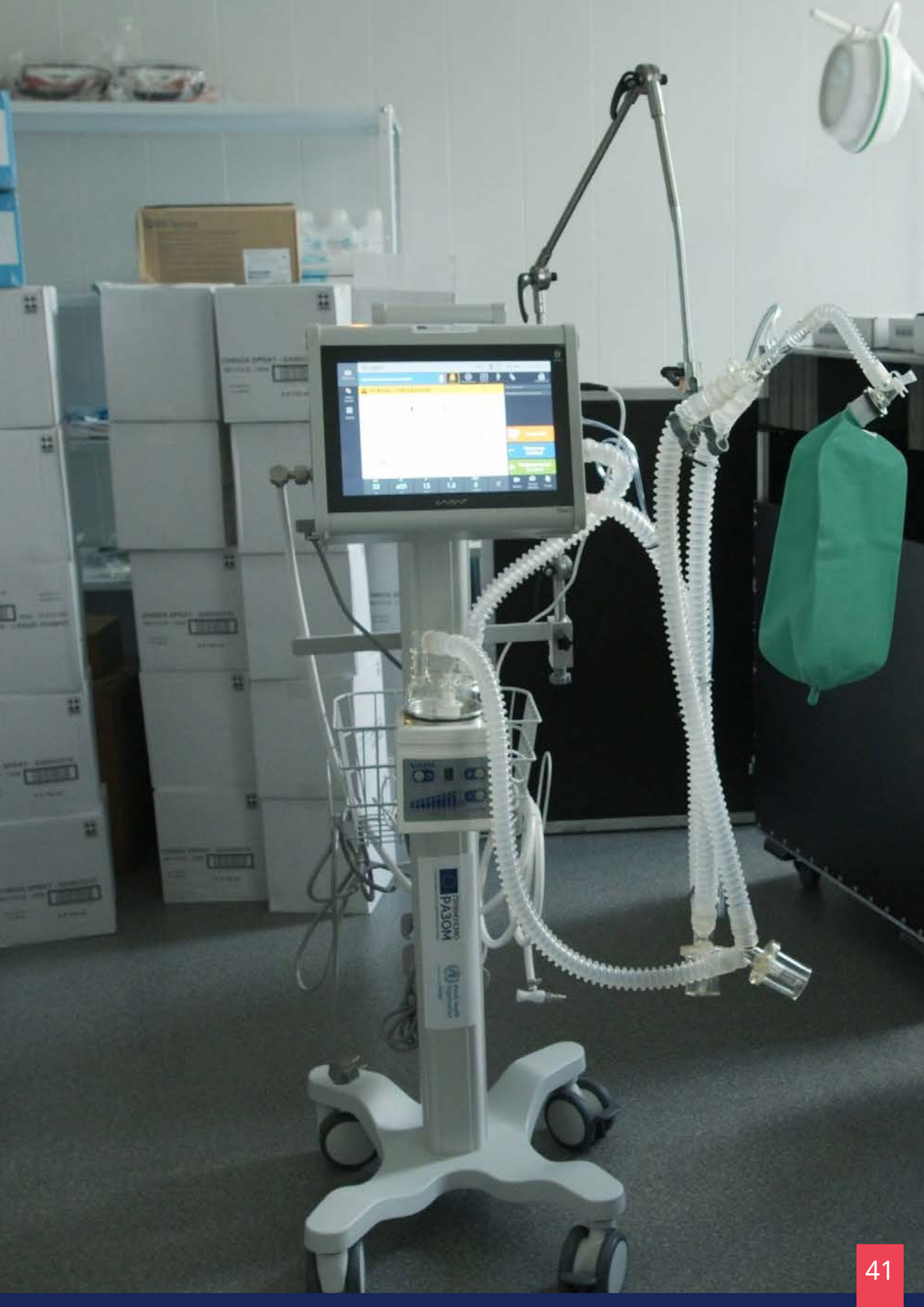
The Government's PHC Roadmap is an important moment in the health system's transition towards a PHC-oriented system; one that has, for instance, a strong gatekeeping role for PHC, strong incentives for PHC providers to perform well in terms of access and quality, and a meaningful role for nurses. However, to implement the Roadmap, additional budgetary support for the PHC sector, various elements may be required. These include: ensuring greater stability in payments for PHC providers (e.g. by increasing the budgetary prioritization of PHC, increasing capitation rates to reverse the erosion of their real value over many years, and linking these in the future to consumer price index, while also considering a performance-based element); introducing eligibility criteria (e.g. by defining health facility-level PHC team composition, competencies and standard job descriptions), contractual specifications, performance indicators and monitoring mechanisms. If these elements are not in place, there is a risk that PHC providers will increasingly shift resources away from UHCP-financed to privately financed services and/or engage in adverse behaviours, such as inappropriate self-referrals, patient selection, and skimping on quality – resulting in a health-care delivery system that is misaligned with key government policy objectives.

3.6. Nurture trust

This assessment has concluded that Georgia is at Level 2: Developing, in this governance behaviour.

Current level of progress: Developing ○●○○

To advance towards a designation of Progressing, current consumer protections should be extended to ensure that citizens' and patients' voices and rights are fully respected. As noted in other domains, licensing, accreditation and contract monitoring can be leveraged to assure quality, and related information should be shared with the public. In addition, conflicts of interest – including those that have emerged due to vertical integration – need to be monitored, with the resulting analysis placed in the public domain and regulatory/enforcement action taken where consumers' health rights or general welfare are negatively affected.


РАЗОМ

4. Summary of findings and recommended actions

Table 2 provides a summary of the findings of the situation assessment, organized by governance behaviour. It identifies the current level of progress designated through the assessment and briefly outlines priorities for action to make further progress along the Progression Pathway *(3)*.

However, it should be emphasized that significant expansion in the technical capacity of the MoIDPHLSA, the RAMA and the NHA – supported by a strengthened information system and better collaborative working between the Government and the private sector – are important preconditions for achieving progress across all six governance behaviours.

Table 2. Summary of findings by governance behaviour: assessment, status and recommended actions

Governance behaviour	Summary of findings – assessment and recommended actions	Status
1. Deliver strategy	The Government published the National Healthcare Strategy 2022–2030 (4) in 2022, setting out a cohesive package of reforms for achieving better performance. It constitutes a major shift in direction for the health system – including an expanded role for the State in governance of the private sector. Many aspects of the Strategy are at the implementation stage. Overall, it represents an important foundation for policy consistency and stability in the Georgian health system – one that may help to guide future private sector decisions (e.g. investment and resource-allocation decisions) in alignment with the intended health financing and service delivery reforms. To move from the designation Progressing to Established (the highest level in the Progression Pathway (3)), the Government needs to build on this foundation by ensuring that action plans for implementation are clearly specified and fully costed (taking into account	**Level 3: Progressing**

Governance behaviour	Summary of findings – assessment and recommended actions	Status
	all related expenditures), aligned to the Government's Basic Data and Directions document (5), and underpinned by enhanced accountability to Parliament, including scrutiny of the State Audit Office.	
2. Enable stakeholders		
2.1 Regulation		
Facility registration and licensing processes	The licensing regime is currently designed to ensure minimum standards for infrastructure and staffing. The Strategy calls for the standards to be upgraded in line with international standards. Enforcement of current requirements is perceived to be strict, but there are concerns that inspection decisions are not risk based (such that even breaches that do not constitute a material risk to safety or quality can give rise to large penalties). This contributes to business risk without actually enhancing patient safety and/or quality of care. The licensing regime will soon be accompanied by an accreditation system (2025), and a new Certificate of Need process. It may be possible to harness the accreditation process to upgrade licensing requirements in accordance with international standards. In this way, accreditation may contribute to a better specified and more effective statutory quality-improvement system. If this is achieved, alongside a shift towards a more explicitly risk-based approach to inspections, the country may advance towards a designation of Progressing (Level 3) in this domain.	**Level 2: Developing**
Regulation of/training institutions	There is in general no proactive needs-based management of the supply of health professionals in Georgia. This results in an excess supply of newly qualified medical doctors, especially in more popular (more remunerative) specialties, and an undersupply of nurses and midwives. In addition, the quality of training of newly educated/trained health professionals is uncertain – due in part to underdeveloped teaching, learning and assessment strategies, and high numbers of students per faculty. Actions to strengthen workforce planning (ensuring that the numbers and composition of trainees/students are aligned with assessed workforce needs), and to ensure higher quality (including in postgraduate training) would be required before Georgia could advance to a Progressing designation.	**Level 2: Developing**

Governance behaviour	Summary of findings – assessment and recommended actions	Status
Regulation of health professionals	For the medical profession, arrangements for registration and initial licensing are well defined, although data quality is poor. The licensing (state certification) process is linked to professional education and practice; and disciplinary procedures are in force (including for violating certification requirements and ethical principles). However, CME/CPD are not mandatory for all specialties. The 2022–2030 Strategy includes proposals to update the CME/CPD system, including linking obligations for health workers to undergo relevant training to professional (re)certification and licensing processes, but these are not yet in place. Overall, nursing as a professional area is underdeveloped relative to international norms. Nurses will require a licence (state certificate) from 1 January 2025 to practise; however, there remains no CPD requirements for nurses, reflecting the low professional status of the nursing profession, as a matter of major concern to several of the private sector stakeholders that were interviewed. Advancing towards a Progressing designation will require, inter alia: (i) improved data collection and analysis on human resources for health; (ii) introduction of regulations for nursing and midwifery in line with international standards; and (iii) updating of CME/CPD requirements across the board for all health professionals.	**Level 2: Developing**
Regulation of clinical practice/ service delivery	Evidence-based national standards, protocols and guidelines for essential health conditions and services exist. A National Council for Clinical Practice Recommendations (Guidelines) and State Standards (Protocols) for Disease Management (and the approval of their regulations) was renewed in May 2023 to continue work on this. It comprises representatives from the MoIDPHLSA, the RAMA, service providers and professional associations. However, in practice, enforcement is irregular and inadequate, due in part to the absence of clear indicators, reporting frameworks and monitoring, along with inadequate technical capacity within the RAMA and the NHA. To advance towards the next level (Progressing), stronger government capacity will be needed (in both the RAMA and the NHA) to create and enforce a more robust and optimized quality-management system, including monitoring of compliance. In addition, the Government should continue to support an expanded role for selected professional associations outlined in the 2022–2030 Strategy, including within the framework of the National Council for Clinical Practice Recommendations (Guidelines) and State Standards (Protocols) for Disease Management (and the approval of their regulations).	**Level 2: Developing**

Governance behaviour	Summary of findings – assessment and recommended actions	Status
Regulation of retail pharmacies	There is a well-defined system for regulating the operation of private pharmacy retailers (there are no public retailers in Georgia). However, governance challenges include the high degree of market concentration in the pharmacy sector, with both horizontal and vertical integration. The former generates upward pressure on prices, and the latter creates risks of conflicts of interest – potentially leading to overprescribing/dispensing of branded drugs compared to generics and contributing to high rates of catastrophic health expenditure (much of which is driven by outpatient medicines). In 2022 a prescription system was introduced for generics, which means that the doctor must prescribe medicines by International Nonproprietary Name rather than by brand – although it was not clear at the point of assessment whether this has fully addressed the problem. This designation recognizes the development of frameworks for quality assurance and price regulation of essential medicines (established in 2021) – but also the need for further supportive actions to control retail prices and eliminate irrational prescribing/dispensing practices. Implementation of such actions may be required to move towards the next level of the Progression Pathway (Established).	**Level 3: Progressing**
Regulation of the PHI industry	Currently, regulation of the PHI industry focuses on basic consumer protection and prudential matters. There is no regulation of coverage; for example, no compulsory minimum standards for all insurance products available in the market (which could encompass essential services coverage, including PHC). Instead, PHI companies offer insurance packages with varying levels of coverage, based on product prices and the individual or group risk status of consumers. However, the Insurance State Supervision Service of Georgia has highlighted the difficulty in purchasing individual insurance, with only a few private insurance companies offering such services. As a result, individuals in general – but especially those who do not have access to corporate/group private insurance – may be uninsured or underinsured. This assessment has concluded that Georgia's designation is Progressing in this domain, in recognition of relatively robust arrangements in place to protect consumers. To progress towards the Established level, further efforts are needed to regulate the levels of coverage provided, with an emphasis on PHC, preventive care, emergency care, and key outpatient services (in addition to inpatient care) – both to protect consumers from gaps in coverage (underinsurance) and to support the broader systemic shift away from heavy reliance on inpatient care.	**Level 3: Progressing**

Governance behaviour	Summary of findings – assessment and recommended actions	Status
Regulation of the private health care market – economic regulation	The extent of fragmentation in the inpatient care market is accompanied by the presence of larger provider networks (e.g. Evex Medical Corporation), accounting for 13.4% of all hospital revenues in 2023. Some networks have facilities in multiple service domains (e.g. PHC and hospitals) and are owned by holding companies that also own, inter alia, pharmaceutical producers/importers, pharmacy retailers and private health insurers, creating conflicts of interest that may result in adverse behaviours. While there are emerging attempts to address market fragmentation – for example, proposed enrichments to licensing criteria and accreditation (both of which may encourage smaller facilities to close, or to merge with larger networks), and a Certificate of Need process that may increase market entry barriers – there are no proposals for regulations to prevent, reverse or address the adverse consequences of vertical integration. To advance to the next level (Progressing), regulations will be needed to address the extent of vertical integration. As a first step, the Government should commission the Georgian Competition and Consumer Agency to carry out a market inquiry into the structure, conduct and performance of the health-care industry, focusing on: the nature and extent of vertical integration; identifying any impacts on competition and conflicts of interest; evaluating the consequences for patients' health and financial status; and proposing recommendations for additional market regulations.	**Level 2: Developing**
2.2 Purchasing		
Purchasing	The UHCP and vertical programmes account for a major proportion of private service providers' revenues. As a result, purchasing arrangements – including the setting of eligibility criteria, contractual specifications, performance monitoring, and payment models – have great potential to reinforce regulatory pressures, and thereby increase state authorities' influence on the market's structure, conduct and performance. Currently, however, the state purchaser, the NHA, acts as a largely passive purchaser; it does not generally engage in selective purchasing – although its experience in doing so in some specific clinical areas (e.g. maternity services) is encouraging. The introduction of accreditation may also lead to greater selectivity (as only those with accreditation will be eligible to receive funds). However, there is currently a moratorium on the wider application of selective contracting. In addition, there are no individual contracts with providers. There are minimal contractual specifications, and NHA monitoring is limited (restricted primarily to claims assessment).	**Level 2: Developing**

Governance behaviour	Summary of findings – assessment and recommended actions	Status
	In PHC, payment is not directly linked to quality of care or outcomes. This is a particular concern given the noted gaps in the regulatory apparatus, and the dominance of private providers in service delivery (such that the control levers afforded by public ownership are unavailable). To advance towards a designation of Progressing, further action to strengthen the NHA's role as a strategic purchaser will be required, incorporating: needs-based selective purchasing across the full range of service domains; individual contracts with providers; and contractual specifications (supported by robust monitoring) that cover access, quality and volume indicators.	
3. Foster relations		
Foster relations	Government stakeholders point to an inclusive approach to strategy and policy development. For example, the 2022–2030 Strategy was developed following extensive consultation with a group of stakeholders, including private service providers' representatives – with the main association involved in working groups for strategy development and an iterative review process. However, key informants from the private sector expressed concern that some policy decisions – including those relating to implementation of the Strategy – were made without adequate consideration of information provided by the private sector, requiring subsequent changes to prevent unintended consequences. Furthermore, some platforms established for dialogue on specific policy areas (e.g. DRG reform) were regarded as being more focused on information provision by authorities about decisions already taken, rather than meaningful deliberation on the decisions, or information sharing on their likely impacts. Although the development of the Strategy included a broader public consultation, Georgia has yet to develop platforms for engaging with stakeholders more generally, such as patients' associations, community groups, or representatives of vulnerable groups (23). This is a particular concern in the Georgian health sector, in which there are private sector interest groups that span multiple sectors (due to vertical integration). In this context, sustained efforts to include a broader range of stakeholders in the policy process are essential to ensure that the potential for bias, conflict of interest, or corruption to influence policy decisions are effectively mitigated. To move to a designation of Progressing, the Government must act to ensure stronger and regularized involvement in policy processes by a broader range of social-interest stakeholders, while ensuring greater transparency in decision-making.	**Level 2: Developing**

Governance behaviour	Summary of findings – assessment and recommended actions	Status
4. Build understanding		
Build understanding	The national HIS has several gaps and limitations. These include: duplication of entries and a lack of clear or uniform data-collection processes; a primary focus on the data required to process payments, rather than on data that could enable monitoring of clinical activity or quality of care; a resulting lack of available information to inform patient choices; a lack of coordination across authorities/stakeholders involved in data collection; and a lack of adequately trained human resources. To move towards a designation of Progressing, the Government will need to address current weaknesses in the HIS. In addition, it is important to invest in the capacities of authorities engaged in data collection (the MoIDPHLSA, the NCDC and the NHA) to perform their functions effectively. For relevant staff in the MoIDPHLSA, the RAMA and the NHA, the ability to access and use data in policy analysis and decision-making should be seen as a core requirement, with training provided accordingly. Ideally, the Government should also ensure the availability of relevant information to the public, on a platform and in a format accessible to the population, to enable and inform patient choices regarding service providers.	**Level 2: Developing**
5. Align structures		
Align structures	Some efforts have been made to align public and private providers towards a PHC-oriented model of service delivery (as stipulated in both the 2022–2030 Strategy and the MoIDPHLSA's PHC Roadmap, developed with WHO support). The Government has established a gatekeeping function for PHC providers, and defined clinical care pathways for four prevalent noncommunicable diseases to regulate referrals from PHC providers to specialized outpatient, diagnostic and hospital services. This is intended to reduce patient self-referrals. However, progress towards a PHC-oriented model of service delivery – with a focus on essential PHC services – is (to some degree) being impeded by severe underfunding at the PHC level. This has the potential result of diverting patients away from essential (publicly financed) to other (privately financed) clinical areas, ultimately reducing coverage of essential services (34). The PHC Roadmap proposes to move towards a PHC-oriented system, and to put in place the structural changes required to achieve this. However, it must also provide the budgetary support required to align public and private providers' incentives with the goals of a PHC-oriented system. If the Government succeeds in doing so, this will represent an advance in this governance behaviour towards a designation of Established (Level 4).	**Level 3: Progressing**

Governance behaviour	Summary of findings – assessment and recommended actions	Status
6. Nurture Trust		
Nurture Trust	There is a well-defined framework for safeguarding patient rights and consumer protection; however, social accountability mechanisms are largely absent. Certain legal provisions allow for improvement of financial protection for patients (e.g. the introduction of DRGs or limiting of co-payments under the UHCP) and these may also serve to improve pricing transparency and trust. However, such protections do not extend beyond the UHCP and there are no reliable or consistent legal provisions or structures in place to protect citizens' and patients' voices and rights. To advance towards the Progressing level, current consumer protections should be extended to ensure that citizens' and patients' voices and rights are fully respected. In addition, conflicts of interest emerging from vertical integration need to be monitored, with the emerging analysis placed in the public domain and regulatory/enforcement action taken where adverse behaviours are observed.	**Level 2: Developing**

5. References[1]

1. UHC watch [online database]. Copenhagen: WHO Regional Office for Europe; 2025 (https://apps.who.int/dhis2/uhcwatch).

2. European Observatory on Health Systems and Policies, WHO Regional Office for Europe. Health systems in action: Georgia. Copenhagen: WHO Regional Office for Europe; 2022 (https://iris.who.int/handle/10665/349232).

3. Country Connector on Private Sector in Health. The progression pathway for governance of mixed health systems [website]. Geneva: World Health Organization; 2025 (https://ccpsh.org/research/progression-pathway-governance-mixed-health-systems).

4. საქართველოს მთავრობის დადგენილება N 230 საქართველოს 2022 - 2030 წლების ჯანმრთელობის დაცვის ეროვნული სტრატეგიის დამტკიცების შესახებ [Resolution No. 230 of the Government of Georgia on the approval of the National Health Protection Strategy of Georgia for 2022–2030]. Government of Georgia; 230; 2 May 2022 (https://matsne.gov.ge/ka/document/view/5453716?publication=0) (in Georgian).

5. BDD [BDD]. In: ბიუჯეტი [Budget] [website]. Ministry of Finance of Georgia; 2025 (https://www.mof.ge/BDD) (in Georgian).

6. Hospital beds (per 10 000 population). In: Indicators. Health service delivery. The Global Health Observatory [online database]. Geneva: World Health Organization; 2025 (https://www.who.int/data/gho/data/indicators/indicator-details/GHO/hospital-beds-(per-10-000-population)).

7. საქართველოს მთავრობის დადგენილება N 385 სამედიცინო საქმიანობის ლიცენზიისა და სტაციონარული დაწესებულების ნებართვის გაცემის წესისა და პირობების შესახებ დებულებების დამტკიცების თაობაზე [Resolution No. 385 of the Government of Georgia on the approval of the Regulation of the Procedure and Conditions for Issuing Licences for Medical Activity and Permits for Inpatient Care Facilities]. Government of Georgia; 385; 17 December 2010 (https://matsne.gov.ge/ka/document/view/1150800?publication=0) (in Georgian).

[1] All references were accessed on 19 March 2025.

8. საქართველოს მთავრობის დადგენილება N 56 „სამედიცინო საქმიანობის ლიცენზიისა და სტაციონარული დაწესებულების ნებართვის გაცემის წესისა და პირობების შესახებ დებულებების დამტკიცების თაობაზე“ საქართველოს მთავრობის 2010 წლის 17 დეკემბრის N 385 დადგენილებაში ცვლილების შეტანის შესახებ [Resolution No. 56 of the Government of Georgia on Amendments to Resolution No. 385 of the Government of Georgia of 17 December 2010 on the approval of the Regulation of the Procedure and Conditions for Issuing Licences for Medical Activity and Permits for Inpatient Care Facilities]. Government of Georgia; 56; 6 February 2017 (https://matsne.gov.ge/ka/document/view/3567739?publication=0) (in Georgian).

9. სამედიცინო პერსონალის პროფესიული განვითარების აუდიტის ანგარიში [Performance audit report on human resources for health]. Tbilisi: State Audit Office; 2023 (https://sao.ge/ka/%E1%83%A1%E1%83%90%E1%83%9B%E1%83%94%E1%83%93%E1%83%98%E1%83%AA%E1%83%98%E1%83%9C%E1%83%9D-%E1%83%9E%E1%83%94%E1%83%A0%E1%83%A1%E1%83%9D%E1%83%9C%E1%83%90%E1%83%9A%E1%83%98%E1%83%A1-%E1%83%9E%E1%83%A0%E1%83%9D%E1%83%A4%E1%83%94%E1%83%A1%E1%83%98%E1%83%A3202402090514104 58ka.html) (in Georgian).

10. Bochorishvili E, Samkurashvili K, Mamrikishvili T. Georgia's education sector. June 2024. Tbilisi: Galt & Taggart; 2024 (https://api.galtandtaggart.com/sites/default/files/2024-06/report/education-sector-in-georgia_eng_0.pdf).

11. Medical education in Georgia: quality assurance, main trends and challenges. Tbilisi: National Center for Educational Quality Enhancement; 2021 (https://eqe.ge/res/docs/2020/TA_NCEQE_MEDICINE_ENG_2021.pdf).

12. საქართველოს კანონი წამლისა და ფარმაცევტული საქმიანობის შესახებ [Law of Georgia on medical products and pharmaceutical activities]. Parliament of Georgia; Law No. 659; 5 May 1997 (https://www.matsne.gov.ge/ka/document/view/29836?publication=30) (in Georgian).

13. Goginashvili K, Nadareishvili M, Habicht T. რამდენად შეუძლიათ ადამიანებს ჯანდაცვის მომსახურების საფასურის დაფარვა? ახალი მტკიცებულება საქართველოში ფინანსური დაცვის შესახებ [Can people afford to pay for health-care? New evidence on financial protection in Georgia]. Copenhagen: WHO Regional Office for Europe; 2021 (https://iris.who.int/handle/10665/342814) [in Georgian]. Licence: CC BY-NC-SA 3.0 IGO.

14. ფარმაცევტული ბაზრის მონიტორინგის ანგარიში [Pharmaceutical market monitoring]. Tbilisi: Georgian Competition and Consumer Agency; 2021. (0e920af7373747e089b6921817fb9e12.pdf) (in Georgian).

15. სადაზღვევო ბაზრის მიმოხილვა 2023 წელი [Overview of the insurance market 2023]. Tbilisi: Insurance State Supervision Service of Georgia; 2023. (https://insurance.gov.ge/ka/Statistics/GetFile/650?type=4) (in Georgian).

16. საქართველოს მთავრობის დადგენილება N 36 საყოველთაო ჯანდაცვაზე გადასვლის მიზნით გასატარებელ ზოგიერთ ღონისძიებათა შესახებ [Resolution No. 36 of the Government of Georgia on some measures to be implemented in order to transition to universal health-care]. Government of Georgia; 36; 22 February 2013 (https://matsne.gov.ge/ka/document/view/1852448?publication=0) (in Georgian).

17. Tvaliashvili M, Sulaberidze L, Goodman C, Hanson K, Gotsadze G. Exploring the risks of fragmentation in health-care markets – an analysis of inpatient care in Georgia. Soc Sci Med. 2024;362:117428 (https://doi.org/10.1016/j.socscimed.2024.117428).

18. Bochorishvili E, Kurashvili S. Georgia's healthcare sector. May 2023. Tbilisi: Galt & Taggart; 2023 (https://api.galtandtaggart.com/sites/default/files/2023-05/report/georgias-healthcare-sector-overview_eng_may-23.pdf).

19. Annual financial statements [website]. Service for Accounting, Reporting and Auditing Supervision (SARAS); 2025 (https://saras.gov.ge/en).

20. Richardson E, Berdzuli N, European Observatory on Health Systems and Policies. Georgia: health system review. Copenhagen: WHO Regional Office for Europe; 2017 (Health Systems in Transition, 19(4); https://iris.who.int/handle/10665/330206).

21. Nozadze T. პირველადი ჯანდაცვის დაწესებულებები, სადაც 7000-ზე ნაკლები ბენეფიციარია, საყოველთაო ჯანდაცვის ამბულატორიულ პროგრამას გამოეთიშებიან [Primary health-care facilities with fewer than 7000 beneficiaries will be excluded from the universal health-care outpatient programme] [news release]. LEPL Public Broadcaster; 30 April 2020 (https://1tv.ge/news/pirveladi-jandacvis-dawesebulebebi-romlebis-beneficiarta-raodenoba-7000-ze-naklebia-savaraudod-sayoveltao-jandacvis-ambulatoriuli-programidan-chaekhsnebian/) (in Georgian).

22. საქართველოს მთავრობის დადგენილება N 629 პოლიტიკის დოკუმენტების შემუშავების, მონიტორინგისა და შეფასების წესის დამტკიცების შესახებ [Resolution No. 629 of the Government of Georgia on the approval of the procedure for development, monitoring and evaluation of policy documents]. Government of Georgia; 629; 30 December 2019 (https://matsne.gov.ge/ka/document/view/4747283?publication=0) (in Georgian).

23. Assessing public participation in the policymaking process. Tbilisi: United Nations Development Programme; 2022 (https://www.undp.org/georgia/publications/policymaking-public-participation).

24. Supporting Member States in reaching informed decision-making on engaging with private sector entities for the prevention and control of noncommunicable diseases: a practical tool. Geneva: World Health Organization; 2024 (https://iris.who.int/handle/10665/378209). Licence: CC BY-NC-SA 3.0 IGO.

25. საქართველოს შრომის, ჯანმრთელობისა და სოციალური დაცვის მინისტრის ბრძანება 41/ნ ამბულატორიული სამედიცინო დოკუმენტაციის წარმოების წესის დამტკიცების შესახებ [Order No. 41 of the Minister of Labor, Health and Social Affairs on approval of the procedure for the production of outpatient medical documentation]. Ministry of Labor, Health and Social Affairs of Georgia; 1 January 2012 (https://matsne.gov.ge/ka/document/view/1459847?publication=0) (in Georgian).

26. საქართველოს შრომის, ჯანმრთელობისა და სოციალური დაცვის მინისტრის ბრძანება N 338/ნ ჯანმრთელობის მდგომარეობის შესახებ ცნობის შევსების წესისა და ჯანმრთელობის მდგომარეობის შესახებ ცნობის ფორმის დამტკიცების შესახებ [Order No. 338 of the Minister of Labor, Health and Social Affairs on approval of the procedure for filling out the health status report and health status report form]. Ministry of Labor, Health and Social Affairs of Georgia; 338; 13 August 2007 (https://matsne.gov.ge/ka/document/view/72454?publication=0) (in Georgian).

27. საქართველოს ოკუპირებული ტერიტორიებიდან დევნილთა, შრომის, ჯანმრთელობისა და სოციალური დაცვის მინისტრის ბრძანება N 01-26/ნ სამედიცინო სტატისტიკური ინფორმაციის წარმოების და მიწოდების წესის შესახებ [Order No. 01/26 of the Minister of Health on the rule of production and delivery of medical statistical information]. Ministry of Internally Displaced Persons from the Occupied Territories, Health, Labour and Social Affairs of Georgia; 01/26; 26 March 2019 (https://matsne.gov.ge/ka/document/view/4509878?publication=0) (in Georgian).

28. Curatio International Foundation. Georgia: support to health sector enhancement program: digital health assessment. Technical Assistance Consultant's report. Mandaluyong City: Asian Development Bank; 2023 (https://www.adb.org/projects/documents/geo-56069-002-tacr).

29. Gotsadze G, Zoidze A, Gabunia T, Chin B. Advancing governance for digital transformation in health: insights from Georgia's experience. BMJ Glob Health 2024;9(10):e015589 (https://doi.org/10.1136/bmjgh-2024-015589).

30. *MoIDPHLSA & WHO. Primary health care roadmap [Unpublished]. Tbilisi: Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs of Georgia; 2020.*

31. Regulatory Scrutiny Board [website]. European Commission; 2025 (https://commission.europa.eu/law/law-making-process/regulatory-scrutiny-board_en#:~:text=The%20Regulatory%20Scrutiny%20Board%20is,legislative%20process%20(Figure%201).

32. Capacity development. Support SAIs in developing their capacity [website]. Vienna: International Organization of Supreme Audit Institutions (INTOSAI) ; 2025 (https://www.intosai.org/what-we-do/capacity-development.html).

33. Health financing progress matrix assessment: Georgia 2023. Summary of findings and recommendations. Geneva: World Health Organization; 2023 (https://iris.who.int/handle/10665/374196). Licence: CC BY-NC-SA 3.0 IGO.

34. სამედიცინო სექტორი ახალი რეგულაციის ქვეშ ექცევა - რომელი კლინიკები დარჩება საყოველთაო ჯანდაცვის პროგრამაში? [The medical sector is subject to new regulation – which clinics will remain in the universal health-care programme?]. Tbilisi: Jandacva; 2024 (https://jandacva.ge/news/sakoveltao-jandacva/sameditsino-seqtori-akhali-regulatsiis-qvesh-eqtseva-romeli-klinikebi-darcheba-sayoveltao-jandatsvis-programashi) (in Georgian).

35. Georgia. In: Universal Health Coverage Partnership [website]. UHC Partnership; 2025 (https://extranet.who.int/uhcpartnership/country-profile/georgia).

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

Member States

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czechia
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands (Kingdom of the)
North Macedonia
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
Türkiye
Turkmenistan
Ukraine
United Kingdom
Uzbekistan

WHO/EURO:2025-11941-51713-79128 (PDF)

WHO Country Office in Georgia

81 Vasily Barnov Street, Tbilisi 0179
Phone: +995 32 299 80 73
Email: eurowhogeo@who.int
Website: https://www.who.int/georgia