ORGANISATION SUISSE D'AIDE AUX RÉFUGIÉS
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Géorgie : accès à des soins médicaux

Recherche rapide de l'analyse-pays

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1 Introduction

Le présent document a été rédigé par l'analyse-pays de l'Organisation suisse d'aide aux réfugiés (OSAR) à la suite d'une demande qui lui a été adressée. Il se penche sur les questions suivantes:

1) L'accès à l'assurance-maladie universelle est-il garanti pour tout le monde ou existe-il un risque que certaines catégories de populations, notamment les personnes avec des problèmes médicaux antérieurs ou celles à risque au niveau sanitaire, seraient écartées ?

2) Quels sont les traitements et médicaments couverts par l'assurance-maladie universelle ? Les dépenses subsidiaires (radios, analyses, scanners, etc.) aux traitements reçus pour des maladies comme l'hépatite C sont-elles couvertes ?

3) Les soins médicaux, et notamment le traitement de l'hépatite C, sont-ils disponibles dans toutes les régions du pays ou certaines régions sont-elles défavorisées ?

4) L'accès aux soins médicaux est-il offert de manière égale à l'ensemble de la population géorgienne ou existe-t-il un risque de discriminations (pour des motifs d'ordre ethnique, racial, religieux, etc.) ?

5) Une personne atteinte d'un trouble mental ou de comportement peut-elle avoir accès à un traitement psychiatrique régulier et notamment un suivi psychothérapeutique ?

Pour répondre à ces questions, l'analyse-pays de l'OSAR s'est fondée sur des sources accessibles publiquement et disponibles dans les délais impartis (recherche rapide) ainsi que sur des renseignements d'expert-e-s.

2 Accès à l'assurance-maladie universelle et couverture des traitements et médicaments

L'assurance-maladie universelle, introduite en 2013, est ouverte à l'ensemble de la population sans paiement de primes. La grande majorité de la population (90 pourcent) y prend part. Le gouvernement géorgien a adopté un système d'assurance-maladie universelle, l' « *Universal Health Care Program* » (UHCP), qui est entré en vigueur en février 2013. Selon la *Banque mondiale* (BM), la couverture de l'UHCP s'étend à l'ensemble de la population et ceci sans contribution financière. Pour en bénéficier, les patient-e-s doivent simplement s'inscrire auprès du fournisseur de soins primaires de leur choix (BM, juin 2017). Selon un courriel daté du 8 août 2018 d'une personne de contact de l'OSAR qui travaille dans une ONG géorgienne spécialisée dans les questions de santé publique, l'UHCP est ouvert à toute personne indépendamment de son état de santé. Les personnes avec des conditions médicales préexistantes ou les populations à risque au niveau sanitaire sont également couvertes. Selon l'*Organisation mondiale de la santé* (OMS), plus de 90 pourcent de la population sont couverts par l'UHCP et les dix pourcent restants ont souscrit à une assurance-maladie privée

(OMS, 2017). Selon des chiffres de 2015, cités dans le rapport de la BM, seul quatorze pourcents de la population étaient au bénéfice d'une assurance-maladie privée, dont près de la moitié étaient des employés de l'Etat (BM, juin 2017).

L'augmentation des dépenses de santé publique a entrainé une réforme de l'UHCP en 2017. Une catégorisation des bénéficiaires en fonction du revenu a été introduite avec comme conséquence l'exclusion des personnes à hauts revenus. Selon le *Bureau du défenseur public*, l'augmentation massive des dépenses de santé publique, qui sont passées de 69 millions GEL en 2013 (environ 26.3 millions CHF d'après le taux de change du 22 août 2018) à 575 millions GEL (219 millions de francs) en 2015, a entrainé en 2017 une réforme du système d'assurance-maladie universelle, avec notamment une catégorisation des bénéficiaires en fonction du revenu (Bureau du défenseur public, 16 janvier 2018). Selon le site d'information *FactCheck*, l'approche universelle a été remplacée, le 1er mai 2017, par une approche plus ciblée, qui vise à limiter les dépenses en offrant des « packages » différenciés en fonction du revenu :

- Selon *FactCheck*, les personnes qui gagnent plus de 40 000 GEL (15 270 fr.) par année ne peuvent plus accéder à l'UHCP (FactCheck, 6 mai 2017). Selon *OC Media*, cette catégorie de hauts revenus concerne environ 32 000 personnes qui, malgré leur exclusion de l'UHCP, peuvent toujours bénéficier de certains programmes, comme le traitement de l'hépatite C ou les services de soins liés à la maternité (OC Media, 17 mars 2017).

- Selon *FactCheck*, une deuxième catégorie concerne celles et ceux dont le revenu mensuel dépasse les 1 000 GEL (380 fr.) mais dont le revenu annuel ne dépasse pas 40 000 GEL et qui n'ont pas d'assurance-maladie privée. Les personnes dans cette catégorie, peuvent utiliser la « version limitée » de l'UHCP. Elles sont toujours remboursées pour des traitements liés à des maladies oncologiques et à la maternité, y compris les césariennes (FactCheck, 6 mai 2017). Selon *OC Media*, cette catégorie concerne près de 300 000 personnes, qui verront 90 pourcents du coût d'une hospitalisation urgente remboursés par l'UHCP. Pour les hospitalisations planifiées, dont le coût dépasse 1 000 GEL (382 CHF), le remboursement se monte à 70 pourcents. Les personnes dans cette catégorie doivent en outre choisir entre l'UHCP et une assurance privée (OC Media, 17 mars 2017). Selon un courriel, daté du 24 juillet 2018, d'une personne de contact de l'OSAR, les personnes dans cette catégorie qui ont choisi une assurance privée peuvent toujours bénéficier de traitements d'urgence ou contre le cancer, mais elles doivent alors payer une quote-part variable (« co-payment »).

- Selon *FactCheck*, une troisième catégorie concerne celles et ceux dont le revenu mensuel ne dépasse pas 1 000 GEL, les personnes dont le revenu est irrégulier et les indépendants. Les personnes dans cette catégorie continueront d'avoir accès à l'UHCP, malgré certaines limitations. Si les gens dans cette catégorie achètent une assurance-maladie privée, alors ils ne sont pleinement remboursés que pour les soins urgents, les traitements de maladies oncologiques et ceux liés à la maternité, y compris les césariennes (FactCheck, 6 mai 2017). Selon *OC Media*, cette catégorie concerne également les personnes qui se situent à la marge de la vulnérabilité sociale et les enfants âgés de six à 18 ans. Les personnes dans cette catégorie sont remboursées à 100 pourcents pour les hospitalisations urgentes et à hauteur de 50

pourcents pour les hospitalisations planifiées, si le coût de celles-ci dépasse 500 GEL (191 fr.). Elles peuvent également bénéficier de l'UHCP et d'une assurance-maladie privée en même temps (OC Media, 17 mars 2017).

- Selon *FactCheck*, la dernière catégorie concerne celles et ceux considérés comme socialement vulnérables et celles et ceux enregistrés dans la base de données des personnes socialement vulnérables et qui oscillent entre 70 000 et 100 000 points, les enfants âgés de six à 18 ans, les enseignant-e-s et les personnes souffrant de handicaps. Celles-ci ont un accès complet à l'UHCP et peuvent également souscrire une assurance-maladie privée en parallèle (FactCheck, 6 mai 2017). Selon *OC Media*, cette catégorie, qui est la cible prioritaire du gouvernement et regroupe près de 1,7 million de personnes, comprend également les retraité-e-s et les enfants de moins de 5 ans. Les personnes dans cette catégorie conservent un accès complet à l'UHCP et elles peuvent souscrire à une assurance-maladie privée en parallèle (OC Media, 17 mars 2017).

L'UHCP couvre un ensemble de soins primaires et secondaires, ainsi que l'achat d'un nombre limité de médicaments. Des programmes « verticaux », indépendant de l'UHCP, assurent des soins pour les problèmes psychiques ou des maladies spécifiques (hépatite C, diabète, etc.). Selon la BM, l'UHCP couvre un ensemble de soins de santé primaires et secondaires, ainsi qu'un nombre limité de médicaments « essentiels » (BM, juin 2017). Selon un courriel, daté du 8 août 2018, d'une personne de contact de l'OSAR qui travaille pour la *Fondation international Curatio* (CIF), une ONG géorgienne spécialisée dans les questions de santé publique, l'UHCP ne couvre entièrement que les dépenses liées à des soins d'urgence ainsi que visites chez un médecin généraliste. Tous les autres services de santé primaires ou secondaires requièrent une forme de quote-part (« co-payment ») de la part des patient-e-s. Selon l'OMS, l'UHCP couvre les services de soins ambulatoires planifiés, les soins d'urgence pour les patient-e-s hospitalisé-e-s et ambulatoires, certaines opérations chirurgicales, les soins obstétricaux et le financement des médicaments « essentiels » (OMS, 2017). Selon *Lela Sulaberizde*, chercheuse à la CIF, à quelques exceptions près, l'UHCP couvre principalement les soins primaires pour les patient-e-s souffrant de problèmes physiques. Les services de soins psychiatriques pour patients hospitalisés ou ambulatoires sont couverts par un programme « vertical » séparé, le « *State Programme for Mental Health* (SPMH) » (Lela Sulaberizde et al., 13 février 2018). Selon un courriel, daté du 8 août 2018 d'une personne de contact de l'OSAR qui travaille pour la CIF, d'autres « programmes verticaux » du gouvernement (23 au total), et qui relèvent de problèmes de santé publique (diabète, hépatite C, leucémie infantile, maternité, tuberculose, etc.) sont disponibles pour l'ensemble de la population, à divers degrés de quote-part. Pour la BM et l'OMS, un des principaux problèmes auxquels fait l'UHCP, et cela vaut également pour les autres programmes de santé du gouvernement, est le manque de financement à long-terme, avec des dépenses de santé qui ont plus que doublé entre 2012 et 2015, passant de 4 à 8,4 pourcents des dépenses publiques totales (OMS, 2017; BM, juin 2017). Pour plus de détails sur les soins psychiatriques, voir la section 5 « **Accès à des soins psychiatriques et à un suivi psychothérapeutique** ». Pour plus de détails sur le programme d'élimination de l'hépatite C, voir la section 3 « **Accès, disponibilité et couverture du programme pour l'élimination de l'hépatite C** ».

L'UHCP a amélioré l'accès aux soins de santé, mais n'a pas eu d'impact significatif sur le niveau des paiements requis de la part des patient-e-s. Ceux-ci représentent une

sérieuse menace de paupérisation pour les personnes à bas revenus. Selon la BM, les populations les plus défavorisées sont celles qui ont comparativement les plus bénéficiées de l'introduction de l'UHCP avec des augmentations significatives du nombre de consultations chez les personnes malades dans cette couche de la population. L'amélioration dans l'accès aux soins pour les personnes défavorisées a surtout été observée pour les patient-e-s hospitalisé-e-s (BM, juin 2017). Selon un courriel, daté du 24 juillet 2018, d'une personne de contact de l'OSAR qui travaille pour la CIF, si l'UHCP a permis d'améliorer l'accès aux soins de santé des personnes malades, elle n'a eu qu'un impact relatif sur la paupérisation induite par les « *out-of-pocket payments* », ou paiements requis de la part des patient-e-s. Entre 2012 et 2015, la proportion des ménages faisant face à des dépenses de santé catastrophiques a même augmenté de six pourcents, passant de 28 à 34 pourcents. Cette augmentation serait principalement liée à des dépenses pour les médicaments. Selon la BM, malgré une nette augmentation des dépenses publiques de santé - celles-ci passant de 4 à 8.4 pourcents des dépenses publiques globales entre 2012 et 2015 - les paiements requis de la part des patient-e-s continuent de représenter la principale source de financement de la santé, avec une part estimée en 2015 à 66 pourcents (BM, juin 2017). Selon l'OMS, le haut niveau de paiements requis de la part des patient-e-s entraine un accès inéquitable aux soins de santé et représente un fardeau financier difficile, en particulier pour les revenus les plus bas, qui risque d'exacerber davantage la pauvreté et d'avoir un impact négatif en termes de santé (OMS, 2017). Selon la BM, la part des dépenses publiques de santé allouées aux médicaments des patient-e-s ambulatoires est particulièrement basse (moins de 0.5 pourcent), ce qui signifie que les patient-e-s doivent généralement acheter ces médicaments eux-mêmes. Pour près de 80 pourcents de la population, et notamment les habitant-e-s des zones rurales, l'UHCP n'a pas amélioré l'accès aux médicaments. Entre 2010 et 2015, la proportion de ménages dont les dépenses de santé représentaient plus d'un quart de leurs dépenses totales est restée stable à 10 pourcents de la population totale (BM, juin 2017). D'après une étude de la CIF, citée par le *Bureau du défenseur public*, les dépenses liées aux médicaments représentent le plus lourd fardeau pour la population, représentant deux tiers des paiements requis de la part des patient-e-s (« *out-of-pocket payments* ») et environ 57 pourcents de l'ensemble des dépenses de santé (Bureau du défenseur public, 16 janvier 2018).

La réforme de l'UHCP a introduit en 2017 un mécanisme de soutien financier limité pour l'achat de médicaments. La réforme de l'UHCP de 2017 a été accompagnée par une composante de financement des médicaments. Selon *FactCheck*, depuis l'été 2017, les personnes enregistrées dans la base de données des personnes socialement vulnérables et dont la notation ne dépasse pas 100 000 points peuvent se faire rembourser l'achat de médicaments associés aux troubles ou maladies suivantes : problème cardio-vasculaire ou cardiaque chronique, maladie chronique des poumons, diabètes (type 2) et problème de la thyroïde. Le remboursement atteint 90 pourcents du coût du médicament, si celui-ci coûte au moins 1 GEL (0.38 fr.). Une liste de 24 médicaments, remboursés par l'UHCP,a aussi été approuvée.. Le gouvernement estime qu'entre 150 000 et 200 000 personnes peuvent bénéficier du programme de financement des médicaments, dont le budget est fixé à 3 360 000 GEL (1.2 millions de francs) pour une période de six mois. Si 150 000 en bénéficient, cela représente un soutien financier de 3.7 GEL (1.4 fr.) par personne et par mois. Le gouvernement a aussi annoncé que la qualité sera dorénavant un critère important dans l'achat des médicaments (FactCheck, 6 mai 2017).

3 Accès, disponibilité et couverture du programme pour l'élimination de l'hépatite C

Le programme de lutte contre l'hépatite C, mis en place ne 2015, a pour l'instant permis de guérir près plus de 44 000 personnes. Le gouvernement prévoit de tester 1.8 million de personnes dans les trois prochaines années. Selon le gouvernement, en 2015 le nombre total de personnes infectées par l'hépatite C en Géorgie était estimé à 150 000 (taux d'infection de 7,7 pourcents). Le gouvernement s'est donné pour objectif l'élimination de l'hépatite C dans le pays d'ici à 2020 (définie comme une réduction du taux d'infection de 90 pourcents) (Gouvernement de Géorgie, 2015).D'après *Amiran Gamkrelidze*, chef du *Centre national géorgien pour le contrôle des maladies et de la santé publique* (NCDC), cité par le site d'information *Agenda.ge*, depuis 2015 et le lancement d'un programme national d'élimination de l'hépatite C, près de 45 000 personnes, sur une population totale de 3,7 millions de personnes, ont suivi un traitement avec un taux de guérison de 98 pourcents (Agenda.ge, 31 janvier 2018). Selon *Agenda.ge*, le gouvernement prévoit de tester un total de 1,8 million de personnes dans les trois prochaines années (Agenda.ge, 31 janvier 2018). Pour le *Centre de contrôle des maladies des États-Unis* (CDC), qui participe au programme, les principaux défis pour parvenir à l'éradication de la maladie d'ici à 2020 sont, entre autres, une meilleure qualité des tests de dépistage et des diagnostics simplifiés et moins coûteux (HHS/CDC, juillet 2017). Pour *Muazzam Nasrullah*, qui travaille pour la NCDC, une mise en œuvre plus large des interventions est nécessaire pour améliorer l'accès au dépistage et au traitement si le gouvernement veut atteindre son objectif d'ici à 2020 (Muazzam Nasrullah et al., 28 juillet 2017). En avril 2018, le *Centre européen pour l'étude du foie* (EASL) estimait que, malgré les indéniables progrès, près de trois-quarts des patient-e-s n'avaient pas encore été diagnostiqué-e-s (EASL, 13 avril 2018).

Des limitations à l'accès au programme ont été levées en juin 2016. Depuis mai 2017, les détentrices et détenteurs de documents neutres, notamment les résident-e-s des territoires disputés de l'Abkhazie et de l'Ossétie du sud, sont également admis. Lors du lancement du programme en 2015, seules les personnes infectées avec une maladie du foie à un stade avancé pouvaient participer au programme. En juin 2016, les critères d'éligibilité ont été étendus pour inclure toutes les personnes infectées (Muazzam Nasrullah et al., 28 juillet 207). En mai 2017, *David Sergeenko*, ministre de la santé, cité par Agenda.org, a annoncé que le programme de traitement de l'hépatite C était ouvert à tous les résident-e-s de la Géorgie, y compris celles et ceux qui ne possèdent qu'une carte d'identité ou un document de voyage neutre (à défaut d'un passeport géorgien). Les documents neutres sont attribués par le gouvernement aux résident-e-s des deux régions disputées de l'Abkhazie et de la région de Tskhinvali (Ossétie du sud) (Agenda.ge, 25 mai 2017). Selon un rapport du *Secrétariat d'État aux migrations* (SEM), citant des représentant-e-s de la société civile, la criminalisation des toxicomanes les empêche d'avoir accès au traitement (SEM, 21 mars 2018). En mars 2017, le gouvernement a ouvert un deuxième centre de gestion de l'hépatite C, après celui ouvert à Tbilissi. Ce nouveau centre est situé dans la ville de Zugdidi, dans la région occidentale de Samegrelo, près de la région disputée de l'Abkhazie. Ce centre, qui est un guichet unique permettant de suivre toutes les étapes du traitement, sera également ouvert aux résident-e-s de l'Abkhazie (Agenda.ge, 22 mars 2017). Lors de début du programme, en avril 2015, il y avait un total de quatre centres de traitements de l'hépatite C, tous situés dans la capitale, Tbilissi. En décembre 2016, ce nombre était passé à 27 au niveau national (HHS/CDC, juillet 2017).

Les médicaments pour le traitement sont disponibles gratuitement, mais les patient-e-s paient le diagnostic et le suivi clinique, en fonction de leurs revenus. Selon le site *Agenda.ge*, alors que le traitement coûte normalement près de 110 000 euros, le test ainsi que le traitement sont fournis gratuitement grâce à un accord passé avec la compagnie pharmaceutique américaine *Gilead* (Agenda.ge, 31 janvier 2018). D'après le *Centre de contrôle des maladies des Etats-Unis* (CDC), une approche dite de « l'échelle mobile » a été utilisée pour les diagnostics et le suivi clinique. Les patient-e-s payant les coûts selon leur capacité de payer, avec le gouvernement local ou le *Ministère de la santé* payant la différence. Pour celles et ceux qui ont suivi le traitement, le médicament (*sofosbuvir*) était fourni gratuitement par la compagnie *Gilead*. Les médicaments supplémentaires (*pegylated, interferon* et *ribavirin*) étaient payés par le gouvernement et fournis à celles et ceux qui en avaient besoin (HHS/CDC, 21 octobre 2016). Selon un courriel daté du 8 août 2018 d'une personne de contact de l'OSAR, depuis 2016, le dépistage et le suivi clinique est pris en charge par le programme ou les gouvernements locaux à divers degré de quote-part. Selon *l'Ambassade de Suisse en Géorgie*, citée dans un rapport du *SEM*, les coûts des tests ont un effet dissuasif sur les groupes de population défavorisés sur le plan financier (SEM, 21 mars 2018).

4 Limitations dans l'accès aux soins de santé et problèmes de discrimination

Couverture géographique limitée des institutions et établissements fournissant des soins de santé. Selon un rapport de la BM de juin 2017, l'accès aux soins n'est pas homogène dans l'ensemble du pays avec des différences significatives entre la capitale, Tbilissi, et les zones rurales. Les services d'ambulances favorisent les habitant-e-s de Tbilissi (BM, juin 2017). Selon le *Bureau du défenseur public*, la disponibilité géographique du système de santé est plutôt satisfaisante, surtout en ce qui concerne les soins de base. Néanmoins, de nombreux établissements médicaux sont situés à Tbilissi, ce qui entraîne des obstacles géographiques et financiers pour les habitant-e-s des zones rurales qui doivent les utiliser. Bien que des hôpitaux soient présents dans les régions habitées par les minorités ethniques (Akhalkalaki, Ninotsminda, Akhmeta, Telavi, Kvareli et Lagodekhi), ces établissements sont souvent dépourvus d'équipements médicaux adéquats, ce qui force la population locale à se rendre dans les centres régionaux ou la capitale pour bénéficier de soins de santé (Bureau du défenseur public, 16 janvier 2018). Selon *Lela Sulaberizde*, les régions de Racha-Lechkhumi et de Kvemo Svaneti, des régions isolées et essentiellement rurales, ne disposent d'aucun service de soins psychiatriques. En conséquence, les patient-e-s doivent voyager sur des distances assez importantes, ce qui entraine des dépenses supplémentaires et limite l'accès aux soins (Lela Sulaberizde et al., 13 février 2018).

Discrimination envers les minorités ethniques, principalement causée par la pauvre maitrise de la langue géorgienne. L'absence de données ventilées sur les minorités ethniques empêche la formulation de politiques réduisant la discrimination. Les femmes issues de minorités ethniques ont un accès particulièrement limité aux services de soins de santé. Selon le *Bureau du défenseur public*, les lacunes du système d'information de santé, notamment l'absence de données désagrégées en fonction de l'appartenance à des groupes marginalisés (travailleuses ou travailleurs du sexe, toxicomanes, LGBTI,

etc), des groupes ethniques, du statut socio-économique ou du lieu de résidence, représente un obstacle à la formulation de politiques fondées sur des données factuelles et engendre un risque de discrimination dans l'accès aux soins de santé (Bureau du défenseur public, 16 janvier 2018). Dans son rapport sur la Géorgie de juin 2016, le *Comité pour l'élimination de la discrimination raciale* (CERD) s'inquiétait également du manque de données ventilées sur les minorités ethniques et les non-ressortissant-e-s en Géorgie, comme les Juifs, les Grecs et les Assyriens (CERD, 22 juin 2016). Le *Bureau du défenseur public* note que malgré les dispositions légales existantes, qui en principe punissent toutes formes de discrimination, y compris dans l'accès aux soins, les minorités ethniques font face à des restrictions dans la jouissance de leurs droits humains, y compris dans l'accès aux soins de santé et aux services sociaux. Ces restrictions sont exacerbées par leur manque de maîtrise de la langue géorgienne (Bureau du défenseur public, 16 janvier 2018). En juin 2016, le CERD notait également que le faible niveau de connaissance du géorgien parmi les minorités nationales et ethniques, faisait obstacle à leur intégration dans la société (CERD, 22 juin 2016). Selon le *Bureau du défenseur public*, les femmes issues de minorités ethniques font face à des obstacles particulièrement importants dans l'accès aux services de soins de santé. De plus, il n'y a pas de services médicaux spécialisés disponibles pour les femmes. Par ailleurs, le taux d'avortement et de grossesses non-planifiées est plus élevé chez les femmes des zones rurales, moins éduquées et les femmes d'origine azérie et arménienne, ce qui suggère que l'accès aux soins de santé reproductive est inégal. Les femmes de la communauté Rom ne sont souvent pas admises dans les maternités et doivent souvent accoucher seules à la maison (Bureau du défenseur public, 16 janvier 2018).

Membres de la communauté Rom particulièrement affectés par la discrimination et le manque d'accès aux services de soins de santé. Selon le *Bureau du défenseur public*, la situation de la communauté Rom serait particulièrement préoccupante, celle-ci faisant face à une forte marginalisation et discrimination avec comme conséquence la pauvreté, le chômage, ainsi qu'un accès très limité à l'éducation et aux services de santé. Beaucoup n'ont également pas les documents nécessaires pour accéder aux programmes de sécurité sociale (Bureau du défenseur public, 16 janvier 2018). Dans son rapport sur la Géorgie de de juin 2016, le CERD notait sa préoccupation par rapport au fait que de nombreux Roms ne possédaient pas de papiers d'identité et qu'un faible nombre d'enfants étaient scolarisés. Le CERD notait par ailleurs que la communauté restait fortement marginalisée et vivaient dans des conditions économiques et sociales précaires (CERD, 22 juin 2016). Dans son rapport de 2014, l'ONG *Minority Rights International* (MRI) notait également que l'extrême marginalisation des Roms et la discrimination à leur égard représentaient de sérieux obstacles à leur accès aux services de soins de santé (MRI, juin 2014). Selon *Giorgi Sordia*, une chercheuse du *Centre européen pour les questions de minorités* (ECMI), citée par l'ONG *Human Rights House Foundation* (HRHF), un total de 1 500 Roms sont enregistrés en Géorgie, dont la plupart vivent à Tbilissi et à Gachiani, dans la municipalité de Gardabani. Dans le village de Leninokka situé dans le district de Dedoplitskaro, où vit une communauté ROM de 133 personnes, la plupart n'ont pas accès à l'éducation, ni aux services de soins de santé. La principale raison en est l'absence de carte d'identité qui les prive d'accès aux services de l'État, y compris l'assurance-maladie universelle. Comme la plupart des enfants naissent à domicile, ils ne sont pas enregistrés et ne reçoivent pas de carte d'identité lorsqu'ils atteignent l'âge de 16 ans. Ils ne sont également pas informés sur les services sociaux de l'État ainsi que les programmes de soins de santé (HRHF, 8 mai 2015).

Discrimination à l'encontre des personnes lesbiennes, homosexuelles, bisexuelles, transgenres et intersexuées (LGBTI). Selon le *Bureau du défenseur public*, les personnes LGBTI font partie d'un des groupes les plus marginalisés et invisibles du pays. Malgré les mesures législatives prises par le gouvernement, celles-ci sont régulièrement victimes de violence et de harcèlement, non seulement du public en général, mais aussi de certaines institutions comme les établissements médicaux. La discrimination sur la base du comportement ou de l'identité sexuelle non-conformiste peut mener à des limitations dans l'accès aux soins de santé, notamment l'accès à l'assurance-maladie ou à des soins médicaux appropriés. Des études ont montré qu'il existe des pratiques de discrimination et de violations du droit à la vie privé et à la confidentialité par le personnel de santé et les prestataires de services de santé à l'encontre de personnes LGBTI. Ces pratiques sont souvent basées sur une méconnaissance ou une ignorance de la part du personnel médical des besoins médicaux spécifiques des personnes LGBTI, ainsi que des stéréotypes négatifs à l'encontre des personnes de ce groupe. En conséquence, les personnes LGBTI évitent souvent de recourir à des services de soins de santé ou fournissent des informations erronées aux docteur-e-s ce qui peut avoir comme effet de voir prescrire un traitement ou médicament inadapté (Bureau du défenseur public, 16 janvier 2018). Les personnes LGBTI victimes de discrimination évitent souvent de s'en plaindre car elles n'ont pas confiance dans les autorités et ont peur d'être encore davantage stigmatisées par la société (Bureau du défenseur public, décembre 2017). Dans son rapport sur la Géorgie de juin 2016, le CERD notait sa préoccupation par rapport à la faible mise en œuvre de la loi anti-discrimination de 2014, due en partie à la capacité limitée du Défenseur public d'examiner les cas de discriminations, les entités privées et les particulières et particuliers n'ayant pas l'obligation de communiquer des informations pertinentes à ce dernier. Le CERD s'inquiétait également de l'absence d'un système efficace de suivi et de collecte de données sur les affaires de discrimination raciale examinées par les autorités judiciaires (CERD, 22 juin 2016).

5 Accès à des soins psychiatriques et à un suivi psychothérapeutique

Les soins psychiatriques sont couverts depuis 1995 par le « State Programme for Mental Health ». Les soins psychiatriques sont fournis par 23 institutions médicales et sont, sauf exceptions, gratuits. Les soins payants concernent ceux liés à la consommation d'alcool ou de drogues. Les soins psychiatriques sont limités pour les patient-e-s ambulatoires. Alors que l'UHCP couvre principalement les soins primaires pour les patient-e-s souffrant de problèmes physiques, selon *Lela Sulaberizde*, les services de soins psychiatriques pour patient-e-s hospitalisé-e-s ou en ambulatoires sont couverts par un programme séparé, le « State Programme for Mental Health (SPMH) », mis en place en 1995 et géré par l'Agence des services sociaux qui dépend du *Ministère du travail, de la santé et des affaires sociales* (MoLHSA). Les soins psychiatriques sont disponibles pour tous les Géorgien-ne-s et fournis gratuitement par 23 services ou institutions psychiatriques à travers le pays. Pour les patient-e-s hospitalisé-e-s, les soins fournis sont généralement plus larges que pour les patient-e-s en ambulatoire et sont disponibles auprès de neuf hôpitaux dans le pays ainsi que de trois unités psychiatriques spécialisées dans les soins intensifs et qui sont intégrées dans les hôpitaux de la capitale, Tbilissi. Ces soins sont en principe gratuits, à l'exception des problèmes psychiatriques liés à des problèmes d'alcool (Lela Sulaberizde et al., 13 février 2018). Selon le site de l'*Agence des services sociaux de Géorgie*, les traitements pour les

désordres ou troubles mentaux causés par les substances psychoactives ne sont remboursés qu'à hauteur de 70 pourcents, dans les limites précisées dans le programme (Agence des services sociaux de Géorgie, pas de date (accès le 8 août 2018). Selon *Lela Sulaberizde*, les patient-e-s ambulatoires peuvent bénéficier de consultations avec un psychiatre et de prescriptions, soit dans un des dix centres ambulatoires indépendants ou polycliniques, soit dans un des huit hôpitaux psychiatriques qui possèdent un département ambulatoire. Les problèmes d'anxiété ou les troubles obsessionnels-compulsifs ne sont pas traités en ambulatoire (Lela Sulaberizde et al., 13 février 2018).

Le Parlement a adopté en 2013 une loi sur la santé mentale qui a été suivie d'une stratégie et d'un plan d'action. En 2013, le Parlement géorgien a adopté une loi sur la santé mentale, le « National Concept on Mental Health », dont le but était de remédier aux problèmes et déficiences du système de santé psychiatrique géorgien. Cette loi a été suivie en décembre 2014 par une stratégie nationale et un plan d'action pour les années 2015-2020 (Bureau du défenseur public, 31 mai 2016). Selon le PNUD, un des objectifs du plan d'action du gouvernement est de parvenir à une distribution équilibrée du budget entre les soins hospitaliers et les soins ambulatoires fournis au niveau de la communauté (UNDP, 14 août 2015). En août 2018, le *Comité de la santé et des affaires sociales* du Parlement de Géorgie a déclaré son soutien à la stratégie nationale et à l'augmentation du budget du SPMH jusqu'à hauteur de 5 millions de GEL (Parlement de Géorgie, 7 août 2018).

Malgré les réformes entreprises depuis 2013, il subsiste encore de sérieux problèmes qui réduisent l'accès aux soins de santé psychiatriques. Il manque de l'argent, des psychiatres, la formation professionnelle est limitée et la qualité des services laisse souvent à désirer. Selon le *Bureau du défenseur public*, malgré les efforts entrepris par le gouvernement ces dernières années, il existe encore de sérieux problèmes, notamment systémiques, avec le système de santé psychiatrique géorgien. Un premier problème concerne le manque de moyen financier. L'augmentation des moyens financiers pour les soins psychiatriques observées depuis 2006 a surtout concerné les soins pour les patient-e-s hospitalisé-e-s, la première priorité de l'État, et dans une moindre mesure les soins de réhabilitation psychologique et les soins ambulatoires. Ce manque de moyens financiers entraine, selon le *Bureau du défenseur public*, des problèmes en termes de personnel insuffisamment qualifié, de mauvaise qualité des soins ou encore d'absence de réhabilitation psychosociale. L'environnement thérapeutique reste également inadéquat et il manque des services communautaires. Les services psychiatriques manquent cruellement de ressources humaines avec un déficit de psychiatre deux fois plus élevé que la moyenne européenne (Bureau du défenseur public, 31 mai 2016). Selon *Lela Sulaberizde*, il n'y a que 3,92 psychiatres pour 100 000 personnes en Géorgie, contre une moyenne de 8,59 psychiatres pour 100 000 personnes en Europe (Lela Sulaberizde et al., 13 février 2018). Selon le *Bureau du défenseur public*, la formation et le développement professionnel du personnel psychiatrique laisse aussi à désirer et a un impact négatif sur la qualité des soins avec parfois des risques de violence verbale ou même physique envers les patient-e-s (Bureau du défenseur public, 31 mai 2016). Selon la *Fondation Internationale Curatio* (CIF), le manque de ressources humaines entraine de longues périodes d'attente, surtout pour les patient-e-s ambulatoires (CIF, juin 2014).

Budget de soins psychiatriques insuffisant et bénéficiant en priorité les malades hospitalisés et les soins urgents. Peu de moyens pour les soins ambulatoires et pour les malades chroniques. Le budget 2018 a été augmenté de près de 15 pourcents avec un objectif qu'au moins 35 pourcents du budget finance l'achat de médicaments. Selon la

Fondation Internationale Curatio (CIF), malgré une augmentation des dépenses pour les soins psychiatriques entre 2006 et 2011, la part de ces soins par rapport aux dépenses globales de santé n'a pas véritablement augmenté, stagnant autour de 2,5 pourcents (CIF, juin 2014). Selon *Lela Sulaberizde,* ce pourcentage atteint en moyenne 5 pourcents dans les pays à hauts revenus (HIC) (Lela Sulaberizde et al, 13 février 2018). Selon la CIF, en 2011, la plus grande part de ces dépenses, ou 71 pourcents, finançait les soins psychiatriques pour les patient-e-s hospitalisé-e-s. Selon le *Programme des nations-unies pour le développement* (PNUD), en 2014, seul 28 pourcents du budget était alloué aux soins psychiatriques ambulatoires (PNUD, 14 août 2015). *Lela Sulaberzde* note que dans les HICs, ce pourcentage tourne plutôt atour de 50 pourcents (Lela Sulaberizde et al, 13 février 2018). La CIF en conclut qu'il n'y a que peu de moyens pour financer les services psychiatriques ambulatoires en Géorgie. Ceux-ci se limitent à prescrire et distribuer des médicaments, souvent de mauvaise qualité et en quantités insuffisantes. Il en résulte que les patient-e-s doivent souvent eux-mêmes acheter les médicaments (CIF, juin 2014). Selon *Tengiz Verulava*, le soutien du gouvernement se limite largement aux soins psychiatriques urgents et il n'existe pas de soutien psychiatrique ambulatoire pour les malades chroniques (Tengiz Verulava et al., avril 2015). En août 2018, le *Comité de la santé* du Parlement de Géorgie a annoncé une augmentation de 14,5 pourcents du budget alloué aux soins ambulatoires pour 2018 (Parlement de Géorgie, 7 août 2018). Selon un courriel, daté du 7 août 2018, d'une personne de contact de l'OSAR qui travaille dans un centre de recherche universitaire géorgien sur la santé mentale, le gouvernement a également déclaré qu'au moins 35 pourcents du budget 2018 seraient alloués aux médicaments, et ceci afin de réduire les paiements requis par les patient-e-s.

Le manque de moyens et la fragmentation et l'insuffisance des soins ambulatoires limitent les possibilités de suivi des patient-e-s. Forts risques de rupture du continuum de services de soins. Selon le *Bureau du défenseur public*, la trop courte période de gestion de la condition aigue des patient-e-s (dix à quatorze jours en moyenne) ne permet souvent pas d'arriver à des améliorations notables, en l'absence d'atteinte de la phase de rémission, et il est probable que la condition des patient-e-s commence rapidement à se détériorer dès la sortie de l'hôpital en raison du manque de suivi dû à un manque de moyens financiers. Les traitements ambulatoires sont fragmentés et sous-développés, ce qui entraîne un fort risque de rechute et de ré-hospitalisation (Bureau du défenseur public, 31 mai 2016). Selon la *Fondation Internationale Curatio* (CIF), le système en place réduit l'implication des services psychiatriques dans le suivi des patient-e-s après que la patiente ou le patient ait quitté l'hôpital. Comme les services psychiatriques ambulatoires sont trop peu nombreux, les patient-e-s qui rechutent sont souvent réhospitalisé-e-s pour de longues périodes (CIF, juin 2014). Selon *Lela Sulaberizde*, la période de trois semaines pendant laquelle les soins psychiatriques intensifs sont fournis, et au terme de laquelle les patient-e-s sont soit libéré-e-s, soit transféré-e-s aux soins de longue durée, est basée sur des considérations financières plutôt que médicales et peut représenter un obstacle aux soins centrés sur les patient-e-s. La manque de suivi du patient entraine une rupture du continuum de services de soins (Lela Sulaberizde et al., 13 février 2018).

Soutien psychosocial et soins de réhabilitation extrêmement limités. D'après les informations disponibles sur le site de l'*Agence des services sociaux de Géorgie*, la réhabilitation psychosociale est pratiquée aussi bien pour les patient-e-s hospitalisé-e-s que pour celles et ceux traités en ambulatoire (Agence des services sociaux de Géorgie, pas de date (accès 8 août 2018). Selon le *Bureau du défenseur public*, en dépit des efforts des du personnel et des institutions psychiatriques, le soutien psychosocial et les services de réhabilitation et de

réintégration sont presque inexistants. Les patient-e-s ne sont la plupart du temps pas impliquées dans des programmes de réhabilitation et il n'y a pas de de travail accompli dans le domaine de la réhabilitation psychosociale (Bureau du défenseur public, 31 mai 2016). Selon la CIF, il n'y avait en 2014 que trois institutions dans le pays qui fournissaient un service de réhabilitation psychosociale et le nombre de patient-e-s qui en bénéficiaient ne dépassaient pas quelques douzaines (CIF, juin 2014). Selon *Lela Sulaberzde*, en 2018, les services de réhabilitation psychologique étaient disponibles auprès de deux centres ambulatoires et d'un centre indépendant. En raison de leur surcharge de travail, les psychiatres limitent souvent leur temps de consultation et ne peuvent pas fournir de soins psychothérapeutiques. Malgré certains progrès, de manière générale la demande en soins de réhabilitation psychosociale dépasse largement l'offre (Lela Sulaberizde et al., 13 février 2018). Selon *Tengiz Verulava*, il est presque impossible de fournir des soins de réhabilitation aux patient-e-s souffrant de problèmes psychiatriques et ceci en raison de manque de moyens financiers. Seul des cours de réhabilitation à très petite échelle sont donnés aux patient-e-s (Tengiz Verulava et al., avril 2015). Selon un courriel, daté du 7 août 2018, d'une personne de contact de l'OSAR qui travaille et dans un centre de recherche universitaire géorgien sur la santé mentale, un traitement psychologique et la réhabilitation psychosociale pour les patient-e-s chroniques est possible en Géorgie mais de manière très limitée, surtout en ambulatoire. Selon un courriel, daté du 17 juillet 2018, d'une personne de contact de l'OSAR, membre du *Comité de la santé et des affaires sociales,* des améliorations majeures sont nécessaires en termes de qualité des soins et de suivi psychothérapeutique.

Médicaments de mauvaise qualité. Selon le *Bureau du défenseur public*, les contraintes financières et le système d'appel d'offre en place se traduisent par l'acquisition de médicaments de mauvaise qualité car ceux-ci sont généralement achetés aux prix les plus bas (Bureau du défenseur public, 31 mai 2016). Selon *Lela Sulaberizde*, le manque de moyens alloués aux soins psychiatriques ne permet pas de fournir des soins ou des médicaments de qualité. En conséquence, la plupart des personnes préfèrent souvent acheter les médicaments elles-mêmes pour disposer de produits de meilleure qualité (Lela Sulaberizde et al., 13 février 2018). Selon *Tengiz Verulava*, l'utilisation de médicaments de mauvaise qualité et le fait que les patient-e-s doivent payer de leurs poches pour acheter de meilleurs médicaments ont un impact négatif sur le traitement (Tengiz Verulava et al., avril 2015). Selon un courriel, daté du 7 août 2018, d'une personne de contact de l'OSAR qui travaille dans un centre de recherche universitaire géorgien sur la santé mentale, les médicaments psychotropes de première génération et bon marché fournis aux patient-e-s, et dont l'origine est souvent indienne ou géorgienne, sont souvent inefficaces.

6 Sources

Agence des services sociaux de Géorgie, pas de date (accès 8 août 2018) :

> « *The state program - Mental health - refers to increase of geographic and financial availability to psychiatric service by the Georgian population.*
>
> *What is covered by the state program - Mental health?*

Outpatient service *includes:*

- *Service of the patients forwarded to the family doctor/district doctor, primary visit to psychiatric dispensary, and if the patient is unavailable to come to the psychiatric institution, home visit of a psychiatrist or other specialist in the field of psychiatry (the law of Georgia "On Psychiatric Assistance") to the patient, in case of approving of the nosologies provided by the program and the desire of the patient, fulfillment of outpatient surveillance of the patient;*

- *Service of the registered patients and the patients forwarded to the psychiatric inpatient institution, considering the nosologies provided by the program, visits to a doctor-psychiatrist, or if needed, with other specialists in the field of psychiatry (the law of Georgia "On Psychiatric Assistance"); according to the prescription of the doctor-psychiatrists, provision with the medicines; if needed, visits of the specialists in the field of psychiatry at home and consultations of other doctor-specialists (therapist and neurologist);*

- ***Psycho-social rehabilitation****;*

- *Mental health of children provides the service for emotional patients and patients with behavior disorders less than 18 years in the day inpatient department, who are characterized with modifications of psychical state and conduct, worsening of social functioning and disadaptation.*

Inpatient service, which covers inpatient service of the patients above 15 years with psychosis register disorders *(on the basis of the order No.87/N of the Minister "On Approving of the Rule of Placement in the Psychiatric Inpatient Department", dated March 20, 2007), in particular:*

- *Short-term inpatient service, that means cutting off the states progressing with acute psychotic symptoms (delay from 2 up to 8 weeks);*

- *Long-term inpatient service, that means prolongation of treatment after the short-term inpatient care, if needed, or treatment of those patients, to whom assistance is not available out of inpatient department for serious disturbances of psycho-social functioning;*

- *Treatment of those patients, to which the judicial resolution on placement of a person in inpatient department for involuntary psychiatric assistance, stipulated by the article 191st of the Criminal Code of Procedure of Georgia, refers;*

- *Additional assistance: provision of protection and security of those patients, to which the judicial resolution on placement of a person in inpatient department for involuntary psychiatric assistance, stipulated by the article 191st of the Criminal Code of Procedure of Georgia, refers;*

- *Provision of those patients with food and personal articles of hygiene, who are taking the inpatient service;*

- ***Rehabilitation service during the long-term inpatient treatment in accordance with the standards of psycho-social rehabilitation****;*

- *Psychiatric inpatient service of the children, including the service of the patients less than 15 years with psychotic register disorders;*

- *Urgent medical service of the patients, including emergency medical service for the patients being in psychiatric, inpatient department on program service within the frameworks of the codes of nosologies defined by the urgent assistance program;*

- *Inpatient service of mental and behavior disorders caused by psychoactive substances.*

***Psychiatric crisis intervention of adults (18 years and above) considers service for the persons with mental and behavior disorders within the administrative-territorial scopes of Tbilisi**:*

- *Psychiatric crisis intervention (crisis day beds) means intensive ambulatory care during crisis;*

- *Emergency ambulatory consultations in the day center;*

- *Fulfillment of crisis intervention by home care crisis mobile group at the place of residence of the patient and, if needed, his/her transmission in the crisis center or other appropriate psycho-social / psychiatric provider institution.*

***Psychiatric inpatient service to be carried out by the mental inpatient institutions in Tbilisi, Rustavi and Kutaisi**:*

- *Inpatient service of the patients above 15 years with psychotic register disorders (order No.87/N of the Minister "On Approving of the Rule of Placement in the Psychiatric Inpatient Department", dated March 20, 2007), in particular:*

    1. *Short-term inpatient service, that means cutting off the states progressing with acute psychotic symptoms;*

    2. *Long-term inpatient service, that means prolongation of treatment after the short-term inpatient care, if needed, or treatment of those patients, who are not able to get assistance out of hospital, because of serious disturbances of psycho-social functioning;*

    3. *Provision of those patients with the personal articles of hygiene and emergency surgical and therapeutic dental service, who are taking the inpatient service.*

- ***Rehabilitation service during the long-term inpatient care, in accordance with the psycho-social rehabilitation standards.***

Who is the beneficiary of the program?

The beneficiaries of the state program - Mental health - are:

- ***The citizens of Georgia, using outpatient and inpatient component of the program;***

- ***Both citizens of Georgia and other persons using involuntary inpatient service, as well as other persons placed in the "penitentiary and imprisonment institutions" notwithstanding possession of official document stipulated by the legislation on identification**.*

How the state program is funded (is there any co-payment and how)?

The service provided by the program is funded by the state completely, except the inpatient care for mental and behavior disorders caused by the psychoactive substances.

The service provided by the sub-component of the inpatient care for mental and behavior disorders caused by psychoactive substances shall be reimbursed by the state by 70% of the actual cost, within the limits of the occurrences specified in the program.

Whom you have to apply for participation in the program?

Financing of the inpatient care for mental and behavior disorders caused by psychoactive substances shall be carried out through immaterialized medical vouchers. In order to get the service, you have to apply to the medical service-provider institution. » Source: Agence des services sociaux de Géorgie, State program - Mental health, pas de date (accès le 8 août 2018): http://ssa.gov.ge/index.php?lang_id=ENG&sec_id=808.

Agenda.ge, 31 janvier 2018:

« ***Around 45,000 people have gone through medical treatment for Hepatitis C in Georgia, 98 percent of which were cured, the head of Georgia's National Center for Disease Control and Public Health (NCDC) Amiran Gamkrelidze said.***

Gamkrelidze encouraged everyone to be tested for Hepatitis C in order to understand whether they have the illness or not as the disease has no symptoms until late in its development.

We should screen the entire population – 3,7 million people, especially adults above 18", Gamkrelidze said.

He said 1,800,000 people will be screened in the next three years, which is a unique chance to cure Hepatitis C as both the test and treatment are free of charge.

Georgia's Health Ministry launched a campaign titled Cure Yourself in order to encourage people to be tested for Hepatitis C last year.

Through the campaign #განიკურნე (Geo. ganikurne, cure yourself) people can apply for screening in order to understand whether they have the illness or not, as the treatment of Hepatitis C is free of charge in Georgia.

Typically the treatment costs €110,000 per person, which is unaffordable for the majority of Georgians.

In partnership with the American company Gilead, Georgia launched a large-scale Hepatitis C Elimination Program in 2015. The program aims to make Georgia a Hepatitis C-free country by 2020.» Source: Agenda.ge, 98% of people in Hepatitis C elimination program cured, 31 janvier 2018: http://agenda.ge/news/94808/eng.

Agenda.ge, 25 mai 2017:

« ***Those living in Georgia's occupied regions but do not hold a Georgian passport will be able to benefit from the free Hepatitis C treatment program Georgia offers its citizens.***

Georgian Health Minister David Sergeenko announced this after a governmental meeting today.

Sergeenko said that a neutral ID card or a neutral travel document will be enough for Abkhazia and Tskhinvali region residents to engage in the free treatment program.

A neutral document is a document that Georgia's Justice Ministry issues to residents of either of Georgia's two Russian-occupied regions in case they don't hold a Georgian passport and apply for a neutral identification document.

Sergeenko said that the free treatment program was very attractive for many of those living in Abkhazia and Tskhinvali region but until now the treatment was only available to Georgian citizens.

In partnership with the American company Gilead, Georgia launched a large-scale Hepatitis C Elimination Program in 2015. The program aims to make Georgia a Hepatitis C-free country by 2020.

Sergeenko said that now Georgia signed a memorandum with Gilead envisaging the expansion of coverage and letting Abkhazians and Ossetians with a neutral document benefit from the program.

As of today, about 38,000 people have registered for the free Hepatitis C program. Of these, about 37,500 have started treatment while more than 29,000 have already completed the treatment course. Officials say that the cure rate is 98 percent.» Source: Agenda.ge, Georgia offers free Hepatitis C treatment to residents of occupied regions, 25 mai 2017: http://agenda.ge/news/80107/eng.

Agenda.ge, 22 mars 2017:

« ***A new modern centre for Hepatitis C management has opened in the town of Zugdidi in Georgia's western Samegrelo region today***.

The centre was opened by Prime Minister Giorgi Kvirikashvili, Health Minister David Sergeenko and United States Ambassador to Georgia Ian Kelly. ***Locals will be able to receive all services relating to Hepatitis C, including screening, diagnosis, consultation, registration and getting medicine through a single-window principle at the new centre.***

Zugdidi is located close to Georgia's Russian-occupied Abkhazia region; Kvirikashvili said the new centre and its services will be available to Abkhazians as well*. […]*

The first Hepatitis C Management Centre opened in the capital of Tbilisi last summer. Zugdidi centre will be the second of its kind, but it is significantly larger than the Tbilisi centre.

Authorities said Zugdidi was selected as the location for the second centre due to the high rate of the virus in the region. » Source: Agenda.ge, New Hepatitis C centre to serve Georgians and Abkhazians, 22 mars 2017: http://agenda.ge/news/76452/eng.

BM, juin 2017:

« ***Georgia has made significant progress in improving access to health services under the UHC Program. The introduction of the UHC Program in February 2013, aimed at improving the general population's access to good quality health care, has benefited more Georgians, particularly those relatively less well-off, by improving access to health services when ill and reducing the likelihood of impoverishment or catastrophic out-of-pocket (OOP) spending on health care.***

The recent overruns in health spending have, however, highlighted a key challenge that the government faces in maintaining the sustainability of the UHC Program. Since the implementation of the UHC Program, health spending has risen sharply (from 4.0 percent to 8.4 percent of total government spending between 2012 and 2015). Notwithstanding these increases, it is still almost the lowest share of government spending among European states and below the European Region middle income country average of 10.5 percent in 2014 (WHO 2016). [...]

In February 2013, the Government of Georgia launched the UHC Program. Universal health coverage is, by definition, about addressing many of the goals referred to above. The UHC Program marked a significant shift in how health care is financed and health services are purchased in Georgia, as well as the culmination of nearly two decades of health system reforms in Georgia. ***The UHC Program extended publicly financed entitlement to health care coverage to the entire population. The nature of the program is noncontributory, in the sense that Georgians do not have to contribute for enrollment. Enrollment involves registering with the primary care provider of choice. The benefits package covers a range of primary and secondary care services and limited essential drugs (Table 2.1). Administratively, the reform transferred responsibility for purchasing health care services from private insurance companies to the SSA under MoLHSA, thus putting in place a platform to shift from passive to active purchasing.***

The health financing reforms introduced since 2013, and backed up by significant increases in public health spending, have moved Georgia closer to European norms. These include: (i) near universal population entitlement to publicly financed health care; (ii) free visits to family doctors; (iii) referral and prescribing systems; (iv) a single purchasing agency; and (v) higher public spending on health (WHO 2016). *Sustaining the coverage achieved to date and deepening coverage through better financial protection against OOP costs are the policy priorities for the Government of Georgia. [...]*

There has been a substantial increase in the government's budget allocation to health in recent years due to the implementation of the UHC. ***Between 2012 and 2014, the public share of total health spending increased substantially from 19 percent to 28.2 percent, with much of the increase associated with the introduction of the UHC Program****.* ***From 2012 to 2015, the health budget more than doubled, increasing from 4.0 percent to 8.4 percent of total government spending, and as a percentage of GDP from 1.3 percent to 2.8 percent****. In this respect, Georgia is experiencing a steep increase in its health sector spending, which is consistent with other middle-income countries' experience at the time of UHC introduction.*

Table. 2.1: Summary of UHC Benefits and User Charges (2015)

Type of Benefit	User Charges			
	Former Medical Insurance Program (MIP) Beneficiaries	Former Beneficiaries of the Program for Pensioners etc.	Veterans	All Others (Previously Uninsured)
Planned outpatient care	Free	Free	Free	Free
Outpatient specialist visits	Free	Free	Free	30% copayment
Essential drugs (around 50)	Covered up to GEL 50 per year (GEL 200 for pensioners). 50% copayment	Covered up to GEL 100 per year for pensioners (GEL 50 for children 0-5 years). 50% copayment.	Covered up to GEL 50 per year	Not covered
Diagnostic tests (basic lab tests)	Free	Free	Free	30% copayment
Diagnostic tests (ultrasound, ECG, x-ray)	Free	Free for most. 10-20% copayment for CT scans.	Free	30% copayment
Normal delivery	Covered up to GEL 500	Covered up to GEL 500	Covered up to GEL 500	Covered up to GEL 500
C-section	Covered up to GEL 800	Covered up to GEL 800	Covered up to GEL 800	Covered up to GEL 800
Elective surgery	Covered up to GEL 15,000 per year	Covered up to GEL 15,000 per year. 10% copayment (pensioners). 20% copayment (children 0-5 years, people with disability, students, teachers).	Covered up to GEL 15,000 per year	Covered up to GEL 15,000 per year. 30% copayment.
Chemotherapy, hormone and radio therapy	Covered up to GEL 12,000 per year	Covered up to GEL 15,000 per year. 10% copayment (pensioners). 20% copayment (children, students, teachers, people with disability).	Covered up to GEL 12,000 per year	Covered up to GEL 12,000 per year. 20% copayment.
Emergency outpatient care	Free	Free	Free	Free
Emergency inpatient care	Free	10% copayment (pensioners). 20% copayment (children 0-5, people with disability, students, teachers).	Free	Covered up to GEL 15,000 per case. 30% copayment.

Source: WHO, World Bank and USAID (2016).

[...]

Public spending on health is allocated largely to curative care services provided at hospitals. Over three-quarters of public spending on health is on curative care and, in particular, inpatient curative care accounted for 55 percent in 2014*. Moreover, 67 percent of total public spending was on hospitals*

and 25 percent on ambulatory care providers (MoLHSA 2016). Similarly, the bulk of UHC Program spending was on emergency inpatient care. These shares have risen over time–reflecting the priority given to adequately covering curative care, particularly hospital services under the UHC Program. ***The share of public spending devoted to outpatient drugs is exceptionally low (less than 0.5 percent), leaving much of this to be purchased out-of-pocket*** *(Annex 2 provides a more detailed breakdown of spending on the UHC and vertical programs). Compared to most OECD countries, the share of public spending on curative care is higher and that on medicines considerably lower in Georgia, reflecting wide coverage of outpatient drugs in most OECD health systems. [...]*

Private health insurance remains modest. In 2015, half a million people (14 percent of the population) had PHI coverage, mostly through corporate policies provided by employers. This includes around 214,000 state employees (about 6 percent of the population) who have PHI paid for by the Ministry of Defense and the Ministry of Internal Affairs in addition to being covered by the UHC Program. The MoLHSA estimates that demand for PHI has risen since 2015 as people look for ways to cover expenses not covered by the UHC Program (WHO 2016). *Since private insurance companies are not obliged to report to the SSA, there have been concerns about the duplication of services by private insurers and the UHC Program. Appendix 4 reviews the role of PHI in Georgia in light of the international evidence on PHI. A key point to note is that no country in the world has achieved UHC by relying on voluntary PHI alone.*

2.20. Despite rising public spending on health, ***OOP remains the dominant source of financing for health in Georgia****, filling the void of health spending that is not covered through public sources (Box 2.2).* ***OOP spending in Georgia is estimated to be 66 percent of all health spending, far higher than other countries in the region*** *(Figure 2.5).* ***High OOP payments are inimical to the goals of UHC, which can create barriers to accessing needed health services and absorb household resources that could otherwise be used for more productive purposes and potentially impoverish households.*** *[...]*

Although the UHC Program has been associated with a reduction in the OOP share of total health spending (73 percent in 2010 to 66 percent 2015), Georgia still has one of the highest shares of OOP in the region. *This is* ***attributable to the following factors****:*

Limited coverage of outpatient drugs in the UHC Program: *While medicines are provided free of charge to patients through MoLHSA's vertical programs and for inpatient use,* ***the UHC Program has a very limited outpatient drug benefit****.* ***Selected groups (the poor, veterans, and pensioners) are eligible for 50 percent reimbursement, while other groups are not eligible for the drug benefit at all****. The annual claim limit per person is low, and prescriptions from rural doctors are not accepted–requiring patients to visit family doctors instead. Spending on outpatient medicines has consistently comprised less than 0.01 percent of total UHC Program costs.*

Complex copayments policy*:* ***The copayments policy does not provide anyone with adequate depth of coverage due to the presence of the annual cap on benefits.*** *In addition, for those beneficiaries who are not eligible for free care, the patient copayment at the hospital is calculated as 30 percent of the hospital price or the maximum SSA tariff, whichever is lower. Patients also have to pay hospitals any difference between the SSA tariff and the hospital's price. To add to this complexity, hospitals' prices vary widely and different entitlements and rules that apply for copayment waivers for different groups cause confusion and undermine transparency (WHO 2016). [...]*

Outpatient visit and hospitalization rates in Georgia have both increased in recent years, reflecting the increase in public spending and coverage for these services. ***Overall, people in Georgia are more likely to seek care when ill today, than they were five years ago****. In 2014, 79 percent of those who were ill in the previous six months consulted a health care provider–a slight increase from 75 percent in 2010 (WHO, World Bank and USAID 2016). On average, there were 4.0 outpatient visits per capita per year in 2015 compared to just 2.3 in 2012, and hospitalization rates have seen a steady increase since 2012. This could largely be explained by the introduction of the UHC Program that offered coverage to a vast number of people in Georgia who were previously uninsured. [...]*

*In terms of equity outcomes****, introduction of the UHC Program was followed by a significant increase in utilization among poorer households*** *(WHO, World Bank and USAID 2016). For instance,* ***the largest increase in consultations among those who reported being ill occurred among lower- and middle-income households****. These households were less likely to have had insurance coverage before the introduction of the UHC Program.* ***Geographical variation in outpatient contacts suggests, however, that there may be serious inequities in access to care across the country: there is a huge discrepancy between rural areas and Tbilisi. Ambulance care also favors people living in Tbilisi (WHO 2016).***

Financial access has improved for inpatient care, but not necessarily for medicines*. The decline in financial barriers to accessing inpatient care was steep among the poorest and the third and fourth income quintiles. As a result, the level of unmet need for inpatient care among the bottom 20 percent of the population is now closer to the level of unmet need experienced by richer people. Financial barriers to accessing medicines fell overall between 2010 and 2014, but the decline was only statistically significant for people in urban areas and the top quintile of the population.* ***These findings suggest that the UHC Program has not improved access to medicines for 80 percent of households and people in rural areas, although the substantial increase in public spending on inpatient care has helped improve coverage in this area.*** *[...]*

OOP payments for health are "impoverishing" to households. *If a household has total consumption expenditures including OOP above the poverty line, while total nonmedical consumption excluding OOP below the poverty line, they could be considered to have suffered impoverishment due to OOP for health. Figure 2.18 shows this graphically based on 2015 data. Households are ranked along the horizontal axis by total consumption. The vertical drip lines represent OOP for health, and the poverty threshold is indicated by the horizontal line. Applying this approach to 2015 household survey data and using an international poverty line of US$2.50/day, it has been estimated that an additional 6.6 percent of Georgian households were poor as a result of OOP for health. In 2010, an additional 6 percent of households were poor due to OOP, implying that* ***risk of impoverishment due to OOP payments has remained unchanged following the introduction of the UHC Program.***

The proportion of households facing "catastrophic" health care costs has changed little from 2010-15*. While impoverishing OOP puts the emphasis on crossing the poverty line irrespective of the size of payments, catastrophic health expenditures occur when they exceed some threshold of total expenditure. The choice of threshold is somewhat arbitrary, but 25 percent of total expenditure is commonly used.* ***In both 2010 and 2015, 10 percent of households had health spending over 25 percent of total expenditure. This ratio remains one of the highest relative to comparator countries****. At the lower threshold of 10 percent of total expenditures, the share of households experiencing catastrophic spending has increased from 28 percent to 34 percent over the same period and probably reflects increased spending on pharmaceuticals*. » Source: Banque mondiale (BM), Georgia public expenditure review - Building a

sustainable future, juin 2017, p.26-49: http://documents.worldbank.org/curated/en/630321497350151165/pdf/114062-PER-P156724-PUBLIC-PERFINAL.pdf.

Bureau du défenseur public, 16 janvier 2018:

« ***The Georgian healthcare system covers both Primary Healthcare and Hospital Sectors. Its geographical availability for the basic care is satisfactory: medical facilities providing outpatient services (e.g. policlinics, Family Medicine Centres) function in the same manner both in large cities, as regional centres. The institution of rural doctors is responsible for the provision of healthcare in villages. However, many medical facilities, especially specialized ones, are located in Tbilisi, which causes geographical and financial barriers for households as it increases direct and indirect costs such as fees for services, transportation and accommodation costs.***

State healthcare programs are implemented by the Ministry of Labor, Health and Social Affairs (MoLHSA) that also comprising the following entities: LEPL Social Service Agency, LEPL L. Sakvarelidze National Centre of Disease Control and Public Health and LEPL Emergency Coordination and Urgent Assistance Centre. ***Given that almost 95% of medical facilities are privately owned, MoLHSA is left with little regulation capacity in hand****. The Oxfam Research Report on Health-Care Reform in Georgia (2009) states, that the other ministries (such as the Ministry of Finance or Economy) and individuals are having great impact on the overall direction of health policy, thus, limiting MoLHSA's mandate with regard to direct service provision, purchasing, and some other aspects of regulation. [...]*

The national health system was financed from the State budget through revenues, but it wasn't capable to keep pace with the growing financial needs created by the Universal Healthcare Program. ***Government spending on healthcare through the Universal Healthcare Program increased from 69 million GEL in 2013, to 575 million GEL in 2015. This increase in costs required a change in the state's approach, resulting amending of the Universal Healthcare Program in 2017. Changes included categorization of beneficiaries based on their income and thus, providing different packages of services based on this categorization.*** *[...]*

Despite the fact that State expenses have significantly increased since 2013 when the Universal Healthcare Program came into effect, their share in relation to the population's healthcare expenditure is still low (6.9%for 2015). As a result, ***out-pocket payments remain high, representing almost 58.6% of total healthcare expenditures in Georgia in 2014. According to the Curatio Study on Health System, the most burdensome expenditures for the population are those associated with medicines, which represented 2/3 of out-pocket payments and amounted to 57,3% of total healthcare expenditures in 2015.*** *[...]*

According to the World Bank, the main challenge associated with healthcare system financing is non-efficient management of public funds. This is further compounded by the complex financing mechanisms due to different tariffs and co-payment schemes, coupled with a fragmented primary healthcare system and lack of motivation on the part of healthcare providers to stimulate proper PHC service delivery. [...]

In addition, the National Centre for Disease Control and Public Health of Georgia collects aggregated data from health facilities country wide. ***The existing healthcare information system proved to have some shortcomings in practice, as the quality of information received through the system doesn't always correspond to standard****.*

This is due to ***lack of, or incomplete or non-disaggregated data, particularly regarding marginalized groups (such as sex-workers, men having sex with men, intravenous drug users, LGBTI, etc.), by geographic location, ethnicity, disability status, economic quintile, etc. This lack of comprehensive disaggregated data hinders the creation of evidence-based policies and practices and can lead to discrimination.*** *[...]*

The Georgian Constitution states that all citizens of Georgia shall be equal in social, economic, cultural and political life, irrespective of their national, ethnic, religious or linguistic belonging. Protection from discrimination based on the ethnic origin of a person is also included in the Georgian anti-discrimination law. In addition, Article 6.1 of the Law on the "Rights of the Patients" explicitly states that "discrimination of the patient based on […] national, ethnic origin should be prohibited".

Nonetheless, ***persons belonging to ethnic minorities face obstacles in their access to rights, remedies, public services (e.g. healthcare, social assistance), employment and higher education, which seem to be enhanced by their lack of proficiency in the Georgian language.***

Women who are part of minority communities are particularly challenged in their access to healthcare facilities and medical services; as stated in a study conducted in 2014, "minority communities, and particularly minority women, do not have proper access to the healthcare system. Existing medical facilities do not allow for adequate medical services to be delivered." In addition, there are no specialized medical services for women*.*

Although hospitals operate in most of the areas residing by ethnic groups (Akhalkalaki, Ninotsminda, Akhmeta, Telavi, Kvareli, and Lagodekhi,) they often lack necessary medical equipment and hence the local population is forced to travel in order to visit larger medical institutions in regional centers or in the capital. This is an additional burden particularly for women and especially when they are in need of timely SRH services.

Higher abortion rates among rural women, less educated women, and women of Azeri descent suggest that access to services is unequal and that Georgia's family planning program needs to expand its reach to disadvantaged subgroups. Rates of unplanned pregnancy were higher among women with the lowest education level and those with the lowest wealth quintile. They were also higher among women with an Azeri (36.3) or Armenian (31.6) background than among Georgian women (24.7). *[...]*

Lesbian, gay, bisexual, transgender and Intersex (LGBTI) persons represent one of the most marginalized and least visible groups in Georgia. *Despite achieving a degree of success in recent years with the adoption of the Law on the Elimination of All Forms of Discrimination (2014) with the explicit indication on sexual orientation and gender identity (SOGI) as a prohibited ground of discrimination,* ***members of the group continue to face violence, oppression and harassment from the general public, as well as from specific institutions, including medical facilities and the workplace.***

Bias-motivated violence based on SOGI frequently goes unreported and, hence, remains without proper investigation and reparation.

Discrimination of marginalized groups and violations of sexual rights can lead to limited access to health and education because of an individual's non-conforming sexual behavior, expression, and

identity. Physical aggression against LGBTI people creates insecurity, especially for poor and already powerless people.

Discrimination on the basis of SOGI in healthcare can prevent access to health insurance or proper medical care, which can leave many people outside social networks and may push them into poverty*.*

With regards to legislation on access to healthcare and non-discrimination, in addition to the Constitution of Georgia and the Law on the Elimination of All Forms of Discrimination, the prohibition of discrimination is also enshrined in the Law of Georgia on the Protection of the Right to Healthcare, according to which discrimination on the grounds of sexual orientation or negative personal attitude is prohibited. Additionally, the Law of Georgia on the Rights of Patients, which aims to protect the rights of citizens in the healthcare system, further prescribes the respect for the dignity of all patients.

Nonetheless, ***several studies conducted in Georgia show existing practices of discrimination and violation of the rights to private life and confidentiality of LGBTI persons by health-care professionals and health service providers in general. A lack of awareness among medical personnel, existing negative stereotypes towards LGBTI persons, and ignorance of the specific medical needs of transgender persons constitute barriers for patients to get quality medical services.***

According to such studies, ***members of LGBTI groups often refrain from seeking medical services and choose self-medication in order to avoid the negative attitudes of doctors. In certain cases, expectations of a negative or indifferent attitude from doctors result in destructive actions, such as giving incorrect information to doctors that would influence the medication or treatment methods chosen by them.***

It is worth noting that ***healthcare needs of LGBTI groups are not analyzed and assessed by the State in Georgia.***

Although ***homosexuality*** *was removed from the International Classification of Diseases (ICD) by the World Health Organization in 1990, it* ***is still considered a disease and deviation by some medical personnel in Georgia – individual representatives of the healthcare sector view homosexuality as a problem requiring medical intervention. Furthermore, some medical textbooks view homosexuality as a behavioral disorder.***

Access to healthcare services for transgender persons is substantially limited due to the medicalization of "transgender" identity and stigma. Currently, the healthcare system in Georgia uses an internationally recognized classification system ICD-10, which classifies "transgenderism" as a mental disorder; thus, the existing healthcare system in Georgia assumes "a completely medicalized and pathological approach towards transgender persons and does not recognize its wide spectrum" and that not all transgender people want and/or need surgical interventions to be comfortable in their own body. Furthermore, "Terminological confusion of sex and gender is a prevailing problem in the ICD-10 Georgian publications, which is a key issue in the process of de-pathologization of transgenderism."

Furthermore, ***national legislation does not address possibilities for sex change, but according to existing practice, medical interventions (including, sex reassignment surgery) are set as a prereq-***

> ***uisite for changing the gender marker in identification documents. As a result, expensive and intrusive medical procedures are not at all financed by the state and more importantly, may be unwanted. Transgender people are thus left without identification documents which accurately reflect their gender identity, resulting in social exclusion violating their rights to health and privacy, and creating major obstacles to the enjoyment of many other fundamental human rights.*** *[...]*
>
> ***A special emphasis should be placed on the situation of the Roma community in Georgia, who face extreme marginalization and discrimination, leading to poverty, unemployment, lack of access to education and healthcare. Due to a lack of access to proper documentation, Roma people are also excluded from social security programs.***
>
> *Also, due to dense cohabitation, in areas inhabited by Roma communities there are often outbreaks of diseases among women and children. In such situations, access to treatment is rather discriminatory: Roma women often suffer from unequal treatment and are not admitted to maternity wards. They are forced to give birth at home, as hospitals do not accept them.* » Source: Bureau du défenseur public, Human rights in the context of sexual and reproductive health and well-being in Georgia: Country assessment, 16 janvier 2018, p.34-37, 96-97, 101-102 : www.ombudsman.ge/uploads/other/5/5305.pdf.

Bureau du défenseur public, décembre 2017:

> « *The realisation of the right to health care is linked with problems.* ***The state programme of universal health care is not fully accessible for those who use private insurance schemes as of 1 January 2017. This limitation of technical nature, and based on a fixed date, is unjustified and requires revision****. [...]*
>
> *LGBTQ (Lesbian, Gay, Bisexual, Trans and Queer) community is one of most vulnerable groups with their representatives facing discrimination in almost every sphere of social life****. LGBTQ people do not feel safe when exercising fundamental rights such as the rights to education, employment, healthcare, et cetera. Yet, they often refrain from making instances of alleged discrimination against them public because of mistrust in state authorities and fears of being stigmatized by society.*** *[...]*
>
> ***Representatives of LGBT community often face discrimination in obtaining services****. There are instances when, according to applicants, they are subject to discrimination regardless of whether they belong to the LGBT community or not. This is mainly conditioned by their appearance, dressing style and behavior which is a matter of their personal autonomy and self-realization. [...]*
>
> *The issue of legal recognition of the sex of transgender persons remains a problem in the reporting period. As a result, transgender persons are not allowed, on certain occasions, to use their identification documents whereas by using them they expose themselves to heightened risk of violence and discrimination.* ***Another problematic issue is the situation regarding a sexual and reproductive health of LGBTQ persons, which results from the absence of special guidelines and instructions tailored to the needs of LGBTQ representatives and especially, transgender persons****.* » Source: Bureau du défenseur public, The Situation of Human Rights and Freedoms in Georgia 2017, 5 décembre 2017, p. 14: www.ombudsman.ge/uploads/other/4/4957.pdf.

Bureau du défenseur public, 2017:

« *At the moment there are no clear and detailed requirements with regard to the quality of care and the delivery of services at the privatized institutions. The only control or monitoring mechanism in place is the Office of the Public Defender, which has the right to monitor all closed institutions.* ***The Public Defender issued a very critical report on mental hospitals in 2015, however this has not had the desired effect i.e. a clear improvement in the quality of care delivered.*** *[...]*

We regret to have to conclude that concerning the quality of treatment and care of the patients in Qutiri, the living conditions and the interrelation between staff and patients there was no sign of improvement since privatization. The improvements in Qutiri were material, e.g. upgrading the water and sewer-system and the renewal of roofs. Although the director said he had many plans to improve the buildings and facilities, he did not mention anything with regard to the improvement of treatment, the quality of care, the range of therapies provided and the attitudes and skills of staff.

In Batumi however, there was a palpable sense that their newly found independence would allow the clinical team to develop the standard of their care and freed them from bureaucratic delays and barriers.

Privatisation can be beneficial to well-led, motivated teams that believe in patient centred care. Equally it can free institutions to superficially improve their physical environments whilst making little or no improvement to the quality of care that their patients have a right to receive. » Source: Bureau du défenseur public, Privatization of Mental Health Care Facilities in Georgia – Assessment, Conclusions and Recommendations to the Georgian Government, 2017, p.31-33: www.ombudsman.ge/uploads/other/4/4590.pdf.

Bureau du défenseur public, 31 mai 2016:

« *In order to respond to the problems and challenges in a systematic way,* ***the Parliament of Georgia, in December 2013 adopted the 'National Concept on Mental Health'.*** *This is the main mental health policy document of the country. The document states that 'Georgia recognizes the importance of mental health'. Moreover, 'Georgia undertakes to organize delivery of mental health services within the country in the manner that people with mental disorders receive treatment in the least restrictive environment, to the extent possible in their own home or close by, based on their basic needs; to ensure maximum protection of their rights and dignity and their full and effective participation in society on an equal basis with others'.* ***To reach the goals identified in the National Concept, the Ministry of Labour, Health and Social Affairs has launched a national strategy and action plan for the years 2015-2020, which was approved in December 2014****.*

This is definitely a step forward. ***Despite the declared government policy, the field of mental health is still in severe condition. The monitoring has identified a number of systemic problems.***

First of all, ***the lack of funding for mental health must be pointed out****, as the amount of funds allocated is directly related to the quality of psychiatric care.* ***Since 2006, health care spending for mental health in Georgia follows the increasing trend, but the ratio of percentage of the costs of mental health in relation to the overall costs on public health has not changed significantly****. A large portion of funds is spent on inpatient psychiatric services and this figure remains high for years.* ***The state's priority is assigned to inpatient care funding, whilst funding for psychosocial rehabilitation stands stagnant and only a small part of available financial resources is allocated to the outpatient care.*** *Along with the lack of funding, the methodology of funding the long-term and acute cases is also a problem. 840 GEL per case is allocated for acute cases and 450 GEL per month for cases of long-term treatment.* ***The scarcity of funding ultimately leads to the problems with insufficiency of qualified personnel at mental***

health institutions, the absence of adequate therapeutic environment, quality of treatment, care, psycho-social rehabilitation, as well as length of stay at hospitals and the lack of community-based services*.*

Georgian mental healthcare system is severely understaffed and lacks human resources. The deficit of psychiatrists is twice higher than the average European index. *A 2015 study on mental health professionals found that in total, number of psychiatric health care personnel in state-funded institutions is less than 40% of the total of the employees.* ***The training and professional development of the personnel of mental health institutions is equally problematic. The lack of qualified staff, in turn, has a negative impact on the quality of psychiatric care, supervision of patients and safe and secure environment in the institutions. This situation increases undue physical restrictions and the risk of use of excessive force when applying such physical restrictions.*** *In addition, extremely hard working conditions result in severe psychological state of the personnel and negative emotions can lead to ill-treatment of the patients.*

The monitoring group has received numerous reports about physical and verbal abuse of patients during the visits at the mental health institutions. In addition, according to the monitoring group, patients are subjected to ill-treatment due to extremely bad conditions of stay, facts of physical and chemical restraints, the methods of physical restraints, administering injections in the presence of other patients, lack of access to timely and adequate treatment of somatic diseases, long-term hospitalization due to the neglect and involuntary medical intervention. The monitoring also revealed that there is a problem of due protection of safety in mental health institutions from the violence among the patients.

The monitoring revealed that the legislative requirements as regards the use of physical restraint are systematically breached. According to surveys of patients, it was found that they are often 'tied down' for lengthy periods of time and left without adequate oversight*. It was obvious that most of the institutions do not carry out the registration of cases of application of physical restrictions and there is no clear system - in most cases the record of the use of physical restraints is made in general logs and not in the patient's medical records or vice versa. The requisite 15-minute interval monitoring record of the dynamics of the patient's condition is found nowhere in any records. Sometimes the time is not set at start and end of application of physical restraint. The reasons for the use of physical restraint are formulated in a manner that is not particularly informative.*

In many cases, it could not be determined why the physical binding was necessary and whether other alternative measures could be used. It should be noted that neither the Law of Georgia on Psychiatric Care nor the above mentioned instructions specify the maximum term for the use of physical restraint, which is dangerous, because it can lead to repetitive application of physical restrictions for 4 hours. The said normative acts also fail to establish the obligation that the information about the physical restraint be included both in the patient's medical record, as well as a special journal (special register).

It is therefore important that the normative acts are brought to order, via including making changes to regulate those two issues.

It is noteworthy that neither the law nor the instructions mention chemical restraint as a measure of restriction. ***According to the assessment of Public Defender, the chemical restrictions are frequent and are often not documented properly. The institutions routinely apply physical restraint together***

with chemical restraint. There is no clear legal framework regulating chemical restraint and no justifications are provided for its application.

This amounts to a violation of standards of international human rights law. The same guarantees of protection should be provided whenever chemical or mechanical means of restraint are used.

The interviews with patients and the inspection shows that the patients are placed in isolation rooms for more than a few days, and bearing in mind the conditions of the isolation rooms, such practice gives rise to concerns for the Public Defender*. In the view of the Public Defender, the isolation rooms in the Republican Clinical Psycho-Neurological Hospital and Mental Health Center, as well as other mental health institutions are not specially and properly equipped and there is high risk of self-harm by patients in such rooms. In addition, the Public Defender considers that the bars on the door and the window are unacceptable, both in terms of safety, and the disruption of the therapeutic environment and its' association with the prison and the punishment cell. Hence,* ***placement of a person in such isolation room may amount to degrading treatment.***

The Public Defender is also concerned about the fact that despite the requirements that the usage of the physical fixation and specialized isolation together with the duration of use of these measures, shall be duly reasoned and documented in accordance with Article 16 of the Law of Georgia on Psychiatric Care and similar requirements established by abovementioned instructions, ***the isolation of the patient is not in reasoned, properly documented and is applied for a long time in violation of applicable laws.***

The Public Defender deplores the fact that the physical restrictions are applied equally to formally voluntary and involuntary patients, which is also contrary to the CPT's position, according to which patients treated on a voluntary basis should not be subject to restraint. If physical restraint is necessary, the legal procedure of the review of the patient's status (voluntary / involuntary) must be immediately initiated.

It is important that patients are provided with the material conditions which will facilitate their recovery and prosperity. It should be noted that ***some of the existing physical environment and sanitary conditions not only fail to contribute to a favorable therapeutic environment, but also create the situation, which in many cases amounts to inhuman and degrading treatment.*** *In particular, old infrastructure, extremely bad sanitary and hygienic conditions, living space that does not correspond to the standards, poor sanitation and impossibility of privacy, as well as disruptions with regards to central heating and ventilation were between major problems at some institutions. [...]*

The Ombudsman is concerned for vulnerable legal position of individuals who are hospitalised, actually involuntarily, based on formal informed consent. They are outside the control of the court, and thus unable to defend their rights and subjected to medical interventions and physical restriction against their will. Thus, the patients' right to personal liberty and security is violated, and being subject to conditions of arbitrary detention, in many cases, they are victims of inhuman and degrading treatment. *[...]*

Whilst examining standards for the treatment of people with mental disorders, the group found that in most institutions, managers, as well as staff, keep understanding of the treatment as reduced to pharmacological therapy only, which is not in compliance with the modern bio-psycho-social approach and evidence-based health care principles.

Intensive pharmacotherapy method is expected to be associated in practice with emergency/high-risk departments, which aim to discharge the patient from the department as quickly as possible. According to the doctors of such emergency/high-risk cases departments, quick discharge of patients from such units is, unfortunately, not based on the medical evidence relating to severe accident management as it should be, but rather on the amount allocated for the treatment of such acute cases, as well as the period, which is optimal for spending the allocated funds. The Special Prevention Group also had the impression that the patient "Pharmacological activity" is actually the only way to control patients. ***Psychiatric cases are mostly managed without any complex therapeutic structure, and the involvement of the patients in meaningful activities is not ensured.***

According to the Public Defender, the short period of management of the acute condition of the patient (10-14 days on average) is not enough to reach comparably solid improvements. Presumably, the improvements achieved as a result of intensive treatment start to deteriorate rapidly, as the remission stage is not achieved and the patient discharged from the hospital does not receive the due out-patient care at all, or due to lack of funding, treatment is limited much lower intensity. *Out-patient services are fragmented and under-developed; therefore, none of these services are available to maintain the achieved improvements. Thus, there is a high risk of re-aggravation of the situation and repeated hospitalizations.*

Monitoring shows that the purchase of high-quality medicines is prevented both by the scarcity of the resources allocated to the psychiatric care, as well as the legal framework governing public procurement. In particular, mental health institutions are buying medications through a simplified electronic tender. The winner of the tender will be the bidder, which offers the lowest price to the purchaser. Such a rule of purchase had a negative impact on the quality of the medication, because there are different producers offering the medicines with the same active substance, while the market price is directly related to the quality of the end product.

The monitoring demonstrated many shortcomings of the medical documentation. In some of the facilities, psychiatrists failed to regularly inspect the patients and thus the results their observation, are also irregularly reflected in the medical cards. *Medical files did not contain data on individual treatment plan. Many entries are practically illegible because of the doctor's handwriting. In most of the institutions the records describing the condition of the patient, the so-called "cursus" are not regularly kept. These records are of mostly blanket nature. [...]*

High patient mortality is of the issue of particular concern for the Public Defender. As it turns out the study of medical records of patients who died, there were many cases calling for appropriate investigation and treatment of somatic health condition, but conduct of any such examination and treatment is not confirmed by medical documentation.

Despite the efforts of staff of mental health institutions, to help beneficiaries in social issues, ***psychosocial support, rehabilitation and reintegration services in hospitals are barely developed****. In some cases, their existence is only a formality and can be considered as a day-activity.*

The monitoring showed prolonged hospitalisation of the children, which according to the Public Defender is the result of the improper performance of the social workers' duties*. No multidisciplinary work is conducted in N5 Clinical Hospital. Work towards resolution of psychological and behavioural problems is absent from the children's individual development plans, which sticks solely to the pharmacological treatment of mental disorders. Apart from this, there is no individual service plan for each beneficiary, the*

fulfilment of which would be monitored by the person responsible for the dynamics to ensure that the patient receives a complete package of services. The Public Defender believes that the therapeutic activities in the children's departments do not meet modern standards and guidelines for international intervention, intervention strategies need to be developed, appropriate competence of the personnel has to be improved etc. The Public Defender is concerned by the cases of placement of children in the hospital units for adults and urges the staff to prevent such practices in the future.

Patients subjected to forcible psychiatric care and those transferred from the penitentiary institutions to undergo involuntary treatment are subject to undifferentiated approach. Patients have limited contact with each other. This includes only pharmacotherapy. Patients are not involved in the rehabilitation and improvement of programs, sports and other activities. The monitoring group was left with the impression that no psycho-social rehabilitation work is being practiced with the patients, and the psychologist help is scarce. *Days are not anyhow planned or structured by meaningful activities and they generally run in the drab, mundane manner. Patients often engage in conflicts.*

There is no individual approach towards patients in the Forensic Psychiatry Department of the National Center for Mental Health. Their individual needs are not identified and the necessary team is not created to perform the relevant multidisciplinary work. ***Patients are not involved in the treatment process.*** *Patients are managed through intimidation and aggression between injections. The risk assessment procedure is not in line with international standards. It is unclear what the evidence of credibility of the instrument is, or how the degree of risk is integrated into the treatment scheme, the treatments are held in uniform, broad blanket structure.*

Finally, it should be noted in particular that there is a problem of proper monitoring of psychiatric care in mental health institutions supervised by state and of protection of patients' rights*. In this regard, the activities of the National Preventive Mechanism are crucial, but the Public Defender considers that bearing in mind the specific nature of the mandate of the National Preventive Mechanism, it is important to ensure effective operation of other state control mechanisms at the same time.* » Source: Bureau du défenseur public, National Preventive Mechanism (NPM) - Report on the monitoring of mental health institutions, 31 mai 2016, p.7-13: www.ombudsman.ge/uploads/other/3/3694.pdf.

CERD, 22 juin 2016:

« *Tout en saluant l'adoption de la loi antidiscrimination en mai 2014 et la désignation du Défenseur public de la Géorgie comme l'organe chargé de l'égalité responsable de l'application de cette loi,* ***le Comité est préoccupé par le faible nombre de procès dans lesquels les dispositions de cette loi sont invoquées.*** *En outre, le Comité note que contrairement aux organismes publics, les entités privées et les particuliers n'ont pas l'obligation de communiquer des informations pertinentes au Défenseur public en vertu de l'article 8 de la loi, ce qui limite la capacité du Défenseur public d'examiner efficacement les affaires de discrimination dans lesquelles des entités privées ou des particuliers sont mis en cause (art. 1 er et 6).[…]*

10. ***Le Comité s'inquiète à nouveau du manque de données ventilées concernant les minorités raciales et ethniques et les non-ressortissants dans l'État partie****, notamment les groupes les moins nombreux comme les Kistines, les Kurdes, les Juifs, les Grecs et les Assyriens (voir CERD/C/GEO/CO/4-5, par. 19) ainsi que les personnes d'ascendance africaine ou d'origine africaine.* ***Il est également préoccupé par l'absence d'un mécanisme de suivi et de collecte systématiques de données sur les affaires de discrimination raciale examinées par les autorités judiciaires*** *en vertu du droit civil ou pénal (art. 2). […]*

12. Tout en saluant les mesures que l'État partie a prises pour améliorer la situation des minorités nationales, notamment l'adoption du programme de quotas « 1 + 4 » et de la Stratégie pour l'égalité des citoyens et l'intégration et du plan d'action s'y rapportant, ***le Comité est préoccupé par :***

a) Le faible niveau de connaissance du géorgien en tant que deuxième langue parmi les minorités nationales et ethniques, qui fait obstacle à leur intégration dans la société, à leur participation à la vie publique et politique et à leur représentation dans les fonctions de décision, en particulier au niveau de l'administration centrale, de même qu'à leur accès à l'éducation et à l'emploi *; b) Le peu de perspectives d'éducation et d'emploi des jeunes, notamment des filles, dans les zones reculées où vivent les minorités nationales et ethniques, comme la vallée de Pankissi, ce qui expose ces jeunes à la radicalisation et au recrutement par des groupes terroristes ; c)* ***Le manque de programmes d'information pertinents et adaptés à destination des minorités nationales et ethniques*** *(art. 2 et 5).[...]*

14. Le Comité note les efforts déployés par l'État partie pour enregistrer les personnes d'origine rom et pour accroître le taux de scolarisation des enfants roms, mais il est toujours préoccupé par le fait que ***de nombreux Roms ne possèdent pas de papiers d'identité et que la scolarisation des enfants reste faible, en particulier au-delà de l'enseignement primaire. Il note également avec préoccupation :***

a) La marginalisation de la communauté rom et les conditions économiques et sociales précaires dans lesquelles vivent ses membres ; b) Les cas d'enfants roms qui vivent et travaillent dans la rue et l'absence de mesures stratégiques visant à s'occuper de cette situation *; c) Les cas de mariages d'enfants ou de mariages forcés dans la communauté rom (art. 2 et 5).* » Source: Comité pour l'élimination de la discrimination raciale (CERD), Observations finales concernant les sixième à huitième rapports périodiques de la Géorgie*, 22 juin 2016, p.2-5: http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2fPPRiCAqhKb7yhsuh9J2cqmL1NA4hM%2b%2fajGw4Rc6TFptQCZp9%2feNGkEDPtXB4CdwVjkepQxj7ZqhW5MF47Cji4tRqVfl7cOmE%2f%2bezqfZhIgXovXzis-kAE%2f0DUr.

CIF, juin 2014 :

« *Public Health allocations on mental health in Georgia had a tendency to increase during 2006-2011, however the share of mental health expenditures (%) in the total public health expenditures has not experienced substantial change and stays at about 2.5%,2 which is much lower than the same indicator of the countries with the similar economic development.*

At the same time Per capita expenditure on the mental health in Georgia significantly differs from that of the countries with the similar development level, where more money is spent on mental health services.

A large portion of the funds allocated to the mental health care is spent on inpatient mental health services (71 %) in Georgia and this figure has remained stably high over the years (from 2006 to present). The developed European countries spend 9-31% on the inpatient mental health services, while having much higher expenditures on community services*. It is worth mentioning that the deinstitutionalization process and the development of community-based services is a result of long-term endeavor in these countries, and Georgia*

will need decades to achieve the same level, however the first steps should be taken today. For example, Australia began to implement similar reforms as far back as in 1950s, and the United Kingdom has been implementing the reforms since 1980s.

In Georgia, the high share of expenditures on the inpatient services poses a significant problem to the development of outpatient services: a) Existing resources for satisfying outpatient programs needs are scarce, b) Until 2014, funds among service providers were distributed according to a "historic budget", which put institutions in unequal conditions – per registered beneficiary expenditures varied from 4 to 17 GEL. *Weakness of the patient registration system is considered one of the causes of the above-mentioned inequality. Overall scarcity of the financial resources allocated from the budget to the Mental Health Care fail to create a favorable environment for service providers for delivering better services.* ***Namely, the competence of outpatient facilities is basically limited to prescription and distribution of drugs, which are of poor quality, and, in some cases, fails to comply with quantitative requirements. As demonstrated by the study findings, some facilities experience drug shortages for a certain period of a month that result in out-of-pocket expenditures by the patients****.*

Currently 18 outpatient mental health care providers operate throughout the country, while only five are authorized to provide psychosocial expertise to persons with disabilities. According to the established procedure of granting the status, repeated assessment is carried out with a pre-determined frequency, that creates geographical barrier to the service accessibility and affects the patient's financial state. It should also be noted that the facility does not receive additional financial benefit for providing expertise service.

In light of the scarce resources, there is a certain type of service – a crisis intervention component, which absorbs 20% of the budget allocated for the outpatient clinics and is available only in 4 regions, while some districts are not covered even by basic outpatient services. ***The psycho-social rehabilitation service, which, in its essence, is aimed to maximally promote the social integration and adaptation conditions for persons with mental disorders, is presently limited to only three institutions and the number of beneficiaries does not exceed a few dozen.***

Long-term hospital beds are occupied by the patients that require shelter or community residential services. Therefore, in some cases, the access to necessary services becomes limited for the beneficiaries.

It is known that the funding models create financial incentives for service providers. ***The existing funding models on one hand stimulate reduction of length of stay and high bed utilization (acute hospitalization), while on the other hand - maximum bed occupancy (long-term hospitalization), that ultimately leads to an inefficient use of the program funds.***

Analysis of cases of 10 months from 2013 program data demonstrates that length of stay in acute inpatient service provider institutions is 14-20 days, consequently, the bed turnover rate is high. Data from the developed countries shows that acute beds length of stay fluctuates in approximately the same range as in Georgia. However, these countries have a developed unified system of treatment/care, the most important components of which are the non-hospital

based services. The latter ensures the treatment continuation and constant supervision of the patient's health. It is interesting that in such systems re-hospitalization is estimated at 30 days and is used as an indicator for the quality of the non-hospital based services. ***In Georgia the setting is different. In particular, the system in Georgia is fragmented - there is no close interaction between hospitals and outpatient services, while the re-hospitalization term of 7 days is considered a problematic issue among the psychiatrists.***

Based on the international experience, it can be stated that the re-hospitalization term of 7-days is inappropriate under such a fragmented system. It does not fulfill its purpose. Furthermore, this regulation might encourage an institution to manipulate with a patient's hospitalization date.

The program design does not consider involvement of a hospital in patient's supervision after discharge. As a result of inadequate outpatient services, some patients return to the hospital. Within the 'conditional' time-frames established under the influence of the financial model, some patients' health state cannot be improved sufficiently to enable them to return to the society, therefore, after receiving acute hospitalization services, these patients become beneficiaries of the long-term hospital service. *All these factors result in additional costs to the program. The funding of hospital services is unevenly distributed, for example, the funding of long-term services fails to cover the existing needs, while the acute hospitalization services are relatively adequately funded. The issue is exacerbated by the lack of criteria for acute and long-term hospitalization at the regulations level.[...]*

The staff are heavily overloaded due to the shortage of human resources. At the outpatient level, beneficiaries indicate the existence of long queues, while at the hospital level the major part of the doctors' working time is devoted to such routine activities as maintaining of patients' medical records and preparation of various supplementary documents*. Computerization of these functions, or delegation of those to the low-skilled staff would help to decrease the existing deficit in human resources.*

Lack of the personnel on one hand and limited financial resources on the other result in the absence of multidisciplinary services at the outpatient level. Again, there are problems with the personnel qualification, especially in the regions, and particularly with psychologists and nurses*. Due to lack of financial incentives, the psychiatric field is not attractive to young doctors. Also the existing funding models do not contribute to the work quality improvement.*

The above mentioned problems are further exacerbated by the fact that the state has not yet developed a vision/strategy for supplying the field with human resources in the future, which would encourage young medical staff to work in this field. » Source: Curatio International Foundation (CIF), Mental Health Care in Georgia: Challenges and Possible Solutions, juin 2014, p.4-10: www.gip-global.org/files/mental-health-policy-brief-eng-web.pdf.

EASL, 13 avril 2018:

« *The world's first hepatitis C elimination programme was initiated in Georgia in collaboration with the US Centers for Disease Control and Prevention (CDC), and with a commitment from Gilead Sciences to donate DAAs. The programme was initiated in April 2015,3 and the results*

from its first 2 years in action were presented today at The International Liver Congress™ 2018 in Paris, France.

***'In Georgia, we have set out to achieve 90-95-95 targets by 2020, which means that we want to diagnose 90% of all HCV-infected individuals, we want to treat 95% of those diagnosed, and we want to cure 95% of those treated'**, explained Professor Tengiz Tsertsvadze from the Infectious Diseases, AIDS and Clinical Immunology Research Center in Tbilisi, Georgia. 'We had previously estimated that there were around 150,000 adults with HCV infection living in Georgia, which represents a prevalence in our population of 5.4%'.4*

***Hepatitis C screening programmes began in Georgia in 2015 and, by the end of April 2017, 43,989 individuals (29.3% of the estimated total population) had been diagnosed with HCV infection and registered with the elimination programme**. A total of 33,673 individuals had initiated treatment with DAAs, and 24,273 individuals had achieved a sustained virological response (SVR), i.e. were cured.*

'In the first 2 years of this programme, we have diagnosed more than one-quarter of our HCV-infected adults in Georgia, we have treated 77% of those diagnosed, and cured over 95% of those completing treatment', said Prof. Tsertsvadze. 'Our priorities now are to develop innovative strategies to increase awareness, expand access to high-quality screening, and remove diagnostic and treatment barriers'. [...]

*'These two HCV elimination programmes in two different settings show promising results', said Prof. Markus Cornberg from the Hannover Medical School, Germany, and EASL Governing Board Member. 'However, the programme in Iceland is unique and special because it is a defined (or better delimited) situation on an island with a defined target population. If elimination of HCV is possible without a vaccine, it will surely be possible in Iceland. **The programme in Georgia still has a long way to go, as three quarters of patients are not yet diagnosed**'.*
» Source: European Association for the Study of the Liver (EASL), Hepatitis C virus elimination programs report encouraging results: Is elimination within reach?, 13 avril 2018: www.eurekalert.org/pub_releases/2018-04/eaft-hcv041318.php.

Eurasianet, 8 mai 2017:

«***Thousands of Georgians have been cured of hepatitis C as a result of a giant experiment, in which the ex-Soviet nation tests the effectiveness of an aggressive public-health strategy.***

In the unprecedented project, all Georgians suffering from hepatitis C – an estimated 130,000 individuals – are being treated with expensive American medications free of charge. The program has entered its third year this May, and by 2020, Georgia hopes to be the first country in the world virtually free of the infectious liver disease.

The project is being undertaken by the US Centers for Disease Controls, the Georgian Ministry of Health and Gilead Sciences Inc., the American pharmaceuticals giant that developed the medications. Starting in 2015, Gilead's medication, dubbed Sovaldi, was administered to 5,800 Georgian hepatitis patients with severe complications like advanced liver fibrosis and cirrhosis. The following year, a newer drug developed by Gilead, called Havroni, was given to anyone with an active infection.

Georgian officials and epidemiologists reported a full recovery rate of over 90 percent among a total of 30,000 citizens who have been treated during the first two years of the program. "We naturally had better results last year because most patients involved did not have significant liver damage, and we had a new, combined drug to give," said Dr. Maia Butsashvili, an infectious disease specialist at Neolab, a clinic participating in the program.

***The success rate was 80 percent in patients with severe liver damage, and 97 percent for those with a less-advanced stage of the disease**, said Butsashvili, who is also a director of Health Research Union, a non-profit working on prevention and treatment of viral infections.*

*In the United States, Gilead Sciences charges $1,000 for a single Sovaldi pill. A 12-week Havroni protocol costs about $84,000. **Gilead's largesse in the Georgian experiment is an investment: if the project succeeds, it could help the company make a case for internationally and nationally funded programs to eliminate hepatitis C worldwide by making the cure available to everyone who needs it.** Gilead representatives did not respond to emailed questions by the time this story was published.*

***Georgia was chosen as a proving ground due to its manageable population size and its high prevalence of hepatitis C.** Georgia has the third highest rate of infection in the world after Egypt and Mongolia. Surveys from the early 2000s estimated that 6.7 percent (almost 200,000 people) of Georgia's total population was infected with hepatitis C.*

The disease spread in Georgia as the country regained independence following the Soviet collapse in 1991 and was plunged into a prolonged period of civil war and economic instability. Sterilization practices were substandard and intravenous drug use was rampant at that time. "The big contamination of the 1990s is catching up with us now. We have lots of men in their 40s who now face life-threatening liver conditions," Butsashvili said. » Source: Eurasianet, Georgia Serves as Proving Ground for Experiment to Eradicate Hepatitis C, 8 mai 2017: https://eurasianet.org/s/georgia-serves-as-proving-ground-for-experiment-to-eradicate-hepatitis-c.

FactCheck, 6 mai 2017:

« ***Four years since its launch, important changes have been enacted within the universal healthcare programme. The state replaces the universal principle with a targeted approach. Moreover, a medication component has been added to the state healthcare programme**.*

Since launching the universal healthcare programme, healthcare experts, governmental opposition, NGOs, media and FactCheck as well have been constantly emphasising the ineffectiveness of the programme alongside its excessive spending. Our recommendation was to make the programme more targeted and focused on those people with the least access to healthcare. Providing funds for medicine within the framework of the healthcare programme was also important because more than half of healthcare expenses is spent on medication.

*Another recommendation was to have private insurance companies implementing the state healthcare programme. In this case, the state purchases health insurance packages from a private insurance company and, in so doing, faces no financial risk. Statistics of the last years (2014-2016) demonstrate that the state is unable to cap universal healthcare programme expenses. In spite of this, no changes have been made to the universal healthcare programme. **The Ministry of Health, Labour and Social Affairs will***

try to limit expenses through the use of differentiated packages and selective contracting of the hospitals.

Differentiated packages of the universal healthcare system

***Since 1 May 2017, Georgian citizens with a higher income level whose annual income exceeds GEL 40,000 cannot use the universal healthcare programme**.*

***Citizens with a medium level income, whose monthly income is more than GEL 1,000 but does not exceed GEL 40,000 annually and do not have private health insurance, can use the limited package of the universal healthcare programme. People in this category (even if they have a private insurance package) still have access to funding for oncologic diseases as well as childbirth/caesarean section**.*

***Low income (less than GEL 1,000) citizens, self-employed individuals and persons with irregular income will retain access to the universal healthcare programme; although, with some limitations. If people in this category purchase a private insurance package, they will be entitled to funds only for urgent and oncologic services together with childbirth/caesarean section**.*

***Socially vulnerable citizens and persons who are registered in the database of socially vulnerable people whose rating points are between 70,000 and 100,000 as well as children from the ages of six to 18 years, teachers and people with limited capabilities will be fully entitled to all of the services provided by the universal healthcare programme. Additionally, they are not restricted from using a private insurance package at the same time**.*

A medication funding component has been added to the universal healthcare programme

From summer 2017, citizens registered in the database of socially vulnerable families whose rating points do not exceed 100,000 will receive funding for medication for chronic ailments. Namely:

Medication for chronic heart and cardiovascular diseases

Medication for chronic lung diseases

Medication for diabetes (type 2)

Medication for thyroid diseases

A programme beneficiary has to be a co-payer and pay 10% of the total value of the medication(s) which should not be less than GEL 0.05 and more than GEL 1.

According to the ordinance of the Government of Georgia dated 25 April 2017, the list of medications which would be funded by the universal healthcare programme was also determined. ***In total, 24 types of medication will be funded within the framework of the programme.***

List of medications:

Enalapril
Losartan
Amlodipine
Metoprolol
Amiodarone
Isosorbid
Dinitrat
Varparin
Clopidogrel
Digoxin
Furosemide
Spironolactone
Atorvastatin
Metformin
Gliclazide
Glimepiride
Thiamazole
Levothyroxine
Budenoside (inhalation suspension)
Budenoside (inhalation aerosol)
Albuterol
Salmeterol/fluticasone
Salbutamol
Tiotropium Bromide
Methylprednisolone

According to the calculation of the Ministry of Health, Labour and Social Affairs, ***the number of people who might benefit from the medication programme is approximately between 150,000 and 200,000****.*

The Ministry of Health, Labour and Social Affairs has already announced a tender to purchase the medicines. The main emphasis for purchase will be on the quality of the medication. As FactCheck was informed by the Ministry of Health, Labour and Social Affairs, it is expected that ***citizens will be able to use this programme from July 2017****.*

The budget for the medication programme is set at GEL 3,360,000. This budget is calculated for a period of six months. As the Ministry of Health, Labour and Social Affairs assumes that at least 150,000 persons will use this programme, it means that an average of GEL 22.4 is allocated per person for the six months which works out to GEL 3.7 per person on a monthly basis. ***The expected amount of programme beneficiaries and the programme's budget do not correspond with each other. Therefore, at the end of the year, we will see that programme's budget is insufficient or a much lesser number of people will actually benefit from this programme.*** » Source: FactCheck, What are the changes in the universal healthcare?, 6 mai 2017: http://factcheck.ge/en/article/what-are-the-changes-in-the-universal-healthcare/.

Gouvernement de Géorgie, 2015:

« ***With an HCV prevalence of 7.7% and an estimated 150,000 persons living with chronic HCV infection, Georgia has one of the highest burdens of HCV infection in the world****. New cases of HCV also are on the rise, with most occurring among persons who inject drugs (PWID). HCV is a preventable and curable blood-borne infection. However, because acute infection is often asymptomatic, most persons*

remain unaware of their infection status until decades later, when they experience life-threatening complications (e.g., liver cancer and cirrhosis). ***In response to this HCV epidemic, the Government of Georgia committed to eliminating HCV in their country by 2020 (defined as 90% reduction in infection prevalence), a goal that is now achievable due to recent availability of highly effective, direct acting antivirals (DAAs) capable of curing >90% of persons treated****. In addition, the country proposed the following elimination goals: a) testing 90% of HCV-infected persons for their infection; b) treating 95% of people with chronic HCV infection; and c) curing 95% of persons treated of their HCV infection.*

Georgia began laying the groundwork necessary to meet these ambitious HCV elimination goals in 2015 by establishing HCV testing and treatment sites throughout the country and treating those found to be infected with curative DAAs made available free of charge by pharmaceutical company Gilead Sciences. *Furthermore, the Government of Georgia (including the Ministry of Labour, Health, and Social Affairs [MoLHSA] and the National Center for Disease Control [NCDC]) convened a Technical Advisory Group (TAG) composed of international experts in the field of viral hepatitis (e.g., representatives from the U.S. Centers for Disease Control and Prevention [CDC], World Health Organization [WHO], and other international partners). The group, which first met in November 2015, was tasked with developing strategies, objectives, and actions that would help Georgia eliminate HCV. One of TAG's primary recommendations was development of a strategic HCV Elimination Plan accompanied by targets and indicators to promote program monitoring and evaluation.* » Source: Gouvernement de Géorgie/Ministère du travail, de la santé et des affaires sociales, Strategic plan for the elimination of hepatitis C virus in Georgia, 2016–2020, 2015, p.8: http://moh.gov.ge/uploads/files/2017/akordeoni/failebi/Georgia_HCV_Elimination_Strategy_2016-2020.pdf.

HHS/CDC, juillet 2017:

« *HCV screening programs began in January 2015, before the launch of the program, and screening services continue to be provided at various settings at no cost (Table). During January 2015–December 2016, a total of 472,890 HCV screening tests* were conducted, 50,962 (10.8%) of which were positive for HCV antibody. The highest rate of HCV antibody–positive screening tests (45.0%) was among persons who attended programs providing services for persons who inject drugs; the lowest rate (0.4%) was among women attending antenatal clinics (Table). Persons who screen positive for HCV antibody are referred to the treatment program for confirmation of chronic HCV infection using polymerase chain reaction (PCR) testing for detection of HCV RNA. Once chronic HCV infection is confirmed, the person is invited to enroll in the treatment program.*

When the treatment program began on April 28, 2015, four treatment centers operated in Georgia, all located in Tbilisi, the capital and largest city. By December 2016, the number of treatment centers had increased to 27 nationwide. From the start to December 31, 2016, a total of 58,223 persons with positive HCV antibody test results sought confirmation of chronic HCV infection through the treatment program, among whom 38,113 (65.5%) initiated a diagnostic evaluation, including confirmation of HCV infection by PCR testing; of those who initiated a diagnostic evaluation, 30,046 (78.8%) were confirmed as having chronic HCV infection and completed the diagnostic workup, and 27,595 (91.8%) of whom began treatment. *Men accounted for 23,062 (83.6%) of all persons starting treatment, including 9,180 men aged 40–49 years, representing one third of all persons who initiated treatment (Figure 1). The average number of persons starting treatment each month increased nearly 300% from April 2015–May 2016 (661 per month) to June–December, 2016 (2,619 per month), peaking in September 2016 at 4,595. A decline occurred from October through December 2016 (Figure 2). During the initial phase of the program (April, 2015–May, 2016), when treatment was prioritized for persons with more*

severe liver disease, most patients initiating treatment (9,088 of 9,259; 98.2%) had advanced liver disease (≥F3 METAVIR fibrosis score or FIB-4 score >3.25). After the expansion of treatment criteria to allow treatment for all persons with HCV infection (beginning June 1 through December 31, 2016), most persons initiating treatment (14,368 of 18,336; 78.4%) had less severe liver disease (<F3 METAVIR fibrosis score or FIB-4 score <1.45) (Figure 2).

As of December 31, 2016, a total of 19,778 persons completed treatment, and 6,366 (32.2%) eligible patients received testing for SVR (undetectable HCV RNA ≥12 weeks after treatment completion) (5). SVR was observed for 5,356 (84.1%) persons tested, indicating that they were cured of their infection. Among the 75.0% (4,774/6,366) who received sofosbuvir (without ledipasvir) treatment regimens, 3,793 (79.5%) achieved SVR, and among the 25.0% (1,592 of 6,366) who received ledipasvir/sofosbuvir-based treatment regimens, 1,563 (98.2%) achieved SVR. Among 537 (1.9%) persons who did not complete treatment, 371 (69.1%) died from their liver disease or another cause during the course of treatment, and the other 166 (30.1%) discontinued treatment for other reasons. [...]

Despite notable progress during the first 20 months of the Georgia HCV elimination program, ***challenges to Georgia achieving the national targets for HCV elimination by 2020 remain. High-quality screening, innovative linkage-to-care strategies, and cost-effective and simplified diagnostic and treatment regimens are needed. Provision of free-of-charge services for HCV screening, diagnosis, care, and treatment in settings serving populations at high risk for HCV infection and in primary care settings can decrease barriers to access of treatment services****. MoLHSA is working with CDC and other international partners to address challenges and introduce innovative strategies. Pangenotypic direct-acting antiviral drugs that are effective across the different genotypes of HCV, point-of-care HCV RNA testing, and HCV core antigen testing are likely to be introduced in late 2017 or 2018 and could have a substantial impact on improving access and simplifying diagnosis and treatment. Information systems capable of linking screening and treatment data are being developed to improve efficiencies****. With increased access to HCV treatment services and full implementation of the country's strategic plan, Georgia can achieve the goal for HCV elimination in 2020.*** *Lessons learned from this program can inform similar initiatives in other countries and help curb the global epidemic of viral hepatitis (8*). » Source: US Department of Health and Human Services (HHS)/Centers for Disease Control and Prevention (CDC), The Role of Screening and Treatment in National Progress Toward Hepatitis C Elimination — Georgia, 2015–2016, Morbidity and Mortality Weekly Report, 28 juillet 2017, www.cdc.gov/mmwr/volumes/66/wr/mm6629a2.htm.

HHS/CDC, 21 octobre 2016 :

« ***Initially, four treatment centers located in Tbilisi (Georgia's capital) provided HCV treatment to program participants. By April 27, 2016, the number of treatment centers had increased to 17 and they were located throughout the country, with staff members that included 95 physicians and infectious disease specialists or gastroenterologists providing HCV treatment services. All patients had access to point-of-care and laboratory-based HCV antibody testing, viral load determination, and genotyping****. Noninvasive tests used to determine the degree of hepatic fibrosis included the following: FIB-4 score, which combines age and standard blood tests (platelet count, alanine aminotransferase, aspartate aminotransferase) (3), and ultrasound or transient elastography, which measures the decrease in tissue elasticity that accompanies liver fibrosis (4,5). Genotyping was performed for all patients who tested positive for HCV by PCR. Six major genotypes of HCV are recognized worldwide, and treatment of HCV infection varies by genotype (6). Patients with advanced liver disease (F3 or F4 by METAVIR† fibrosis score) were prioritized to receive treatment during the first year of the program.*

A sliding-scale approach was used for diagnostics and clinical monitoring, with patients charged based on their ability to pay and the local government or MoLHSA paying the balance. All program participants received sofosbuvir-based treatment regimens, provided free-of-charge by Gilead Sciences; the Georgian government purchased additional medications (i.e., pegylated interferon and ribavirin) and provided them at no cost to patients for whom such treatment was indicated.» Source: US Department of Health and Human Services (HHS)/Centers for Disease Control and Prevention (CDC), National Progress Toward Hepatitis C Elimination — Georgia, 2015–2016, Morbidity and Mortality Weekly Report, 21 octobre 2016, p. 1132: www.cdc.gov/mmwr/volumes/65/wr/pdfs/mm6541a2.pdf.

HRHF, 8 mai 2015:

« ***According to official information about 1500 Roma are registered in Georgia. Their big part lives in Tbilisi and Gachiani. In accordance to the survey conducted by the project researcher at the European Center for Minority Issues [ECMI] Giorgi Sordia, compact settlements of Roma people are in Leninovka village of Dedoplitskaro district, in Gachiani village of Gardabani municipality, in Telavi, Kutaisi, Kobuleti and in Isani-Samgori district and Lilo settlement in Tbilisi. The oldest and most traditional settlement of Roma people is in Leninovka where 18 Roma families/133 people live. Residents of this settlement have one common problem: majority of them have no access to education and healthcare services.*** *[...]*

Co-founder of the nongovernmental organization "Disarmament and No to Violence" Irma Gelenava said ***Roma people cannot involve state programs because they do not have ID cards. "Majority of Roma people are impoverished. Without ID cards they cannot get various social services under state programs."***

"Roma, who does not have ID, cannot enjoy universal insurance program. There is Medical Center for Mothers and Children in Mitskevich Street, Tbilisi. Coordinator for Minority Issues in this Center Ketevan Gabruashvili assists us with medicines. We provide many Roma people with primary medical care with those medicines," Veneral Martkoplishvili said.

Irma Gelenava said during illness Roma rarely go to doctors because they do not have documents. Many elderly Roma people cannot get pension because of the same problem.

*Project Assistant at the ECMI Elene Proshikian is ethnic Roma and has been working on the Roma problems for years. "****Since Roma children are born at home, they cannot get ID cards at the age of 16. Romas do not know which institution they can apply to resolve their problems. They are not informed about state social and healthcare programs. They cannot write applications because they are illiterate. Lack of education is the barrier which is the biggest obstacle for Roma to integrate into the society."***

Elene said birth at home damages children's health conditions. "Pregnant women do not apply to doctors for monitoring or treatment; that means during pregnancy nobody takes care of the embryo. Consequently, many children are born with grave health problems," Elene said.

According to Elene Proshikyan, children from Leninovka village have IDs with the support of the ECMI.

Council under the auspices of the State Minister for Reintegration, which worked on the Roma issues, functioned only several months and then closed. According to the researchers, the Ministry of Justice

should be very active in the defense of Roma's rights that means to register Roma and issue ID documents on them. » Source: Human Rights House Foundation (HRHF), Roma Population in Georgia, 8 mai 2015: https://humanrightshouse.org/articles/roma-population-in-georgia/.

Lela Sulaberidze et al., 13 février 2018:

« ***Georgia has transformed healthcare financing and has undertaken a number of health system reforms over the last two decades, including in the mental health sector. The Universal Health Coverage Programme (UHCP), a state funded programme introduced in 2013, mainly provides primary care for individuals with physical health problems, but includes some limited mental health disorders. Specialist in-patient and outpatient psychiatric services are covered separately by the State Programme for Mental Health (SPMH), which was introduced in 1995 and managed by the Social Service Agency as part of the Ministry of Labour, Health and Social Affairs (MoLHSA). As such, outpatient and acute and long-term inpatient psychiatric care is available free of charge to all citizens of Georgia through 23 mental health services distributed across the country. Services include outpatient consultations with a psychiatrist, and subsequent prescriptions, either in one of 10 independent ambulatory centres or polyclinics, or in one of eight psychiatric hospitals that have an established outpatient department. Outpatient care also covers psychosocial rehabilitation services, which are offered at 2 outpatient centres and 1 independent facility, and psychiatric crisis resolution, which is provided at 4 hospitals with outpatient services. Currently, a number of common mental disorders, such as anxiety and obsessive-compulsive disorders (OCD), are excluded from any outpatient treatment.***

In-patient care includes a broader range of services compared to outpatient care, and whilst most inpatient care is provided free, care provided for alcohol-related psychiatric disorders are subject to a sizable co-payment*. Care is also provided to those living in supported housing (a combination of accommodation and support services to maintain independent living).* ***There are 9 standalone hospitals throughout the county and 3 inpatient psychiatric units integrated into the general hospitals in the capital city, which only provide acute inpatient care services. The reallocation of psychiatric hospital beds from large institutions to newly opened psychiatric departments within general hospitals in 2011 was seen as one of the most significant reforms within the mental health system in Georgia.***

The financing mechanisms for delivering services differ according to the type and setting of the services provided.

Outpatient services are financed directly through the historic allocation of funds from the SPMH budget, whilst long-term inpatient services are reimbursed through a standard per-diem or monthly tariff. The exception is for alcohol-related disorders where case-based payment is used. Although there is much discussion about modernizing the delivery of mental health services to ensure equity of access to treatment, there are no studies documenting barriers to care. The only study among the Internally Displaced Population found that utilization of psychiatric services for common mental disorders is unsatisfactorily low and one of the major barriers in service utilization are costs related to drugs and services. *[...]*

Health expenditure data showed that Georgia has seen a substantial increase in the proportion of GDP spent on healthcare since 1995 (Fig. 1), with an 83% increase between 1995 and 2011*. This*

was similar to EUR-A group countries, where increasing health expenditure trends are also seen. Expenditure decreased rapidly in the period 2009–2013. Even so, in 2014 Georgia's health expenditure as a proportion of GDP stood at 7.4%, which was still greater than CIS and EUR B + C countries.

An analysis of per capita total health expenditure in PPP $ (Fig. 2) shows that, although the proportion of GDP spent on health was relatively high in Georgia, actual health expenditure (PPP $) was lower than in the other groups.

Mental health expenditure as a percentage of total government health expenditure was compared between a number of countries (Fig. 3). ***Whilst Georgia's mental health expenditure of 2.83% of total health expenditure is higher than the 2.32% median mental health expenditure of UMCs, this is still nearly half the amount of the median value for HICs at 5.1%, indicating that Georgia has a long way to go.***

An analysis of the distribution of resources between outpatient and in-patient care was further undertaken through comparing expenditure on mental hospitals as a percentage of the total mental health spending for 2011 (Fig. 4). It can be seen that this distribution varies greatly across countries. ***Georgia spent 71.14% of its total mental health budget on inpatient care in 2011****, a value similar to the median of other lower middle-income countries and UMCs (73% and 74%, respectively). However, an almost equal distribution of resources between inpatient and outpatient care is observed in HICs, with a median of 54% allocated to inpatient care.*

Due to limited data availability, further detailed analysis of international comparators was not possible. However, local data allowed some comparison between different mental health institutions within Georgia. ***Analysis revealed that there are twenty-three individual facilities that offer a range of services from long-term in-patient care to supported accommodation. Across these facilities, 18 offer outpatient services; 12 offer long-term in-patient services with a capacity of 1207 beds; 10 offer acute in-patient services; four provide crisis intervention; three provide psycho-rehabilitation; and only one provides supported accommodation (Table 3). The total number of psychiatrists working across these services was estimated at 176 (3.92psychiatrists per 100,000 people). In addition to the services on offer, Table 3 also demonstrates the huge variations between regions in terms of the availability of services. Due to the extreme topographical nature of Georgia, straight-line distances do not accurately reflect the true distance between populations and services. While services are, as one would expect, most often located in the populous cities of the region, some regions are still left underserved.*** *[...]*

The results present a broad range of ***barriers to the development and implementation of reforms within the current mental health system*** *in Georgia. [...]*

These barriers include information barriers, insufficiency of resources, resource distribution, resource inappropriateness, resource inflexibility and resource timing*.*

At a patient level, there is a ***lack of information about the free treatment available for those with mental health conditions.*** *The absence of explicit policies or guidelines for the consistent identification and on-ward referral to mental health services following a diagnosis of a mental health disorder propagates the ineffective and costly (to the patient) treatment of patients.*

Information barriers at the system level include barriers to the transmission of information about best practice at a clinician/organisational level, but also the lack of local evidence available to policy-makers about

the effectiveness of the SPMH. Furthermore, whilst there are relatively sophisticated systems in place for collecting data about patients and their treatment through electronic patient records, there is no overall monitoring of services to identify the most effective care models/pathways that could be used in the planning and commissioning of services by policymakers.

This is further highlighted by the ***lack of any quality measures or indicators that allow benchmarking of services and opportunities for transparent oversight and scrutiny of the delivery of services, which are reported as being highly variable****. In addition to this, the* ***lack of awareness of public procurement procedures among facility managers is one of the barriers that leads to low quality drugs procurement at outpatient mental health facilities.***

Insufficiency of resources

*A major problem facing many LMICs is that of allocative planning for mental health. The majority of LMICs, especially those in Africa and Asia, spend less than 1% of their total health budget on mental health****. Lower middle-income countries, such as Georgia and some other FSU countries, spend an average of 2.62% of their total health budget on mental health, compared with higher-middle-income countries and high-income countries, which spend 4.27% and 6.88% respectively****. As demonstrated by the logarithmic scale for the relationship between the budget for mental health (as a proportion of total health budget) and GDP, the poorer the country the less is spent on mental health. Knapp et al. identified the following reasons for resource insufficiency: poor economic conditions; the low priority attached to mental health by the government or other key funders; low willingness to seek or pay for treatment; and poor stewardship.*

In terms of prioritisation by the government, the picture is mixed. Following the introduction of the SPMH, mental health services and medications have been provided free at the point of care, addressing one of the major barriers to improving mental healthcare. ***Although healthcare expenditure in Georgia has increased, the allocation of funding for mental health has only seen a modest rise, which is insufficient to deliver effective and efficient services. This is exemplified by the low quality of medications provided by many facilities, where patients often prefer to purchase their medications privately, outside the SPMH, to access higher-quality medications****. The existence of independent procurement practices and restricted budgets at each facility does not allow the purchase of high quality drugs at a lower price.*

A unified procurement mechanism might solve this problem. Furthermore, ***due to their high workload, psychiatrists are restricted in the amount of time available for consultations, limiting the possibility of delivering psychological therapies****. Nevertheless, even with limited resources, there seems to be potential to improve allocative and technical efficiency by better integrating services and setting standards to improve the quality of drugs.*

Resource distribution

In Georgia, the highest population density is seen in the capital, ***Tbilisi, which has the highest number of acute facilities (five)*** *but a relatively small number of long term acute beds. Conversely,* ***the Racha-Lechkhumi & Kvemo Svaneti region, a particularly remote and sparsely populated rural area, has no provision of mental health services. As a result, patients are often required to travel large distances. This can be prohibitive due to the costs/time involved and creates a barrier to accessing treatment.***

As there are currently no reliable data on the prevalence of mental disorders across the regions of Georgia, it is extremely difficult to effectively plan services that meet the needs of the population. *Instead, budgetary distributions to facilities are based on historic allocations. This highlights a particular problem faced by those proposing reform of mental health services. In order to develop a comprehensive mental health policy and subsequent programme, a needs-based policy assessment is required [14]. This would necessitate a more rigorous understanding of the needs of patients through epidemiological surveys of the disease burden, and also a wide-ranging assessment of the needs of a range of stakeholders including service providers, patients and their caretakers.* ***In addition to the geographical location of facilities, the existence of unequal tariffs has been reported where different facilities receive between 4 GEL (2.5 USD) to 17 GEL (10.6 USD) per patient despite providing the same outpatient services****. This naturally affects the resources available to provide these services.*

There is currently a lack of provision for some common mental disorders, especially anxiety and OCD*, as is the case in a number of European countries [15]. A comprehensive mental health system would ensure that all conditions diagnosed are included within the health care programme. There may however be an alternative route to integrate anxiety disorders with physical healthcare under the provision of the UHCP introduced in 2013.*

Moreover, the concept of public mental health, especially relating to preventative health or risk reduction, is not currently seen as a priority and currently no programmes exist to ensure the wellbeing of the population.

Resource inappropriateness

The balanced care model highlights the need for the provision of mental health services balanced appropriately between inpatient and outpatient/community care and the management of conditions using a balance of pharmacological and psychological treatments [16]. ***The current mental healthcare budget allocates more than 70% of resources to hospital care, whilst less than 30% is assigned to outpatient services. Whilst there has been some diversification of services with the introduction of psychosocial rehabilitation and crisis intervention, current demand far outstrips supply. The current provision of community teams is extremely limited, with few resources allocated to this area and restrictive budgets preventing their development.*** *Furthermore, only one supported housing service is provided in the whole of the country, with just 100 places, meaning that many patients that could be discharged from long-term care often remain in hospital due to a lack of social support, increasing the risk of institutionalisation.*

Although de-institutionalisation seemed to have been the direction of travel of many FSU and post-communist countries, there has been some concern that a reduction in psychiatric beds can shift the patient burden to other sectors representing a re-institutionalisation of mental health care, as first proposed by Penrose [17]. Recent evidence has suggested that this does not seem to be the case in the majority of FSU countries [18]. Despite this, re-institutionalisation has been observed in a number of Western European countries [19].

Moreover, the SPMH lacks an integrated approach, which results in separate funding for the different levels of mental health care. ***Inpatient facilities are not involved in patient supervision after discharge. As a consequence, the continuum of care is not ensured****.*

Another issue that has been identified is that of the designation of all new admissions as acute care patients, for whom a higher tariff is paid than for long-term care patients. The classification of these 'acute care patients' is an administrative classification i.e. due to their recent admission, not based on their actual clinical need and resource requirements, which leaves the system open to manipulation. Developing the financial models that encourage providers to create and maintain a continuum between different levels of mental health services and discourage policy makers from separating budgets according to the type of care may support the development of a 'fairer'system.

Furthermore, ***the three-week time period during which an acute crisis should be resolved and the patient either discharged or transferred to long-term care, has been arbitrarily set based on financial rather than clinical need and may act as a barrier to the delivery of patient-centred care.***

Resource inflexibility

Strict public finance management rules and "silo budgeting" do not allow facility managers to appropriately reallocate recources based on needs. This acts as a barrier to innovation and the diversification of services at a facility level. ***At the patient level, complications emerge due to restrictive policies that prevent an individual patient simultaneously receiving inpatient treatment from more than one programme; thus treatment covered by the SPMH cannot occur concurrently with treatment for a physical healthcare condition. This has a significant effect on those with co-morbidities, requiring discharge from one programme before patients are eligible for treatment within another****.*

Resource timing

*Knapp et al. broadly outline resource timing to include areas such as training, supply and capacity****; in the context of the mental health system in Georgia, a number of barriers were identified within this domain. These barriers mainly focus on capacity within the system, both in terms of clinical care and resources within the system to plan and monitor the delivery of health services. The low numbers of psychiatrists, especially those in training, and the lack of specialist mental health nurses were identified as major challenges to the health system, both currently and for the future. Whilst there are currently only 3.92 psychiatrists per 100,000 people, which is higher than the median for lower middle income countries (0.54 per 100,000), this number falls significantly short of the European median of 8.59 per 100,000 [5]. In addition, the limited mental health human resources are not adequately used. Psychiatrists spend inadequate amounts of time with patients, as most of their time is taken up by paper work.***

Shifting responsibilities between doctors and nurses and introducing electronic patient records would free up psychiatrists' time for patients [20, 21]. ***With relatively low salaries and perceived poor working conditions, many medics have limited interest in pursuing a career in psychiatry****. Without effective monitoring and workforce planning, this is unlikely to change. In addition to the lack of diversity of services, there is also a lack of diversity of human resources, with mental health facilities almost solely staffed by psychiatrists and general nurses. If a diversification of service provision is pursued, as is hoped by many, a concomitant diversification of the workforce is also required to ensure that the right skills and competencies are also developed.* » Source: Lela Sulaberidze, Stuart Green, Ivdity Chikovani, Maia Uchaneishvili, George Gotsadze, Barriers to delivering mental health services in Georgia with an economic and financial focus: informing policy and acting on evidence, 13 février 2018, p.2-11: https://link.springer.com/content/pdf/10.1186%2Fs12913-018-2912-5.pdf.

OC Media, 17 mars 2017:

« ***Georgia's Minister of Labor, Health, and Social Affairs, Davit Sergeenko, announced a 'second wave' of public universal healthcare on 16 March, which would provide differentiated packages for universal healthcare users. The proposals would deprive roughly 32,000 high income citizens of medical services currently covered by the universal healthcare programme.***

Sergeenko outlined several categories of probable healthcare users:

- *The target group, consisting of:* ***people with disabilities, socially vulnerable people (as defined by the Social Services Agency), children under five, students, teachers, and pensioners****. The group consists of roughly 1.7 million Georgian citizens. The group* ***will maintain the current coverage of universal healthcare services and will continue to be able to benefit from universal healthcare services and private insurance packages simultaneously****.*

- *Citizens with high income rates would be divided into two sub-categories:*

    - ***Citizens with incomes of more than ₾40,000 ($16,000) a year — around 32,000 people — will no longer receive medical services under the universal healthcare programme, but will still benefit from some programmes*** *(hepatitis C treatment, maternity services, etc.).*
    - ***Citizens with annual incomes of ₾10,800–40,000 ($4,300-16,000) — around 300,000 people — will have 90% of their costs covered for urgent hospitalisation. For planned hospitalisation, where the cost of treatment exceeds ₾1,000 ($400), 70% of the costs will be covered.*** *Georgian citizens in this category will have to choose between private insurance and the public healthcare system.*

- *Citizens with low or irregular incomes:*
    - *Citizens with monthly incomes of less than ₾900 ($360) and self-employed citizens — around 1.2 million people.*
    - *Citizens on the margins of social vulnerability (as defined by the Social Services Agency) — around 102,000 people.*
    - *Children aged 6–18 — around 503,000 people.*

Citizens with low or irregular incomes will continue to be fully covered for urgent hospitalisation, and will still be able to benefit from universal healthcare services and private insurance packages simultaneously*. For planned hospitalisation they will be fully covered if the cost of treatment exceeds ₾500. They will receive 50% coverage for outpatient care.*

According to the minister, offering differentiated healthcare packages was first envisioned in March, after the universal healthcare programme was first renewed.

In Georgia, healthcare is provided by both public and private healthcare systems*. After the collapse of Soviet Union, Georgia abolished its universal healthcare system, leading to mass privatisation of clinics and a shift to a market-dominated system.*

After the change of government in 2013, a universal healthcare system was reintroduced, which started providing healthcare to, according to the Georgian Parliament and media reports, more than 90% of the population. The programme operates alongside a system of private medical facilities and private insurers.

The programme is considered by many to be the crowning achievement of the Georgian Dream government, and was one of their main pre-election promises in 2012. However, it has faced some criticism for 'unfair financing', 'poor management' and 'ineffective control of expenses'.

The programme's budget has increased annually, from ₾470 million ($190 million) in 2015, to ₾570 ($228) million in 2016, and according to Georgia's 2017 budget, ₾660 million ($264 million) this year. » Source: OC Media, Georgian 'universal healthcare' reforms to strip 32,000 people of coverage, 17 mars 2017: http://oc-media.org/georgian-universal-healthcare-reforms-to-strip-32000-people-of-coverage/.

OMS, 25 août 2017:

« ***In Georgia, about 150 000 people (or 1 in 20), were affected by hepatitis C in 2015. That same year, the country became the first in the WHO European Region to set the goal of eliminating hepatitis C as a public health threat. Two years later, 32 000 people have been successfully cured****. On World Hepatitis Day 2017, on 28 July, national and international experts met in Tbilisi with representatives of WHO/Europe to assess progress and challenges of the Georgia hepatitis C elimination programme.*

Opening the meeting, Dr Nedret Emiroglu, Director of the Division of Health Emergencies and Communicable Diseases, WHO/Europe, commended Georgia for its ambitious elimination goal. She continued: "Georgia's hepatitis C elimination programme is an example of an effective public–private partnership that secures access to services to all, particularly the vulnerable ones, in the spirit of universal health coverage".

An exemplary journey

Georgia set its hepatitis C elimination goal in 2015 with the support of WHO, the United States Centers for Disease Control and Prevention and other partners, and signed a memorandum of understanding with a pharmaceutical manufacturer with the objective of providing new highly effective treatment for hepatitis C.

A year later, ***a long-term strategy for 2016–2020*** *was adopted to eliminate the disease from the country. This strategy* ***has driven improvements in monitoring and surveillance, infection control and prevention; it has also expanded access to hepatitis C screening, diagnosis and treatment services****.*

Since the launch of the programme, almost 40 000 patients have started treatment with new antiviral medicines, out of which almost 32 000 have already completed the treatment successfully*. Large-scale activities are taking place to ensure at-risk groups are screened, including key populations, medical personnel and all hospitalized people.* » Source: Organisation mondiale de la santé (OMS), Georgia's hepatitis C elimination programme setting

an example in Europe, 25 août 2017: www.euro.who.int/en/health-topics/communicable-diseases/hepatitis/news/news/2017/08/georgias-hepatitis-c-elimination-programme-setting-an-example-in-europe.

OMS, 2017:

« *Since 2013, Georgia has laid the foundation for health policy that is oriented towards public health and welfare.* ***In February 2013, it implemented a universal health care insurance programme to provide state-funded medical care (20). More than 90% of the population participates in the programme; the remaining 10% is covered by private medical insurance.***

The programme covers planned outpatient, emergency in- and outpatient services, elective surgeries, cancer treatments, obstetrical care and funding for essential drugs. Georgia's universal health care reform has improved access to health services and reduced financial barriers and out-of-pocket costs for the population.

The proportion of private household out-of-pocket expenditure has decreased since 2000, and was 58.6% in 2014. However, the 2014 expenditure was almost twice the average for the WHO European Region. This likely results in inequitable access to health care and financial hardship for many households – especially poorer households – which may in turn exacerbate poverty and have a negative impact on health*.*

WHO estimated that Georgia's total expenditure on health (as a percentage of GDP) slightly increased between 2000 and 2014 to 7.4%. This level of expenditure was close to the average for the CIS (6.6%) and a little below the average for the WHO European Region (8.2%).

The number of physicians in Georgia has been increasing since 2006, and is notably higher than the averages for the WHO European Region and the CIS. In contrast, the number of nurses has been decreasing since 1998 and is much lower than the averages for the WHO European Region and the CIS *(Table 2). […]*

Over recent decades, the Government of Georgia has shown a commitment to health policy that embraces the Health 2020 value of equity. As a result, ***Georgia has made notable progress in improving the health status of the entire population while addressing major risk factors and threats to health.***

The Government has implemented a series of health reforms that have included establishing a state-based health insurance programme to provide equitable and universal access to health care and to protect citizens from catastrophic health expenditure; introducing and improving data collection systems; committing to the elimination of hepatitis C; and adopting a health promotion strategy that includes tobacco control measures. *Going forward, it will be essential to closely monitor progress towards the goals of these programmes, and to ensure their positive impact on the health of the population.*

Despite these actions, Georgia faces significant challenges related to the sustainability of its programmes and the health of its population. Maternal and infant mortality, cancer, cardiovascular diseases and the high rate of tobacco smoking among males all pose threats to health

and well-being in the country. Premature mortality has been reduced in the past 20 years, but is still higher than the average for the WHO European Region.

To overcome these challenges, ***the country must establish a sustainable health financing system*** *and continue to address key health issues, including both communicable diseases and NCDs.* » Source: Organisation mondiale de la santé (OMS), Georgia - Highlights on Health and Well-being, 2017, p.11-14: www.euro.who.int/__data/assets/pdf_file/0004/351697/WHO_GEORGIA_HIGHLIGHTS_EN.pdf?ua=1.

MRI, juin 2014 :

« ***Roma communities face extreme marginalization and discrimination, leading to poverty, unemployment, lack of access to education and health care. Due to a lack of access to proper documentation, they are excluded from social security programmes***. » Source: Minority Rights International (MRI), Partnership for all? Measuring the impact of Eastern Partnership on minorities, juin 2014, p.17: http://minorityrights.org/wp-content/uploads/old-site-downloads/download-1373-Policy-paper-English.pdf.

Muazzam Nasrullah et al., 28 juillet 2017:

« *Georgia, a country in the Caucasus region of Eurasia, has a high prevalence of hepatitis C virus (HCV) infection. In April 2015, with technical assistance from CDC, Georgia embarked on the world's first program to eliminate hepatitis C, defined as a 90% reduction in HCV prevalence by 2020 (1,2). The country committed to identifying infected persons and linking them to care and curative antiviral therapy, which was provided free of charge through a partnership with Gilead Sciences (1,2). From April 2015 through December 2016, a total of 27,595 persons initiated treatment for HCV infection, among whom 19,778 (71.7%) completed treatment. Among 6,366 persons tested for HCV RNA ≥12 weeks after completing treatment, 5,356 (84.1%) had no detectable virus in their blood, indicative of a sustained virologic response (SVR) and cure of HCV infection.* ***The number of persons initiating treatment peaked in September 2016 at 4,595 and declined during October–December. Broader implementation of interventions that increase access to HCV testing, care, and treatment for persons living with HCV are needed for Georgia to reach national targets for the elimination of HCV.***

In 2015, an estimated 5.4% of the adult population of Georgia (approximately 150,000 persons) had chronic HCV infection, and of those, nearly two thirds were unaware of their infection (Georgia Ministry of Labour, Health, and Social Affairs [MoLHSA], unpublished data, 2016). Populations with the highest rates of HCV infection include men, persons aged 30–59 years, persons with a history of injection drug use, and persons with a history of receipt of blood products (MoLHSA, unpublished data, 2016). Initially, when the program was launched in April 2015, national guidelines limited treatment to HCV-infected persons with advanced liver disease, defined as one or both of the following: F3 or F4 by METAVIR fibrosis score (a system used to assess the histological extent of hepatic inflammation and fibrosis in patients with hepatitis C infection) on transient elastography or FIB-4 score (a noninvasive test based on a combination of biochemical values and patient age) >3.25 (3,4). In June 2016, treatment eligibility criteria were expanded to include all HCV-infected persons, regardless of disease severity. » Source: Muazzam Nasrullah et al., The Role of Screening and Treatment in National Progress Toward Hepatitis C Elimination — Georgia, 2015–2016, 28 juillet 2017: www.cdc.gov/mmwr/volumes/66/wr/mm6629a2.htm?s_cid=mm6629a2_w.

Parlement de Géorgie, 7 août 2018:

« *The Health Committee, within the Parliamentary oversight held the* ***hearing on strategic document for mental health sphere and implementation of the state program****. The Deputy Health Minister, psychiatrists, field experts and Directors of the Hospitals introduced the information about the challenges in mental health sphere and future visions.*

"We consider the significant program within the Parliamentary oversight. It is noteworthy that ***the Committee has unanimously supported increase of financing for the program with 5 ml GEL thus expressing our support to the reform.*** *Today, we heard the information about implementation of the strategic document and state program, allowing us getting cognizant with the outcomes and measures to be undertaken", - the Chair, Akaki Zoidze stated.*

The Deputy Health Minister, Maia Lagvilava introduced the presentation on ***Mental Health Development Strategic Document and Action Plan for 2015-2020. The financing of all the components have increased in 2018 conditioning establishment of the new services, increase of the mobile teams and facilitation to in-patient and out-patient services. Out-patient service funding has increased with 14.5% and allocations have been directed to mental service for the children with mental disorder. The reporter stated that if there were 3 mobile teams in 2017 in Tbilisi, the number increased to 11 in 2018 covering other regions as well. "We have made significant steps though the challenges remain. I hope we achieve all objectives under the strategy for 2020"****, - she noted.* » Source: Parlement de Géorgie, The Health Care and Social Issues Committee discussing the Mental Health Strategic Document and State Program implementation, 7 août 2018: www.parliament.ge/en/saparlamento-sagmianoba/komitetebi/djanmrtelobis-dacvisa-da-socialur-sakitxta-komiteti-149/axali-ambebi-jandacva/djanmrtelobis-dacvisa-da-socialur-sakitxta-komitetis-sxdomaze-fsiqikuri-djanmrtelobis-sferos-strategiuli-dokumentisa-da-saxelmwifo-programis-shesrulebis-mimdinareobaze-imsdjeles.page.

PNUD, 14 août 2015:

« *Despite these changes,* ***Georgia still has a long way to go in mental healthcare reform. The five-year National Action Plan, developed by over 70 mental health professionals and experts including Dr. Chkonia with help from the UNDP takes further steps toward the deinstitutionalization of large psychiatric hospitals and diversification of services available to patients****.*

"It is going to be a long process which will require new ways of thinking and excellent coordination throughout the healthcare and social service systems," Dr. Chkonia says.

Moving from her office to a ward for chronic female patients, I didn't know what to expect. Standing in front of an iron door leading to the ward, I remember feeling nervous – the only psychiatric hospitals I'd ever seen were in movies. When a door opened, I saw a huge corridor and the patients peering out of their rooms to see what was going on. They seemed pleased with having guests. As I learned later, most of them had been living there for years and not many enjoyed regular contact with the outside world.

Isolation and social stigma are two major challenges to people with mental health disorders in Georgia, and can sometimes prevent them either from seeking professional help or reintegrating into society following treatment*.*

One solution to these issues is to expand community-based services for mental healthcare users, providing them with more opportunities to access services and prevent longer-term hospital stays.

***This can include crisis intervention centers, dispensary clinics, social services, and a mobile team of doctors and psychologists who visit patients at home**.*

***"The #1 goal of the National Action Plan is to create a balanced system of mental health service, transitioning from a hospital-only system to a balanced system of psychiatric treatment which includes community services,"** says Nino Agdgomelashvili, project manager at the Global Initiative on Psychiatry – Tbilisi (GIP-T), a local foundation that provided technical guidance to the Action Plan elaboration process.*

In 2014, 70 percent of mental health financing in Georgia was put toward hospital care. 28 percent was dedicated to out-of-hospital services, although the majority of these services were still focused on specialized, institutional care. Only 4.5 percent of state funding went toward modern, community-based services like crisis intervention and mobile clinics. The new Action Plan envisions that by 2020, a more balanced system will be in place, with 50 percent of funding dedicated to hospital care, and 50 percent devoted to community care. » Source: Programme des nations-unies pour le développement (PNUD), How Georgia is Reforming Mental Healthcare, 14 août 2015: www.ge.undp.org/content/georgia/en/home/ourperspective/ourperspectivearticles/2015/08/14/how-georgia-is-reforming-mental-healthcare.html.

SEM, 21 mars 2018 :

« *Ab Programmbeginn im Jahr 2015 bis Mitte 2017 haben fast 40'000 Personen die Behandlung mit neuen antiviralen Medikamenten begonnen, so die WHO. Fast 32'000 von ihnen schlossen die Behandlung erfolgreich ab, das heisst, sie wurden von Hepatitis C geheilt. Laut dem Direktor der georgischen NGO Health Research Union lag die Erfolgsrate bei Patienten mit schwerer Lebererkrankung bei 80 %, bei Patienten mit weniger fortgeschrittener Krankheit bei 97 %.*

Die WHO lobt das georgische Angebot für Diagnostik und Therapie von Hepatitis C. Auch die im medizinischen Bereich aktive georgische Zivilgesellschaft beurteilt das Programm grundsätzlich positiv. Aktivisten fordern den Staat auf, die gesamten Kosten für alle notwendigen Tests zu übernehmen, da diese Kosten eine finanzielle Hürde für einen Teil der Bevölkerung darstellen. ***Die Schweizerische Botschaft in Georgien bestätigt, dass sich die Kosten für die Tests abschreckend auf finanziell benachteiligte Bevölkerungsgruppen auswirken. Aus der Zivilgesellschaft wird zudem bemängelt, die Kriminalisierung von Drogensüchtigen halte infizierte Süchtige davon ab, sich behandeln zu lassen**.»* Source: Secrétariat d'Etat aux migrations (SEM), Focus Georgien - Reform im Gesundheitswesen: Staatliche Gesundheitsprogramme und Krankenversicherung, 21 mars 2018, p.13: www.sem.admin.ch/dam/data/sem/internationales/herkunftslaender/europa-gus/geo/GEO-reform-gesundheitswesen-d.pdf.

Tengiz Verulava et al., avril 2015:

« *According to the representatives of medical institution, the number of patients with mental health problems is increasing annually; correspondingly, the state funding for mental health does not cover their needs.* ***Due to lack of funding, less expensive and less new generation of medicines are used. The patients are given low cost older drugs not sufficient for the whole month, but only 15 days' supply. As a result, the patient is forced to buy the remaining days' supply of medications. This negatively affects the treatment outcomes**. Poor treatment increases the frequency of exacerbations of the disease. According to experts, the financing scheme is not favorable neither for medical service providers nor for*

beneficiaries. ***After the state funding limit (single voucher for 840 GEL) for treatment of a patient with acute psychosis is used the medical institution tries to get rid of the patient, or the patient is transferred for the treatment of short and long term care that gives patient possibility for continuation of the treatment****.*

There are cases when number of clinics avoids covering treatment expenses themselves and discharging a patient even with acute or nonstable psychotic condition. Also ***the amount allocated for outpatient care per patient is very low on average of 10-15 GEL per day (it includes all expenses: food, utilities, staff salaries, clothing, hygiene costs, etc.). Very scarce funding makes it practically impossible to provide the rehabilitation course. Obviously, in such a situation it is impossible to provide a full service and the patients cannot receive expensive rehabilitation course. Medical institution is forced to deliver only small scale rehabilitation course to patients.*** *[...]*

Another problem is related to the tenders announced on the procurement of materials. According to experts, the hospital has to design a plan in advance for procurement during the year and submit it to the National Procurement Agency. Practically it is impossible to pre-define the volume of medicines which will be needed by the hospital during the year. ***Besides, the quality of drugs purchased under the tender are very low since as a rule the tender is won by a company proposing the lowest price. Eventually very often low quality medicines are provided with less therapeutic effect.*** *[...]*

Although the number of patients with mental health problems is annually increasing, the volume of funding for state mental health program does not increase. Due to the lack of funding the patients themselves have to cover the costs for certain services (e.g., Drugs), which negatively effects treatment outcomes. Often the medical institution itself is forced to bear the costs of the treatment. The problem of re-hospitalization still remains acute. The state program finances only urgent medical cases, which poses a challenge to both patients and hospitals. The funding does not cover the costs of quality services. *Salaries of medical personnel are quite low. Part of the patients doesn't require hospital treatment, but because they do not have private property, remain at a psychiatric hospital for years.* ***There is no outpatient medical service for chronic patients.*** *The rights of patients are violated (including property rights). The court also supports the healthy plaintiff rather than a patient. The level of medical service in Tbilisi and the regions is not similar. Particularly, in regions the qualification of doctors is rather low. Awareness of the patients or their relatives about the course of treatment is low.* » Source: Tengiz Verulava et al., Accessibility to Psychiatric Services in Georgia, 7 avril 2015: www.omicsonline.org/open-access/accessebility-to-psychiatric-services-in-georgia-Psychiatry-1000278.php?aid=52622.