Health Service Utilization, Expenditures and Health Status among IDP Population in Georgia

Contents

Abbreviations

ELRHA	
GEL	Georgian national currency – Lari
GoG	Government of Georgia
GPS	General Population Survey
HRU	NGO - Health Research Union
HUES	Health service utilization and expenditure survey
IDP	Internally Displaced People
MIP	Medical Insurance Programme
MOLHSA	Ministry of Labor, Health and Social Affairs
NCDC	National Center of Disease Control and Public Health of Georgia
OOP	Out of pocket payment
PPS	Probability Proportional to Size
PSU	Primary Sampling Unit
R2HC	Research for Health in Humanitarian Crises
SSA	Social Service Agency
SSU	Secondary Sampling Unit
TSU	Tertiary Sampling Unit
UHC	Universal health care
USD	US dollar
VHI	Voluntary health insurance

Introduction

There are over 300 000 IDPs currently residing on the territory of Georgia, which comprises over 15% of total population. Country had a few waves of IDPs as a result of military conflicts on the territories of Abkhazia and Samachablo (South Ossetia) starting from 1990's with the latest large wave in 2008. Most of the IDPs live in compact settlements, such as old administrative buildings or specially constructed camps. In both cases, living conditions and social-economic status of IDPs are below Georgia's national average.

Individuals affected by the humanitarian crisis have differential healthcare needs and capacity to meet those needs compared to general population. Therefore, starting from 2008, Georgia launched targeted health insurance coverage for a selected group of IDPs. Health insurance covered essential primary healthcare services, selected hospital care and essential drugs.

Health Research Union (HRU) with support from ELRHA/R2HC program conducted a survey tostudy health service utilization and expenditures among IDPs, and measure the effect of targeted intervention versus untargeted, integrated approach to health financing. The study was designed to contribute to the debate over the type of intervention that best fits the healthcare needs of humans in crisis.

The objectives of the survey were:

- Measure household health expenditure, outcomes of healthcare utilization and self-reported health status among IDPs;
- Analyze factors that have impact on health utilization and expenditures among IDPs

Report Structure

The body of this report is divided into three main parts:

- The first part describes the survey methodology and the instrument used.
- The second part presents major findings of the survey: demographic and social characteristics of respondents; health care coverage and awareness; self-perceived health status of IDPs; tobacco and alcohol use among IDPs; health service utilization patterns and users' experience and satisfaction with health services. The section also describes health expenditures for various occurrences, such as health expenditure related to chronic diseases, self-treatment, and hospitalization during last 30 days and during last 12 months.
- Last section provides conclusions and policy recommendations.

Methods

The research employed household surveys (HHS) for assessment of self-reported health expenditures, healthcare utilization and health status among IDPs. This is a common survey method used in many countries, particularly in those with high out-of-pocket health expenditures (low- and middle-income countries).

The survey was carried out among IDPs currently living in Georgia mainly residing in compact settlements - specifically built accommodation or administrative building allocated by the Municipal Government. Sampling Frame was based on the 2015data on IDPs from the Ministry of Internally Displaced Persons of Georgia.

Sampling from the target population was performed by a multi-stage sampling approach. The Primary Sampling Units (PSU) were represented by the Geographic Clusters area – all regions of Georgia where IDPs are currently residing (in total 10 clusters including Capital Tbilisi). The number of sampling units for each cluster was defined by Probability Proportional to Size (PPS) approach. The Secondary Sampling Units (SSU) were the IDPs' compact settlements which were selected by simple random sampling within each cluster. Within the IDPs' compact settlements the starting point was selected randomly, and every 5th household by geographic neighborhood was approached. Twenty five households were selected for each SSU which represented the Tertiary Sampling Units (TSU) for this study.

Kish methodology was used for selection of study participants from the selected household. Whenever selected subjectwasnot home at the moment of selection, at least three attempts were made to enroll him/her into the study. No replacements were done for the selected individuals.

All participants were asked to sign an Informed Consent form. Participants who refused to participate and those with mental problems were excluded from the study.

Sample size calculation was performed for the criteria listed in the Table 1:

Parameter	Explanation	Value
Target population size:	*Approximate IDP population size for Georgia*	265 000
Estimated percentage in the target population with the event of interest:	*50 % - the value maximizing the sample size estimation has been considered*	50 %
Confidence interval width	*Sample percentage to be within +/- 3.5 % of the target population value*	3.5 %
Confidence coefficient	*95 % confident that the confidence interval around the sample percentage captures the target population value.*	95 %
Number of clusters	*10 clusters will be included for the study*	10
Estimated Design effect (*DEFF*)	*Sample variance could be 1.5 times bigger than it would be if the survey were based on the same*	1.5

	sample size but selected by simple random sampling	
Percent Response	*It is estimated that 90 % of those selected will participate*	90%

By this approach the total sample size taking into account the response rate was estimated to be equal to 1200. In total 48Sampling Units wereselected. In each sampling unit average number of study subjects was 25.Allocation of these 48 sampling units to the selected 7clusters based on the Probability Proportional to Size (PPS) approach is presented in the table 2 (3 clusters were de-selected according to PPS sampling):

Region	IDP population by region	Percent from all selected regions	Sampling units allocation
Tbilisi	100944	38.87 %	18
Imereti including main city Kutaisi	25 228	9.59 %	5
KvemoKartli including main city Rustavi	12 691	4.82 %	3
Adjara Including main city Batumi	6 622	2.52 %	2
Samegrelo-ZemoSvaneti Including main city Zugdidi	85 188	32.38 %	15
Kakheti Including main city Telavi	1 477	0.56 %	0
ShidaKartli Including main city Gori	16 828	6.4 %	3
Samtskhe-Javakheti Including main city Akhaltsikhe	2 333	0.89 %	0
Mtskheta-Mtianeti Including main city Mtskheta	10 956	4.16 %	2
Racha-Lechkhumi Including main city Ambrolauri	834	0.32 %	0

Specific areas were selected from the list of IDPs compact settlements with total numbers of residents (the database was obtained from the Ministry of Internally Displaced Persons from the Occupied Territories, Accommodation and Refugees of Georgia). This included capital city Tbilisi and selected settlements from Western and Eastern Georgia. Thus, the survey collected information from the nationally representative sample of IDP households living in compact settlements.

Survey Instrument

The questionnaire was developed based on a number of existing questionnaires that have been used in Georgia to conduct health services utilization and expenditure survey among general population in three rounds: 2007, 2010 and 2014.

The first draft of the questionnaire was pre-tested and modified based on the findings. An adult household member who was most knowledgeable about the health condition and service utilization by other household members was interviewed. Those members with some medical conditions and service users were also asked case-specific questions.
The survey instrument consisted of 7 sections.

Table 1: Structure of the survey questionnaire

Sections	Units covered
Section A	Completed by an interviewer about the household and interview logistics (interview date, start & end time; reasons for non-participation)
Section B	General demographic information about the household
Section C	Self-reported health condition of household members
Section D	Tobacco and alcohol use
Section E	Health service utilization and expenditure during last 6 months
Section F	Health service utilization and expenditure during last 30 days
Section G	Hospitalization during last 12 months (except those occurring during last 30 days)
Section H	Cases when hospitalization was needed but did not happen

Fieldwork for the survey was carried out by the National Center of Disease Control and Public Health of Georgia (NCDC) from May through August 2015. Interviewers from NCDC were trained on the survey protocol and instrument. Double-data entry was carried out and inconsistencies were checked and resolved. Incomplete questionnaires were annulled.

In total 1,319 completed questionnaires collecting data about 4,359 household members were analyzed. The Statistical software SPSS 22.0 was used for data analysis.

Major findings

Socio-demographic characteristics of household members

In total 1.319 households with 4,359 household members were recruited and interviewed for the survey. Breakdown of household members by gender, age, marital status and educational level is presented in Table 2. Male accounted for almost 55% of all household members in the survey.

Table 2: Socio-demographic characteristics

Characteristics	Number	%
Gender		
Female	1978	45.4
Male	2377	54.6
Total	4355	100
Age		
0-14	1007	23.1
15-25	541	12.4
26-45	1248	28.6
45-65	1032	23.7
66+	530	12.2
Total	4358	100

Slightly less than half of respondents were married; children under the age of 15 constituted 23% of all IDPs surveyed.

Table 3: Marital status

Marital status	Number	%
Currently married	1955	45%
Never married	760	18%
Widow/Widower	443	10%
Divorced	146	3%
Separated	37	1%
Other	4	0%
Child aged 15 or younger	993	23%
Don't know/Refused to answer	1	0%
Total	4339	100%

Distribution of IDPs by the highest level of education completed is presented in Figure 1. Children of pre-school age and those with incomplete secondary education accounted for 39% of all respondents. Only 23% of IDPs have completed higher education level; and 17% - vocational, so-called professional-technical schools.

Figure 1: Education level

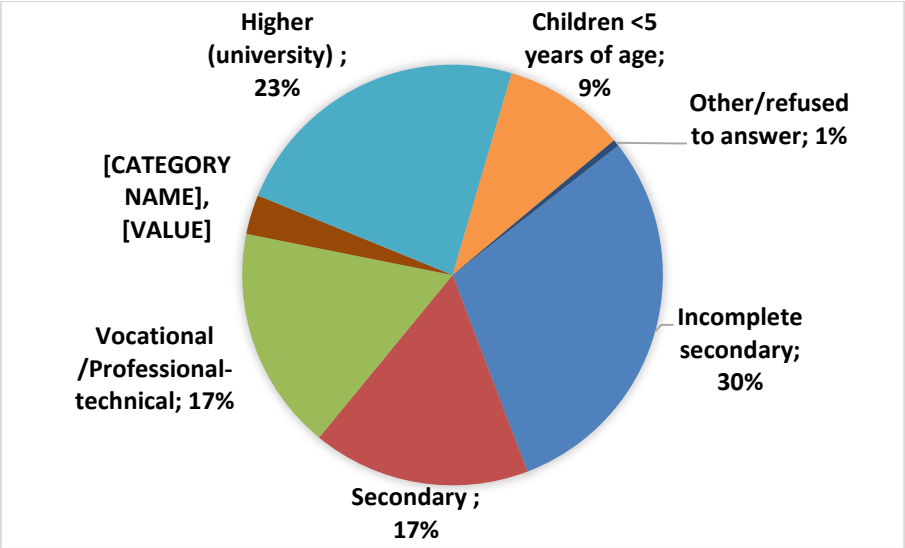

Table 4: Distribution of households by geographic regions

Region	Number	%
Tbilisi	1632	37.6
Shida Kartli	286	6.6
Kvemo Kartli	306	7
Atchara	196	4.5
Samegrelo	1305	30
Imereti	409	9.4
Mtskheta-mtianeti	207	4.8
Total	4341	100

Study limitation

More than one third of all household members lived in Tbilisi (37.6%); and slightly less (30%) lived in Samegrelo. Vast majority 98.1% lived in compact settlements established by the State for IDPs with only 1.9% residing in private houses/apartments. Therefore, the survey results can be only generalized to those IDPs who remain in compact settlements, and most likely, are socially most vulnerable and financially fragile. Due to the same reason, majority of survey respondents were entitled to almost identical healthcarebenefits, which has substantially limited the ability of the survey to measure the effect of targeted intervention versus untargeted, integrated approach to health financing.

Healthcare coverage: Targeted Health Insurance and universal healthcare

Over the last ten years Georgia health care system has been undergoing substantial reforms especially with regard to health coverage of the population.

Major milestones:[1]

2007 year: The Government of Georgia introduced a Medical Insurance Programme (MIP) for targeted groups (poor households, teachers, orphaned children) that involved purchasing health services for beneficiaries from private health insurers. Population was free to choose their insurer.

2009 year: A new initiative was announced to introduce state voluntary health insurance (VHI) that was designed to encourage population to share responsibilities for their personal health. Population groups aged 4-59 years old (not covered by other state health programs) were expected to get enrolled into health insurance scheme voluntarily through funding one-third of the monthly premium. The State declared it would finance remaining two-thirds of the premium for every insured people. The monthly premium varied based on the package population would buy. The cost of basic voluntary health insurance package for patients was 5 GEL per month.

2010 year: Geographical distribution of private insurance companies was initiated that envisioned that private insurance companies should compete to become the sole insurer in each geographic region of Georgia. Therefore, program beneficiaries no longer had a freedom of choice of insurer.

2012 year: The pool of MIP beneficiaries was extended to other vulnerable groups, such as pensioners, children under 5 years old, students, and people with disabilities. Certain co-payment schemes as well as limits were set for different types of health services as well as for covering the cost of essential drugs.

2013 year: After the Parliamentary election in 2012, the Government was changed and the ruling party – Georgian Dream initiated the universal healthcare (UHC) programme that is being implemented from February, 2013. The UHC has led to a major expansion in population entitlement to publicly financed health services.[2] Since then, the Universal Healthcare programme has been administered by the Social Service Agency (SSA) under the Ministry of Labor, Health and Social Affairs. The entire population, except those with private insurance packages, became entitled to a minimal benefits package once they registered with a primary care facility of their choice. The UHC package was expanding to include delivery and C-section, cardiac surgery, chemotherapy, radio-therapy, and others.

The programme budget has increased from $190 million in 2015, to $228 million in 2016, and to estimated $264 million in 2017.5The UHC programme administration was criticized by experts and political opponents for unjustifiably high healthcare cost and poor management.[3]

In March, 2017 the Minister of Health announced introduction of differentiated packages for beneficiaries based on their income level and age that have entered into force starting from May 2017.

Currently, the State-supported universal healthcare prioritizes certain groups: socially vulnerable people living under the poverty line (with the status defined by Social Service Agency); internally displaced people from the 2008 Russia-Georgia war who live in compact settlements owned, or rehabilitated by the State and

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[1] GEORGIA HEALTH UTILISATION AND EXPENDITURE SURVEY(HUES) 2014. World Bank, MOLHSA, USAID. 2015 Georgia

[2] HUES in Georgia. 2014. PPT. AparnaaSomanathan and RouselleLavado. World Bank
On behalf of the HUES Team. Personal communication with K. Goginashvili, MoLHSA

[3] Media materials, reportages, talk-shows

other partner agencies; children under 5; students; teachers;people with disabilities;military personnel, and pensioners. These groups account around 50% of the whole population.

Brief description of differentiated publicly financed healthcare benefits:

Citizens with high income (more than (40.000 GEL) $16,000 year)will have to pay for all medical services except delivery/C-section.

Citizens with annual income of $4,300-$16,000 (1000 GEL monthly but less than 40,000 GEL annually) are entitled to receive state-financedhealth services for certain medical conditions, such as emergency hospitalization (with 10% co-payment), planned surgeries (with 30% co-payment), chemo-therapy & radio-therapy, delivery/C-section, and in some cases, visits to family doctors.

Citizens with low and un-regular income will continue to be beneficiaries of the UHC with some limits set for the ceiling amounts as well as for co-payment(e.g. state covers 50% of outpatient care; 70% of planned hospitalization and 90% of urgent hospitalization).[45]

There are also differentiated packages based on the social status (SSA ratings) and age that seem less relevant to IDPs and therefore, are not described in the report.

Internally displaced householdsfrom the 2008 War living in compact settlements, alongside with the Poor Households (SSA score under 70,000) continue to receive *the most comprehensive service package* compared to any other population groups who are beneficiaries of the UHC.
The Table 5 below briefly summarizes the benefit packages for IDPs and other population groups with somewhat similar health benefits financed publicly.

[4] MoLHSA www.moh.gov.ge
[5]http://oc-media.org/georgian-universal-healthcare-reforms-to-strip-32000-people-of-coverage/

Table 5: Universal Healthcare program for IDPs and other populations. [6]Health benefits and user charges[7]

Types of services	**Covered by the State**	***User Charge***	
		IDPs from 2008 Russia-Georgia war residing in compact settlements; Poor populations (under 70,000 scores)	**Other groups covered (0-5 children; pensioners; people with disabilities; teachers; students, etc.)**
Emergency outpatient care	Fully covered	No charge	No charge
Planned outpatient care	Fully covered	No charge	No charge
Outpatient specialist visits	Fully covered	No charge	No charge
Essential drugs	Covered up to 50 GEL per year; (for pensioners, children, people with disabilities - up to 100 GEL per year)	50% co-payment + above the limit	50% co-payment + above the limit
Diagnostic tests (basic lab tests- blood, urine, glucose; ALT, AST, TSH, etc.)	Fully covered	No charge	No charge
Diagnostic tests (ECG, X-ray, ultrasound)	Fully covered	No charge	20% co-payment; (10% co-payment for pensioners; no co-payment for disabled veterans)
Physiological delivery	Covered up to 500 GEL per year	Above the limit	Above the limit
C-section	Covered up to 800 GEL per year	Above the limit	Above the limit
Planned (elective) Surgery	Covered up to 15,000 GEL per year	Above the limit	20% co-payment; (10% co-payment for pensioners; no co-payment for children under 5years; disabled persons including veterans with disabilities)
Emergency hospitalization	Fully covered	No charge	20% co-payment; (10% co-payment for pensioners; no co-payment for children under 5years; disabled

[6] Only selected target groups are described; the table is not exhaustive for all available health packages under the Universal Healthcare Program in Georgia

[7]Government of Georgia Ordinance #36. February 21, 2013 ssa.gov.ge/files//2013/Sajaro/6/1/12/10.12.2013_07.doc

			persons including veterans with disabilities)
Emergency therapeutic care	Covered up to 5 hospital days	Above the limit	Above the limit
Emergency surgeries (including day-care hospital)	Covered up to 15,000 GEL	Above the limit	Above the limit
Oncological care	Covered up to 15,000 GEL per year (fully covered for 0-5 children; disabled persons)	Above the limit	20% co-payment; (10% co-payment for pensioners; no co-payment for children under 5years;disabled persons including veterans with disabilities)
Chemotherapy, radio therapy	Covered up to 12,000 GEL per year	Above the limit	20% co-payment + above the limit

As shown in Table 5, IDPs are entitled to receive most services without any copayment except for medications where the limit set is trivial and with 50% co-payment.

Prices for inpatient care by classification of diseases/services are derived through provider-submitted data on the amounts paid by private insurers. Providers upload these amounts to a web-based portal that through using formulas set by the State, automatically generates the unit price the SSA will pay for the UHC beneficiaries.[11]

Out of pocket payments (OOPs) made by IDPs that are presented in the report occur largely because of the established by the State service fees. These fees sometimes are lower than the service costs at certain types of health institutions, and the patients choosing more expensive service provider medical facilities are obliged to pay the difference in cost.

The UHC also set the limits to cover essential drugs on a positive list[8] of generic drugs to treat certain categories of diseases (cardiovascular, allergies, respiratory diseases, gastrointestinal diseases, antibiotics, etc.). Drugs' prices are not regulated by the Government.

While analyzing the OOPs for health services occurred during last 12 months, last month or at last consultation, we decided to present the mean, median as well as the range of OOPs; however all of them need to be interpreted with caution: in most categories the median of out of pocket was zero as most IDPs do not pay for health services within the established limits at certain medical institutions. Instead of presenting the range of the amount paid with its minimum and maximum values, we present only the maximum as all ranges start from zero.

[8] http://apps.who.int/medicinedocs/documents/s19025en/s19025en.pdf accessed on August 21, 2017

We also need to acknowledge that the mean for most indicators about OOPsmay not be an accurate measurement due to an extremely wide range generated from those who paid nothing to outliers who paid hundreds and sometimes several thousand GEL for specific services.

All indicators that show service fees of user fees are presented in local currency –GEL, as well as in US dollars. The annual exchange rate 1 USD=2.27 GEL for 2015 used in the report is based on official rate provided by the National Bank of Georgia.[9]

Awareness of universal healthcare program among IDPs

Majority of IDPs (91.1%) are aware of universal healthcare program and this indicator is higher than that for general population: 74% of general population surveyed during the HUES in 2014 were aware of the UHC. Good awareness of the UHC can be explained by the fact that vast majority of IDPs (more than 90%) report being beneficiaries of universal healthcare program.

Only 62 persons say they do not have any types of health insurance coverage; 5% of IDPs are covered by corporate health insurance and only 1% has private insurance.

Table 6: Distribution of IDPs by types of health insurance

Types of healthcare coverage	N	%
Yes, beneficiary of Universal Health Care Program (formerly uninsured)	731	16%
Yes, beneficiary of Universal Health Care Program (IDPs, under the poverty line, teachers)	2631	59%
Yes, beneficiary of Universal Health Care Program (pensioners, children 0-5 years old, students)	568	13%
Yes, health insurance program of military personnel	63	1%
Yes, corporate health insurance program	212	5%
Yes, individual private insurance	73	2%
No	62	1%
Don't know	95	2%

It should be noted that both surveys show that there is limited awareness of the range of benefits the UHC program covers: only 56% of IDPs think they know what types of services are covered by the State.

In addition to the Universal Healthcare program, the Government of Georgia finances number of state (so called vertical) programsin health, such as HIV/AIDS, tuberculosis, immunization, ambulance, antenatal care, mental health, palliative care for incurable patients, drug addiction treatment, referral program, dialysis, treatment of infectious diseases, etc.

IDP respondents were asked to list the programs funded by the GoG to assess their awareness of available health services beyond the Universal Healthcare. [10]As shown in Table 7, awareness of health programs is extremely low among IDPs: vast majority (above 90%) did not know that the Government funds programs

[9]https://www.nbg.gov.ge/index.php?m=582

[10]State health programs in Georgia. http://ssa.gov.ge/index.php?lang_id=GEO&sec_id=804

on mental health, antenatal care, tuberculosis, medications for diabetes, etc. Only 20% know about immunization state program.

Table 7: Awareness of other health programs supported by the State (beyond Universal Healthcare Program)

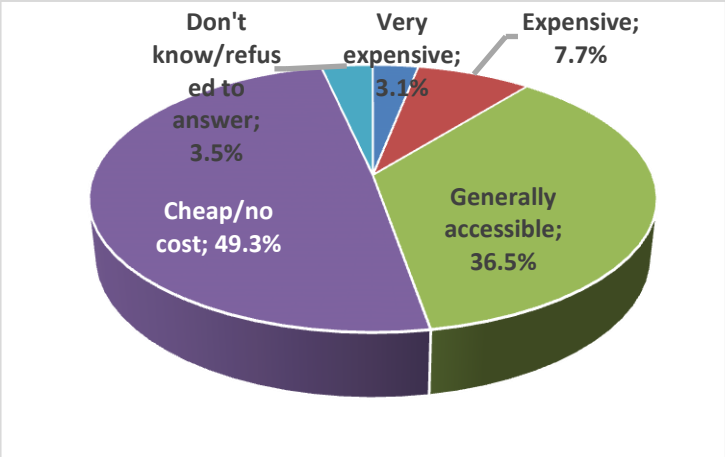
State programs in health	Yes N(%)	No N(%)
Ambulance	805 (60.5%)	526 (39.5%)
Mental Health	32 (2.4%)	1294 (97.6%)
Village doctor	66 (5.0%)	1260 (92.4%)
Antenatal care	101 (7.6%)	1225 (92.4%)
Medications for diabetes	66 (5.0%)	1261 (95.0%)
Immunization	266 (20.1%)	1060 (79.9%)
Tuberculosis	74 (5.6%)	1253 (94.4%)

Majority of households reported they refer to policlinics (54%) or hospitals (33%) when they seek medical services. On average, they need 19 minutes (median time -15 minutes) to reach these facilities.

Majority of IDPs - 78.9% know that they do not have to pay for counselling a doctor at most frequently visited health facility. However, almost half of them are not aware of which services are not free and how much service fees they might be requested to pay at this facility.

In general, majority of IDPs believe that healthcare is accessible for them and almost half of IDPs believe that health services for them are cheap or at no cost to patients. However, every tenth person (10.8%) thinks that health services are either expensive or very expensive for them.

Figure 2: Affordability of healthcare cost



Only 28% (366/1323) of all IDPs who sought health services in the last 12 months were counseled on *healthy diet* from medical personnel; even smaller share of IDPs (15%) were counselled on *physical activity* from health care workers in previous year.

Health status and illnesses among IDPs

Self-perceived health status among IDPs

Respondents were asked to rate their health as excellent, very good, good, fair, poor or very poor. Respondents were instructed that "health" means not only the absence of disease or injury, but also includes their overall physical, mental and social well-being. Survey findings show that more than half perceive their health status as good or fair; and 16% rate their health status as poor or very poor.

Figure 3: Self-perceived health among IDPs

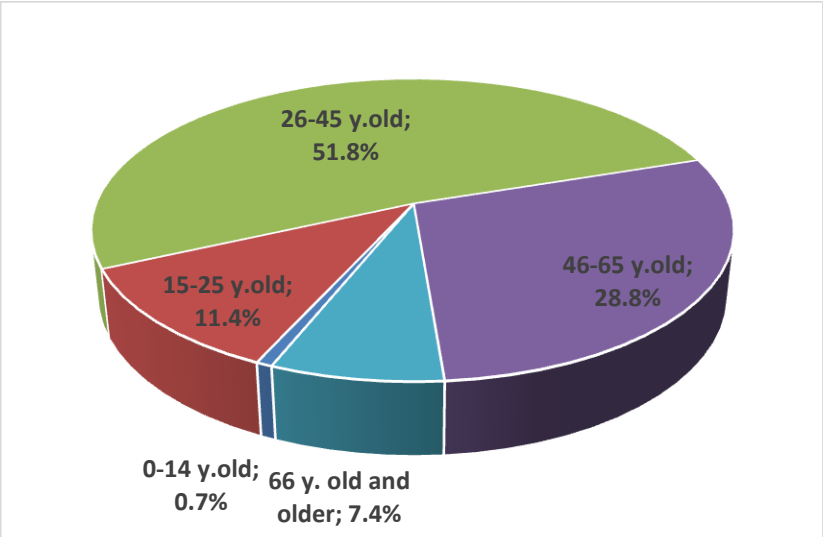
Tobacco use

Respondents were asked questions about tobacco use, awareness of tobacco use related harm and exposure to second-hand smoke. Only 22 persons under the age of 18 years reported ever smoking tobacco that can be assumed is largely underreported due to social stigma associated with tobacco smoking among minors. To make comparison of tobacco smoke indicators among IDP population with that among general population, data from *adult respondents* (18 years old or older) was analyzed and presented below.

Adult male IDPs were significantly more likely to have smoked than adult females: 75% of males and only 8% of females reported ever smoking tobacco(χ^2=1448.079, df=1, p=0.000).

Statistically significant difference was found among current smokers by gender: half of male respondents said they were current tobacco smokers at the timeof survey vs. only 3% of females (χ^2=90.162, df=1, p=0.000).

Figure 4: Breakdown of current smokers by age groups



In total, less than one fourth (23%) of all IDPs (of both sexes) were current smokers that is slightly lower than that from the General Population Survey (GPS) conducted among general population in 2015. The GPS study involving 4,805 randomly selected respondents throughout the country was conducted within the frames of the Addiction Research Development in Georgia project funded by USAID and Czech Development Agency.

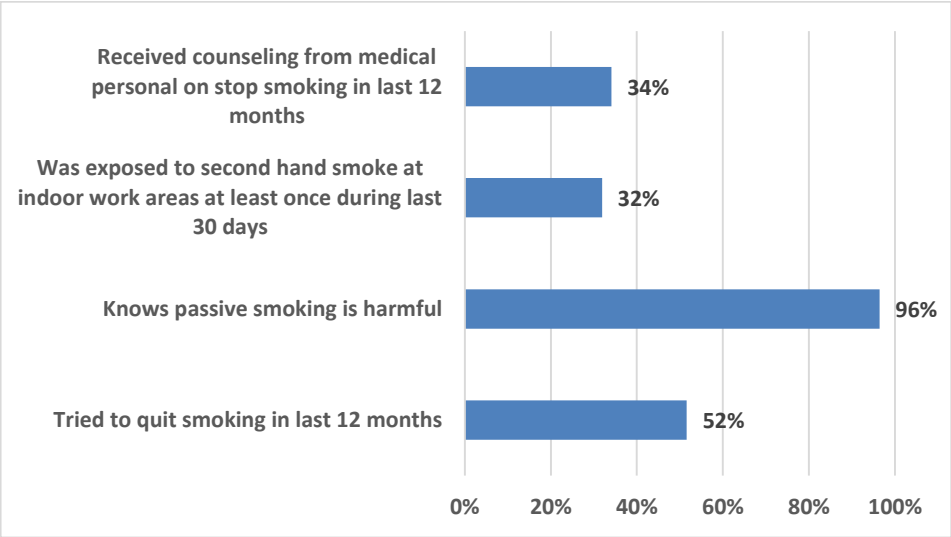
Table 8: Tobacco use among IDPs and general population (2015)

Tobacco consumption	IDPs			General population		
	Male	Female	Total	Male	Female	Total
Ever smoked tobacco (Yes)	75%	8%	36%	85%	24%	54%
Smokes currently (Yes)	50%	3%	23%	55%	6%	30%

Of those who said they currently smoke tobacco, more than half attempted to quit smoking at least once during last 12 months.

Vast majority of respondents are aware of harmful effects of secondhand smoke, but almost one third report being exposed to secondhand smoke at indoor workplaces at least once during last 30 days.

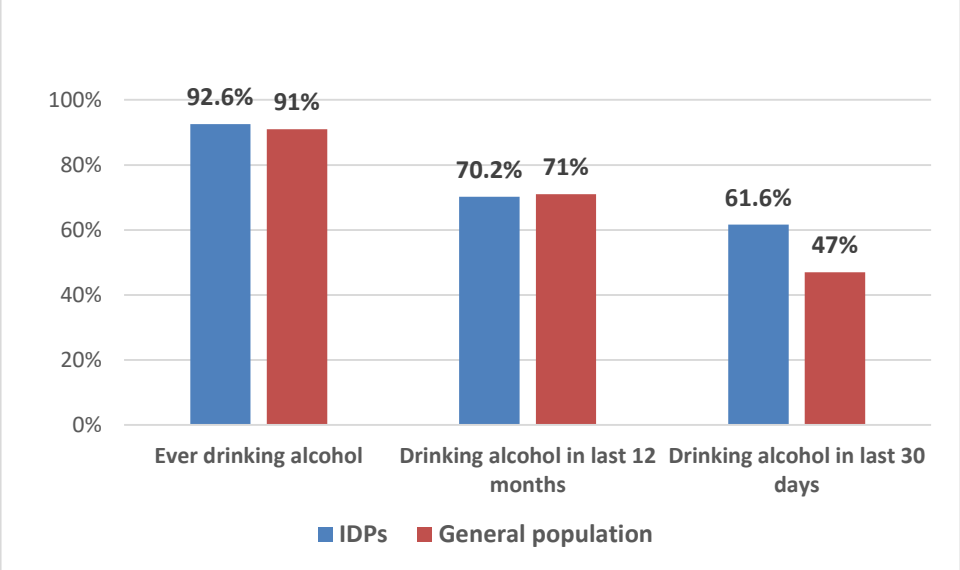
Figure 5: Awareness, attempt to quit smoking and exposure to secondhand smoke at workplace



Alcohol consumption

Vast majority of survey population reported that they consumed alcohol at least once in their lifetime; 70% reported drinking alcohol in last 12 months. Lifetime use of alcohol and alcohol use during last 12 months among IDPs are almost identical to that among general population. However,larger share of IDPs reported alcohol use during last month (61.6%) compared to general population (47%).

Figure 6: Alcohol consumption among IDPs and general population (2015)

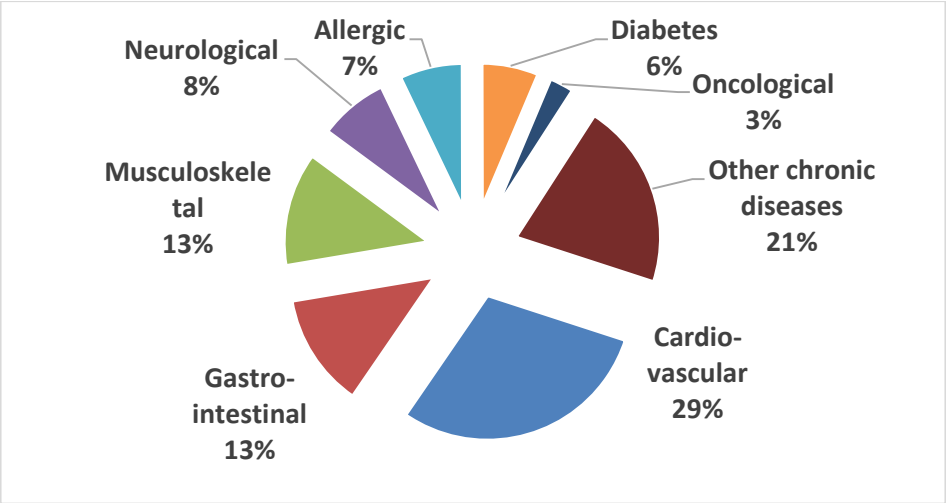


Chronic diseases

In total, 40% of all respondents(1729 persons) report being chronically ill and identify a wide range of conditions. Of them 532 report having 2 or more chronic diseases. About a thirdof occurrences (29%) of

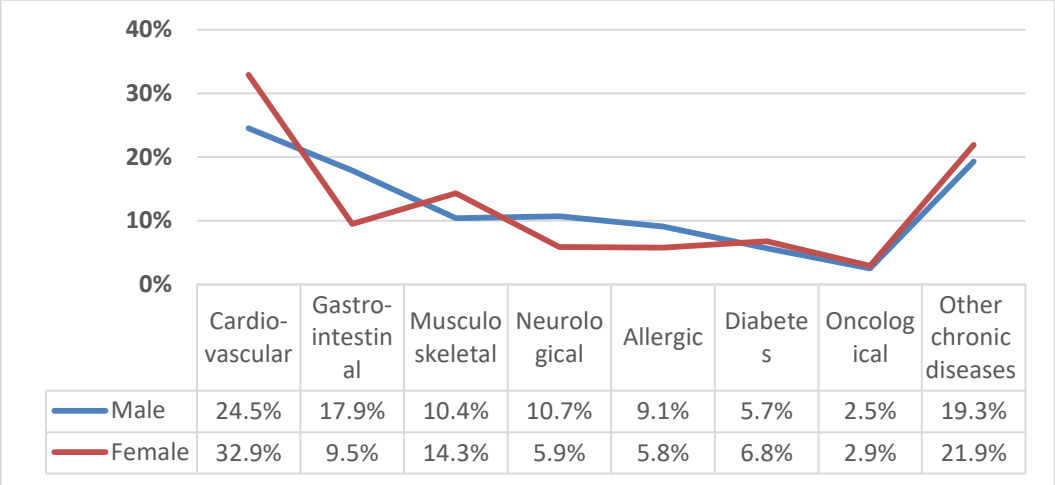
chronic diseases is attributed tocardiovascular diseases. Musculoskeletal and gastrointestinal diseases (each) constitute 13% of all occurrences of chronic diseases.

Figure 7: Occurrences of chronic diseases among IDPs



Breakdown of chronic illnesses by types of diseases among men and female follows similar trend with no visible difference by gender.

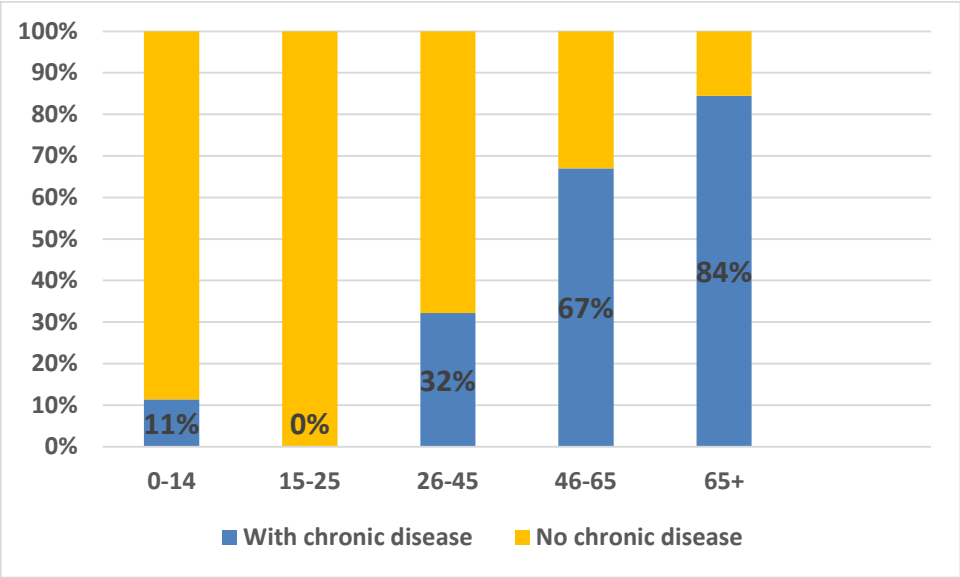
Figure 8: Chronic diseases by types among male and female IDPs



	Cardio-vascular	Gastro-intestinal	Musculoskeletal	Neurological	Allergic	Diabetes	Oncological	Other chronic diseases
Male	24.5%	17.9%	10.4%	10.7%	9.1%	5.7%	2.5%	19.3%
Female	32.9%	9.5%	14.3%	5.9%	5.8%	6.8%	2.9%	21.9%

As expected, aging is a significant risk factor for developing chronic diseases. The prevalence of chronic diseases among adult population increases as the age advances with the highest rate among those aged above 65 with 84% reporting having at least one chronic disease. Eleven percent of children under 15 years of age have some chronic medical problems, and no chronic disease was reported for young people in the 15-25 age group.

Figure 9: Prevalence of chronic diseases among IDPs by age groups

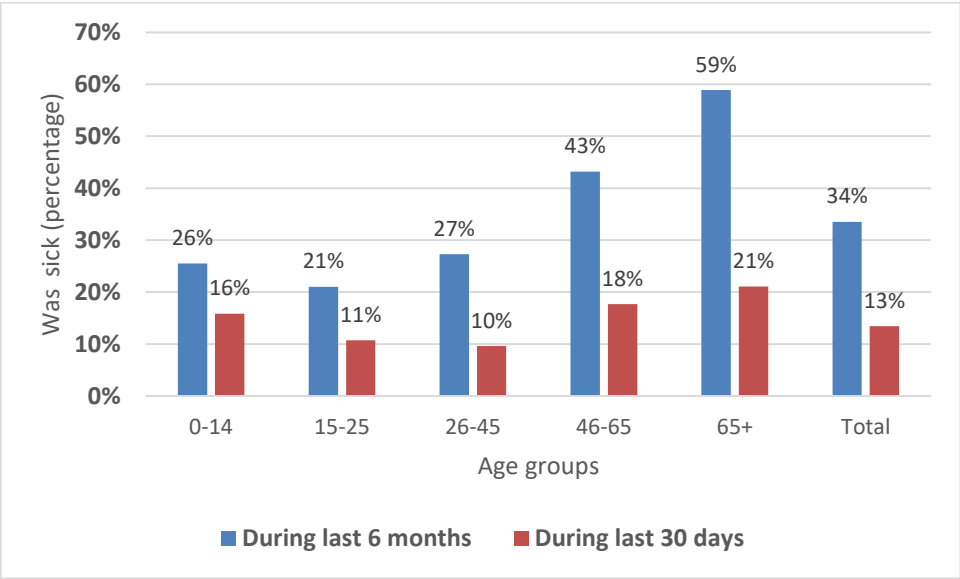


Out of the 1624 respondents with chronic disease(s), 58% said they are taking medications regularly or permanently to treat chronic disease(s).

Illnesses during last 6 months and 30 days

Of those who reported having at least one chronic disease, 16.5% said they have had some other (non-chronic) health problems during last 30 days.

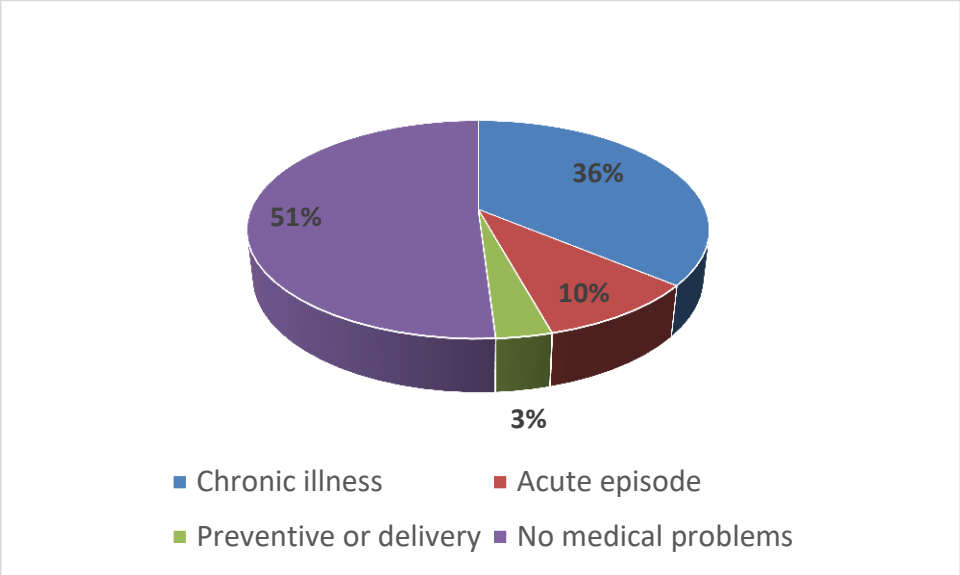
Figure 10: Illnesses during last 6 months and last 30 days by age groups



Slightly more than half of respondents (51%) reported they have not experienced any health problems during last 30 days. Out of those who reported some types of medical problems, 73.5% said that was due to

chronic disease(s); almost 10% had acute health condition; and only 3% used medical services for preventive services or delivery.

Figure 11: health problems during last 30 days



Pregnancy and delivery

During last 24 months 129 household members gave birth. These women were asked about antenatal services they received. Findings are summarized in Table 9. All women reported having done urine test at least once during the last episode of pregnancy.

Table 9: Antenatal services during pregnancies in the last 24 months

Scheduled antenatal visits during pregnancy	%	Measured blood pressure during pregnancy	%
Up to 4 visits	37.2%	At least 4 times	33.9%
5 to 10 visits	57.4%	5 to 10 times	61.2%
More than 10 visits	5.4%	More than 10 times	5.8%

User's satisfaction

A set of questions was designed to assess users' experience and satisfaction with health services:64.9% stated that they absolutely or sufficiently trust the health facilities they refer to most frequently. Only 6% said they do not trust the facility they visit commonly.

Table 10: Overall satisfaction with services at most frequently visited facility

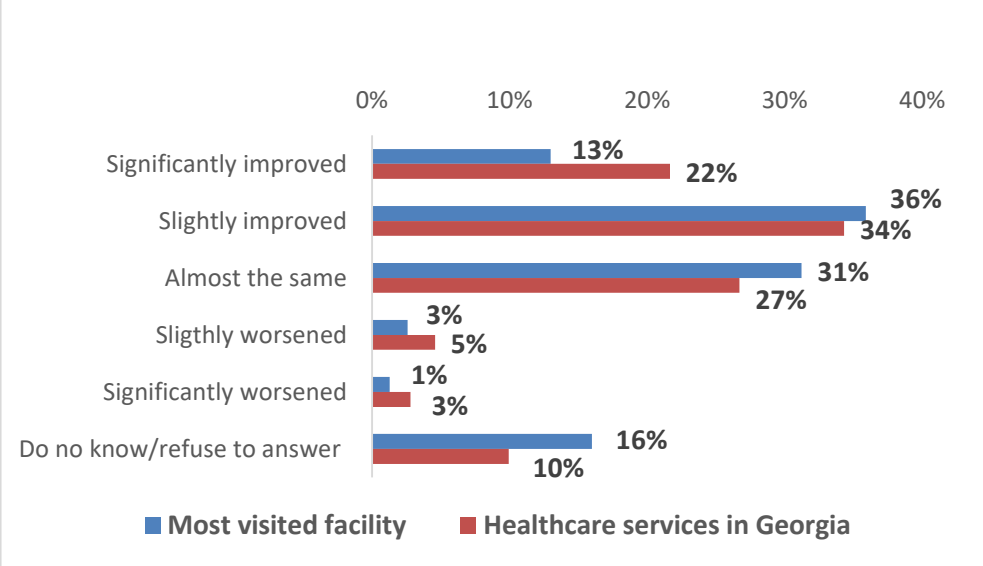
Overall satisfaction with services at most frequently visited facility		
	N	%
Very satisfied	275	22%

Satisfied	627	51%
Neutral	259	21%
Unsatisfied	38	3%
Very unsatisfied	1	0%
Don't know/Refused to answer	40	3%
Total	1240	100%

Apparently, majority of IDPs know that they do not have to pay for counseling a doctor when they seek medical service,but almost half of them are not aware how much service frees they might be requested to pay at most frequently visited facility. Despite the fact that they may face unexpected charges while receiving health services, their perception about the quality of health services is favorable.

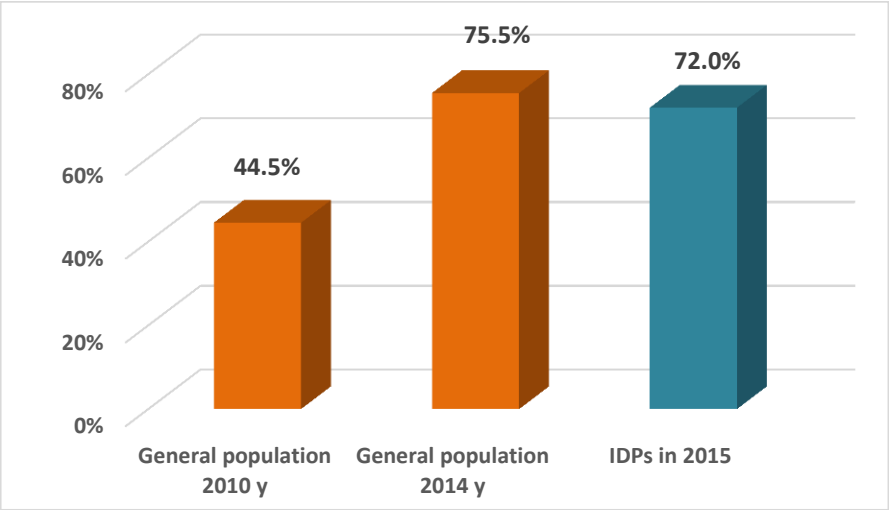
Approximately half of IDP respondents think that the quality of health services at the facility they visit most frequently as well as healthcare services in general have significantly or slightly improved over the last three years.

Figure 12: Respondents perception: Improvement of health services in general and at most visited facility over the last 3 years



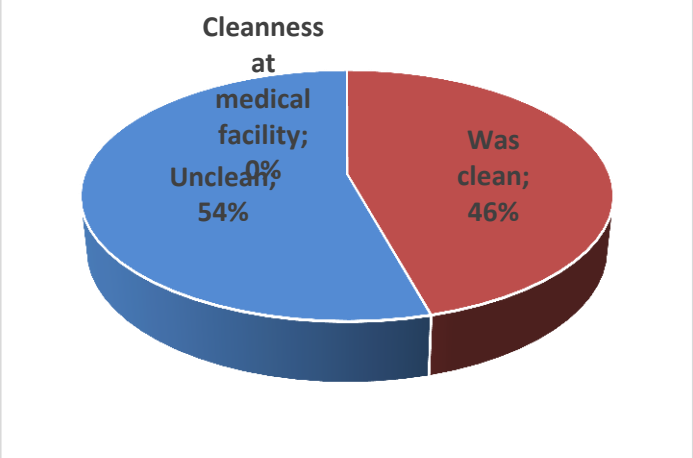
Since 2010, the percentage of services where users are given a receipt for all payments made by patients has substantially increased in Georgia. The HUES 2014 among general population found that every three person out of four service users received receipts for all payments made. This indicator is similar for IDPs as 72% of service user IDPs reported receiving receipts for all the amounts they paid.

Figure 13: Percentage of services where users got a receipt for all payments made



Hygienic condition of medical facilities remain largely dissatisfactory based on the IDPs perception: more than half respondents (54%) found the facility unclean.

Figure 14: Hygienic condition at last visited medical facility



Illnesses, health services and user charges

Out of pocket payment for chronic diseases

More than half of respondents (58%) with chronic diseases said they are taking medications regularly or permanently for the disease(s), and vast majority of them (95.4%) reported that the treatment was prescribed/advised by doctor.

On average, the patients with chronic disease spend more than 50 GEL for prescribed medications every month; 40% of patients pay less than 50 GEL, and 7% do not pay out of pocket for medications to treat chronic disease. Counseling a doctor about the chronic disease poses less financial burden on households,

however 15% still pay under the US$20, and 9% spend more than US$20 every month to consult with a doctor.

Figure 15: Distribution of households by average monthly cost related to existing chronic disease

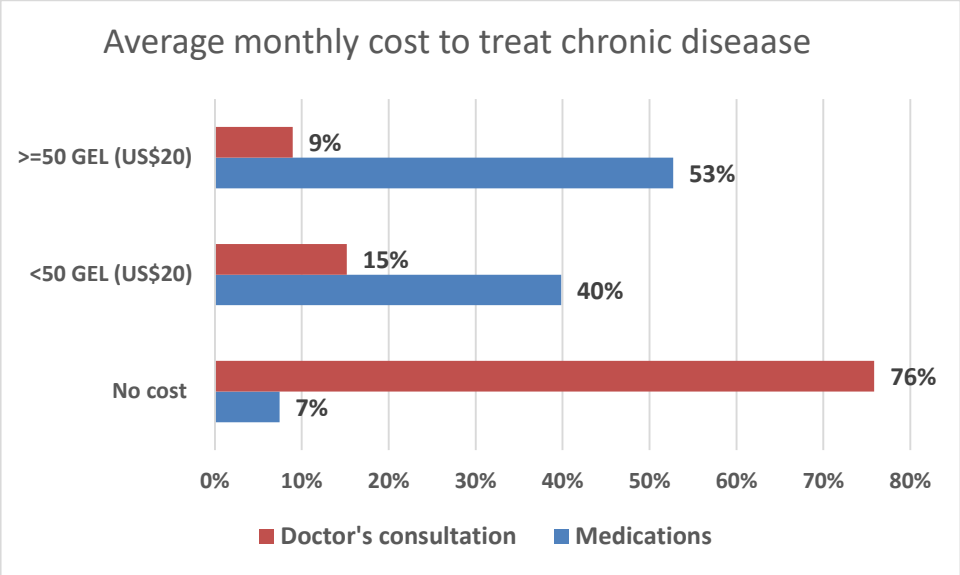


Table 11: Average out of pocket payment for chronic diseases in a month

	Mean		Maximum amount paid	
Spending for *chronic diseases* in a month	GEL	US$	GEL	US$
For medications	GEL 85.15	$ 37.51	GEL 2,000	$ 881.06
For doctor consultation	GEL 10.31	$ 4.54	GEL 300	$ 132.16
Other (nursing, physiotherapy, herbal, etc.)	GEL 4.7	$ 2.05		

Table 12: Average out of pocket payment for diagnostics for chronic diseases during last year

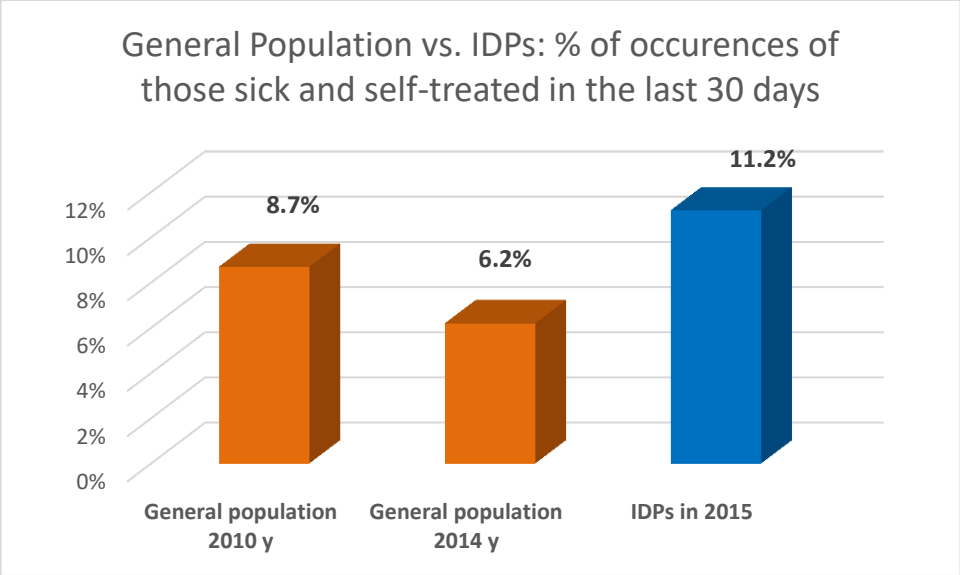
Mean of OOP for diagnostics for *chronic diseases* during last year		
	GEL	US$
Average amount paid for diagnostics per year	GEL 146.4	$ 64.51
Breakdown by types of diagnostic services:		
Clinical and laboratory diagnostics	GEL 50.9	$ 22.43
X-ray	GEL 5.5	$ 2.43
Ultrasound	GEL 18.7	$ 8.24
Tomography	GEL 26.5	$ 11.68

Self-treatment

In total 549 persons reported having acute disease in past 30 days; and 27% of them initiated self-treatment without consulting a doctor to treat the condition. Two-third of respondents (65.5%) stated they completed the self-treatment.Interestingly, self-treatment is more common practice for acute medical conditions, presumably for common flu or other respiratory diseases.

The percentage of occurrences of those sick and self-treated during last 30 days was 11.2%. As shown inFigure 16 this indicator is noticeably higher than that among general population.[11] The HUES survey conducted among general population indicates that fewer people self-treat when sick in 2014 compared with the 2010 data. It would be interesting to compare main reasons for self-treatment among IDPs and general population, however, only limited data from the 2014 HUES was accessible that limited our ability to make comparison.

Figure 16: Self-treatment during last 30 days



Patients who referred to self-treatment during last 30 days on average spent 25 GEL (US$11) for medications (median 15 GEL (US$7). The maximum amount paid by one patient for self-treatment in the previous month reached 220 GEL (US$97).

Primary reasons for not seeking medical treatment outside the household varied with the largest percentage of respondents (34.2%) reporting that treatment would be too expensive for them followed by 23.2% persons who thought the condition was not serious.

Table 13: Reported reasons for not receiving treatment outside the household

Reported reasons for not receiving treatment outside the household	N	%
Thought not serious	44	23.2%
Got better soon after being sick	20	10.5%
Could not access care due to its location	2	1.1%
Was inconvenient to access care (e.g., inconvenient operating hours)	1	0.5%
Too expensive/not enough money	65	34.2%
Could not identify good provider	7	3.7%
The patient (or household member) is a doctor him/herself	4	2.1%

[11] HUES among general population, 2014.

The patient (or household member) knows how to treat	31	16.3%
Other	14	7.4%
Don't know/Refuses to answer	2	1.1%
Total	190	100%

Health services and out of pocket payments in last 30 days

In total 531 households sought health servicesduring last 30 days. Patients, when they fall ill, are more likely to consult a specialist doctor or seek health service from hospital doctor rather than going to a general practitioner, or a family doctor. Almost half of IDP respondents (49%) who received health service during last 30 days visited specialist or hospital doctor (vs 33% consulting a family doctor or district doctor).

Table 14: Main person addressed while seeking medical services during last 30 days

Main person addressed	N	%
Family doctor	142	27%
District doctor	31	6%
Specialist doctor	219	41%
Hospital doctor	41	8%
Nurse	1	0%
Pharmacist	6	1%
Dentist/dental technician	61	11%
Lab/diagnostic technician	3	1%
Alternative provider (e.g. chiropractor, sorcerer, acupuncturist, extra-sense)	2	0%
Other	23	4%
Don't know/Refuses to answer	2	0%
Total	531	100%

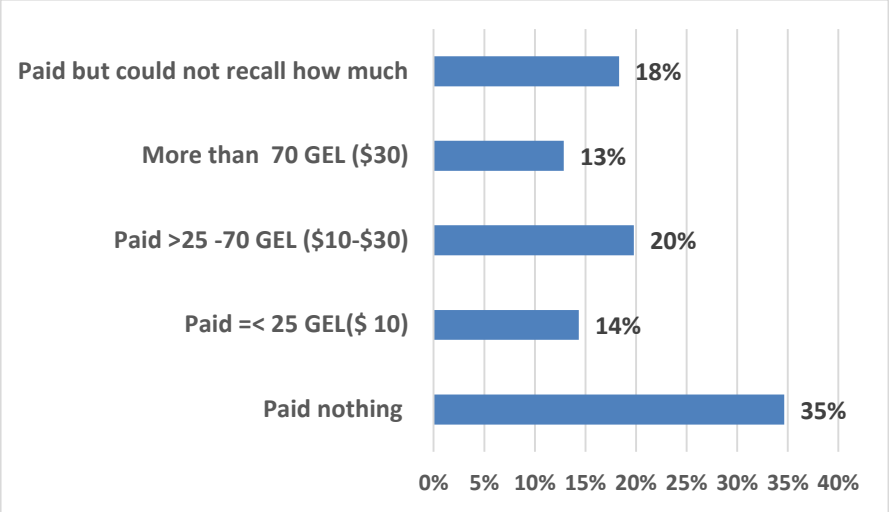
Out of 410 respondents answering questions about out of pocket payments in the last 30 days, 177 (43%) reported receiving medical services at no cost to patients. Those patients who paid for services in the last 30 days, on average they pay 195 GEL ($86). The amount paid during one occurrence of sickness by patients in last month varied considerably from zero to the maximum payment made by one patient – 5000 GEL ($2,202).

Table 15: Out of pocket payment for health services in the last 30 days

	Mean	
	GEL	US$
Average amount paid during last 30 days	GEL 195.0	$ 85.9
Breakdown of OOPs by types		
Main service provider for counseling/treatment	GEL 33.4	$ 14.70
Other medical personnel	GEL 2.6	$ 1.15
Medications	GEL 30.3	$ 13.34
Non-durable medical supplies	GEL 22.6	$ 9.95

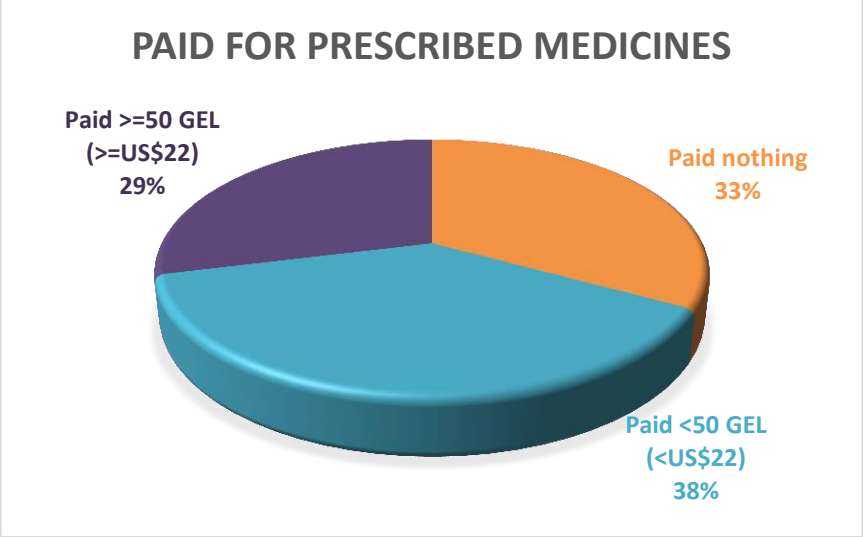
Medical equipment/appliance (e.g. wheelchair)	GEL 1.5	$ 0.64
Total diagnostic services	GEL 65.9	$ 29.05

Figure 17: Distribution of households by the amount paid for diagnostic services during one occurrence of sickness in last month



One third of IDPs did not pay for medication for prescribed treatment they received at service provider organization/medical institution. Others reported they had to buy prescribed medication outside service provider institution; 38% spent under 50 GEL (US$20); and 29% paid more than 50 GEL.Ten patients paid more than $100 (GEL 300-700) for medicines during last month.

Figure 18: Payment for medicines prescribed at medical institution but purchased outside of institution



Almost three fourths (74.5%) of IDPs reported they could cover total costs for the health service they received during last month with their household regular income; 25.5% had to mobilize funds to cover the expenses; and of them 36% borrowed money. Financial burden becomes more intense if there are more than one occurrence of sickness within a household during one-month period. In such situation, the

percentage of those who could cover healthcare cost with their household regular income decreases from 74.5% to 69%.

In total, 58 persons said they borrowed money to cover health care cost in the last 30 days; of them 74% borrowed less than 500 GEL (approx. US$ 220) and only one fourth reported borrowing more than 500 GEL.

Other OOPs for hospitalization during last 30 days

In total, 44 occurrences of hospitalization were reported during last 30 days. Of them 11 said they had to buy supplies for personal care such as soap, toilet paper, etc., spending on average 13 GEL ($6). Every third hospitalized patient reported bringing his/her own food to hospital and average OOP spent for meals per hospitalization was GEL 80 ($35).Only 6 persons said they gave a gift to medical personnel while hospitalized, though the maximum value of the gift did not exceed 30 GEL ($13).

Medicines prescribedduring last episode of sickness in the last 6 months

Out of 1,812 respondents who have used health service at least once in previous 6 months, 76% reported that medicines were prescribed by a provider; 88% of them say prescribed medicines were geographically accessible.

Less than three fourth of those who received prescriptions (72.3%; 974/1346) managed to get all prescribed medicines. Overall, patients were more likely to get all medicines when prescribed by a hospital doctor (83.3%) than by a family doctor (67%).

Figure 19: Prescription of medicines, availability of drugs and patients' adherence during last episode of sickness in previous 6 months

	Prescribed by family doctor	Prescribed by specialist	Prescribed by hospital doctor	Other	Total
Medicines were prescribed					
Yes	526 (84.3%)	635 (78.5%)	112 (73.2%)	98 (43.4%)	1371
No	98 (15.7%)	174 (21.5%)	41 (26.8%)	128 (56.6%)	441
Prescribed medicines were geographically accessible					
Yes	444 (84.7%)	568 (91.9%)	90 (84.9%)	88 (88.9%)	1190
No	80 (15.3%)	50 (8.1%)	16 (15.1%)	11 (11.1%)	157
Managed to get all presribed medicines					
Yes	350 (67.0%)	451 (73.5%)	88 (81.5%)	85 (83.3%)	974
No	172 (33.0%)	163 (26.5%)	20 (18.5%)	17 (16.7%)	372

Laboratory tests &diagnosticsprescribed during last episode of sickness in the last 6 months

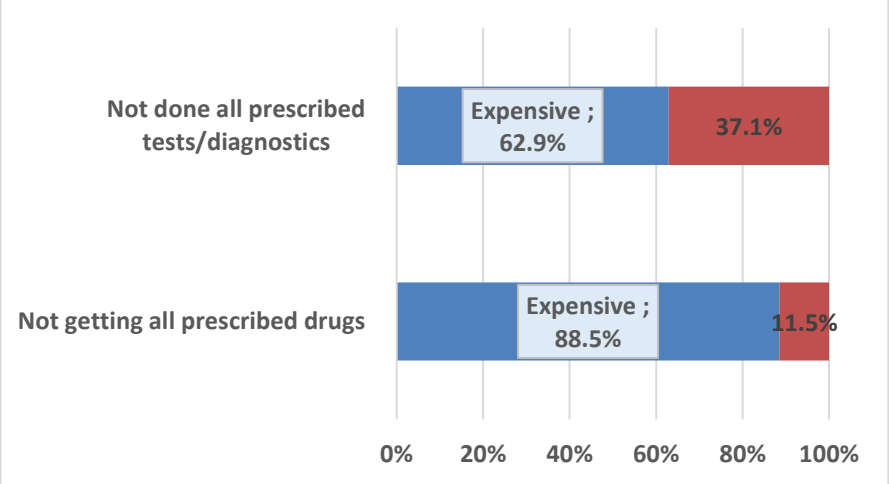
More than half of respondents (58%) who sought medical service in previous 6 months reported that a provider prescribed laboratory tests and other diagnostics during last episode of sickness. Of them 85% said prescribed lab tests were geographically easily accessible; majority (86%) followed the provider's prescription and all procedures were done.

Figure 20: Laboratory tests and diagnostics, accessibility of prescribed procedures and patients' adherence during last episode of sickness in previous 6 months

	Prescribed by family doctor	Prescribed by specialist	Prescribed by hospital doctor	Other	Total
Provider prescribed laboratory tests/diagnostics					
Yes	334 (53.4%)	534 (66.0%)	114 (74.5%)	69 (30.3%)	1051
No	292 (46.6%)	275 (34.0%)	39 (25.5%)	159 (69.7%)	765
Laboratory diagnostics tests prescribed were geographically accessible					
Yes	272 (81.2%)	473 (89.9%)	104 (93.7%)	34 (50.0%)	883
No	63 (18.8%)	53 (10.1%)	7 (6.3%)	34 (50.0%)	157
All prescribed diagnostics were done					
Yes	284 (84.3%)	458 (87.4%)	105 (92.1%)	46 (75.4%)	893
No	53 (15.7%)	66 (12.6%)	9 (7.9%)	15 (24.6%)	143

The single major reason for not getting prescribed medicines, or not doing all laboratory tests/diagnostics recommended by a health provider during last episode of sickness in previous 6 months was the cost (88.5% and 62.9%, respectively).

Figure 21: Reasons for not getting prescribed medicines and laboratory diagnostics



Hospitalization during last 12 months

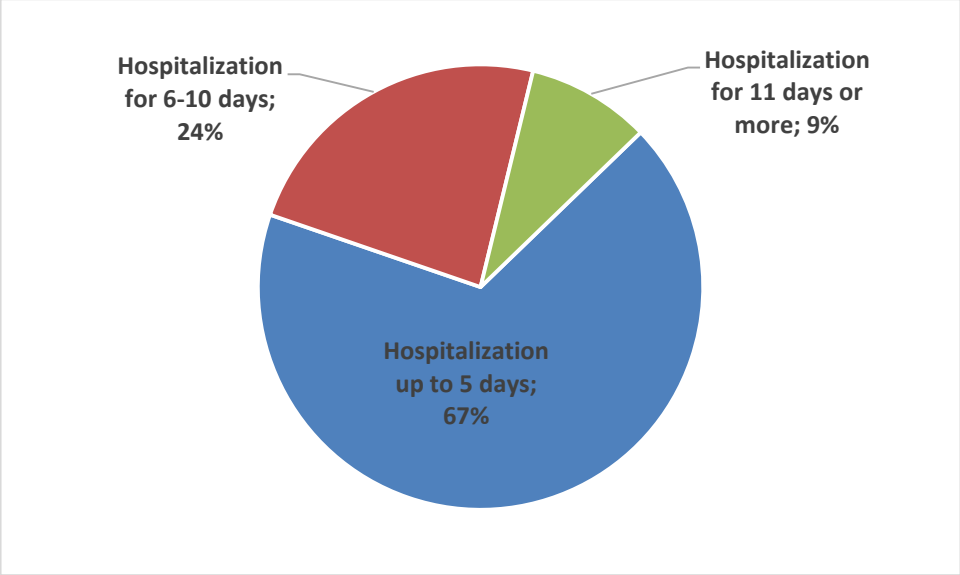
In total 323 occurrences of hospitalization was reported during last 12 months. In 2/3 of cases of hospitalization patients stayed at hospitals for up to 5 days; 24% spent from 6 to 10 days; and only 9% remained hospitalized for more than 10 days with the maximum stay –up to two months.

Table 16: Duration of hospital stay during last 12 months

Hospitalization duration (number of hospital days)	
Mean (# of days)	6
Median (# of days)	5
Frequencies of cases of hospitalization by duration	
Hospitalization up to 5 days	218

Hospitalization for 6-10 days	76
Hospitalization for 11 days or more	29

Figure 22: Frequencies of cases of hospitalization by duration of hospital stay



Reasons for hospitalization during last 12 months varied considerably that are grouped and presented in Table 17. Most cases of hospitalization are attributed to cardio-vascular diseases, such as: hypertension, heart diseases, chest pain, cardialgia, chronic dyspnea, lower extremity swelling, etc. Respiratory diseases and abdominal/gastrointestinal disorders also represent most frequently cited reasons for hospitalization. Out of all patients hospitalized during last 12 months, 42% (139 IDPs) reported having surgery.

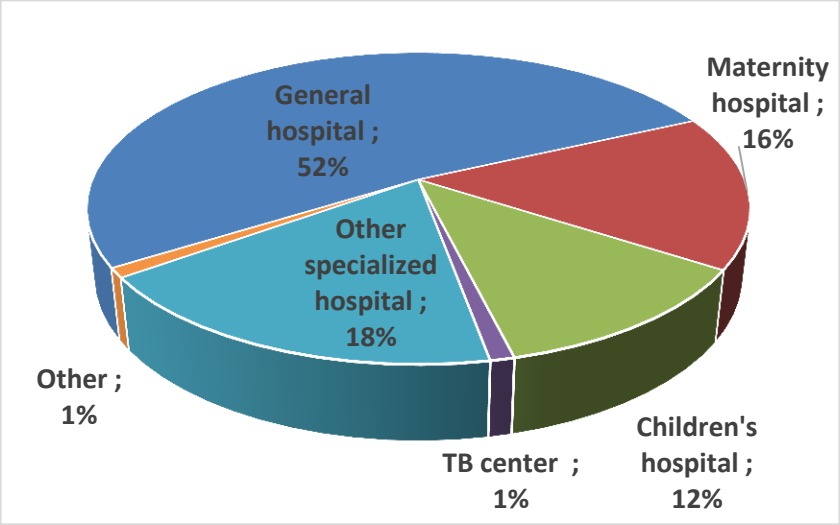
Table 17: Reasons for hospitalization among IDPs during last 12 months

Reasons for hospitalization	Number	%
Cardio-vascular diseases	61	18%
Respiratory diseases /pneumonia/influenza/bronchitis/asthma	60	18%
Abdominal/gastrointestinal /ulcers/	32	10%
Deliveries (normal)	28	8%
Deliveries (C-section)	22	7%
Neurological/attack of migraine, stroke, myositis, neuralgia, headache, back pain/ psycho-emotional disorder	18	5%
Other trauma/injuries	15	5%
Cancer	10	3%
Gynecological	10	3%
Urogenital	9	3%
Musculoskeletal/Rheumatism/arthritis	7	2%
Tuberculosis	4	1%
Diabetes	4	1%
Skin problems/dermatitis	3	1%

Road traffic accident	3	1%
Eye chronic diseases	3	1%
Goiter	2	1%
Poisoning /intoxication	2	1%
Other acute illness	20	6%
Other chronic diseases	12	4%
Other	5	2%
Total (all hospitalization during last 12 months)	330	100%

More than half of cases of hospitalization occurred in general hospitals, followed by specialized (18%), maternity hospitals (16%) and children's hospital (12%). 74% of those hospitalized say they were hospitalized in the same region they reside.

Figure 23: Hospitalization by types of medical institutions



Hospitalization cost during last 12 months

Out of 330 cases of hospitalization during last 12 months, 270 gave answers to the questions about out of pocket payments incurred during hospitalization. Of them, 98 (36%) reported that the treatment cost was fully covered with zero co-payment involved. Majority reported paying certain amount for hospitalization during last 12 months, and the amounts of OOPs reported varied considerably from as low as 16 GEL (US$7) to the maximum -12,200 GEL ($5,374).

Table 18: Out of pocket payments during hospitalization in last 12 months

	Number of hospitalization	Out of total patients hospitalized (N=270)	Out of those who paid for hospitalization (N=172)
Paid nothing	98	36%	NA

Paid <=150 GEL ($66)	42	16%	24%
Paid >150 -1,000 GEL ($66-$440)	94	35%	55%
Paid >1,000 - 2,500 GEL ($440-$1,100)	22	8%	13%
Paid more than 2,500 GEL (> than $1,100)	14	5%	8%
Total number of hospitalization	270	100%	100%

As shown in Table 18, out of those 172 cases of hospitalization involving OOPs, majority (55%) paid from 150 GEL to 1,000 GEL. One fourth paid under 150 GEL. At least one out of every five IDPs being hospitalized during last 12 months (21%)paid more than 1,000 GEL.

While analyzing OOPs data per hospitalization during last 12 months, the average spending (524 GEL ($231) was considered to be skewed due to *two "outliers"* in the dataset reporting the highest OOPs:

- Case 1: OOP 7,600 GEL ($3.348); Reason for hospitalization – rheumatism
- Case 2: OOP 12,200 GEL ($5,374); reason for hospitalization- hypertension/heart disease.

For calculating average amount of OOPs paid during hospitalization in last 12 months, several scenarios were used.
Scenario 1 (SC1): Average OOP paid by IDPs when all hospitalized cases are included is $231 per case.
Scenario 2 (SC2): excludes those who paid nothing for hospitalization in last 12 months. Those households who paid for hospitalization, on average paid $363.
Scenario 3 (SC3): when two outliers are excluded from the dataset, the mean OOP reduces to $316 per hospitalization.

Table 19: Out of pocket payment during hospitalization in last 12 months: mean and median

OOPs	Out of total patients hospitalized (N=270) (SC1)		Out of those who paid for hospitalization (N=172) excluding those who paid nothing (SC2)		Out of those who paid for hospitalization (N=170) excluding 2 outliers*) (SC3)	
	GEL	US$	GEL	US$	GEL	
Mean of OOPs	GEL 524.35	$ 230.99	GEL 823.11	$ 362.60	GEL 716.32	$ 315.56
Median of OOPs	GEL 150.00	$ 66.08	GEL 350.00	$ 154.19	GEL 338.50	$ 149.12

It is difficult to draw reliable conclusion whether IDPs pay less or more for health services than general population due to lack of comparable data. The 2014 HUES found that the average amount spent per hospitalization in last 12 months was GEL 365 ($206,[12] current) in 2014 that was lower than in 2010 -578 GEL ($342, current). Even though that IDPs enjoy having most comprehensive package under the universal health care with minimal co-payments than other population groups, analysis suggests that IDPsare not financially more protected than general population: the mean of OOPs paid by IDPs is*higher* than that for general population ($231 vs $206, respectively).

[12] Exchange rate 1USD=1.77.GEL; 2014 National Bank of Georgia

Table 20: Receiving receipts for the fees paid for hospitalization during last 12 months

Did your receive a receipt for the fees paid for hospitalization		
	Number	%
Yes, all receipts	135	68%
Only part of receipts	15	8%
No, did not receive	29	15%
Don't remember	19	10%

As shown in Table 20, Majority of households (68%) received receipts for all the fees paid by them during hospitalization in last 12 months; 15% did not receive receipts, and 8% received only part of the receipts. Only one third of those who paid out of pocket(33%; 57/172) received reimbursement for the cost incurred. Most of them were reimbursed by the Sate under the Universal Healthcare program. Rough calculation of total OOPs and total amounts reported as reimbursed suggests that 54% of OOPs are reimbursed by the State or other health insurance companies. (Interestingly, none of the two patients (the outliers) who paid 7,600 GEL and 12,200 GEL reported receiving any reimbursement of the costs incurred during hospitalization.)

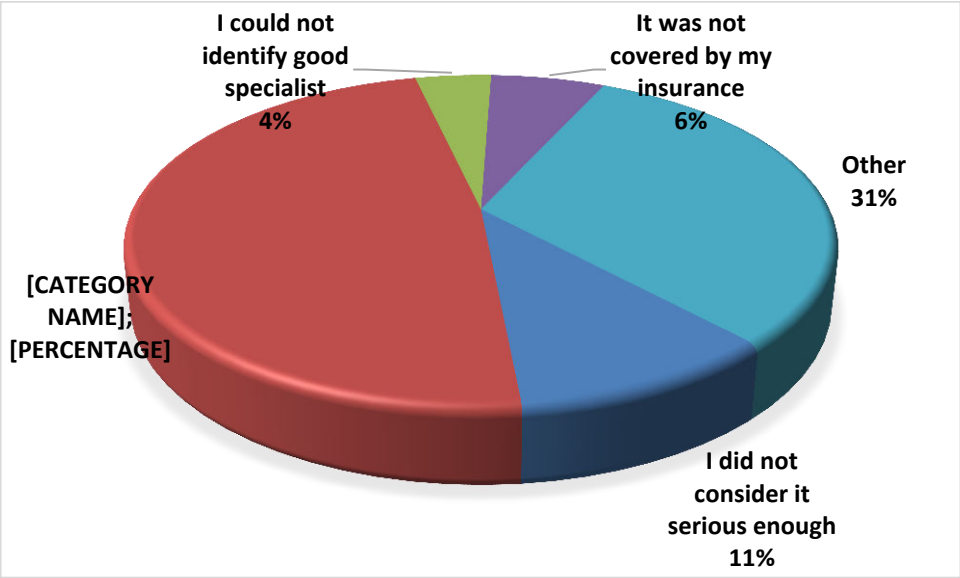
Table 21: Reimbursement by types of health coverage/insurance

Types of health coverage	# of occurrences of reimbursement
Universal healthcare	50
State vertical programs	1
State program for military personnel	1
Corporate health insurance	3
Other/individual	2

No hospitalization when needed

In total 50 households told that they needed hospitalization and in 44 cases hospitalization was recommended by a medical doctor. Reasons for refusing hospitalization are shown in Figure 24. Most frequently cited reason was thehospitalization cost: 48% said it was too expensive and they could not afford to pay for the service even though all of them were insured under the IDP status or were beneficiaries of UHC.

Figure 24: Reasons for no hospitalization when needed (N=50)



Conclusions and Policy Recommendations

- **State supported universal health care and targeted healthcare benefit packages for specific population groups have improved access to health services and reduced financial burden on patients.**Ninety percent of all survey respondents were beneficiaries of either IDP-targeted healthcare coverage or other packages under the Universal Health Care. The share of uninsured population did not exceed 1%. Majority survey respondents state that health services are free of charge or affordable to them. Originally, one of the objectives of the *Health Service Utilization and Expenditure Survey among IDPs* was to measure the effect of targeted health insurance coverage for a selected group of IDPs (as a result of the 2008 Georgia-Russia war) versus untargeted, integrated approach to health financing for remaining group of IDPs. However, the survey results have revealed that majority of survey respondents were entitled to almostsimilar healthcare benefits: only 16% of survey respondents were beneficiaries of untargeted, universal healthcare program, and vast majority of IDP households were beneficiaries of either IDP-targeted program, or other targeted packages for specific, vulnerable population groups, such as households under the poverty line, children under <5 years old, teachers, military personnel, and pensioners. Due to this, no visible difference between across different targeted health care benefit packages was found.
- **The survey results indicate that awareness of universal healthcare and targeted health benefit packages is suboptimal.**Efforts should be intensified to provide more information to beneficiaries about the services they are entitled to. It is recommended to establish so called patients education clubs where trained community leaders will work with individuals and groups in their communities to increase their awareness through informal education, engagement and community support. Some national stakeholders also recommend to create a network of community nurses employed by public health institutions/MoLHSA to ensure more sustainable and formal response.

- **The survey has found that self-treatment remains to be more commonly practiced by IDPs than general population** (11.2% among IDPs vs 6.2% among general population[13]). Thorough assessment of the factors affecting IDPs health behaviors can become a subject of further research. Most likely, IDPs lack information about negative consequences of self-treatment that is potential contributor to pathogen and drug resistance as well as increased morbidity. Lack of knowledge about adverse effects of self-medication should be addressed through formal or informal education. In addition, there is need to implement effective mechanisms to control enforcement of the drug prescription law that came into force in September 2014 to make sure that controlled drugs are not sold over the counter without a prescription.

- **Majority of IDPs think that the quality of healthcare services has improved over the last three years, but more than half of respondents believe that sanitation and hygiene conditions at medical institutes are bad.** Cleanliness of medical institutes is one of the key dimensions of quality of care, and patients' perception of cleanliness is one of the key indicators of patients' satisfaction.Obviously, establishing higher standards and maintenance of the hygiene at medical facilities should become one of the priorities of the State as well as private healthcare provider institutions. The factors to be considered might be diverse, including inappropriate facility design, poor infrastructure and obsolete equipment, lack of consumables and erratic supplies, as well as poor motivation of personnel and patients/community to upkeep good hygiene at medical facilities.

- **Getting prescribed drugs and laboratory diagnostics remains to be a major financial barrier for IDPs:**Slightly more than one fourth of patients could not buy all prescribed drugs and every seventh patient could not do all instrumental and laboratory diagnostics prescribed by medical doctors. The most frequently cited single reason for non-adherence is high price of drugs and services. The Government of Georgia recognizes the importance of affordability of essential drugs and has taken further steps, such as: provision of 50- 100 GEL vouchers to cover 50% of drug's prices for pensioners, disabled persons, and children; as well as offering 90% co-payment for drugs to treat certain diseases (cardio-vascular, diabetes, thyroid goiter, etc.). However, the problem still persists and the affordability of medicines remains largely unsolved.

  It is recommended that the Government revisits health benefit packages and elaborates rational schemes that would reduce financial burden for at least most vulnerable population groups, including IDPs. This may become even more critical given that the cost of health services and medicineshas been on rise. Based on the findings of most recent research – *Health Care Barometer*conducted by *Curatio International Foundation* in 2017, the majority of health experts (76%) believe that the cost of medicines has increased slightly or significantly over the last 6-month period, and moreover, half of the respondents anticipate that the cost will further increase in the next 6 months.[14]There are numerous factors that potentially contribute to high cost of medicines in Georgia. Some of them are summarized in the assessment of the Georgia Pharmaceutical Market

[13] Health Service Utilization and Expenditure Survey among general population, 2014. World Bank, Ministry of Health
[14] Health Care Barometer in Georgia, Curatio International Foundation, IX wave, http://curatiofoundation.org/wp-content/uploads/2017/09/HSB-9-Results_September-18-2017.pdf?utm_source=Barometer+experts+-+9th+wave&utm_campaign=f9a707710a-Bar+%239_sharing+with+respondents&utm_medium=email&utm_term=0_14f1e3f2a8-f9a707710a-451376245

conducted by Transparency International Georgia in 2012.[15]These factors include the following: strong concentration of market power of a few large companies that are able to dominate the pharmaceutical market; potential conflict of interest as two largest Georgian pharmaceutical companies also own insurance companies and hospitals, and may be tempted to promote certain sets of locally produced and costly medicines; potential influence of pharmaceutical industries on prescription behavior of most doctors who continue to receive incentives in various forms: gifts, funds for continuous education program and conference attendance, etc.[16; 17]; absence of reference pricing, etc. Obviously, to make drugs more affordable not only for IDPs, but also for population in general, substantial efforts should be undertaken not only by the government, but also by civil society that needs to strengthen its watchdog and advocacy functions, and engagement in public policies.

- **Even though that targeted health care benefit program for IDPs and other targeted programs of UHC have improved access to health care, it could not provide full protection of households against catastrophic health care cost**. Out of pocket payments, particularly for hospital care varied considerably amounting in some cases to thousands of GEL. Few respondents also stated that refrained from hospitalization, when prescribed, due to anticipated high cost. It is recommended to conduct qualitative research to find out why IDPs do not refer to those hospitals where the cost of treatment will be close to the reference prices set by the State per disease classification. In such settings, patients would be able to receive treatment at no cost to them or with smaller OOPs involved. The study should examine whether the reimbursement tariff established by the Government is far below the market price, and, thus, is unlikely to ensure high quality healthcare at the hospitals that are preferred and most-trusted by patients. The research findings may inform health officials as well as community groups about the underlying reasons that can stimulate the public debate over the reference pricing, and may trigger policy changes.
- **The need for systematic research**: The *Health Service Utilization and Expenditure Survey among IDPs* conducted through the support of ELRHA/R2HC has ever in Georgia has generated valuable and reliable information, and established a baseline about the impact of ongoing healthcare reform for IDP population in Georgia. It is highly recommended to conduct follow-up study to assess the effect of fast-changing policies and operational models in health care system in the country. Trend analysis will be instrumental for health officials and policy makers enabling most rational and informed decision making process. Repeated studies can be conducted in very two or three years. Even though the survey instrument can be further optimized, researchers should ensure comparability of data across studies. While refining the survey instrument further, engagement of national stakeholders and civil groups should be ensured. It is advisable to have more standardization with the HUES questionnaire that would enable to observe the difference among targeted and non-targeted health benefit packages for IDPs, other vulnerable groups and general populations.

[15]Transparency International Georgia. The Georgian Pharmaceutical Market With the support of the Embassy of the Kingdom of The Netherlands. 2012. Tbilisi, Georgia

[16] Quality and accessibility of medicines – challenges of Health care in Georgia. Prepared within the OSGF funded project: "Health Policy monitoring for quality and accessible medicines." 2015. Tbilisi, Georgia.

[17]Centers for Medicare and Medicaid Services (2014) Official website for Open Payments (the Sunshine Act). http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/index.html. Accessed 09.17.2017