Georgia WHO mission: Public Health Services, 7-10 May 2017

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Background

Georgia's population is 3.7 million, and from July 2017 it is classified as an lower-middle-income economy by the World Bank[1], with 10% of the population continue to live under the poverty level. Live expectancy is 70 for males and 78 for females. Infant mortality and under-five's mortality is 2.5 times higher than elsewhere in Europe, indicating health system[2] performance issues. Proportion of GDP spending on health is 8.2% with 2.8% designated for public health.

The WHO Public Health Services Programme has been invited to support the Ministry of Labour, Health and Social Affairs (MOLHSA) of Georgia and the National Center for Disease Control and Public Health (NCDC) as they work intensively on the strategic development of the public health system in Georgia and elaboration of the associated action plan, which aims to strengthen capacities and services of the existing public health model. The invite followed Georgia's participation in the Coalition of Partners expert meeting in Jan 2017, where Georgia took an active role in outlining the key issues in relation to strengthening public health services, focusing on the key enabler functions such as development of the public health workforce and effective governance and management of public health functions.

The mission was undertaken as part of a package of WHO health systems missions, including health systems finance and integrated people-centered care.

The **mission objectives** were:
(i) To discuss current public health services in Georgia with a particular focus on:
a. implementing national strategies/programmes at the municipality level
b. institutions and procedures/mechanisms for enforcing key public health legislation (i.e. tobacco-control law, communicable diseases etc.)
c. integrated solutions / collaboration of the primary health care with public health
d. human resources for public health incl. education of public health professionals
(ii) To support the discussion in regard to the development of a long-term vision for public health in Georgia.

The **mission team** consisted of five individuals in total:

[1] World Bank 2017 https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups

[2] **Tallinn charter definition of Health System**: A health system is the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health. Health systems encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health.

- WHO Programme Manager Public Health Services, Dr Anna Cichowska,

who was accompanied by four international experts from the Netherlands, France, UK and Lithuania:

- **Neringa Tarvydiene** – Director of Klaipeda District Municipality Public Health Bureau, Lithuania
- **Anne Bruant-Bisson** - Inspector at the "Inspection Générale des Affaires Sociales" (IGAS) which is the French Government Audit, Evaluation and Inspection Office for Health, Social Security, Social Cohesion, Labour and Employment policies and organizations. Previously Deputy Director General of the former French Public Health Institute (Institut de Veille sanitaire, now Agence Santé publique France)
- **Salman Rawaf**, Professor of Public Health and Director of the WHO Collaborating Centre on Primary Care and Public Health (Imperial College London UK)
- **Kasia Czabanowska** - Associate Professor at the Department of International Health at Maastricht University. And (at the time of the mission) President-elect of Association of Schools of Public Health in the European Region (ASPHER).

Caveat to the findings presented in this report: as this was the first mission to Georgia of the Public Health Services Programme, and covering a vast technical area in four days, the assessment findings and proposed areas of focus for further technical work should be taken as **preliminary**, and warrants closer consideration in due course.

Situation analysis

Public Health Services and the health system in Georgia.

The health system in Georgia has moved away from the Semashko model it inherited at independence in 1991. The system is now highly decentralized and was extensively privatized under reforms introduced from 2007 to 2012. As part of this reform programme, the system was also heavily deregulated and MoLHSA is now working to ensure the quality of care provided is adequate. Since 2012, Georgia has been striving to provide universal health coverage through a social health insurance model, although the coverage at present is still limited with a high proportion of out of pocket spending (60% of healthcare).

The Public health system in Georgia has been developed based on the legacy of Sanepid. As part of the restructuring, two different public health "authorities/capacities" have been created initially: a) *public health* (covering surveillance, outbreaks, disease prevention and health promotion etc.) and b) *sanitary inspectorate*. Sanitary codex was endorsed and includes all sanitary control. Later on sanitary service was abolished; different parts were transferred to different institutions, e.g. food safety and drinking water to Ministry of Agriculture; while other waters are under Ministry of Environment.

The National Center for Disease Control and Public Health (NCDCPH) was created in spring 2007, after a merger of the Public Health Department and the National Centre for Disease Control and Medical Statistics. NCDCPH is responsible for the public health of the entire population, including immunization, surveillance, disease prevention,

health promotion and the laboratory system for health, and coordinates the public health lab services based on "One Health" principle together with the Ministry of Agriculture. Public Health Law has been endorsed in 2007. The structure of the main public health structures is as follows:

- The National Centre for Disease Control and Public Health (NCDCPH) – incl. public health laboratory network
- 9 regional branches of the NCDCPH
- Public health centers in 61 municipalities

While the first two structures are connected in terms of their work programme with coordination provided centrally by the NCDCPH, the municipality centers are under local authority control. The NCDCPH provides some funding to the municipality centers (e.g. certain surveillance, outbreaks etc.); however there is little alignment between these entities.

Health system has been extensively privatized in Georgia, 90% of hospitals at the municipality level and primary healthcare, are private. Public health centers remain publicly funded. Hospitals are obliged to report to public health centers, but the authority of public health centers seems to be very low; the centers have no powers to act as inspectorates. Georgia would like to improve collaboration between public health and primary care to improve population health. Good examples of ability for implementation have been observed with the successful elimination of malaria and the current Hep C Elimination Programme. Progress on TB control and mother-to-child HIV transmission has been made, but both remain high on political agenda.

Burden of disease. As in many countries in the European region the burden of disease is dominated by non-communicable diseases (NCDs), with reported NCD mortality of 93%. Worryingly, 69% mortality is reported to arise from cardiovascular diseases (CVD) alone (i.e. 2/3 of the population in Georgia dies from CVDs). Although data quality issues have been quoted, the numbers remain of serious concern. Particularly as it appears that there is lack of information on the specific root causes and issues that are surrounding these statistics in the Georgian context. Prevalence of smoking, alcohol use and obesity is showing in upward trend for all of these health topics. 22% of mortality in Georgia is associated with tobacco use. There is a clear need to mobilize the whole health system to address these issues.

Public health outcome driven service delivery. The team observed limited systematic approaches to link healthcare and public health policy and service delivery to population health needs and population health outcomes. E.g. in view of the above mentioned burden of disease pattern, it was noted that disease prevention and health promotion practices for NCDs are still underdeveloped areas of practice both at national level (MOLHSA/NCDC) and local municipality level. The Georgian system is mainly orientated towards acute care (hospital care) and communicable disease control.

Population and systems approach to health. The current vision to achieve improved public health outcomes, and how this translates into policy development and public health practice, lacks a whole-systems approach and does not systematically take into

account population health needs and public health outcomes. There is e.g. a big discrepancy in the available capacity and capability for public health between the national and local level within the (public) health system. Especially public health authority at the local level, to enable clear public health leadership across sectors (healthcare, public health, social care, education etc), is lacking. Moreover financing of public health services at local level comes from multiple sources and it remains unclear to the visiting team how public health financing and spending operates at local level to improve the health of the population. Spending on healthcare remains a priority. Efficiency and impact are key challenges for both local and national public health programmes.

Enforcement of laws and regulations that protect health. Law enforcement, supervision and control were to be implemented through a specific State department, in accordance to the sanitary Code (2003 Law on the sanitary code). The code was never enforced and was abolished in 2007, with two major impacts:

- law enforcement functions, as well as part of the inspection function, are now divided and delegated to the ministries of Agriculture, Environment and Health as well as local municipalities;
- some major sectors have been left beyond regulation (e.g. hazardous chemicals registration, sanitary assessment and control of water supply, sewage systems and seawater-using facilities, sanitary control of public facilities, occupational health regulations and control, indoor air quality, sanitary control of most daily consumer goods).

As all healthcare services became private during that time, sanitary control of healthcare and social healthcare providing services became very difficult. The enforcement law function is thus very weak to non-existent whereas it should be central to the public health system.

Preliminary feedback

1. ***Addressing CVD, and NCDs as a whole, should be a key priority for Georgia in light of the reported burden of disease pattern.*** Prevention, including early detection and effective management (i.e. secondary prevention), and health promotion are effective approaches to do this and should be prioritized. A paradigm shift towards prevention and health promotion is needed at all levels of the health system.

The WHO team identified the following suggestions for possible next steps:

a) An in-depth exploration of the root causes of the high CVD mortality in the Georgian context;
b) A national multi-disciplinary policy dialogue (incl. policy makers, professions, international experts) focusing on prevention, including the role of primary healthcare, and health promotion;
c) The National Center for Disease Control and Public Health (NCDCPH) could consider how they can make prevention and health promotion their core agenda, i.e. give the ''Public Health'' element of their institute's name explicitly a more prominent role;

d) Learn more about options to establish a ''Director of Public Health'' role, with appropriate authority, at local level. Study tour to England (and/or other countries) where such a role exists may be a good starting point. The study tour would focus on addressing NCDs;
e) Review the existing funding arrangements for prevention and health promotion activities at national and local level.

2. ***A whole-systems approach should be taken when considering strengthening public health services in Georgia.*** Based on the current state of public health service management and practice in the country this will require significant changes in the way modern public health is understood and practiced, particularly at local level. As a first step this includes a) establishing strong accountability structures and legislative mandate for public health outcomes (governance, finance & legislation), b) enabling cross-system/cross-sector leadership and stakeholder engagement (i.e. public health leadership) towards improved public health outcomes (incl. integration e.g. with primary care practice), and c) building capacity of modern public health competencies in the health workforce.

The WHO team identified the following suggestions for possible next steps:

- Prioritize establishment of clear financing structures and accountabilities linked to public health outcomes.
- The study tour mentioned under point 1 could provide a good starting point to examine governance, finance & legislation for public health outcomes in countries with a strong track record on this, including its practical manifestation at local level.
- Empowerment of public health practice and individuals, especially at local level, to practice cross-systems/cross-sector leadership for improved public health outcomes. This can be done e.g. through the establishment of a 'Director of Public Health' role with adequate authority across sectors. More generally public health leadership competencies and other modern public health practices could be strengthened through relevant seminars and training events as part of a continuous quality improvement programme.

3. Sanitarily control and inspection: enforcement law function is very weak, whereas it should be central to the public health system. From an organizational perspective, the splitting of functions between the ministries in charge of different public health-related regulations is not an issue *per se,* provided a strong coordination process is established and a coordinating authority is clearly identified, preferably at the ministry in charge of public health. While (re-)centralizing the implementation of public health policies may look desirable; in reality it might prove counterproductive as the needs of the population are better attended to at the local level. A stronger coordination and authority, including at local municipality level, is required. The question of a specific sanitarily control and inspection workforce should be considered. As for the domains currently not covered by regulations, they clearly have to be addressed as a matter of urgency through passing of relevant laws.

The WHO team identified the following suggestions for possible next steps:

- Establishment of a stronger authority and coordination for sanitary control and inspection across ministries; and national-municipality level public health practice.
- Formulate laws for the domains currently not covered by any regulations.
- Review of the capacity of the current sanitarily control and inspection workforce across the system.

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