Using the *Package of interventions for rehabilitation* in Georgia

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Contents

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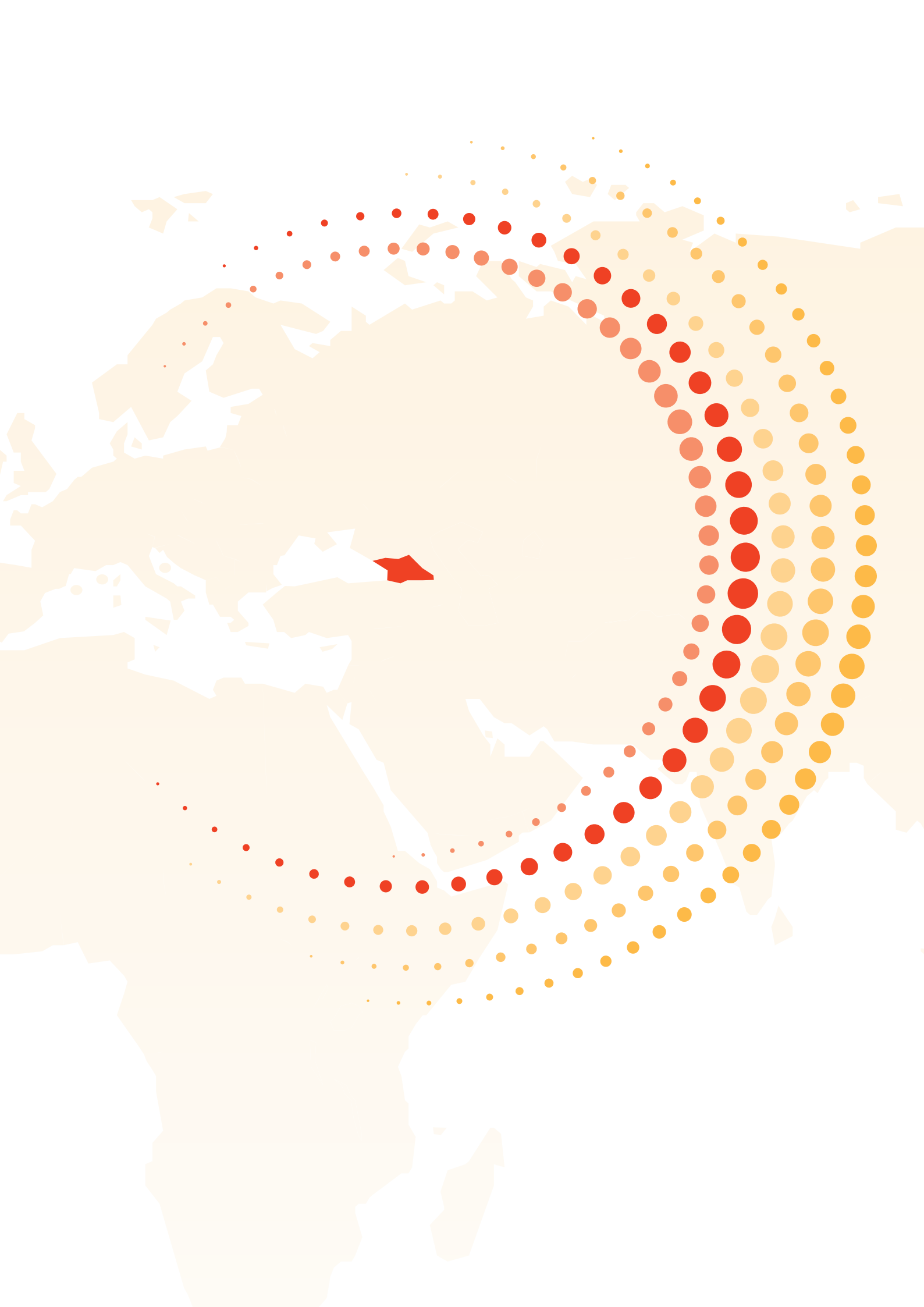
Abbreviations

CIF	Curatio International Foundation
LMICs	low- and middle-income countries
PIR	Package of interventions for rehabilitation
PRM	physical and rehabilitation medicine
STARS	Systematic Assessment of Rehabilitation Situation
TWG	technical working group
UHC	universal health coverage
UHCP	Universal Health Care Programme
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
USAID	United States Agency for International Development
WHO	World Health Organization
YLDs	years lived with disability



1. Introduction

Rehabilitation is one of the essential health services for universal health coverage (UHC) *(1)*. To scale up access to rehabilitation, including the provision of assistive products, countries need to provide rehabilitation services that are accessible to people in need and without the financial burden of out-of-pocket payments. Developing an accessible rehabilitation service package that incurs no financial hardship is essential – as is defining the sustainable funding sources, specifying the beneficiaries of services, and selecting the authorized service providers and related quality assurance measures.

In many countries less than 50% of the population have access to rehabilitation, and where rehabilitation services are available, payment often has to be made out-of-pocket *(2)*. Countries integrating rehabilitation into UHC and scaling up access to rehabilitation may need to adopt a stepwise approach. Prioritizing funding for services in terms of what the country can afford to deliver requires decisions as to "what is in and what is out" and "who gets access to what services" *(3)*. Over time, countries can expand funded services in their efforts to achieve UHC. To support countries in these endeavours, in 2021, the World Health Organization (WHO) developed the *Package of interventions for rehabilitation* (PIR) *(4)*.

This report illustrates the use of the PIR in developing a first rehabilitation service package in Georgia. It demonstrates how the PIR was used to prioritize the target population for this service package, as well as how information on interventions for rehabilitation was used to define the service package, and how the costing of it was informed. Insights into the steps that were taken to implement the service package are also described.

Together with the lessons learned from these processes, this report provides useful information on how countries can use the PIR when developing a rehabilitation service package and the practical aspects to be considered during implementation.

2. Background information on Georgia

In Georgia, the Ministry of Internally Displaced Persons, Labour, Health, and Social Affairs oversees the development, endorsement and implementation of health policies. In addition, the Ministry of Internally Displaced Persons, Labour, Health, and Social Affairs monitors the health of the Georgian population, the quality of the health services, equity in access to health care, public health interventions, and the implementation of social programmes supporting vulnerable populations. While rehabilitation is coordinated within both the Social Protection Policy Unit and the Health Policy Unit, the provision of assistive technology is the remit of the Social Protection Policy Unit only. General information about Georgia, its global ranking and milestones relevant to strengthening rehabilitation in the health system, are provided in Box 1.

Box 1. About Georgia

Georgia is part of the Caucasus region and considered a transcontinental country located between Eastern Europe and West Asia. In 2022, Georgia's population was 3 694 600 *(5)*. It is anticipated that by 2050, 25% of the population will be more than 65 years of age.

Georgia is considered a developing country. It has a Human Development Index (HDI) that has continuously improved – from 0.694 in 2000 to 0.814 in 2022 (rank 60 in the global ranking, which is considered very high) *(6)*.

Milestones relevant to strengthening rehabilitation in the health system:

2013 Ratification of the UN Convention on the Rights of Persons with Disabilities; Introduction of the Universal Health Care Programme.

2020 Systematic Assessment of the Rehabilitation Situation.

2022 Situation assessment of assistive technology.

2022 Strategic plan for the development of rehabilitation services; Development of the first state-funded rehabilitation service package.

2023 Official adoption of the Strategy for the Development of Rehabilitation Services (2023–2027); Implementation of the first rehabilitation service package in 5 rehabilitation centres.

In 2013, Georgia ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) *(7)*; under which, Article 26 refers to habilitation and rehabilitation. Accordingly, the Georgian State Program for Social Rehabilitation and Childcare provides guidance on benefits and subprogrammes for persons with disability. For people falling outside of this programme, however, rehabilitation was not included in any policy.

Also in 2013, Georgia introduced its Universal Health Care Programme (UHCP) which now covers most of the population. The programme has become the primary mechanism for health financing and enables the largely private health providers (an estimated >85% of providers are private) to access public revenue. Since its launch, the UHCP has gradually expanded and currently includes a selection of health conditions, and definitions of corresponding benefits packages *(8)*. However, rehabilitation was not addressed in these benefit packages.

Following the launch in 2019 of WHO's *Rehabilitation in health systems: guide for action (9)*, the Ministry of Internally Displaced Persons, Labour, Health, and Social Affairs requested support from WHO to conduct an assessment of the rehabilitation situation in the country.

2.1 Rehabilitation in the health system of Georgia – the initial situation

In 2020, Georgia conducted a situation assessment using the Systematic Assessment of Rehabilitation Situation (STARS) tool *(10)*. The health systems building block framework was used to describe the situation. The following content of this report draws on this assessment and includes recent updates.

Historically in Georgia, the governance of rehabilitation was linked with disability; rehabilitation services were viewed primarily as disability services. In 2020, there was no mention of rehabilitation in the national health plans or reporting; it was addressed only in the disability legislation and policy frameworks.

The financing of rehabilitation, likewise, was linked to disability. The Ministry of Internally Displaced Persons, Labour, Health, and Social Affairs, through the Social Services Agency, provided more than US$ 4 million annually for rehabilitation services and assistive products. However, government funding was limited only to rehabilitation services for children and adults with disabilities; all other rehabilitation services had to be paid for by individuals (e.g. adults who had not gone through a disability determination process and had no disability card), almost exclusively as out-of-pocket expenditures. Voluntary health insurance covered some rehabilitation services, but the majority did not. Children and adults with disabilities could also access municipal budgets to pay for certain services on a case-by-case basis only.

Assistive products in Georgia have been financed through several sources, including the central budget (a state programme, managed by the Ministry of Internally Displaced Persons, Labour, Health, and Social Affairs and the Care Agency); the defence budget (the Ministry of Defence); municipal budgets (through individual requests within broader social or health budgets); out-of-pocket payments; and donations from charities. The situation assessment of assistive technology *(11)* undertaken in 2022, found that 75% of costs for assistive products were made through out-of-pocket payments. Only a few assistive products targeting hearing, vision and mobility impairments, are provided through the state programme; certain other products such as electric/pediatric wheelchairs, white canes and smartphones with videocall capability, are supplied only to persons registered as disabled. Further details of the financing of rehabilitation in countries is provided in Box 2.

Box 2. Rehabilitation in health financing *(12)*

To increase health spending, countries commonly raise funds in three ways: public (e.g. government taxes, mandatory contributions to social health insurance); private (e.g. private insurance premiums, out-of-pocket expenditure); and external (e.g. grants or loans from donors, foreign investments or remittances). In countries that are pursuing univeral health coverage (UHC), it is important that health services are funded sufficiently to meet the essential needs of the population, and that revenues are raised predominantly from stable domestic and public sources that ensure equitable access to services.

Health financing seldom includes rehabilitation and therefore the health system expenditures for rehabilitation are either nonexistent or insufficient, especially in low- and middle-income countries (LMICs); this results in high out-of-pocket costs. Rehabilitation budgets are frequently anchored in the social, education and defence ministries; their associated statutory agencies and insurance schemes cover rehabilitation services for specific population groups only (e.g. people with disabilities, people injured at work). To help advance UHC goals that are inclusive of rehabilitation, the planning processes for public health financing policies and health services need to include rehabilitation to ensure a steady stream of funding for integrated service delivery within the health sector. Where there is fragmentation of financing mechanisms (as described above through different ministries and sources), coordination with additional revenue sources from outside the health sector is important to ensure efficiency.

Financing mechanisms for rehabilitation should pool financial risk and distribute resources across population groups. Pooled resources are used to pay for the services provided by health care providers to beneficiaries. Access to these funded services should consider people with different risk profiles, including those with the most severe health conditions who are often older or financially poorer). The decision on which services will be funded requires a strategic purchasing approach which links the payments to provider performance and population needs.

Health benefit packages define the beneficiaries and those services that are financed and provided cost-free to the beneficiaries with or without copayment. A clear definition of benefits packages facilitates the costing and financial planning. Benefit packages should be informed by empirical evidence on population needs and demand, as well as by opportunities to supply the services. Importantly, they should reflect budgetary realities and supply-side readiness. While benefit packages highlight essential services to UHC, in many countries, especially in LMICs, existing benefit packages rarely include rehabilitation.

No consolidated numbers of the rehabilitation workforce have existed in Georgia. Estimates from 2020 have suggested around 500 physiotherapists; 300 physical and rehabilitation medicine (PRM) physicians; 30 speech and language therapists; 25 occupational therapists; and 3 prosthetist and orthotists. Of the 300 medical doctors with a specialization in PRM, however, only a small number were employed. Basic education and training (to Bachelor or Masters degree level) is available for physiotherapy, occupational therapy, and speech and language therapy. There is no training for prosthetists and orthotists. A postgraduate training for specialization in rehabilitation ("rehabilitologist") is available for doctors. While general education and training were available for psychologists and nurses, no specialization in rehabilitation for these professions has existed.

As with the rehabilitation workforce, there were no consolidated data on numbers and location of rehabilitation services in Georgia: information on rehabilitation was not included in routine

data collected from health facilities. Funded rehabilitation services, including some assistive products, were rooted mainly in child-focused social and disability programmes, such as early childhood development programmes or rehabilitation services for children with disability. Specialized rehabilitation centres existed, including some with inpatient beds, but all were private and therefore users had to pay out-of-pocket for costs. Most of the people in need could afford only a limited number and type of rehabilitation services, if any at all.

> *"Before the service package existed, people had to pay 'out of the pocket', so most of the people who came to our centre, just selected physiotherapy. There were just some people who took speech therapy. The majority, however, could only afford one type of therapy, if at all. As well, the length of rehabilitation was very short. We had people with comprehensive needs coming from the region for only ten sessions of physiotherapy. In such cases, we focused on developing a home programme. After that, they went back home."*

Neurologist from Ken Walker Rehabilitation Clinic, Tbilisi, reviewing the rehabilitation plan of a patient.

Existing rehabilitation services typically used treatment techniques and approaches, historically considered as "spa resort therapy", which usually comprised electrotherapeutic, light, thermal and ultrasound treatments, massage and exercises (an approach frequently found in countries formerly of the Soviet Union).

The provision of assistive products depended on the limited finances; these were available only at a very few rehabilitation service providers, and were insufficient to meet the needs.

2.2 The rehabilitation needs in Georgia

According to the estimation of global rehabilitation needs, in 2019 almost half of Georgia's population (about 1.5 million people) had at least one condition that would have benefited from rehabilitation services *(13, 14)*. The majority of people with rehabilitation needs were aged older than 15 years, many of the needs arising from health conditions for which disability certification processes had not been conducted. In 2021, the number had increased to 1.6 million people. The highest rehabilitation needs across gender and all age groups were reported as follows: injuries (fractures: 380 000; other injuries of the musculoskeletal system: 320 000; traumatic brain injury: 32 000; spinal cord injury: 11 000); non-traumatic musculoskeletal conditions (low back pain: 380 000; osteoarthritis: 240 000; neurological conditions (Alzheimer's disease and other dementia: 44 000; stroke: 39 000); sensory impairments (hearing loss: 250 000; vision impairment: 210 000); cancer: 70 000); and chronic obstructive pulmonary disease: 57 000 *(15)* (Figure 1).

Figure 1. Rehabilitation needs in Georgia, 2019 *(14)*

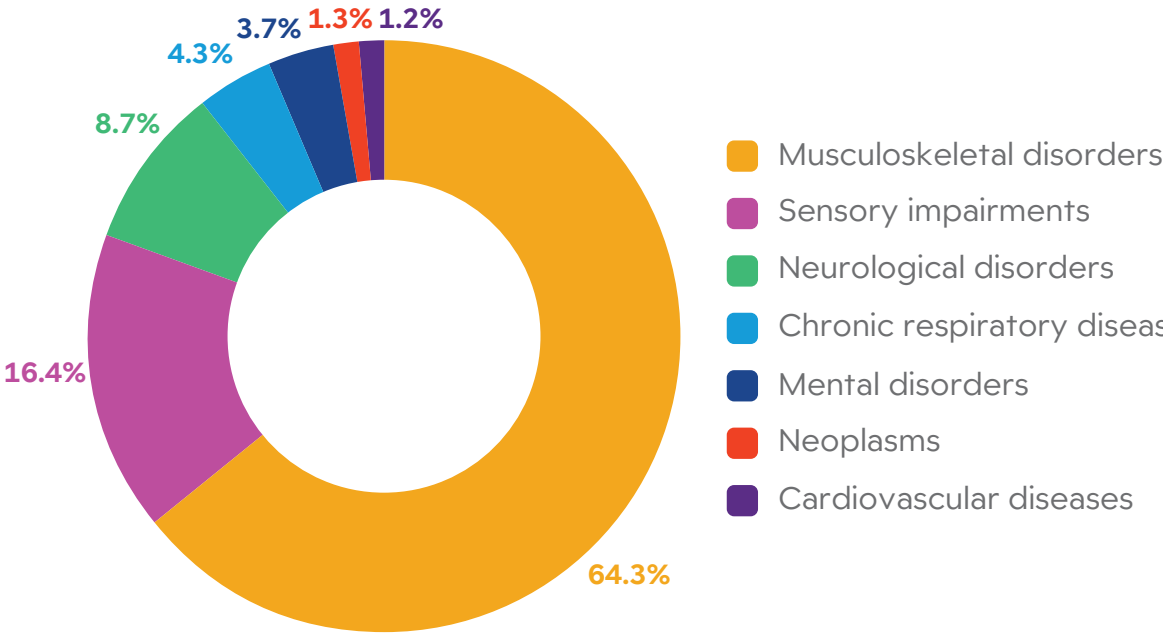
Who?

Prevalence of people with at least one condition that would benefit from rehabilitation services, according to age and sex

0–14 years		15–64 years		≥65 years	
Female	Male	Female	Male	Female	Male
7 015 969	7 732 784	124 338 991	124 338 991	73 762 199	51 359 760
14 748 753		254 422 110		125 121 959	
394 292 822					

What?

Health conditions contributing to the prevalence of the need for rehabilitation services



All data are from 2019

With noncommunicable diseases expected to increase in the coming years, rehabilitation needs will continue to increase correspondingly.

2.3 Georgia's national rehabilitation strategy: towards universal health coverage

On 1 February 2023, the Government of Georgia adopted the Strategy for the Development of Rehabilitation Services (2023–2027), which was formulated based on the results of STARS *(10).* The overall goal of the strategy is to improve access to timely, effective, person-centred rehabilitation services, integrated into all levels of Georgia's health care. The specific objectives comprise:

1. integrating rehabilitation into the national health care system;
2. capacity-building of employees in the rehabilitation sector;
3. strengthening of rehabilitation services; and
4. improving access to rehabilitation data.

With the adoption of this strategic plan and the related resolution, rehabilitation became a priority health service to be integrated into the UHCP. This presented a major step in integrating rehabilitation into the national health system (objective 1 of the strategy) and health financing processes. However, the Georgian government set a clear budget limit with guidance to not exceed this amount. In line with the existing practices to expand the UHCP benefit package, the plan was to define beneficiaries of the packages through selecting priority health conditions. This would help ensure that the costs of providing rehabilitation services did not become greater than the budget allocated.

> *"In Georgia, we have a four-year time frame for the budgeting of the health services. Within this budget, we had a 10% increase for the budget for rehabilitation, and we think this will continue to increase because of the growing population in need for rehabilitation. This progress is because the state has defined rehabilitation to become a priority within UHC, and thus there will be continuous financing for rehabilitation in the future."*
>
> Mzia Jokhidze, Chief Specialist of Regulation Division of Healthcare Policy Department at Ministry of Internally Displaced Persons, Labour, Health, and Social Affairs

The strengthening of rehabilitation services (objective 3) considered specifically the expected ageing of the Georgian population. The strategy therefore addresses the need to integrate rehabilitation services for adults and older people, which were rarely part of existing state health care programmes. The strategy also aims to increase access to assistive products by expanding the types and quantity of products as described in WHO's *Priority assistive product list (16).*

A report on the capacity to facilitate the implementation of priority rehabilitation service *(17)* set a foundation for the current work in Georgia, where the development of a state funded rehabilitation service package presented the logical next step. Using the WHO *Package of interventions for rehabilitation* (Box 3) would facilitate this development.

Box 3. The WHO *Package of interventions for rehabilitation* *(4)*

The WHO *Package of interventions for rehabilitation* (PIR) is one of the technical products developed within the WHO Rehabilitation 2030 initiative *(18)*; it targets strengthening rehabilitation service delivery with a specific focus on incorporating evidence-based rehabilitation into universal health coverage. The PIR addresses the call to countries to "*to expand rehabilitation to all levels of health, from primary to tertiary, and to ensure the availability and affordability of quality and timely rehabilitation services…*" and "*to ensure the integrated and coordinated provision of high-quality, affordable, accessible, gender-sensitive, appropriate and evidence-based interventions for rehabilitation along the continuum of care…*" as requested in the resolution on strengthening rehabilitation in health systems *(19)*.

The PIR was developed to address 20 health conditions; the development followed a structured methodology *(20)*. The selection of health conditions was necessary due to time limitations; however, it is important to note that many more health conditions can benefit from rehabilitation. The health conditions included in the PIR are those with the highest global prevalence and related levels of disability per disease area. Rehabilitation experts representing all world regions and relevant professions selected interventions that are essential to each of the health conditions, while taking into consideration existing evidence, costs, and feasibility in a low- and middle resource context. Together with the related information on materials (e.g. assistive products, equipment and consumables) and human resource requirements, the PIR provides users with information relevant to the planning, budgeting and implementation of interventions for rehabilitation at all service delivery levels.

The PIR has the potential to serve many users and specific purposes; these include academics who want to ensure that curricula include the training and education on evidence-based interventions; service providers who want to ensure evidence-based service delivery at their centres; or researchers who want to inform their research agendas.

From a health system strengthening perspective, the use of the PIR to develop evidence-based policy may be the most important area of application. Using the information from the PIR to identify interventions or packages of interventions to be included in health benefit packages, may represent the first step in integrating high-quality and evidence-based rehabilitation into health systems to achieve UHC.

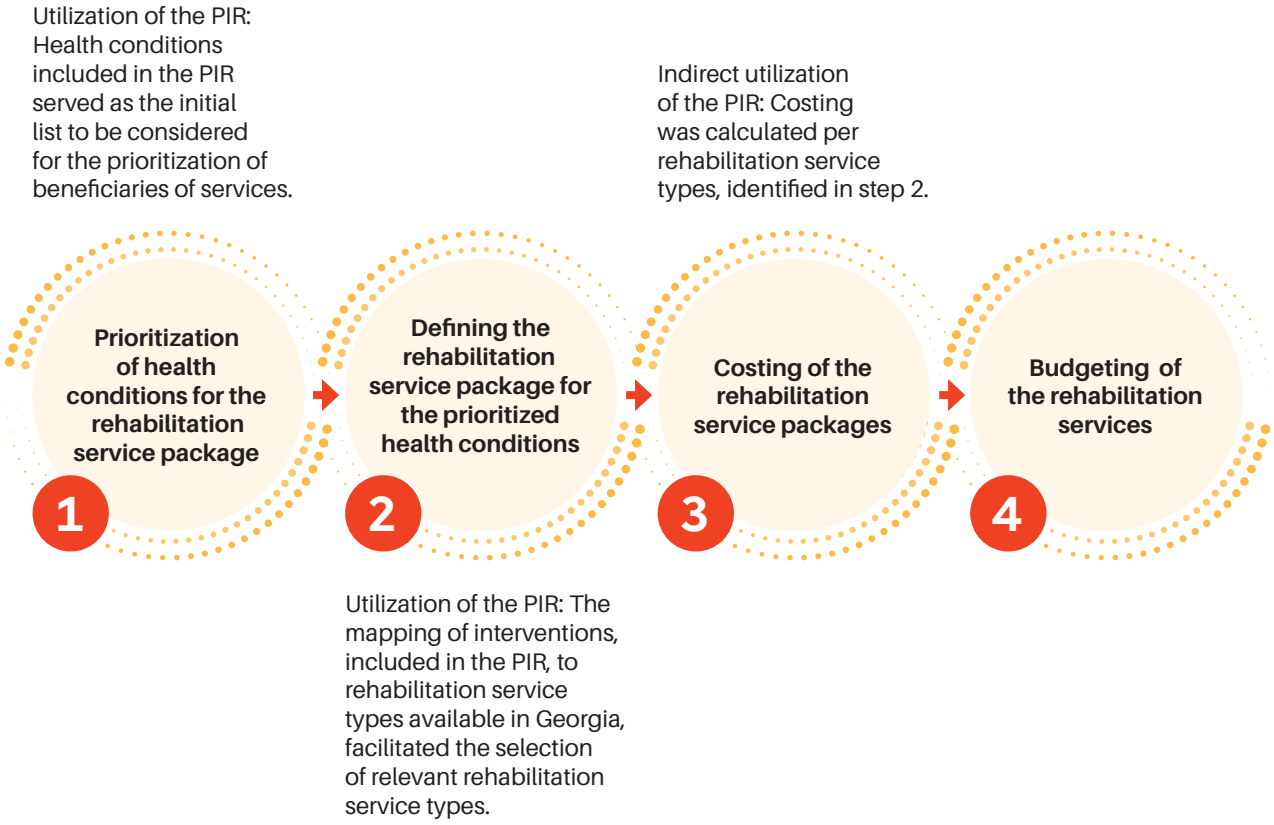
3. Development of a rehabilitation service package in Georgia

In 2022, already before the official adoption of the Strategy for the Development of Rehabilitation Services, the Health Systems Strengthening Accelerator *(21)*, an initiative funded by the United States Agency for International Development (USAID) that supports countries to translate, adapt and build more effective and sustainable health system interventions on their journeys to self-reliance, partnered with Curatio International Foundation (CIF) *(22)*, a not-for-profit, nongovernmental organization with a mission to improve health through better functioning health systems. This collaboration aimed to provide technical assistance to the Ministry of Internally Displaced Persons, Labour, Health, and Social Affairs, with the specific objective to develop a rehabilitation service package that integrates rehabilitation in the UHCP and to develop rehabilitation services in Georgia accordingly.

Under the lead of CIF, a technical working group (TWG) was formed, composed of rehabilitation specialists working with different service providers and providing various rehabilitation services. Specific objectives were to a) prioritize beneficiaries; b) define the interventions contained in the service package; and c) cost and budget the rehabilitation service package for inclusion into the country's UHCP *(23)*.

In all countries, the service package needs to adapt to the existing budget and expand progressively when more budget is allocated or becomes available. In Georgia, a prioritization of interventions took place which considered recipient groups. In the first prioritization process, the availability of a workforce with competencies to deliver specific intervention types was also taken into account. A four-step process was therefore initiated, in which the PIR played a crucial role (Figure 2).

Figure 2. The four steps of developing the rehabilitation service package in Georgia using the WHO *Package of interventions for rehabilitation* (PIR)



3.1 Prioritizing health conditions for the rehabilitation service package

The prioritization of health conditions to be included in the service package involved the following steps. First, the estimates for rehabilitation needs related to years lived with disability (YLD) were produced for each condition, by age group, using the *WHO rehabilitation need estimator (15)*. The YLD were used to assign scores (1–5) to health conditions for different age groups, so that a hierarchical order of the health conditions was produced. Thereafter, the list of health conditions identified from the analysis was compared with the health conditions included in the PIR. Only health conditions included in the PIR were considered for the next step. Using a scoring system, the TWG members evaluated different criteria: burden of disease across age groups; availability of evidence-based interventions in Georgia; interventions recommended by the World Bank *(24)*; the cost–effectiveness of interventions; and relevance based on expert opinion. To evaluate the cost–effectiveness of interventions, a literature review was conducted, and the results presented to the TWG. From all individual criteria, a total score was calculated for each health condition. A cut off >20 of the total score was defined for health conditions to be considered for the final prioritization of conditions to be included in the service package *(23)*. Table 1 provides a summary of the results of this selection process.

Table 1. Prioritization of health conditions to be included in the rehabilitation service package of Georgia

Disease area	Health conditions	YLD (n)[a]	Prevalence (n)[a]	Total score[b]	Priority[c]
Musculoskeletal conditions	Low back pain[d]	46 000	380 000	**26**	0
	Fractures[d]	22 000	390 000	**35**	++
	Osteoarthritis[d]	14 000	240 000	16	0
	Neck pain	10 000	100 000	–	0
	Other injuries	9 900	320 000	–	0
	Amputation[d]	4 800	160 000	**22**	++
	Rheumatoid arthritis[d]	610	3 400	–[f]	0
Neurological conditions	Stroke[d]	12 000	39 000	**29**	++
	Alzheimer's disease and dementia[d]	10 000	45 000	19	0
	Traumatic brain injury[d]	4 700	32 000	**22**	++
	Cerebral palsy[d]	4 000	18 000	**26**	+
	Spinal cord injury[d]	3 400	11 000	**21**	++
	Parkinson disease[d]	640	2 200	9	0
	Multiple sclerosis	320	960	–	0
	Guillain-Barré syndrome	22	75	–	0
	Motor neuron disease	21	86	–	0
Sensory conditions	Hearing loss[d]	19 000	250 000	**35**	+
	Vision impairment[d]	13 000	210 000	**35**	+
Cardiopulmonary conditions	Chronic obstructive pulmonary disease[d]	5 100	58 000	19	0
	Heart failure[e]	3 000	26 000	18	0
	Acute myocardial infarction[e]	170	1 900		
Mental health	Schizophrenia[d]	5 800	9 000	14	0
Neurodevelopmental disorders	Autism spectrum disorders[d]	6 000	32 000	**21**	+
	Disorders of intellectual development[d]	3 500	45 000	**26**	+
Neoplasm	Cancer[d]	4 300	4 300	11	0

YLD = years lived with disability.

Bold letters = cut off of >20 reached, and thus, considered for final prioritization.

0 = not prioritized; + = prioritized, but a state-funded service package is already available in Georgia; ++ = prioritized for the development of the new rehabilitation service package.

[a] YLD and prevalence (total) in Georgia in 2019, available at the *WHO rehabilitation need estimator (15)*.

[b] The individual criteria, from which the total score was calculated, are available elsewhere *(23)*.

[c] Based on the final consensus decision among the stakeholders.

[d] Health condition included in the WHO *Package of interventions for rehabilitation*.

[e] Summarized in the *Package of interventions for rehabilitation* under "Ischaemic heart disease".

[f] Although rheumatoid arthritis is included in the WHO *Package of interventions for rehabilitation*, the technical working group decided to not score this health condition for Georgia: at the time of development it was considered not relevant to the country context.

Eleven health conditions reached the cut off. Five of these – cerebral palsy, vision impairment, hearing loss, disorders of intellectual development, and autism spectrum disorders – already had state-funded service packages in Georgia, and were therefore not considered for the rehabilitation service package. The remaining six conditions – stroke, traumatic brain injury, spinal cord injury, low back pain, fractures and amputation – were discussed in a national stakeholder meeting and, following consensus, all of these except low back pain were prioritized for inclusion in the first rehabilitation service package.

3.2 Defining the rehabilitation service package for prioritized health conditions

For the costing and budgeting of the service package, information on the costs related to the provision of rehabilitation was needed for each health condition. The interventions included in the PIR for the five prioritized health conditions were each mapped to broader rehabilitation service types that are usually provided by rehabilitation specialists in Georgia. For each service type, the duration of one session had a specified time and therefore also a specified cost. An overview of the rehabilitation service types, related rehabilitation specialists and time per session is provided in Table 2.

Table 2. Overview on rehabilitation service type, specialist, time and costs per session, in Georgia

Rehabilitation service type	Rehabilitation specialist	Time per session (in minutes)	Price per session (GEL)
1. Multidisciplinary team assessment (incl. development of individual rehabilitation plan)	(Rehabilitation) doctor, physiotherapist, occupational therapist, other professions (e.g. speech and language therapist, psychologist, prosthetist and orthotist[a], nurse[b]) as needed	60	227
2. Individual physiotherapy	Physiotherapist	30	39
3. Individual physiotherapy: Aqua therapy in the pool	Physiotherapist	30	40
4. Lymphatic therapy	(Rehabilitation) doctor, nurse[b]	60	78
5. Occupational therapy (individual or group)	Occupational therapist	30	45
6. Speech and language therapy	Speech and language therapist	45	50
7. Psychotherapy	Psychologist	45	76
8. Provision and training in the use of assistive products	Physiotherapist, occupational therapist, prosthetist and orthotist[a]	45	56
9. Education of patients, families and caregivers	(Rehabilitation) doctor, nurse, other professions as needed	60	72
10. Rehabilitation doctor's consultation/supervision	(Rehabilitation) doctor	–	54

GEL = Georgian lari.

[a] The number of prosthetists and orthotists in Georgia is very low (an estimated 3 in 2020). Thus, the provision of assistive products, including the provision of prosthesis and orthoses, was assigned to physiotherapists or occupational therapists. However, if a prosthetist or orthotist is available, their time will be reimbursed at the same rate as for physiotherapists and occupational therapists.

[b] In Georgia, there is no specialization in rehabilitation for nurses; nurses have only a minor role in rehabilitation, specifically in outpatient rehabilitation services.

All interventions included in the PIR for the five health conditions were extracted whereas pharmacological interventions were not considered at this point. All other interventions were then mapped to one of the rehabilitation service types defined for Georgia (see **Table 2**). However, some interventions could not be mapped to a service type (either due to unavailability of the service type or because the intervention is not considered an intervention for rehabilitation in Georgia) and were therefore not considered for the service package. In contrast, "Aqua therapy in the pool", which was not included in the PIR, being considered too expensive in a low- and middle-resource context, was added in the Georgia package as it is a relatively widely practiced rehabilitation intervention in the country. **Table 3** shows the mapping of interventions from the PIR for fractures to the Georgian rehabilitation service types. The final list of rehabilitation service types available for each health condition presented the basis for the costing exercise.

Table 3. Mapping of interventions for fractures to rehabilitation service types, in Georgia*

Actions (assessments and interventions) in the PIR	Service type	Rehabilitation specialist	Time per session (in mins)
• Assessment of structure of the bones • Assessment of skin • Assessment of oedema • Assessment of respiratory functions • Assessment of muscle functions • Assessment of joint mobility • Assessment of pain • Assessment of balance • Assessment of gait pattern and walking • Assessment of hand and arm use • Assessment of mobility • Assessment of activities of daily living • Assessment of carer and family needs • Vocational assessment	Multidisciplinary team assessment (incl. development of individual rehabilitation plan)	Medical doctor (rehabilitologist/ orthopedic doctor), occupational therapist, physical therapist, psychologist, prosthetist and orthotist	60
• Respiratory (breathing) exercises • Positioning for oedema control • Range of motion exercises • Soft tissue techniques • Stretching • Joint mobilization • Muscle strengthening exercises • Graded sitting and standing training • Gait training • Balance training • Mobility training • Functional training for hand and arm use	Individual physiotherapy	Physiotherapist	30
• ADL training • Vocational counselling, training and support	Occupational therapy	Occupational therapist	30
• Education and advice on self-management of the health condition (incl. information on modification of the home environment[a]) • Education and advice on self-directed exercise programme • Caregiver and family training and support	Education of the patient, families and caregivers	Medical doctor (rehabilitologist, orthopaedic doctor), nurse	60
• Provision and training in the use of compression therapy • Provision and training in the use of orthoses • Provision and training in the use of assistive products for mobility • Provision and training in the use of assistive products for self-care	Provision and training in use of assistive products[b]	Physiotherapist, occupational therapist, prosthetist and orthotist	45
The following non-pharmacological interventions included in the PIR were NOT CONSIDERED for the Georgian essential service package			
• Skin and wound care[c] • Thermotherapy			
The following pharmacological interventions included in the PIR were NOT CONSIDERED for the Georgian essential service package			
• Paracetamol • Anticoagulants			

*Using the interventions for fractures included in WHO's *Package of interventions for rehabilitation (25)*

ADL = activities of daily living.

PIR = Package of interventions for rehabilitation.

[a] The topic listed in parentheses is originally an intervention in the PIR carried out by rehabilitation professionals. Since this is not available in Georgia, it was included among topics for which education, advice and support should be provided.

[b] Several of the products specified in the PIR and listed in the left column are not included in the current state-funded service package for assistive technologies. Thus, they may not be delivered during a rehabilitation course related to the rehabilitation service package if a patient is unable to afford them.

[c] While "skin and wound care" was not specifically considered for the rehabilitation service package, any person who requires this, will receive it as part of routine care.

An overview of the mapping of PIR interventions to the Georgian rehabilitation service types for other health conditions selected for the service package, is available in **Annex 1**.

3.3 Costing of the rehabilitation service package

The anticipated costs of the services package should inform the final budgeting and implementation. Workforce time only was considered in the costing, and was calculated as number of sessions needed per service type ("unit costs") for one individual per each health condition and rehabilitation phase. While the unit costs were independent from the health condition and phase of rehabilitation, the TWG estimated the number of sessions needed for the different health conditions per service delivery level (acute, subacute inpatient rehabilitation, outpatient rehabilitation), and for outpatient services, per severity (mild, moderate, severe) of the health condition. An example of the costing of the service package for spinal cord injury for one individual is provided in **Annex 2**.

For the costing of "Provision and training in the use of assistive products", only the workforce time was calculated; the costs for the products were part of another government funding line (see section 2.1).

In addition to the costs related to the workforce time, the costs for one bed-day (without medicines or diagnostics, etc.) were calculated for inpatient care (acute and subacute phases). The numbers of inpatient days were agreed by the TWG: 14 for stroke, traumatic brain injury and spinal cord injury; 7 for amputation and fractures; costs were calculated as 213 Georgian lari (GEL) per day.

To define the total costs related to the needs in Georgia, the number of people in need had to be established. Estimates for the proportion of people in need per health condition and service delivery level (acute and subacute inpatient, and outpatient rehabilitation) were proposed by the TWG. For outpatient rehabilitation, estimates for the number of people in need were further specified for different severity levels of the conditions to address different rehabilitation needs (see **Annex 3**).

Given these numbers, the total costs for the comprehensive, multidisciplinary service package for the five prioritized health conditions across all service delivery levels and severities, related to the needs, were estimated to be 38.7 million GEL per year (5.2 million for acute inpatient rehabilitation; 14.0 million for subacute inpatient rehabilitation; 19.5 million for outpatient rehabilitation).

3.4 Budgeting of the rehabilitation service package

For the budgeting, additional country-specific considerations were taken into account which comprised: a) the number of adults in need per health condition and region; and b) the capacity for inpatient rehabilitation in these regions. It was estimated from this that 95% of the total number of people in need live in regions where rehabilitation services are currently available, and that 50 beds for inpatient rehabilitation could be available in 2023 throughout Georgia. Given this scenario, the capacity-based budget needed to finance the service package resulted in a total of 30 million GEL per year (4.9 million for acute inpatient rehabilitation; 6.7 million for subacute inpatient rehabilitation; and 18.4 million for outpatient rehabilitation). This budget estimate impacted the final decision on the implementation of the service package.

Criteria were defined to specify the eligibility of the beneficiaries of the state-funded service package. Since 100% funding was not possible for all eligible beneficiaries, additional criteria were defined to specify a range of 80% to 100% funding for different subgroups. **Annex 4** provides an overview of all eligibility criteria and the categories that define the amount of funding.

Under the benefit package, rehabilitation costs can be covered for a maximum of 90 days. However, and if necessary, beneficiaries may apply for a continuation of the rehabilitation cycle to the rehabilitation subprogramme of the National Health Agency, which is the contracting authority of the Georgian State Program for UHCP. Such a request, however, will be approved only if certain improvements have been realized during the previous 90-day cycle. The outcome of the 90-day rehabilitation cycle is evaluated by the service provider using selected outcome measures.

4. Implementation of the rehabilitation service package and next steps

Following the processes of prioritization of the five health conditions, the costing and budgeting of the service package for these conditions, and definitions of the eligibility criteria, the Ministry of Internally Displaced Persons, Labour, Health, and Social Affairs prepared the implementation of the service package at the service provider level. For the initial phase, it was decided to start with implementation for three neurological conditions (stroke, traumatic brain injury, and spinal cord injury) for adults at multidisciplinary outpatient services only. The selection was based on the high prevalence of these conditions in Georgia and the huge unmet need for funded rehabilitation services for these populations. An evaluation of the first phase was to be conducted after a specified time, and, if needed, adjustments made. The service package could then be expanded to include inpatient services for these three neurological conditions, as well as for two musculoskeletal conditions (amputation and fractures). Any expansion would be dependent on the future budget allocation for rehabilitation.

4.1 Establishment and role of a commission

To initiate the implementation of the service package and evaluate the eligibility of people with health conditions to be beneficiaries of rehabilitation services, a commission was established at the Ministry of Internally Displaced Persons, Labour, Health, and Social Affairs. The commission is composed of six neurologists and two representatives from the Georgian Ministry of Health and is led by a medical doctor specialized in rehabilitation. The role of the commission is to review the application forms submitted by potential beneficiaries. The form includes, among other items, the result of a multidisciplinary assessment conducted by the registered rehabilitation service provider. The commission also defines the criteria by which service providers become registered for the programme.

In the first phase of implementation of the service package, the commission at the National Health Agency of Georgia suggested a rehabilitation cycle (scope of the course, numbers of sessions, etc.), to be shared with the beneficiary and the service provider. Once the rehabilitation cycle has been initiated, and even though the service provider is obliged to follow the prescription provided by the commission, the cycle can be adjusted depending on the patient's health condition and needs. After the first year of implementation, this process can be changed based on feedback received. Following this, the commission only determines the eligibility of a beneficiary based on the documental review; the provider has sole responsibility for determining the scope of the course and number of sessions, based on the assessment of the multidisciplinary team.

4.2 Authorization of registered service providers

Rehabilitation service providers who are interested in being enrolled in the programme, have to apply and prove certain requirements to become authorized. The requirements comprise: a) the availability of the scope of service types (as listed in Table 1); b) having a permit for an inpatient institution and/or a permit for a rehabilitation-revitalization inpatient clinic; and c) having at least one certified doctor specialized in rehabilitation (i.e. specialization attained through completing an accredited course). By 2024, and since the start of the programme, six rehabilitation centres have been authorized. The centres are located in four of the eleven (nine regions and two autonomous republics) geographical regions of Georgia. Three centres are in the capital Tbilisi, with one each in the Imereti, Kvemo Kartli, and Adjara regions.

4.3 Next steps

The development and initial implementation of a state-funded rehabilitation service package for three of the five prioritized health conditions for outpatient rehabilitation, were first steps in addressing Georgia's national strategy to strengthen rehabilitation services. In the next phase, and depending on the available budget, Georgia plans to expand the service package to include the two other health conditions as well as implementing all service packages at all service delivery levels. The inclusion of a basic set of interventions at the acute and post-acute care levels will be a priority. Along with implementation of the current service package and the plan to include other health conditions, developing national clinical guidelines for rehabilitation has also become a priority, and would support the provision of evidence-based rehabilitation within the service package.

Ministry-led initiatives focus on scaling access to assistive products through capacity-building exercises, strengthening provision at the primary care level, and establishing quality criteria for products on the national assistive product priority list. Other actions are also needed to complement the successful integration of rehabilitation in the health system; these include the following:

To ensure and further develop rehabilitation service provision, Georgia has prioritized the strengthening of the rehabilitation workforce in their national strategy and, to address this, plans to perform an evaluation of the rehabilitation workforce in the country using WHO's *Guide for rehabilitation workforce evaluation (26)*. This evaluation will inform the strengthening of the rehabilitation workforce which in turn will help to ensure the future provision of rehabilitation services through a qualified workforce, competent in delivering evidence-based interventions such as those included in the PIR.

Implementing rehabilitation services in health systems will involve evaluating the type and outcome of services. The national strategy, therefore, includes improving access to rehabilitation data. Georgia plans to implement the collection of rehabilitation data in their routine health information system following WHO's *Guidance on the analysis and use of routine health information system: rehabilitation module (27)*.

5. Lessons learned

The development of the first Georgian state-funded service package for rehabilitation and its implementation has presented many lessons. Both the implementation and future expansion of the service package are works in progress; the country is continuously adapting to lessons learned in relation to further developments to the service package, as well as access to, and delivery of, the services. The most important lessons learned from the evaluation process are described in the following sections.

5.1 Use of the *Package of interventions for rehabilitation* in developing the rehabilitation service package

The PIR has proved a useful tool for countries to develop a rehabilitation service package: i) it provides a list of health conditions that can benefit from rehabilitation, and therefore can inform the prioritization of beneficiaries in a country; and ii) it facilitates the identification of rehabilitation service types based on evidence-based interventions to be included in the package. Using the PIR to develop a service package in Georgia presented the following relevant considerations:

- The prioritization of beneficiaries of benefit packages for health conditions often requires a stepwise approach. Georgia is an example of how the PIR can be used for this. The PIR presents a list of 20 health conditions that have the highest rehabilitation needs globally. Country-specific data for these conditions are provided in the *WHO rehabilitation need estimator (15)* which can be used to inform prioritization. Countries can use either YLD or prevalence data for the prioritization process. Additional criteria for prioritization could include, for example, conditions with a higher degree of associated functioning problems, or those relevant to specific age groups.
- The PIR provides a list of essential and evidence-based interventions for each included health condition. However, the costing and budgeting of a rehabilitation service package is not necessarily based on the information related to each intervention. Nonetheless, valuable uses of the PIR include i) mapping the evidence-based interventions available to defined service types with defined costs per session; ii) defining the number of sessions needed per service type; and iii) calculating the costs for all service types plus total session numbers, as conducted in Georgia. This approach makes sense because even though the majority of people require the same types of services, not every individual patient needs every single intervention included in the PIR.
- Mapping the essential and evidence-based interventions available with the PIR to service types helps to highlight potential gaps related to the provision of evidence-based, comprehensive and multidisciplinary rehabilitation in a country. For Georgia, most interventions from the PIR could be mapped to service types and rehabilitation specialists that were already available in the country (see **Table 3** and **Annex 1**). However, due to the lack of prosthetists and orthotists, it was not possible to define a specific service type for the provision of prostheses and orthoses since these are often highly specialized procedures requiring specific skills and competencies. To compensate for this, related interventions were mapped to the service

type "Provision and training in the use of assistive products". Until a sufficient number of prosthetists and orthotists in Georgia becomes available, physiotherapists and occupational therapists may assist in delivering this intervention. While defining the rehabilitation service types and assigning responsibility to rehabilitation specialists occurs within countries, identifying the gaps related to service delivery can help to inform future workforce and service planning.

- Pharmacological interventions were not considered for funding in the Georgian rehabilitation service package. The inclusion of medicines as an integral part of comprehensive rehabilitation to achieve optimal functioning outcomes was considered essential during the development of the PIR; several specific medicines for different health conditions were therefore included. Because some rehabilitation outcomes are likely to be less effective without medication, a general exclusion of pharmacological interventions from rehabilitation packages should be carefully considered. Without pharmacological treatment of, for example, pain, spasticity or other body functions, some non-pharmacological interventions become more difficult to deliver and thus potentially less effective. While the prioritization of interventions, and of beneficiaries, is often necessary, the inclusion of specific medications should be discussed as part of the prioritization process. This may help to achieve the best rehabilitation outcomes of a service package with the available financial resources. In Georgia, beneficiaries with no financial support who were enrolled in the Georgian state programme, had to pay out-of-pocket costs for medicines which was perceived as a burden.

5.2 Evaluation of the implementation of the rehabilitation service package in Georgia

Nine months after implementing the service package in the country, CIF performed an evaluation, as requested by the Ministry of Health *(28)*. The objectives of the evaluation were i) to identify factors impeding implementation; and ii) to inform the adaptation of the programme based on the findings. Highlights of the evaluation and the discussions conducted in preparation of this report are described below.

Outcomes of service package provision

The experiences of providing and receiving the state-funded rehabilitation service package confirmed both the need for, and benefits of, the service package. When compared to the provision of a few single service type sessions – as was typical before implementation of the service package – the provision of comprehensive, multidisciplinary and person-tailored rehabilitation improved rehabilitation outcomes. Patient satisfaction was also high for both the application process and receipt of the rehabilitation service.

> *"The people here at the rehabilitation centre give me hope and with their work; they do everything they can to help me to become better and healthier.*
>
> *If I would not get this rehabilitation that I get now, I would be at home. I would not be able to leave the home. I would not feel any delight or happiness. There wouldn't be any sense in continuing living.*
>
> *However, as a pensioner, it is already a problem for me to cover 10% of the costs. Those who work probably do not have this problem."*

Stroke patient receiving gait training led by a physiotherapist at Ken Walker Rehabilitation Clinic, Tbilisi

Nonetheless, concerns were raised from both service providers and beneficiaries and included the following:

- With situations where rehabilitation was not started immediately during, or following, acute care, the delay from condition onset to initiation of the rehabilitation cycle often resulted in the development of complications. A significant amount of time may be spent addressing such complications, which include contractures, spasticity, or pain. With the seamless provision of rehabilitation, not only can these situations be prevented in many cases, but more time can be spent focusing on interventions that target the improvement of functioning, resulting in more successful outcomes.

> *"When people with traumatic brain injury come to our rehabilitation centre only four months after the injury, we already see contractures, muscle problems; there are problems with the positioning, with the vital functions, and all these things. Often, the only intervention they received until then was massage. For people with traumatic brain injury, and for those with stroke and other conditions, this is not really helpful. Sometimes we see patients only after eight months, or one year, or one year and a half. They are still eligible for the service package, but after one year and a half, what can be achieved in one month of rehabilitation?"*

Neurologist, Ken Walker Rehabilitation Clinic, Tbilisi

Ideally, rehabilitation in these phases is integrated into acute inpatient care in hospitals, or provided in specialized inpatient rehabilitation centres. In Georgia, there is a lack of rehabilitation services integrated into acute or post-acute care. Without appropriate rehabilitation in this phase, the risk for the development of complications increases. The integration of at least a basic set of interventions for rehabilitation into acute and post-acute care could help to prevent this. Furthermore, no standardized referral pathways are in place that have rehabilitation integrated into the continuum of care. Such models of care with related referral pathways from and to the services needed can help to close care gaps and prevent delays in the onset of rehabilitation, thereby increasing the efficiency of rehabilitation services and outcomes.

> *"At the BAU hospital, rehabilitation measures already begin in the inpatient care; in the case of a stroke, in the intensive care unit. At the beginning of this state programme, after discharge, patients had to first obtain a disability status in order to be eligible for the benefits package. This sometimes took three months, which was lost time. Now we can start the programme immediately after the patient is discharged from the hospital. The good thing here at the BAU is that we already know the patient from acute care and can now carry out continuous follow-up during outpatient rehabilitation."*

Rehabilitation team at BAU Rehabilitation Centre, Batumi during a team meeting

- From a consumer perspective, concerns were raised regarding the additional costs related to the uptake of a rehabilitation cycle. As not all beneficiaries receive 100% funding, some will have to face the financial burden of contributing to costs. The service package is provided as an outpatient service only, and since the five service providers are located in Tbilisi and Batumi only, some beneficiaries may also incur additional costs related to transportation or accommodation which are not covered by the service package. Furthermore, costs related to medicine are not covered and may present a potential additional financial burden.

Uptake and provision of the service package

The initial uptake of the service package was slower than expected, and fewer people were enrolled in the first phase of the programme than the funding would have allowed. Information on the availability of the service package was often communicated by word-of-mouth, mainly through medical providers only. The limited uptake was assumed to be caused by a lack of awareness of rehabilitation in general and, more specifically, awareness of the availability of the service package among health workers.

As a consequence, with support from the WHO Country Office, the Georgian Ministry of Health conducted an awareness-raising campaign (using visits to the regions, national TV channels by the Ministry of Health's officials and Ministry of Health's Facebook page). Representatives from the Ministry of Health, from one rehabilitation service provider, and from the WHO Country Office, visited all 11 regions of the country, reaching out to health-care workers in both urban and rural areas. The campaign focused on highlighting the importance and benefits of rehabilitation. The presentation provided detailed information about the newly-adopted service package, enabling health-care workers to identify and refer eligible patients to participate in the programme. Although the aim was to increase referrals to the registered service providers, no significant increase in claims for the service package resulted. As a next step, another awareness-raising campaign was considered, this time targeting the population and potential beneficiaries.

These experiences highlight the need to raise awareness of rehabilitation – both the benefits, and its integration into the continuum of care – among all service providers, health workers and potential beneficiaries. Such awareness-raising should be included at the start of a benefit programme – specifically at the implementation phase – to ensure that the service package is being used. In addition, the development of service delivery models that integrate rehabilitation into structured referral pathways along the continuum of care, may help to increase referrals, and thus the uptake of rehabilitation services.

> *"At the moment, we are facing some problems in terms of awareness of the state rehabilitation programme. Many beneficiaries do not know about the existence of this programme and that they can get this kind of service. So the uptake could be more.*
>
> *In a first phase, we started raising awareness among the doctors, and WHO helped us with that. Practically every doctor got to know about this programme, with approximately 1000 participants during these meetings. This was an important stage. However, it was not enough, and we see the need to raise awareness among the population and the beneficiaries as well. Thus, the next step to increase the uptake is to inform the population about the existence of this programme and its importance."*

Irakli Natroshvili, Head of the Ken Walker Rehabilitation Clinic, Tbilisi; Rector of Tbilisi State Medical University

Authorization of service providers and quality aspects related to the service provision

As of July 2024, five rehabilitation centres in Georgia have been authorized to deliver the service package. Providers were interested due to the potential of a significant increase in patients seeking rehabilitation services and the opportunity to foster the development and advancement of the rehabilitation field within the country. In addition, the programme was considered an opportunity for healthy competition in the delivery of best quality care. However, future improvements were identified that could help with the authorization of service providers and service delivery:

- Initial experiences – including the administrative steps necessary to becoming an authorized service provider for the services package – were not always clear. Difficulties were reported in accessing the information needed and in managing the reporting and claims submission process. Establishing standard operating procedures that describe all the necessary steps could be useful in facilitating the application and reimbursement processes, and thus the enrollment and engagement of service providers in the programme.
- At the initiation of the programme, no global or country-specific standards for rehabilitation services were available. Such standards provide information on the quality of service delivery, without which neither the service provider nor the commission have guidance to inform the approval process. To address this, the Georgian Ministry of Health developed standards for the outpatient service delivery which were finally available in July 2024 *(29)*. These standards address the minimum criteria for infrastructure, workforce composition, and quality assurance for outpatient rehabilitation service providers; they also now serve the authorization of service providers for outpatient rehabilitation service delivery. WHO is currently preparing global *Standards for quality rehabilitation services (30)* which will address the quality of rehabilitation services at all delivery levels, and support countries in developing their own national standards for rehabilitation services. It is anticipated that this resource will be available in 2025.
- As with the standards for rehabilitation services, at the start of the programme there were no clinical rehabilitation guidelines for the prioritized health conditions. Georgia has now started to develop these for the health conditions included in the current service package. Ideally, with the initiation of a service package, such national guidelines or protocols should be available for each prioritized health condition. The PIR provides essential information in this regard, which can be used at service delivery level. The interventions described in the PIR can be adapted to each country's national needs and available resources. Moreoever, using the PIR can help countries secure the development process and standardize the rehabilitation service provision based on evidence-based interventions. The information on the interventions in the PIR can also help train the rehabilitation workforce and ensure that they have the required competencies to deliver the service package.

6. Conclusion

This report illustrates how the PIR was used to develop the first state-funded rehabilitation service package in Georgia; it also provides insights into the lessons learned from implementation. It is worth noting that Georgia chose to use a progressive approach in its realization of the benefit package, starting with the inclusion of three conditions only, but with the intention of expanding soon.

The manner in which Georgia used the PIR – for example, for prioritizing beneficiaries and defining and costing the service package – could serve as a template for other countries. Many of the decisions made are specific to country context and often dependent on the available budget, the availability of service providers, and other resources. Decisions may also involve prioritizing the specific beneficiaries; assigning interventions to rehabilitation service types; or defining the service delivery level where people with rehabilitation needs will have access to the service package.

Importantly, the development and implementation of service (or benefit) packages cannot be conducted without considering aspects related to, among others, financing (including revenue raising for funds; pooled financing; strategic purchasing of rehabilitation services and evaluation of such arrangements; tracking and reporting of rehabilitation expenditure; and reviewing existing benefit packages); the rehabilitation workforce needed (e.g. competencies and numbers of rehabilitation professionals); and the quality of the service delivery of such service packages. WHO has published several products that address these topics to support countries in their efforts to integrate rehabilitation into UHC *(31)*.

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Annex 1. Mapping of interventions from the *Package of interventions for rehabilitation*, to service type and rehabilitation specialist in Georgia

Stroke

Table A1.1 Mapping of interventions included in the *Package of interventions for rehabilitation in stroke (1)* to rehabilitation service types in Georgia

Actions (assessments and interventions) extracted from the PIR for stroke	Service type	Rehabilitation specialist	Time per session (in mins)
• Assessment of cognitive functions (intellectual, attention, memory functions) • Assessment of perceptual functions • Screening for vision impairment • Assessment of language • Assessment of speech functions • Assessment of communication • Assessment of swallowing • Assessment of pain • Assessment of defecation functions • Assessment of urination functions • Assessment of oedema • Assessment of joint mobility • Assessment of muscle functions • Assessment of muscle tone functions • Assessment of voluntary movement • Assessment of balance • Assessment of gait pattern and walking • Assessment of hand and arm use • Assessment of exercise capacity • Assessment of activities of daily living • Vocational assessment • Assessment of participation in community and social life • Assessment of lifestyle risk factors • Assessment of carer and family needs • Assessment of mental health (depression, anxiety, emotional distress) • Assessment of nutritional status • Referral to specialist assessment	Multidisciplinary team assessment (incl. development of individual rehabilitation plan)	Medical doctor (rehabilitologist), occupational therapist, physical therapist, psychologist, prosthetist & orthotist	60

Actions (assessments and interventions) extracted from the PIR for stroke	Service type	Rehabilitation specialist	Time per session (in mins)
• Vision skills training • Transcutaneous electrical nerve stimulation (TENS) • Range of motion exercises • Pain-relieving positioning • Positioning for oedema control • Positioning for the prevention of contractures • Antispastic pattern positioning • Muscle-strengthening exercises (incl. pelvic floor) • Biofeedback • Neuromuscular electrical stimulation (incl. functional electrical stimulation) • Mirror therapy • Balance training (may include Tai Chi, treadmill training, virtual reality training) • Gait training (may include virtual reality training) • Constraint induced movement therapy • Functional training for hand and arm use (may include virtual reality training) • Fitness training (including walking) • Physical exercise training	Individual physiotherapy	Physiotherapist	30
• Retrograde massage (Manual lymphatic drainage)	Lymphatic therapy	Doctor/nurse	60
• ADL Training (may include virtual reality training) • Participation focused interventions • Vocational counselling, training and support	Occupational therapy	Occupational therapist	30
• Language therapy • Speech therapy • Communication skills training • Swallowing therapy	Speech therapy	Speech therapist, occupational therapist, medical doctor	45
• Cognitive training • Psychological therapies	Psychotherapy	Psychologist/ psychotherapist	45
• Education, advice and support for self-management of the health condition (incl. information on nutritional management, bowel and bladder management skills, urinary catheterization, enteral nutrition, modification of the home and workplace environment[a]) • Education and advice on self-directed exercises • Education, advice and support for healthy lifestyle • Peer support • Caregiver and family training and support	Education of the patient, families and caregivers	Medical doctor (rehabilitologist), nurse	60

Actions (assessments and interventions) extracted from the PIR for stroke	Service type	Rehabilitation specialist	Time per session (in mins)
• Provision and training in the use of assistive products for cognitive functions • Provision and training in the use of assistive products for communication • Provision and training in the use of incontinence products • Provision and training in the use of products for compression therapy • Provision and training in the use of assistive products for mobility • Provision and training in the use of assistive products for self-care	Provision and training in use of assistive products[b]	Physiotherapist, occupational therapist, prosthetist and orthotist	45
The following intervention, NOT INCLUDED IN THE PIR, was considered for the Georgian essential service package			
• Aqua therapy	Physical therapy in the pool	Physiotherapist	30
The following non-pharmacological interventions, included in the PIR, were NOT CONSIDERED for the Georgian essential service package			
• Intermittent pneumatic compression			
The following pharmacological interventions, included in the PIR, were NOT CONSIDERED for the Georgian essential service package			
• Oral muscle relaxants (Amitryptiline, Duloxetine, Baclofen, Tizanidine) • Botulinum toxin (for chemodenervation) • Oral non-steroidal anti-inflammatory drugs • Non-opioids • Intra-articular corticosteroidal injections • Laxatives • Anticholinergic agents • Anticoagulants			

ADL = activities of daily living.

PIR = Package of interventions for rehabilitation.

[a] The topics listed in parentheses are interventions in the PIR carried out by rehabilitation professionals. Since these are not available in Georgia, they were included among topics for which education, advice and support should be provided.

[b] Several of the products specified in the PIR and listed in the left column are not included in the current state-funded service package for assistive technologies. Thus, they may not be delivered during a rehabilitation cycle related to the rehabilitation service package if a patient is unable to afford them.

Traumatic brain injury

Table A1.2 Mapping of interventions included in the *Package of interventions for rehabilitation in traumatic brain injury (1)* to rehabilitation service types in Georgia

Actions (assessments and interventions) extracted from the PIR for traumatic brain injury	Service type	Rehabilitation specialist	Time per session (in mins)
• Assessment of cognitive functions • Assessment of sleep disturbances • Assessment of fatigue • Assessment of problems with behaviour • Screening for vision impairment • Screening for hearing impairment • Assessment of vestibular functions • Assessment of language • Assessment of speech functions • Assessment of communication • Assessment of swallowing • Assessment of pain • Assessment of defecation functions • Assessment of urination functions • Assessment of sexual functions and intimate relationships • Assessment of respiratory functions • Assessment of blood pressure functions • Assessment of cardiovascular system functions • Assessment of joint mobility • Assessment of muscle functions • Assessment of muscle tone functions • Assessment of balance • Assessment of gait pattern and walking • Assessment of mobility (incl. fall risk) • Assessment of hand and arm use • Assessment of exercise capacity • Assessment of activities of daily living • Assessment of interpersonal interactions and relationships • Educational assessment • Vocational assessment • Assessment of participation in community and social life • Assessment of carer and family needs • Assessment of mental health (depression, anxiety, stress disorders) • Assessment of nutritional status • Assessment of skin (incl. risk factors for skin damage) • Assessment of heterotopic ossification • Referral to specialist for assessment of hearing functions • Referral to gastrostomy	Multidisciplinary team assessment (incl. development of individual rehabilitation plan)	Medical doctor (rehabilitologist), occupational therapist, physical therapist, psychologist	60

Actions (assessments and interventions) extracted from the PIR for traumatic brain injury	Service type	Rehabilitation specialist	Time per session (in mins)
• Sensory stimulation • Graded sitting and standing training • Relaxation training • Physical exercise training • Vision skills training • Vestibular training • Respiratory muscle-strengthening exercises • Airway clearance techniques • Functional positioning • Range of motion exercises • Muscle-strengthening exercises • Manual therapy • Balance training • Gait training • Mobility training • Functional training for hand and arm use • Fitness training • Positioning for pressure relief	Individual physiotherapy	Physiotherapist	30
• ADL training • Participation focused interventions • Vocational counselling, training and support	Occupational therapy	Occupational therapist	30
• Speech therapy • Language therapy • Communication skills training • Swallowing therapy	Speech therapy	Speech therapist, occupational therapist, doctor	45
• Cognitive remediation therapy (incl. e.g. metacognitive strategies, memory strategies, etc.) • Cognitive behavioural therapy • Behavioural interventions • Psychological therapies	Psychotherapy	Psychologist/ psychotherapist	45
• Education and advice on self-management of the health condition (incl. information on bowel and bladder management skills, urinary catheterization, enteral nutrition, energy conservation techniques, social skills, education, modification of the home environment[a]) • Education and advice self-directed exercise programme • Educational counselling, training and support • Peer support • Caregiver and family training and support	Education of the patient, families and caregivers	Medical doctor (rehabilitologist, orthopaedic doctor), nurse	60
• Provision and training in the use of assistive products for pressure relief • Provision and training in the use of incontinence products • Provision and training in the use of products for compression therapy • Provision and training in the use of assistive products for cognitive functions • Provision and training in the use of assistive products for communication • Provision and training in the use of orthoses • Provision and training in the use of assistive products for mobility • Provision and training in the use of assistive products for self-care	Provision and training in use of assistive products[b]	Physiotherapist, occupational therapist, prosthetist and orthotist	45

Actions (assessments and interventions) extracted from the PIR for traumatic brain injury	Service type	Rehabilitation specialist	Time per session (in mins)
The following interventions, NOT INCLUDED IN THE PIR, were considered for the Georgian essential service package			
• Aqua therapy	Physical therapy in the pool	Physiotherapist	30
• Manual lymphatic drainage	Massage	Doctor/nurse	60
The following non-pharmacological interventions, included in the PIR, were NOT CONSIDERED for the Georgian essential service package			
• Skin/wound care[c]			
The following pharmacological interventions, included in the PIR, were NOT CONSIDERED for the Georgian essential service package			
• Amantadine • Zolpidem, Zopicione • Second generation antipsychotics • Oral non-steroidal anti-inflammatory drugs • Laxatives • Antihyptensives (Midodrine, Fludrocortisone) • Oral muscle relaxants (Tizanidine, Baclofen, Dantrolene) • Botulinum toxin (for chemodenervation) • Anticoagulants • Bisphosphonates			

ADL = activities of daily living.

PIR = Package of interventions for rehabilitation.

[a] The topics listed in parentheses are originally interventions in the PIR carried out by rehabilitation professionals. Since these are not available in Georgia, they were included among topics for which education, advice and support should be provided.

[b] Several of the products specified in the PIR and listed in the left column are not included in the current state-funded service package for assistive technologies. Thus, they may not be delivered during a rehabilitation cycle related to the rehabilitation service package if a patient is unable to afford them.

[c] While "skin and wound care" was not specifically considered for the rehabilitation service package, any person who requires this, will receive it as part of routine care.

Spinal cord injury

Table A1.3 Mapping of interventions included in the *Package of interventions for rehabilitation in spinal cord injury (1)* to rehabilitation service types in Georgia

Actions (assessments and interventions) extracted from the PIR for spinal cord injury	Service type	Rehabilitation specialist	Time per session (in mins)
• Screening for cognitive impairment • Assessment of communication • Assessment of swallowing • Assessment of pain • Assessment of defecation functions • Assessment of urination functions • Assessment of sexual reproductive functions • Assessment of sexual functions and intimate relationships • Assessment of respiratory functions • Assessment of heart functions • Assessment of blood pressure functions • Assessment of oedema • Assessment of joint mobility • Assessment of muscle functions • Assessment of muscle tone functions • Assessment of balance • Assessment of gait pattern and walking • Assessment of mobility • Assessment of hand and arm use • Assessment of exercise capacity • Assessment of activities of daily living • Assessment of interpersonal interactions and relationships • Educational assessment • Vocational assessment • Assessment of participation in community and social life • Assessment of lifestyle risk factors • Assessment of carer and family needs • Assessment of mental health • Assessment of nutritional status (incl. body composition and nutrition needs) • Assessment of skin (incl. risk factors for skin damage) • Assessment of autonomic dysreflexia • Assessment of heterotopic ossification • Referral to specialized service (for assessment of sleep apnea) • Referral to pressure ulcer surgery • Referral for assessment of bone health (DEXA)	Multidisciplinary team assessment (incl. development of individual rehabilitation plan)	Medical doctor (rehabilitologist), occupational therapist, physical therapist, psychologist	60

Actions (assessments and interventions) extracted from the PIR for spinal cord injury	Service type	Rehabilitation specialist	Time per session (in mins)
• Transcutaneous electrical stimulation (TENS) • Physical exercise training • Respiratory (breathing) exercises • Respiratory muscle-strengthening exercises • Positioning for oedema control • Range of motion exercises • Positioning for pressure relief • Positioning for the prevention of contractures (including weight-bearing) • Muscle-strengthening exercises • Neuromuscular electrical stimulation (incl. functional electrical stimulation) • Antispastic pattern positioning • Stretching • Balance training • Gait training • Mobility training (incl. wheelchair skills training) • Functional positioning • Functional training for hand and arm use • Fitness training	Individual physiotherapy	Physiotherapist	30
• ADL training • Participation focused interventions • Vocational counselling training or support	Occupational therapy	Occupational therapist	30
• Swallowing therapy	Speech therapy	Speech therapist, occupational therapist, Medical doctor	45
• Cognitive behavioural therapy • Psychological support/counselling	Psychotherapy	Psychologist/ psychotherapist	45
• Education and advice on self-management of the health condition (incl. information on nutritional management, bladder and bowel management skills, urinary catheterization, airway clearance techniques, coping effectiveness, education, modification of the home, school and workplace environment[a]) • Education and advice on self-directed exercise programme • Education and advice on healthy lifestyle • Peer support • Caregiver and family training and support	Education of the patient, families and caregivers	Medical doctor (rehabilitologist), nurse	60
• Provision and training in the use of assistive products for pressure relief • Provision and training in the use assistive products for bladder and bowel management • Provision and training in the use of products for compression therapy • Provision and training in the use of assistive products for communication • Provision and training in the use of assistive products for mobility • Provision and training in the use of assistive products for self-care • Provision and training in the use of assistive products for work	Provision and training in use of assistive products[b]	Physiotherapist, occupational therapist, prosthetist and orthotist	45

Actions (assessments and interventions) extracted from the PIR for spinal cord injury	Service type	Rehabilitation specialist	Time per session (in mins)
The following interventions, NOT INCLUDED IN THE PIR, were considered for the Georgian essential service package			
• Aqua therapy	Physical therapy in the pool	Physiotherapist	30
• Manual lymphatic drainage	Massage	Doctor/nurse	60
The following non-pharmacological interventions, included in the PIR, were NOT CONSIDERED for the Georgian essential service package			
• Skin and wound care[c] • Invasive ventilation (incl. weaning from ventilation) • Non-invasive ventilation (Continuous positive airway pressure, Bilevel positive airway pressure)			
The following pharmacological interventions, included in the PIR, were NOT CONSIDERED for the Georgian essential service package			
• Amitryptiline • Oral non-steroidal anti-inflammatory drugs • Laxatives • Anticholinergic drugs • Alpha-1-blockers • Phosphodiesterase-5-inhibitors • Antihypotensives (Midodrine) • Fast-acting antihypertensives (Glyceril trinitate, Captopril, Nifedipine) • Oral muscle relaxants (Tizanidine, Benzodiazepine, Baclofen) • Botulinum toxin (for chemodenervation) • Phenol (for chemodenervation) • Anticoagulants • Bisphosponate			

ADL = activities of daily living.

PIR = Package of interventions for rehabilitation.

[a] The topics listed in parentheses are originally interventions in the PIR carried out by rehabilitation professionals. Since these are not available in Georgia, they were included among topics for which education, advice and support should be provided.

[b] Several of the products specified in the PIR and listed in the left column are not included in the current state-funded service package for assistive technologies. Thus, they may not be delivered during a rehabilitation course related to the rehabilitation service package if a patient is unable to afford them.

[c] While "skin and wound care" was not specifically considered for the rehabilitation service package, any person who requires this, will receive it as part of routine care.

Fractures

Table A1.4 Mapping of interventions included in the *Package of interventions for rehabilitation for fractures (2)* to rehabilitation service types in Georgia

Actions (assessments and interventions) in the PIR	Service type	Rehabilitation specialist	Time per session (in mins)
• Assessment of structure of the bones • Assessment of skin • Assessment of oedema • Assessment of respiratory functions • Assessment of muscle functions • Assessment of joint mobility • Assessment of pain • Assessment of balance • Assessment of gait pattern and walking • Assessment of hand and arm use • Assessment of mobility • Assessment of activities of daily living • Assessment of carer and family needs • Vocational assessment	Multidisciplinary team assessment (incl. development of individual rehabilitation plan)	Medical doctor (rehabilitologist/ orthopedic doctor), occupational therapist, physical therapist, psychologist, prosthetist and orthotist	60
• Respiratory (breathing) exercises • Positioning for oedema control • Range of motion exercises • Soft tissue techniques • Stretching • Joint mobilization • Muscle-strengthening exercises • Graded sitting and standing training • Gait training • Balance training • Mobility training • Functional training for hand and arm use	Individual physiotherapy	Physiotherapist	30
• ADL training • Vocational counselling, training and support	Occupational therapy	Occupational therapist	30
• Education and advice on self-management of the health condition (incl. information on modification of the home environment[a]) • Education and advice on self-directed exercise programme • Caregiver and family training and support	Education of the patient, families and caregivers	Medical doctor (rehabilitologist, orthopaedic doctor), nurse	60
• Provision and training in the use of compression therapy • Provision and training in the use of orthoses • Provision and training in the use of assistive products for mobility • Provision and training in the use of assistive products for self-care	Provision and training in use of assistive products[b]	Physiotherapist, occupational therapist, prosthetist and orthotist	45
The following non-pharmacological interventions, included in the PIR, were NOT CONSIDERED for the Georgian essential service package			
• Skin and wound care[c] • Thermotherapy			
The following pharmacological interventions, included in the PIR, were NOT CONSIDERED for the Georgian essential service package			
• Paracetamol • Anticoagulants			

ADL = activities of daily living.

PIR = Package of interventions for rehabilitation.

[a] The topic listed in parentheses is originally an intervention in the PIR carried out by rehabilitation professionals. Since this is not available in Georgia, it was included among topics for which education, advice and support should be provided.

[b] Several of the products specified in the PIR and listed in the left column are not included in the current state-funded service package for assistive technologies. Thus, they may not be delivered during a rehabilitation course related to the rehabilitation service package if a patient is unable to afford them.

[c] While "skin and wound care" was not specifically considered for the rehabilitation service package, any person who requires this, will receive it as part of routine care.

Amputation

Table A1.5 Mapping of interventions included in the *Package of interventions for rehabilitation for amputation (2)* to rehabilitation service types in Georgia

Actions (assessments and interventions) in the PIR	Service type	Rehabilitation specialist	Time per session (in mins)
• Assessment of body image • Assessment of pain • Assessment of the skin • Assessment of vascular functions • Assessment of oedema • Assessment of joint mobility • Assessment of muscle functions • Assessment of balance • Assessment of gait pattern and walking • Assessment of mobility • Assessment of exercise capacity • Assessment of activities of daily living • Assessment of interpersonal interactions and relationships • Educational assessment • Vocational assessment • Assessment of participation in community and social life • Assessment of lifestyle risk factors • Assessment of mental health (depression, anxiety, stress disorders) • Assessment of carer and family needs	Multidisciplinary team assessment (incl. development of individual rehabilitation plan)	Medical doctor (rehabilitologist/ orthopedic doctor), occupational therapist, physical therapist, psychologist, prosthetist and orthotist	60
• Positioning for oedema control • Range of motion exercises • Soft tissue techniques • Stretching • Muscle-strengthening exercises • Gait training • Balance training • Fitness training • Mobility training	Individual physiotherapy	Physiotherapist	30
• ADL training • Participation focused interventions • Vocational counselling, training and support	Occupational therapy	Occupational therapist	30
• Cognitive behavioural therapy • Psychosocial interventions	Psychotherapy	Psychologist/ psychotherapist	45
• Education, advice and support for the self-management of the health condition (incl. information on education, modification of the home, school and workplace environment[a]) • Education, advice and support for healthy lifestyle • Peer support • Carer and family training and support	Education of the patient, families and caregivers	Medical doctor (rehabilitologist, orthopaedic doctor), nurse, physiotherapist, or occupational therapist	60

Actions (assessments and interventions) in the PIR	Service type	Rehabilitation specialist	Time per session (in mins)
• Provision and training in the use of products for compression therapy • Provision and training in the use of Early Walking Aids (EWA) • Provision and training in the use of lower limb prosthesis • Provision and training in the use of upper limb prosthesis • Provision and training in the use of assistive products for mobility • Provision and training in the use of assistive products for self-care • Provision and training in the use of assistive products for sports and recreation	Provision and training in use of assistive products[a]	Physiotherapist, occupational therapist, prosthetists and orthotist	45
The following non-pharmacological interventions, included in the PIR, were NOT CONSIDERED for the Georgian essential service package			
• Skin/wound care[c] • Rigid dressing			
The following pharmacological interventions, included in the PIR, were NOT CONSIDERED for the Georgian essential service package			
• Amitryptiline			

ADL = activities of daily living.

PIR = Package of interventions for rehabilitation.

[a] The topic listed in parentheses is originally an intervention in the PIR carried out by rehabilitation professionals. Since this is not available in Georgia, it was included among topics for which education, advice and support should be provided.

[b] Several of the products specified in the PIR and listed in the left column are not included in the current state-funded service package for assistive technologies. Thus, they may not be delivered during a rehabilitation course related to the rehabilitation service package if a patient is unable to afford them.

[c] While "skin and wound care" was not specifically considered for the rehabilitation service package, any person who requires this, will receive it as part of routine care.

References

1. Package of interventions for rehabilitation: module 3: neurological conditions. Geneva: World Health Organization; 2023 (https://apps.who.int/iris/handle/10665/370504, accessed 31 October 2024).
2. Package of interventions for rehabilitation: module 2: musculoskeletal conditions. Geneva: World Health Organization; 2023 (https://iris.who.int/handle/10665/370503, accessed 31 October 2024).

Annex 2. Costing of the rehabilitation service package

Table A.2 Cost calculation, in Georgian lari, of the rehabilitation service package (workforce time) for spinal cord injury per individual in Georgia.

Acute and subacute inpatient rehabilitation		Number of sessions		Cost of service package per patient (GEL)	
Service type	**Unit costs (GEL)**	**Acute**	**Subacute**	**Acute**	**Subacute**
Multidisciplinary team assessment and development of individual rehabilitation plan	227	2	2	455	455
Individual physiotherapy	39	10	28	394	1104
Individual physiotherapy: Aqua therapy in the pool	40	0	0	0	0
Lymphatic therapy	78	2	3	156	234
Occupational therapy (individual or group)	45	1	8	45	359
Speech and language therapy	50	2	2	99	99
Psychotherapy	76	1	6	76	457
Education of patient, families and caregivers	72	1	3	72	217
Provision and training in the use of assistive products	56	1	3	56	169
Medical consultation	54	3	2	163	109
TOTAL				**1518**	**3204**

Outpatient rehabilitation		Number of sessions			Cost of service package per patient (GEL)		
Service type	**Unit costs (GEL)**	**Mild**	**Moderate**	**Severe**	**Mild**	**Moderate**	**Severe**
Multidisciplinary team assessment (incl. development of individual rehabilitation plan)	227	3	3	3	682	682	682
Individual physiotherapy	39	30	50	42	1183	1971	1656
Individual physiotherapy: Aqua therapy in the pool	40	10	10	0	397	397	0
Lymphatic therapy	78	1	2	2	78	156	156
Occupational therapy (individual or group)	45	25	32	30	1123	1437	1347
Speech and language therapy	50	10	40	15	496	1984	744
Psychotherapy	76	8	12	10	609	914	762
Provision and training in the use of assistive products	56	15	25	18	846	1409	1015
Education of patient, families and caregivers	72	5	5	8	362	362	580
Medical consultation	54	6	8	8	327	436	436
TOTAL					**6103**	**9749**	**7377**

GEL = Georgian lari

Annex 3. Estimates for the numbers of people in need

Table A.3 Overview of the numbers of people in need of rehabilitation in Georgia, per health condition, rehabilitation phase, and level of severity.

Health condition	n[a]	Proportion of people in need for rehabilitation				
		Inpatient			Outpatient	
		acute	subacute	total	per severity	
Stroke, traumatic brain injury	3567	40%	40%	40%	mild	60%
					moderate	25%
					severe	15%
Spinal cord injury	165	100%	100%	100%	mild	60%
					moderate	25%
					severe	15%
Fractures/Endo-prosthesis of hip and knee joints[b]	4054	100%	30%	100%	mild	60%
					moderate	25%
					severe	15%
Amputation	471	100%	30%	100%	mild	60%
					moderate	25%
					severe	15%

[a] Total incidence of adults with the health condition (projected for 2023).

[b] Endoprosthesis of hip and knee joint due to conditions other than fractures were included to ensure optimal outcomes for joint replacement surgeries that are already funded in Georgia.

Annex 4. Eligibility criteria to become a beneficiary and receive funding

Table A.4 Eligibility criteria for beneficiaries of the rehabilitation service package in Georgia and the amount of funding needed.

Broader category	Eligibility criteria			
General eligibility criteria				
Diagnosis	• Patient has a diagnosis that is included in the service package (defined with ICD codes) • Diagnosis is not older than 24 months			
Medical state of the patient	• Patient is in a medically stable state • Patient can actively participate in intensive rehabilitation • Patient can perform/follow at least one-step instructions, if necessary, with communication support • Patient has sufficient attention and ability to follow simple rehabilitation instructions for involvement in the rehabilitation process • Injury does not progress during the rehabilitation process • Mental state, actions do not pose a risk, either to the patient themselves (self-harm) or to the people around them			
Interest and ability of the patient to travel	• Patient has the desire to participate in the rehabilitation programme • Patient can travel (from the place of residence to the service provider and back) or the patient travels with support of a family member and/or legal representative			
Review by commission	• Including the beneficiary in the rehabilitation course will be reviewed by the commission for management of rehabilitation measures			
Access to subsequent courses	• Funding for each subsequent course following the first course, is determined by the total score obtained through the Functional Independence Measure (FIM).[a] Where there is an increase in the FIM total score by more than 10%, the following rehabilitation course(s) will be funded according to the category			
Criteria for proportion of funding		**Funding**		
		100%	**90%**	**80%**
Socially vulnerable persons	• Persons registered in the "Unified Database of Socially Vulnerable Families" whose rating score does not exceed 70 000	X		
Place of residence	• Family members of persons internally displaced from the occupied territories of Georgia as a result of the armed assault on Georgia by the Russian Federation since 6 August 2008, who were resettled in residential areas purchased, rehabilitated or newly built by the state or other legal entities	X		
	• Families residing in the vicinity of the occupied territory of the Autonomous Republic of Abkhazia	X		
	• Persons living in the villages adjacent to the dividing line with the occupied territories of Georgia	X		
	• Beneficiaries of educational institutions, shelters for mothers and children, and community organizations	X		
	• Beneficiaries residing in the territorial units of the State Care Agency, at child-care institutions, and boarding houses for older persons and disabled persons	X		

Broader category	Eligibility criteria			
General eligibility criteria				
Criteria for proportion of funding		**Funding**		
		100%	**90%**	**80%**
Professional group	• Teachers	X		
	• People's artists, people's painters and Rustaveli Award winners	X		
	• Veterans registered in the information base of LEPL State Service of Veterans Affairs	X		
	• State pension recipients with the retirement age		X	
	• Students (including professional students)			X
Disability status	• Persons with the disability status			X

[a] Following a first feedback, tools other than the FIM were allowed to evaluate progress.