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# GEORGIA HEALTH SYSTEM STRENGTHENING PROJECT (HSSP) MID-TERM EVALUATION

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# GEORGIA HEALTH SYSTEM STRENGTHENING PROJECT (HSSP) MID-TERM EVALUATION REPORT

## **DISCLAIMER**

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## ACRONYMS

BBP	Basic benefit package
CIS	Commonwealth of Independent States
CTC	Center for Training and Consultancy
DCA	Development Credit Authority
EBM	Evidence-based medicine
ECA	European and Central Asian Region (World Bank)
EDL	Essential drug list
EU	European Union
GDP	Gross domestic product
GEL	Georgian lari
GH Tech	Global Health Technical Assistance Project
GHA	Georgian Hospital Association
GIA	Georgian Insurance Association
GoG	Government of Georgia
GPIH	Georgian Pension and Insurance Holding
HCM	Health care module
HeSPA	Health and Social Program Agency
HIMS	Health Insurance Mediation Service
HIT	Health Systems in Transition
HMIS	Health management information system
HSD	Health and Social Development Office (USAID/Georgia)
HSR	Health sector reform
HSSP	Health System Strengthening Project
HUES	Health Utilization and Expenditure Survey
ICD	International Classification of Diseases
ICPC	International Classification of Primary Care
IPECC	Insurance Professional Education and Consultancy Center
MAP	Medical Assistance Program
MoLHSA	Ministry of Labour, Health and Social Affairs
NCDC	National Center for Disease Control
ODB	Outpatient drug benefit
PHC	Primary health care
SIMS	Social Information Management System

SOW	Scope of work
SSA	Social Service Agency
TPM	Team planning meeting
USAID	U.S. Agency for International Development
WB	World Bank
WHO	World Health Organization

## EXECUTIVE SUMMARY

At the end of 2006, the Government of Georgia (GoG) made the decision to embark on considerable changes to its health sector strategy. As part of this process, the government focused on market mechanisms to improve access to health care, upgrade infrastructure, enhance the quality of health care services, and increase the efficiency of service provision. The GoG pursued a three-pronged strategy: better means-tested targeting of state resources to address the health needs of the poor and disadvantaged; increased privatization of health care providers (including hospitals and primary health care facilities); and an enhanced role for private health insurers.

HSSP's goal was to support GOG's health reform efforts aimed at enhancing the population's health status and improving access to and satisfaction with the quality of health services. The project has three objectives: strengthen insurer capacity to provide quality health insurance services; strengthen provider capacity to manage and deliver quality health care services; and strengthen GoG capacity to guide and monitor health reforms.

In September 2010 the project's scope was further expanded to assist the Ministry of Labor, Health and Social Affairs (MoLHSA) in developing an integrated national health management information system (HMIS) and supporting the expansion of voluntary health insurance coverage.

In August 2011 USAID/Georgia decided to conduct a mid-term evaluation of HSSP to assess the project's achievements and identify future needs in providing technical assistance to Georgia's health sector. The evaluation also envisaged updating an assessment of the Georgian health system conducted by USAID in 2009. The evaluation team, which included an external consultant, reviewed all project-related literature and surveys, agreed on an evaluation methodology, conducted field visits/key informant interviews, and analyzed data, using the information gathered to develop this evaluation report.

The evaluation team faced a limitation, in that the Health Sector Strategy Paper was still under GoG review at the time of assessment and the team was unable to obtain a draft version of the paper. As a result, the team based recommended interventions, goals, and objectives for the project's remaining three years on informed assumptions about the directions of the new health sector strategy.

The evaluation team found that HSSP implementation has been in overall compliance with the task order and work plan. In cases when planned interventions have not been fully implemented, the cause was generally external factors (e.g., an uncertain and changing environment and priorities in the health sector, lack of long-term planning by various health sector stakeholders, weak evidence-based decision-making capabilities) rather than due to poor performance on the part of HSSP. Various publications produced by HSSP's international and local experts have been high in quality, in line with accepted international standards, and have contributed to the design of new policies.

Under Objective I (strengthen insurer capacity to provide quality health insurance services), HSSP has succeeded in developing sustainable training courses for insurers, with courses developed in claims management, underwriting, and insurance risk management product development. Additionally, the project conducted an executive seminar for health insurance leaders and a seminar on hospital design. Representatives from the University of Georgia and Caucasus School of Business participated in training-of-trainers for the two insurance courses. The University of Georgia incorporated course material into its insurance-related master's

degree programs. Iliia University also included the materials in its newly launched Master's of Insurance Business program. The new training facility established by the Georgian Insurance Association (GIA), the Insurance Professional Education and Consultancy Center (IPECC), has rolled out the claims management course on a regular basis with the help of an HSSP grant.

Georgian Pension and Insurance Holding (GPIH) started a pilot aimed at addressing fraud by introducing changes in provider reimbursement, contracting, claims management, and other insurance operations. The HSSP grant to GIA also targets work with insurers and providers to create examples of functional new provider payment models that reward performance, rather than volume of health service, as do traditional fee-for-service reimbursement models.

HSSP developed a risk analysis for including outpatient drug benefit (ODB) in insurance programs (specifically for the Medical Assistance Program, or MAP). The intention was to help decision makers better understand the complexity of issues that should be taken into account when introducing ODB. International experts conducted the analysis and engaged policy makers in a discussion of the analysis and the resulting recommendations.

HSSP carried out a survey of the ability and willingness of middle-class Georgians to buy health insurance. Information from the survey was expected to feed into technical assistance and inform the design of health insurance packages that would be both useful and attractive for the nearly 3 million Georgians who lack health insurance. The survey data was transferred to GIA, allowing the association an opportunity to analyze the information and inform the industry on the survey's results.

HSSP analyzed international experience with health promotion within the context of health insurance and presented the analysis and lessons learned to health insurers and MoLHSA, as well as the First Lady of Georgia, Sandra Roelofs. Executives from GPIH and Imedi L expressed interest in learning more about incorporating health promotion into insurance packages. However, subsequent meetings between company executives and international and Georgian HSSP experts revealed the reluctance of insurers to invest in health promotion benefits, as customers appear unwilling to pay for them.

In collaboration with the National Centers for Disease Control, HSSP developed Web-based software enabling a user-friendly environment for using medical classification systems throughout the various parts of Georgia's health care system (GoG/MoLHSA, providers, insurers).

Through a grant to GIA, HSSP is supporting the establishment and development of a health insurance mediation service (HIMS) that will serve the mediation needs of all those insured under private schemes (that is, those not funded by the GoG). The new HIMS, which will be a unit of GIA, will provide mediation services between clients and insurance companies and will cover the more than 450,000 people who are insured under non-GoG schemes.

Under Objective 2 (strengthen providers' capacity to manage and deliver quality health care services), HSSP international experts developed courses in human resource management, financing and costing, quality improvement, and development of successful working relations with insurance companies. The courses were piloted through multiple deliveries to hospital managers across all regions of Georgia. University of Georgia staff were trained as trainers and provided with training materials and trainer guides. In addition, the training materials were incorporated into their academic programs.

HSSP is facilitating the work of Georgian professional medical associations to develop a code of medical conduct for use in Georgia. The code is intended to strengthen the quality of care and improve the customer experience in health care facilities. The code has been completed and is currently ready for dissemination.

HSSP has served as a strong supporter of the Georgian Hospital Association (GHA), established in 2009. HSSP provides GHA with office space and a venue for meetings, organized the GHA's launch event, and assisted in creation of a strategic plan for the association. In collaboration with GHA, HSSP launched a pilot supporting the establishment of hospital accreditation.

Additionally, HSSP assisted in the completion of a critical stage in the Development Credit Authority (DCA) bank loan guarantee review process.

Under Objective 3 (strengthen GoG's capacity to guide and monitor health reforms), the HSSP has delivered to MoLHSA a concept concerning a health care module for a social information management system (SIMS), a concept for a health management information system (HMIS), and a blueprint for an electronic medical record system. The documents are state-of-the-art syntheses of best international practices in health information management, and have been adopted by MoLHSA. In October 2010, MoLHSA's new leadership requested that HSSP discontinue its work on SIMS. Much of what should have been in the SIMS health care module has been incorporated into the HMIS. HSSP has created various HMIS elements/modules, guided by MoLHSA's priorities regarding its construction.

HSSP conducted a seminar focusing on the pros and cons of introducing a basic benefit package (BBP) as part of insurance. The seminar was well attended by MoLHSA and insurance executives. HSSP also produced and disseminated at the seminar a technical paper that discussed the subject and provided information on BBP-related international experience. As a result MoLHSA and insurers agreed that introduction of a BBP in Georgia would be premature at this time.

To support extending outpatient drug coverage through the expansion of health insurance to reach a broader swathe of vulnerable populations in Georgia, HSSP developed an analytical policy paper advocating for inclusion of the elderly in GoG-subsidized insurance.

HSSP organized a training seminar for MoLHSA outreach experts and journalists from various media outlets. The seminar's purpose was to help both sides understand Georgia's current health finance and delivery model and promote better relations and more regular contacts between MoLHSA and journalists. HSSP also conducted special trainings for journalists from national and regional media to improve their understanding of the Georgian health insurance model.

HSSP supported the HIMS in conducting an information campaign to increase awareness of its services among the Georgian population and inform beneficiaries about state health programs for their entitlements.

HSSP designed and delivered a workshop for Georgian healthcare policy makers. The workshop introduced the concept of evidence-based approaches to setting public healthcare priorities. It was attended by more than 25 participants from various government agencies.

HSSP's main challenge is related to the environment in which health sector reforms in Georgia take place. This environment is fast-changing and uncertain. Preparation for the upcoming parliamentary and presidential elections in 2012 and 2013 may bring new developments in GoG health policies. As a result, HSSP must remain flexible and be prepared to respond to the changing needs of the sector and project partners. At the same time, HSSP should continue to base its assumptions and recommendations on the best available evidence-based practices while dealing with all project partners, particularly MoLHSA.

The evaluation's recommendations on future priorities were developed by means of consultations with major stakeholders (MoLHSA, GIA, medical associations, and others) as well as through the study of available materials, including information on the key future directions of

the health sector strategy. Under Objective 1, it is recommended that HSSP continue its close cooperation with GIA, given the assessment finding that GIA has developed sustainable training courses for insurers and has won the industry's trust and respect.

As the assessment process indicated, there are several areas in which HSSP could re-concentrate its efforts and provide technical support to insurers. One potential area could be in developing a new provider payment system – a change from the current fee-for-service model to performance-based reimbursement systems that would provide more incentives for cost-effectiveness and service quality. It would be advisable if HSSP assists insurers in creating innovative insurance packages. Designing such packages would promote the expansion of population coverage through the use of voluntary health insurance. Insurance companies would benefit by gaining new clients from non-poor segments of the population and would consequently be better able to manage insurance risks by increasing the size of risk pools.

Under Objective 2, HSSP should continue its support to medical associations. The GoG has high hopes for professional associations, believing they will play an important future role in self-regulating the quality of health care. Unfortunately, professional medical associations are both weak and under-resourced, and not very active at the moment. They are also not well-recognized among health care providers. Therefore, support to professional medical associations in various activities (providing assistance in capacity building, developing recommendations on becoming sustainable, respected entities, and so forth) should be a priority of Objective 2. Together with capacity-building activities, HSSP should work with associations on several other important issues, including implementation of a code of conduct; development of a program of continuous medical education; accreditation and other steps to ensure quality of health care; and development of effective tools and practices to support industry communications with the media.

Establishing and maintaining good working relations with MoLHSA is crucial not only for successful implementation of interventions planned under Objective 3, but also for the success of the overall project. Changes in health care policy directions can be expected in line with new political circumstances. This is particularly true for the next two years, when the country will be holding parliamentary elections and might decide to expand health insurance coverage and include pensioners in publicly funded insurance programs. HSSP has already prepared a paper on opportunities for providing health insurance coverage to Georgian pensioners. This work should be continued and expanded to include a detailed description of the path forward to achieve adoption of the recommendations presented in the paper.

Two of MoLHSA's most urgent priorities are already apparent—developing a workable health management information system and strengthening the health insurance mediation service. Given that the support of USAID and HSSP in developing the e-health system and mediation service have been greatly appreciated by high-level MoLHSA decision makers, including the Deputy Minister of MoLHSA, the project should continue and strengthen its assistance in these directions.

## **I. HSSP: INTRODUCTION AND BACKGROUND**

The Health System Strengthening Project (HSSP) was launched on October 1, 2009, and is scheduled to run through October 2014. The project's overall objective is to support the health reform efforts of the Government of Georgia (GoG), which are aimed at improving the population's health status and increasing access to and satisfaction with the quality of health services. HSSP has three specific objectives over its five-year period:

- Objective 1: Strengthen insurer capacity to provide quality health insurance services
- Objective 2: Strengthen provider capacity to manage and deliver quality health care services
- Objective 3: Strengthen government capacity to guide and monitor health reforms

In September 2010, the project's scope was further expanded to assist the Ministry of Labor, Health and Social Affairs (MoLHSA) in developing an integrated national health management and information system (HMIS) and support the expansion of voluntary health insurance coverage.

In October 2010, MoLHSA's new leadership requested that HSSP activities focus intensively on HMIS development in the country. This request was incorporated into the FY2011 work plan. In parallel with these developments and as an outcome of the Georgian Health Care Medea conference in February 2011, MoLHSA commissioned the development of a medium-term health sector strategy (white paper) for Georgia. The draft strategy was still under GoG review during this evaluation.

As identified in the scope of work (SOW), the purpose of the assessment was to assist the USAID/Georgia Health and Social Development (HSD) Office in conducting a mid-term evaluation of HSSP and developing recommendations on its future direction. The evaluation had five objectives:

1. Review compliance of HSSP implementation with the task order and annual work plans; if necessary, identify internal and external constraints that hindered the implementation of planned activities.
2. Review HSSP achievements to date, with the emphasis on outcome- and impact-level results.
3. Update an assessment of the Georgian health system conducted by USAID in 2009, and define and prioritize future technical assistance needs.
4. Verify relevancy of HSSP objectives and goals, based on the assessment's results. Goals and objectives should be aligned to the newly approved health sector strategy (white paper).
5. Propose recommendations for future directions for HSSP, including specific activities, timing, and output- and outcome-level indicators.



## II. OVERVIEW OF HEALTH AND HEALTH REFORM IN GEORGIA

Georgia's health and social services sectors are struggling to overcome the ill-effects of low government spending in these areas since independence in 1991. Starting in 1997, the GoG made several attempts to transform Georgia's health care system into one that improves the efficiency, accessibility, and quality of health care services. The first rounds of reforms predominantly focused on developing a nationwide primary health care network. The reforms were less successful than anticipated in achieving their objectives, partly due to weak GoG leadership and a lack of effective donor coordination. Health facilities have not been well-maintained and the quality of health care remained low. Even so, Georgia has managed to keep its life expectancy rate stable and keep vaccine-preventable diseases in check. In the years following the Rose Revolution in 2003, the government has undertaken major reforms within its health sector and dramatically increased public health care spending.

Among Georgia's continuing health care challenges are the following:

- Limited access to and unaffordability of essential health services for some segments of population
- Low quality of clinical care
- Continuing low public expenditures on health
- Heavy burden of non-communicable diseases and injuries
- Higher infant and maternal mortality compared to European Union (EU) countries
- Abortion rates that are still high, though declining
- High prevalence of tuberculosis
- An emerging HIV/AIDS epidemic concentrated in high-risk groups

The proportion of people suffering from chronic illnesses, already high, increased from 37% to 41% between 2007 and 2010. Almost 15% of respondents to the 2010 Health Utilization and Expenditure Survey (HUES) indicated having more than one chronic disease, compared to 11% in 2007. The proportion of individuals rating their health as "good" or "better than good" decreased from 51% to 48% (statistically significant decrease:  $p < 0.01$ ) during the same period (HUES, 2010).

Improvement of health outcomes in Georgia remains a continuing challenge. The appropriate, equitable, timely use of quality health services is a key proximate determinant of health status. Health services utilization rates in Georgia are the lowest in the World Bank European and Central Asian (ECA) region, with less than two outpatient visits per capita and less than five inpatient visits per 100 people. Out-of-pocket payments for treatment are still a major barrier to seeking care. Illness is one of the primary causes for falling into poverty: an additional 10% of individuals cross the official poverty line as a result of incurring hospitalization costs.<sup>1</sup> The 2010 HUES revealed that household health care expenditures increased by 59% in nominal terms between 2007 and 2010, significantly higher than the general rate of inflation in the Georgian economy during the same period.

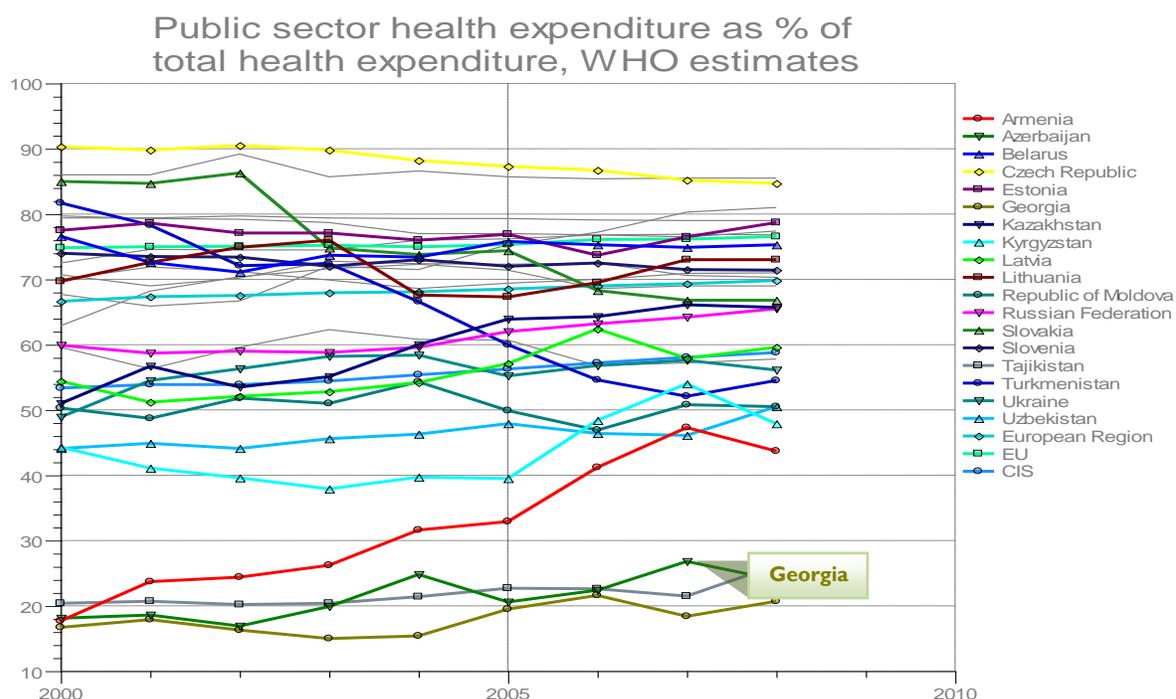
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<sup>1</sup> U.S. Government. *Georgia Global Health Initiative Strategy*. Accessed September 5, 2011. <http://www.ghi.gov/documents/organization/175130.pdf>.

## HEALTH SECTOR REFORMS

The GoG has historically allocated a small portion of its budget to the health care sector, with public spending on health care remaining low compared to total health care expenditures since 1991. Starting in 2004, the government began to dramatically increase its health sector spending, although as part of GDP it remained low compared to developed countries. In 2003 public spending on health constituted just 0.6% of GDP; in 2010 the figure reached 1.8%. In absolute figures, total per capita health expenditure increased from U.S. \$74 in 2003 to U.S. \$256 in 2009 (World Bank, 2011). Almost 80% of total health expenditure is in the form of private spending. According to WHO estimates, Georgia has one of the lowest rates of public spending on health as a proportion of total health expenditure in the European and Central Asian region (Figure 1).

**Figure 1. Public Sector Health Expenditures as Percentage of Total Health Expenditure for Selected Countries and Regions (WHO Estimates 2000–2008)**



Source: WHO, European Health for All Database, 2011.

Public sector expenditure on health promotion and disease prevention is particularly low, declining from 8% to 2% of total public health expenditures between 2001 and 2008 (WHO, 2009).

Since the mid-1990s, the GoG with the support of international donors embarked on reforms aimed at modernizing the country's health system. Following the recommendations of the donor community and international experts, the reforms focused on decentralization, optimization of health facilities, and promotion of primary health care (PHC). While the reforms also included the privatization of some facilities, this process was fragmented and privatization was not systematically applied.

Starting in 2007, the GoG initiated a bold new round of health sector reforms, relying on market mechanisms to increase access to health care, improve the quality of care, and increase the efficiency of service provision. The reforms consisted of initiatives in the following areas:

- Privatization of health care infrastructure
- Targeting of the most vulnerable population groups with comprehensive health insurance coverage
- Channeling of public funding to reach targeted vulnerable groups through private insurance companies
- Reduction of health sector regulation to an essential minimum, while retaining essential public health functions as a government responsibility

Expansion of the private sector's role has been accompanied by a significant reduction of the state's ineffective regulatory functions. The GoG takes the position that professional medical and provider associations are able to fill this role and provide certain regulatory functions within the sector. However, the weak regulatory capabilities of professional associations do not support this. Another issue is the need for a supporting suite of changes in health legislation. Generally speaking, health legislation has not adequately supported the market-oriented changes occurring in the health sector. According to the Public Defender's 2010 Report, the legislative base for health insurance is in need of further revision and improvement – for example, the restriction on a consumer's right to choose an insurance company contradicts existing legislation.

Georgian pharmaceutical companies have benefited from the market-oriented reforms and have become influential players in the health sector. This is particularly true in the case of two companies, PSP and Aversi, which have substantially expanded their business base in Georgia beyond the import of pharmaceuticals. In addition to opening pharmaceutical factories and health clinics, the two companies have recently established insurance companies.

The growth of the pharmaceutical industry has been accompanied by a steep increase in household pharmaceutical expenditures. According to the 2010 HUES, household spending on pharmaceuticals increased by 85% in per capita terms, rising from 105 to 194 Georgian lari (GEL) from 2007 to 2010; that translates into 60% of household health spending devoted to pharmaceuticals in 2010, compared to 50% in 2007. According to HUES, oligopolistic practices in the pharmaceutical market and weak state regulations may be behind the sharp increase in spending. For example, the prescribing practices of doctors are often influenced by pharmaceutical companies, which rely on various bonuses to sway doctors' decision making.

## **PRIVATE HEALTH INSURANCE**

The GoG views private insurance as a principal tool for ensuring the public's financial access to health care services and protecting households from catastrophic health costs. Four years after the initiation of reforms, some 1.3 million people out of a total population of 4.4 million are covered by health insurance provided by private insurance companies, paid through either public or private funding.

The GoG's decision to insure the poorest segments of the population through private insurance has resulted in a steep increase in the number of poor people who are privately insured, which reached 887,706 in July 2011 (GIA, 2011). Interestingly, the poor in Georgia have become the majority of clients served by private health insurance companies: According to the 2009 Georgia Health System Performance Assessment, 75% of people with private health insurance were from the poorest population group. Currently, more than 300,000 Georgians have private voluntary (corporate or individual) health insurance, compared to just 40,000 in 2005 (GIA, 2011).

At this point, any further expansion of voluntary insurance coverage faces significant challenges. Low and unstable household income, combined with the high proportion of the workforce employed in the non-formal and agricultural sector and the lack of awareness of the benefits of insurance, all pose major barriers to expanding insurance coverage. Accompanying these factors are the adverse selection fears of the insurance companies, as the decision to purchase health insurance is often triggered by the need for expensive treatment. Insurance companies usually refuse to cover pre-existing conditions, diminishing people's trust in private insurance. Purchasing individual insurance packages is generally quite difficult and insurance companies are not eager to develop and market such products. In addition, some experts believe that private insurance companies have become overly comfortable with GoG-subsidized programs (e.g., the Medical Assistance Program, or MAP) and therefore have little motivation to develop innovative programs and products to stimulate more people to purchase voluntary insurance.

So-called "cheap 5-lari insurance," introduced and subsidized by the government in 2009 as a pilot, only continued for a year. This program covered the costs of urgent care in case of accident, 50% of urgent non-accident inpatient care costs, urgent outpatient care, unlimited visits to a primary health care physician, and limited laboratory and diagnostic tests at the PHC level; medicines were not included in the package. The government subsidized GEL 40 of the 60 GEL annual premium, with each beneficiary paying the remaining GEL 20. However, the program proved unattractive for the population, mainly due to tight coverage limits and a lack of reimbursement for even part of the cost of medicines.

As a consequence, up to 70% of the population lacks insurance coverage and is destined to pay out of pocket for health services. People over age 60 are provided with a limited health service package that fails to provide protection from catastrophic health costs. Essential medicines are only partly covered through publicly paid private health insurance policies. Many beneficiaries of public health care programs are unaware of their entitlements and fail to benefit from available services. The health information system is not yet fully functional and cannot provide the timely, accurate data needed to support evidence-based decision making.

## **HOSPITAL PRIVATIZATION**

According to HUES, hospitals are the main sources for patient consultations, even for outpatient services. In 2010, hospitals' outpatient departments were the first places for seeking care for almost 30% of patients, compared to 24% for polyclinics and 9% for village ambulatory centers. This held true even in rural areas, where the proportion of individuals who sought care in village ambulatories decreased from 20% in 2007 to 18% in 2010. This trend was accompanied by an increase in the use of hospital outpatient and inpatient services. Interestingly, about 90% of patients seeking care in non-PHC facilities were self-referred (HUES, 2010).

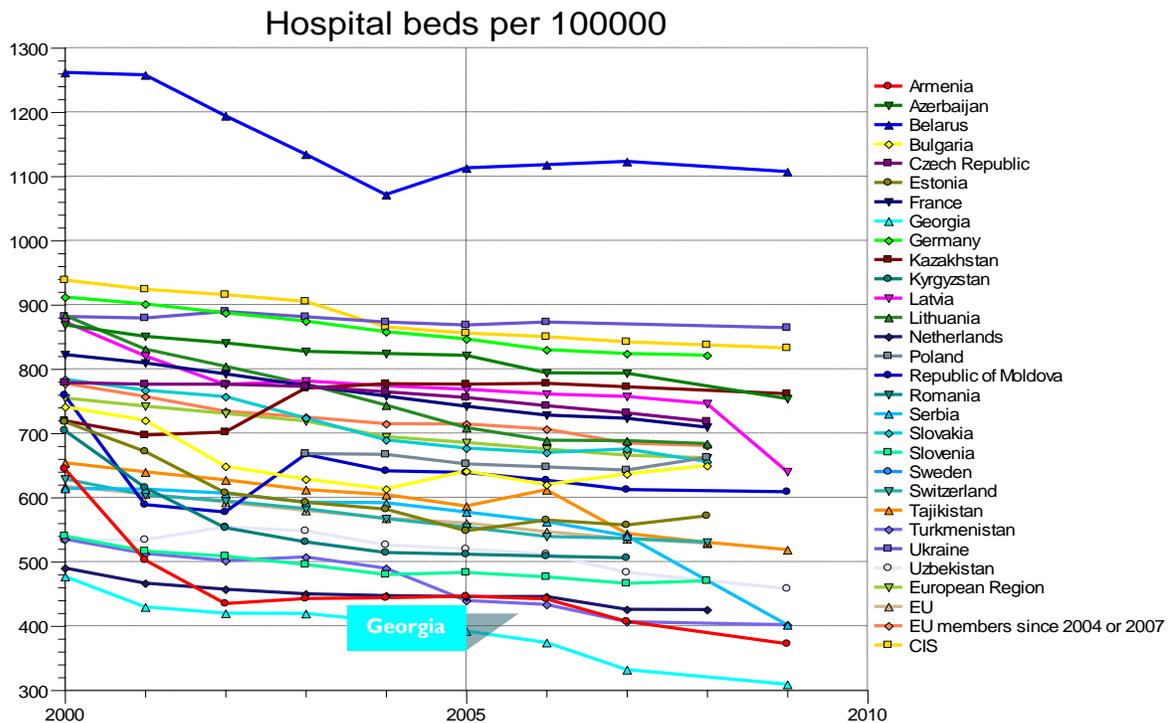
The hospital privatization process, which stalled in 2008, has been redesigned and revitalized by the GoG and is currently under way. Largely due to gaps in beneficiaries' insurance literacy and inability to differentiate between the various offerings of insurance companies, the GoG decided last year to replace insurance vouchers with a new tender mechanism. The country was divided into 27 health care districts, and insurance companies were invited in March 2010 to compete for the opportunity to provide health insurance to the eligible poor for a period of three years in each of the districts. Along with the obligation to provide the state-defined health insurance package, the bidders were also requested to build small hospitals in designated districts by December 2011. According to the Hospital Sector Infrastructure Development Plan, insurance companies are required to build and operate 46 new hospitals countrywide.

The hospital renovation/construction process is currently under way and several facilities have already opened. A noteworthy issue is the weak managerial capacity of the new hospital

managers. Building and operating hospitals across the country was a completely new task for emerging insurance companies, causing further difficulties in the implementation of their main mission.

Another issue for the new hospitals is their limited bed capacity. Georgia had one of the lowest rates of available hospital beds in the World Health Organization (WHO) European region before the initiation of market-oriented reforms. Managers of some of the new hospitals have already expressed their concern regarding the increase in demand for inpatient services and the unavailability of hospital beds in the newly renovated district-level hospitals. Figure 2 depicts recent trends in hospital bed availability in Georgia in comparison to countries in WHO's European region.

**Figure 2. Hospital Beds per 100,000 in Selected Countries and Regions, 2000–2009**



Source: WHO, European Health for All Database, 2011.



### **III. METHODOLOGY**

The methodology to be used for the evaluation was identified in the SOW, which is provided in Annex A. During an initial team planning meeting, the team members further reviewed the methodology and agreed on data collection methods, along with instruments, tools, and guidelines.

#### **PHASES OF EVALUATION**

The assessment was comprised of the following four phases:

- A literature and survey review
- A team planning meeting (TPM)
- Field visits/key informant interviews
- Analysis, consultations with USAID, and reporting

#### **Literature and Survey Review**

In the evaluation's first phase, the team carried out a wide-ranging desk review of documentation related to overall GoG health sector reform and policies, as well as the 2009 Health Sector Assessment report, the HSSP task order, HSSP implementation reports (Performance Monitoring, Year I Annual Report, and monthly progress reports), various survey reports, and publications developed within the framework of the project.

#### **Team Planning Meeting**

The TPM was held at the beginning of the assignment. The following issues were discussed and agreed during the meeting:

- Agreeing on an approach for working with USAID staff and partners throughout the assignment
- Developing data collection methods, instruments, tools, and guidelines
- Developing a preliminary draft outline for the team's report and assigning drafting responsibilities for the final report
- Reviewing and finalizing the assignment timeline to share with and be approved by the Mission
- Enabling USAID staff to discuss with the team the overview and purpose of the SOW
- Clarifying individual team member roles and responsibilities
- Reviewing and clarifying logistical and administrative procedures for the assignment

#### **Field Visits and Key Informant Interviews**

During this phase, the Team Leader created and finalized data collection instruments that were approved by USAID prior to any key informant interviews or site visits. Interviews were conducted in Tbilisi as well as in the regions in order to obtain relevant information on project implementation, outputs, and future plans. Key health sector stakeholders, including MoLHSA decision makers, the Health and Social Affairs parliamentary committee, representatives of health insurance companies, private health service providers, other donor agencies, non-governmental organizations (NGOs), and professional medical associations were interviewed. A detailed list of interviewees is presented in Annex B. Qualitative research methods were used to

obtain primary data from project beneficiaries and other stakeholders, with further secondary data collected and analyzed, as needed.

### **Analysis and Consultations/Reporting with USAID**

The final phase was analysis, consultation, and reporting, during which time the team reviewed the results of data collection and synthesized its findings. A final evaluation debrief – a summary of the data, draft recommendations and draft report – was provided to USAID for its comments and feedback. Most of the comments were incorporated into the document. This report is the outcome of the described process.

### **TEAM COMPOSITION AND TIMEFRAME**

A three-person team was formed, as described in the SOW. The team consisted of:

- One external consultant hired through the GH Tech contract (Team Leader)
- A Health Systems Strengthening (HSS) and Public Health Advisor from USAID’s Bureau for Europe and Eurasia
- A Program Management Specialist, Senior Health Systems Advisor, from USAID/Georgia’s HSD Office

The period of performance was from August 18 to October 15, 2011.

### **LIMITATIONS OF THE ASSESSMENT**

The evaluation team faced a limitation, in that the Health Sector Strategy Paper was still under GoG review at the time of assessment and the team was unable to obtain a draft version of the paper. As a result, the team had difficulties developing appropriate output and outcome indicators and properly aligning the goals and objectives of the future project to the new health sector strategy. Even so, no major shifts are anticipated in the overall direction of the GoG’s health policy, as team members learned during stakeholder interviews.

## IV. FINDINGS

The evaluation team found that HSSP implementation has been in overall compliance with the task order and work plan. When interventions have not been fully implemented as originally planned, it was generally due to external causes (e.g., changing environment and priorities in the health sector, lack of long-term planning and evidence-based decision making by key health sector stakeholders, etc.), rather than poor performance on the part of HSSP. Various publications produced by HSSP international and local experts have been high in quality and in line with accepted international standards. Some of these publications have provided a basis for or triggered the design of new policies.

The evaluation's findings from HSSP's three objectives are presented below in detail, illustrating HSSP's achievements over the past two years, with an emphasis on issues related to the sustainability, drawbacks, and challenges associated with each intervention. The section begins with an overall description of what has worked and what has not during the project and the reasons why, drawing from information provided by the HSSP team. This information was later triangulated with data received from other sources. It should be noted that all stakeholders interviewed praised the project; in effect, the evaluation team heard no criticism regarding HSSP performance. Future HSSP priorities are discussed later in the report.

### EVALUATION OF THE PROJECT'S WORK TO DATE

#### **Objective I: Strengthen Insurer Capacity to Provide Quality Health Insurance Services**

Intervention: Strengthening insurance management skills, building upon efforts to date to establish curriculums and build the capacity of local universities in training insurance company executives and other professional staff

#### **Achievements:**

HSSP conducted an assessment of training needs and demand to determine the most suitable type of professional trainings to offer to insurers. The assessment found a substantial need for building skills in product development, underwriting, claims management, and sales. University program curricula were reviewed by experts and found to be sound for the purpose of academic teaching.

The following short-term professional and on-demand training courses and seminars have been developed and piloted:

- An executive seminar for health insurance leaders was conducted to galvanize the capabilities of insurance executives to formulate a strategic vision on the type of professional growth for employees that would best support future organizational and industry aspirations.
- Seminars on hospital design was developed and delivered in response to strong demand on the part of insurers tasked by GoG to construct hospitals. An international expert prepared and delivered the seminars. The two seminars were attended by more than 30 executives and insurance experts.
- Two courses – a claims management course and a course on underwriting and product development for insurance risk management – combined best international practices with an understanding of the Georgian context and local health insurance realities. The length of courses ranged from 1 to 5 days. The courses were attended by more than 60 professionals.

### **Sustainability:**

Representatives from the University of Georgia and the Caucasus School of Business took part in training of trainers for the two insurance courses. Universities were invited to incorporate any part of the trainings in current or future academic curricula. The University of Georgia incorporated course material into its insurance-related master's program; Ilia University also included the materials in its newly launched Master's in Insurance Business program. A new training facility established by the Georgian Insurance Association (GIA) with the help of the HSSP grant has rolled out the claims management course, and at the time of the evaluation was planning to roll out the underwriting course in September 2011. HSSP's assessment of tangible results from the training courses demonstrated a variety of outcomes, ranging from the launch of a successful health insurance product by Georgian Pension and Insurance Holding (GPIH), to modest operational changes at other insurers.

### **Drawbacks and Challenges:**

- Despite excellent ratings on the quality and practicality of HSSP courses, insurance companies have been slow to operationalize the knowledge and skills they have acquired. This can be explained by a number of factors: the proliferation of priorities resulting from the continuous changes in the rules of the game governing health insurance, the profitability of MAP insurance, which has placed insurers in a comfort zone, the elimination of market forces and competition for MAP beneficiaries, and the resulting reduced incentive for innovation – a key driver and user of new skills and knowledge acquired through training.
- Universities lack staff with practical experience in insurance. Having practitioners as course leaders plays an important role in the success of training delivered to working professionals.
- The strategic interest of the Caucasus School of Business has shifted away from serving the educational and training needs of health insurers.
- Senior insurance managers are key decision makers on a broad range of strategic, tactical, and day-to-day operational issues. Executives have assumed a broad range of responsibilities and have centralized decision-making powers along multiple vertical and horizontal intra-company dimensions. As a result, executives are an ideal target group for professional training, yet they rarely attend training courses. While those who do attend recognize the value of HSSP courses, they have largely failed to incorporate the knowledge gained into their operations.

Intervention: Development of systems for insurance fraud detection and prevention while strengthening systems to safeguard confidential personal data in compliance with international privacy standards

### **Achievements:**

- HSSP conducted an assessment to identify the root causes of insurance fraud and abuse. The results revealed that countering fraud and abuse was mainly an insurance infrastructure problem, requiring industry-wide collaboration to be successfully implemented. An adequate response from industry would mean introducing substantial changes in certain core insurance functions – for example, in provider financing, where the currently dominant fee-for-service reimbursement model should be replaced by reimbursement systems that encourage cost-containment, improved hospital operations, and enhanced service quality.
- The assessment report was disseminated to insurance executives.
- Presentations and discussions were held to gauge executives' interest in tackling the problem, with close technical support provided by HSSP international and Georgian experts.
- HSSP and GPIH started a pilot aimed at addressing fraud by introducing changes in provider reimbursement, contracting, claims management, and other insurance operations. The

objective was to create an environment conducive to closer collaboration with providers, more equitable sharing of risk and rewards between providers and insurers, and production of solid evidence that fraud and abuse can be successfully tackled through changes in insurance operations and provider reimbursement. The lessons learned from the pilot would have provided the rest of the insurance industry with a proven operational alternative for successfully addressing and lowering the incidence of insurance fraud. HSSP suspended the pilot in April in agreement with USAID pending the project assessment.

- HSSP is building a health management information system with multiple capabilities for detecting and preventing fraud and abuse in health insurance. Different HMIS modules help reduce fraud by enabling the transparency of reporting, providing real-time data that can trigger rapid online and on-spot audits, detecting double insurance and identity abuse, building capabilities for real-time reference checking of patient insurance status, and much more.

### **Sustainability:**

The pilot with GPIH has the potential to produce sustainable results due to the strong commitment of executives and employees to the pilot's objectives and the reputation of the firm as an innovator within the industry.

### **Drawbacks and Challenges:**

- An industry-wide approach to tackling insurance fraud might have been more effective than a pilot. Individual insurers are still not used to working together on industry-wide challenges.
- Insurance executives rarely attend forums where important presentations are made to help improve insurance industry performance. GPIH leadership stands out for its consistent attendance at HSSP events and enthusiasm for joint initiatives.
- Many of the causes of insurance fraud and abuse stem from flawed insurance operations and infrastructure, not from ill intentions on the part of providers or the insured. Examples include weak contracting practices, poor data collection, and health insurance information management issues.
- Insurers are concerned that they could potentially be accused of perpetrating or tacitly supporting fraudulent practices that could be linked to the misuse of state resources. This could be perceived as corruption by state authorities and result in jail sentences or fines.

Intervention: Provide technical assistance to GIA and MoLHSA to develop an electronic database of insurance clients

### **Achievements:**

- HSSP engaged MoLHSA and GIA in discussions related to the creation of a health care module (HCM) to MoLHSA's Social Information Management System (SIMS). A database of insured clients was envisioned as a part of that module. HSSP, GIA, and MoLHSA's Social Services Agency (SSA) signed a memorandum of understanding to collaborate in the creation of the SIMS' HCM by 2011.
- Interviews were conducted to determine the insurance industry's expectations related to the database. Insurers stated their interest in a database of blacklisted clients – that is, clients who have not paid premiums, or paid them late, or have abused their insurance policies in some way. The insurance industry had commissioned the creation of a database of blacklisted clients for car insurance several years before, and had this model in mind for a database of blacklisted health insurance clients. HSSP decided not to engage in the development of such a database due to its controversial nature and risks involved.
- Instead of a blacklist of insured clients, HSSP proposed to the insurance industry the creation of a data exchange system that would prepare comparative demographic profiles,

counter fraud, and measure customer satisfaction. The exchange would enable insurers to benchmark their performance against industry trends measured as the amount spent per member per month on inpatient care, outpatient care, pharmacy, costly diseases, etc.; utilization rates like admissions/1,000, days/1,000, and services/1,000; and key ratios like public-to-private members, loss ratios, and age-sex factors. A minimum of three insurers were needed to launch the project in order to use the database as a benchmarking tool by effectively blinding the data submitted by any one insurer. The project could not be launched, as only two insurers expressed interest in participating – IRAO and GPIH.

### **Sustainability:**

The leadership of MoLHSA changed in the fall of 2010. The new leadership redirected HSSP's work on SIMS' HCM, stating that a reevaluation of this work would be needed in light of MoLHSA's intention to develop its own HMIS. The database will eventually be a part of the new HMIS that HSSP is developing following MoLHSA's specifications and technical requirements.

### **Drawbacks and Challenges:**

There are systemic long-term risks related to the quality of health insurance. Health insurers have experienced exponential growth of several hundred percent over the past two years. Before the GoG presented health insurers with a growth opportunity through the MAP insurance program, their business operations were far from conforming to best international practices; since then, they have had little opportunity to improve. Tepid growth is only one of the reasons why the industry has failed to reach operational maturity. Another possible factor has been the hefty profitability of MAP, which provided the industry with the illusion that they had mastered the intricacies of the market. The fact is that insurers in Georgia do not have to be accredited to offer health insurance – nor are they required to demonstrate capabilities in designing, creating, marketing, distributing, and servicing health insurance – yet the GoG tasked them with administering a ready-made state-owned insurance product. As a result, although MAP presented health insurers with a growth opportunity, insurers lacked the internal capacity and support from the public sector to expand to fill their new role. Even so, contrary to expectations, the results from recent surveys of the insured demonstrate a high level of satisfaction with health insurers.

Intervention: Provide technical assistance to insurance companies to develop and offer standard benefit plans, including outpatient drug benefits based on an essential drug list (EDL)

### **Achievements:**

- HSSP developed a risk analysis for including outpatient drug benefit (ODB) in insurance programs (specifically for MAP). The intention was to help decision makers better understand the complex issues that need to be taken into account when introducing ODB. International experts completed the analysis in record time and engaged policy makers in a discussion to generate analysis and recommendations.
- HSSP developed a training seminar for insurance companies participating in MAP insurance to help them gain understanding and develop skills for smoother incorporation of ODB into their MAP-related services.
- HSSP conducted a survey of the ability and willingness of middle-class Georgians to buy health insurance. Information from the survey was expected to feed into technical assistance for the design of health insurance packages that would be attractive and useful for the nearly 3 million Georgians who lack health insurance. The survey data was transferred to GIA, which was interested in analyzing it and informing the industry.
- HSSP offered free-of-charge to all insurers in Georgia international expert assistance to help them design new or redesign existing health insurance products. Only two insurers expressed interest – Imedi L and PSP insurance. HSSP has postponed providing further

international short-term technical expertise to support this activity in agreement with USAID pending the upcoming project assessment.

### **Sustainability:**

The current ODB in the amount of 50 GEL per year per insured is a step in the right direction. The benefit is used and appreciated by MAP beneficiaries. The terms of the current MAP program extend through 2012. The inclusion of ODB in MAP programs after 2012 is almost certainly due to its popularity with the insured.

### **Drawbacks and Challenges:**

The ODB included in future modifications of the MAP program may or may not be based on WHO's Essential Drug List. MoLHSA may not update the EDL before 2012 or the updated EDL may not include the drugs that MoLHSA is determined to include in future ODB under MAP.

Outside of the state-funded MAP, standardization of insurance packages is not a viable approach in a competitive private insurance market. Insurers compete on the basis of private insurance product features, including design, distribution, service, and prices. However, certain clauses of the provider-insurer contract might be standardized.

Health insurance companies have been overwhelmed by constantly changes in the “rules of the game” from the GoG. The companies were far from being good health insurers at the time GoG tasked them with constructing and operating their own hospitals. For the foreseeable future, insurers face significant obstacles in building their own analytical capabilities or using international expert advice to help them consider the inclusion of health promotion benefits in insurance products.

Introducing new private insurance packages has posed significant challenges. A number of the new packages have not succeeded due to poor design; this failure reflects weaknesses in insurance company skills and the companies' lack of knowledge of insurance products and markets. Companies face serious challenges in making health insurance desirable, available, and affordable for uninsured Georgians. Obstacles include: lack of a strong desire on the part of the public for health care and low priority placed on healthcare insurance as a necessary expenditure for households (even large numbers of currently insured self-treat); unregulated clinical quality; poor knowledge and understanding of health insurance and health; the tendency to form informal self-insurance pools, in which relatives and friends share catastrophic health costs; and the free-of-charge provision of health care in emergencies. These and other factors have created a serious systemic barrier to the expansion of private health insurance in Georgia.

HSSP has asked MoLHSA if its drug agency requires technical assistance to update the EDL. The agency's leadership has assured the project that it has the required knowledge and capabilities to update the EDL. The WHO representatives in Georgia has also assured HSSP that assisting MoLHSA with EDL issues is clearly within its scope and, as such, is on its radar screen.

Intervention: Provide technical assistance to insurance companies to develop insurance plans that include health promotion benefits and incentives

### **Achievements:**

- HSSP analyzed international experience with health promotion in health insurance, and presented analysis and lessons learned to health insurers, MoLHSA, and the First Lady of Georgia. The event was well attended by MoLHSA leadership and insurance company executives.
- Executives from GPIH and Imedi L expressed interest in learning more about health promotion programming. Subsequent meetings between company executives and HSSP international and Georgian experts revealed the reluctance of insurers to invest in health

promotion benefits, seeing them as benefits customers are not willing to pay for. The two insurers lost interest in health promotion, viewing it as potentially premature for customers in Georgia.

**Sustainability:**

The activity may only be sustainable as the insurance market in Georgia matures, both on the insurer and customer side.

**Drawbacks and Challenges:**

There are considerable challenges facing successful implementation of this intervention. Insurance companies have limited capacity in the design of insurance packages; in addition, more needs to be done to inform consumers of health insurance and health care concepts, including health promotion. Designing insurance packages is a different process from designing a product principally based on what the customer wants. Unless consumers are healthcare experts, they may not know which benefits provide the greatest health benefit. Designing insurance products with benefits geared to appeal to relatively health-naïve consumers would require insurers to offer many different designs, given that different consumers want different services. This was demonstrated by focus groups conducted by HSSP to better understand consumer ability and willingness to pay for private health insurance. Offering a large number of different benefit designs is a costly proposition to administer, requiring much higher premiums. In addition, the risk for specific products would be high, as people would buy only the products they would use, putting additional upward pressure on costs and further raising premiums. Thus, by following the current trend of trying to please consumers first, the result could well be insurance packages that are unaffordable and not particularly beneficial in terms of health outcomes.

Intervention: Assist providers, insurers, and the government in adopting standard medical intervention classification systems and developing new provider payment models in collaboration with GIA and MoLHSA

**Achievements:**

- In collaboration with the National Centers for Disease Control, HSSP developed a Web-based software enabling a user-friendly environment for use of the medical classification systems throughout the various parts of Georgia’s health care system (GoG/MoLHSA, providers, insurers). The software comes with an online training tool accessible by anyone with an Internet connection and posted on MoLHSA’s e-health site. The software and training are essential enablers for the rapid deployment of the classifications throughout Georgia’s health system.
- HSSP started a pilot with GPIH to change the provider reimbursement system for five categories of clinical cases. The pilot’s results were intended to serve as a roadmap and stimulus to other insurers to begin changing the current fee-for-service hospital reimbursement system. HSSP has suspended the pilot in agreement with USAID pending the project assessment.
- The HSSP grant to GIA also targets work with insurers and providers to create examples of functional new provider payment models that reward performance, rather create incentives to increase the volume of health service, as does fee-for-service reimbursement.

**Sustainability:**

The classification of medical interventions is sustainable within the Georgian health care model. It has been adopted by MoLHSA, and providers and insurers must use it for reporting on state-funded health services. The classification system is user-friendly for the computer-literate and can be easily integrated into any organizational IT system through a Web-services application.

The sustainability of the new provider payment systems depends on a number of factors, especially the successful outcome of pilot programs, along with the interest and commitment of insurers in investing in improved operations and support systems and in strengthening human resource capabilities.

### **Drawbacks and Challenges:**

Insurance companies may not be interested in doing what is needed to successfully transition from a fee-for-service to performance-based reimbursement systems. The principles and requirements related to reimbursements, including case-based reimbursement systems, are poorly understood.

Unreliable or non-existent data and health information systems constitute a serious impediment to the introduction of new provider reimbursement approaches. For most insurers, there appears to have been little conscious effort made to collect, store, process, analyze, and use data beyond that required for reporting. HSSP has used its training courses for insurers to emphasize the crucial role data plays in enabling good health insurance practices.

Intervention: Continue provision of technical assistance to the Health Insurance Mediation Service

### **Achievements:**

HIMS was designed with USAID's support to help protect the vulnerable in Georgia, encourage consumer choice in health care, and provide the public with information on health insurance. USAID's predecessor project to HSSP, CoReform, provided technical and financial support for HIMS from its start until September 2009. On July 1, 2010, the HIMS became a legal entity subordinated to MoLHSA and funded through an earmarked portion of insurance premiums, as per the recommendation of the CoReform project.

In response to HSSP recommendations, the following steps were taken:

- MoLHSA expanded the scope of HIMS to include not only mediation of disputes between the insured and insurers, but also mediation of disputes between health care providers and insurers.
- In its draft Year 2 work plan, HSSP proposed to assist HIMS in developing new institutional capabilities that will enable it to fulfill its expanded mandate to mediate disputes between health care providers and insurers. MoLHSA's new leadership asked the project to focus exclusively on the development of health management information systems.
- In response to MoLHSA's request, HSSP provided funding for HIMS promotional materials to increase awareness of the service among the population.
- Through a grant to GIA, HSSP supports the foundational/developmental stage of a health insurance mediation service that will serve the needs of mediation of all insured under private schemes not funded by the GoG. The new HIMS, which will be a unit of GIA, will provide mediation services to the more than 450,000 insured under non-GoG schemes.

### **Sustainability:**

The sustainability of MoLHSA's HIMS is ensured, as its budget is formed from fixed annual deductions from insurance premiums due to insurers. Another sustainability factor is that HIMS provides services bringing political dividends to MoLHSA.

The sustainability of GIA's HIMS will depend on whether the service will establish itself as beneficial to both insurers and the insured.

## **Objective 2: Strengthen Providers' Capacity to Manage and Deliver Quality Health Care Services**

Intervention: Strengthening management skills of hospital and PHC managers

### **Achievements:**

- HSSP assessed the professional training needs of hospital managers.
- Using the assessment findings as a guide, HSSP international experts developed courses in human resource management, financing and costing, quality improvement, and building successful working relations with insurance companies.
- The courses were piloted through multiple deliveries to hospital managers across all regions in Georgia. University of Georgia staff were trained as trainers and provided with training materials and trainer guides, with the materials incorporated into academic programs.
- HSSP supports the University of Georgia in its marketing of a short-term professional certification program, developed on the basis of the HSSP courses.
- The GIA is also interested in delivering the trainings to hospital managers at hospitals and clinics owned by insurers. HSSP provided the training materials and trainer guides to GIA and is helping its trainers prepare for the delivery of trainings.
- The leadership of the Center for Training and Consultancy (CTC) also expressed an interest in delivering the HSSP trainings to hospital managers to respond to a growing market need for such trainings.
- HSSP assessed the level of implementation of the practical knowledge and skills obtained by hospital managers through HSSP courses. The assessment revealed that most of the trained hospital managers have implemented parts of their newly acquired knowledge.

### **Sustainability:**

According to MoLHSA, there will be a total of 190 hospitals newly built or thoroughly renovated by 2012. The roll out of HSSP trainings by the University of Georgia, GIA, and potentially CTC will serve the immediate management training needs of these hospitals. The sustainability of the course content is further secured through its incorporation into University of Georgia's academic programs. Hospital owners and insurance company managers have shown ample interest in the HSSP courses and the three organizations are well-positioned to serve that interest.

### **Drawbacks and Challenges:**

The market demand for these courses may not exceed 380 trainees in 2011-2012, and at most 10% of that in following years. The assumption for the estimate is that up to 2 managers per hospital will be trained initially ( $2 \times 190 \text{ hospitals} = 380$ ), followed by trainings of new managers replacing old ones at  $10\% \times 380$  per year. Given the reduced needs of trainings in 2013 and beyond, the market for trainings may be too small to support deliveries from three training organizations. The smaller market size may present a sustainability issue.

Intervention: Provide technical assistance and training to assist medical associations in developing programs and processes aimed at improving the quality of the health care services and facilities of their members

### **Achievements:**

MoLHSA's leadership has explicitly stated that the ministry will not regulate medical quality. If any regulation occurs, it will have to take place through self-regulation by professional medical and provider associations. HSSP has initiated interventions that support the move toward self-regulation:

- HSSP is facilitating the work of Georgian professional medical associations on a code of medical conduct for Georgia. The code is intended to strengthen quality of care and improve the customer experience in health care facilities. The code is ready for dissemination and HSSP is working with medical associations on an implementation plan that should ensure the sustainability of the code.
- HSSP has been a strong supporter of the Georgian Hospital Association (GHA), established in 2009. HSSP is providing GHA with office space and a venue for meetings, organized the GHA's launch event, and assisted in creation of a strategic plan for the association.
- In collaboration with GHA, HSSP launched a pilot to support the establishment of hospital accreditation. Six hospitals are participating in the pilot. The hospitals are implementing 13 basic quality standards through a process of self-assessment, with implementation assisted and monitored by HSSP. HSSP provided on-site training to pilot hospital managers in applying international quality improvement techniques during the pilot.
- HSSP conducted an assessment of a selected group of professional associations to evaluate their capabilities to provide continuous professional development to medical professionals. The results of the assessment were encouraging, revealing that all assessed associations possessed such capabilities. The assessment results were shared with MoLHSA, which took them into account when evaluating options for transferring professional development responsibilities to medical associations.

#### **Sustainability:**

The code of medical conduct has already been approved by many professional associations. Further HSSP support is necessary to ensure sustainability during the implementation phase.

The hospital self-assessment pilot provided valuable insights into the potential obstacles to a hospital accreditation system. It was expected that by the end of the pilot, GHA would be an association with a growing membership base and increased clout in the health sector. Regrettably, GHA has not grown in size and its activities have slowed down in the past four months. Organizational and funding issues (collection of membership fees) have plagued the association, slowing its growth. In its Year 2 budget, HSSP had allocated \$50,000 for a grant to GIA. One of the foreseen objectives of the grant was to develop and implement a hospital accreditation system (the pilot is already under way in six hospitals).

#### **Drawbacks and Challenges:**

The most serious risk to improving the quality of hospital services is the lack of financial incentives to improve quality and disincentives to inhibit poor quality. Hospital reimbursement systems are fee-for-service, which encourages service volume, not quality improvement. Insurance-provider contracts lack benchmarks for quality. Somewhat surprisingly, results from a number of patient surveys indicate that the overwhelming majority are satisfied with the quality of hospital services, which means there is little consumer/patient demand to improve quality. MoLHSA's opinion on the subject of quality control is that this issue should be left in the hands of associations, relying on their will and ability to self-regulate. GHA is interested in becoming the accreditation entity for hospitals in Georgia. However, the organization is not currently sustainable and its future is uncertain.

The implementation of a code of medical conduct will be a challenging task, requiring commitment and substantial effort from all stakeholders, including associations, doctors, providers, and insurers.

Intervention: Improve access of Georgian medical professionals to modern evidence-based medical knowledge

**Achievements:**

- During the project's first year, the HSSP team analyzed options, risks, and opportunities related to the establishment of an evidence-based medicine (EBM) information clearinghouse and EBM training course.
- A draft concept for the EBM clearinghouse was produced for internal review.
- HSSP identified potential sources/providers of internationally recognized courses in EBM. A major implementation push for this area of the project was planned for Year 2.

**Sustainability:**

In September 2010 the leadership of MoLHSA changed. The new leaders asked USAID to focus remaining HSSP resources on the creation of the HMIS. USAID requested HSSP to consider rationalizing some of the ongoing initiatives under Objectives 1 and 2 to increase the resource pool available to the HMIS. EBM was one of the rationalized project interventions.

**Drawbacks and Challenges:**

Georgian medical professionals have access to EBM information through multiple sources. The MoLHSA's Web site provides access to the more than 100 clinical guidelines that have been developed by Georgian professionals using international methodologies and approved by MoLHSA over the past several years. Medical professionals can access EBM literature through the Internet. Much of the literature is available in various languages, including Russian, which most medical professionals use freely.

The issue at hand is not so much impeded access of Georgian professionals to EBM but rather the lack of incentives to employ EBM in medical practice. In the absence of such incentives, the investment in the development of an EBM clearinghouse in Georgia is unlikely to produce a decent payoff. Financial incentives appear to be the principal potential driver for behavior change that would create demand for EBM. At the current stage of their development, health insurance companies are not keen on linking provider reimbursement with quality of service.

Intervention: Assist USAID in monitoring implementation of the approved DCA hospital investment projects and identifying possibility of new hospital DCA projects

**Achievements:**

In June 2010 HSSP responded to USAID's urgent call for assistance in the completion of a critical stage in the Development Credit Authority (DCA) bank loan guarantee review process. HSSP provided technical assistance to carry out the following tasks:

- Determine the financing needs of potential health DCA borrowers, including insurance companies and other private health businesses but excluding pharmacies and ambulatory clinics.
- Evaluate the credit readiness of potential DCA borrowers, including financial management skills and capacity to develop a loan proposal.
- Ascertain the capacity of the DCA candidate financial institutions to meet the financing needs of potential health DCA borrowers by evaluating loan products and loan underwriting policies and procedures.
- Develop recommendations for technical support to promote effective use of a \$20 million portfolio DCA guarantee.
- Develop a day-long training seminar on the rules and methods for complying with environmental norms and regulations. The seminar was delivered four times to various potential borrowers and bank employees, resulting in training for more than 40 individuals.

### **Objective 3: Strengthen GoG's Capacity to Guide and Monitor Health Reforms**

Intervention: Facilitate discussions between medical associations and the regulatory department in MoLHSA to identify how the associations can assist the ministry in performing its health facility licensing and accreditation

#### **Achievements:**

Minimally essential regulation for business activity is a key tenet of the GoG's philosophy. This philosophy applies across all sectors, whether in vital utility services, such as water and electricity, as well as a range of other sectors, including health care, transportation, and so forth. The main rationale behind the concept is to lower or eliminate barriers to starting businesses and erase sources of corruption. MoLHSA's position is that it will refrain from regulating service quality and leave the field open for self-regulation by medical associations.

HSSP has started two initiatives that could lead to self-regulation of service quality at all levels of Georgia's health system:

- One of the initiatives is to create a code of conduct for medical professionals in Georgia. The code was prepared by representatives of four professional medical associations. Many other professional medical associations expressed their backing for the initiative and readiness to support its implementation. The second initiative, carried out in conjunction with the GHA, involves a hospital operations quality improvement pilot carried out through a process of self-assessment. The pilot is intended to demonstrate the benefit of introducing hospital accreditation, initially using a set of basic standards (adapted from those used by the Joint Commission International) that all hospitals should be capable of meeting without making additional investments. Six hospitals participated in the pilot.

#### **Sustainability:**

The future sustainability of the code of conduct is promising at this stage, provided that USAID and other donors extend their support to the implementation stage.

The sustainability of hospital accreditation depends on the sustainability of GHA, which remains uncertain at present.

#### **Drawbacks and Challenges:**

Health care associations are having difficulty filling the regulatory gap due to associations' weakness and somewhat shaky credibility. Associations are small and under-resourced, and generally not very active. Low membership fees do not support genuine sustainability; moreover, there are questions regarding the value of the services they offer to members. Associations are largely unwilling to impose requirements or rules on members. Associations' underlying concern is losing their membership base to other associations that do not impose such rules or do not enforce them.

Over the last several years, medical associations used international donor support to develop more than 100 medical guidelines; they have since conducted trainings for their members and others on implementing the guidelines. Despite these efforts, associations have neither required nor monitored member compliance with the guidelines. There is ample anecdotal evidence that the guidelines remain largely unused, including by doctors who received training on using them.

As the main payers for health service delivery, insurance companies have the power to influence service quality through their provider reimbursement systems. While insurers are not opposed to better quality of services, they generally remain reluctant to take actions that would influence such improvements.

**Intervention:** Assist MoLHSA in developing and implementing a Health Information System and a Management Information System for Social Services in partnership with other donor agencies, such as World Bank and EU Commission

**Achievements:**

- HSSP has delivered to MoLHSA a concept on a health care module for a social information management system, a concept for a health management information system for Georgia, and blueprint for an electronic medical record. The documents are state-of-art syntheses of best international practices in the area. MoLHSA has accepted the documents with satisfaction.
- In October 2010, MoLHSA' new leadership asked HSSP to discontinue its work on SIMS. Much of what should have been in the SIMS health care module has been made a part of the HMIS. Guided by MoLHSA's priorities regarding the construction of HMIS, HSSP has created various HMIS elements/modules, which have been designed based on specifications from MoLHSA. Some of the modules are aimed at improving the functioning of legacy HMIS systems, while others focus on building new HMIS capabilities. Currently the HMIS includes the following modules:
  - A hospital case registration module that enables hospitals to register cases directly on an Internet-based interface, providing MoLHSA with a real-time view of the entire hospital sector's delivery of services to beneficiaries of state-funded programs
  - A connectivity module that enables Internet-based financial and service delivery reporting of providers on vertical health programs, enabling more than 5,000 health care providers, including rural doctors, to submit standardized reports to MoLHSA via the Internet and Web interfaces
  - A search engine/convertor module for classifications of medical interventions to enable health care providers, insurers, MoLHSA staff, and other interested parties to access a MoLHSA database of classifications of diseases and medical interventions (ICD10, NCSP, ICPC2, and Laboratory Classification) through Web applications or Web services
  - A validation of reporting forms module that enables MoLHSA to detect problems by the quality of filled forms, returning them to users for completion or revision
  - A financial module for ambulatories that will enable online reporting of medical service delivery and financing

**Sustainability:**

The HMIS is built to serve the information management needs of the state-funded vertical health care and health insurance programs, and is sustainable to the extent that these programs will be continued in the future. HSSP employs flexible technologies in the creation of HMIS. It uses metadata architecture that allows modules to be modified relatively easily upon demand from the owner (MoLHSA).

**Drawbacks and Challenges:**

Over the past few years, GoG has dramatically reduced its direct involvement in the delivery of health care services for its population. It has outsourced the administration of health financing to insurers, which has reduced utilization of the health system. In the long term GoG's reluctance to regulate the quality of health services could have a negative impact on the health status of the population. The HMIS serves only the needs of the GoG as related to state-funded health care programs. It improves reporting and visibility into state-funded services and reduces fraud. The private sector is left to create its own health information systems. Private insurers and providers may resort to a mix of health information solutions that may not communicate easily with each other. If this happens, it will contribute to the further fragmentation of health care delivery and increased service delivery costs. It will also impede competition, as the costs of adapting one IT

system to the different IT requirements of a potential partner could be prohibitive. Without securing a certain level of system standardization for the finance and delivery of health care outside of GoG programs, costs will certainly increase – and these costs will be paid by the customers of the Georgian healthcare system.

Intervention: Strengthen MoLHSA capabilities and skills to engage in negotiations with the insurers and services providers.

### **Achievements:**

The relationship between insurers and MoLHSA with regard to MAP program implementation is regulated by GoG Decree 218 from December 9, 2009. The GoG has decided that the high importance of that relationship justifies a regulatory, rather than a contractual approach. The decree sets “the rules of the game” in MAP insurance for three years—2010–2012.

In preparation for the introduction of Decree 218, the GoG considered incorporation of the concept of a basic benefit package in that decree. Given the importance—and not always straightforward understanding—of the subject, HSSP offered the leadership of MoLHSA and insurers its services in conducting a seminar on the BBP concept and the pros and cons of introducing it in insurance. The offer was accepted, with the following results:

- A two-day seminar was conducted that was well attended by MoLHSA and insurance executives, including the current minister of MoLHSA.
- A technical paper discussing the subject and providing international experience was produced by HSSP and disseminated at the seminar.
- As a result of the seminar MoLHSA and insurers agreed that the introduction of a basic benefit package in Georgia would be premature at that time.

HSSP responded to a call for technical assistance from MoLHSA to retrospectively recalculate the risk-based premium for state insurance programs for 2008, 2009, and 2010, examine the fairness of the premium paid, and develop a methodology for estimating the premium for state-subsidized health insurance programs. GIA provided feedback to the scope of work for this exercise and agreed with its objectives. The outcome of this assistance, provided largely by actuaries working for insurance companies, will establish an objective basis for calculating insurance premiums for state-funded insurance programs in the future. Such objectivity would serve as a central piece in any negotiations that MoLHSA may decide to carry out with the insurance industry when setting up its MAP program for 2013 and beyond.

### **Sustainability:**

Negotiations between insurers and providers are a difficult process due to various factors: history of mistrust and abuse of each side by the other; providers’ poor understanding of the insurance business; indemnity-based provider reimbursement systems that encourage providers to inflate the volume of services; poor data collection and management practices that produce unreliable data that cannot serve as the basis for improved contracting; failure to recognize the interests of the other party when negotiating; and difficulty understanding the complementary roles providers and insurers play in delivering value to the customer. One of the natural results of poor relations between insurers and providers is reduced spending on health services and increased waste. Much of the cost of poor contracting is in the form of insurance fraud and abuse. The ability of insurers and providers to negotiate in good faith need to be strengthened, beginning with provider training on what health insurance is and how it works. The two sides need help to work out objective criteria to determine what fair compensation is, so that they can establish an objective basis for negotiations.

**Drawbacks and Challenges:**

There are practically no risks related to improving the skills of insurers and providers to negotiate. Such skills are sought by insurers and providers alike, and requests for trainings in negotiation skills have been made by both sides during HSSP lead trainings.

Intervention: Improve access to essential medicines within GoG subsidized insurance packages

**Achievements:**

- To support the extension of outpatient drug coverage through the expansion of health insurance to wider vulnerable populations, HSSP advocated for the inclusion of the elderly into GoG-subsidized insurance. HSSP developed an analytical paper on the subject.
- HSSP organized a training seminar on a similar topic for policy makers, including representatives from MoLHSA, Parliament, the Municipality of Tbilisi, the Office of the Prime Minister, and GIA.
- Upon request from the leadership of the Municipality of Tbilisi, HSSP held technical discussions and conducted trainings on methods and approaches to designing and extending insurance coverage to various population groups, including the elderly, children, and the working middle class.

**Sustainability:**

MOLHSA introduced a drug benefit in the MAP package in the amount of 50 GEL per person per year. This is a step in the right direction, with the benefit used and appreciated by the insured. The terms of the current MAP program extend through 2012. The inclusion of ODB in MAP programs after 2012 is almost certain due to its popularity with the insured.

As with other interventions under Objective 3, activities in this area were discontinued in Year 2 upon request from MoLHSA's leadership and in agreement with USAID to free up resources for HMIS development.

**Drawbacks and Challenges:**

The ODB in subsequent MAP programs may or may not be based on EDL. MoLHSA may be slow to update the EDL before 2012; alternatively, the updated EDL may fail to consider the inclusion of the drugs that are currently part of the ODB and which MoLHSA strongly supports as a part of future MAP programs (whether or not they meet all criteria for inclusion in EDL).

Standardization of private insurance packages is not a viable concept in a competitive private insurance market. Insurers compete on the basis of the specific features and services related to an insurance product, including design, distribution, customer relations, and price.

Introducing new private insurance packages is a challenge. A number of packages that have been introduced in the past have not succeeded due to their poor design; this failure reflects weaknesses in insurance company skills and lack of knowledge of insurance products and local markets. Companies face serious challenges in making health insurance desirable, available, and affordable for uninsured Georgians. These challenges include the weak desire among Georgians for formally delivered healthcare; unregulated clinical quality; poor knowledge and understanding of health insurance and health; informal self-insurance pools where relatives and friends share catastrophic health costs; and the free-of-charge provision for health care in emergencies. A combination of these and other factors has created a serious systemic barrier to the expansion of private health insurance in Georgia.

Intervention: Empower consumers of health care services to make informed health care seeking decisions and enhance insurance literacy among general public

**Achievements:**

- HSSP organized a training seminar for MoLHSA public outreach specialists and journalists from various media outlets. The purpose of the seminar was multifold – to help both sides understand the current health finance and delivery model in Georgia, and to foster more regular contacts and improved relations between MoLHSA and journalists.
- HSSP conducted special trainings for journalists from national and regional media to improve their understanding of the Georgian health insurance model. The trainings strengthened the skills of journalists in analyzing important issues related to the Georgian health care model. The trainings introduced journalists to representatives of insurers, GIA, providers and provider associations, doctors and professional medical associations, MoLHSA, and Health Insurance Mediation.
- Trainings resulted in improved quality of publications on topics of health insurance and health care reforms.
- Under a grant from HSSP, GIA is building and strengthening the capabilities of a new consumer services unit, which aims to strengthen customer and public education and create and disseminate information on health insurance. GIA prepares informational materials on health insurance and disseminates them through various channels, including the media. HSSP and GIA are working on a consumer guide to health insurance. One of the features of the guide will be a glossary of insurance terms in language understandable to the layperson.

**Sustainability:**

HSSP had planned to continue to strengthen MoLHSA's capacity to communicate with journalists in the project's second year and to deepen and widen training for journalists. MoLHSA's plan was to focus on building practical communication skills-building related to press-conferencing, media monitoring, press release preparation, etc. In October 2010, MoLHSA's newly appointed leadership requested that USAID and HSSP concentrate all project resources on the creation of a health management information system. In response to this request and with USAID concurrence, all HSSP planned activities under Objective 3, except those related to HMIS, were discontinued.

**Drawbacks and Challenges:**

Issues with the communication skills of public relations officers are among the sources of reported strained relations between journalists and MoLHSA. Poor relations contribute to negative publications in the press, further tarnishing the image of the health care system and health reforms.

Georgian media companies are not devoted to the concept of subject journalism, where journalists concentrate on particular spheres of life such as social, health, economic, and environmental. Most journalists in Georgia are generalists, making their education on any particular topic less than rigorous and not sustainable. This is one reason why most publications on health issues traditionally focus on sensational stories. There is little if any analysis of the underlying issues, and often the symptoms of problems are confused with the causes.

Intervention: Assist MoLHSA in identifying essential public health services to remain in the GoG's responsibility and developing models for involvement of the private sector in delivering such services

**Achievements:**

The National Center for Disease Control (NCDC), a unit of MoLHSA, is responsible for public health in Georgia. HSSP and USAID representatives, in consultations with the head of NCDC, determined the specific needs of NCDC related to this HSSP direction. Based on NCDC feedback, HSSP carried out the following interventions:

- HSSP designed and delivered a workshop for Georgian healthcare policy makers. The workshop was intended to introduce the concept of evidence-based approaches to setting public healthcare priorities. The workshop was attended by more than 25 participants from various governmental agencies participating in development of the health care budget, including the head and other key representatives from the Health Department of the Ministry of Labor, Health and Social Affairs (the divisions of budget, regulation, policy and administration), the now abolished Health and Social Programs Agency (HeSPA), the Department of Budget of the Ministry of Finance, NCDC, the representatives of the Office for Healthcare of the Tbilisi Municipality (Capital region).
- During the workshop, HSSP extended an offer to participants to provide technical assistance in areas where they need support in relation to the prioritization of health services for funding, outsourcing, or other purposes.

#### **Sustainability:**

In October 2010, MoLHSA's new leadership requested that USAID and HSSP concentrate the majority of project resources on the creation of a health management information system. This activity was curtailed in agreement with USAID.

#### **Drawbacks and Challenges:**

No drawbacks or challenges could be identified from discontinuing this intervention.

## **FUTURE PRIORITIES**

It was planned to align the future project's goals and strategies to the newly approved health sector strategy (white paper) and develop relevant output and outcome indicators. However, the health sector strategy paper was still under the internal review of MoLHSA and GoG at the time of this evaluation. The team was unable to obtain a draft of the paper. However, during a meeting with the Deputy Minister of MoLHSA, the Deputy Minister provided a general overview of the paper and noted some five main directions of the country's future health sector strategy: 1) Reduction of inequality/improved access; 2) quality; 3) patients' rights; 4) public health promotion, prevention of communicable and non-communicable diseases, disaster preparedness, and bio-security and safety; and 5) system governance and management. During the meeting some stakeholders remarked that they were not expecting major surprises and deviations from the current GoG's market-oriented approach. However, without having the final white paper, the evaluation team had difficulties in developing output and outcome indicators based solely on rumors and premature assumptions. The future priorities listed below were developed on the basis of thorough consultations with major stakeholders (MoLHSA, GIA, medical associations, etc.) and a study of all available materials and information (for example, on the principal future directions of the health sector strategy).

### **Objective I: Strengthen Insurer Capacity to Provide Quality Health Insurance Services**

The GoG has long considered private health insurance as a principal approach for improving access to health care services and reducing catastrophic health expenditure by households. However, there are many uncertainties concerning the direction of health insurance in the future. Insurers have had little opportunity to master the health insurance business. While they were working to address that, they were forced into the business of constructing and operating hospitals, clinics, and possibly primary care providers in the near future. As a result, activities targeted at building the capacity of insurers should remain a priority for the HSSP project, as properly developed insurance packages will help make health services more affordable for Georgians.

There should be capacity in place to design and deliver high-quality, targeted (customized to meet particular demand), practical professional training courses. The organizations delivering such courses should possess the capability to design and deliver trainings in anticipation of demand. The deliverer should be active in detecting shifts in need and demand and reacting proactively to such shifts by supplying what is needed. In this respect, further strengthening its cooperation with GIA could be a good step for HSSP. A new GIA training center may be best suited among all training institutions to engage in on-demand course development and deployment. The center has access to the best health insurance practitioners; it also has the flexible, responsive capacity within its organization needed to detect early changes in priorities at health insurers, and to design and deliver courses within a short lead time in response to such changes. Due to its association with GIA, the training center has become a trusted source of knowledge and skills in health insurance.

As the assessment process indicated, there are several areas in which HSSP could better concentrate its efforts and provide technical support. These areas include:

- Developing a new provider payment system – changing from a fee-for-service system to performance-based reimbursement systems that will provide greater incentives for cost-effectiveness and service quality. The current fee-for-service system does not provide motivation to insurers or providers to improve performance. HSSP should continue assistance in piloting new provider payment systems, and use the models created and lessons learned to scale up their use by more insurers.
- Assistance with creation of innovative insurance packages—designing such packages will promote expansion of population coverage with voluntary health insurance. The insurance companies will also benefit, as having new clients from non-poor segments of the population will allow them to better manage insurance risks, owing to the larger risk pools.

## **Objective 2: Strengthen Provider Capacity to Manage and Deliver Quality Health Care Services**

### **Support to GMA**

Despite their numbers, the capacity of many medical associations is still weak. At the same time, MoLHSA decision makers expect the associations to take responsibility for regulating and ensuring health care quality in the future. Therefore, continuous support of medical associations should be a HSSP priority, particularly in the following areas:

#### **1. Implementation of a code of conduct**

A code of conduct has already been prepared by medical associations with support of the HSSP. However, implementation of code of conduct in the current market-driven environment is a major challenge, requiring great effort on the part of all stakeholders. This will require a multi-year effort, as individual doctors lack strong incentives to improve the quality of health services. Providers and insurers have levers to incentivize doctors to follow the code and create disincentives for not following it. Executives of providers and insurers must become strong partners in the code's implementation for it to be successful.

#### **2. Continuous medical education**

MoLHSA considers that continuous medical education as no longer the government's job and believes that health providers and individual doctors should take responsibility to upgrade their own knowledge base. According to MoLHSA's Deputy Minister: "There will be no public doctors in a short time and private doctors are responsible for deciding how to spend their money." However, evidence shows that a huge gap exists in the field of continuous medical education and many doctors have not undergone professional training

for many years. HSSP's support to medical associations will produce positive outcomes, as associations have expressed readiness to take on this responsibility.

### 3. Ensuring health care quality

All interviewed stakeholders acknowledged that ensuring health care quality is the greatest challenge currently facing the Georgian health care system. GoG's decision to step back from regulating health care quality has left a gap that medical associations will find challenging to fill. Thus, work with medical associations, along with providers and insurers, should be strengthened to develop and enforce quality standards in health care facilities. The evaluation team acknowledges that achieving quality health care in the current circumstances will be a difficult and long-term process, and will require understanding and conscious effort from all parties involved. This will be one of the most challenging tasks for HSSP in the coming years.

### 4. Communication with media

The role of Georgian media outlets to accurately and professionally educate the population on ongoing processes in the health sector is still weak. According to the Chairman of the parliamentary Healthcare and Social Issues Committee, media should play a much more active role in health promotion and health behavior change. The evidence shows that the active, frequent communication of journalists with medical professionals is absolutely essential for effectively informing the population and achieving success in the health reform process.

## **Support to GHA**

As previously noted, there has been a slowdown in development within the GHA, which faces sustainability issues. If GHA reaches sustainability, HSSP should provide the association with technical support in the following areas:

- **Accreditation:** HSSP should provide technical assistance in data analysis and capacity building to GHA so it can build the capacity of hospitals and implement a hospital accreditation system.
- **Technical assistance for costing:** More information is needed on how to set the prices of health care services. Many prices are still set based on the old Soviet system and not on calculations of the true cost of service provision.
- **Replace current reimbursement system:** The current ineffective fee-for-service reimbursement system should be replaced by reimbursement systems that encourage cost-containment, improved hospital operations, and improved service quality.

## **Objective 3: Strengthen Government Capacity to Guide and Monitor Health Reforms**

MoLHSA's uncertain, spontaneous decision-making style poses serious issues for planning HSSP's future priorities. This is particularly true in defining future priorities for the project's third objective of strengthening GoG's capacity to guide and monitor health reforms. As previously noted, MoLHSA has asked HSSP to concentrate on e-health and HMIS. HSSP is preparing to start the development of three new modules:

- A financing module, which will connect financing to delivery of services reporting, will strengthen transparency and speed of information exchange and reduce payment delays.
- A regulations module will provide an online tool for systematic, timely presentation of information on health care laws and regulations, and will enable online application for licenses and permits.

- A pharmaceutical module will strengthen the visibility of MoLHSA in the production and import of drugs and drug substances, and enable pharmaceutical companies to register new and imported drugs online.

In addition to HMIS support, HSSP can support MoLHSA in the following activities:

1. Technical assistance to further strengthen HIMS

The HIMS has been recently established as a public law legal entity. However, HIMS human and technical capacity to successfully perform mediation function is limited and needs considerable improvements. During the meetings with MoLHSA, top officials expressed great appreciation for the USAID project's previous support for HIMS establishment and asked for further assistance in upgrading HIMS capabilities and skills.

2. Educational campaigns on insurance for the public

In spite of GoG's efforts in the past year to promote health insurance in Georgia, the majority of Georgians are unaware of the concept of insurance and its potential benefits. Various surveys indicate that even people who have health insurance have little understanding of how insurance works and only a vague concept of the benefits to which they are entitled. To tackle this problem, MoLHSA needs to develop and implement an effective educational campaign for the general public.

3. Actuarial assistance

Due to market-oriented reforms in the health sector, MoLHSA needs frequent interaction with private insurance companies and providers. To effectively negotiate with insurance companies and set realistic premiums for publicly funded insurance programs, MoLHSA must develop its base of actuarial skills. HSSP has already started to work on this issue, efforts that should be further strengthened during the next project.

4. Assist in the development of new insurance models

According to MoLHSA's Deputy Minister, the GoG is planning for 2.5 million Georgians to have private or publicly funded health insurance by 2015. However, expanding insurance coverage has recently slowed down and it remains one of the most challenging tasks among the GoG's current suite of health sector reforms. The GoG's previous optimistic assumption – that Georgians would be able to purchase health insurance themselves outside of MAP – has turned out to be unrealistic. Expanding insurance coverage will require a continuous effort on the part of the GoG, including the development of innovative new models that promote the concept of health insurance among the general public. HSSP has great potential to work with MoLHSA on this issue and help develop pragmatic new insurance models.

## **Risks and Assumptions**

The main risks are related to the fast-changing and uncertain environment in which health sector reform takes place in Georgia. The coming parliamentary and presidential elections in 2012 and 2013 could bring changes in GoG health policies. Therefore, HSSP should remain flexible and responsive to the changing needs of the project's partners. At the same time, HSSP should continue to base its assumptions and recommendations on the best available evidence-based practices while dealing with all project partners, particularly with MoLHSA.



## **V. CONCLUSION AND RECOMMENDATIONS**

Despite constant change in the needs and priorities of the project's partners, HSSP has managed to carry out a great deal of work during its relatively short two-year span. HSSP can be fairly assessed as the single most comprehensive donor-supported project in the Georgian health care sector, targeting all major stakeholders: insurers, providers, and the government. HSSP has generally succeeded in meeting its objectives. In cases where the interventions have not been fully achieved, this was mainly due to other external reasons (e.g., an uncertain and dynamic health sector environment, lack of government planning, politically motivated rather than evidence-based decision making, fast-changing priorities on the part of project partners, etc.) rather than by poor performance or mismanagement by HSSP. The various publications produced by HSSP's international and local experts have been high in quality and in line with acknowledged international standards. At the same time, some modifications in project implementation are needed, as the current assessment has revealed. Below are presented the evaluation's recommendations, grouped according to HSSP objectives:

### **OBJECTIVE 1**

Working with a particular private insurance company has failed to produce tangible results; in addition, this strategy has required a significant investment in terms of time and other resources. Nor have private insurance companies shown a high level of enthusiasm for the project's work. Stakeholder interviews and project implementation reports revealed that only a few insurance companies (mainly GPIH) have had fruitful interactions with HSSP. HSSP should continue its assistance to GIA, which, with support from the project, has established a professional insurance training center and developed sustainable training courses for insurers and providers. As the assessment has shown, GIA has managed to develop a good reputation and is a trusted provider of capacity-building initiatives for the industry.

### **OBJECTIVE 2**

The assessment revealed that, compared to GIA, professional medical associations tend to be weak, under-resourced, and relatively inactive. They are also not well recognized among health care providers. At the same time, the GoG has high hopes for professional associations and believes they will play a leading role in regulating health care quality in Georgia in the future. That said, the current reality is that a huge gap exists in terms of ensuring adequate health care quality in today's environment. Steps are required to address the problem of low care quality and, most important, any further deterioration in the health status of the Georgian population. Therefore, providing support to professional medical associations in various activities (providing assistance in capacity building, developing recommendations on how associations can become respected, sustainable entities, etc.) should be a priority of Objective 2. Together with capacity-building activities, HSSP should work with associations on other issues noted in Section IV in the subsection on future priorities.

### **OBJECTIVE 3**

Working with MoLHSA will be a challenging task, requiring flexibility and the designation of a distinct part of the project's budget for contingency purposes in case of changing priorities. This holds particularly true for the next two years, when the country will hold parliamentary and presidential elections. There is a high probability that the GoG will decide to expand health insurance coverage and include pensioners in insurance programs funded from public money.

HSSP has already prepared a report on opportunities for providing health insurance coverage to Georgian pensioners. The work should be continued on with a focus on adoption of recommendations presented in the report.

At the same time, two of MoLHSA's most important priorities are already apparent – developing a health information management system and strengthening the Health Insurance Mediation Service. USAID and HSSP support in developing an e-health system and a mediation service are highly appreciated by MoLHSA's high-level decision makers (e.g., the Deputy Minister of MoLHSA). The project should continue and strengthen its assistance in these areas.

## APPENDIX A. SCOPE OF WORK

### Scope of Work Georgia Health Systems Strengthening Evaluation

#### I. PERFORMANCE PERIOD:

Work in country will begin o/a August 29 through September 24, 2011 (29 days total, including 5 days of preparation, 10 days in country visit, 11 days for drafting and finalizing the evaluation report, and 1 day for final debrief).

#### II. OBJECTIVES AND PURPOSE OF THE ASSIGNMENT:

The purpose of the assignment is to assist the USAID/Georgia Health and Social Development (HSD) Office to conduct a mid-term evaluation of the Health System Strengthening Project and propose recommendations for its future directions.

#### III. BACKGROUND:

At the end of 2006, the Government of Georgia (GOG) embarked on a new health sector strategy by turning to market mechanisms to improve access to health care, upgrade infrastructure, improve the quality of health care services, and increase the efficiency of service provision. The Government pursued a three-pronged strategy: better means-tested targeting of state resources to address the health needs of the poor and disadvantaged; increased privatization of health care providers (including hospitals and primary health care facilities); and an enhanced role for private health insurers. In response to the GOG's reform agenda and emerging needs in the Georgian health sector, in October 2009 USAID/Georgia awarded a five year Health System Strengthening Project (HSSP), with the life of project funding of \$7,999,806. The goal of the HSSP is to support GOG's health reform efforts aimed at improved population health status, access to, and satisfaction with the quality of health services. The project has three objectives:

- **Objective 1:** Strengthen insurer capacity to provide quality health insurance services.
- **Objective 2:** Strengthen providers' capacity to manage and deliver quality health care services.
- **Objective 3:** Strengthen GoG's capacity to guide and monitor health reforms

In September 2010 the project scope was further expanded to assist the Ministry of Labor, Health and Social Affairs (MoLHSA) in developing an integrated national Health Management Information System (HMIS) and to support the expansion of voluntary health insurance coverage. The project ceiling funding was increased to \$9,977,078.

In October 2010, the new MoLHSA leadership requested that HSSP activities focus intensively on the development of HMIS in the country. This request was incorporated into the FY2011 work plan. In parallel to these developments and as an outcome of the Georgian Health Care Medea conference, held in February 2011, MoLHSA commissioned the development of a medium term health sector strategy (white paper) for Georgia. The strategy, to be approved in May 2011, will define GOG's vision on major directions of health sector development in Georgia.

Given the circumstances above, USAID/Georgia intends to conduct a mid-term evaluation of HSSP. The evaluation results will be used to identify needs and focus technical assistance

provided to the Georgian health sector. The outcome of the evaluation will inform decisions on re-alignment, prioritization and streamlining of activities within HSSP's scope.

#### **IV. SCOPE OF WORK:**

One consultant is needed for the following SOW.

1. Review compliance of the HSSP implementation with the Task Order and annual work plans; if necessary, identify internal and external constraints that hindered the implementation of planned activities.
2. Review the HSSP achievements to date, with the emphasis on outcome and impact level results.
3. Update an assessment of the Georgian health system, conducted by USAID in 2009 and define and prioritize future technical assistance needs.
4. Verify relevancy of the HSSP objectives and goals, based on the assessment results. Goals and objectives should be aligned to the newly approved health sector strategy (white paper).
5. Propose recommendations for future directions of the HSSP, including specific activities, timing, and output and outcome level indicators.

#### **V. METHODOLOGY:**

Document and literature review: The USAID/Georgia Health and Social Development (HSD) Office will provide the consultant with all the necessary background documents (Health Sector Assessment report from 2009, HSSP task order, annual work plans and reports, GOG health sector strategy, etc). The consultant, together with the HSSP COTR is expected to conduct a desk review of the documents.

Team Planning Meeting (TPM): In addition, a two-day TPM will be held at the beginning of the assignment. The meeting is essential for the following reasons:

- Agreeing upon an approach for working with USAID staff and partners throughout the assignment.
- Developing data collection methods, instruments, tools and guidelines.
- Developing a preliminary draft outline of the team's report and assigning drafting responsibilities for the final report.
- Reviewing and finalizing the assignment timeline to share with and be approved by the mission.
- Enabling USAID staff to discuss with the team the overview and purpose of the SOW.
- Clarifying individual team members' roles and responsibilities.
- Reviewing and clarifying logistical and administrative procedures for the assignment.

Field Visits/Key Informant Interviews: The consultant will create and finalize data collection instruments that will be approved by USAID prior to any key informant interviews or site visits. Key health sector stakeholders in Georgia include, but are not limited to MoLHSA decision makers, Parliamentary committee of Health and Social Affairs, representatives of health insurance companies, private health service providers, other donor agencies, non-governmental organizations and professional medical associations.

USAID/Georgia meetings: The following meetings are suggested -

- Initial organizational/introductory meeting at which the consultants will present an outline and explanation of the design of the Evaluation
- Additional consultation meetings with USAID staff, as needed.
- Final Evaluation debrief - summary of the data, draft recommendations and draft report prior to departure from country.

## **VI. CRITERIA TO ENSURE THE QUALITY OF THE EVALUATION REPORT:**

- The evaluation report should represent a thoughtful, well-researched and well organized effort to objectively evaluate what worked in the project, what did not and why.
- Evaluation reports shall address all evaluation questions included in the scope of work.
- The evaluation report should include the scope of work as an annex. All modifications to the scope of work, whether in technical requirements, evaluation questions, evaluation team composition, methodology or timeline need to be agreed upon in writing by USAID.
- Evaluation methodology shall be explained in detail and all tools used in conducting the evaluation such as questionnaires, checklists and discussion guides will be included in an Annex in the final report.
- Evaluation findings will assess outcomes and impact on males and females.
- Limitations to the evaluation shall be disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Evaluation findings should be presented as analyzed facts, evidence and data and not based on anecdotes, hearsay or the compilation of people's opinions. Findings should be specific, concise and supported by strong quantitative or qualitative evidence.
- Sources of information need to be properly identified and listed in an annex.
- Recommendations need to be supported by a specific set of findings.
- Recommendations should be action-oriented, practical and specific, with defined responsibility for the action.

## **VII. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT:**

It is expected that three person team will complete the activities described in the SOW above. The team will consist of:

- One external consultant hired through GH-Tech contract (Team Leader);
- HSS and Public Health Advisor from USAID Bureau for Global Health
- Program Management Specialist, Senior Health Systems Advisor from USAID/Georgia HSD Office

Team Leader: The Team Leader will have at least 7 years of experience in conducting health sector project evaluations, should be familiar with post-Soviet health care systems and specifically, ongoing health care transformation in Georgia. S/He will have served as a team leader on previous evaluations/assessments, and will have well developed communication skills (both verbal and written), the ability to conduct interviews and facilitate discussions, and write reports. She/he should have solid client interaction skills, leadership, flexibility, and management skills, and experience interacting with host government officials, civil society partners, and members of the professional association and NGOs, as appropriate.

The Team Leader will take specific responsibility for assessing and analyzing the project's progress towards quantitative targets, factors for such performance, benefits/impact of the strategies, compare with other possible options, and defining and prioritizing future assistance directions from HSSP. S/he will provide leadership for the team, finalize the evaluation design, coordinate activities, arrange meetings, consolidate individual input from team members, and coordinate the process of assembling the final findings and recommendations. S/he will also lead the preparation and presentation of the key evaluation findings and recommendations for future directions of the project to the USAID/Georgia Health Team and key partners if desired.

**Team Member from the Bureau for Global Health:** The second team member will participate in developing data collection methods, instruments, tools and guidelines, drafting preliminary outline of the assessment, will participate in the interviews and summarize findings, review the draft assessment report and ensure alignment of the proposed HSSP future priority assistance areas with the GHI principles.

**Team Member from USAID/Georgia HSD:** The third team member will ensure scheduling of the interviews; participate in the design of data collection instruments and tools; participate in the interviews, review the draft assessment report and ensure alignment of the proposed HSSP future priority assistance directions with the Georgia GHI Strategy, participate in the verification and development of output, outcome and impact level indicators for the project.

**Illustrative table of Level of Effort (LOE):**

Consultant is needed to start on/ about August 15

<b>Activity</b>	<b>Total Consultant Days (Team Leader/ USAID Team Members)</b>	<b>Period of Performance (to be revised based on start date)</b>
Review background documents	3 days/3 days	Starting August 29
RT travel to/from country	2 days/ 0 days	
Develop detailed evaluation framework and ToC of the report (Team Planning Meeting)	2 days/2 days	Intermittently
In country visit and field work	10 days/10 days	Intermittently
Develop draft evaluation report (discussion, data analysis; report writing)	6 days/6 days	Intermittently
Debriefing w/ Mission	1 day/1 day	
Completion & submission of draft report prior to departure	1 day/1 day	
Incorporate draft comments and finalize report	4 days/2 days	Intermittently
Report is edited/formatted (approx. 30 days) —by GH Tech	—	
<b>TOTAL</b>	<b>29 days/25 days</b>	

A six day work week is approved when team is working in country.

## **VIII. LOGISTICS:**

USAID/Georgia HSD office will assist the consultant in scheduling meetings and interviews, as well as allocate work space.

GH Tech will provide transportation and international travel to/from Georgia and arrange for lodging, travel concurrence, local travel expenses, etc.

## **IX. BACKGROUND DOCUMENTS:**

- Assessment of Georgian Health Sector Opportunities and Constraints, USAID, 2009
- HSSP Task Order
- HSSP Work plan, FY 2010
- HSSP Annual Report, FY2010
- HSSP Work plan, FY2011
- HSSP technical deliverables and reports

## **X. DELIVERABLES AND PRODUCTS:**

The team will be responsible for producing the following deliverables:

Work Plan/Methodology Plan: During the Team Planning Meeting, the Team will prepare a work plan which will include the methodologies to be used in the evaluation as well as the final list of evaluation questions to be answered. The work plan will be submitted to the Health Team for approval prior to start of key informant interviews and/or site visits.

Debriefing with USAID: The Team will present the major findings of the evaluation to USAID/Georgia through a PowerPoint presentation. The debrief will include a discussion of future directions of the HSSP, including specific activities, timing, output and outcome level indicators.

Submission of Draft Evaluation Report: The Team will submit a draft report to the USAID Health Team incorporating feedback and comments received from the debriefing. USAID will have 10 days to provide the team with one set of written comments.

Final Report: The Team will submit a final report that incorporates the team responses to Mission comments and suggestions no later than approx. five days after USAID/Georgia provides written comments on the Team's draft evaluation report. This report should not exceed 45 pages in length (not including appendices, lists of contacts, etc.). The format (see below) will include an executive summary, table of contents, methodology, findings, and recommendations. The report will be submitted in English, electronically. The report will be disseminated only within USAID.

A public version of this report, excluding any potentially procurement-sensitive information, will be submitted (also electronically and in English) for dissemination among implementing partners and stakeholders. The report will be released as a public document on the USAID Development Experience Clearinghouse (DEC) (<http://dec.usaid.gov>) and the GH Tech project web site ([www.ghtechproject.com](http://www.ghtechproject.com)).



## **APPENDIX B. PERSONS CONTACTED**

### **Parliament of Georgia**

Otar Toidze, Head of Health and Social Affairs Committee

### **Ministry of Labour, Health and Social Affairs (MoLHSA)**

Misha Dolidze, Deputy Minister

Rusudan Rukhadze, Head of Department of Health

Moris Tsamalashvili, ICT Consultant

### **Social Service Agency (SSA)**

Kakha Khealdze, Deputy Director

### **Health Insurance Mediation Service (HIMS)**

Nika Chichinadze, Senior Specialist

### **Ministry of Health and Social Affairs of Adjara Autonomous Republic**

Temur Gabaidze, Minister

### **Health System Strengthening Project (HSSP)**

Julian Simidjiyski, COP

Keti Datashvili

Alexander Turdziladze,

Alexander Nodia,

Tata Kobakhidze

Ushangi Kiladze

Lali Beitrishvili

### **Georgian Insurance Association (GIA)**

Devi Khechinashvili, Head

### **Georgian Hospital Association (GHA)**

Maia Makharashvili, Head

### **Family Medicine Association**

Guram Kiknadze, Head

### **Georgian Health Law and Bioethics Society**

Givi Javashvili, Head

### **Association of Family Medicine Practitioners**

Irine Karosanidze, Head

Tamar Gabunia

### **Georgian Medical Association**

George Tsilosani, Head

**World Bank Tbilisi Office**

Nino Moroshkina, Health Specialist

**Delegation of the European Union in Georgia**

Nino (Nika) Kochishvili, Project Manager

**Abasha District Hospital**

**Akhaltzikhe District Hospital**

**PHC doctors (Gori, Sarpi)**

## **APPENDIX C. DISCUSSION GUIDE**

### **DISCUSSION GUIDE FOR STAKEHOLDERS' INTERVIEW**

What are the major issues (challenges) of health sector reforms in Georgia?

How effectively has HSSP responded to the issues of ongoing health sector reforms in Georgia?

Specifically, has HSSP answered your needs and expectations?

What have been positive aspects of HSSP?

What has been the most positive aspect of HSSP?

What have been weaknesses of HSSP?

What has been the weakest point of HSSP?

Has HSSP contributed in improving your organization's capacity?

How helpful (practical) were inputs and recommendations from international experts of HSSP?

How helpful was the support from local experts of HSSP?

Do you agree that HSSP project should be further continued?

1. strongly disagree    2. disagree    3. agree    4. strongly agree

Do you agree that HSSP project should be further expanded?

1. strongly disagree    2. disagree    3. agree    4. strongly agree

What would you recommend to change in HSSP in order to make it more responsive to your needs?

What kind of technical assistance do you (your organization) specifically need from HSSP?



## APPENDIX D. REFERENCES

- Chanturidze, T., T. Ugulava, A. Durán, T. Ensor, and E. Richardson. *Georgia: Health System Review*. Health Systems in Transition, 2009; 11(8):1-116.
- HSSP. *Attitude towards Health Insurance*. Institute for Polling and Marketing. Tbilisi, Georgia. 2010.
- HSSP. *Monthly Progress Report*. July, 2011.
- HSSP. *Opportunities for Providing Health Insurance Coverage to Pensioners of Georgia*. Patrice Korjenek, December, 2010.
- HSSP. *Performance Monitoring and Annual Report (Year 1: October 1, 2009 – September 30, 2010)*. Abt Associates Inc., in collaboration with Banyan Global MD Informatics, 2010.
- MoLHSA. *Hospital Sector Infrastructure Development Plan*. November, 2010.
- MoLHSA, Geostat, Oxford Policy Management, Curatio International Foundation. *Georgia Health Utilization and Expenditure Survey (HUES)*. Final report, December, 2010.
- Public Defender of Georgia. *The Situation of Human Rights and Freedoms in Georgia*. Annual report, 2010.
- UNICEF. *Survey of Barriers to Access to Social Services*. Preliminary report, Tbilisi, July, 2011.
- U.S. Government. *Georgia Global Health Initiative Strategy*. Retrieved from <http://www.ghi.gov/documents/organization/175130.pdf> on September 5, 2011.
- WHO. *European Health for All Database*. Updated: January, 2011.
- WHO. *Georgia Health System Performance Assessment 2009*. WHO Regional Office for Europe, 2009.



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<http://www.ghtechproject.com/resources.aspx>

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