

HEALTH INSURANCE FOR POOR: GEORGIA'S PATH TO UNIVERSAL COVERAGE?

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RESEARCHASSESSING EFFORTS TOWARDS UNIVERSAL
FINANCIAL RISK PROTECTION IN LOW AND MIDDLE INCOME
COUNTRIES

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ABSTRACT

The inconclusive global evidence on advantages or disadvantages of private for-profit intermediaries in provision of an insurance coverage for the population and its poorest segments through public funds along with near absence of comprehensive reviews of such experiences in low and lower-middle income countries and potential shortcomings and emerging problems in the design and implementation of Georgia's health financing reform targeting the poor, were serious arguments in favor of systematic study of Georgian experience in implementing the large scale pre-payment schemes through public-private partnership. This study assessed the impact of new health financing initiatives in Georgia on two key dimensions of universal coverage - equity in access to essential health care services and financial protection against health care costs. From this perspective, the study focused on the national program for Medical Assistance to the Poor (MAP) developed by the Georgian government in 2007. Under MAP the government purchases coverage for the vulnerable households identified through the means testing system from private insurance companies for outpatient and inpatient services with no co-payments, but only with very limited drug benefit. The overall study approach was an exploratory and partially explanatory drawing on the policy analysis triangle framework and using holistic single case study design. A range of quantitative and qualitative methods was used. The study findings showed that MAP was moderately successful in improving equity of access and financial protection of the insured poor and had limited overall effect on the same dimensions for the general population. While no significant positive effects on the catastrophic health outlays and improvement rates in the general population were observed by the year 2010, MAP beneficiaries were three times more likely to receive completely free outpatient care ($p < 0.01$) and up to 7 times more likely to obtain free inpatient treatment ($p < 0.01$) compared to non-beneficiaries. The qualitative research findings described and explained how and to what extent the policy content, context, actors and processes of MAP design and implementation have affected the observed outcomes. The policy analysis demonstrated that the context and certain actors were crucial for MAP inception, while MAP design and implementation process and content (contracting and purchasing arrangements and the benefit package) have largely determined the outcomes. The recent governmental decision on major expansion of MAP coverage and inclusion of additional drug benefit are expected to significantly enhance the overall MAP impact and its potential as a viable policy instrument for achieving universal coverage. The Georgian experience presented in this paper may be useful for other low and middle income countries that are contemplating ways to ensure universal coverage for their populations.

KEY WORDS

Health insurance for the poor, catastrophic expenditures, financial protection, service utilization, targeting of the poor, policy analysis, universal coverage

BACKGROUND

Achievement of universal health coverage for the population - to enable everyone to access health care services and not be subject of financial hardships in doing so – is one of the key global health policy objectives promoted by the World Health Assembly Resolution 58.33 from 2005 [1]. There is common set of actions recommended by the World Health Organization (WHO) for accomplishing this objective by raising sufficient resources, reducing the reliance on direct payments for health services and improving efficiency and equity. Yet, country level approaches may differ. Sources of additional funds for health sector may be diverse ranging from general government revenues and compulsory insurance contributions to excise taxes and user fees. The pooling may occur in one national pool or in multiple, sometimes competing pools managed by the private insurance companies. Even when the additional resources are raised, pooled and directed through prepayment schemes, important trade-offs remain on who, what services and to what extent to cover [2]. Many low and middle income (LMIC) countries are engaged in diverse health financing reforms in order to move closer to the universal coverage. Content of these reforms differ depending on the decisions that each country makes regarding the available alternatives. Georgia, one of the LMIC countries of the Eastern European and Central Asia (ECA) region, has also chosen its own path in reforming health financing system by allocating general government revenues to purchase fairly comprehensive coverage for the poor identified through the means testing system.

The focus on priority groups and specifically on the poor segments of the population is a common feature of health financing reforms in other LMIC countries, including Cambodia [3], China, Lao PD [4], Indonesia [5], Mexico [6], Philippines [7], Tunisia [8], Viet Nam [9]. Nonetheless, the Georgian experience may be considered somewhat unique for two reasons. Firstly, the Georgian government has chosen to provide more generous benefits to the poor than to other groups of the population, which is not a common practice globally, as in most cases the wider welfare entitlements - including those in health - are directed towards the most organized or politically the most powerful [10] and the people least likely to be covered are those with high health care requirements and needing financial protection [11]. Secondly, the coverage for the poor is purchased through competing private insurance companies. Only 11 countries out of 154 LMIC channel at least 10 per cent of total health expenditures through private risk prepayment schemes and for most of these countries private for-profit schemes are generally limited to the wealthy minority [12]. Columbia (Regimen Subsidiado) and India (Rashtriya Swasthya Bima Yojna) are the only other LMIC countries described

in the literature that have established similar Public Private Partnership (PPP) for the insurance of the poor [13] [14].

In general, due to reduced bureaucratic process and often better business practices, private health insurance may be more efficient than public or quasi-public social insurance schemes, although, the efficiency gains may be outweighed by higher administrative and acquisition costs. Most of the countries relying on voluntary health insurance are commonly unable to extend coverage to the majority of the population, or tend to leave the large segments of the population uncovered (South Africa, Jordan, Lebanon, Zimbabwe, India, etc.) [12]. Fragmentation of the national pools is another problem in countries where mandatory coverage is provided through competing private health insurance companies. These countries (Switzerland, Netherlands and Czech Republic) are compelled to use cross-subsidization between multiple pools to improve equity and viability of the health financing system [2]. Overall, comparative advantages of engaging competing insurance companies for providing health insurance for the general population or priority groups are at best unclear.

The inconclusive global evidence on the advantages or disadvantages of private for-profit intermediaries in provision of the insurance coverage for the population and its poorest segments through public funds along with near absence of comprehensive reviews of such experiences in low and lower-middle income countries [15] and potential shortcomings and emerging problems in the design and implementation of Georgia's health financing reform targeting the poor [16], were serious arguments in favor of systematic study of Georgian experience in implementing the large scale pre-payment schemes through public-private partnership.

The purpose of the Georgia Case Study presented in this paper was to assess the impact of new health financing reform initiatives of the Georgian government - equity of access to essential health care services and financial protection against the health care costs – which, together, are two key dimensions of the universal coverage plans. From this perspective, the study focused on the State Health Program for Medical Assistance to the Poor (MAP), - one of the most important health financing policy instruments developed by the Georgian government that may eventually help the country to achieve the universal coverage for the population given that the high level commitment to the universal coverage is sustained in national health policy making.

Careful documentation and analysis of this experience produced by the current study are anticipated to be useful for other low and middle income countries that are struggling with similar issues while contemplating the ways to ensure the universal coverage for essential health services for their populations. The fact that this new health financing initiative in Georgia was at initial stage of implementation by the time of the study inception, presented good opportunity for researchers to monitor and systematically document the policy implementation process in “real time”. In particular, detect emerging problems, identify successes and failures of employed approach in improving

financial protection of the Georgian population and finally, derive lessons that have most likely contributed to the informed policy implementation on its early stages.

This paper reflects the key results and conclusions of the case study, drawing on more than one year of the in- country research (from October 2010 through February 2012), including extensive document review, in depth interviews with key stakeholders and players; focus group discussions with health providers, private insurance companies and patients; media monitoring and analysis of the secondary data. The paper first provides a brief review of MAP and its impact. It then outlines in more detail the factors explaining the patterns of MAP implementation and observed impact, which leads to conclusions and policy recommendations.

METHODS

ANALYTICAL FRAMEWORK

The policy content, context, actors and processes affecting MAP design, implementation and outcomes are analyzed using the “policy triangle framework” developed by Walt and Gilson, which employs political economy perspective and considers how all these four elements interact to shape the policy-making and influence the policy impact [17]. The diagram on the Figure 1 shows how this analytical framework guides final analysis and responds to the relevant research questions of the study.

The context for the case studied is examined at two levels: firstly, the general context outside the health sector; and secondly, the health status and health system context, including broader health financing reform context. For the general context outside the health sector the researchers looked at social, economic and political indicators and main developments. For the health status and the health system we look at key health system performance dimensions as defined by the WHO health systems framework [18]: stewardship; resource generation; service delivery and health financing. The final function – health financing – is studied in more detail.

The content of the reforms is scrutinized focusing on factors initially identified as having potential to affect the outcomes of MAP. These factors that shaped the case study propositions for testing included: (a) targeting mechanism (eligibility criteria); (b) the benefit package design; and (c) institutional arrangements for the involvement of private insurance companies as intermediaries in providing health insurance coverage for MAP beneficiaries.

The process of MAP formulation and implementation is assessed using “good practice hypothesis” adapted from Hercot et al. This approach helps to review country experience in conducting health financing reform against the explicit list of hypothesis of good practice associated with such reforms [19].

The roles, positions and influences of key actors in formulating and implementing MAP are identified and analyzed across four groups suggested by Kingdon [20] and Hercot et al [19]: elected officials, appointed officials, members of the interest groups and individuals (patients and insured). Special attention is devoted to the position of the key actors on the potential of MAP as a viable policy instrument for achieving universal or near universal coverage for the Georgian population.

The impact is assessed across several dimensions: (a) responsiveness of MAP insurance carriers and providers and satisfaction of MAP targeted population; (b) breadth, scope and depth of the achieved coverage for the general population [21]; (c) access to health services and financial protection for MAP targeted and the general population; and (d) any other predefined MAP policy objective established by the study. The researchers use the incidence of catastrophic health expenditures and impoverishment rate to characterize the financial protection of the population, while the access to health services are measured using the indicators for availability of medical personnel, health services utilization and health expenditures. The catastrophic health expenditures are defined as occurring once out of pocket payments cross some threshold share of household expenditure, at which the household is forced to sacrifice other basic needs, sell assets, incur debt or be impoverished [22] [23]. For estimating the catastrophic health expenditures we use methodology suggested by the K. Xu et al, which defines catastrophic health expenditure in relation to the households' nonfood expenditures. The health expenditure is determined as being catastrophic if a household's financial contributions to the health care system equals and/or exceed 40% of household's nonfood expenditure or Capacity to Pay (CTP). A CTP is estimated after subtracting Subsistence Expenditure from monthly household expenditure (i.e. consumption) obtained from the quarterly household budget survey. Subsistence Expenditure for the purposes of our calculations corresponds to the average food expenditure of the households in the 45th and 55th percentile, adjusted to the size of the given household [24]. A non-poor household is considered impoverished by health payments when it becomes poor after paying for health services - when its expenditure is equal to or higher than subsistence spending, but is lower than subsistence spending net of out-of-pocket health payments [23].

For the assessment of MAP impact on the breadth, depth and height of the coverage achieved in the Georgian health system and comparison of the initial policy design with the actual implementation, the research team uses the conceptual framework for assessing health financing system reform towards universal coverage that is currently developed by the World Health Organization [25].

METHODOLOGICAL APPROACH AND METHODS

Overall approach used for the presented research is an exploratory and partially explanatory, holistic single case study design as this method is generally best suited for longitudinal observation and systematic documentation of the "real time" policy implementation and allows exploration of both "how" and "why", while taking into consideration how the policy at interest is influenced by the

context within which it is situated [26]. As proposed by Keen and Packwood - „Case studies are valuable where policy change is occurring in messy real world settings”, as in Georgia and “...it is important to understand why such interventions succeed or fail” [27]. The case is the nationwide medical assistance program for the poor in Georgia. All four elements of the policy framework – context, content, process and actors and the policy impact are analyzed at the national level. Variety of qualitative and quantitative research methods, including in-depth interviews with key informants, focus group discussions, media monitoring and secondary data analysis were used to achieve holistic understanding of the studied phenomenon. The data from the multiple sources were collected and then converged in the analysis process to respond to the case study research questions. Short description of the data collection methods and materials used in the study is presented in the Table 1.

The research was undertaken in three stages. The first stage involved the overview of the key issues pertaining the agenda setting and policy formulation for MAP introduction through developing an initial description of the chronology of reform evolution with reference to key features of context, actors and design. This chronology also involved documenting any changes in MAP design introduced during the implementation, up until the period of the study launch. This initial overview was derived from a comprehensive review of relevant documents, as well as, key informant interviews with a first set of policy-makers, technical advisors and experts that were directly involved in the reforms at focus. Interviews were open-ended broadly based on the research questions (see Figure 1) and adapted list of the “good practice hypothesis” framework (see Table 4). The information collected from key informants was used for the revision and fine-tuning of in-depth interview and focus group guides that were utilized for further data collection. The research findings of this stage were analyzed using the conceptual framework for assessing health financing system reform towards universal coverage, identifying the laws, regulations and directives that form the legislative bases for MAP, mapping all organizations carrying out health financing functions pertaining to MAP (with special emphasis on pooling and purchasing function relevant for this particular case study) and other major political, economic and social bodies involved in the design and implementation of MAP. The first stage also involved the retrospective media analysis of main national newspapers, magazines and television broadcasters to supplement the information and perspectives on context actors and processes of MAP design and introduction. The media monitoring and analysis initiated at this stage were continued throughout the study period.

The 2nd stage encompassed in-depth interviews and focus group discussion with primary and secondary stakeholders (high and middle level policy makers, private insurance companies, private and public sector providers, users/patients and their interest groups, NGOs and other civil society organizations either involved in MAP implementation or affected by this program) identified during the first stage of the study, through the document review and employing a “snowball technique”

with initially interviewed key informants. In-depth interviews with policy makers were used to obtain more comprehensive understanding of the process of MAP formulation and implementation, as well as, its future prospects. In-depth interviews with stakeholders at this stage were conducted one-on-one using semi-structured interview guides, which were fine-tuned at the first stage of the study. Focus Group Discussions (FGD) with patients, providers, private insurance companies and NGOs were conducted to acquire more in depth perspective on MAP impact dimensions. Total of 10 focus group discussions were performed, out of which 4 FGD were for patients (2 in the capital of Georgia - Tbilisi, 2 in Regions – Eastern and Western Georgia); 4 FGD for providers (2 in Tbilisi, 2 in the regions – Eastern and Western Georgia) and 1 FGD for each of the remaining groups (PICs and NGOs).

The 3rd stage entailed assessment of MAP impacts and testing/identification of factors shaping the pattern of MAP development, implementation and impact using the survey reports and secondary data analysis of the population based surveys – nationally representative Georgia Household Health Utilization and Expenditure Surveys (HUES) 2007 [28] and 2010 [29], Georgia MAP Impact Evaluation Survey (MAPIES) 2008 [30] and Survey of Barriers to Access to Social Services in Georgia (SBASS) 2010 [31]. HUES 2007 and MAPIES 2008 have been conducted at initial phase of MAP implementation and provided necessary baseline for evaluating the observed MAP impact across the criteria identified above: impoverishment due to the health care costs; incidence of catastrophic health expenditures; the breadth, depth and height of the achieved coverage; health services utilization and health expenditure patterns; beneficiary awareness and satisfaction. The impact was evaluated by comparing these baseline findings with the findings of the HUES 2010 and SBASS 2011¹ (for MAPIES) that have generated comparable data for MAP targeted poor population, and the poor and general population not covered by MAP benefits. Additional results of these surveys on several key outcomes, including health system responsiveness and health-related behaviors, were also considered for capturing the full impact of MAP. The utilization patterns and probability to receive free benefits by MAP targeted and not targeted population were assessed through the analysis of combined HUES 2007 and 2010 databases using the difference-in-difference approach with logistic regression method. The impoverishment and catastrophic health expenditure rates were estimated by the researchers using the HUES 2007 and 2010 databases using the methodology presented in Gotsadze et al. [32]. For comparison, alternative estimates for the same indicators were also obtained from Rukhadze and Goginashvili [33]. Their estimates are based on the annual level data obtained through the quarterly Georgia Integrated Household Survey (IHS) implemented by the GeoStat.

¹ While the methodology for MAPIES and SBASS differed, certain findings on beneficiary awareness and satisfaction were still considered relevant for comparison.

This stage also included a repeated set of in-depth interviews with primary stakeholders to assess a degree of change over the time in interests, perceptions and positions of key actors involved or affected by MAP implementation process. These interviews were conducted after almost one year since the first set of interviews and helped testing new propositions - on factors affecting MAP impact - that have emerged from the quantitative surveys. Final document review and media analysis at this stage allowed capturing any changes in MAP implementation process.

The research team used the grounded approach described by Corbin and Strauss [34] for the analysis of the qualitative data obtained through the variety of the data collection methods described above. The analysis was also amended through a simple deductive framework. This combined approach was used by the researchers with the aim to capture the complex environment and wide range of new issues and propositions that emerged during the study process - rather than focusing analysis solely on predetermined propositions and prior understandings, as required in a more deductive approach. In practice, a broad coding structure derived from the study's overall conceptual framework was initially used in analyzing documents and key informant interviews. This coding structure was then adapted and revised as data obtained through this process were analyzed. Information derived from each of the sources of the qualitative data used at every stage of the study was triangulated within and between data sets with the aim of identifying common understandings of the experiences of issues at focus, as well as differences of opinion between various stakeholders. Following triangulation, the data sets then were used to develop specific analyses, such as timelines summarizing the chronology of policy change, descriptions of particular processes used in the design or implementation of MAP and stakeholder analyses of actor positions on specific features of MAP design and implementation at specific time and future prospects of the program. During this process the researchers attempted to address each of the study propositions.

These specific analyses finally informed the overall analysis presented in the study report.

Preparation of the final report was an iterative process in which the research team met frequently to reflect and review their evolving understanding of the experiences being analyzed. The researchers' views and understandings derived from the stakeholder interviews and focus groups discussions, including those expressed in final findings and analysis were validated to the extent possible through small group review with key informants including policy makers and technical advisors. Lastly, the inputs from the external peer reviewers in country were sought for the final analysis and the study report.

RESULTS AND DISCUSSION

CONTEXT

GENERAL CONTEXT

Georgia – former Soviet Republic is situated along the Black Sea shore, bounded by Turkey, Russian Federation, Armenia and Azerbaijan. Despite its small size (population of 4.47 million in 2011) Georgia is ethnically heterogeneous, with ethnic Georgians accounting for up to 84 per cent, Azerbaijani for 6.5 per cent, Armenians for 5.7 per cent, Russians for 1.5 per cent, and other ethnic minorities for 2.3 per cent of the total population. Up to 1.1 million or 25 per cent of the country population resides in Tbilisi - the capital of Georgia. The median age is 39 years with annual growth rate at 0.77 per cent. About 53 percent of population lives in urban areas [35]. Key social, economic and health indicators are presented in the Table 2

According to the World Bank classification, Georgia is a lower-middle-income country. After dramatic economic decline and raging inflation following the civil war and ethnic conflicts in the period from 1990-1993, the economic recovery was slow up until the Rose Revolution in 2003, when the new government introduced radical economic reforms focused on deregulation, privatization, the fight against corruption and transformation of social, health and education sectors. The radical institutional and economic reforms backed by the revolutionary mandate were based on the libertarian and neoliberal ideologies favoring free market; minimalist, but strong state and deregulation. Economic stimulus packages, anticorruption efforts and the institutional measures implemented by the state to improve the business environment, has led to rapid development of major sectors of economy, including the banking and insurance industries. These sweeping reforms attracted foreign direct investments and fueled the economic growth [36]. As a result, despite the war with Russia in 2008 and the world economic recession, the country's Gross Domestic Product (GDP) per capita has more than doubled - from \$1,187 in 2004 to \$2,690 in 2010 - and the state budget has increased from less than 500 million US\$ in 2004 to 4 billion US\$ in 2010 [37]. However, the economic growth has not benefited all sectors of the economy and all groups of population equally. Poverty has remained a pervasive problem for Georgia. Whilst the incidence of poverty at 60% of median consumption has somewhat fallen in the period from the year 2004 to the year 2009, more than one fifth of the population (21 per cent) remains below the poverty line [35]. As a result, the poverty reduction was retained as a one of the key national priorities for the government and international development partners [38]. National debates on the most effective way of addressing this problem has largely centered on the choice between the “universalism” or “targeting” approach in poverty eradication. This debate has started even prior to the Rose Revolution and profoundly influenced the direction of social protection and social assistance systems' reforms. The laws adopted just prior the Rose Revolution on social insurance, social health insurance and pension

insurance in 2003 have been abolished in 2005, along with the social tax, thus effectively dismantling the social insurance model that has been constructed in Georgia from mid-nineties. The Georgian Government has explicitly declared that the “priority of the state is to ensure social integration and decent quality of life for those individuals that cannot afford social protection due to objective reasons, rather than providing social welfare for all” [39]. This approach was central to creation of the proxy-means testing system for awarding the targeted social benefits to the poor that the government introduced in 2005-2006, which in turn has paved road for the introduction of MAP.

HEALTH AND HEALTH SECTOR CONTEXT

During the last two decades, the Government of Georgia (GoG) has implemented several reform efforts to increase the efficiency of country’s health system and to move away from the highly centralized Semashko model inherited from the Soviet Union. Initial reforms in 1995- 1996 included provider – purchaser split, delegation of significant autonomy to health providers, changing health financing modalities and transformation of stewardship and governance arrangements in the health sector. One of the major changes GoG has introduced in 1995, was abolishment of the constitutionally defined universal entitlement to free health care that was no longer affordable once the public expenditures on health care fall dramatically, from the estimated US\$130 in 1990 to less than US\$1 per capita [40]. It is noteworthy that Georgia was one of the first among former socialist countries to make this politically difficult move. Albeit certain progress in the health sector institutional reforms - low priority of the health sector in public finance allocations and inherited and perpetuated inefficiencies in the health services delivery system - resulted in a major mismatch between health needs of the population and means to address these needs, including financial and human resources, health technologies and infrastructure. Access and affordability of essential health care services were extremely constrained. A second wave of the health sector reforms were conceptualized and launched in 2005-2006. New initiatives entailed institutional transformation in the context of wider social protection system reform; remodeling of the health services delivery and health care financing systems to improve the equity and affordability in access to quality health care services for the Georgian population [41].

As a result of these reforms - by the time of MAP introduction - the **Stewardship function** of the Ministry of Labour, Health and Social Affairs (MoLHSA) was concentrated on policy making and regulation, while management of the health system and its components is decentralized. The policy making capacity of the MoLHSA has been improving over the time, however frequent reorganizations and changes in the senior management had negatively affected the realization of its full potential.

Resource generation for health care system suffered from the years of underfunding; until 2003-2005 investments in health infrastructure and human resources have been low. Even after, the increase in available funds from donor, public and private sources - a desired level of capital

investments in country's health facilities has not been reached. Efficient allocation of scarce resources was a major challenge throughout the last decade and remains so with increased funds available for health sector investments. Starting from 2003, the World Bank and EU supported projects provided up to 30 million US\$ for construction and upgrade of rural Primary Health Care (PHC) facilities and retraining of over 1,800 family medicine teams. In 2006, the GoG also initiated 100 New Hospital Program aimed at mobilization of private investments for complete restructuring of the national hospital sector in a three year period (2007-2009) through a large scale PPP. By the year 2008, more than 80 per cent of all operating hospitals were sold to private investors (mostly real estate companies), which had an obligation to construct/upgrade the hospitals and operate them for the minimum of seven years as health care facilities. Albeit, the war with Russia in 2008 and global economic recession have negatively affected the real estate market in Georgia and positive outlook for the 100 New Hospital Program. As a result, by 2009 the program stalled [41]. Pharmaceutical market is well developed with fair supply of pharmaceutical products. However, financial access to quality drugs and consumables is still problematic. There are perceived gaps in pharmaceutical regulation. Production of human resources, their training and continuous education process is yet to achieve modern standards.

Service delivery for personal health services is still characterized by underutilized excess infrastructure with the emphasis on hospital facilities and physician centered care. Ratio of physicians per population (47 per 10,000 population) significantly exceeds the European average (33 per 10,000) [42], however their geographical distribution is skewed towards urban areas, - creating possible physical access problems in certain rural and mountainous districts. Nurses per population ratio are significantly lower than European average (32 per 10,000 vs. 80 per 10,000) [42] and their training level and autonomy are constrained. Skilled managers are in high demand at all levels of the health system. In overall, the skill mix of human resources providing services to the population are below optimal. The system of service delivery for non-personal health services is represented by the central agency – National Center for Diseases Control, subordinated to the MoLHSA. Local bodies - Public Health Centers were abolished in most of the local constituencies of the country [43].

Health financing - since the inception of health financing reforms, due to the changing broader political and social policy context, the country has experimented with various institutional set ups for the health financing system. Basic features and development stages of the Georgian health financing system across three main functions: revenue generation, pooling and purchasing are presented in Table 3. After series of reforms, the national health system is now financed through general budget revenues with relatively limited basic benefit package for the entire population. The level of public expenditures on health, despite more than threefold increase since 2003, was still low compared to developed countries at app. 34 US per capita (2006), which led to high private out of pocket expenditures and financial barriers in access to health services. According to the national health

accounts data, this share of private expenditures in 2006 was up to 73 per cent of total health expenditures, nearly 90 per cent of which are direct out-of-pocket payments [44]. This is one of the highest level of private expenditures on health not only in the WHO European Region (app. 23 per cent in average), but also considerably exceeds the global average (app. 36 per cent) [45]. This level of private out-of-pocket spending in the health sector contributed to high prevalence of catastrophic health expenditures among the Georgian households. There is evidence that suggests that the share of households that faced catastrophic health expenditures have increased considerably from 2.8 per cent in 1999 to 11.7 per cent by 2007 and became the significant factor contributing to impoverishment of the Georgian households [32]. Financial access problems in turn, have led to decreased utilization of the most essential health services by the population and particularly by the poor. By the year 2005, Georgia had one of the lowest health services utilization rates in the ECA (Eastern Europe and Central Asia) Region, with less than 1.7 outpatient visits per person, less than 6 inpatient visits and less than 1.6 surgical procedures per 100 people per year [43].

Past and present problems in health system performance, along with deterioration of certain social and environmental determinants of health probably had their long lasting negative effect on the health status of the Georgian population: the key health indicators such as life expectancy at birth, infant, under - 5 and maternal mortality have dramatically worsened during the transition. Since year 2000 they show steady positive trend, however available data on these indicators suggest that there is still an ample room for improvement to which the better health system performance may also contribute. For instance, the life expectancy at birth is reported at 73.7 years for both sexes combined (2009), which is higher than Commonwealth of Independent States (CIS) average of 67 years, but lower than Western European average of 78.5 years. Figures for child mortality under five and maternal mortality are on the track for reaching the MDG target for Europe and Central Asia, however are still well below the European average. There is a need not only to sustain, but accelerate these trends to put Georgia on track in achieving the MDG goals for under - 5 and maternal mortality [43].

HEALTH FINANCING REFORM AND MAP

This situation well justified the intention of the Government of Georgia to introduce major changes in health financing policy and restructure the health system to reverse the negative trends observed in equity, affordability and quality of essential health service for significant part of the country population and particularly for the poor.

Addressing the stated problems in equity and financial protection against health care costs through re-attainment of universal coverage for essential health care services for the entire population was one of the longstanding and explicitly stated national health policy goals [46]. However, first practical steps towards achievement of this goal were made only in the recent years, when more public funds became available to the health sector. Paradoxically, this happened in the situation

when the overarching goal of achievement of the universal coverage for the entire population through public funds has been removed from formal public agenda in favor of the “selective” approach targeting the priority groups [39]. According to the key informants – the universal approach in defining acceptable and realistic benefit package for all was not possible due to the limited public funding available (no more than 25 per cent of total health expenditures). For instance, “...making the financing of the universal State Program for Urgent Care realistic and in par with market prices for health services would have meant either substantial increase in the funding levels - which was not affordable, or increase in the level of patient co-payment from 25 per cent to 75-80 per cent – which was not politically acceptable. Focusing the available limited funding to fully financing the acceptable benefit package for priority groups was considered as only viable alternative policy option” [47].

Back from the year 2001, the government operated national health program that offered higher health care benefits to poor. However, the administrative system used to deliver subsidies to the poor was inherited from the Soviet Union and was based on social categorical groups (e.g. internally displaced, war veterans, etc.). This system significantly limited the effectiveness of the state health subsidies. In 2005, the government started developing a proxy-means-tested system for the detection of poor households and for delivery of the state subsidies (cash and in-kind). By mid-2006, this new administrative system became functional throughout the country that allowed delivering targeted health care benefits to poor households in addition to poverty cash benefits through then existing single public purchaser for health care services State United Social Insurance Fund (SUSIF)² In the years 2006-07, the government has launched ambitious health financing reform program with an overall goal to improve equity and financial access to essential health services with a special focus on the poor. The state assumed responsibility for purchasing coverage for essential health services for the poor population and for a selected cadre of public servants (e.g. teachers, law enforcement, and military) through private insurance companies. Since the beginning of the year 2009, this Private Public Partnership (PPP) in health financing was widened through the new GoG initiative under which the state subsidized private voluntary insurance for defined essential health services for the rest of the population. The State subsidization of private voluntary insurance covering a basic package of services (emergency care, urgent care and basic PHC) was expected to further promote affordable health insurance against catastrophic health care expenditures. Finally, after several important adjustments MAP, in March 2012, the Government of Georgia has announced major initiative for MAP expansion that will result in insurance coverage for one out of two citizens of Georgia (see Figure 2 for the timeline).

² In 2007, the SUSIF was transformed into two entities: Health and Social Programs Agency (HeSPA) for administering and financing health programs and Social Assistance and State Employment Agency (SASEA) for administering social assistance and labor programs. In 2010, both agencies were merged again into Social Services Agency (SSA) subordinated to the MoLHSA

CONTENT

ELIGIBILITY CRITERIA AND TARGETING MECHANISM

Beneficiaries of MAP are chosen based on welfare scores derived from a proxy means test. This proxy means test system is managed by the Social Services Agency (SSA) subordinated to the MoLHSA. The test includes over 100 variables to estimate a household's welfare standing. The system was launched in July 2006, after 1.5 years of careful preparation, including developing and testing a proxy means targeting mechanism, designing implementation procedures, developing institutional and human resource capacity and piloting. The proxy means testing mechanism was considered adequate for Georgia because of high level of informal economy, which makes declared income from formal sources an inaccurate indicator of household welfare. All Georgian households are entitled to apply to be included in the poverty database [38]. By January 2012, there were about 500 thousand households (45 per cent of the households) with more than 1.6 million individuals (35 per cent of the population) registered with the SSA database. The system allows identification of the poor with sufficient degree of certainty. Both inclusion and exclusion errors under 54,000 score threshold (eligible to social cash assistance) are estimated at no more than 20 per cent [38], which is in par with best international experience in targeting [48]. The sensitivity of the proxy means test decreases with the increase in score. The inclusion error may amount to 25-30 per cent at a threshold of 100,000 and will reach unacceptable levels above this [49]. Initially, households with scores below 100,000 were allowed to obtain health insurance coverage under MAP. In the early 2007, due to budget limitations, the government changed the inclusion threshold, requiring a score of 70,000 or below to be qualified for MAP. However, Tbilisi municipality and the government of the Autonomous Republic of Adjara (one of the Georgia regions) continued to purchase coverage for up to 100,000 individuals having welfare scores between 70,000 and 100,000 residing in Tbilisi and Adjara through supplemental local government programs. The proxy means testing system and certain indicators used for defining the welfare status has received an increased attention from mass media and criticism from the political opposition. The targeting mechanism was considered too narrow excluding many in real need. For instance, ownership of an old Soviet TV set or refrigerator by the household was enough to alleviate a household's welfare score to the levels exceeding the eligibility threshold for the targeted social assistance or MAP. Responding to the criticism, the GoG introduced changes into the proxy means testing methodology decreasing its sensitivity to such variables in 2010. This decision was widely advertised by the political leadership as an example of the GoG's responsiveness to the needs of the poor people. Yet, stories criticizing the targeting mechanism still appear in the media, one story broadcasted by the independent channel "Kavkasia" claiming that almost 25,000 individuals were excluded as a result of the change in methodology [50].

By the beginning of the 2011, the national MAP program along with Tbilisi municipality program were covering up to 910,000 beneficiaries which represent over 50 percent of the estimated number of the poor population or up to 20% of the total population.

BENEFIT PACKAGE DESIGN

MAP benefit package covers the following: 1) Urgent out-patient and in-patient treatment, including necessary diagnostic-laboratory tests for determining need for hospitalization; 2) Planned in-patient services, excluding expenses for cosmetic treatment, aesthetic surgery, resort treatment, sexual disorder, infertility, treatment abroad, sexually transmitted infections, HIV, and hepatitis C, outpatient pharmaceuticals with the annual insurance limit of 15.000 GEL; 3) Chemotherapy and radiation therapy within 12,000 GEL annual insurance limit; 4) Out-patient care and limited diagnostic and lab tests prescribed by the family physician or general practitioner; 5) Compensation of delivery costs (up to 400 GEL); 5) Outpatient prescription drugs from predefined essential drugs list and with the annual limit of 50 GEL and with 50 per cent copayment (was added in 2010).

Beyond this, up until recently, the benefit package did not undergo any other major changes. As noted above, the President and GoG have announced the plans to revise the benefit package in September 2012 by including significantly increased outpatient drug benefit. Details of this change are not yet known at the time of writing this paper.

INSTITUTIONAL AND PURCHASING ARRANGEMENTS

Initially implemented through SUSIF- a single payer under the MoLHSA - in September 2007 the government has contracted out the delivery of MAP benefits to Private Insurance Companies (PICs) on pilot basis in two regions of Georgia. Vouchers were distributed to approximately 200,000 people eligible for MAP, and the recipients had freedom of choice of participating private insurance companies. All 14 private insurance companies operating in Georgia by the year 2007 and licensed by the National Bank of Georgia had the right to participate. The participating insurance companies were mandated to provide the benefit package defined by the state and were not able to refuse membership to any beneficiary with vouchers. The insurance companies contract health services from a network of public, private, or their own clinics and hospitals. The average annual insurance premium per beneficiary paid to the insurance companies at the initial phase of the pilot was 84 GEL, which was later increased to 132.12 GEL (9.23 GEL per month for beneficiaries below the age of 64 years and 15.01 GEL for those above 64 years of age). From the beginning of 2008 MAP pilot was extended nationwide and fully managed by the private insurance companies under the contract with single public purchaser (currently SSA) subordinated to the MoLHSA. By the end of 2008, total of 666,651 MAP beneficiaries were covered. In 2009, the annual insurance premium was increased to 180 GEL per beneficiary and number of covered individuals increased to over 900 thousand. Important changes were introduced since mid-2010. The country was divided into 26 medical

regions and three year contracts for each region were awarded to PICs identified through the competitive tendering procedure. The insurance premiums paid by the state for MAP beneficiaries have been determined as a result of a tender using the least price mechanism and amounted to 116.4 GEL in Tbilisi and two other regions and 132 GEL in the remaining 23 medical regions. MAP voucher holders are obliged to enter into insurance contracts with PICs according to their place of residence. However, beneficiaries still have the right to change the insurance carrier once a year, in case if they are not satisfied with provided services. Since 2011 - reacting on allegation regarding the pervasive delays in distribution of the insurance contracts (“policy”) to the beneficiaries [51] - the GoG mandated the PICs to organize this process through the SSA employed social agents and pay a fixed amount of 3 GEL per contract distributed to the SSA. These arrangements will be in place up until the year 2013. The PICs that won tenders for MAP implementation were mandated to construct/upgrade hospitals and medical centers in respective medical regions to ensure the access to quality health services for MAP beneficiaries insured by them. By the beginning of the year 2012, seventy five medical centers/hospitals were constructed throughout Georgia. Another 75 will be completed by the beginning of the year 2013 (see the Figure 2). The Chamber of Control of Georgia (CCG) audit also claimed that the insurance premium rate paid to the PICs was inadequately high, as the direct loss ratio³ for MAP beneficiaries reported by the PICs in the period from the beginning of the 2008 through the end of 2010 did not exceed app. 53 per cent of the 311.3 million GEL paid by the State to the PICs in the same period [51]. The remaining 146.8 million GEL, according to the CCG, were “unjustified earnings” for the PICs and hence can be considered as “misappropriated public money”. On the other hand, according to the GIA and PIC representatives, not only the CCG assessment of the direct loss ratio was inaccurate, but also that direct loss ratio is an inappropriate measure for MAP efficiency, as it does not take into account the significant acquisition, administrative and investment costs (including capital investments in hospital infrastructure) required for suitable implementation of MAP. When all the costs are taken into account, the combined loss ratio will be app. 93 per cent in average for all PICs, leaving “only” 7% of the average net profit margin, which is within the range observed internationally. Moreover, even this “moderate” profit has to be reinvested in health infrastructure for MAP beneficiaries as mandated by the conditionality of the three years contracts with PICs. For instance, “GPI Holding” - one of the participating PICs, plans to invest all the profits received and top up this with additional capital, which considerably exceeds the total profit received by the company from more than three years of participation in MAP. In addition, as a result of the competitive tender, the premium rate for the years 2011-2013 has been reduced by 27 per cent. This will also diminish future earnings, even to the level that - according to the PIC FGD participants - may jeopardize future financial viability of the

³ Loss ratio is the ratio of total losses paid out in claims plus adjustment expenses divided by the total earned premiums

program [52]. In any case, the CCG audit report was one of the main reasons for changing MAP content in 2010 in terms of institutional arrangements. It was assumed that shifting to longer term - three year contracts will remove the need for substantial expenses related to beneficiary acquisition and motivate the PICs to invest more money in keeping insured healthier through expanded prevention services and free up some funds for investments in infrastructure to improve the quality of services. As noted above, the latter has been made as a key conditionality for the extended contract.

PROCESS

Our overall assessment of the “good practices” in MAP formulation and implementation process is presented in the Table 4.

AGENDA SETTING

Agenda setting stage for MAP has been closely linked with overall policy and economic reform context and was driven by strong national ownership, vision and leadership. The need for health financing reform was emphasized by the President of Georgia who created a special commission on health reforms under the Prime Minister in 2006. After four months of work, the special commission came up with medium term health policy objectives “Main Directions in Health 2007-2009” which embodied same key principles characteristic for reforms in post-revolutionary Georgia: “marketization”, PPP, private provision, private purchasing, liberal regulation and minimum supervision [41]. MAP became an integral part of this policy once the option of private purchasing through the PPPs with PICs has been selected as a preferred mode for the program implementation. Time devoted to preliminary situation analysis was limited due to the electoral considerations. Overall understanding of the problems related to financial barriers to health services existed but specific and detailed situation analysis was not performed [49]. The idea of MAP as a precise targeting instrument for delivering health benefit along other social cash benefits to the poor - was “...floating since 2005, when the development of the proxy means testing system started, and certain preparatory work was done during the November-December of 2005, however this work then stopped and suddenly, without any further preparation MAP introduction started just prior the local elections in summer of 2006 through the MoLHSA issued vouchers” [47]. MAP was considered as a key instrument for achieving one out of four main policy objectives defined in the 2007-2009 medium term health strategy – “to ensure the overall affordability of basic health services and protect the general population from catastrophic financial health risks”. However, the concrete policy objectives for the program were never formulated explicitly in any legal or policy document. Two main objectives were implied: (1) “creation of a targeting system for public financing of health services for the socially vulnerable” and (2) “redirection of the public funds to support the development of private insurance” [53]. The development of the private pre-paid schemes was also

sought to decrease both informal and formal out-of-pocket expenditures, increase the share of the prepaid resources and enhance risk pooling. The increased risk pooling in the national health system, in turn, was anticipated to make the health coverage more affordable to the majority of population. Vouchers distributed to MAP beneficiaries were considered as preferred method for individual targeting and as the means for delegating them the right of “free choice” of insurance companies. This was an investment in free choice and “an informed citizen” [54]. Another objective was related to legalization of financial flows in the health sector by decreasing informal payments [52]. Same policy objectives with similar wordings were mentioned by all interviewed policy makers among key stakeholders. “The MAP design was determined by the main perceived purpose of MAP: to protect socially vulnerable from catastrophic risks and to manage their out-of-pocket expenditures” [54]. No specific final and/or intermediary targets for improved financial protection, access and utilization of health services were set. Moreover, as one of the key informants stated: “increased utilization observed and reported during the initial phase of MAP implementation and implied as a key objective by the international experts, was a positive externality, rather than a predefined objective” [54]. Three explicit objectives and targets for MAP were defined only after three years of implementation in 2011. The Law on the State Budget of Georgia 2012 adopted in September 2011 defines three MAP objectives: (1) to increase financial access to health services for the targeted groups of the population; (2) to mitigate the financial burden induced by the health expenditures for the targeted groups of the population; (3) to reduce the OOP expenditures in health sector. Respectively, three targets and indicators for the year 2012 are determined: (1) number of insured under MAP (1 million 700 thousand for the year 2012); (2) Reduction of the share of OOPs in total health expenditures by 10 per cent; (3) Increased utilization of outpatient and inpatient services by 2-3 per cent for the population insured under MAP in 2010 [55]. It is noteworthy that in this document the increased utilization is specified as an explicit policy objective for MAP.

FORMULATION STAGE

Formulation stage was also affected by the limited timeframe determined by swift move towards MAP implementation. Certain efforts in considering the International scientific evidence during the formulation stage are documented. One high level governmental conference with participation of the leading WHO and the World Bank experts in health financing was organized in 2005 to review the international experience in health financing reforms in general and public vs. private health insurance in particular. The arguments against the private purchasing of health services in LMIC and specifically in the Georgian context were “listened but not heard”, as the “impression was that the government was looking not for an evidence-informed policy decision but for a policy decision-informed evidence” [56]. According to another key informant, this decision was adopted after considerable debates within the government. Initially the counter arguments prevailed that the PICs have weak capacity and will not be able to effectively use provided public resources. However,

eventually the supporters of the public private partnership within the government have gained advantage in this debate and the President finally supported the decision to engage PICs in providing the health coverage for the nation's poor [47]. Starting from the end of the year 2006, attempts were also made to consult wide range of international and local experts on different aspects of MAP design. However, despite the formal involvement of a number of national and international technical experts in the discussions regarding the new MAP design, short time period between the adoption of a political decision on transferring purchasing arrangements for MAP to the Private Insurance Companies (PIC) and actual implementation of the program (six months) did not allow sufficient time for preparation and reflection of qualified research and technical advice into the initial MAP design. The same reason – short time period between the decision and action – has not allowed for early identification of accompanying measures. This in turn - according to the technical experts interviewed - led to significant deficiencies the beginning (pilot phase and beyond) of MAP implementation. One of these deficiencies was related to initial weak capacity of the private health insurance companies to manage large pools of insured. Sudden increase in numbers of privately insured from 2% of the population in 2006 residing mostly in the capital, to more than 20 per cent of the total population residing in all regions of Georgia, posed serious challenges for private insurance companies in contracting and procuring services from large numbers of providers to ensure adequate access of beneficiaries to all outpatient and inpatient health benefits. The situation was further complicated with parallel health delivery system reforms that entailed wide scale privatization of the hospitals nationwide. Stories reported by the mass media and health sector NGOs suggested that these problems may have been manifesting by the year 2008 in refusals from health providers (both public and private) to render services to MAP beneficiaries due to the problems with timely reimbursement from the private insurance companies. The MoLHSA and Parliamentary Committee on Social and Health Issues have repeatedly intervened on several occasions during the year 2008 to resolve these problems between the private insurance companies and health providers in order to protect the interests of MAP beneficiaries. Other problems observed was inadequate premium rate per insured paid by the State and high acquisition costs per beneficiary for PICs at this stage resulted in high loss ratios (140-150%), misinterpretation of MAP benefit package, absence of coverage for services provided by the providers not yet contracted by the PICs, etc. [54]. Moreover, the initial piloting of new purchasing arrangements for MAP in two regions of Georgia: Tbilisi and Imereti during the year 2007 has been performed without rigorous monitoring and evaluation framework. These pilots did not have clearly articulated objectives, or “what” to pilot, beyond perhaps the premium rate per insured. The latter has been adjusted from 7 GEL to 11 GEL as a result of the pilot. Any other significant adjustments to the initial design of MAP have occurred in 2008-2010, or long after the pilot implementation. According to the key informants this was not even a pilot program, rather a phased (region-wise) approach in introduction MAP

nationwide. “We did not have time for careful deliberation, measurement and evaluation. The timing and pace of implementation was crucial and all efforts were directed towards averting political and not the technical fiasco that may have occurred as a result of dragging the implementation process” [47]. However, certain positive effects may still have resulted from these pilots. Based on the FGD with PICs, it is an impression that beneficiaries are acting as more informed customers in those regions where pilot implementation was initiated due to the fact that they had more experience with MAP [52].

The process of MAP formulation was led by the State Minister’s Office for Reforms Coordination. Policy makers and technical staff of the MoLHSA were involved, but mostly were positioned at the back seat of the reform. Parliamentary committees were informed participants of the process, but not the ones steering the process. The PICs were actively consulted and engaged through Georgia Insurance Association (GIA) both during MAP design and pilot implementation stages. Health providers and user/patient interest groups were not involved [47] [49]. Most importantly, the overall consultation process with key stakeholders was not institutionalized and rather ad-hoc [47] [56]. Despite these deficiencies in the consultation process, once initiated, MAP content appeared to meet fully the preferences of several key actors: governmental stakeholders and PICs, less so, for initially uninformed health providers and users [54].

PROGRAMMING AND IMPLEMENTATION STAGE

Programming and implementation stage has generally adhered to the list of good practice in health financing reform with the exemption of organized capacity building efforts for all sides in need of additional skills and knowledge to adhere to new rules in purchasing, provision and supervision of health services introduced by MAP (see Table 4).

MAP was implemented in certain sequence – first 9 months directly through the public agency under MoLHSA, then another 12 months private insurance “pilot” in two out of 10 regions of Georgia, and finally, nationwide implementation after 21 months since the introduction. Yet, as noted above, not enough time was allowed between the different phases to ensure appropriate planning and smooth implementation. The general attitude towards planning and sequencing can be summarized in the phrase used by one of the key informants: “when there is a window of opportunity you seize it, and ... you plan and adjust as you go” [56].

MAP introduction was accompanied with broad communication strategies mainly targeted at users/beneficiaries. The communication was mainly through mass media, as well as the actual insurance policies distributed to MAP beneficiaries during the contracting describing the beneficiary entitlements. But the communication did not appear to be very effective in the initial stage of MAP implementation. MAP Impact Evaluation Survey (MAPIES) 2008 commissioned by the MoLHSA and the World Bank found that while 92 per cent of the respondents were aware of their insurance status, a significant share of MAP beneficiaries had misperceptions regarding the entitlements that this program provides: less than half of the survey respondents were aware about the specific services included in MAP benefit package [30]. The difficulties in obtaining information about benefits were also reported [57]. Furthermore, there was a deficiency in communication targeted at different stakeholder groups. Even after three years of implementation, the Survey on Barriers to

Social Services (SBASS) 2010 has found significant informational barriers regarding MAP entitlements among ethnic minority groups [31]. The health providers participating in the FGDs of our study reported the misinformed beneficiaries as a problem and voiced the need for provision of additional information on MAP entitlements and procedures to providers [58]. The majority of patients participating in the FGDs noted that they are generally aware regarding the free entitlements from the insurance contact and accompanying information booklet, however, some patients mentioned that often the information provided is ambiguous (11 per cent of SBASS respondents said the same) and they become aware what is financed and what is not only after actual encounter with a health provider. They are also aware regarding the referral procedures - which are often communicated by a social agent or the Primary Health Care (PHC) provider - and generally know that the PHC physician should be their primary contact in order to gain access to higher level health services [59]. This statement is corroborated by the SBASS findings, where 63 per cent of respondents mentioned social agent and physician as their primary source of information on insurance entitlements and procedures [31]. This contradicts with some of the providers' opinion on low level of patients' awareness regarding the referral procedures, as many patients come directly to hospitals foregoing the PHC level and the hospital staff is obliged to explain required procedure to them and refer back to the PHC physician, which often triggers patient's dissatisfaction [58]. Another problem identified during the FGDs is lack of knowledge among MAP beneficiaries on health providers that they can apply for receiving free services. They become aware of this information only when health problem occurs. In emergency cases, lack of knowledge on designated service provider often causes dangerous delays in obtaining required medical attention [59]. According to the PIC representatives, the lack of information on MAP among beneficiaries, particularly in the rural areas also contributed to relatively high initial acquisition costs per insured incurred by the PICs during the year 2008 [52].

The budgetary deficit affected MAP only once during the initial introduction in the year 2006, obliging the GoG to reduce the number of MAP beneficiaries by decreasing the eligibility threshold at national level from 100,000 to below 70,000 points of the welfare score [49] [56]. Shifting MAP to the insurance mode on national scale in 2008 made the necessary financial resource projections more predictable and medium and long term budgetary planning more feasible. As a result, MAP had never experienced the budgetary deficit in subsequent years. The rules for contracting and beneficiary enrollment under MAP were clearly defined in relevant resolution of the Government of Georgia, which included definition of the procedures and time frames for enrollment and disenrollment of beneficiaries [60]. However, up to 17 changes were introduced in this resolution during MAP implementation. Some of these changes were triggered by the violations found during the CCG audit as mentioned above.

The detailed definitions and instructions for MAP benefit package were not developed prior to MAP introduction and became subject of misunderstandings between the beneficiaries, provider, PICs and MoLHSA. In the course of implementation certain clarifications and agreements with PICs were reached on precise meaning behind the wording of MAP benefit package. According to the MoLHSA and GIA, in most cases, the dubious statements on eligible benefits were decided in favor of beneficiaries, i.e. extending covered benefits [61] [62]. Although, there is evidence obtained from FGDs with providers and patients that suggests that resolution not always favored interests of MAP beneficiaries [58] [59].

Both technical and political leadership roles initially rested with the State Minister's Office for Reforms Coordination, however after 2009, the technical leadership role has gradually moved to the MoLHSA. By the year 2011, a special coordination unit – a Technical Council on Insurance has been

established within the MoLHSA which is comprised from the representatives of the MoLHSA, GIA, international organizations and NGOs. This council is charged with responsibility to steer the technical side of MAP implementation. Yet, according to the interview data, the MoLHSA never acquired final decision making rights regarding any significant changes in MAP content and process [61] [63].

Systematic capacity building efforts for the key MAP stakeholders such as health providers, supervisors/regulators from the MoLHSA did not occur prior to MAP introduction. Some training by the international organizations was provided to journalists and representatives of the Health Insurance Mediation Service (HIMS) – an independent mediator between the insured and insurance companies created after the MPA introduction.

Number of violations in abiding the rules established for MAP was also identified. First type of such violations was related to MAP eligibility. The overall effectiveness of MAP targeting mechanism appears to be satisfactory, as judged by the extent of the inclusion or exclusion errors reported by the World Bank Poverty Assessment 2009, HUES 2010 and SBASS 2010 [38] [29] [31], however, the audit of MAP performed by the Chamber of Control of Georgia in 2010 has revealed certain violations in this respect. Up to 36 thousand individuals (about 4.5 per cent of all beneficiaries) were faultily included as MAP beneficiaries at the time of the audit. Among them were “dead souls” – deceased individuals, double entries, beneficiaries having “double coverage”, etc. Some employees of the SSA were also illegitimately receiving MAP benefits. As a result, 12 million GEL (about 4% of the total allocated premium in 2008-2010) has been assessed as illegitimate expense under MAP and was recovered from the PICs into the state budget. Secondly, there were unlawful delays in awarding the insurance coverage to the households whose eligibility was already established – the CCG found that during the years 2008-2010 about 75 per cent of contracts with beneficiaries were concluded disrespecting legally defined timeframe. The GoG took an action and mandated the PICs to distribute the insurance contracts using the SSA agents. Thirdly, providers report cases of unsubstantiated denial of services to the beneficiaries by representatives of the PICs, even when these services are included in MAP benefit package: “Referrals to specialists and diagnostic services, particularly more expensive ones like computer tomography are refused even when these referrals are backed by the second opinion and approved by the administration of the health facility. Some times this leads to worsening in a patient’s health status - we already had plenty of such cases” [64]. “Often case managers from PICs are interfering with clinical decision making, even if they are not physicians; sometimes they are even attending surgeries to make sure that the diagnosis we supplied is accurate” [65]. Concerns regarding the denial of expensive services and bureaucratic hurdles in referrals consuming extra time and money (for instance, transportation costs) were reported by the participants of the patient FGDs [59]. Media spots telling similar stories were also frequent. However, only 4 per cent of MAP beneficiaries - SBASS survey respondents - reported any bureaucratic difficulties with insurance companies (including denial of needed services) [31]. One final notable violation of rules was observed in 2010, when the first attempt to conduct 3 year tender for the PICs have failed – the results of the tender were annulled by the GoG, with Prime Minister and Minister of Labour, Health and Social Affairs accusing the PICs in conspiring to achieve desired premium levels through the tender. “We all live in Georgia and know how the large industries work, where key players are often coordinating their interests. Naturally, we were concerned that there might be attempts of price damping, from any new company participating in the tender, and secondly, we presumed that there may be certain concession between the participating companies. But, it was impossible for us to imagine that 9 companies would count it

necessary to just waste a lot of people's time, by engaging in completely inappropriate business behavior" [66].

There was no predesigned monitoring and evaluation framework for MAP, which is not unexpected considering that even key policy objectives were not explicitly defined prior to MAP introduction. Several studies were commissioned by the MoLHSA and international development partners to evaluate different aspects of MAP, including MAPIES in 2008 and SBASS in 2010. Yet, adequate monitoring and reporting mechanisms for MAP were almost absent beyond reporting of simple administrative data. Currently, the MoLHSA with support from USAID is developing comprehensive health management information system that is expected to significantly improve MAP accountability framework [47] [49] [56] [61].

ACTORS

The list of key policy actors in MAP formulation and implementation, their influence, nature of interest and perceived position on possible future MAP expansion (beyond the one planned for 2012) are presented in Table 5.

INDIVIDUAL CITIZENS

As noted above, creation of an empowered and informed citizen/user was one of the key perceived policy objectives of MAP. There is certain evidence that MAP beneficiaries are showing or begin to show such characteristics, as they are becoming more informed regarding their entitlements [31] [29] and more appeals regarding their rights as MAP users are received and reviewed by the Health Insurance Mediation Service (HIMS) [67]. Conversely, the absence of public debates on MAP content and its future throughout MAP implementation period shows that they are rather passive participants of this policy process. In general, those recipients of MAP are highly supportive of this initiative as evidenced by the high levels of overall satisfaction with MAP coverage demonstrated by the SBASS. The same survey found high demand for MAP coverage among those vulnerable households that classify themselves as poor, but are not eligible for MAP based on the current eligibility criteria [31]. The better off individuals with private health coverage or no coverage, are most likely non-mobilized on the issue of MAP expansion.

ELECTED OFFICIALS

President of Georgia Mr. Michael Saakashvili is the only key actor from the elected officials who played and plays an important role in MAP formulation and implementation. His endorsement was sought for any critical decisions concerning MAP. He personally communicated to the population the decision on MAP introduction and voiced any important changes to MAP, including the recent initiative on major expansion of MAP that is planned from September 2012. His political style – swift and bold action once a policy decision is adopted – most likely has deeply influenced the process of MAP implementation, do not leaving much space for lengthy deliberations and technical

preparation. According to his latest public statements on the future development of MAP, and more generally, state funded health insurance – he supports the idea of universal access to the “basic insurance package” for the entire population: “By the end of 2012, every second Georgian Citizen, or 2.5 million individuals will be insured, which will provide them with access to need health services... We will continue our efforts beyond, until every Georgian will have affordable access to health care” [68]. The planned “basic insurance package” is comprised from current MAP benefit package with considerably improved outpatient drug benefit with quadrupled annual limit at 200 GEL [69]. As a “first step”, according to the President, the GoG will purchase such coverage for children under-6 years of age and elderly population eligible for the state age pensions⁴ starting from September 2012. This initiative has been already reflected in the State Budget Law 2012 [70]. This fact gives more assurance that the President’s initiative is not just a pre-election promise that will stay on paper. Other actors categorized under the elected officials – parliament and its committees have participated in the decision making, but they role was limited. The parliamentary opposition/minority was moderately supportive of MAP idea, however, against the involvement of the PICs. Evidenced from their public statements, the parliamentary opposition, as well as key political parties currently not represented in the parliament are strongly in favor of MAP expansion to other groups of the population, including those currently in the poverty database but not yet eligible for MAP. As one of the influential politician from opposition stated that “increasing public expenditures on health and providing the affordable health care for the entire population is one of our key priorities” [71]. On the other hand, as a political opposition they usually “welcome” any failures in public policy that can be attributed to the President and ruling party. For instance, the opposition was first to publicly declare the GoG’s affordable insurance initiative as a “complete fiasco” [72]. There is a definite possibility that despite the obvious public value, the same attitude will be maintained towards any governmental initiative related to MAP expansion. Currently the political influence of the opposition is relatively low; however, this standing may change with elections planned in 2012-2013.

APPOINTED OFFICIALS

Members of the Government: From the appointed government officials, an important role in conception and introduction of MAP was assumed by Mr. Zurab Nogaideli, the former Finance Minister in one of the pre-revolution governments and the first post-revolution government (2004-2006) and the Prime Minister of Georgia in the years 2006-2008. As a Finance Minister he was a proponent of a consolidated and centralized budget and against any extra-budgetary funds and hence, opposed to the social insurance model for health and social sectors that was developed in Georgia in 1997-2003. He was not able to achieve this up until the Rose Revolution, when the

⁴ Females over 60 years of age and males over 65 years of age

earmarked mandatory social contribution and later the social tax were abolished and the social insurance fund was dismantled. A strong supporter of targeting, he inspired the elaboration of the means testing system for social assistance and headed the Commission on Health Reforms formed by the President that elaborated the policy framework necessary for MAP introduction. Both the general directions and details of the health sector reform, including MAP, were elaborated under the leadership of the State Minister for Reforms Coordination, Mr. Kakha Bendukidze, - “father” of the Georgian public sector and economic reforms [47] [49] [56] [63]. Mr. Lado Gurgenidze - the Prime Minister in the years 2007-2008 - an investment banker and supporter of “compassionate libertarianism” [36], has played important role in decision making on engaging PICs in MAP implementation [49] [63]. He and then Minister of Labour, Health and Social Affairs, Dr. Kvitashvili, were also the prime driving factors behind the “affordable health insurance” initiative in 2009, with the aim to expand the health coverage against catastrophic health expenditures with state subsidies (roughly 60-80 per cent of the annual premium) to wider population groups [63]. However, after performing well below the anticipated targets [73], this important initiative has been abandoned in 2010. Current Prime Minister, Mr. Nikoloz Gilauri (2009-present) has personally adopted key decisions determining the course of MAP implementation for the last 3 years, including the last pivotal decision on longer term contracts for the PICs that are linked to investments obligations in the health infrastructure [63] [61] [69]. According to the public statements, his position on the future of MAP coincides with that of the President’s [72].

Minister of Health and other Ministry officials: While the concept of MAP and PPP in its implementation has originated from the technical discussions that the leadership of the MoLHSA (the Minister Dr. Lado Chipashvili and the Deputy Minister Dr. Vakhtang Megrelishvili) has held with technical experts in the field, the role and influence of the Minister of Labour, Health and Social Affairs was limited in political decision making regarding MAP introduction and implementation. Still, Dr. Megrelishvili has retained a coordinating role in elaboration of MAP content until the appointment of the new minister in 2009 [47] [49] [54]. The roles of subsequent Ministers of Labour, Health and Social Affairs Mr. Alexander Kvitashvili and Dr. Andrew Urushadze were more prominent after Mr. Bendukidze have left the post of the State Minister and MAP coordination function has been relegated to the MoLHSA [49] [56]. Current position of Dr. Urushadze on MAP expansion is in-line with the President’s initiative. He does not support expansion of MAP to the population self-classified as poor that are included in the poverty database and whose scores are above 100,000, as he believes that there will be unacceptably high level of the inclusion error (interview data) and is undecided regarding any other option for the expansion of MAP coverage [69].

Ministry of Health’s first line staff: shift of the technical leadership function to the MoLHSA at the end of 2008, also led to more active involvement of the first line staff of the MoLHSA (deputy ministers, heads of relevant departments) in MAP implementation [63]. Not all MoLHSA staff and

subordinated bodies were supportive to the decisions taken with regards to MAP. According to the key informants the leadership of the SUSIF and its successor HESPA – the structure initially responsible for the management of the funds allocated for MAP – were strongly opposed to the decision on engaging PICs, as they were losing control over significant amounts of resources and diluting the function of SUSIF/HESPA as a single public purchaser of health services. This opposition from the institution directly responsible for the monitoring and supervision of MAP implementation may have contributed to curtailing the stewardship function of the MoLHSA in relation to MAP up until the year 2010, when the HESPA was finally abolished and its purchasing functions were transferred to the SSA, previously responsible for administering means testing system and social assistance programs [47]. The positions of the first line ministry staff (deputy ministers and heads of relevant departments, head of SSA) are moderately supportive for further expansion of MAP (beyond what has already been announced by the President), however, undecided about the exact course of such expansion [61] [74].

MEMBERS OF THE INTEREST GROUPS

Private Insurance Companies (PICs) and Georgia Insurance Association (GIA): GIA was actively involved since the very beginning of MAP formulation. The head of the GIA, Mr. Devi Khechinashvili was among the group of the national technical experts that have conceived and promoted to the GoG the general idea of the targeted health insurance for the poor through the private insurance intermediaries. Individual PICs get engaged at later stage of the process, when the discussion on the preferred mode of MAP implementation was taking place in the inner circle of the GoG. According to the interviewed key informants, their engagement as “backstage actors” with key governmental decision makers most likely has determined the final decision on MAP institutional arrangements through PICs [47] [56]. Since inception, the GIA has assumed an important role of a mediator between the GoG and the PICs and served as a technical advisory body for both the GoG and the PICs, until the Technical Supervisory Council for Health Insurance was established within the MoLHSA. The GIA was also instrumental in creation of an independent Insurance Mediation Service, which was initially financed through the contributions from the PICs. GIA has a highly opposing position towards further expansion of MAP to other groups of the population. GIA leadership believes that individual responsibility for one’s own health should be promoted and further penetration of the pre-payment schemes should occur through the development of the “insurance mentality” and increased demand for health insurance in individual citizens, who are better-off, than those currently covered by the publicly funded insurance [62].

Health Providers: Most of the health providers in Georgia are private for profit, with few public providers remaining. As a result of the latest changes in MAP institutional arrangements, considerable share of the health provider network is currently under the ownership of the PICs. Undoubtedly they are one of the key stakeholders for MAP. Yet, in the past they acted more likely as

“supporting actors with no text lines” in relation to MAP formulation and implementation. Their passive role may be partially explained by the fact that health providers in Georgia are not organized in any kind of influential association and/or union and thus have low mobilization potential. Current position (if any) of health providers as an interest group is most likely highly influenced by owners – PICs. For other health providers, not owned by the PICs, further expansion of MAP may be both beneficial and harmful - because the increased insurance coverage will most likely lead to increased utilization of health services, while the involvement of third party payers (PICs) in provider-patient relationships may drive down the prices. According to the PIC representatives, the latter trend has already been observed. For instance, one of the PICs has negotiated with one of the health providers reduced price for cardiac bypass surgery by more than 35 per cent for MAP beneficiaries. This in turn led to reduced price for other (non-MAP) users and obliged competing health providers to reduce their prices at the same scale for the same procedure [52]. Considering this anticipated twofold effect of MAP expansion, the position of “independent” health providers will most likely be neutral at best.

Pharmaceutical Companies: Pharmaceutical industry is one of the most powerful players in Georgia health care market, where the expenditures on pharmaceuticals account for more than 50 per cent of the total health expenditures at app. 1.8 billion GEL [75]. Once MAP was rolled out to the national scale, two leading pharmaceutical companies became closely engaged in the program. Along with owning strong health provider network, these pharmaceutical companies also established PICs. The PIC “Alpha” owned by the pharmaceutical company “Aversi” has won the tender for provision of services to MAP beneficiaries in Tbilisi and two other medical regions of Georgia. Other PICs have accused “Alpha” in disrupting the insurance market with inadequately low premium rates that this company entered MAP [72]. Another leader of the national pharmaceutical industry - “PSP” has also established its own insurance company that plans to aggressively penetrate the private health insurance market with the aim to secure sizable share of MAP in close future. Both of these companies have attracted considerable media attention and coverage while been repeatedly accused in monopolistic practices in pricing and inappropriate “kick-backs” to health providers leading to high level medical inflation in the country [76] [77] [78]. Concerns have been also voiced regarding the consequences of consolidation of the insurance carrier, health provider network and pharmaceutical company under single “roof” that has occurred in case of “Aversi” and “PSP”. Almost all the interviewed stakeholders and FGD participants stressed that in the existing “soft” regulatory environment in health and pharmaceutical sectors, these developments may negatively affect the quality of services for MAP beneficiaries, perpetuate irrational prescription practices fueling pharmaceutical consumption and sales, and further escalate the pharmaceutical prices [49] [49] [56] [63] [61] [52]. The position of the pharmaceutical companies owning health providers and insurance carriers is also affected by two opposite factors: increased number of insured and increased

utilization may lead to increased revenues from premiums and volume of health services, however, the improved case management by the third party payers and competition may lead to decreased utilization of pharmaceuticals and reduced prices on services and pharmaceuticals. Respectively, the two leaders of the pharmaceutical market will perhaps be inclined towards neutrality in MAP expansion issue, while other pharmaceutical companies will be cautious and perhaps, moderately opposed.

International Development Partners: Most of the International Development Partners (IDPs) were strongly opposing the engagement of the PICs as intermediaries in MAP. In 2007, the key players: WHO, the World Bank and USAID have sent a joint letter to the MoLHSA advising against contracting out MAP to insurance companies [47] [56]. Since that time, their positions regarding the policy choice made by the GoG have not changed much [63]. However, they were continuously providing support to the MoLHSA in the technical issues related to MAP implementation, monitoring and evaluation. The World Bank has commissioned the MAPIES and together with other donors also supported HUES 2007 and 2010. USAID and UNICEF have financed the SBASS. The USAID financed project provides technical assistance to the MoLHSA in developing Health Management Information System, several modules of which are custom tailored for MAP monitoring. USAID also financially supported the establishment of the HMIS and provided grants to a local NGO for organizing public discourse on the issues related to MAP and protecting the rights of MAP beneficiaries. Similar project was financed by Swedish International Development Agency through another local NGO. Interviews with representatives of several IDPs showed that those active in the health sector of Georgia are strong supporters of further expansion of MAP insurance to the entire population in order to achieve universal coverage with basic health services [79] [80] [81] [82]. However, WHO and the World Bank still maintain the position opposing the fragmentation of the risk pool by utilizing multiple competing private insurance companies for MAP implementation. Yet, their influence over health policy process in Georgia appears to be weak.

NGOs: NGOs and civil society organizations are commonly active participants in policy processes in Georgia. But only few NGOs operated in the health sector. MAP formulation and implementation have drawn attention of most of these NGOs. For example, the Open Society Institute - Georgia Foundation commissioned a study of the early results of MAP in 2007, Transparency International Georgia has conducted a study on “affordable health insurance” initiative that was closely related to MAP [78]. Partnerships for Social Initiatives has conducted series of public discussions on MAP, prepared several publications and provided training to journalists to educate on health insurance and MAP related issues [83]. However, the NGOs are not mobilized in any coalition or thematic group, their political influence is moderate and position on MAP expansion is mixed. Some of these NGOs are publicly supporting a general idea of universal coverage [72], while others can be considered as non-mobilized [84].

Academic/technical experts: According to the interviews with key informants, who were directly engaged in MAP formulation, several national technical experts played an important role in generating the key principles and concept of MAP with overall policy objectives. However, after actual policy uptake their involvement in subsequent process has been limited [47] [49] [56]. While some of these technocrats have been periodically consulted on different aspects of MAP or intended changes to MAP design, their engagement in the policy process was never formalized or institutionalized through any kind of technical panel or advisory group. However, the interviewed policy makers directly involved in MAP implementation confirmed that they were aware of the most notable survey and analytical reports regarding MAP and have consulted with authors and even used in several occasions in decision-making process [63] [61] [74]. Moreover, the leadership of the MoLHSA has admitted that the interim findings of this study produced in by the end of 2011 and directly communicated by researchers to the Ministerial staff have contributed to shaping design features of the recent major initiative in MAP coverage and benefit package expansion [69]. Most of the experts interviewed are strongly supportive to the idea of increased public outlays on health and further expansion of the prepaid schemes to reduce the OOPs and improve financial protection of the population; however there are fundamental differences in approaches. Some experts are in favor of relegating the publicly finances health insurance function to the public single payer [85] [79], while others believe in existing but improved PPP in provision of the health insurance coverage at least against catastrophic health insurance for the entire population [47] [62] [86]. Past experience with MAP shows that while having no direct power, the technical experts can still indirectly influence the policy process if the right time, right way and the right point (persons) for application of policy advocacy efforts are applied.

Press and Media: The role of the media, particularly the electronic media as public opinion-maker is as important in Georgia, as elsewhere [87]. In the period from 2009 through 2011 MAP has received impressive national media coverage. Total of 665 TV spots, 275 articles in printed media and 103 articles in internet based news and information agencies were produced. In depth analysis of this coverage depicts surprisingly detailed chronology of MAP process; reflection of all changes introduced, its problems and achievements; and finally, positions of different actors. In overall, the media monitoring shows that broadcasts and publications with the “neutral” attitude – containing only facts without value judgments - towards MAP and directly related issues prevail at 43 per cent of all coverage, the “positive” attitude – with explicitly favorable assessment towards the topic with relevant epithets and metaphors – was observed in 27 per cent, the “negative” attitude – with explicitly disapproving assessment of the topic or event was found in 16 per cent and finally, the “critical” attitude – with diversity of opinions, containing both positive and negative facts and assessments – was characteristic to 15 per cent of all reviewed broadcasts and publications [72]. Extensive media coverage of MAP perhaps served as a supplementary tool for increased awareness

for general public and MAP beneficiaries regarding different aspects of MAP. Indeed, the SBASS reports 8 per cent of MAP beneficiaries receiving information exclusively from media [31]. It also indicates an active role of media throughout MAP implementation which presents good opportunity for open public debates regarding the future of MAP. Relatively small share of the negative media coverage, may indicate general positive attitude towards MAP not only from the side of media, but also potentially of general public, which increases the chances for the viability of MAP.

IMPACT

MAP impact is assessed across several dimensions: (a) responsiveness of insurance carriers and health providers and satisfaction of MAP targeted population; (b) breadth, depth and height of the achieved coverage for the general population; (c) access to health services and financial protection for MAP targeted and the general population; and (d) any other predefined MAP policy objective.

RESPONSIVENESS OF MAP INSURANCE CARRIERS AND PROVIDERS AND SATISFACTION OF MAP TARGETED POPULATION

Responsiveness to non-medical needs of the population can be considered as one of the fundamental goals of the health system [18] [88]. Consumer satisfaction is one the basic components of the health system responsiveness [89]. Satisfaction with different aspects of a health care system and its responsiveness also often determine the access and utilization of health services [18]. Thus, satisfaction of MAP beneficiaries with the program was considered by the researchers as an important element of the assessed MAP impact. In 2008, on initial stage of MAP implementation, a MAPIES of approximately 3.500 households was conducted for comparative assessment of the responsiveness and satisfaction with health providers and insurance carriers of MAP beneficiaries and non-beneficiaries in two types of regions with different eligibility thresholds (70,000 vs. 100,000). The results of the regression-based estimation of responsiveness ratings by MAP beneficiaries and non-beneficiaries of the insurance program and estimation of mean satisfaction scores for beneficiaries showed above average (1 to 5 scale) satisfaction of the beneficiaries with insurance carriers and lower provider responsiveness towards beneficiaries in the lower threshold regions. The problems with information on benefits (from app. 7 to app. 14 per cent of beneficiaries) and obtaining payment exemptions or special rates (from app. 9 to app. 17 per cent of beneficiaries) were also identified. Discussing the survey results, the authors suggested that this decline in provider responsiveness may have been triggered by transferring MAP from the public agency to the private carriers, or may have been a temporary effect of the transition process itself [57]. Findings of the later survey, SBASS 2010, though not directly comparable to MAPIES, have found relatively high level of the beneficiary satisfaction and responsiveness of both insurance carriers and health providers. SBASS has assessed little over 1,000 households, classified as poor, majority of which, had monthly expenses less than 117.5 GEL counted for one equivalent adult in this

household. The final database contains both the MAP beneficiaries (n=432) and non-beneficiaries (n=435). According to the SBASS findings, the majority of those who used the services in the preceding 12 months (n= 269) were very satisfied or quite satisfied with the insurance carrier's services, with 21 per cent reporting that they were "neither satisfied, nor dissatisfied". Only a small percentage of respondent families reported some bureaucratic difficulties in covering the cost of services (4 per cent). Over 90 per cent of the beneficiaries that have used the services did not experience any detrimental attitude from the side of the insurance carrier or health provider. A negative attitude from doctors was experienced by 8 per cent of beneficiaries and only 4 per cent had negative experience with insurance carrier agent. About 10 per cent of beneficiaries indicate that the medical services they receive are different from the services provided to other users who pay for the services themselves. The majority of respondents (77 per cent) do not feel that they are treated differently. The satisfaction of beneficiaries across several dimensions of health services was also measured (physical conditions of health facility, human attitude of the staff, knowledge and qualifications of the medical staff and result of the treatment). Majority of the beneficiaries, as well as non-beneficiaries were satisfied with health services [31].

These quantitative research findings are largely corroborated by the qualitative research findings of our study and another study conducted by GIA with financial support of USAID/Georgia. Almost all participants of our FGDs expressed overall satisfaction with MAP, though identifying certain noteworthy problems: insufficient qualification of PCH doctor's, particularly in the regions and cases of selective approach from provider's side in obtaining necessary referrals and diagnostic services. Three waves of interviews conducted (900 direct interviews and 80 in-depth interviews of MAP beneficiaries in Tbilisi) in the period July through October 2010, showed that the overall rate of satisfaction, as well as the rates of satisfaction with different aspects (qualification, timeliness and responsiveness) of services provided by the private health insurance carriers is above 80 per cent. Seventy per cent of insured have trust in their carriers, 76 per cent think that PICs are helpful in protecting their health and about 50 per cent are sure that the PICs are completely fulfilling their obligations (with 9 per cent thinking the opposite) [90].

BREADTH, DEPTH AND HEIGHT OF THE ACHIEVED COVERAGE FOR THE GENERAL POPULATION

Total Health Expenditures (THE) in the years 2006-2009 grew significantly from 8.4 per cent to 10.1 per cent of GDP indicating high level of medical inflation. In nominal terms the public expenditures on health - since MAP inception - has increased by impressive 63 per cent from 58 GEL per capita in 2006 to 95 GEL in 2009 [75]. However, this increase only slightly outpaced the health inflation and as a result the upward change in public expenditures on health was minimal as a share of THE from 21.6 per cent to 23 per cent (Table 2). With such moderate increase in available public resources for health, it was logical to suggest that radical transformation of combined envelope of breadth, scope

and depth of coverage did not occur. Yet, introduction of MAP has considerably reshaped these three dimensions of the coverage. Total public funds allocated to MAP accounted to 43 per cent of the total health budget, with remaining 54 per cent going to public health and vertical programs. Breadth of coverage - who is covered, or the definition and share of the population entitled to receive benefits [21]: The entire population of Georgia is entitled to the limited “universal basic benefit package”, which mostly includes non-personal health services (public health), and prevention and treatment of the socially dangerous and infectious diseases. Defined groups of the population are entitled to different limited benefits through the vertical state health programs administered by the SSA. Most prominent of these programs provides urgent care benefits with significant copayments to children under 3 years of age and elderly population over 60 years of age that comprise about 24 per cent of the total population (see also Table 6). Further, the share of the population with fairly comprehensive health benefit package covered by MAP has reached about 21 per cent in 2011. Another 10 per cent of the population is covered by the other state funded and private corporate and individual insurance (see Figure 3). MAP accounts for roughly 60 per cent of the insured population from any sources and about 90 per cent of the state insured the remaining including military, police, government officials, and selected other small groups of population. According to the HUES 2007 and 2010, MAP coverage is reported by households from all income quintiles⁵ (see Table 7), with higher shares of coverage among the poorest, however MAP coverage is also extended to 13 per cent of the “richest” ones.

Scope of coverage – what services are covered, or range of services within the benefits package [21]: The range of services covered under MAP is fairly comprehensive. According to the SBASS, during the 12 months preceding the survey, only about 20 per cent of MAP beneficiaries needing health care (self-perceived) did not use the health services because they were not included in MAP benefit package. The biggest deficiency identified by all the interviews and participants of focus FGDs in the scope of services covered by MAP is extremely limited outpatient drug benefit. This is corroborated by SBASS findings. About 40 per cent of respondents of the SBASS reported needing the medications on a daily basis and only in 11 per cent of cases the costs associated with the medicines were covered by MAP insurance for MAP beneficiary families [31]. The benefit package covered through the vertical health programs includes predefined “urgent conditions” for the population less than 3 years and over 60 years of age; free services of PHC physicians for the rural population, inpatient services for mental and TB patients, drugs for selected chronic conditions such as diabetes and hemophilia; financing of renal dialysis services; public health and prevention and treatment of infectious diseases, etc. (see Table 6). In summary, scope of services covered by the state for the population other than MAP and the State funded health insurance for selected groups of the

⁵ The quintiles divide the population into five equally size groups based on the level of consumption-expenditure reported in their household over the preceding quarter [29]

population through the PICs is fragmented and narrow. The scope of the private insurance coverage ranges from very basic – covering catastrophic health expenditure (for instance, those still insured under the affordable health care initiative) to corporative and individual packages that include wide range of outpatient and inpatient services, with most generous packages also encompassing outpatient drug benefit.

Depth of coverage - to what extent services are covered, or the share of the cost of each service that is covered and, conversely, the level of patient cost sharing required to obtain each service [21]: The services covered under the vertical state health programs are subject to annual limits and have significant of co-payment requirements. MAP services covered are exempted from co-payments and have considerably higher annual limits for planned inpatient services than those included in the “universal basic benefit package” financed through the vertical state health programs (see Table 6).

ACCESS TO HEALTH SERVICES AND FINANCIAL PROTECTION OF MAP

TARGETED AND GENERAL POPULATION

Utilization: Evaluation of an initial phase of MAP implementation rendered certain encouraging results on access to health services for MAP beneficiaries. The study conducted by the World Bank in 2008 using a regression discontinuity design to assess MAP during the first 6 months of the program in 2006 using administrative inpatient claims data for acute/urgent surgeries (when MAP was implemented by the SUSIF/HESPA), revealed that MAP beneficiaries were nine times more likely to utilize urgent care than households that were not qualified, utilization also increased among the poorest of the poor. The study concluded that MAP has significantly increased utilization of acute surgeries/inpatient services by the poor and that the benefits have successfully reached the poorest among the poor. The study findings suggested that Georgia was on the right path and the government efforts to improve the poor’s access to and utilization of health services were yielding results [91]. However, MAPIES study conducted two years after, in 2008, did not found any significant differences in utilization for both inpatient and outpatient services between MAP beneficiaries and general population [92]. Corroborating findings were obtained from the HUES 2007 and 2010 studies. While there was some increase in utilization of health services for individuals with acute sickness and hospitalizations, there was no overall increase in utilization for the general population between the years 2007 and 2010 [29]. This assumption is also corroborated by the administrative data from routine statistical system showing the increase in hospitalization rates from 7 per cent in 2008 to 7.5 per cent in 2010 and slight decrease in outpatient contacts per capita (Table 2). The analysis of combined HUES 2007 and 2010 databases using the difference-in-difference approach and logistic regression method, conducted by us, did not reveal any statistically significant difference in overall utilization for MAP beneficiaries and non-beneficiaries [93]. On the other hand, the SBASS found that MAP beneficiaries were more likely to use the health services than non-beneficiaries from the same income quintile. For example, they were more likely to use PHC

physician services (36 per cent as compared to 22 per cent), specialist doctors' services (54 per cent as compared to 41 per cent) and inpatient services (20 per cent, as compared to 13 per cent) compared to non-beneficiaries [31]. Observed MAP effects on utilization are comparable to the effects found by other studies of similar programs targeted at the poor [92].

Geographical access and availability of health personnel: Much of the focus of the GoG's PHC reforms in the past 7 years have been directed at increased access to primary health facilities and qualified medical personnel trained in family medicine in rural areas, thus encouraging patients to use these services [41]. By the year 2010, changes in access to basic health services provided at PHC level have been notable in terms of both physical access to facilities and availability of doctors in these facilities. According to the Georgia HUES 2007 and 2010, the proportion of households that report using a facility within 30 minutes travel time has increased significantly in rural areas and for the population as a whole representing an increase in access from 74 per cent in 2007 to 82 per cent in 2010. There has also been a significant increase in the proportion of the population who report that doctors are present for at least 5 days a week at the relevant health facility [29]. The SBASS found that Geographic distance to medical facilities is still an issue for some parts of the rural population. Physical distance to inpatient facilities is considered an "absolute barrier" by 19 per cent of families in eastern Georgia, and 15 per cent in western Georgia. Importantly, distance is reported as an absolute barrier to access to outpatient services by 13 per cent of families living in east Georgia while these rates are negligible in west Georgia and in Tbilisi [31]. It is noteworthy that SBASS did not find any significant difference in access to all types of health services in MAP beneficiaries compared to non-beneficiaries, thus not supporting assumption that MAP beneficiaries may have more significant geographical barriers to health services as a result of restrictions on choice of health provider imposed by the PICs.

Financial access: MAPIES 2008 found that OOP payments by MAP beneficiaries were about 50 per cent lower for outpatient services and 40 to 58 per cent lower for inpatient services than what non-beneficiaries have spent on respective types of services. MAP beneficiaries were 17 to 26 per cent more likely to receive free care, had lower risk of high inpatient medical care costs and were much less likely to forgo services due to financial reasons. They were statistically significantly less likely to report that they should have been hospitalized but were not due to costs: 69 per cent to 81 per cent of beneficiaries in the relevant sub-samples (with different eligibility thresholds) cited this reason, compared to 95 per cent of non-beneficiaries [92]. SBASS 2010 found that the main source of paying for medical treatment (other than pharmaceuticals) during the 12 months prior to the survey for the vulnerable families surveyed was via the regular income of a family (40 per cent) followed by the insurance (34 per cent). Fourteen per cent of families resort to borrowing to pay for health services. For MAP beneficiaries, the main source for covering the cost was MAP insurance, (62 per cent) and they were considerably less likely to pay from their regular income (25 per cent) than non-

beneficiaries (60 per cent). Non-beneficiaries were more likely to use unsustainable coping mechanisms. There is a large difference in degree of a perceived burden between MAP beneficiaries and non-beneficiaries: 78 per cent of non-beneficiaries report that the burden of health care cost was “quite heavy”⁶ or “extremely heavy”⁷ compared to 39 per cent among MAP insured. The cost of pharmaceuticals appeared to be a higher financial burden than other health services for both MAP beneficiaries and non-beneficiaries (79 per cent and 82 per cent respectively). For all types of services the cost of care was twice as less likely to represent an absolute barrier for MAP beneficiaries than for uninsured non-beneficiaries [31]. Similar findings were derived from the HUES 2007-2010 database. Our analysis showed that MAP insured were three times more likely to receive completely free outpatient care ($p < 0.01$) compared to non-insured from the general population and 6.9 times more likely to obtain free inpatient treatment ($p < 0.01$). Odds of obtaining free treatment for chronic illness were 2.1 for MAP insured ($p < 0.05$). Most of MAP benefits accrued among poorest 40 per cent of population [93]. Some other HUES 2007-2010 findings are also noteworthy, as they relate to overall financial access characteristics for the general population. For example, the share of individuals with an acute illness in the preceding 30 days that did not undertake a medical consultation for reasons of costs did not change over the time and amounted to 16 per cent of the population. The proportion of individuals who could not afford all the medicines prescribed also remained almost unchanged at 12 to 13 per cent. Conversely, while mean costs per case of hospitalization increased almost for all groups it has to be noted that a statistically insignificant decline from 2007 was observed among vulnerable and poorest groups. Furthermore, an increasing proportion of patients (from 17 per cent to 25 per cent) report receiving inpatient care that is free at the time of service and the proportion of the individuals who said that they required hospitalisation but were not hospitalised because they could not afford it was small and has declined slightly, but significantly, from 3.9 to 2.6 per cent [29].

Catastrophic health expenditures and impoverishment: The analysis conducted by Rukhadze and Goginashvili using the results of the Georgia Household Budget Survey (HBS) shows that the share of households that faced catastrophic health expenditures has increased from 6.1 per cent in 2006 to 8.5 per cent in 2010. Similarly, the share of those who were impoverished due to high expenditures on health also increased from 1.8 per cent in 2006 to 2.6 per cent in 2010. Though slight improvements were observed across both parameters between 2009 and 2010, when the share of population with catastrophic health expenditure and rate of impoverishment declined from 9 per cent to 8.5 per cent and from 2.7 to 2.6 per cent respectively. Poorest quintile households were more likely to face catastrophic expenditures rather than other consumption quintile groups. The share of such households with catastrophic health expenditures has increased from 10.8 per cent in

⁶ Defined as “these costs significantly affected our family budget”

⁷ Defined as “these costs have basically forced us into extreme poverty”

2006 to 13.3 per cent in 2010. However, gradient between the poorest and richest households in the same period declined more than twice (see Table 8). The same applied to impoverishment rates. Based on the results of the logit regression performed to identify determinants of the catastrophic health expenditures, Rukhadze and Goginashvili suggest that hospitalization of a family member, or having a family member with chronic diseases and acute conditions were related to the probability of a household facing high expenditures. Hospitalization represented greatest risk factor, followed by chronic and acute diseases respectively. It should be noted that risk of incurring high health payments caused by hospitalization was decreasing gradually starting from 2006 and has declined by more than 2.3 times since 2006 year (OR=70 in 2006 vs. OR=30.1 in 2010). In addition, the odds of facing catastrophic health spending were about 2 times higher among urban population compared to the rural. Moreover, one of the determinants of high expenditure was having senior family members (above 60), that perhaps can be explained by relatively high incidence of chronic conditions among elderly [33]. Our results on catastrophic health expenditures obtained using the HUES 2007-2010 database show similar trend, (see Table 8). However, the actual values for catastrophic expenditures for health derived from the HUES are much higher than those reported by Rukhadze and Goginashvili using the HBS data. This may be explained by significantly higher level of health expenditures captured by the HUES compared to HBS [32].

There appear to be several controversies in the findings across the dimensions of access and financial protection presented above. Firstly, the impressive growth in acute care utilization among MAP beneficiaries reported by the 2006 study is not upheld by subsequent MAPIES 2008 and HUES 2007/2010 findings on utilization. This may be partially explained by the stated limitations of the 2006 study regarding possible misclassification or misreporting of the data. But more importantly, given that the study covered only the first six months of MAP introduction, dramatic increase in utilization of surgeries may be related to the phenomenon of “accumulated demand” (mainly for non-urgent surgeries) that has been realized once the financial barriers has been alleviated. This is also acknowledged by the authors of the 2006 study [91]. Another factor may also have contributed to this reported initial spike in the utilization. According to key informants of our study, due to electoral considerations, MAP vouchers in 2006 were often handed out to the population on a “needs-base” - to those poor and not so poor requiring medical care and particularly planned surgeries - rather than strictly adhering to the eligibility criteria [49] [56].

Secondly, the SBASS 2010 in contrast with MAPIES 2008 and HUES 2010 also reports higher utilization for MAP beneficiaries compared to the non-beneficiaries. There may be at least two reasons for this discrepancy: one related to possibility of actual relative increase in utilization of both outpatient and inpatient services among MAP beneficiaries vs. non-beneficiaries in 2010 as compared to 2008 as an outcome of more than two years of the program implementation and

adjustments. The other reason may be rooted in methodological differences and limitations of both the SBASS and HUES.

Finally, the findings on improved financial access for both MAP beneficiaries and the general population from one side and unchanged overall utilization patterns and worsened financial protection indicators from the other side, requires explanation. There are several possible causes for the observed effect. Double negative impact of the war with Russia and the global economic recession on the Georgian economy and population welfare has significantly reduced the households' total consumption from 408.6 GEL in 2008 to 364.6 GEL in constant 2006 prices [33], while increase in total and private health expenditures has outpaced the inflation rate and GDP growth: THE increased from 8.7 per cent of GDP in 2008 to 10.2 per cent of GDP in 2010, with private expenditure increasing from 69.8 per cent to 72.1 per cent of THE in the same period, and adversely affecting the financial protection against health care costs for the entire population. This increase was most notable for private expenditures for pharmaceuticals consumed on a daily basis by 40 per cent of the Georgian vulnerable households [31] and mostly not covered by MAP. These expenditures amounted to 50 per cent of THE [75] and 60 per cent of total household expenditures on health in 2010, which, in turn in the period from 2007 through 2010 has increased by 21 per cent in real terms [29]. Furthermore, there is compelling evidence that despite the extended breadth, depth and scope of coverage provided by MAP, MAP was not able to shield vast majority of the population from catastrophic health expenditures. In the period from 2008 through 2010 only 13.8 per cent of MAP beneficiaries have used the insurance. In 45 per cent of insurance cases reimbursed health expenditures did not exceed 20 GEL (less than 5 per cent of total household consumption). As a result, only 10 per cent of MAP beneficiaries, or mere 2 per cent of total population "have benefited from insurance against real financial risks" [51]. On the other hand, 75 per cent of the MAP insured families - that used health services - reported not been able to cover the costs of needed treatment if they did not have had MAP coverage, with another 10 percent claiming that they would have fallen in extreme poverty in the absence of MAP [31].

Considering all the above, we suggest that the extended MAP coverage and increased financial access provided by the program, most likely, were not able to reverse this adverse effects of economic slow-down and escalating health expenditures and have only cushioned the negative impact for the poorest by decreasing the poor/rich gradient in the rates of catastrophic health expenditures.

OTHER POLICY OBJECTIVES

Other perceived initial policy objectives for MAP established by our study were defined as following: (a) reach the poor; (b) develop private insurance; (c) improve risk pooling through increased share of prepaid resources in the national health system; (d) make health insurance products more affordable due to the enhanced national risk pool, (e) decrease level of informal payments and

support legalization of the financial flaws in the health system, and finally, (f) empower “an informed” citizen with a free choice. The study findings showed that:

- (a) The MAP has fared relatively well in reaching the poor: from 40 per cent [29] to 53 per cent [31] of the poorest income quintile was covered by the year 2010. However, the MAP coverage was also extended to considerable shares of better-off households [29].
- (b) In the period from 2006 to 2010, the number of PICs functioning in Georgia has increased from 14 to 16, with combined assets amounting to 448 million GEL, or 2 per cent of GDP. The total mobilized premium in 2010 was 372.5 GEL, over 66 per cent of which were health insurance premiums from more than 1.5 million insured (up from 200 thousand insured in 2006). This represents a significant increase since the year 2006, when the health insurance premiums accounted for only 26 per cent of total. The large scale PPP established for MAP played crucial role in these developments [94].
- (c) The share of prepaid resources in THE has also increased from 23.1 per cent in 2006 to almost 29 per cent in 2010 (see Table 2). The share of the private insurance in the THE have grown from 0.8 per cent in 2006 to 3 per cent in 2010. Almost all this increase is associated with the MAP.
- (d) Since 2007, the PICS have started offering a range of innovative and affordable health insurance products, such as individual insurance (not offered in the past), insurance for elderly population over age of 65 (since 2011) and even insurance purchased at the time of medical care. Premium for the least expensive insurance coverage offered on the market does not exceed 5-10 GEL per month and provides coverage against catastrophic financial risks. In 2006, the minimal premium threshold for private insurance was above 35 GEL. Although current trend in increased affordability of private health insurance may be terminated and even reversed in future, if the financial viability of MAP will become compromised due to possible imbalance between the decreased premium rate paid by the GoG since 2010 and considerable investment costs that PICs are carrying for fulfilling their obligations in upgrading the health infrastructure. The risks of such course of events may increase with planned expansion of the breadth, scope and depth of coverage, if this expansion is not handled well.
- (e) Evidence of increased legalization of financial transactions in the health sector and decreased level of Informal payments was reported by SBASS and HUES 2007/2010.

In 2010, only 10 per cent of both MAP beneficiaries and non-beneficiaries that used health services in the last 12 months had to pay informally directly to the doctor/nurse in cash or in the form of a present [31]. There has been a substantial increase in the proportion of medical encounters where users obtained a receipt for all payments made – from 35 per cent in 2007 to almost 45 per cent in 2010. This increase was significant in both urban and rural areas. Yet this share still remains less than half of all users [29]. In overall, the observed picture in 2010 in relation to informal payments differs much from the one reported in 2004, when “paying [informally] for health services in Georgia was a really common and accepted practice” [95].

- (f) At the initial stage of MAP PPP in 2007-2008, every second citizen having MAP insurance was neither informed, nor empowered as he had significant misperceptions on the entitlements that this program provided and on services included in the benefit package. About one third experienced problems with insurance carriers in obtaining information, reimbursement of claims and needed health services [57]. While provided with a free choice of insurance carrier, MAP beneficiaries have lost freedom in choice of health provider enjoyed under the SUSIF/HESPA managed MAP. This situation raised concerns on how the major shift in MAP institutional arrangements would affect the financial protection of poor and effectiveness of public policy aimed at delivering health care benefits and expanding to those the most in need [57]. However, as the program evolved, some of these initial deficiencies have smoothed out. The beneficiary level of awareness on MAP entitlements and services improved [31]; the PICs have contracted with or acquired most of the health provider network and as a result have widened choice of provider for their insured. Yet some problems in beneficiary awareness regarding the health facilities to go in case of medical need are still reported, along with problems in freely accessing the health providers owned by other PICs [59] [58]. In 2010, the choice of health carriers was also removed. Yet, a MAP beneficiary can still change an insurance carrier once a year, in case if not satisfied with services. Starting from the end 2011, the GoG is also applying major efforts to strengthen the HIMS and turn into a powerful aid for MAP beneficiaries in protecting their rights and realizing their entitlements. In overall, it appears that MAP is on the right path to transform its beneficiaries into “informed consumers”.

Finally, one other important MAP impact, which was not anticipated in the beginning of the program, should also be mentioned. Major parallel reform effort aimed at complete restructuring of the health care delivery system was considered as a potential threat to success of MAP at the time

of inception of this study. However, this has never been turned into real hindering factor. On contrary, the important decision taken in 2010 by GoG on linking the obligations for health infrastructure investment to MAP, made possible to revive the hospital investment program which is crucial for providing physical access to better quality health services for both MAP beneficiaries and the general population.

CONCLUSIONS

Overall political and policy contextual factors have been the key determining factors for the introduction of MAP in Georgia. MAP was an outcome of several policy processes, including reevaluation of the country's social protection model on the subject of a fundamental choice about whether the core principle behind social provisioning will be "universalism", or selectivity through "targeting" and subsequent abolishment of social insurance; the GoG's attempts to fund most effective and at the same time politically most acceptable ways of spending scarce public resources available for health; and finally, political business cycle prior to local elections in 2006, which significantly "expedited" MAP introduction, even without proper technical preparation. Post Rose Revolution strive of the Georgian leadership towards libertarian ideals and "small government" as main tool in fighting corruption has also influenced transfer of the purchasing function for MAP from the State purchaser to the Private Insurance Companies. This agrees with similar experience internationally, as political factors were decisive in adopting decisions on similar policy issues, like user fee removal policies in Africa [96], or the insurance for the poor in Latin America [12].

Presence of functional means testing system and targeting mechanism was a key to acceptance and introduction of MAP and appear to be effective in reaching the neediest; however there are still equity problems in MAP eligibility that need to be addressed. Transformation of category based social assistance system (inherited from the Soviet Union) into "means tested" social assistance system with functional targeting mechanism for the poor in 2004-2005 was one of the key determining factors and was a unique window of opportunity for MAP introduction in Georgia. Despite concerns on accuracy and precision of the means testing targeting mechanism both in terms of inclusion and exclusion errors, this targeted mechanism allowed MAP to reach up to 40 per cent of the nation's poor. This achievement is in par with international best practice in effectiveness of individual targeting [97]. Yet, the current targeting mechanism is far from being equitable, as it discriminates the population by a place of residence: people with test scores over 70,000 and not residing in Tbilisi or Adjara are not eligible receiving MAP benefits, while they may, in fact, be very poor.

Surprisingly, up until recently, an explicit definition of MAP goals, objectives and targets was absent, thus complicating MAP impact assessment. Up until 2011, MAP goals, objectives and targets were not defined in any of the legal or policy documents. This has left an ample room for

various stakeholders to imply and often speculate on intended goals of the program and made it difficult to assess the success and/or failure in achieving MAP impact against predefined policy objectives.

Wide circle of national and international partners and experts were consulted, however no due deliberation time was given for reflection of their recommendations in the initial MAP design and subsequent changes introduced that led to numerous major deficiencies at the early stages of the program implementation. Despite the formal involvement of a number of national and international technical experts in the discussions regarding the new MAP design, short time period between the adoption of a political decision on transferring purchasing arrangements for MAP to the Private Insurance Companies (PIC) and actual implementation of the program (6 months) did not allow sufficient time for preparation and reflection of qualified research and technical advice into the initial MAP design. Thorough assessment of MAP policy options (public vs. private) was never conducted with final decision on implementation modalities based on political and ideological preferences and not on policy or technical soundness of the selected alternative. This in turn led to significant deficiencies during the initial (pilot phase and beyond) of MAP implementation – inadequate premium rate per insured paid by the State and high acquisition costs per beneficiary for PIC resulting in high loss ratios (140-150%), misinterpretation of MAP benefit package, absence of coverage for services provided by the providers not yet contracted by the PICs, etc.

The entire process of MAP implementation was artificially accelerated by the considerations of political “urgency” which resulted in some shortcomings during the implementation. Initial piloting of new purchasing arrangements for MAP in two regions of Georgia: Tbilisi and Imereti during the year 2007 has been performed without rigorous monitoring and evaluation framework, thus decreasing the opportunity to learn from pilot testing. Moreover, these pilots did not have clearly articulated objectives, or “what” to pilot, beyond perhaps the premium rate per insured. The latter has been adjusted from 7 GEL to 11 GEL as a result of the pilot. Any other significant adjustments to the initial design of MAP have occurred in 2008-2010, or long after the pilot implementation. More generally, not enough time was allowed between different phases to ensure appropriate planning and smooth implementation. Most common violations of rules during MAP implementation identified by our research were related to: the beneficiary inclusion, timely issuance of insurance contracts to the beneficiaries, interpretation of MAP benefits and insurance terms, illegitimate denial of services included in the benefit package to the beneficiaries and creation of additional bureaucratic barriers for users to defer them from services.

High level political actors have dominated the process of MAP formulation and implementation. High level policy actors, such as the President, Prime Ministers and State Minister for Reforms Coordination played a defining role in MAP inception and implementation. The Ministers of Health played little role in MAP inception but has assumed more influence in the last two years MAP

implementation. Private Insurance Companies and Georgian Insurance Association also had active role throughout the policy process. MAP received substantial media coverage. Other interest groups such as individual citizens, health providers and technical experts having limited influence over the policy decisions associated with MAP.

Development of insurance and generating widespread demand for insurance still faces significant challenges in the country. Despite the articulated objective for MAP to support the development of the private insurance and “insurance mentality” and impressive increase in overall insurance coverage in the country, the specifics of the insurance mechanism are yet to be understood not only by the insured, but also by all relevant governmental stakeholders, as evidenced by the recent accusations voiced by the Chamber of Control and the Prosecutor General of Georgia in misappropriation of the public money allocated for MAP. According to the Chamber of Control, the direct loss ratio of app. 45% for MAP beneficiaries reported by the PICs in the period from 2008-2010 shows that PICs have enjoyed unjustified earnings and that premium rate paid by the public is artificially inflated. When arriving to this conclusion, the Chamber of Control inspection has neglected very significant acquisition costs that PICs have incurred for attraction and enrolment of MAP beneficiaries and investments costs in health provider infrastructure and information systems to serve these beneficiaries. These accusations were widely discussed and in most often cases misinterpreted in the mass media triggering unnecessary damage to the reputation and credibility of the MPA program and health insurance in general.

Creation of an independent mediator between the PICs and MAP beneficiaries is considered as a beneficial addition to the mechanism of MAP implementation. Establishment of “Insurance Mediation Service” (IMS) initially sponsored by the PICs participating in MAP has been assessed as very positive development in improving the observance of the rights and entitlements of MAP beneficiaries. However, the financial dependence of the IMS on PICs has been negatively regarded by the new MoLHSA leadership and as a result the IMS has been transformed into publicly supported body. IMS services and its hotline number are currently widely advertised to MAP beneficiaries by the MoLHSA through mass media.

The government has been moderately successful in raising the awareness regarding MAP and communicating the rights and benefits provided by MAP. Further efforts are needed to improve communication, particularly targeted to national minorities. According to the HUES 2010 Knowledge of MAP is widespread in the population, with 93% of respondents saying that they knew it, although only 65% said they knew what benefits it provided. Both surveys (HUES 2007 -2010) suggest that there are concerns around both under-coverage of the poorest households and inclusion of better-off households in MAP. These findings need to be considered in the light of some limitations to the data, including that the Social Services Agency program includes a cash transfer which may itself lift some households into a higher quintile.

MAP has been instrumental in increasing all three dimensions - breadth, scope and depth of the population coverage. There has been a striking increase in the coverage of health insurance since 2007, with some 30% of individuals covered by 2010, out of which 21% are covered by MAP. As a result, the share of the population covered with fairly comprehensive health benefit package has reached slightly over 30 per cent of the population, or about 1.5 million individuals (see Figure 3). Out of this number, MAP accounts for roughly 60 per cent of the insured population from any sources and about 90 per cent of the state insured the remaining including military, police, high level government officials and selected other small groups of population. by the beginning of the year 2012, entire population was entitled for limited universal benefits, including mainly non-personal, population based services and 54 per cent to certain personal health care benefits, out of which, relatively comprehensive MAP coverage accounted for about 21 per cent of the total population.

MAP has managed to improve financial protection of the beneficiaries against expenditures related to the inpatient care, which in turn had positive impact on financial access indicators for the general the population, but had limited overall effect on utilization of health services and financial protection for the general population as measured by the rates of catastrophic health

expenditures and impoverishment. According to the HUES 2010, an increasing proportion of general population (from 2007) report receiving inpatient care that is free at the time of service, increasing from 17% to 25% of those hospitalized. MAP beneficiaries were three times more likely to receive completely free outpatient care ($p < 0.01$) and up to 7 times more likely to obtain free inpatient treatment ($p < 0.01$) compared to non-beneficiaries. The initial increase in utilization among MAP beneficiaries compared to non-beneficiaries from similar social-economic groups was smoothed out over the time. The rates of the catastrophic health outlays and improvement rates in the general population have increased in the period from 2007 through 2010. However, the rich/poor differences have decreased in the same period that may be attributed to MAP.

Exclusion of outpatient drug benefit from MAP benefit package during the first three years of implementation has detrimentally affected the potential impact of MAP on financial protection of the population. MAP benefit package has been steadily expanding since MAP inception. However, the benefit package as of January 1, 2012 still fails to cover a bulk of the essential outpatient services and most importantly, a drug benefit for chronically ill, which is one of the main cost drivers and for health services and a source of catastrophic health expenditures in Georgia. Initial design of MAP benefit package was mostly oriented towards inpatient services with limited outpatient coverage. After three years of full scale implementation the benefit package was gradually expanded covering some additional instrumental and diagnostic services and very limited outpatient drug benefit in 2010. Nevertheless, the pharmaceutical treatment for chronic diseases remains main trigger for increased health expenditures and a potential source of catastrophic health expenditures even for MAP beneficiaries, as pharmaceutical expenditures account for up to 50% of THE and up to 60 per

cent of households health expenditures [8]. Alternative approaches to protecting these households might need to be explored, most important of which may be the expansion of MAP benefit package to cover the reasonable outpatient drug benefit that will include the coverage for the leading causes of chronic illnesses such as hypertension and other cardiovascular diseases, bronchial asthma, gastroenterology disorders, etc.

It is still unclear, what is the cumulative effect of using PICs as purchasers for health services for the poor funded by the public. However, our study has identified number of notable achievements and shortcomings that may be attributed to the PPP in realization of MAP.

The achievements that may be attributed to the PPP in realization of MAP:

- + Budgetary planning became more predictable and risk of the budgetary deficit was alleviated;
- + Mobilized more than 150 million GEL in capital investments for health care infrastructure and achieved a breakthrough in nationwide health care delivery system restructuring;
- + Partially curbed the health care inflation;
- + Supported the legalization of the financial flows within the health system
- + Made health care insurance more affordable to the general population and contributed to diversification of health insurance products;
- + Improved demand for private health insurance;
- + Supported development of the private insurance industry, with private health insurance accounting for more than 2/3 of the total mobilized insurance premium;
- + Achieved relatively high levels of responsiveness to the needs of beneficiaries and beneficiary satisfaction
- + Contributed to creation of empowered and informed health care consumer

The shortcoming that may be attributed to the PPP in realization of MAP:

- Contributed to fragmentation of the national risk pool;
- Has high administrative costs;
- Concerns in protection of the MAP beneficiary rights and access to health service entitlements;

These mixed effects identified concur with international experience. Available evidence regarding the involvement of private insurance companies as intermediaries in provision of the universal coverage from both high and middle income countries relying on private insurance in covering large share of the population is controversial. Expected efficiency gains resulting from competition and

more entrepreneurial approaches brought by the private actors may be outweighed by relatively high administrative costs and gaps in coverage triggered by the adverse selection and cream-skimming practices, - typical problems of the private insurance market. These problems may only be mitigated through sophisticated regulation in the conditions of the strong governmental stewardship, which is gradually developing but is not still there in Georgia.

The recent governmental decision on major expansion of MAP coverage and inclusion of additional drug benefit are expected to significantly enhance the overall MAP impact and its potential as a viable policy instrument for achieving universal coverage. However, it appears that there is no clear consensus yet among policy makers in which direction to proceed in future for further improving the financial protection of the population, which presents a window of opportunity for the researchers and advocacy groups to provide evidence and influence the decision making process. Additional 1 million individuals under 6 years of age and elderlies are expected to be insured by MAP by the end of the years 2012, extending coverage to almost half of the total population. However, longer term plans regarding MAP expansion are not yet determined. According to the key informant interviews - two prevailing ideas are contemplated by the policy makers currently. "Universalists" support the idea to further expand MAP coverage using the same "means testing" system by elevating MAP eligibility criteria from 70,000 to 100,000 and hence further increase MAP coverage by about 600,000 individuals self-declared and registered as poor in the MoLHSA's Social Services Agency (SSA) with respective scores, which will also eliminate existing discrimination in MAP coverage between the residents of Tbilisi and Adjara and the rest of the country. In this case, MAP coverage will be extended to almost half of the population. Those in favor of "selectivity" in social policy are against further expansion of the coverage beyond the poorest; however support the increase in the scope and depth of coverage by including far more generous outpatient coverage. There are arguments in favor of both approaches which need to be carefully deliberated and costs and benefits analyzed. This clearly presents the window of opportunity for researchers and advocacy groups to participate in this process and generate and communicate sound evidence that may influence the decision making. The research team believes that findings and results of the current study may also help to inform policy makers to determine the future path of the planned health financing reform, while the research findings dissemination activities planned following the Study (policy briefs, workshop and dissemination through the websites of the advocacy groups) will be timely and contribute to the policy uptake process.

COMPETING INTERESTS

The authors declare that they have no competing interests.

AUTHORS' CONTRIBUTIONS

AZ led the research design and implementation as a principal investigator, conducted literature and document review, together with NR interviewed key informants and policy makers, performed overall analysis of the qualitative and quantitative data and finally, drafted the manuscript. NR together with KC (who also provided overall coordination of the research) conducted other qualitative research (including interviewing process and facilitation of the FGDs), and together with GG worked on the secondary data analysis. GG also reviewed the draft manuscript. All authors have read and approved the final manuscript.

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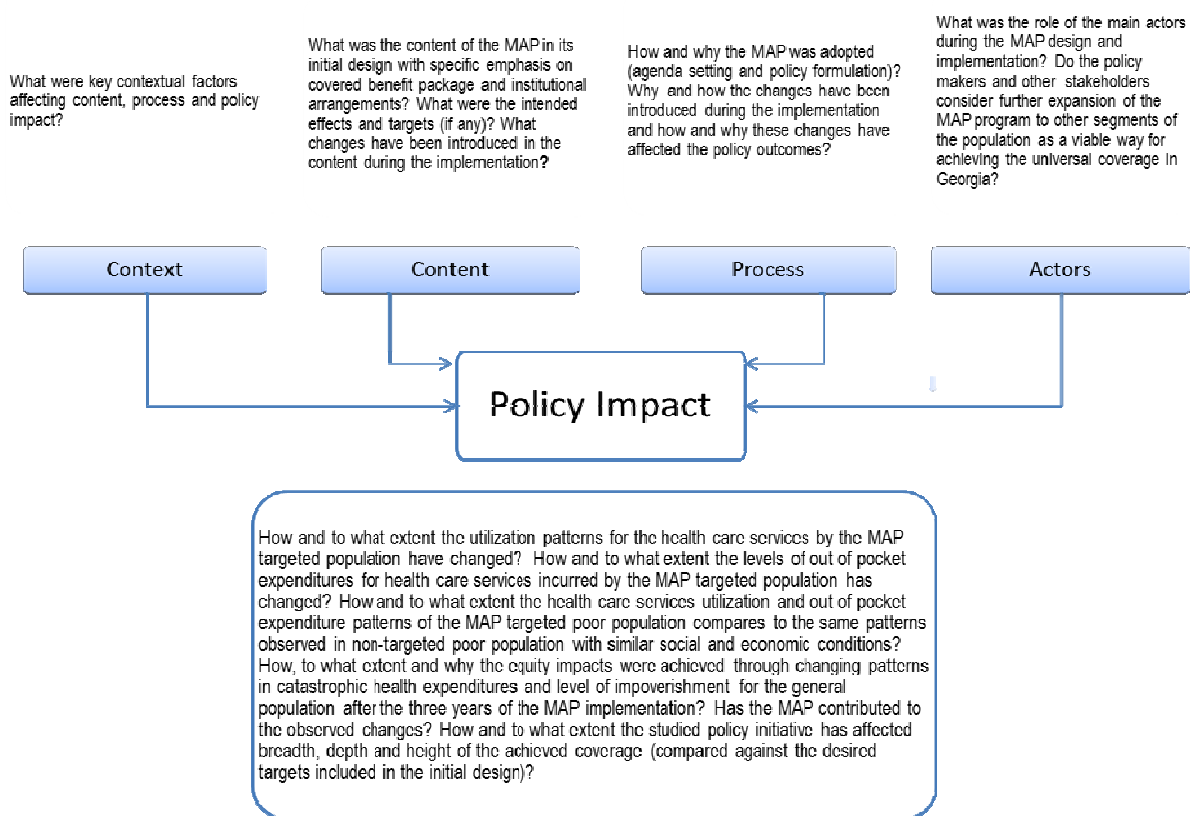
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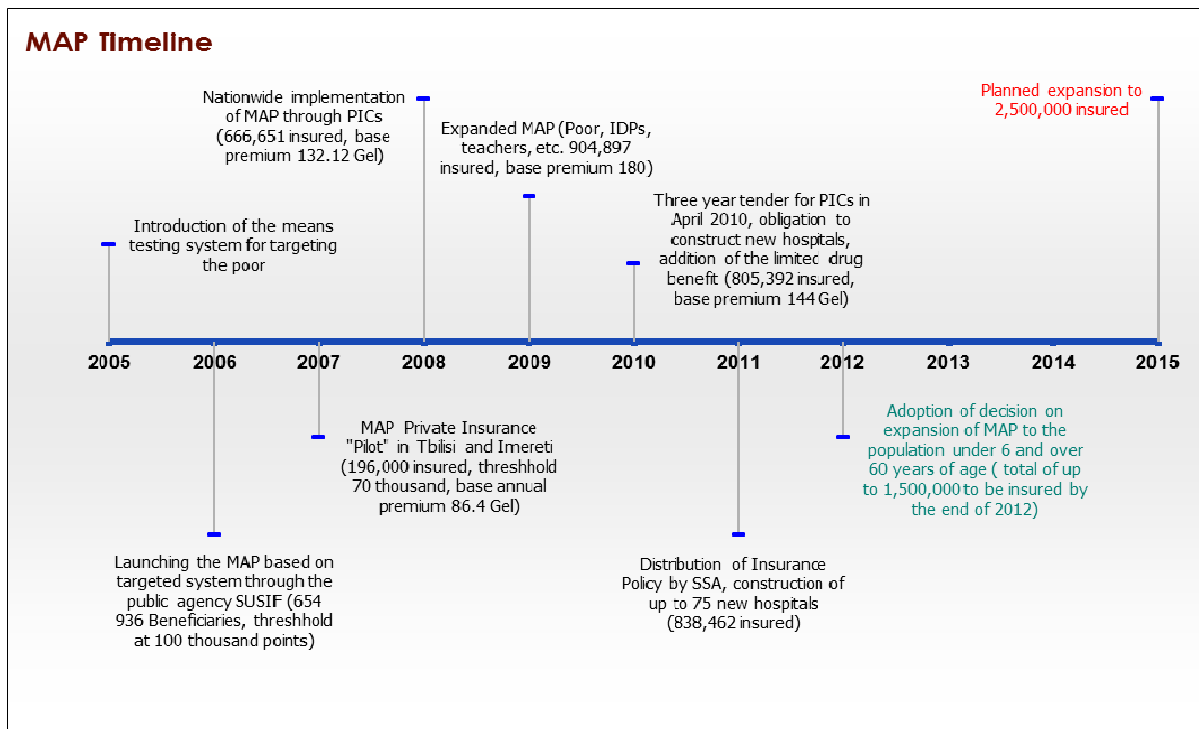
ILLUSTRATIONS AND FIGURES

Figure 1 THE STUDY ANALYTICAL FRAMEWORK AND RESEARCH QUESTIONS



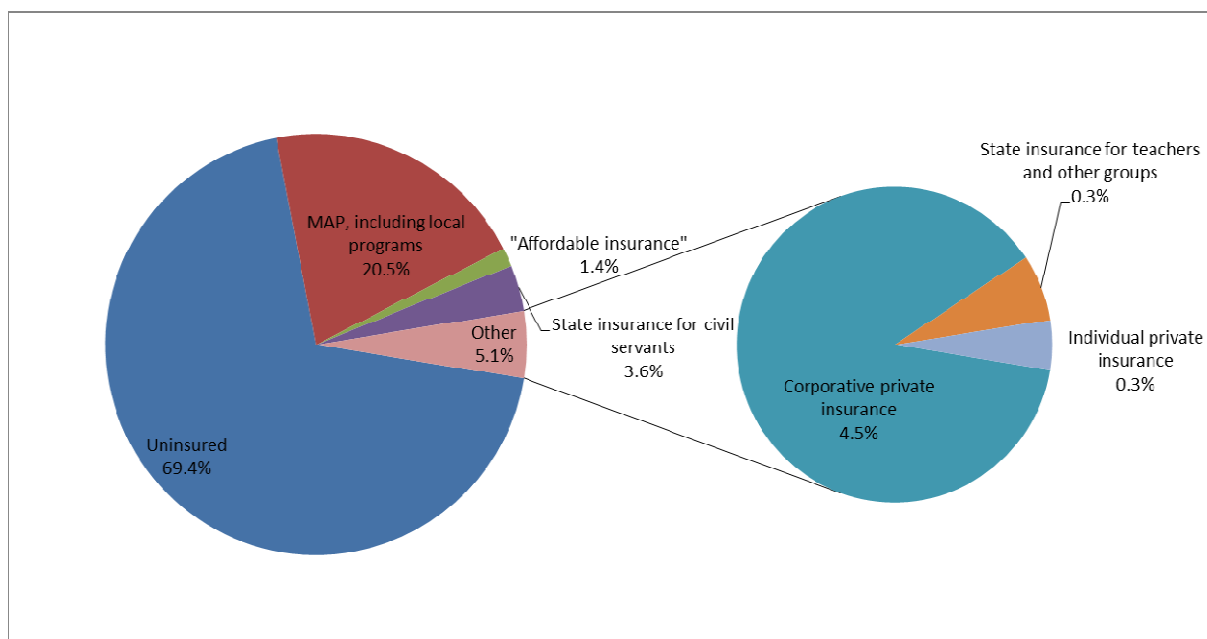
Source: Based on analytical framework proposed by Walt and Gilson in 1994.

Figure 2 MAP TIMELINE



Source: compiled by authors

Figure 3 BREADTH OF INSURANCE COVERAGE IN GEORGIA, 2010



Source: Georgian Insurance Association

TABLES AND CAPTIONS

Table 1 Description of the Study Data Sources and Materials

<i>Data Sources</i>	<i>Description</i>
Document Review	International literature, laws, regulations, ministerial decrees, organizational policies and instructions, minutes of the parliamentary debates, Parliamentary committee meetings, governmental meetings of different levels concerning MAP introduction and implementation were reviewed.
Media analysis	Retrospective analysis of electronic archives of 2 major broadcasters, 6 national daily newspapers, 2 weekly magazines and 3 news agencies were conducted for two years preceding the study (2009-2010). Continuous media monitoring and analysis was maintained throughout the year 2011 on issues related to MAP implementation and impact and also broader health sector issues.
In-depth interviews	Interviews were conducted with representatives of the political, economic and social organizations involved in MAP design and implementation; 6 interviews with key informants were conducted at the first stage using the open ended questionnaire. 12 more interviews with key stakeholders were conducted during the first stage of the study and additional 8 interviews at the final stage of the study.
Focus group discussions	The focus group discussions involving private insurance companies, health providers and patients/representatives of patient interest groups; total of 10 focus group discussions at central (Tbilisi) and regional level (with total 92 participants) were performed.
Secondary data	Involved the analysis of the quantitative comparative data obtained through the population based surveys – the nationally representative Georgia Household Health Utilization and Expenditure Surveys in 2007 and 2010.
Published evaluations	The World Bank, MAP Impact Evaluation Survey Report (2008). UNICEF and USAID, Survey of Barriers to Access to Social Services in Georgia (2010).
Report review process	Two national peer reviewers using the research team network were contacted and asked to provide contribution.

Table 2 selected economic, social and health indicators for Georgia for the years 1990, 1993, 2000 and 2003-2010

	1990	1993	2000	2003	2004	2005	2006	2007	2008	2009	2010
Economic Indicators											
GDP per capita (\$)	1492	541	678	922	1187	1470	1761	2318	2919	2449	2630
GDP per capita (PPP\$)	4,433	1,437	2,218	2,951	3,220	3,611	4,044	4,687	4,905	4,776	5,073
GDP growth (annual %)			1.8	11.1	5.9	9.6	9.4	12.4	2.0	-3.8	6.3
Public Expenditures (% of GDP)			11.6	10.7	14.6	17.3	20.3	22.9	29.1	30.9	30.7
Annual inflation rate (%)	4.8	3,126			7.5	6.2	8.8	11.0	5.5	3.0	11.2
Gel/USD exchange rate (year end)			1.975	2.075	1.799	1.793	1.714	1.592	1.667	1.686	1.773
Demography and Labour											
Population in 1,000	5,438	5,137	4,435	4,342	4,315	4,321	4,401	4,394	4,382	4,385	4436.4
Annual growth rate (%)	0.775	-2.660	-0.673	0.989	0.840	-0.219	-0.107	0.616	0.948	0.775	0.769
Employment level (%)		54.3	56.8	57.7	55.8	54.9	55	55.2	53.2	52.9	53.8
Self Employed (% of employed)			62	65.8	66.2	65.3	65.3	63.3	64.2	65.5	64.5
Unemployment (%)		2	10.3	11.5	12.6	13.8	13.8	13.3	16.5	16.9	16.3
Social and Poverty											
Average Salary in the economy					156.6	204.2	277.9	368.1	534.9	556.8	631.3
Subsistence minimum (average for household)					141.5	160.7	178.7	198.9	214.6	216.0	225.3
Poverty											
PPP\$ 2 daily consumption (% of pop.)			25.31	36.7		30.18			32.21		
PPP\$ 1 daily consumption (% of pop.)			9.59	17.65		14.09			15.27		
National poverty line (%)			23.1					23.6			
Share of population with less than 60 per cent of the median consumption					24.6	24.1	23.3	21.3	22.1	21.0	
Share of population with less than 40 per cent of the median consumption					10.9	10.1	9.4	9.2	9.5	8.8	
GINI coefficient			38.85	40.37		40.78		36.3			
Beneficiaries of poverty assistance in 1,000								279	368	436	430
Beneficiaries of poverty assistance (% of total population)								6.4	8.4	9.9	9.7
Health Status and Health System											
Life Expectancy at birth	73	72	71.3	72.1	71.6	74.0	74.3	75.1	74.2	73.6	74.4
Infant Mortality (per 1,000 live births)	20.7	27.6	22.6	24.8	23.8	19.7	18.4	14.1	14.3	14.91	12.0
Maternal Mortality (per 100,000 live births)	20.47	32.4	49.18	49.79	42.36	23.65	23.01	20.29	14.14	52.07	19.4
Immunization coverage	95	54	80	76	78	84	87	98	92	88	91
Physicians per 100,000 population	493	500	473	489	466	468	455	454	462	469	477
Nurses per 100,000 population	981	1,013	471	397	396	379	363	439	447	424	435
Beds per 100,000 population	979	939	477	419	407	391	374	331	321	310	272
Average bed occupancy rate	54.8	31.8	22	25.8	27.2	26.8	32.3	34.4	38.4	36.1	36.2
Hospitalizations per 100 population	13.31	7.02	4.51	4.81	5.49	5.71	6.01	6.33	7	7.09	7.5
Outpatient facilities			1,055	1,113	1,123	1,124	1,140	1,090	1,064	1,015	1
Outpatient visits per capita	8	5.3	1.4	1.8	2	2.1	2.2	1.95	2.1	2	
Health Financing											
Total Health Expenditures (THE) (% of GDP)			7.4	8.5	8.5	8.6	8.4	8.2	8.7	10.1	10.2
Public Expenditures on Health (% of THE)			16.7	15	15.4	19.5	21.6	18.4	20.7	23	23.1
Private Expenditures on Health (% of THE)							73	72.4	69.8	71.2	72.1
External Expenditures on Health (% of THE)							5.1	9.2	10.5	5.8	4.8
THE (year 2005 PPP\$) per capita			141.7	232.9	262.1	302.9	339.1	384.6	433.0	499.0	510
Out of Pocket Expenditures (% of private health expenditures)			99.4	99.5	99.0	99.0	98.5	97.9	96.3	94.1	96
Public expenditure on health (% of total public expenditure)			4.6	5.87	5.4	5.7	5.7	4.2	4.9	6.1	6.3

Source: Geostat, National Bank of Georgia.

Table 3 Basic Features and Development Stages for Georgian Health financing

	Revenue Collection	Pooling of Funds	Purchasing of services
1995-2004	State budget	Ministry – for administrative purposes	Output based
	SMIC (1997–2002)	State Health Fund (1995)/ SMIC (from 1997)/ SUSIF (2004) – for personal services	Contracts
	Local government Budgets		
	Private insurance companies	PHD – for collective services	Capitation for PHC
	International Organizations	Municipal Health Funds (1995)/ Regional Health funds (1997) - for municipal programs	Case based (Global Budget for mental health) - for Hospitals
	Users	Private insurance companies International Organizations Providers Parallel health systems	Premiums - for private health insurance Fee for services (FFS) – for direct payment
2005-2006	State budget	Ministry – for administrative programs	Output based
	Local government Budgets	SUSIF – for personal services	contracts
	Private insurance companies	PHD – for collective services	
	International Organizations	Local Health entities	Capitation for PHC
	Users	Private insurance companies International Organizations Providers Parallel health systems	Case based (Global Budget for mental health) for Hospitals Premiums for private health insurance Fee for service (FFS)
	2007-2011	State budget	Ministry – for administrative programs
Local government Budgets		HESPA and then SSA– for personal services and preventive care (HESPA abolished in 2010)	Contracts
Private insurance companies			
International Organizations		NCDCPH (former PHD)– for epidemiological surveillance	Capitation for PHC
Users		Local Health entities Private Insurance companies – for voluntary insurance or state insurance scheme for poor International Organizations Providers Parallel health systems	Case based (Global Budget for mental health/TB) – for Hospitals Premiums for health by state insurance schemes Premiums for private health insurance

HESPA- Health and Social Programs Agency

NCDCPH – National Centre for Diseases Control and Public Health

PHD – Public Health Department

SMIC- State Medical Insurance Company

SUSIF – State United Social Insurance Fund

Source: Adopted from Rukhadze et al. “Distribution of Health Payments and Catastrophic Expenditures in Georgia: Analysis for 2006-2010”. Forthcoming

Table 4 good practices in MAP formulation and implementation

Good Practices	Assessment
Agenda Setting	
1. Preliminary situation analysis (H)	+/-
2. Vision, ownership and leadership (C)	Yes
3. Clear policy objectives (I)	+/-
Policy Formulation	
4. International national scientific evidence used (H)	No
5. Contextualized scientific evidence and local knowledge used (C)	+/-
6. Different policy options assessed (H)	-/+
7. Thorough assessment of the selected option (I)	No
8. Early identification of accompanying measures (I)	No
9. Key implementation stakeholders are involved in the formulation stage (C)	+/-
10. The content of the reform meets preferences of key stakeholders (C)	Yes
Programming & implementing	
11. Sequencing reform elements (H)	+/-
12. Planning implementation steps (C)	-/+
13. Broad communication strategies (C)	Yes
14. Medium-term commitment to budgetary burden (C)	Yes
15. Clear rules for contracting and beneficiary enrollment (C)	+/-
16. Clear rules for interpretation of the benefit package (C)	Yes
17. Technical leadership by the Ministry of Health (C)	+/-
18. Capacity building (H)	No
19. Empowered co-ordination unit (C)	+/-
20. New rules are abided by different actors (C)	+/-
Monitoring & evaluation	
21. Monitoring & evaluation of the reform (C)	-/+

(C)- Crucial, (H) – Helpful; (I) – Important;

“Yes” – Largely adhered to good practice; “+/-” partially adhered; “-/+” only few components of the best practice identified; “No” – Not adhered

Source: adapted from Hercot et al.

Table 5 Policy actors by categories, power, nature of their interests and position regarding MAP expansion

Player name	Nature of the interest in MAP Expansion	Category	Position	Power
Academic/Technical experts	Public/Professional – addresses the public issue of professional concern	Interest group – civil society	Medium Support	Low
Citizens, insured	Solidarity – their fellow citizens receive equal benefits in health	Individual	Non-Mobilized	Low
Citizens, insured and uninsured, better off	Solidarity – their fellow citizens receive equal benefits in health	Individual	Non-Mobilized	Low
Citizens, uninsured	Beneficial – access to basic health insurance, financial protection	Individual	Non-Mobilized	Low
Georgian Insurance Association	Public/Professional – will reduce the individual responsibility for one’s own health, constrain the development of the private insurance in long term	Interest group - commercial	High Opposition	Medium
Gilauri, Nikoloz (Prime Minister)	Political/Personal – winning move for his political team, may be regarded as one of the major accomplishments of his term	Appointed officials	Medium Support	High
Health Providers (not owned by PICs)	Financial – both harmful and beneficial – expanding insurance may increase utilization and provide increased revenue however expanding insurance may drive down prices the services they provide	Interest group - Commercial	Non-Mobilized	Low
International Development Partners and NGOs	Global/Public – the way towards universal coverage in health care, financial protection of the population	Interest group - international	High Support	Low
Local Governments	Political/financial – may increase the satisfaction of their constituents, will save funds for those (Tbilisi and Adjara) currently financing coverage above the national eligibility threshold for MAP	Elected/ appointed	High Support	Medium
Ministry of Finance	Financial/harmful – will require major additional public outlays	Appointed officials	Medium Opposition	High
MoLHSA	Policy – ensuring access to health services as a necessary precondition for successful health policy	Appointed officials	Medium Support	Medium
National NGOs	Public – addresses the issues of public concern, equity, rights of disadvantaged	Interest group – civil society	Medium Support	Low
Opposition Minority in the Parliament	Political/Symbolic – provides winning issue for public statements and debates in the parliament; may strengthen their political position and popularity both for national and local elections	Elected officials	High Support	Low
Pharmaceutical Companies	Financial – both harmful and beneficial – more insured will provide more premium revenue for those owning PICs, however expanding insurance may drive down prices both for drugs and services	Interest group - commercial	Medium Opposition	High

Political Parties outside the Parliament	Political – may strengthen their political position and popularity both for national and local elections	Interest Group – Political	<input type="checkbox"/> High Support	<input type="checkbox"/> Low
Press and Media	Public/Financial – addressing the issue of high public concern that may increase sales	Interest group – media	<input type="checkbox"/> Medium Support	<input type="checkbox"/> Medium
Private Insurance Companies	Financial/moderately beneficial -		<input type="checkbox"/> Medium Support	
Ruling Party Majority in the Parliament	Political - Electoral considerations for the local elections in 2014	Elected officials	<input type="checkbox"/> Non-Mobilized	<input type="checkbox"/> Medium
Saakashvili, Michael (President)	Political and Personal - will demonstrate his concern with well-being of the population, can be winning move for next elections, may be regarded as one of the major accomplishments of his presidency	Elected	<input type="checkbox"/> Medium Support	<input type="checkbox"/> Huge

Source: Key informant interviews, interviews with key stakeholders, focus group discussions, media monitoring.

Table 6 Breadth, scope and depth of coverage of state funded health programs and health insurance

State vertical programs covering personal health services and State funded or subsidized Insurance programs	Breadth	Scope	Depth (covered by the state program)
Urgent care (population over 60)	830 thousand - about 19 per cent of the total population	Defined inpatient urgent conditions	First 6 days of ICU care, 75 per cent of actual cost for predefined conditions
Urgent and hospital care for children less than 3 years of age	220 thousand - 5 per cent	Defined urgent and inpatient conditions	Full cost in case of critical conditions and population residing in high mountainous areas; 80 per cent of actual cost for predefined inpatient conditions
General outpatient care	Little over 1 million – about 22 per cent (children under-6, elderly over 60, oncologic and diabetes patients)	Visits to PHC physician/nurse, 4 home visits, immunization, limited list of express lab tests, management of the chronic diseases	Fully covered/no co-payment
Rural outpatient care “rural physician”	Little over 2 million – about 47 per cent	Visits to PHC physician/nurse, 4 home visits, immunization, limited list of express lab tests, management of the chronic diseases	Fully covered/co-payment
Maternal Child Health	Women of reproductive age and children	4 prenatal visits for all. Defined list of tests, extended care for high risk pregnancies and complicated delivery	Upper limit from 833 to 3000 GEL for complicated pregnancy and delivery
Emergency care (ambulance)	Entire population	Ambulance service, medical transportation	Fully covered/no co-payment
Referral program	Entire population	Medical needs during emergency situations, MAP eligible beneficiaries not yet insured; individual cases	Fully covered/no co-payment
Cardiac surgery	Entire population	Defined conditions. Waiting list for planned interventions	Fully covered for children less than 18 years of age. From 50 to 75 per cent of the predefined price for each type of

Management of Oncologic diseases	Entire population	Defined conditions. Outpatient and inpatient care	surgery Fully covered for children less than 18 years of age. 70 per cent of the predefined price of defined interventions with upper limits (e.g. for chemotherapy)
Dialysis and renal transplantation	Entire population	Defined conditions	Fully covered/no co-payment
TB control	Entire population	DOTS, outpatient and inpatient care	Fully covered/no co-payment
Mental health	Entire population	Defined outpatient and inpatient care	Fully covered/no co-payment
Other programs (war veterans, draftees, etc.)	Small groups	Defined list of outpatient and inpatient care	Fully covered/no co-payment
MAP insurance	About 820 thousand poor below eligibility threshold 70,000, about 100 thousand above 100,000 score; about 95 thousand other groups (teachers, IDPs, orphans, etc.) – total about 1 million, or 22 per cent of population	Comprehensive defined list of urgent care, critical care and inpatient services; defined list of outpatient services, outpatient drug benefit from essential drug list	Annual limits: Planned inpatient services – 15,000 GEL Chemotherapy and radiation therapy – 12,000 GEL Delivery – 400 GEL Outpatient drugs – 50 GEL, with 50 per cent co-payment
Affordable insurance*	125 thousand – 2 per cent	Urgent outpatient and inpatient care and critical conditions. Outpatient services included in general outpatient care program	Fully covered PHC. Annual limits: Urgent outpatient care – 300 GEL Critical care from 1,000 to 5,000 GEL With co-payment from 0-50 per cent

* 2010 data

Source: compiled by authors

Table 7 Coverage of the population by any health insurance and by MAP insurance, by income quintiles, 2007 and 2010

	Year	Poorest	2 nd	3 rd	4 th	Richest
Percentage of population reporting being covered by any health insurance (government, private or employer)	2007	18.5	14.8	12.5	14.4	8.6
	2010	39.9	31.1	26.6	23.7	26.2
Percentage of the population in households covered by MAP	2007	14.3	13.2	8.3	9.3	4.2
	2010	39.2	26.8	20.1	16.7	13.1

Table 8 Estimates of shares of households with catastrophic health expenditures in 2007 and 2010 (per cent)

	2007		2010	
	HUES	HBS	HUES	HBS
Poorest	17.7	11.6	27.0	13.3
2 nd quintile	12.0	6.3	27.9	9.8
3 rd quintile	10.1	4.5	24.2	7.2
4 th quintile	8.4	3.8	24.5	5.8
Richest	10.3	3.7	20.6	6.4
Total	11.7	6.0	24.8	8.5