Georgian state rehabilitation program: implementation research study report

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List of Acronyms

FGDs	Focus group discussions
FIM	Functional Independence Measure
IAC	Independent Assessment Committee
ICD-10	International Classification of Diseases
IDIs	Semi-structured in-depth interviews
MoH	Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs of Georgia
NHA	National Health Agency
OT	Occupational Therapist
PT	Physical Therapist
SDG	Sustainable Development Goals
SLT	Speech and Language Therapist
SOPs	Standard Operating Procedures
ToC	Theory of Change
UHC	Universal Health Care
UHCP	Universal Healthcare Program
WHO	World Health Organization

Background

Rehabilitation services play a significant role in enhancing the well-being of individuals confronted with physical or mental health conditions, disabilities, or injuries. The services offered, such as physical, occupational and speech therapy, psychological counseling, and social support, aim to improve individuals' functioning and independence and in their overall quality of life. The importance of rehabilitation services cannot be overstated, as they facilitate recovery, prevent secondary complications, and reduce the likelihood of future health problems[1]. Integrating rehabilitation into state-funded benefits packages is essential for ensuring equitable access to rehabilitation services, promoting health outcomes, and reducing long-run healthcare costs. Incorporating rehabilitation services in UHC is an effective strategy for reducing health inequalities and achieving universal health coverage, as envisioned by the Sustainable Development Goals (SDGs).[2] Georgia embarked on integration of rehabilitation service into Universal Healthcare (UHC), and this implementation research aims to document initial results and challenges to inform and facilitate the program timely scale-up beyond the initial package of interventions.

Study context

Georgia, a former Soviet state located in the Caucasus region with a population of 3.68 million as of 2022, introduced a general tax-funded health financing scheme – the Universal Healthcare Program (UHCP) - in 2013. UHCP helped the government expand the breadth and depth of population coverage. Now, eligible individuals can benefit from a comprehensive set of preventive and curative healthcare services free of charge or with an established co-payment (depending on one's beneficiary group). The National Health Agency (NHA), which operates under the Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs of Georgia (MoH), acts as a single-purchaser for UHCP and purchases services from both private and public healthcare providers using pooled public funds[3]. Up until 2022, rehabilitative services were not included in the UHCP benefits. However, due to growing need and demand, the MoH took initial steps by adding a limited set of rehabilitation services to the UHCP benefits beginning November 2022[4].

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[1] World Health Organization. (2021). Rehabilitation. https://www.who.int/news-room/fact-sheets/detail/rehabilitation

[2] World Health Organization. (2019). Rehabilitation in health systems. Geneva, Switzerland: World Health Organization.

[3] World Health Organization. Regional Office for Europe, European Observatory on Health Systems and Policies, Richardson, Erica & Berdzuli, Nino. (2017). Georgia: health system review. World Health Organization. Regional Office for Europe. https://apps.who.int/iris/handle/10665/330206

[4] Government of Georgia decree #522, which brought modifications to decree #36 of the Universal Health Coverage Program (UHCP)

The included rehabilitation services were for conditions related to stroke, traumatic brain injuries, and spinal cord injuries. Under this initiative, a rehabilitation sub-program was created under the UHCP, which aimed at removing/reducing the financial access barrier to rehabilitation for the eligible population. Thus, the sub-program objectives were to 1) allocate state budget funds for adult rehabilitation and reduce financial access barriers to care, and 2) based on initial experiences, scale up program implementation to cover services for an expanded list of health conditions in 2024.

Specifics of the Sub-Program

The rehabilitation sub-program provides full or partial coverage for rehabilitative services for the eligible population. The eligibility criteria for the sub-program are outlined as follows:

Condition: The sub-program encompasses individuals with illnesses related to disruptions of blood flow to the brain, traumatic brain injuries, and spinal cord injuries, defined with relevant *International Classification of Diseases* (ICD-10) codes specified in the governmental decree.

Time of Disease Occurrence: Individuals who have suffered from these conditions within the past 24 months are entitled to the benefits.

Eligible Patient Categories: Beneficiaries and Co-payment Conditions for the sub-program were defined under Decree №72 of the Government of Georgia (21 February 2023).

Population Category	100% State Funding	90% State Funding	80% State Funding
Socially vulnerable families/individuals with proxy means tests score ≤ 70,000	✓		
Internally displaced people from occupied territories of Georgia resulting from Russian invasion of Georgia on 6 August 2008	✓		
Beneficiaries of foster institutions, mother and child shelters and community organizations, including those under jurisdiction of Agency of State Care	✓		
Prominent artists and the National ward (Rustaveli Prize) holders	✓		
Public school teachers, administrators and technical staff and teachers of professional educational institutions funded by the state.	✓		
Households residing in the bordering regions of the occupied territories of Abkhazia	✓		
Veterans registered in the national database of the State Service of Veteran Affairs	✓		
Individuals residing in the villages of Gori, Kaspi, Kareli, Khashuri, Dusheti, Oni, Sachkhere, Zugdidi, Mestia, and Tsalenjikha municipalities, located along the administrative boundary line with the occupied territories of Georgia	✓		

Population Category	100% State Funding	90% State Funding	80% State Funding
State pension recipients of retirement age		✓	
Students			✓
Persons With Disabilities (including all groups)			✓
A Georgian citizen under 18 with a disability, not covered in any earlier categories			✓

A checkmark (✓) indicates eligibility for the corresponding coverage level. If a beneficiary falls into multiple categories, their service coverage will be provided according to the category with the highest percentage of state funding.

Service providers: As for providers, facilities must submit an official request to the MoH to be recognized as a service provider and be contracted under this program. Only facilities that are licensed[5] to provide in-patient care can apply to be a service provider for the rehabilitation sub-program. This report refers to the healthcare facilities that failed to obtain provider status under the UHCP as "non-providers."

Program administration: To be enrolled in the program, patients are required to apply and submit the necessary documentation to the NHA. The decision regarding patient inclusion in the program is determined by an *Independent Assessment Committee* (IAC) housed in the NHA. Upon receipt of a favorable IAC decision (in the form of an official letter sent to the patient, referred to as a voucher), patients can seek services from a healthcare provider recognized as a service supplier by MoH and NHA. The Governmental decree also outlines a predefined list of approved out-patient rehabilitation interventions, which providers must adhere to when treating patients. However, the treating doctor determines the quantities of delivered interventions. Once a patient completes a full course of treatment prescribed by group of rehab-specialists, achieving a minimum functional improvement of 10% in the *Functional Independence Measure* (FIM) score, they can be re-enrolled and continue their rehabilitation journey with state support., The government is paying 4,177 GEL per course of rehabilitation for conditions related to blood flow disruptions to the brain and brain injuries, and 5,031 GEL per course for spinal cord injuries.

Contextual impediments

Based on interviews, since its inception, the rehabilitation sub-program has faced several obstacles. A foremost challenge is the observed need for more service providers capable of meeting the MoH-determined permit requirements. Due to the limited scale of the sub-program, at the time of this study, only three providers were contracted (at different times) by NHA and delivered rehabilitation services under UHCP. In the absence of ambulatory facility standards some outpatient providers faced barriers in joining the program and are waiting until regulations are amended/modified and outpatient facilities are allowed to deliver the service under state

[5] Licensing entails specific requirements for building, facilities, equipment and staff categories.

funding. By far, only ambulatory standards would not be sufficient for scale-up because the country lacks adequately trained rehab staff largely due to gaps in the regulations governing rehab staff education and qualification. Certain staff categories (Physical Therapist (PT), Occupational Therapist (OT), and Speech and Language Therapist (SLT)) required for the delivery of rehabilitative services are not legally recognized in Georgia, and their education, training, and certification are not regulated (*The Georgia Rehabilitation Service Development Strategy (2023-2027)*, 2023). These impediments existed before sub-program initiation and are expected to affect the program scale-up phase.

Plans for sub-program rollout.

In 2022, the MoH outlined plans to expand the program. This plan includes the addition of new health conditions to the existing list and broadening the eligibility criteria to allow a larger population to enroll. The MoH's plan also intends to increase the number of providers. However, achieving this objective is anticipated to necessitate significant efforts and regulatory adjustments by the government and providers alike. To support program rollout, this research aims to investigate the initial steps of the implementation process and gather empirical evidence, the primary objective of which is to gain insights as to how the implementation strategy and plans could be adjusted to maximize favorable outcomes during the program's rollout phase.

Objectives

The primary objective of this research is to document the initial outcomes of the rehabilitation sub-program and identify necessary modifications (if any) that will contribute to a smooth rollout of the program in 2024. To achieve this objective, the research team has developed two specific research questions:

1. What are the main modifiable and unmodifiable factors impeding the implementation of the state program?
2. How can the implementation of the state program be adapted/changed to achieve the best outcomes after rollout?

Methods

To answer these questions and adequately interrogate all possible factors influencing implementation, the researchers used a theory-based approach and developed the *Theory of Change* (ToC) for the rehabilitation program in Georgia, encompassing crucial inputs, processes, environment, and desired outcomes (see Figure 1). The ToC was useful in undertaking deductive qualitative data analysis.

Research Design

This study utilized a qualitative research design to explore the experiences and perspectives of participants, providers, and policymakers regarding state rehabilitation program. Semi-

structured in-depth interviews (IDIs) and focus group discussions (FGDs) were conducted with conveniently sampled individuals and helped gather rich and detailed data about program implementation.

Sampling and Recruitment

The study used purposive sampling due to the limited number of providers and patients engaged in the sub-program. The approach allowed for gathering data from participants who were most likely to have relevant experiences or perspectives on the research topic[6] by selecting participants based on specific criteria related to our research questions.

Interviews were conducted using semi-structured guides tailored to each group (patients, providers, MoH representatives, i.e., policymakers) as necessary. The face-to-face interviews ranged from 15 to 45 minutes, while the focus group discussion (FGD) lasted approximately 75 minutes. Upon securing written consent, all interviews were recorded using audio equipment and transcribed verbatim. A saturation approach was employed to ensure the sufficiency of data collection. The sample for this study was composed of 8 patients and/or their family members, alongside two representatives from a service provider facility, two representatives from non-provider facilities, two representatives from the MoH (total of 14 interviews), one FGD with three non-provider facility representatives.

Ethical considerations

Ethical approval (IRB # 2023-014) for this study was granted by The National Bioethics Committee of Georgia housed at the National Center for Disease Control. Written informed consent was obtained from all participants prior to their inclusion in the study. Participants were provided with a consent form that outlined the purpose, the procedures involved, and the risks and benefits of participation. The form also included information on the participants' rights, including their right to withdraw from the study at any time and their right to protect their confidentiality and privacy. The consent form was written in simple Georgian language and explained to the participants understandably. Any questions or concerns raised by the participants were addressed before signing the form.

Data Analysis

The analysis process involved multiple steps, including familiarization with the data, generating initial codes, searching for themes, reviewing and refining themes, and producing memos for each theme. Specifically, we used data-driven (inductive) and concept-driven (deductive) coding approaches for qualitative data analysis. The deductive approach was utilized to map the emerging themes on the ToC blocks (see Figure 1).

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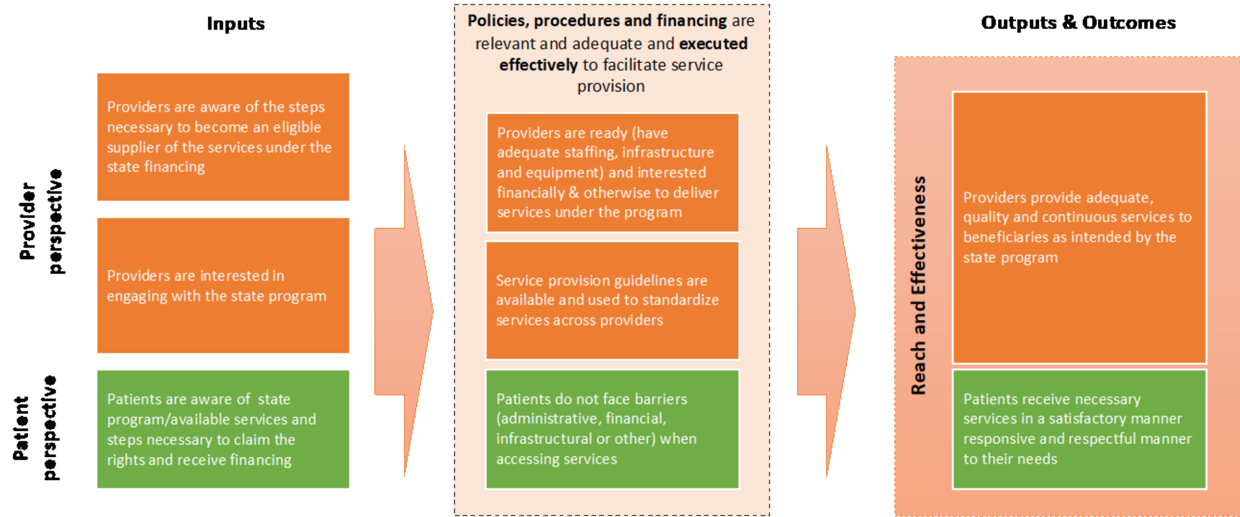
[6] Patton, M. Q. (2015). Qualitative research & evaluation methods: Integrating theory and practice (4th ed.). Sage Publications.

Figure 1 Theory of Change



Major categories from the ToC and the themes that emerged from the qualitative interviews were also used to develop the coding system. The coding and reconciliation process was carried out by two researchers independently and coding was compared, discussed, and agreed upon by researchers to ensure rigor of findings. Both coding approaches allowed for comprehensive data analysis and ensured that important aspects were captured to the extent possible. Qualitative data analysis was carried out in NVIVO 12™.

Findings

For this section of the report, we use the ToC as an organizing framework to present the study findings and to align with and accurately represent the program's success and challenges, providing a more nuanced understanding of its results and possible areas for improvement.

Patient and Provider Awareness

Awareness about the availability of program services, eligibility criteria, and entitlements and the rules for engaging with the program as a provider was seen as an important condition for (a) patients to demand and access the services and claim their rights and (b) providers to enter into a contractual arrangement with the NHA and deliver services under the sub-program and get reimbursed.

The interviews uncovered that most patients received information through word-of-mouth and mainly from medical providers. Therefore, the level of awareness was variable, at times faulty and/or imposing barriers to accessing services in a timely manner. The in-depth interviews revealed that patients' understanding of the necessary steps to obtain financial support was

moderate and heavily dependent on the information supplied by the treating doctor or nurse. Although most participants could identify the required steps for receiving care, they only acquired this knowledge after experiencing the process and not through other organized means of information delivery.

"... it is good that there is such a center [rehab clinic], many people do not know about it, and I am very satisfied...if that professor had not told me...I would not have known...". (Patient N3)

According to NHA, during November 2022 – July 2023 (almost 8 months) there were 509 applications in total (average 64 applications a month), out of which at the time of this report production 385 applications were reviewed 295 (76.6% were approved).

The need for greater awareness about the program also featured prominently among interviewed providers. Healthcare personnel talked about the need for more knowledge about the program details in order to give patients proper instructions on necessary steps or prescribe rehabilitative interventions covered by the state program. Overall, awareness featured low among patients and providers alike.

"…By the way, I explained [the program details] to many people because many people do not know [what services the program offers], they are not well-versed in the district...more than half of [our] district did not know...can you imagine that the doctors did not know". (Patient N12)

Despite the formal announcement of the program's initiation on the national TV channels by the Ministry of Health officials and MoH's Facebook page, providers discussed the need for more substantive and proactive communication from MoH. After the start of the program, the necessary administrative steps for providers to become the suppliers of the services were not fully clear. According to providers, the system established to respond to patient or provider inquiries was not functioning effectively. Finally, also according to providers and patients, the entities responsible for program implementation (NHA units and its regional centers, MoH reception desk, and hotline) had varying degrees of knowledge about the administrative details of the program. The Central NHA office was relatively more informed in guiding patients and providers than its regional divisions, where awareness about procedural steps for provider contracting was not at the required level (according to key informants). While the policy division was fully aware of the program details, the knowledge level was lower among entities under MoH subordination or at MoH hotline (according to respondents (patients and providers) who called the hotline).

Lack of awareness building efforts, which was not part of the program design from the outset, bears negative consequences manifested in different forms. One healthcare provider faced a sudden patient increase but encountered difficulties managing the reporting and claims

submission process. They had no prior association with the UHCP and no experience dealing with the online claims submission system used by NHA. It took weeks to seek and understand the necessary procedures for accessing the reporting portal and its electronic modules for claim submission to the NHA. Another facility completely suspended its rehabilitation service provision for some months due to the inability to obtain program-related information from the regional NHA center.

"Do we have to upload [claim] somewhere? Or does the patient have to take it [claim]? Where should s/he take it? The [regional] NHA could not help [guide] us, and I do not have any information...". (Provider N9)

Provider interest to engage with state program

Three reasons were named by providers (those contracted by NHA and those planning to join the program) when explaining their desire to participate in the state program:

Increased Number of Patients: Providers are interested in the program due to the potential for a significant increase in patients seeking rehabilitation services. With the program's focus on affordability, more individuals who previously could not afford rehabilitation can now access these services. This means providers can expand their patient base, ensuring that their expertise and skills are fully utilized. The opportunity to positively impact more individuals by helping them to regain their health and well-being was noted as a driving force behind their interest. While providers did not explicitly discuss the financial interests linked to increased patient flow, their responses implied that generating more revenues was also a motivating factor.

The Rehabilitation Field Development: According to providers, the sub-program holds the promise of fostering the development and advancement of the rehabilitation field within the country. Providers recognize that participating in the program can contribute to the growth and improvement of rehabilitation services on a broader scale. This includes enhancing the quality of care provided and pushing the boundaries of research. The sub-program acts as a catalyst for professional development and stimulates providers to continuously update their knowledge and skills, ultimately raising the standard of rehabilitative care in the country.

Healthy Competition: Providers think the program creates an environment for healthy competition, further fueling their interest. Providers are motivated to deliver the best quality care to patients to distinguish themselves within the marketplace.

First of all, it was very necessary because there are many patients, and stroke affects younger age groups, there are many people who can achieve functional independence and improve their quality of life, but they remain without these [rehabilitation] services due to lack of money...". (Provider N3)

"The patient flow, that is all. It is very simple when the patient [service] is funded, he/she comes [to get services], when s/he is not funded, s/he struggles." (Non-provider Focus Group Participant 1)

"...the accompanying competition that comes with this [state program] is healthy and will contribute to the field [rehabilitation] development...". (Non-provider Focus Group Participant 2)

Policies, Procedures and Execution

According to providers and representatives of the MoH, although the program has achieved a lot within a very short time, there is always room for further improvements in the policies or process that would facilitate program scale-up.

Provider footprint expansion

The absence of outpatient rehabilitation facility standards will most likely be addressed over the coming months because the World Health Organization (WHO) is developing global guidance for setting facility standards (requirements) for outpatient rehabilitation services. However, this document is expected to be released during the second half of 2024. This time delay concerns the providers that claim to be ready to deliver the outpatient rehabilitative services today. On the other hand, MoH needs to balance the quality of rehabilitative services with the need for geographic expansion of services, for which two options exist (a) growing services only with the help of inpatient facilities that have well-established outpatient departments that meet state requirements and/or (b) with the help of outpatient facilities. Finding the right balance would require time and close observation of suppliers and their capacity (infrastructural and human) in the marketplace.

Patient eligibility criteria

The second policy-related impediment is the eligibility criterion stating that patients must have the legal status of a " *person* with disability", which according to existing regulations, requires three months from the onset of illness/accident. According to respondents, MoH introduced this requirement as a precautionary measure to control budget expenditures during sub-program initiation. However, the respondents felt that this measure falls short of achieving fiscal objectives in a medium to long-term period, as it only delays budget outlays by approximately 3-4 months (before an individual is granted disability status), while negatively affecting patients' health outcomes and well-being – since timely initiation of rehabilitation services is an important pre-requisite for better functionality outcomes.

Procedures for Provider Inclusion

Thirdly, while the government decree regulating the sub-program has broad provisions for provider eligibility, patient health conditions, and payments covered under the program, detailed

and clear procedures/instructions (process steps) for provider inclusion in the program[7], for billing, reporting, and reimbursement and/or timelines for the application processing were missing. Consequently, For some providers, it took months before they joined the program and delivered services. For others, inclusion was fast, but the invoicing and payment process proved challenging. According to respondents, a detailed description of the process steps (usually reflected in documents like *Standard Operating Procedures*) would have been helpful, especially for those less knowledgeable of UHC procedures who faced challenges during the billing process, while others faced delays in securing supplier status under the program as clear timelines for application processing were not known.

"...We called the MoH hotline, but unfortunately, they did not put us through to anyone...they told us they would figure out who the responsible person is [at the MoH], and maybe they are still figuring it out. I do not know." (Non-provider N9)

"…they were waiting for some signature, then another, etc. There were constant delays because of all this bureaucracy of sending [document] from one office to another. Maybe it was for an objective reason, or it could be a subjective one." (Provider Focus Group Participant 2)

Lack of flexibility in claim reimbursement

Another significant challenge for implementation stemmed from a lack of flexibility from the payer to account for individual rehabilitation needs. According to providers, initially, claim reimbursement was contingent upon healthcare providers completing 100% of the prescribed interventions spelled out in the voucher, not considering the patient's adherence ability and dedication to rehabilitation. However, this requirement later underwent a modification, allowing partial reimbursement (50% of the total amount) if at least half of the interventions were carried out, and full reimbursement if more than half of the prescribed interventions were completed. This change addressed some of the rigidity concerns, but the program's limited flexibility continues to pose challenges and could potentially negatively affect the rollout.

Lack of patient-centric (needs-based) approach

Furthermore, providers think that the program is not sufficiently patient-centric, thereby further contributing to its rigidity. The interventions selected for state funding were standardized in the government provisions instead of allowing for a tailored approach to meet the individual patient's health needs. Moreover, the decision-making regarding which interventions to approve for patients is centralized within IAC. Providers believe this structure lacks the medical expertise to make informed medical decisions. Moreover, the committee needs more detailed knowledge of the MoH decree, as this study found that it prescribed interventions not included in the state program on several occasions. Finally, the committee never established direct personal contact

[7] Especially those that never took part in the UHC program delivery.

with patients, further raising questions among providers about its competency in understanding patients' specific conditions and needs.

> *"There were confusing cases. We knew well that this [rehabilitation] program does not include electrical stimulation [intervention]. The neurologist's recommendation written in the form #100 prescribed electrical stimulation, which has been sent and approved by the commission [IAC]. Consequently, twenty electrical stimulations were prescribed [in voucher], but I ignored this because the state program does not reimburse electric stimulations". (Provider N5)*

> *"Anything can be written there [prescription approved by the IAC], such procedures that are not supported with evidence at all. For example, physioelectrophoresis, is neither listed in the guidelines nor has supporting evidence, nor is it written in the state program. "*
>
> *(Provider N3)*

Provider readiness and interest

As for facility readiness, firstly, all the healthcare facilities that participated in the study, including both providers and non-providers, asserted their readiness and capacity to cater to the increased patient load, along with possessing the appropriate infrastructure and equipment. They reported having adequate healthcare professionals, such as doctors, nurses, physical therapists, and other staff required to meet the patient's needs. These findings were corroborated by the feedback from the patients who utilized the services of the facilities, underscoring the sufficiency of staff numbers, quality of training, and satisfaction with the infrastructure. However, validating this statement with administrative data about the provider and his/her compliance with the state requirements was beyond the study's scope.

According to respondents, the issue of financial adequacy does not appear to have been a concern for any of the healthcare facilities. This observation applies to the facilities already engaged in the program and those that expressed interest in participating. None of them voiced dissatisfaction regarding the reimbursement rates set by the government. Patients did not report any additional charges imposed by providers beyond established co-payments.

Nonetheless, the inception of data collection for this study marked more than four months since the program's official announcement, at which time only one provider was rendering services, while an additional two joined the program later and had rather limited experience. This led to a question: why did the "good to go" facilities delay joining the state program? As our investigation delved further into the matter, it revealed several inhibiting factors described elsewhere in this document.

Service provision guidelines

Our findings suggested that national guidelines exist only for the rehabilitation of post-stroke and respiratory system disease. Where such guidelines are available, they are followed by staff for intervention planning and delivery.

Program Outcomes

A notable pattern that emerged across all respondents was overwhelmingly positive feedback reported within a relatively short timeframe of sub-program implementation. Personal satisfaction was consistently expressed by all patients, encompassing various aspects such as therapy effectiveness, functional improvement, quality of interaction with healthcare personnel, and the overall environment within provider facilities.

A notable aspect was the providers' responsiveness to patient needs. Although not explicitly mentioned by every participant, the general descriptions of healthcare personnel and their interactions with patients (as conveyed by patients) suggested a high level of trust and confidence in their abilities as well as satisfaction with the services obtained. According to patient respondents, this trust was nurtured through a demonstrated understanding of their unique needs and a genuine commitment to addressing them responsibly. The adaptability and flexibility exhibited by healthcare professionals (in a constrained environment described earlier) in tailoring treatment plans and interventions to the individual requirements of the patient were also noted by the providers.

Overall, patient feedback, recognizing the limitations of the study noted below, revealed easy access to services without much administrative or financial burden to the patients. Exploring the financial aspects of the state program, a captivating narrative emerged that almost all patients were pleased with the level of financial coverage despite the expectation of co-payments from certain groups. The study did not capture any major complaints or grievances regarding the administrative procedures. Patients spoke of their visits to the MoH with ease, which did not leave them frustrated. The application processing times appeared reasonable without causing undue delays or frustration among the beneficiaries.

However, certain aspects noted by the patients could be addressed in the future. Namely:

- **Lack of funding for transportation costs:** Transportation expenses for individuals with disabilities are of particular concern. Some patients expressed the need for financial support to cover the costs associated with commuting to and from the rehabilitation facilities.
- **Cost of drugs necessary for the treatment of the main condition:** The concern revolved around the cost of outpatient drugs necessary for the treatment of the main health condition, not currently covered by the state program. Patients highlighted the need for financial assistance to improve access to these medications, as they played a crucial role

in recovery. However, transportation and drug costs were raised as suggestions for improvement, as they did not dampen the patients' overall satisfaction with the program.

- **The validity period for vouchers**: The voucher serves as proof of approved treatment and has a relatively short validity period of 30 days. The patients need to initiate their treatment within this limited timeframe. However, there were limited instances when delayed responses from the IAC meant that patients were not able to initiate the treatment within a 30-day period, and vouchers expired.

"...there were several cases when the voucher was issued at the end December, the patient received the paper towards the end of January, and when a patient reached us, the voucher was already expired… then we all had to go through the whole process again, which is very uncomfortable..." (Provider N??)

Discussions

The study findings bear importance when planning for the sub-program expansion. Namely, the low awareness noted among patients requires additional actions to increase the demand for services. Patient reflections captured through in-depth interviews were confirmed with low monthly application numbers to NHA, pointing towards the importance of a well-developed awareness campaign that will be necessary for generating higher demand.

Our study also found that providers are interested in the program's potential, which would allow them to attract more patients to their practice. This, in turn, could foster healthy competition and contribute to the development of the rehabilitation field in the country. The program's emphasis on reducing financial access barriers for the patients, coupled with the provider's interest in joining the program, is a conducive precondition for the expansion of rehabilitation services when adequate demand is generated. However, there are further impediments to expansion that require attention. Namely, the current lack of outpatient provider standards is a major inhibiting factor for the sub-program roll-out. Waiting for WHO-developed provider standards, planned for mid-2024, seems rather remote in time and would likely constrain and further delay sub-program rollout plans. Therefore, it seems there is a need for timely development and implementation of interim outpatient rehabilitation facility standards by MoH before WHO standards emerge to facilitate the provider network expansion (most importantly, outside of big cities). The outpatient modality for rehabilitation service provision, which is so prevalent in well-developed healthcare systems, further emphasizes the need for timely and interim action. Next, we noted that awareness of MoH and NHA organization units (sub-structures) about the steps necessary for provider inclusion was low, and unless these units and their staff are capacitated to guide providers through this process, the program expansion could be delayed. Developing standard operating procedures could be a simple solution for resolving such bottlenecks.

While noted actions could be helpful in program roll-out, this would not be sufficient unless eligibility criteria linked to disability status are removed. The MoH's intent to control program costs with such eligibility criteria seems not to be fit for purpose. Rather than saving costs, this approach delays program outlays by three months, potentially increases the costs of treatment, and incurs additional costs linked to disability pension payments. Thus, eligibility to state-funded rehab services that are linked to disability status leads to patients losing valuable time (3 months) post-accident (stroke, traumatic brain injury, and spinal cord injury) before they can access and initiate state-funded rehabilitation services. Initiation of rehabilitation services as soon as possible after an accident leads to better outcomes and faster improvements in functionality. Therefore, a three-month delay may negatively affect rehabilitation outcomes and/or require longer and costlier rehabilitation interventions, which effectively entails risks of increasing required state funding (instead of controlling it). Disability-linked pensions further increase demand on the state budget, while faster rehabilitation could help alleviate such pension-related costs. Next, existing administrative systems (lack of a single national registry of individuals that have obtained legal status of a "person with a disability") limit effective administration of the stated policy and lead to further delay in treatment initiation, even when people possess such a status. Thus, the eligibility clause emerges as a significant barrier without any fiscal benefit and sometimes leads to a complete exclusion of an individual from the program. Therefore, this eligibility clause is not beneficial for the state nor the patient and is recommended to be abolished.

Next, the rigidity of state-imposed regulations, described in the findings section, creates a non-conducive environment for better rehabilitation outcomes. This rigidity, coupled with weaknesses in the program execution, is expected to constrain program scale-up and rollout. Therefore, these weaknesses must be addressed before program expansion, originally planned for mid-2023 but eventually moved to 2024.

Based on study findings, to positively affect the quality of rehabilitation service, it would be necessary to develop clinical guidelines for the health conditions expected to be added to the program and for which currently clinical guidelines are either missing or not reviewed and approved by the government.

Finally, certain concerns related to the cost of transportation, lack of funding for outpatient drugs, and validity period for the voucher could be addressed to further enhance patient access and satisfaction during the sub-program rollout.

Policy recommendations

Drawing upon the results, several targeted actions are being proposed to enhance the program's effectiveness and ensure the delivery of patient-centered services that could facilitate program rollout and deliver better health outcomes.

1. **Policy amendments** - **removal of disability status as a precondition for entitlement**. This eligibility clause is not beneficial for the state and/or the patient and neither administrative system of the country supports its implementation. Therefore, it is recommended to abolish it in its entirety. By removing this precondition, all individuals that require rehabilitation services can access the program if other eligibility conditions are met.
2. **Awareness-raising activities** need to be planned and delivered targeting (a) patients to generate demand and (b) providers (e.g., neurologists, traumatologists or GPs who identify rehabilitation need) to facilitate engagement with the UHCP rehabilitation sub-program. Effective awareness-raising activities would be crucial for program rollout to ensure that both patients and healthcare providers are well-informed about the state program and its procedural details. Different strategies should be employed for patients and providers. For patients, awareness campaigns should focus on the program's benefits, eligibility criteria, and how to access services. Several approaches could be considered: (1) more active utilization of the MoH official website as well as a Facebook page to promote the program among both patients (caretakers) and providers; (2) distribution of program leaflets in facilities providing acute care for patients with conditions such as stroke, traumatic brain injury, spinal cord injury; and (3) through its claims database, the NHA could proactively screen potential patients and send targeted communication to providers directing them to appropriate facilities, as well as send messages to eligible patients.

   For providers, the emphasis should be on facilitating their engagement with the program, and educating them about the referral process, reimbursement procedures, and the benefits of participation. Well-planned and targeted awareness activities can increase program enrollment and patient and provider engagement.

3. **Patient guides:** To help patients easily navigate the system, a booklet or flyer could be developed that includes a roadmap outlining the steps patients need to follow, from initial application to receiving rehabilitation services. The roadmap should cover aspects such as eligibility criteria, application procedures, required documentation, criteria for care continuation, and any follow-up requirements. Clear rules and guidelines will help streamline patient processing and ensure a smooth and efficient patient experience.
4. **Provider guides:** Similar to patients, healthcare providers should also have a roadmap outlining the rules, requirements and process steps for their inclusion and interaction with the state program. This roadmap should cover aspects such as the criteria for provider eligibility, the process for becoming a service supplier, the documentation and reporting requirements, reimbursement procedures, and any other expectations or responsibilities. Providers can navigate the program requirements effectively by having a clear roadmap, ensuring their inclusion and proper engagement in delivering rehabilitation services to eligible patients.

5. **Development standards for outpatient rehabilitation facilities**: Before WHO delivers a comprehensive guideline for developing outpatient rehabilitation facility standards, the MoH may need to take immediate action and bridge the regulatory gap only if MoH sees expanding outpatient services as a solution to meet the population's health needs[8]. Due to the urgency of program expansion and the need to have sufficient throughput capacity for ambulatory service provision, would it be throughput inpatient or outpatient facilities, MoH needs to take such a decision sooner rather than later. If the MoH decides to include additional outpatient facilities as eligible providers, the MoH should adopt temporary (or minimal standards). It is important to recognize that adopting temporary or minimal standards will not replace the comprehensive standards the WHO will provide later. Instead, it will be a pragmatic approach to address the immediate need and facilitate the program expansion process geographically.
6. **Independent Assessment Commission responsibilities**: Addressing this issue of the IAC requires a thorough review of their rights and duties within the context of the program. Two potential recommendations emerge from this analysis. Firstly, it is suggested that the scope of the IAC's responsibilities be revised to focus solely on administrative tasks, specifically the review of documentation and determination of patient medical eligibility for the program. By limiting their role to administrative functions, the IAC can contribute to streamlining the medical eligibility review process without encroaching on the medical decision-making domain of providers. Alternatively, if the decision is made to retain the IAC's involvement in medical assessments and intervention approvals, it will become imperative to ensure that the commission is composed such that members possess the necessary medical expertise. This can be achieved through comprehensive training programs that equip them with the knowledge and skills required for accurate medical assessments and prescribing appropriate interventions based on physicians' recommendations. By adopting either of these recommendations, the program can address the challenges associated with the IAC's current role and performance.
7. **Service delivery guidelines** would become necessary before new conditions are added to the rehabilitation program. Such guidelines would be necessary to standardize the quality of care and exclusive use evidence-based rehabilitative interventions across the providers.

Limitations

There are several study limitations to note which require careful treatment of the findings. Firstly, the timing of this work, which was conducted before the program rollout, afforded limited time for initial implementation. Most likely, the limited time since the start of the sub-program negatively affected the number of providers engaged in the service delivery, as in total, we were only able to speak to three service suppliers that engaged with the program during different time

[8] With support from R4D and Curatio International Foundation MoH late 2022 already received recommendations about future/expansion needs and is equipped with the information to take decision.

periods and had different length of implementation experience. This lack of diversity in provider and, correspondingly, patient experiences may have influenced the study results and restricted the generalizability of the findings. Albeit, this aspect was beyond the research team's control.

Another limitation relates to the recruitment strategy of participants (patients), which may have resulted in biased sampling (by the provider) towards satisfied patients because patient recruitment was facilitated through a designated rehabilitation program coordinator and they were responsible for obtaining patient’s consent for the interview. This could have resulted in a skewed representation of patient experiences and perceptions and may not fully represent the broader patient population. Additionally, we were unable to interview patients who were denied access to the program. It's important to understand their perspectives, including the reasons for denial and the barriers they are facing.

Despite several attempts by the research team, two representatives from the National Health Agency refused to be interviewed. It is believed that their non-participation in the study may have led to a missed opportunity to obtain additional perspectives on the execution of the rehabilitation program. Specifically, their input helped shed light on program implementation shortcomings identified by other study participants.