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Learning for Action Across Health Systems: Georgia Case Study

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Executive summary

This case study is part of the health systems strengthening project supported by the Bill and Melinda Gates Foundation (BMGF), which aims to explore the current application of evidence in guiding health sector policies globally, and to gather country-level stakeholders' perspectives on how this learning can contribute better to improving the performance of public health systems. The eight countries were selected for cases studies to assess 'why, when, and how' countries learn from each other; they are Bangladesh, Burkina Faso, Cambodia, Ethiopia, Georgia, Nepal, Rwanda, and Solomon Islands. This report presents the case study of Georgia.

Background: Georgia is a small (population around 3.72 million in 2016) lower middle-income country in the Caucasus region of Eurasia, with a life expectancy at birth of 73 (2016), and a gross national income (GNI) per capita, purchasing power parity, of $3,810[1]. Georgia was selected as a case study for three reasons. First, the country pursued broad system-wide reforms after the collapse of Soviet Union, moving from low-income to lower-middle-income – and for a while to upper-middle-income (in 2015 only) – status in the past two decades. Second, it has made significant progress towards achieving the Millennium Development Goals (MDGs). Third, it has pursued extensive health sector reforms, with some directions closely resembling developments in the region, and with others being almost unique and sometimes quite radical.

Reform of focus: We chose the *health financing* and *hospital privatisation* reforms as the units of analysis. The rationale behind the choice was that both of these reforms were significant, and also, while Georgia broadly applied internationally approbated approaches to the health financing reforms, it defined its own pathway for hospital privatisation.

Methodology: We undertook a review of the peer-reviewed and grey area literature. Key informant interviews were a key source of information. A standard set of criteria was applied to select interviewees in Georgia. A standard interview guide (applied to all case studies) was used to collect information (Annex B). Data were verified through email or telephone correspondence, were analysed, and are presented in this report.

Key findings

The following key findings came out of the analysis:

- **The importance of evidence-based policies is fully recognised by key health sector actors in Georgia.** However, evidence is applied with differing intensity along the phases of *conceptualisation, formation, internalisation, contextualisation, operationalisation, and evaluation,* being adopted most in the conceptualisation and least in the implementation phases.
- **The choice and application of evidence is often 'purpose-driven' and predefined by political agenda.** Key decision makers have a critical role in seeking, applying (or blocking), and disseminating evidence.
- **Evidence is best provided when international agencies support healthcare reforms alongside the whole policy cycle** (often through long-term technical assistance (TA) projects). The World Bank, US Agency for International Development (USAID), EU and UN agencies played critical role in supplying evidence to the Government of Georgia (GoG) and helping in its application. When large TA projects cease, UN entities are the main providers of evidence (as they remain in the country). However, their role is limited to supplying evidence primarily in the conceptualisation phase.

[1] World Bank, 2016.

- **Overall, there is limited funding for supporting evidence generation nationally**. While selective players have a say, civil society is still quite weak in regard to accumulating evidence and reaching out decision makers.
- In this context, **the role of national policy institutions is critical in supporting sustained evidence-based policies**. Both the generation/collection and application of evidence is hampered when these institutions are abolished or absent.

Direct implications for BMGF

Three factors emerged from this case study as having the most significant implications for generating and applying evidence:

- First, work with national decision makers is critical, to secure political willingness and a conducive environment for evidence-informed decisions and learning.
- Second, investments in establishing and institutionalising national (health policy) institutions is seen as a valuable support to generating a sustained institutional demand for learning, and creating a continued platform for applying evidence in policy decisions.
- Third, consistency and continuity in supplying evidence, as much as the quality, matters in accelerating learning from other countries (well delivered, large TA projects being an example).

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List of abbreviations

BMGF	Bill and Melinda Gates Foundation
DFID	UK Department for International Development
GDP	Gross domestic product
GNI	Gross national income
GoG	Government of Georgia
HBP	Health Benefit Package
HiT	Health Systems in Transition
HUES	Health Utilisation and Expenditure Survey
M&E	Monitoring and evaluation
MCV	Measles-Containing Vaccine
MDGs	Millennium Development Goals
MoH	Ministry of Health
MoLHSA	Ministry of Labour, Health and Social Affairs
NAs	National Accounts
NHAs	National Health Accounts
NGO	Non-governmental organisation
OECD	Organisation for Economic Co-operation and Development
OPM	Oxford Policy Management
OPPs	Out-of-pocket payments
SHI	Social health insurance
TA	Technical assistance
THE	Total health expenditure
UHC	Universal health coverage
WHO	World Health Organization
UNDP	UN Development Programme
UNICEF	UN Children's Fund
USAID	United States Agency for International Development

1 Introduction

This case study is part of the health systems strengthening project supported by BMGF, which aims to explore the current application of evidence in guiding health sector policies globally, and to gather country-level stakeholders' perspectives on how this learning can contribute to improving the performance of public health systems. The eight countries were selected for cases studies to assess 'why, when, and how' countries learn from each other; they are: Bangladesh, Burkina Faso, Cambodia, Ethiopia, Georgia, Nepal, Rwanda, and Solomon Islands. This report presents the case study of Georgia.

1.1 County selection criteria

Three criteria were used to select countries in which interviews were to be conducted, including the following:

a) the country was low-income in 2000 and made a transition towards an improved economic status;

b) the country has made significant progress against the MDGs; and

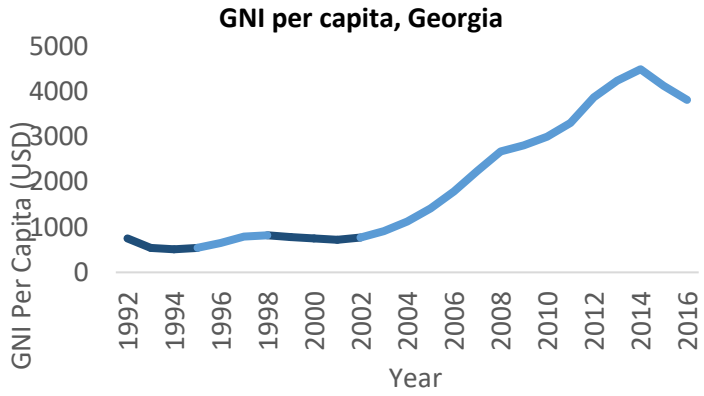
c) OPM has sufficient networks to arrange and carry out interviews in the country.

Georgia meets all three inclusion criteria, as demonstrated below.

1.1.1 Criteria 1: Economic status and progress made

In 2000, Georgia had a GNI per capita of $750, and was classified as low-income. Countries are classified as low-income if they have a GNI per capita lower than or equal to $755 (World Bank, 2017). In the graph below, the dark blue lines represent when Georgia was considered to be 'low-income', and the light blue represents when it was considered to be 'lower middle-income'.

Figure 1: GNI per capita, Georgia (data collected from World Bank, 2017)



Georgia has undergone significant political and economic changes since 2000. Following the collapse of the Soviet Union, the country's development was challenged by civil war, secessionist movements, and an inflow of refugees. This resulted in a dramatic fall in gross domestic product (GDP) (-29.3% in 1993) and hyper-inflation between 1989 and 1994 (World Bank, 2009).

The 1990s saw continued political and economic uncertainty. However, the 2003 'Rose Revolution' created confidence in the GoG's ability to execute national reforms (*ibid*.). Remarkable progress

was made in economic development (GDP growth was 12.3% in 2007) (World Bank 2017), mainly through creating a favourable environment for foreign investments, trade, and tourism. Georgia made immense progress on 'ease of doing business', coming 11th in the world in 2009 and topping business-friendly locales such as Poland, the Netherlands, Japan and Switzerland (GoG, 2009).

From 2012, the new government has continued the pervious administration's low-regulation, low-tax and free market policies while increasing social spending, strengthening protections for workers and encouraging public–private sector dialogue (US Department of State, 2014).

1.1.2 Criteria 2: Progress on MDGs

Georgia has achieved positive results as measured by the MDGs. The MDG Progress Index measures individual countries' progress on achieving specific targets by assessing annual data and accounting for both absolute and relative progress. Indicators are chosen based on accuracy in capturing the original MDGs, data availability, and usage in development literature. Baseline data are compared to current data to measure country achievements, and performance under each target is aggregated. If a country's rate of improvement is above the requirement for meeting the target, it receives a score of 1. Countries that achieve at least 50% of the requirement receive a score of 0.5 (Leo and Barmeier, 2010). In 2011, Georgia achieved a *progress score* of 4.5*,* ranking 29 overall and 14 in its income group (Center for Global Development, 2011).

Georgia has made several improvements in health outcomes since 2000. The under-five mortality rate per 1,000 live births was reduced from 24.9 in 2000 to 13.0 in 2013. Over 90% coverage for the first Measles-Containing Vaccine (MCV) has been maintained. Maternal mortality rate per 100,000 live births was reduced from 49.2 in 2000 to 22.9 in 2012. Georgia is the only Eastern European country to have maintained universal access to antiretroviral treatment, and incidence of malaria per 100,000 has been reduced from 5.5 in 2002 to 0.02 in 2013 (GoG, 2014). See Annex A for a table displaying outcomes related to each MDG.

1.1.3 Criteria 3: OPM in-country network to conduct interviews

Principal consultant Tata Chanturidze, through whom interviewees were identified and contacted, provided the connections necessary to organise in-country interviews. Tata's network in Georgia arises from her role as a Deputy Minister of Labour, Health and Social Affairs in Georgia in 2006–2007, during which time she was involved in health policy development, implementation and oversight; state health budgeting and programme development; primary healthcare and hospital reforms; and collaborating with associated stakeholders, clients, and colleagues.

1.2 Identification of 'tracer' reforms

Two reforms were selected to demonstrate how the conceptualisation, implementation, and evaluation of policies are influenced by evidence and learning from other countries. These reforms involve *health financing* and *hospital privatisation*. The selected reforms were determined to be appropriate for the study since they have both been of fundamental importance in shaping the current healthcare system. Furthermore, it is generally understood that these reforms differ with regards to their origin: the health financing reforms were largely based on the advice given by international agencies, while hospital privatisation was the result of nationally-driven efforts.

1.2.1 Health financing reforms since 1995

After the collapse of the Soviet Union in 1991, Georgia felt an increasing need to fund its healthcare system in the midst of sudden political and economic changes. the total health expenditure (THE) as a percentage of GDP fell to 0.3% (WHO Health for All database, 1995) and out-of-pocket payments (OPPs) increased dramatically to above 75% of THE (Ministry of Health (MoH) Georgia). In response, the GoG introduced the Social Health Insurance (SHI) scheme in 1997, in which '3%+1%' contributions were to be collected from employers and employees, respectively. The concept envisaged collecting the SHI contributions purely from the formal sector, acknowledging a lack of means to collect it from informal sector, as well as reflecting an understanding of the implications of high unemployment rates on fund pooling. Meanwhile, the promise was that all layers of the total population would have universal access to health services. The State Medical Insurance Company was established to receive accumulated funds and purchase services. In the short-run, it appeared evident that the scheme was not viable.

Following the Rose Revolution in 2003, the new government pledged to reform social welfare and achieve improvements in health for the entire population (Naylor, 2008; Schaapveld and Rhodes, 2004). The government was faced with the challenges of addressing the high of OPPs, maintaining the deteriorated and excessive health infrastructure, and dealing with growing inequity in access to health services (Chanturidze *et al*., 2009). Trust in the new government triggered donor interest following a conference in 2003 in Brussels, resulting in a pledge of $1 billion (Gotsadze *et al*., 2005). International aid organisations started to support health sector strategic planning, health financing, and primary healthcare reforms (Rukhadze, 2013; Naylor, 2008).

The new government abolished the SHI and re-established a budget funding system for healthcare. The funding was linked with 'selected categories' of the population, who became beneficiaries of vertical state health programmes. These categories were identified based on a 'proxy-means testing methodology', proposed by the World Bank, and included the poorest and most vulnerable (Chanturidze *et al*., 2009). In 2006–2007 the GoG made the decision to engage the private insurance industry in procuring health services under the state health programmes. While the reform increased access to and utilisation of services by the socially vulnerable, it generated dissatisfaction in a large part of the population who were left out of the state coverage. This was accompanied by the dissatisfaction of medical personnel who received pressure from the private insurance sector to treat an increasing number of patients, with poor remuneration. Cream skimming was another cited result of this market-based approach (Sehngelia *et al*., 2016).

The third wave of health financing reforms started in 2012, with a new government coming into power that committed to universal health coverage (UHC). The concept of the reform was to significantly increase state allocations to the health sector; to cover additional target groups, particularly the elderly and children; and to propose more generous entitlements to all others (e.g. universal coverage for emergency and urgent care for all) (*ibid*.). This required a significant increase in state allocations to the health sector. Indeed, public spending on health as a percentage of GDP increased from 1.3% in 2012 to 2.24% in 2015 (Ministry of Labour, Health and Social Affairs (MoLHSA), 2016). The state started to administer public finding, substituting the private health insurance industry in this role. Selected studies signalled positive implications of this reform (e.g. increased public satisfaction, MoLHSA, 2014); however, overall outcomes and impact have yet to be assessed. Commonly cited features of these reforms, albeit among scarcely available literature, include: lack of purchaser-provider separation, low official reimbursement rates, patient unawareness of official hospital costs, and low productivity of physicians (*ibid.*).

1.2.2 Hospital sector reforms

In 2003–2006 the MoLHSA, with the support of aid partners, was working intensively on a broader health sector reform comprising hospital and primary healthcare sector reorganisation. The vision was to strengthen the role of the state in organising, managing, and regulating service provision, and investing in the renovation of state-manged hospitals and primary healthcare facilities. The reform proposal was rejected by the new government in 2006 as it opposed the ultra-liberal spirit of the country's development strategy at the time. The presiding argument was that healthcare may be more effectively provided by increasing the role of the private sector (Megrelishvili and Chanturidze, 2008). A new health reform strategy was adopted based on almost full privatisation of health service provision and simplification of government regulations (*ibid*.).

The Hospital Development Master Plan (2007) aimed at attracting private investments for renewing the hospital network. The Plan determined total hospital sector capacity, the location of inpatient facilities based on a 45-minute geographic accessibility, an optimal number of hospital beds based on population needs, types of hospital services, and conditions for the operation of hospitals (Chanturidze *et al*., 2009). The privatisation process was jointly run by the Ministry of Economic Development and MoLHSA, and was overseen by the Prime Minister.

By 2010, over 70% of government health facilities were sold to private owners (MoLHSA, 2016). It was largely understood that the main objectives of the reform had materialised: sufficient investments were brought to innovate the hospital sector and hospital infrastructure was rationalised. However, the speedy privatisation process generated substantial undesirable consequences, with the following being detrimental: (i) the regulatory framework was poorly developed to enable good governance of privatised hospitals, resulting in poor procurement, cost escalation, and worsened quality of services; (ii) since all types of investors were allowed to participate in the hospital privatisation process, large pharmaceutical companies took over hospitals, monopolies developed, and prices increased (*ibid.*).

2 Methodology

2.1 Aims of the study

The purpose of this assessment is to understand the current application and contribution of international (and national) evidence in guiding policies in Georgia, and to gather country-level stakeholders' perspectives on how they could better use other countries' experiences.

Overall, the assessment sought to answer the following questions:

1) 'How do decision makers at country, state, and province levels access ideas and evidence about how to make their health systems work better and where does international evidence fit in that picture?'; and
2) 'What gaps do decision makers at country, state, and province levels perceive in their access to appropriate evidence in general, and evidence about other countries' experiences in particular?'

The final recommendations of this case study aim to examine the mechanisms that are currently being used which may be further strengthened by investment and the spaces for new initiatives.

2.2 Approach and methodology

The study was conducted by a senior consultant with in-depth knowledge of the selected country and a research assistant who assisted in data collection and analysis.

2.2.1 Selection of interviewees

A standard set of criteria (developed for all case studies) was applied in order to select interviewees in Georgia. This included identifying respondents from the following five categories:

- politicians with health policy portfolios;
- senior civil servants in health ministries;
- senior health advisers in international organisations;
- health system experts (independent and civil society representatives); and
- academics.

Annex C summarises the selection categories of, and positions held by, interviewees currently and/or in the past. Names were taken out from this table to comply with the Chatham House rules.

2.2.2 Interview guide

Interviews were semi-structured and were based on a standard interview guide used in all of the case studies. The guide focuses on six stages of policy development, namely conceptualisation, formation, internalisation, contextualisation, operationalisation, and evaluation. These stages were identified in a scoping review written prior to the in-country interviews, the goal of which was to understand the mechanisms through which policy transfer takes place (McPake *et al*., 2017). The main questions support soliciting information on how policy was developed throughout those stages with an emphasis on the type of evidence used, the perspectives of decision makers, the knowledge of interviewees about the processes of using evidence, and methods for sharing evidence. The guide also includes probing questions which the researchers could choose to employ if appropriate.

Interviews were not audio recorded due to the politically sensitive nature of the reforms in question; however, notes were taken. Data were then verified through email and/or telephone correspondence and references collected during the assessment.

2.2.3 Data analysis

The findings from the interviews were considered with respect to the goals of the study. Analysis of the findings considered how interviewees positioned themselves in relation to the six phases of policy transfer; the use of evidence throughout the development of the reforms; perspectives on what helps and hinders learning from the experiences of other health systems; institutions and mechanisms that facilitated policy transfer; and the implications for future investment in opportunities for cross-country learning.

2.2.4 Ethical considerations

Respondents requested that their names not be mentioned in the case study report. They did give consent to refer to the positions they held in the past and currently in cases were these positions did not automatically reveal the respondent's identity. Therefore, we apply the Chatham House rules, which allow for participants to be acknowledged but specific comments and opinions kept un-attributable to the individual from whom they were collected. Interviewees were advised of these procedures when they consented to the interviews.

3 Results

3.1 Positioning of interviewees in relation to policy transfer

Interviewees were involved in the identified health financing and hospital privatisation reforms in a multitude of capacities. Some interviewees were formerly directors and vice ministers within the MoLHSA, with policy, regulation, and administration roles. Others served as health policy advisers and specialists advising key decision makers in health. Interviewees who influenced policy development outside of public agencies include those from universities, non-governmental organisations (NGOs) and consultancies. Interviewees were engaged primarily in advising key reforms concepts, implementing reforms, and/or assessing the effectiveness of health policies and the health system in Georgia.

Overall, most interviewees were able to comment on each of the stages of policy development identified in the interview guide. Responses were largely consistent with each other, despite some differences in interviewees' backgrounds with regards to their political and/or practical opinions on the reforms as they were being implemented. This may be due to the nature of the research which is focused on the mechanisms of learning.

The following sections describe the results of the interviews concerning the conceptualisation, formation, contextualisation, internalisation, operationalisation, and evaluation of policy; and the facilitators of, and barriers to, evidence-based policy. A brief conclusion regarding the results is then given.

3.2 Conceptualisation

The health financing and hospital privatisation reforms were understood by interviewees to have quite different origins. **The concept for introducing UHC,** which was noted by several interviewees to be a mostly typical illustration of the development of health policies in Georgia, **was set forth by international agencies and subsequently adopted by the GoG**. WHO and the World Bank suggested the introduction of UHC in Georgia and played important roles in the conceptual and planning stages of the reform. While WHO was largely cited as the originator of the idea, interviewees consistently mentioned WHO's inability to provide support in the implementation of the reform, attributing this to lack of funding.

Conceptualisation of hospital privatisation, however, is largely considered to be the result of political motivations, and to some extent theory-driven ideology held by key decision makers within government. Prior to formation of the policy, the GoG had requested assistance from international agencies and organisations in the development of a plan for rationalising and optimising Georgia's hospital sector assets. While the World Bank proposed a plan for hospital restructuring in 1998 which essentially differentiated hospitals that could be left in the public domain, privatised, or no longer used for healthcare provision, opposition parties in the early 2000s halted these plans. A change in government after the Rose Revolution brought in two companies, Conseil Santé and Scandinavia Care, to provide assistance in developing a second hospital rationalisation plan. During this time, USAID assisted the GoG in developing a hospital accreditation system partnering with Abt Associates, Curatio International Foundation, and CARE International. In 2003, the government focused on primary healthcare reform and was supported by the UK Department for International Development (DFID), the World Bank, and the European Union. The primary healthcare reform support programme, funded by DFID, was implemented by OPM.

Despite significant involvement of the international and donor communities in the planning for hospital sector reform in previous years, the idea of large-scale privatisation of hospitals in 2006–2007 is largely attributed to the State Minister in charge of all public sector reforms. He created the concept of attracting investments and collecting funds for hospitals in order to substitute outdated infrastructure and equipment. The rationale for a private sector approach was the lack of public funds to maintain state-owned and operated hospitals, and the necessity to update or replace excessive hospital infrastructure. Interviewees mention that the State Minister frequently referred to the liberalisation theory of Milton Friedman (Friedman, 1962), who argues for economic freedom as a precondition for political freedom. The State Minister reportedly discussed the concept with the Prime Minister, by whom it was approved.

Opponents of the radical hospital privatisation included representatives from the MoLHSA (including selected vice ministers), and the First Lady who believed that ultra-liberal approaches should not be driving (or at least should be carefully applied in) health sector reforms. Concerns were also communicated by the World Bank, European Commission (EC) and other international agencies. Concerns from international agencies mostly addressed the speed and scale of privatisation. Also, agencies were unsure that allowing all types of investors to own and operate hospitals would produce effective results or improved health outcomes. Pharmaceutical companies, for example, already had a vested interest in hospitals promoting pharmaceuticals, whereas development companies had limited knowledge of the health sector in general. However, both of these types of investors were allowed to participate in tenders and subsequently became hospital owners.

3.3 Formation and contextualisation

Evidence during the formation and contextualisation phases of reforms within Georgia is produced primarily from three sources: (i) international databases; (ii) independent studies and surveys conducted by international organisations, universities, and NGOs; and (iii) national public institutions, such as the National Centre for Disease Control and Public Health and the National Statistics Office of Georgia, which publish national accounts, National Health Accounts, annual health statistics, and reports.

In regard to the health reforms, evidence collected from within Georgia largely indicated a recognition of the need for health reform, while evidence from other countries informed how health financing reform could be implemented. Reports consulted during the health financing reform included:

- National Health Accounts reports (produced annually);
- National Health Reports (produced annually);
- Health Systems Performance Assessment reports (produced in 2009 and 2012);
- Health Utilisation and Expenditure Survey reports (produced in 2008, 2011, and 2014); and
- Health Systems in Transition, Georgia, 2002 and 2009.

While these documents provide information on the key characteristics of health financing, they do not include information necessary to guide the health network reorganisation or health service delivery. Some of these tools (e.g. HUES in 2014) were designed and continue to be mostly focused on population satisfaction with health services. They were each applied in the health financing and hospital privatisation reforms to differing degrees.

Some evidence from other countries was obtained and utilised in the formation of UHC. The MoLHSA assigned its policy department staff to examine evidence from UHC initiatives in other

Eastern European countries. Additional evidence was provided by the World Bank, WHO, and USAID on how other countries organised their UHC reforms and how they achieved efficiency gains. From annual policy forums which were organised by the MoLHSA, with the engagement of the World Bank, WHO, and USAID, there was a mobilisation of stakeholders who shared the UHC objectives.

The process of forming the hospital privatisation reform (once it had been conceptualised largely by the State Minister), involved: conducting situation analysis to examine existing hospital network capacity, identify major gaps, and inform decision making on strategic priorities; conducting analyses of international evidence on hospital care models (specifically regarding the ownership, effectiveness, and efficiency); a national consultative process led by the State Minister's office; and endorsement of a concept, and implementation and enforcement measures, by the government.

Key decision makers had identified continued public ownership and operation of hospitals to be financially unsustainable. The State Minister, though the MoLHSA, formulated hospital privatisation in a Hospital Investment Programme in 2006–07.

Respondents identified key factors which enabled speedy implementation of the hospital privatisation reform, including:

- the creation of a national development strategy to liberalise the economy and apply liberal approaches in public sectors;
- the identified need to upgrade and substitute outdated hospital infrastructure;
- strong leadership from the State Minister and substantial technical support from the MoLHSA; and
- the consent of the MoLHSA leadership to liberalise the health sector.

Evidence for the formation of the hospital privatisation reform was searched locally and from other countries. Data were collected on existing hospital sector capacity (e.g. number and type of beds, acute vs. long-term care hospitals, accessibility and utilisation criteria, etc) and were analysed by the MoLHSA. This included primary data from Regional Health Departments, and secondary data from annual health statistics reports. Evidence on hospital sector capacity was also sought from other EU countries. Examined sources included WHO databases, reports and publications on hospital sector development in EU countries, including regulatory requirements and standards for hospitals of different profiles, and publications of the European Observatory for Health Systems and policies.

Although international agencies were consulted, for instance the World Bank and EC, their reservations concerning hospital privatisation were not necessarily considered. Other consultations were held with potential investors to understand what would make a hospital sector reform attractive to them, and to take their requirements into account while formulating tender requirements and templates for contracts.

Thus, while evidence did inform the formation and contextualisation of the health financing and hospital privatisation reforms, the government had a larger and more *politically-disposed vision for how reforms should be formed and implemented.* Interviewees overwhelmingly cited **political influence** as the main driver for how policies are formed in Georgia. A couple of respondents mentioned that policymakers consider political motives, specifically for election purposes, and therefore politically relevant and attractive policy options, before considering the extent of the policy issues, the implications of suggested reforms, or evidence from local or international contexts.

Connected to the role of political influence is **the role of key decision makers**, which almost all interviewees identified as critical for the formation of the identified health policy reforms. Reforms in Georgia are sometimes decided 'in the moment', as one respondent noted, and depend on the politician who is in the leadership position at the time. Evidence is considered by decision makers when it is politically relevant and locally-applicable, superseding the international evidence that may be more difficult to contextualise. For example, while evidence on efficiency in relation to the size of hospitals was considered, decisions were made to maintain hospitals with 50 or less beds in small Rayons, bearing in mind Georgia's specific needs.

Respondents also named **international aid agencies as influential actors affecting policy formation** in Georgia, especially those that support TA projects and accompany reforms through the entire health policy cycle. For example, due to the advocacy and technical advice provided by the World Bank, the very first health financing reform was shaped and undertaken from 1997 onwards, helping the government to introduce SHI. Later, in the mid-2000s, means-tested approaches suggested by the World Bank were introduced to identify beneficiaries for healthcare provision. Finally, the latest health financing reforms introducing UHC were fully informed by the World Bank and WHO.

In addition to the important influential factors and players mentioned above, respondents mentioned a few instances in which **advocacy by civil society and the private sector** shaped the formation of health policy. For example, doctors lobbied for the UHC programme because they wanted to secure funding from the government. Similarly, the private insurance industry heavily lobbied for state funding to be given to the private insurance sector for administration, and they succeeded. Advocates of hospital privatisation included insurance and pharmaceutical companies, who became owners of hospitals though the hospital privatisation reform, and who continue to own a large portion of hospital infrastructure to date.

3.4 Internalisation

Respondents referred to **formalised systems for internalisation which are followed in the case of all policies that are introduced in Georgia**. This process includes the following steps: Once the concept for a policy or reform is finalised, politicians discuss it with other policymakers, parliamentarians, and local and international experts. The finalised reform concept is translated into a State Programme if state funding supports implementation. This concept is shared with line ministries and aid partners for feedback. The programme is then updated to reflect the received feedback, and the final version is submitted to the Governmental Committee for approval. It is then submitted to the Parliament to be approved and reflected in regulations. Thus, there is a formal procedure to achieve minor refinements in a suggested policy and seek consensus between different stakeholders.

Aside from the systems of internalisation that are used by public agencies in Georgia, the importance of political influence and the role of decision makers are reflected similarly in processes of internalisation. **Political imperatives may be the reason why evidence exists and is recognised, but is not used by policymakers**. It is largely understood by interviewees that reforms are determined by political imperatives, such as liberalisation and moving to private ownership in the case of the hospital reform, and stronger state involvement and governance in the case of the recent health financing/UHC reforms. This is why policymakers disregarded opposing views – for example, valuing 'economic growth' over 'soft, human issues' – during hospital privatisation, as one respondent noted.

Moreover, **interviewees stressed the need to adapt evidence to local contexts** to improve a policy's fit for the national socio-economic and cultural context of Georgia. They also underlined

the power of nationally generated evidence. For instance, one interviewee referred to the fact that while the UHC agenda was initially promoted by the WHO and World Bank, it was partially due to the presentation of evidence collected internally that the need for UHC was recognised by the government and was subsequently adopted. This evidence included:

- the National Health Accounts report in 1999, which revealed that OPPs were above 75%, thus supporting the introduction of UHC;
- the Household Budget Review in 1999–2000, which further supported the findings on OPPs; and
- an insurance sector survey of 2012, and opinion polls conducted in 2012, 2014, and 2015, which continuously drew attention to the need for government to reform health sector financing.

3.5 Operationalisation

Operationalisation is generally understood to be a process that is not sufficiently supported by evidence in Georgia. One of the reasons for this that was mentioned by respondents relates to the lack of support for implementation from international agencies and donor partners. Perhaps as a result of this, interviewees generally described the implementation of health financing and hospital privatisation reforms as being poor. Some illustrations of this include references to outdated and irrelevant service purchasing mechanisms, with no means to influence service costs, quality, and delivery patterns. This is compounded by the fact that the great majority of service providers are private and function under poor regulatory frameworks. As a consequence, the government is now facing a deficit for the UHC State Programme and is adding about 50–60 million GEL (Georgian currency) to the state health budget every year to cover the shortage, as one of the interviews stated.

Overall, however, respondents noted that UHC has been successful, providing 90% of Georgians with publicly financed health services, up from 25% in 2010 and 40% in 2012. In addition, people are more likely to see a healthcare provider when sick, OPPs have been reduced (especially for outpatient exams and inpatient care), and population satisfaction with health services has significantly increased.

Evidence that affects the operationalisation of health policies comes from a mix of locally- and internationally-produced data. For example, local experts, especially in narrow specialties such as tuberculosis and mental health (although less so with regards to health systems), work with the MoLHSA to inform best practices in health service delivery. Overall, respondents agreed that more national experts are needed to inform the implementation of policy.

Evidence from international agencies with regards to operationalisation has been inconsistent. Between 2000 and 2005 international agencies including the World Bank, DFID, and EC supported the implementation of health reforms through large-scale TA projects. These projects provided support to the MoH and MoLHSA in applying international evidence and best practice examples at the stage of operationalisation. TA projects are no longer implemented, however. Interviewees consistently cited the discontinuation of such projects as a large deterrent to the use of evidence from other countries. Respondents agreed that while WHO is helpful in conceptualising policy, it does not provide assistance in implementation. WHO does, however, provide evidence on how other countries are implementing UHC. Respondents noted that this information is useful, specifically regarding how other countries increase their budgets and improve efficiency.

Interviewees pointed towards situations in which support for the operationalisation of health policy reforms has failed due to *competing private sector interests and the inadequacy of support*

organisations. One example that was provided was of powerful pharmaceutical companies rejecting generic drugs because they can limit sale of drugs that are most expensive: they initiated a campaign to damage the image of generics and were successful in achieving this, despite the GoG's attempt to avert the process.

3.6 Evaluation

Although regulations on evaluation are in place, interviewees largely agree **that structures, processes, and expertise for evaluation need significant development in Georgia's health system**.

Formally, regulation obliges state agencies to undertake monitoring and evaluation (M&E) of state programmes. The 'Basic Data and Directions' document prepared by the Ministry of Finance asks all line ministries to conduct M&E of state programmes, and a separate government decree states that public sector programmes should conduct analysis of all stages of policy cycle. A new government document for standards on policy writing and monitoring was circulated in 2016. Outside of government regulations for evaluation, a conditionality of a World Bank loan requires that the government conducts public expenditure reviews.

These processes, however, are normally undertaken to follow regulatory requirements rather than to learn from programme performance, observe strengths and weaknesses, and apply findings. Most state healthcare programmes through which state funding is channelled to providers do not properly implement M&E frameworks. Vigorous evaluation of the health financing and hospital privatisation reforms has not yet been conducted.

Interviewees attributed inadequate evaluation to two primary factors: lack of capacity and lack of funding. It was agreed that there is limited capacity in the public sector to conduct M&E properly, report findings, and learn and improve based on identified outcomes. Moreover, there is fragmentation in the current registration and reporting structures. Because of the various information systems that are operating currently in the health sector, the data collected and reported by separate agencies are inconsistent. As a result, there are problems with the quality of evidence that is offered to policymakers. Other interviewees mentioned lack of funding as a barrier to evaluation, and that spending on evaluation is seen as 'wasted money'.

Some interviewees mentioned that when information cannot be sought locally, evidence about current implementation is sought from the WHO and World Bank.

3.7 Facilitators of, and barriers to, evidence-based policy

Many respondents agreed that even though the importance of evidence is clearly recognised, evidence is not consistently utilised. They mentioned the existence of various gaps that limit the use and application of evidence.

Some respondents attributed this issue to the **limited capacity to analyse and interpret evidence**, others referred to **limited willingness to search and analyse evidence.** Few respondents referred to a recently published annual audit report by Georgia Health Care Group, the largest health service provider in Georgia, which owns the pharmaceutical industry, hospital and diagnostic networks, and outpatient facilities, showing that they had 'a 26.6% market share as of 31 December 2015, with 2,670 hospital beds, with the widest geographic coverage among its peers with facilities located in six regions that contain three-quarters of the population of Georgia'. 'GHG was also the largest medical insurer in Georgia with a 38.4% market share as of 31 December 2015, based on revenue and with approximately 234,000 people holding GHG's

medical insurance policies as of 31 December 2015.' (BGEO, 2015: 5). Respondents argued that, from the perspective of application of evidence, these facts should prompt the GoG to more profoundly analyse the limitations in the purchaser/provider split, the restricted ability of the state to negotiate price and quality with monopolist providers, and the broader issues around the sustainability of the system.

Respondents gave more examples to illustrate gaps existing in local capacity to generate, collect, and analyse evidence. It was mentioned that **the absence of a state policy institution, where evidence could be collected, analysed and shaped on a continuous bases in a policy-friendly format, enhances current gaps in the evidence base.**

Others think that **the value of evidence and evidence-based policy is undermined in selected cases**. For example, internally conducted assessments and surveys, as well as feedback from the general population, pointed towards including a minimum package of pharmaceuticals and services for chronic patients in state financing. This knowledge was not immediately used to revisit the state programmes; however, better understanding of it was developed years after.

Respondents stated clearly that **there is a prioritisation of political objectives over evidence-based thinking**. Often the choice of evidence is subjective and 'purpose-driven', used to support political choices or to persuade the government to favour a particular reform. One interviewee argued that political priority has not been effectively matched with the needs and opinions of the population. Hospital privatisation, for instance, was largely a social transformation in addition to an economic one that in many ways created social resistance to reform. People then protested when mechanisms for ensuring access were not implemented properly.

Another 'gap' is **the 'merging' of stages of policy development, rather than recognising, delimitating, and implementing them as separate processes. Interviewees consistently argued that a six-stage policy development process (used by this report) is unrealistic**. Although the MoLHSA may recognise that sequential planning is important, it is not implemented. Because some stages, such as contextualisation and internalisation, are omitted, the collection of evidence as it applies to these stages is also 'not happening'. Moreover, 'gaps' in the use of evidence, such as time constraints, unavailability of data, and the influence of the election agenda, are further amplified. One interviewee stated: 'I can't name any government (at least in the post-Soviet region) that is willing to spend the entire duration of their electorate time in carefully preparing reforms, as they need to show results to be re-elected.'

Further example of a 'gap' **is the absence of TA projects funded by aid agencies, which had largely contributed to the evidence base in previous years.** At the moment, there is a lack of support from international agencies to health sector reforms, which limits access to and application of evidence that was previously provided through large-scale TA projects. Multi-year TA projects by international agencies are no longer implemented, as some donors have left the country due to its socio-economic status (no longer low-income), others do not prioritise health sector support in Georgia.

Furthermore, **civil society is weak in generating and advocating for evidence.** There are only a couple of organisations that can work at the policy level, others are not particularly active. Partially as a result of this, private sector interests that compete with the use of evidence (e.g. the unwillingness of pharmaceutical companies to sell non-profit-making drugs) prevail.

Most interviewees did not identify specific institutions that constrain the use of evidence, however some gave examples of how evidence was at times more or less handled. One interviewee mentioned that since hospitals receive more funding for conducting C-sections, doctors are recommending C-sections unnecessarily and report the rise in C-sections as attributable to

complications in which babies are in the bridge position. However, it is improbable that there would be such a large increase in these complications (based on international comparisons). Evidence is therefore shaped to meet the needs of the provider.

Interviewees were largely consistent in their recommendations for the mechanisms that can be introduced to improve the use of evidence in policy. The most common recommendations included the following:

- **The establishment of a health policy institute or a national body for evidence-based policy,** a sort of 'think tank' that would help the MoLHSA with producing, understanding, and using evidence in the health sector.
- **The need for increased involvement of international agencies in the provision of evidence**, specifically the involvement of agencies that are credible.
- Although **conferences and discussion forums** are mentioned as a useful medium for familiarisation with evidence, a need for more profound and in-depth support for projects was underlined. In this respect, **donor-supported TA projects and international consultations that bring knowledge on applied evidence are seen as effective.**

Organisations that are mentioned as effective at promoting evidence-based policy include those that maintain broad international experience at the same time as staying immersed in their knowledge of the Georgian context **(**e.g. the Curatio International Foundation); those with experience of informing reforms in low- and middle-income countries (such as OPM); those that have worked on the regionalisation of health services at hospital and outpatient levels (such as John Snow University); and those that can assist with assessing the performance and quality measures of health services (such as the Joint Commission)[2].

Other countries have been interested in learning from Georgia's experiences of health policy reform. Learning from/by other countries has been achieved through the following initiatives:

- Health ministers and officials from Armenia, Kazakhstan, Ukraine and Moldova visited Georgia to learn about UHC and hospital privatisation.
- The World Bank organised meetings on UHC in Georgia that were attended by colleagues from former-Soviet countries.
- Ministers from Georgia present at conferences to show what Georgia is doing, such as at regional committee meetings for the WHO and EU meetings.
- Health financing courses in Barcelona run by the WHO and WHO publications highlight Georgia as an example of successful health financing, largely as a result of UHC, which has decreased OPPs from 75% to 57% over the last few years.

[2] We appreciate this list might be limited to the experience of the respondents within the named organisations.

4 Analysis/discussion

4.1 Patterns across the six stages of policy development

4.1.1 Use of systematised evidence

The importance of systematised evidence is fully recognised by health sector actors in Georgia. However, the application of it varies across the policy process.

In analysed the health financing reforms undertaken since 1995, **evidence was intensively collected and applied throughout the conceptualisation and internalisation phases**. The internalisation phase is fairly standardised and strictly followed as part of the GoG's official regulatory framework requirements. The conceptualisation phase attracts national and international stakeholders and allows time for policy discussions and consultations. Therefore, the application of evidence in these stages has been fairly consistent.

Policy stages where evidence is applied the least in Georgia include formation, contextualisation, and operationalisation. Monitoring systems, processes and practices need further refinement and improved capacity building. The absence of evidence-based thinking in implementation has detrimental implications for the healthcare sector. Reform initiatives are often pursued without investing in the systems, instruments and processes that should support these reforms. Subsequently, the limited introduction of relevant systems or instruments while new concepts materialise often results in failure due to poor implementation, compromising the entire reform initiative.

Evidence-based policymaking practice was more explicit in early 2000s and became weaker in late 2005, being re-established in 2013 with the emphases on UHC. Reforms in 1995 beyond health financing were profoundly supported by international agencies through TA projects, which reinforced evidence-based thinking in design, but also the formation, contextualisation and implementation stages. This trend was discouraged in late 2005 when the new government brought an ultra-liberal vision to health sector, without a particular search for evidence on its implications. The drift was reverted in 2013th in relation to the UHC agenda.

4.1.2 Balance between cross-country learning and other types of evidence

This assessment demonstrates that **systematised evidence and learning from other countries is searched for equally, but applied differently in various health sector reforms in Georgia**. Some of the factors influencing the differentiated uptake include the political will of the government to guide decisions by evidence; the availability of evidence; and national capacity to generate, analyse and apply evidence.

This study demonstrates that evidence from other countries, as well as systematised sources, was searched for during both the hospital and health financing reforms. Organisation for Economic Co-operation and Development (OECD)/EU countries in particular were targeted to gather international evidence, and studies undertaken systematically were used to solicit evidence from within Georgia. The study also shows that evidence from both international and systematised sources was not always readily available. Due to the poor national capabilities and limited resources evidence gaps were not always filled in.

This suggests that **future investments in cross-country learning and evidence uptake for Health Systems Strengthening (HSS) needs to be grounded in strengthening national**

capabilities to solicit evidence from both systematised sources and other countries, but also in enhancing the supply/ availability of international /systematised evidence.

4.2 Institutions and mechanisms supporting evidence

Organisations that are mentioned as effective at systematising and promoting evidence-based policy can be categorised into two clusters: national and international actors.

National actors include:

- top government (e.g. the State Minister in charge of public sector reforms) and the MoLHSA;
- The Health Management Centre (a public institution affiliated with the MoH) in the period from late 1995 to early 2000;
- The Health Policy Institute in 2005; and
- selected members of civil society (e.g. Curation International Foundation (an NGO); PMCG (an NGO); and selected individual health experts).

International actors include:

- aid partners: World Bank, USAID, DFID, EC, and UN agencies, especially UNICEF and WHO on a continuous basis, but more recently also UN Development Programme (UNDP) and INFPA; and
- consultancies: OPM, the Joint Commission, John Snow University, Abt Associates, CARE International, Conseil Santé, and Scandinavia Care (This list should be treated with caution, as it is not comprehensive and represents companies the interviewees worked / are familiar with).

Instruments and products that support evidence uptake in Georgia include:

- National Health Accounts reports (produced annually);
- National Health Reports (produced annually);
- Health Systems Performance Assessment reports (produced in 2009 and 2012);
- Health Utilisation and Expenditure Survey reports (produced in 2008, 2011, and 2014);
- the 'Basic Data and Directions', Ministry of Finance, 2016;
- Health Systems in Transition, Georgia, 2002 and 2009; and
- Public Expenditure Review, Ministry of Finance, 2016.

The extent to which these institutions and mechanisms facilitate a robust consideration of evidence and its relevance to the policy is discussed above.

4.3 Potential facilitators of evidence

Suggested mechanisms and institutions identified through this case study by which evidence can be systematised and learning from other countries could be introduced include the following:

- the establishment of a national health policy institute to be affiliated to the MoLHSA, with a portfolio of supporting evidence-based policymaking;
- renewed focus on comprehensive TA projects supported by aid organisations to provide long-term support to healthcare reforms throughout the policy cycle;
- health systems performance assessments and performance assessments of health service institutions;

- greater emphases on small-scale assessments and studies to inform the formation, implementation, and evaluation of specific health reforms;
- greater participation of national government and stakeholders in international forums and conferences; and
- strengthening civil society 'know-how' and engagement in health sector reforms.

4.4 Implications for future investments

Three factors emerged from this case study as having the greatest implications for generating and applying evidence:

- **Work with the national decision makers is critical, to secure political willingness and a conducive environment for evidence-informed decisions and learning.**
- **Investments in establishing and institutionalising national (health policy) institutions is seen as a valuable support to generating a sustained institutional demand for learning, and creating a continued platform for applying evidence in policy decisions.**
- **Consistency and continuity in supplying evidence, as much as the quality, matters in accelerating learning from other countries (well delivered large TA projects being an example).**

Thus, to stimulate learning between countries and uptake of evidence, the BMGF may wish to consider supporting the following:

- the establishment and organisational development of the National Health Policy Institute (a public body under the MoLHSA to support identification and utilisation of evidence);
- long-term TA projects to support health financing, health service organisation, and governance reforms;
- health sector performance assessments and performance assessments at organisational level (e.g. service providers, service purchasers, and policy institutions);
- small-scale surveys and studies to inform particular reform initiatives; and
- national participation in international forums and conferences.

5 Conclusion

Interviewees who were consulted throughout the course of the study provided rich insights into the development of the health financing and hospital privatisation reforms in Georgia from a variety of perspectives, both within and outside of government. The results demonstrate how evidence is used and reveal gaps in current application of evidence to health policy reforms.

Overall, the importance of evidence-based policymaking is clearly acknowledged in Georgia. Learning from other health systems, as well as from the evidence sourced within the country, did emerge as a strong factor. However, even if evidence is provided 'systematically', both from internal and external sources, it may not be consistently considered or utilised, being diluted by the political agenda. The evidence is best traced and applied at the conceptualisation stage of reforms, while in the contextualisation and operationalisation phases there is a lack of its uptake. Similarly, while the internalisation of policies is fairly standardised, monitoring systems and practices need further refinement and strengthening.

Key findings of the study highlight a need for (i) intensifying work with the national decision makers to secure political willingness and a conducive environment for evidence-informed decisions and learning; (ii) investing in national health policy institutions to generate a sustained institutional demand for knowledge transfer, and creating a continued platform for applying evidence in policy decisions; and (iii) ensuring consistency, continuity, and quality in supplying evidence (well delivered large TA projects being an example).

References

BGEO (2015) 'BGEO group: Capturing growth opportunities, a platform to develop talent. Annual Report 2015'. Retrieved online. http://192.168.1.1:8181/http://bgeo.com/uploads/annualreports/2015-737.pdf

Center for Global Development (2011) 'MDG Progress Index: Gauging Country-Level Achievements'. Washington, DC: Center for Global Development.

Center of Medical Statistics and Information (1999) Georgia health care statistical data 1998. Tbilisi: Center of Medical Statistics and Information.

Chanturidze, T., Ugulava, T., Duran, A., Ensor, T., and Richardson, E. (2009) 'Georgia: Health system review'. *Health Systems in Transition* 11(8): 1–116.

Friedman, M. (1962) *Capitalism and Freedom*. Chicago: University of Chicago Press.

Gotsadze, G., Cashin, C., Zoidze, A., and Valdin, J. (2005) 'Descriptive background to health care financing reform strategy development in Georgia'. Abt Associates Inc., Care International, Curatio International Foundation, and Emerging Markets Group. Retrieved online. www.abtassoc.us/reports/HCF_Background_Paper_ENG_fin_05_2005(Georgia).pdf

GoG (2009) 'Georgia ranks #11 in ease of doing business 2010, the only Eastern-European country in top 20'. Retrieved online. http://gov.ge/files/34_29526_968146_GEORGIARANKS11INEASEOFDOINGBUSINESS2010, THEONLYEASTERN-EUROPEANCOUNTRYINTOP20.pdf

GoG (2014) 'Georgia National Report on Progress Towards Achieving the Millennium Development Goals'. Retrieved online. www.ge.undp.org/content/dam/georgia/docs/publications/GE_UNDP_MDG_Report_English_2014.pdf?download

Gzirishvili, D., and Mataradze, G. (1998) 'Healthcare reform in Georgia: Discussion paper series no. 5'. Tbilisi: UNDP.

Jones, S.F. (2015) 'Kakha Bendukidze and Georgia's failed experiment'. Retrieved online. www.opendemocracy.net/od-russia/stephen-f-jones/kakha-bendukidze-and-georgia%e2%80%99s-failed-experiment

Kukava, M. (2015) 'The draft State Budget of Georgia: Analyses and recommendations'. Transparency International Georgia. Retrieved online. www.transparency.ge/node/4869

Leo, B., and Barmeier, J. (2010) 'Who are the MDG trailblazers? A new MDG progress index'. Washington, DC: Center for Global Development.

Mays, J., and Schaefer, M. (1999) 'Health financing study of Georgia: Impacts of alternative prototypical options. A technical report'. Tbilisi: Actuarial Research Corporation.

Megrelishvili, V., and Chanturidze, T. (2008) 'Georgian health care system reform overview'. In *Introduction to primary health care in Georgia, Volume 1*. Ed. Naylor, M. Oxford, United Kingdom: OPM. Retrieved online. www.opml.co.uk/sites/default/files/Introduction%20to%20Primary%20Health%20Care%20in%20Georgia%20-%20Volume%201.pdf

MoH (2016) 'Statement of development objectives'. In Department of Health Statement of Strategy. Tbilisi: MoH, 2.

MoLHSA (2013) 'Report of health system effectiveness'. MoLHSA, Georgia.

MoLHSA (2014) 'Health service utilization and expenditure survey'. Tbilisi: MoLHSA.

MoLHSA (2016) National Health Accounts. Retrieved online. http://ghdx.healthdata.org/organizations/georgia-ministry-labor-health-and-social-affairs

National Statistics Office of Georgia (2015) Statistical Yearbook of Georgia, 2015. Retrieved online. www.geostat.ge/?action=wnews&lang=eng&npid=433

Naylor, M. (2008) *Introduction to primary health care in Georgia, Volume 1*. Oxford, United Kingdom: OPM. Retrieved online. www.opml.co.uk/sites/default/files/Introduction%20to%20Primary%20Health%20Care%20in%20Georgia%20-%20Volume%201.pdf

Oxfam International (2000) 'Health-Care Reform in Georgia, A Civil-Society Perspective: Country Case Study'. Oxfam International Research Report. Retrieved online. http://lib.icimod.org/record/14529/files/5029.pdf

Parliament of Georgia (1997) Law on state property privatization of May 30, 1997 (as Amended). Tbilisi: Parliament of Georgia.

Rukhadze, T. (2013) 'An overview of the health care system in Georgia: Expert recommendations in the context of predictive, preventive and personalized medicine'. *EPMA Journal* 4(1): 8.

Saltman, R.B., and Figueras, J. (1997) 'European health care reform: Analysis of current strategies'. Copenhagen: WHO Regional Office for Europe.

Schaapveld, K., and Rhodes, G. (2004) 'Observations on health financing reform in the Republic of Georgia, 1996–2002'. *Applied Health Economics and Health Policy* 3(3): 127–132.

Sehngelia, L., Pavlova, M., and Groot, W. (2016) 'Impact of healthcare reform on universal coverage in Georgia: A systematic review'. *Diversity and Equality in Health and Care* 13(5): 349–356.

Transparency International Georgia (2007) 'Promoting Civil Society Monitoring of Secondary Healthcare Reform'. Retrieved online. www.transparency.ge/sites/default/files/Promoting%20Civil%20Society%20Monitoring%20of%20Secondary%20Healthcare%20Reform-%20eng.pdf

Verulava, T. **(**2015) **'**Healthcare costs in line with the recommendations of the World Health Organization and the funding of Georgia's healthcare system'. Institute for Development of Freedom of Information. Retrieved online. https://idfi.ge/en/health-care-expenditure-who-recommendations-georgia

World Bank (1999) 'Georgia poverty and income distribution, vol.1'. Report no. 19348-GE. Washington, DC: World Bank.

World Bank (1999) 'Project appraisal document on a proposed credit to Georgia for a structural reform support project'. Report no. 19373-GE. Washington, DC: World Bank.

World Bank (2015) The World Bank Health Expenditure: Public (% of GDP). World Bank Open Data. Retrieved online. https://data.worldbank.org/indicator/SH.XPD.PUBL.ZS

World Bank (2017) GDP growth (annual): World Bank national accounts data and OECD National Accounts data files. Retrieved online. https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?locations=GE

WHO (2010) World Health Report 2010. Health Systems Financing: The Path to Universal Coverage. Retrieved online. http://apps.who.int/medicinedocs/documents/s20169en/s20169en.pdf

Zoidze, A., Gzirishvili, D., and Gotsadze, G. (1999) 'Hospital financing study for Georgia'. Tbilisi: CIF, 51.

Annex A MDG outcomes in Georgia

Outcome	Indicators
1) Eradicate extreme poverty	The poverty headcount has decreased and extreme poverty has declined, falling from 6.7% in 2010 to 3.7% in 2012.
	Poverty severity has fallen.
	Declining trend in extreme poverty among children, from 9.4% in 2011 to 6% in 2013
	Low prevalence of underweight children.
	15,441 out of 28,528 families provided with durable housing solutions, transferred living spaces into their private ownership
	The government has committed to transitioning public housing-dependent families to self-reliance.
2) Ensure coherence of Georgian educational systems with educational systems of developed countries through improved quality and institutional set-up	Preschool education is accessible for 46% of children, compared to 26% in 2003.
	Preschool education is now free.
	School education system has been transformed to a 12-year cycle.
	Establishment of the National Assessment and Examination Centre ensured the consistency of national assessment systems with international standards where international studies (such as TIMSS, PIRLS, and PISA) are conducted.
	Education indicators have been revised to comply with internationally suggested indicators.
	187 educational programmes were granted accreditation in 2013, of which 51% were higher education institutions.
	New models for enrolment and financing developed for vocational education.
	In 2012 inclusive education became compulsory for all public schools.
3) Promote gender equality and empower women	The Labour Code includes anti-discrimination and protection clauses, and addresses official leave during pregnancy, child-birth, and child-care.
	In 2011 a voluntary quota for women's participation in political party lists was adopted.
	Seven women have been elected to the current Parliament to represent single-mandate election districts, compared to one in 2008 and two in 2004.
	In 2013 the Prime Minister appointed an Assistant on Human Rights and Gender Equality Issues to contribute to gender equality and women's empowerment policy.
	49 gender focal points were adopted at the municipal level to ensure all actions promote and protect gender equality.
	In 2013 a Gender Equality Department was established within the Public Defender's Office.
4) Reduce child mortality	Under-five mortality rate per 1,000 live birth has been reduced from 24.9 in 2000 to 13.0 in 2013.
	Since 2000, Georgia has maintained over 90% coverage for the first MCV, reporting 93% coverage in 2012 and 96.5% in 2013.
5) Improve maternal health	Maternal mortality per 100,000 live birth has been reduced from 49.2 in 2000 to 22.9 in 2012.
	Proportion of births attended by skilled health personnel is increasing, reaching almost 100%.

6) Combat HIV/AIDS, malaria, and other diseases	Georgia has low HIV prevalence, with estimated adult prevalence at 0.3%.
	Georgia is the only Eastern European country that has achieved and maintained universal access to antiretroviral treatment.
	Incidence of malaria per 100,000 population has been reduced from 5.5 in 2002 to 0.02 in 2013.
	New tuberculosis cases per 100,000 population decreased from 96.5 in 2000 to 84.1 in 2012. Prevalence in the same period fell from 133.4 to 110.9.
7) Ensure environmental sustainability	Greenhouse gas emissions in 2011 were only 29% of the level in 1987.
	Appropriate legislation to control ozone-depleting substances is established. Georgia is in full compliance with control measures under the Montreal Protocol.
	In 2014, the total area of protected areas comprised 8.62% of the country's territory.
	Spatial Planning and Construction Code of Georgia is based on the best European experience of facilitating spatial planning and construction legislation.
8) Global partnership for development	In 2014 Georgia ratified the EU–Georgia Association Agreement including the Deep and Comprehensive Free Trade Agreement.
	In 2013, Georgia recorded its highest economic freedom score ever, going from a 'moderately free' to a 'mostly free' country.
	The National Bank of Georgia has carried out reforms to improve the regulatory framework of the financial system.
	Since 2006, Georgia has abolished import duties on almost 85% of goods and reduced the number of import duties from 16 to three.
GoG (2014)	

Annex B Topic guide

1. We believe you were actively involved in the development of the (specified) Health policy. Could you describe the role you played?

    Probes: How and when did this potential policy/reform first arise in the relevant agenda? Describe all the stages of the development of the policy in which you were involved. At each stage: Who were the advocates? Were there opponents? What was your position? What were the critical factors that influenced the progression of the debate to the point that the policy/reform was able to proceed?

Depending on the stage(s) at which the interviewee acknowledges involvement in the policy/reform development, and the extent to which the stages implicit in the questions below reflect the actual policy development process, the following question(s) can be selected. A priori, these are divided into the six phases of policy transfer identified in the Landscaping Review, Part 3. In practice, these phases may not fit the interviewees' understanding of the steps involved in the specific policy under discussion, and the interviewer may modify the phase descriptions accordingly.

2. *Conceptualisation*: To what extent was the identification of a possible policy initiative influenced by formal forms of evidence (written accounts of the experience of similar policies or reforms in other national or international settings).

    Probes: How did you first hear about this policy and from whom? What evidence was offered? (Please summarise it, including from where the evidence was drawn – locally or internationally, and what the evidence suggested would be the impact of the policy.) Who identified that evidence? Do you know from where they sourced that evidence? Did you identify any relevant sources of evidence? How did you go about identifying that and were there any individuals or institutions that supported you in this? Was the team able to identify all the evidence it wanted? And where there were gaps identified, how was the way forward decided? Was there evidence put forward at any stage that it was decided could not be trusted, or could not helpfully contribute to the debate?

3. *Formation and contextualisation*: Once the policy had gained traction and a more detailed proposal started to be developed, to what extent were discussions about the detail of that proposal and its implementation influenced by formal forms of evidence and/or domestic political considerations?

    Probes: What evidence was offered? (Please summarise it, including from where the evidence was drawn – locally and/or internationally, and what the evidence suggested should be thought about in policy detail.) Who identified that evidence? Do you know from where they sourced that evidence? Did you identify any relevant sources of evidence? How did you go about identifying that and were there any individuals or institutions that supported you in this? Was the team able to identify all the evidence it wanted? And where there were gaps identified, how was the way forward decided? Was there evidence put forward at any stage that it was decided could not be trusted, or could not helpfully contribute to the debate? What kinds of evidence were used and how were they assessed?

4. *Internalisation*: Once a detailed proposal for the policy/reform had been finalised, to what extent were discussions aiming to ensure formal consent (such as approval through a constituted committee or legislative process) informed by formal forms of evidence? What mechanisms were used to assess evidence?

    Probes: What evidence was offered? (Please summarise it, including from where the evidence was drawn – locally or internationally, and what the evidence suggested would be the impact of the policy or supported the policy design.) Who identified that evidence? Do you know from where they sourced that evidence? Did you identify any relevant sources of evidence? How did you go about identifying that and were there any individuals or institutions that supported you in this? Was the team able to identify or produce all the evidence it wanted? And where there were gaps identified, how was the way forward

decided? Was there evidence put forward at any stage that it was decided could not be trusted, or could not helpfully contribute to the debate?

5. *Operationalisation*: As implementation mechanisms were worked out, to what extent were those informed by formal forms of evidence and existing implementation capacity?

   Probes: What evidence was offered? (Please summarise it, including from where the evidence was drawn – locally or internationally, and what the evidence suggested should be included in implementation design.) Who identified/developed that evidence? Do you know from where they sourced that evidence? Did you identify any relevant sources of evidence? How did you go about identifying that and were there any individuals or institutions that supported you in this? Was the team able to identify or develop all the evidence it wanted? And where there were gaps identified, how was the way forward decided?

6. *Evaluation*: As the policy was refined on the basis of experience (either pilot or full operational experience), what kinds of evidence were gathered and applied? Was there evidence put forward at any stage that it was decided could not be trusted, or could not helpfully contribute to the debate?

   Probes: What M&E was undertaken? (Please summarise it, including from where the evidence was drawn – locally or internationally, and what the evidence suggested should be included in implementation design.) Who identified that evidence? Do you know from where they sourced that evidence? Did you identify any relevant sources of evidence? How did you go about identifying that and were there any individuals or institutions that supported you in this or were directly responsible for the M&E? Was the team able to identify all the evidence it wanted; and where there were gaps identified, how was the way forward decided? Was there evidence put forward at any stage that it was decided could not be trusted, or could not helpfully contribute to the debate?

For all respondents:

7. Do you think the experience of identifying, developing, gaining approval for, and designing an implementation strategy for this policy is typical of the processes that are usually involved here, in this sector and/or others?

   Probes: What other policies/reforms have you had detailed involvement in (a few examples if the list is long)? What factors drive those involved to seek out evidence or to fail to seek out evidence? Are there differences in the kinds of evidence or the sources of evidence used by different participants in the process? What specifically is typical or atypical in relation to interest or lack of interest and use/lack of use of other countries' experiences?

8. Overall, what is your assessment of the quality, relevance, and availability of evidence to inform health system development, across the different stages?

   What gaps have you experienced in finding and using appropriate evidence concerning global good practices, both at a general level but also in terms of finding evidence from, and learning from, particular countries? What mechanisms can you imagine, or are aware of, operating in other contexts, that you think would better support the use of evidence in this kind of decision making?

   Probes: Are there existing organisations that you think are well placed to encourage learning from other countries? What would those organisations need to do to improve the ability of countries to learn from each other? Do these organisations provide conflicting advice?

9. Are there institutions or individuals that constrain the use of evidence in this kind of decision making?

   Probes: Raise types of evidence and knowledge brokers that the respondent has not mentioned; ask about their potential to be helpful or tendency to be unhelpful; ask specifically about some of the ideas we are considering/that came out of the consultation,

such as use of observatories, relationships with individuals in UN agencies, study tours, academic research groups.

10. Have representatives from other countries and global stakeholders shown an interest in learning from your experiences?

    Probes: What types of information did they want? How did they approach you? Have you put any mechanisms in place to facilitate others learning from your experiences? Do you think they are working well?

Annex C Key informants interviewed

Position of interviewees	Selection categories defined in the Terms of Reference
1) Vice Minister of MoLHSA	Politicians with health policy portfolios over the period of the development of the selected policies/reforms
2) Former Vice Minister of MoLHSA	
3) Member of Parliament (not available)	
4) Former Minister of Finance	
5) Former Head of Policy Department, MoLHSA	Senior civil servants in health ministries and equivalent at state/provincial level, as relevant, in office over the period of the development of the selected policies/reforms
6) Head of Policy Department, MoLHSA	
7) Former Head of Regulations Department, MoLHSA,	
8) Health Specialist, UNICEF Georgia	Senior health advisers in UN agencies; health systems experts in specialist health agencies in office over the period of the development of the selected policies/reforms
9) Health Specialist, WHO Georgia (not available)	
10) Health Financing Expert, NGO	Senior health advisers and similar NGOs identified as involved in the selected policy/reform processes
11) Health Financing Expert, Transparency International	
12) Professor, Tbilisi State Medical University	Academics (from university health-related departments) and staff members identified as providing advice to the selected policy/reform processes
13) Lecturer, Tbilisi State Medical University	