Georgia’s Medical Insurance Program for the Poor

Owen Smith

Human Development Network

Universal Health Coverage Studies Series (UNICO) UNICO Studies Series No. 16
UNICO Studies Series 16
Georgia’s Medical Insurance Program for the Poor

Owen Smith, World Bank¹

The World Bank, Washington DC, January 2013

¹ The author would like to thank Daniel Cotlear, George Gotsadze, Huong Lan Dao, Karima Saleh, Aparnaa Somanathan, and participants in the Authors’ Workshop for their helpful comments.
All people aspire to receive quality, affordable health care. In recent years, this aspiration has spurred calls for universal health coverage (UHC) and has given birth to a global UHC movement. In 2005, this movement led the World Health Assembly to call on governments to “develop their health systems, so that all people have access to services and do not suffer financial hardship paying for them.” In December 2012, the movement prompted the United Nations General Assembly to call on governments to “urgently and significantly scale-up efforts to accelerate the transition towards universal access to affordable and quality healthcare services.” Today, some 30 middle-income countries are implementing programs that aim to advance the transition to UHC, and many other low- and middle-income countries are considering launching similar programs.

The World Bank supports the efforts of countries to share prosperity by transitioning toward UHC with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, successful implementation requires that many instruments and institutions be in place. While different paths can be taken to expand coverage, all paths involve implementation challenges. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Study Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the nuts and bolts of programs that have expanded coverage from the bottom up—programs that have started with the poor and vulnerable rather than those initiated in a trickle-down fashion. The protocol consists of nine modules with over 300 questions that are designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following: (a) manage the benefits package, (b) manage processes to include the poor and vulnerable, (c) nudge efficiency reforms to the provision of care, (d) address new challenges in primary care, and (e) tweak financing mechanisms to align the incentives of different stakeholders in the health sector. To date, the nuts and bolts protocol has been used for two purposes: to create a database comparing programs implemented in different countries, and to produce case studies of programs in 24 developing countries and one high-income “comparator,” the state of Massachusetts in the United States. The protocol and case studies are being published as part of the UNICO Studies Series, and a comparative analysis will be available in 2013.

We trust that the protocol, case studies, and technical papers will provide UHC implementers with an expanded toolbox, make a contribution to discussions about UHC implementation, and that they will inform the UHC movement as it continues to expand worldwide.

Daniel Cotlear
UNICO Studies Series Task Team Leader
The World Bank
Washington, DC
# TABLE OF CONTENTS

Abbreviations ............................................................................................................................................... iv
Executive Summary ............................................................................................................................................. v
Introduction ..................................................................................................................................................... 1
Putting MIP in Context: An Overview of Health System Financing and Delivery in Georgia ....................... 2
Institutional Architecture and Interaction of MIP with the Rest of Health System ....................................... 4
Targeting, Identification, and Enrolment of Beneficiaries............................................................................. 6
Public Financial Management and Fiscal Considerations ............................................................................. 7
Management of the Benefits Package ......................................................................................................... 8
Monitoring and Evaluation of MIP ............................................................................................................. 9
Special Theme: Contracting Out the Purchasing Function to Private Insurance Companies ....................... 11
Pending Agenda for MIP ............................................................................................................................ 14
Annex 1 Spider Web ................................................................................................................................... 16
References ................................................................................................................................................... 19

FIGURES

Figure 1 Health Financing in the Europe and Central Asia Region, 2010...................................................... 3
Figure 2 Coverage and Targeting of MIP by Decile .................................................................................... 7
Figure 3 MIP Impact Evaluation Findings .................................................................................................. 11

TABLES

Table 1 MIP Budget Trends, 2008–11 .......................................................................................................... 5
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP</td>
<td>gross domestic product</td>
</tr>
<tr>
<td>HMO</td>
<td>health maintenance organization</td>
</tr>
<tr>
<td>HUES</td>
<td>Health Utilization and Expenditure Survey</td>
</tr>
<tr>
<td>IT</td>
<td>information technology</td>
</tr>
<tr>
<td>MIP</td>
<td>Medical Insurance Program</td>
</tr>
<tr>
<td>MoLHSA</td>
<td>Ministry of Labor, Health, and Social Affairs</td>
</tr>
<tr>
<td>TSA</td>
<td>Targeted Social Assistance</td>
</tr>
</tbody>
</table>
Executive Summary

Georgia launched its Medical Insurance Program (MIP) for the poor in 2006. This program draws from general tax revenues to provide comprehensive, means-tested health insurance to the poorest 20 percent of the population as identified by a proxy means test. The government contracts private insurance companies who serve as financial risk carriers and purchasing agents for the program. MIP is well targeted to the poor and has had a major impact on improving financial protection of its beneficiaries. It has also served as a launching pad for significant investments in hospitals and information technology (IT) systems.

However, managing private insurers has been an ongoing challenge and has met with mixed results so far; by late 2012 their role was being reconsidered. In addition, broader health system weaknesses, including with regard to primary care and pharmaceutical markets, have curtailed MIP’s effectiveness in enabling better access to high-quality health care goods and services. Nonetheless, the journey to universal coverage is long, and Georgia’s experience with MIP offers potential lessons for other countries contemplating their own path.
Introduction

During the transition period following independence in 1991, Georgia undertook various health reform initiatives related to financing, service delivery, and stewardship. However, few of these efforts were successful, in large part because the broader environment during the 1990s was characterized by severe economic collapse, fiscal distress, and civil conflict. The Rose Revolution in 2003 ushered in a new reform era, with several notable achievements, including improved security, stronger revenue collection, and robust economic growth.

Following implementation of far-reaching reforms in several sectors, including the creation of a cash-benefit program targeted to the poor as its flagship social sector priority, the government turned its attention to the health sector in 2006. At the time, the health system suffered from chronic underfunding—the government health budget amounted to only about 1.5 percent of gross domestic product (GDP)—and thus about 75 percent of total health expenditure came from out-of-pocket sources. While there was universal health coverage in principle, the funding level was such that benefits were very limited. Infrastructure was in poor condition and the quality of care was weak. In line with its broader strategy to pursue limited government and to target social spending to the poor, Georgia launched its Medical Insurance Program (MIP) for the poor that year. The major objective of MIP was to provide financial protection to the poorest segment of the population.

In brief, MIP is a program funded through general taxation that provides a fairly comprehensive benefits package of health services to the poorest 20 percent of the population as identified via a proxy means test. There are no copayments for services. Although run by a state purchaser during the first two years, since 2008 its key feature has been that private insurance companies are contracted by the Ministry of Health to bear financial risk and to purchase services from both public and private providers on behalf of poor beneficiaries. The government sets policy, pays a per capita premium per beneficiary to private insurers, and conducts program oversight.

Overall health outcomes in Georgia are about average for a middle-income country, with life expectancy of about 72 years. But similar to other countries in the Eastern European region, there has been relatively slow progress in improving health outcomes over many decades after initial gains against infectious diseases and maternal and child health in the 1950s and 1960s. Life expectancy in the late 1960s was about 68 years. At present, noncommunicable diseases, especially cardiovascular disease, account for over 90 percent of the disease burden in terms of mortality.

This case study provides an overview of how MIP is designed, its achievements to date, and challenges for the future. A key theme discussed in further detail, and of potential interest to other countries contemplating a push toward the achievement of universal health coverage, is the contracting of private insurance companies to purchase services on behalf of the poor. Some attention is also given to MIP’s targeting approach.

A new government took office after elections in late 2012, with uncertain implications for the direction of MIP design and for health reform more broadly. A further rapid expansion of health coverage to the previously uninsured population and the creation of a new state purchasing
agency were under discussion at the time of writing. This case study focuses on the evolution of MIP prior to this period.

**Putting MIP in Context: An Overview of Health System Financing and Delivery in Georgia**

Total health expenditure in Georgia is about 9 percent of GDP, which is high for a lower-middle-income country. But about 70 percent of total health expenditures are from private out-of-pocket sources, at least half of which is spent on pharmaceuticals. Thus, pooling of health care resources is weak on the system level. About 20 to 25 percent of total health expenditures, or about 2 percent of GDP, passes through the government budget and is financed from general tax revenues. The share of the total government budget allocated to health is low. The health budget is divided between MIP for the poor and a patchwork of programs for the rest of the population.

Figure 1 shows how health financing in Georgia compares with the Europe and Central Asia region. This picture—and in particular, Georgia’s position in the upper left—may appear to indicate that it has covered very little ground on the road to universal health coverage. The reason that Georgia offers an interesting case study is that it launched a comprehensive program for the poor in the absence of any significant coverage for the better off, and in doing so it adopted a unique institutional design that relies on private insurers.

More specifically, at the time of its launch, the MIP benefits package was the most comprehensive offered by government to any segment of the population. The non-MIP population, including most of the better off, was eligible for a basic universal package. In principle, this consists of various service guarantees, based on a mixture of specific diseases (for example, oncology), services (for example, emergency care), and target groups (for example, children), which may be subjected to copayments of 25 to 50 percent. However, the benefits package for the non-MIP population was not clearly defined or well understood by the population, and under-the-table payments are common, particularly at the hospital level, due largely to underfunding. Thus, for those not covered by MIP, the main alternative has continued to be high out-of-pocket payment for most services. However, civil servants (including the military, police, and teachers) receive a program similar to MIP, and some formal sector workers also have employment-based coverage.
In September 2012 (just prior to elections), the government extended a comprehensive MIP-style benefits package to additional groups, including pensioners, children under five, and students. Promises to achieve universal coverage are also occasionally made. But otherwise, it is notable that the better off in Georgia do not have access to any well-funded government health program. Thus, MIP is not aiming to extend a government-funded benefits package to the poor that is already enjoyed by the better off, since the better off typically do not have proper coverage themselves. Thus, unlike in some other countries, MIP is intended to improve coverage of the poor despite the relative absence of such coverage for higher socioeconomic groups.

With respect to the delivery of care, most providers in Georgia are private. This reflects reforms undertaken between 2005 and 2010, consistent with the government’s overall privatization agenda, which spanned all sectors. Thus, primary care and outpatient specialists are essentially all private, although physicians in rural areas do receive a stipend from government. About 80 percent of all hospital beds are private, again largely as a result of recent reforms. Many are owned by private insurance companies. A small number of public hospitals remain, most of which are single-profile hospitals (for example, TB, psychiatry). Under MIP, contracts signed with private insurers in 2010 included a requirement to build and operate hospitals. The premium negotiations for these contracts reflected this contractual requirement, but construction was executed by the insurance companies with government oversight. About 150 new or fully refurbished hospitals are expected by the end of 2013.

While MIP represents a major demand-side effort to improve coverage, and the hospital program represents a major supply-side investment initiative, it is notable that primary care in Georgia is quite weak. The population tends to bypass primary care doctors and seek care directly from specialists at a polyclinic or hospital, or to self-treat at a pharmacy. For example, only 5 percent of survey respondents report consulting a family doctor as the first point of call when they have been feeling ill, far lower than corresponding figures in Central Asia, Moldova, and Russia.
primary care was privatized between 2005 and 2010, although the problems with primary care date back many years to the period of public ownership (private provision of primary health care is also the norm in about two-thirds of OECD [Organization for Economic Co-operation and Development] countries). Nor is geographic coverage the main problem; rural areas generally have primary care doctors, and there is a so-called village doctor program funded by government, which pays a stipend to ensure that doctors in small towns and villages can make a livelihood in low-density areas. Instead, the major challenge in primary care would appear to be the quality of the services provided. This is a major constraint on MIP to fulfill its potential with regard to improving health outcomes.

In the area of public health, major efforts in the 1950s and 1960s (that is, during Soviet times) to address priorities such as infectious diseases and maternal and child health resulted in the achievement of relatively strong performance on Millennium-Development-Goal-type health indicators in Georgia several decades ago. Childhood immunization programs generally function well, and the prevalence of HIV/AIDS is low. As in other countries in the region, however, there is scope to improve the public health system, in particular by shifting toward a greater population focus, and addressing new priorities such as health promotion and the prevention of noncommunicable diseases. Tuberculosis, including drug-resistant TB, remains a key public health challenge.

Institutional Architecture and Interaction of MIP with the Rest of Health System

MIP provides a comprehensive benefits package of health care services to the poorest 20 percent of Georgia’s population, as identified by a proxy means test. MIP is funded by general tax revenues but implemented by private insurance companies and private providers under Ministry of Labor, Health, and Social Affairs (MoLHSA) oversight. The program was launched in 2006 but has evolved significantly since then. The fundamental objective of MIP has been to provide health insurance to the poor. The most commonly cited aim has been to improve financial protection of the poor, not to improve health outcomes, per se.

MIP is the responsibility of the MoLHSA, and its subordinated implementing agency, the Social Services Agency. The MoLHSA is accountable to the cabinet and parliament. There is no titular head of MIP; the director of the Social Services Agency and the minister of the MoLHSA are responsible, but have other duties, as well. The MoLHSA is in charge of policy setting (through various decrees and legislation), financing (through general tax revenues), and monitoring of MIP implementation (including through mandatory reporting via IT systems). The Social Services Agency makes premium payments to private insurers, but does not deliver services or pay providers. Regional governments also play a role in MIP; two regions, Adjara and Tbilisi (the capital city), have elected to fund additional beneficiaries (specifically the near-poor, or those with slightly higher proxy means test scores, as described below) out of their own revenues. Finally, the government also supports a semi-independent Health Insurance Mediation Service, which serves as an MIP ombudsman. It resolves disputes among insurers, beneficiaries, and providers, and provides information to beneficiaries about program benefits and rules. Overall, the national government has been supportive and a key champion of MIP.
Private insurance companies are contracted for three years on the basis of a competitive tendering process for regional “packages.” They receive a per capita premium determined by government (based on some rough actuarial work) for each beneficiary. They are responsible for purchasing health care services, as defined in the benefits package identified by government, based on medical claims submitted by contracted providers, for all eligible beneficiaries within a specific geographic area. They are free to negotiate contracts with providers (for example, reimbursement prices and payment mechanisms) as they choose, but must provide a certain level of geographic coverage. Increasingly, the private insurers have moved into ownership of their own provider network. Patients have a modest degree of provider choice within these networks. The role of private insurers is discussed in further detail in Section 8.

Providers deliver care to MIP beneficiaries per their contracts with insurance companies. There has been no effective functioning accreditation system for providers in Georgia in recent years (Chanturidze et al. 2009), but the government is starting to pursue reforms in that direction.

With respect to the interaction of MIP with the rest of the health system, in essence, MIP is the centerpiece of health reform in Georgia. Until recently, beyond MIP there was only a patchwork of disease-specific programs funded by government, while the rest of the system was mainly out-of-pocket funding by individuals seeking care from private providers in a largely unregulated environment. There is also some corporate private insurance. Rather than interfering with or complementing the “main” health system, MIP is in fact the major building block around which a new health system will be developed from the ashes of a nearly devastated system that emerged from the transition period.

For example, starting from September 2012, a benefits package similar to MIP was extended to over 750,000 beneficiaries in nonpoor groups such as pensioners, children, and students. This expansion is also relying on private purchasing by insurers contracted for the task. In addition, MIP has led to government support for hospital and IT investments that should also be beneficial to the non-MIP population.

Table 1 shows the trend of the MIP budget since 2008, in relation to the larger government health budget and GDP. The slight decline in funding in 2011 reflects the renegotiation of the monthly premium paid to insurers (discussed further below), not a decline in enrolment or benefits.

### Table 1 MIP Budget Trends, 2008–11

<table>
<thead>
<tr>
<th>Year</th>
<th>Total MIP Expenditures (GEL)</th>
<th>As % of MoLHSA Expenditures</th>
<th>As % of Total Public Expenditures</th>
<th>As % of GDP</th>
<th>Number Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>GEL 136m</td>
<td>42.6</td>
<td>2.3</td>
<td>0.6</td>
<td>972,912</td>
</tr>
<tr>
<td>2010</td>
<td>GEL 147m</td>
<td>44.7</td>
<td>2.7</td>
<td>0.7</td>
<td>805,392</td>
</tr>
<tr>
<td>2009</td>
<td>GEL 127m</td>
<td>43.6</td>
<td>2.4</td>
<td>0.7</td>
<td>750,838</td>
</tr>
<tr>
<td>2008</td>
<td>GEL 80m</td>
<td>35.5</td>
<td>1.5</td>
<td>0.4</td>
<td>706,336</td>
</tr>
</tbody>
</table>

Source: MoLHSA and World Bank staff calculations.
Note: GEL 1 = approximately US$0.60.
Targeting, Identification, and Enrolment of Beneficiaries

One of the strongest elements of Georgia’s MIP is the explicit aim of targeting the poor through a rigorous means-testing process, even in the absence of a proper government program for the better off. The government responsible for MIP was explicitly aiming for a smaller state, but attempted to target its social spending envelope to the poor, while leaving other population groups to take care of themselves (although this started to change with recent coverage expansions to other groups). This section provides a brief overview of how the MIP targeting and eligibility system works.

The proxy means test was originally developed, with some outside technical support, for a cash assistance program referred to as Targeted Social Assistance (TSA), which aims to reach the 10 percent of the Georgian population estimated to be living in extreme poverty. A dedicated survey was undertaken to identify which household characteristics are the best predictors of consumption poverty. Over 100 indicators are included in the proxy means test, significantly more than in many other such programs in the region. These include mostly asset-based indicators, but some demographic and regional data are also used in the formula.

Households that believe they are eligible must apply to the Social Services Agency, an implementation unit of the Ministry (MoLHSA). Enrolment is not automatic. A social worker will visit the applicant’s household to collect information on the relevant indicators. These are then fed into a complex formula that results in a household score. Eligibility is determined on a household, not individual, basis, although MIP beneficiaries are ultimately given individual identity (insurance policy) cards.

Once eligible, they will be enrolled in MIP within three months. Eligibility is for a period of three to four years, after which beneficiaries should undergo a recertification process based on the same proxy means test, in case household living conditions have changed in the interim. Certain one-off efforts to undertake audits of the eligibility status of beneficiaries may also lead to the withdrawal of benefits before that time (for example, if a recipient is found to have provided false information on their application by concealing assets). There are concerns that some beneficiaries have cheated on their applications, and some anecdotes have been publicized in the past, but overall it is seen as a relatively clean program with regard to the probity of implementation. MIP is not open to the nonpoor; that is, they cannot get the same benefits package for the same premium paid out of pocket.

Nearly half the Georgian population has applied during the last six years. There is little evidence—anecdotal or otherwise—of stigma associated with program eligibility. Households with a score of 70,000 or below are eligible for MIP. There are currently about 900,000 beneficiaries. Households with a score of 57,000 or below are eligible for TSA; there are about 400,000 TSA beneficiaries. TSA was intended for the extreme poor (10 percent of the population), and thus the proxy means test was chosen to best identify this group. MIP is intended for the 20 to 25 percent of the population that is poor—a group over twice as large as the extreme poor. Thus, there have been some questions as to whether the current proxy means test is ideally suited for identifying MIP eligibility. But for administrative simplicity (that is, not
having two separate proxy means tests), the prevailing system has remained in place. However, there are periodic attempts to fine-tune the methodology to improve targeting.

Due to the inevitable errors of inclusion and exclusion associated with any targeting mechanism, the eligibility system is not perfectly covering the poor while excluding the nonpoor. Figure 2 shows indicators of targeting and coverage. Although it is generally a well-performing proxy means test compared to other similar programs worldwide, the errors of exclusion highlight a drawback faced by targeted programs, since over half of the poorest quintile of the population still do not get MIP benefits. There have been slow but steady improvements of targeting and coverage indicators over time.

The targeting system for MIP is not a parallel structure, since it uses the only existing poverty-based targeting mechanism used by government. In addition, there are no special rules or considerations for special categories—MIP eligibility is strictly based on the same proxy means test for all. The same agency, the Social Services Agency, is in charge of enrolment and administration. They do not have discretion beyond the proxy means test results. There are mechanisms of redress that involve community participation to review results of the application process. There is some political pressure to ensure that the beneficiary identification process excludes the nonpoor from benefiting.

### Figure 2 Coverage and Targeting of MIP by Decile

![Figure 2 Coverage and Targeting of MIP by Decile](chart.png)


### Public Financial Management and Fiscal Considerations

The management of public funds by MIP has not been a major topic to date. The program’s budget is essentially a monthly premium paid to insurers for each eligible enrollee times the number of total beneficiaries. In this sense, there is little difference from a cash transfer program, such as social assistance or pensions. Georgia also had previous experience with a single purchasing agency, and thus provider reimbursement has not been uncharted terrain from a
Management of the Benefits Package

The MIP benefits package is defined in the legislation establishing the program on the basis of MoLHSA recommendations. It has both a positive list and negative list, but generally only by broad categories (for example, “outpatient services”). Services that are less conducive to insurance, such as dental and optical, are excluded. High-cost care such as kidney dialysis is provided under a separate state program, as are certain other services such as mental health care. The benefits package is broadly informed by disease burden and basic cost information, without formal criteria for inclusion or exclusion (for example, cost-effectiveness, scientific opinion, and so forth). No major changes to the benefits package have been made since the beginning of the program, with the exception of a small additional benefit for outpatient drugs that was included in 2010. A further expansion of the drug benefit has been proposed for the future.

More specifically, the MIP package includes (a) urgent outpatient and inpatient treatment, including diagnostic or laboratory tests used to determine the need for hospitalization; (b) planned inpatient services, excluding expenses for certain services such as cosmetic treatment or treatment abroad; (c) chemotherapy and radiation therapy; (d) outpatient care and limited diagnostic and lab tests prescribed by the family physician or general practitioner; (e) child delivery costs (up to 400 GEL); and (f) a small benefit for outpatient pharmaceuticals (up to GEL 50 or US$30 annually with a 50 percent copayment). The Health Insurance Mediation Service serves as a check on key actors to help ensure that the right of beneficiaries to access the government-defined benefits package is protected.

With regard to costing and cost containment, the original budget was based on a mix of local and donor-funded actuarial work, but with a heavy dose of guesswork due to a lack of necessary micro data. The available budget is inevitably part of the calculus for benefits package design. There are various caps by service type, but these are quite high—for example, GEL 15,000 for an operation (about US$9,000), or GEL 12,000 for radiation or chemotherapy. High-cost diagnostics such as MRIs and CT scans are excluded except for inpatient surgery and hospitalization cases. There are no copayments except for the outpatient drug benefit noted above. Program eligibility and enrolment are not manipulated for cost purposes; if a person is covered, the finances will in principle be available. There have been no major problems with MIP funding drying up during its program life. But there may be a longer-term funding challenge if or when utilization rates increase, necessitating a higher premium.
The relatively low coverage of outpatient drugs from the benefits package is notable for several reasons. The drug benefit is kept small in part as a cost-containment measure, since pharmaceutical spending is very high in Georgia (at about 3 to 4 percent of GDP, one of the highest levels in the world), and thus more comprehensive coverage could lead to unsustainable demands on the MIP budget. The pharmaceutical market is characterized by high prices; high markups; and significant cartel control of importing, wholesale, and retailing (Transparency International 2012). Moreover, there is anecdotal evidence of overprescription by doctors who are compensated by the industry, and a tendency to overconsume among the population. However, the purchasing power that MIP offers could help confront these problems, including through generic promotion and essential drug lists. This will be an ongoing conundrum, especially since drugs for cardiovascular disease and other conditions have the potential for major health gains if they were successfully integrated into the MIP benefits package.

In general, the financial risk embodied by the benefits package “promise” is borne by insurers, most of which are owned by commercial banks. Payment methods may vary by private insurer, but in general, fee-for-service is used for inpatient services and capitation for primary care. There have been proposals to introduce case-based payments such as diagnosis-related groups (DRGs), but this has not yet been done. Prices and reimbursement rates are the outcome of negotiations between insurers and providers. No detailed information is available on contract specifics between private insurers and private providers, such as whether price-and-quantity contracts are invoked to manage costs. In a growing number of cases, these are the same entity (that is, insurer-owned hospitals similar to health maintenance organizations [HMOs]).

**Monitoring and Evaluation of MIP**

Significant IT investments and standardization of information flows have been undertaken by the MoLHSA with donor support, and these efforts are ongoing. Insurance companies must report claims data to the National Bank of Georgia as the supervisory authority, and utilization data to MoLHSA. This information is used to monitor finances and inform future premium calculations, although it is not currently being used to improve the delivery of health care services to any significant extent. MIP itself does not have specific program goals for which it is accountable or must report. In general, there is currently no strong analytical unit or function institutionalized within MIP. However, studies to better assess program performance have been undertaken and are briefly described here.

To assess the impact of MIP on key outcomes of interest, an impact evaluation was undertaken in 2009 (Bauhoff, Hotchkiss, and Smith 2011a; 2011b). The sample was evenly divided into MIP and non-MIP beneficiaries. To ensure that MIP participants who were surveyed—the “treatment” group—could be compared with the most similar possible “control” group of non-MIP households, the survey only collected data on households just above and just below the eligibility thresholds of 70,000 or 100,000 (depending on the region). That is, the approach used was a regression discontinuity design.

The study found that MIP has a significant impact on reducing out-of-pocket expenditures for health care. As shown in figure 3, for outpatient care in Adjara and Tbilisi, and inpatient care in all regions, MIP beneficiaries pay approximately 40 to 60 percent less than nonbeneficiaries.
(there is no statistically significant difference for outpatient care in the regions with a cutoff score of 70,000). The survey also found that MIP beneficiaries were more likely to report receiving free or reduced-price care because of insurance, and less likely to report that they could not pay for the costs of care out of their usual income. Together these findings indicate that MIP has made a major contribution to reducing out-of-pocket spending among its beneficiaries, and is therefore achieving one of its key program goals. The main reason why out-of-pocket spending has not fallen to zero among MIP members is because of drug expenditures, which are largely not covered. The study was undertaken prior to the recent introduction of an outpatient drug benefit as part of MIP. However, some respondents also reported paying for certain services that are supposed to be covered by MIP, indicating that informal payments may persist and there is scope to improve knowledge of the benefits package.

The survey results also indicated, however, that the program has not had any impact on utilization. While it is difficult to pinpoint a single major explanation for this finding, various reasons are possible. First, many households reported that they were not aware of their beneficiary status, and thus various measures have been taken to improve implementation (including cancellation of the voucher mechanism in favor of competitive bidding for regional packages). Second, low quality of care is probably an important reason, and the current efforts to improve the supply side (including a new hospital construction program as part of MIP) should help in this regard. Third, the absence of a pharmaceutical benefit at the time of the evaluation (introduced in May 2010) may have reduced the motivation for the beneficiary population to seek care from their doctor.

The evaluation also looked at indicators of health behavior and general checkups, in addition to the diagnosis and treatment of common chronic illnesses such as high blood pressure, asthma, diabetes, depression, and arthritis. There are generally no systematic differences across beneficiaries and nonbeneficiaries in this regard. In additional analysis, there were no differences found in reported health status, as measured by questions on activities of daily living. Finally, provider responsiveness was lower for MIP patients than for the rest of the population outside of Adjara and Tbilisi.
More up-to-date analysis has generally confirmed these trends using data collected since 2009. A difference-in-difference analysis of the Health Utilization and Expenditure Survey (HUES) undertaken in 2007 and 2010 yielded similar findings of a significant MIP impact on financial protection but relatively little impact on utilization (Gotsadze et al., forthcoming). Preliminary evidence from 2011 indicates that MIP beneficiaries are using health care services more than non-MIP individuals. These results compare full populations of MIP and non-MIP individuals, and therefore may not fully isolate the causal effect of MIP on outcomes of interest. A study to be undertaken in 2013 should help to further update the evidence on MIP’s impact.

Special Theme: Contracting Out the Purchasing Function to Private Insurance Companies

During the first two years of implementation (2006–08), the purchasing of health care under MIP was done by the state purchasing agency. In 2008, this responsibility was transferred to private insurance companies. Initially beneficiaries were given a voucher and allowed to choose their own private insurance company. However, this approach was revised in 2010, and insurers were instead selected on the basis of competitive tenders for “medical regions”—that is, they became de facto single purchasers for all beneficiaries within a certain geographic region for the period of contract duration (currently three years). The experience with private insurers is discussed further in this section.

Georgia opted for the private insurance model for MIP largely due to the prevailing pessimistic view among key decision makers in government about the capability of the state to run such a scheme itself, a view influenced by the early postindependence experience during the 1990s, when Georgia struggled to establish robust state institutions. (A further consideration was that under traditional public finance management rules, public purchasers were budgetary institutions that could not bear financial risk.) The so-called “public” system that existed before MIP was in many respects a myth and certainly a failure, with low levels of public funding, a predominance of out-of-pocket funding, public providers that were poorly reimbursed and weakly regulated, deteriorating infrastructure, and widespread corruption. Reforms were essential. The decision to
privatize the purchasing function under MIP (and to privatize most delivery) was consistent with a broader government strategy applied to other sectors, as well.

The initial mechanism for assigning MIP beneficiaries to insurance companies (that is, from 2008–10) was with vouchers. Households that gained eligibility were supposed to receive the voucher from a primary care doctor, and they could then choose their private insurer, who would give the voucher back to government in order to claim the per capita premium revenue for that household. However, numerous problems emerged with this approach. Many households did not receive a voucher or got it after many months’ delay. Survey evidence suggested that many households did not perceive that they in fact had a choice of insurers. In effect, the vouchers had a significant monetary value to insurance companies, and this led to high acquisition costs incurred by insurers (and thus, implicitly, an unproductive use of MIP budget funds) because they sought to hire agents to lobby households for their voucher. It also led to outright fraud, since primary care doctors became agents of insurers, and in some cases gave the voucher to insurers without informing the household.

Thus, it was decided in 2010 to change the method by which beneficiaries were assigned to insurers. A competitive tendering process was implemented, and insurance companies made bids for regional medical “packages” of MIP enrollees for a three-year period. The tendering procedure had to be run twice after collusion mired the first attempt. Eight to ten private insurers won different regional packages across Georgia. This approach for engaging private insurers resembles some Indian schemes. The contracts will expire in 2013, and the new government may choose to revise the model.

Several medium-term issues related to the private insurance model loom on the horizon, including in the area of the efficiency of spending. Private insurers receive premium revenue from the government and typically have four potential “uses” for these funds: (a) reimbursement of medical services (this share is often termed the “loss ratio”), (b) marketing costs, (c) administrative costs, and (d) profits. Each of these items raises policy issues for the successful operation of MIP in the future. These are discussed below.

**Medical care costs:** In principle, the private insurers could keep reimbursement costs down through smart or “active purchasing” of health care services, and this may be facilitated because they are increasingly integrated with the hospital system (HMO style). In other systems with multiple insurers (for example, the United States), prices of health services tend to be higher because the fragmentation of purchasing gives greater bargaining power to the providers (especially hospitals, which typically enjoy substantial market power). This may be mitigated in Georgia due to the noncompetition of insurers within a geographic area once MIP contracts have been signed, and because of the growing integration of insurers and providers.

But the government and MIP beneficiaries together will need to monitor this in order to ensure accountability both with regard to covering the MIP benefits package as required and providing a high quality of care. The Health Insurance Mediation Service and ongoing investments in IT by the Social Services Agency can help in this regard. An important concern here is that keeping costs down may result in less provision of “necessary” care, including preventive care. One key consideration is the expected duration of the relationship between the insurance company and the
patient; in the United States, where there is high turnover in the market, there is evidence that insurers neglect many preventive services because they do not expect to be covering the patient in 5 or 10 years, when a health condition may become more serious and therefore costly.

Marketing costs: These were quite high prior to 2010, when competition occurred through vouchers for beneficiaries, as insurers went to great effort to attract customers. The transition to competitive tendering for three-year contracts has reduced this cost pressure significantly.

Administrative costs: The approach of multiple private insurers has led to high administrative costs in some other countries (for example, the United States), due to inconsistent procedures, duplication, and a proliferation of paperwork. Georgia’s recent efforts to establish a strong IT platform, including standardization of reporting procedures, is a positive step. But much remains to be done. Since Georgia’s insurance industry is relatively young, it is natural to expect higher fixed investments by insurers in IT and other systems than in the long term.

Profits: Some multiple insurance systems allow profits (for example, Chile, the United States) while others do not (for example, Germany, and Switzerland on the basic package), and yet others are mixed between for-profit and nonprofit insurers (for example, the Netherlands). A clear picture on current insurer profits of MIP is not available, although industrywide evidence reported to the National Bank of Georgia suggests that the loss ratio (medical care expenses divided by premium revenue) was only about 50 to 60 percent in 2008–09, but has since risen to about 80 percent in 2011. This suggests that profit margins have narrowed significantly. As noted, higher administrative and investment costs are to be expected in a nascent industry, so lower loss ratios are not automatically a reflection of high profits.

In the United States, the Affordable Care Act has mandated loss ratios (including measures to improve quality of care) of at least 80 to 85 percent. High insurer profits and concerns about collusion have been a source of debate in Chile. In general, a low loss ratio should raise concerns that an insurance program is getting poor value for money with the taxpayer’s health dollars. Some stakeholders have acknowledged that the MIP premium was deliberately set quite high in the early program years as a way to encourage private insurers to participate in the program. Loss ratios on MIP will merit close monitoring going forward.

The expiry of current MIP contracts expected in 2013 provides an opportunity to review many of these issues, if indeed the decision is made to keep the current model and renew the contracts. A key longer-term issue facing MIP is that if and when the utilization of services by beneficiaries starts to rise, there will be important implications for the required premium paid to insurance companies, and therefore for the health budget. In the long term, broad population coverage under various health insurance programs will be a key requirement for achieving health sector objectives.

If a prominent role for private insurers is maintained, a major unanswered question is whether the health system evolves toward a U.S. model with a high degree of fragmentation and inefficiency and significant market failure in the individual and small group insurance markets, leaving a large share of the population uncovered, or toward a European model (for example, Austrian, Dutch, German) in which insurer activities are more closely regulated and insurance is
mandatory. Evidence would suggest that the latter model offers a better route toward universal coverage. But the new government may opt for a completely different approach.

Pending Agenda for MIP

A significant agenda remains with respect to the further strengthening of MIP in Georgia. In recent years, it has served as the cornerstone of health reform in the country, and future progress with regard to the achievement of universal coverage will depend on improvements to MIP and an expansion of its benefits to the rest of the population. A selection of key issues corresponding to the topics discussed in the preceding sections is highlighted here.

First, MIP was designed as a demand-side approach to the achievement of universal coverage, with funding attached to beneficiaries in the form of a per capita premium paid by government to insurers. In effect, money followed the patient. Initially, there were few efforts to address the supply side, especially infrastructure and quality of care. There has been a widespread acknowledgement that quality of care is problematic in Georgia, and this may be one factor that helps explain the finding from the early evaluation of MIP that there was no difference in utilization rates between MIP and non-MIP populations. Since 2011, there has been a strong effort to upgrade hospital infrastructure, and most of the new hospitals include outpatient departments. But a key outstanding issue is the quality of primary care. As noted, most Georgians bypass the primary care level and seek care at more specialized facilities or via self-treatment at pharmacies. This challenge has yet to be adequately addressed either by MIP or through broader health system strengthening activities, but long-term health outcome improvement, especially in terms of managing noncommunicable disease risk factors, will require a strong primary care system.

Second, there is an ongoing challenge to improve coverage of the poor. Although the proxy means test used by MIP is generally well targeted, about half of the poorest quintile is still not covered. There has been gradual improvement of this indicator between 2009 and 2011, but many poor remain outside the health safety net. While focusing limited government resources on the poor is one of the most laudable aspects of MIP, it also highlights a tradeoff between a targeted and universal approach, since better coverage of the poor might have been achieved through a more broad-based (albeit more costly) expansion of health coverage to the population. Nevertheless, a better understanding of why many poor are not covered by MIP—for example, whether it is due to information barriers that prevent people from applying, or methodological issues with the proxy means test that lead to exclusion of legitimately poor households—will be important and can help inform policy measures to better cover the poor. Survey work by UNICEF in 2011 suggested that some minority populations (for example, Azeri, Armenian) appear to be underrepresented among beneficiaries of MIP, most likely due to language barriers. Some tailored outreach campaigns may help remedy this situation.

More generally with regard to population coverage, there has been uncertainty regarding how rapidly MIP or “MIP-like” programs would be expanded. As of mid-2012, MIP covered about 20 percent of the population. In September 2012, the government started to cover pensioners, students, and children with a similar program that also relies on private insurers. But even then,
about half of the Georgian population was left without adequate health coverage. In late 2012, the new government indicated that it would move rapidly to expand coverage to the remaining 50 percent of the population, but this will introduce its own challenges.

Third, with respect to the benefits package, this is already quite comprehensive in terms of health care services, but coverage of pharmaceuticals is quite low. This translates into high out-of-pocket spending for outpatient drugs. Expanding the benefits package to include some essential drugs would significantly enhance financial protection. A key obstacle here is that the pharmaceutical market in Georgia is subject to high prices arising from an oligopolistic market structure, and thus expanding drug coverage could come at substantial cost. But it works both ways; using government purchasing power could help mitigate the cost implications. In any event, given the key role of essential drugs for the management of chronic diseases (which predominate Georgia’s disease burden), and the current high levels of out-of-pocket payments for drugs, expanding MIP to include a more comprehensive benefit would represent a significant step with respect to improving both health outcomes and financial protection.

Fourth, on the issue of MIP’s fiscal implications, while current MIP costs are not high, experience in health systems around the world suggests this will change over time, as coverage is expanded and benefits are enhanced. In addition, the premium currently paid by government to insurers is relatively low, reflecting historically low utilization of health care in Georgia. But as quality and utilization increase, there will be added pressure on the public budget due to MIP.

Finally, significant efforts were made to collect data through a new IT system to capture utilization and reimbursement information between insurers and providers. But there is no systematic, institutionalized effort to analyze this data for program purposes, or to collect data from households or to do rigorous program evaluation. Building analytical capacity will be an important challenge for MIP going forward.

Overall, MIP has registered significant achievements during its first five years of operation. It is well targeted, has made a large impact on the financial protection of beneficiaries, and considerable institutional groundwork has been carried out. But a large agenda remains with regard to covering more of the poor, leveraging supply-side improvements in service provision, and ultimately achieving an impact on health care utilization and outcomes. With regard to passing a verdict on its key feature, the role of private insurers, this will require significantly more time and evidence on how MIP and the overall health system evolve. With a new government seeking to forge its own health reform agenda, many questions remain about how Georgia’s long road toward universal coverage will unfold going forward.
Annex 1 Spider Web

I. Outcomes comparisons:
Georgia and Lower Middle Income Countries

Note on interpretation:
In this plot ‘higher’ is ‘worse’ – since these indicators are positive measures of mortality / morbidity. Life expectancy is converted to be an inverse measure.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

The table below summarizes outcome comparisons with the average lower middle income country (LMIC).

<table>
<thead>
<tr>
<th>Country Data</th>
<th>Georgia</th>
<th>LMIC</th>
<th>% Diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>GNI pc (2000 USD)</td>
<td>218.5</td>
<td>599.4</td>
<td>-59.5%</td>
</tr>
<tr>
<td>IMR</td>
<td>20.0</td>
<td>50.3</td>
<td>-90.3%</td>
</tr>
<tr>
<td>U5MR</td>
<td>22.4</td>
<td>65.4</td>
<td>-68.7%</td>
</tr>
<tr>
<td>Stunting</td>
<td>18.3</td>
<td>70.7</td>
<td>66.9%</td>
</tr>
<tr>
<td>MMR</td>
<td>6.2</td>
<td>200.0</td>
<td>-99.5%</td>
</tr>
<tr>
<td>Adult Mortality</td>
<td>176.9</td>
<td>244.1</td>
<td>-27.5%</td>
</tr>
<tr>
<td>100 Life Expectancy</td>
<td>26.7</td>
<td>34.6</td>
<td>-21.0%</td>
</tr>
<tr>
<td>Neonatal Mortality</td>
<td>15.0</td>
<td>29.1</td>
<td>-48.5%</td>
</tr>
<tr>
<td>CD mortality</td>
<td>9.0</td>
<td>47.0</td>
<td>-97.8%</td>
</tr>
</tbody>
</table>


II. Inputs comparisons
Georgia and Lower Middle Income Countries

Note on interpretation:
This plot shows indicators which measure spending on health or the number of health workers per population.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

The table below summarizes inputs comparisons with the average lower middle income country (LMIC).

<table>
<thead>
<tr>
<th>Country Data</th>
<th>Georgia</th>
<th>LMIC</th>
<th>% Diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>GNI pc (2000 USD)</td>
<td>218.5</td>
<td>599.4</td>
<td>-59.5%</td>
</tr>
<tr>
<td>THE as % of GDP</td>
<td>10.1</td>
<td>4.2</td>
<td>139.3%</td>
</tr>
<tr>
<td>Hospital bed density</td>
<td>3.1</td>
<td>1.4</td>
<td>132.5%</td>
</tr>
<tr>
<td>Physician density</td>
<td>0.5</td>
<td>0.8</td>
<td>518.8%</td>
</tr>
<tr>
<td>Nurse/midwife density</td>
<td>0.3</td>
<td>0.8</td>
<td>218.8%</td>
</tr>
<tr>
<td>GHE as % of THE</td>
<td>38.2</td>
<td>40.3</td>
<td>-5.3%</td>
</tr>
</tbody>
</table>

THE as % of GDP: Health expenditure, total (% of GDP) (2010). Hospital bed density: Hospital beds per 1,000 people (latest available year). Physician density: Physicians per 1,000 people (latest available year). Nurse/midwife density: Nurses and midwives per 1,000 people (latest available year). GHE as % of THE: Public health expenditure (% of total expenditure on health) (2010). All data from World Bank's World Development Indicators.
III. Coverage comparisons
Georgia and Lower Middle Income Countries

Note on interpretation:
In this plot “higher” is “better” – since these indicators are positive measures. In this case, all are percent of the population receiving or having access to a certain health related service.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

The table below summarizes coverage comparisons with the average lower middle income country (LMIC).

<table>
<thead>
<tr>
<th>Country Data</th>
<th>Georgia</th>
<th>LMIC</th>
<th>% Diff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>GNI pc (1000 USD)</td>
<td>218.5</td>
<td>597.4</td>
<td>17.3%</td>
</tr>
<tr>
<td>DPT</td>
<td>91.6</td>
<td>78.7</td>
<td>15.6%</td>
</tr>
<tr>
<td>Prenatal services</td>
<td>97.6</td>
<td>78.1</td>
<td>24.9%</td>
</tr>
<tr>
<td>Contraceptive</td>
<td>47.3</td>
<td>36.1</td>
<td>30.8%</td>
</tr>
<tr>
<td>Skilled birth</td>
<td>99.6</td>
<td>56.8</td>
<td>75.8%</td>
</tr>
<tr>
<td>Sanitation</td>
<td>95.6</td>
<td>47.0</td>
<td>103.5%</td>
</tr>
<tr>
<td>TB success</td>
<td>75.0</td>
<td>88.6</td>
<td>-14.4%</td>
</tr>
</tbody>
</table>

IV. Infrastructure comparisons
Georgia and Lower Middle Income Countries

Note on interpretation:
In this plot “higher” is “better” – since these indicators are positive measures of provision of certain good / service, and a measure of urban development.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

The table below summarizes infrastructure comparisons with the average lower middle income country (LMIC).

<table>
<thead>
<tr>
<th>Country Data</th>
<th>Georgia</th>
<th>LMIC</th>
<th>% Diff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>GNI pc (1000 USD)</td>
<td>218.5</td>
<td>597.4</td>
<td>17.3%</td>
</tr>
<tr>
<td>Paved roads</td>
<td>94.1</td>
<td>49.5</td>
<td>19.9%</td>
</tr>
<tr>
<td>Mobile phones</td>
<td>102.3</td>
<td>79.3</td>
<td>29.3%</td>
</tr>
<tr>
<td>Internet</td>
<td>99.1</td>
<td>81.3</td>
<td>17.6%</td>
</tr>
<tr>
<td>Water</td>
<td>91.6</td>
<td>85.0</td>
<td>5.1%</td>
</tr>
</tbody>
</table>

Paved roads: % of total roads paved (most recent). Internet users: users per 100 people (2010, with some estimates from prior years). Mobile phone users: mobile cellular subscriptions per 100 people (2010). Access to improved water: % of population with access to improved water source (2010). All data from World Bank’s World Development Indicators.
V. Demography comparisons
Georgia and Lower Middle Income Countries

Note on interpretation:
Indicators here measure births per woman, the extent of rurality, and the number of dependents.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

The table below summarizes demographic indicators comparisons with the average lower middle income country (LMIC).

<table>
<thead>
<tr>
<th>Country Data</th>
<th>Georgia</th>
<th>LMIC</th>
<th>% Diff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>TFR (2009)</td>
<td>7.6</td>
<td>5.4</td>
<td>30.8%</td>
</tr>
<tr>
<td>Dependency (Total)</td>
<td>44.7</td>
<td>58.8</td>
<td>-24.0%</td>
</tr>
<tr>
<td>Youth share</td>
<td>53.7</td>
<td>46.7</td>
<td>13.0%</td>
</tr>
<tr>
<td>Rural pop.</td>
<td>47.1</td>
<td>60.6</td>
<td>-23.3%</td>
</tr>
</tbody>
</table>

TFR: total fertility rate (births per woman), 2009. Dependency ratio: % of working-age population (2010) aged less than 15 or more than 64. Youth dependency: % of working-age population (2010) aged less than 15. Rurality: % of total population in rural areas (2010). All data from World Bank's World Development Indicators.

VI. Inequality comparisons
Georgia and Lower Middle Income Countries

Note on interpretation:
In this plot ‘higher’ is ‘inequal’ and indicators here measure inequalities in selected health outcomes by taking the ratio of prevalence between Q1 and Q5.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

The table below summarizes inequality indicators comparisons with the average lower middle income country (LMIC).

<table>
<thead>
<tr>
<th>Country Data</th>
<th>Georgia</th>
<th>LMIC</th>
<th>% Diff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>GNI per ($2000 USD)</td>
<td>718.5</td>
<td>922.4</td>
<td>29.4%</td>
</tr>
<tr>
<td>IMR Q5/Q1</td>
<td>NA</td>
<td>2.0</td>
<td></td>
</tr>
<tr>
<td>U5MR Q5/Q1</td>
<td>NA</td>
<td>2.6</td>
<td></td>
</tr>
<tr>
<td>Stunting Q5/Q5</td>
<td>2.6</td>
<td>2.7</td>
<td>-3.4%</td>
</tr>
<tr>
<td>ARI Q5/Q1</td>
<td>1.0</td>
<td>1.3</td>
<td>-25.0%</td>
</tr>
<tr>
<td>Diarrhea Q5/Q1</td>
<td>1.4</td>
<td>1.5</td>
<td>-8.3%</td>
</tr>
</tbody>
</table>

All indicators measure the ratio of prevalence between the poorest (in Q1, the first wealth distribution quintile) and the richest (in Q5, the fifth wealth distribution quintile). The data (latest data available) are taken from HNPstats [http://data.worldbank.org/data-catalog/HNP Quintiles].
References


The World Bank supports the efforts of countries to share prosperity by transitioning toward universal health coverage (UHC) with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, the quality of the instruments and institutions countries establish to implement UHC are essential to its success. Countries will face a variety of challenges during the implementation phase as they strive to expand health coverage. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Studies Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the nuts and bolts of 27 programs in 25 countries that have expanded coverage from the bottom up, starting with the poor and vulnerable. The protocol consists of 300 questions designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following:

- Manage the benefits package
- Manage processes to include the poor and vulnerable
- Nudge efficiency reforms to the provision of care
- Address new challenges in primary care
- Tweak financing mechanisms to align the incentives of different stakeholders in the health sector

The UNICO Studies Series aims to provide UHC implementers with an expanded toolbox. The protocol, case studies and technical papers are being published as part of the Series. A comparative analysis of the case studies will be available in 2013.