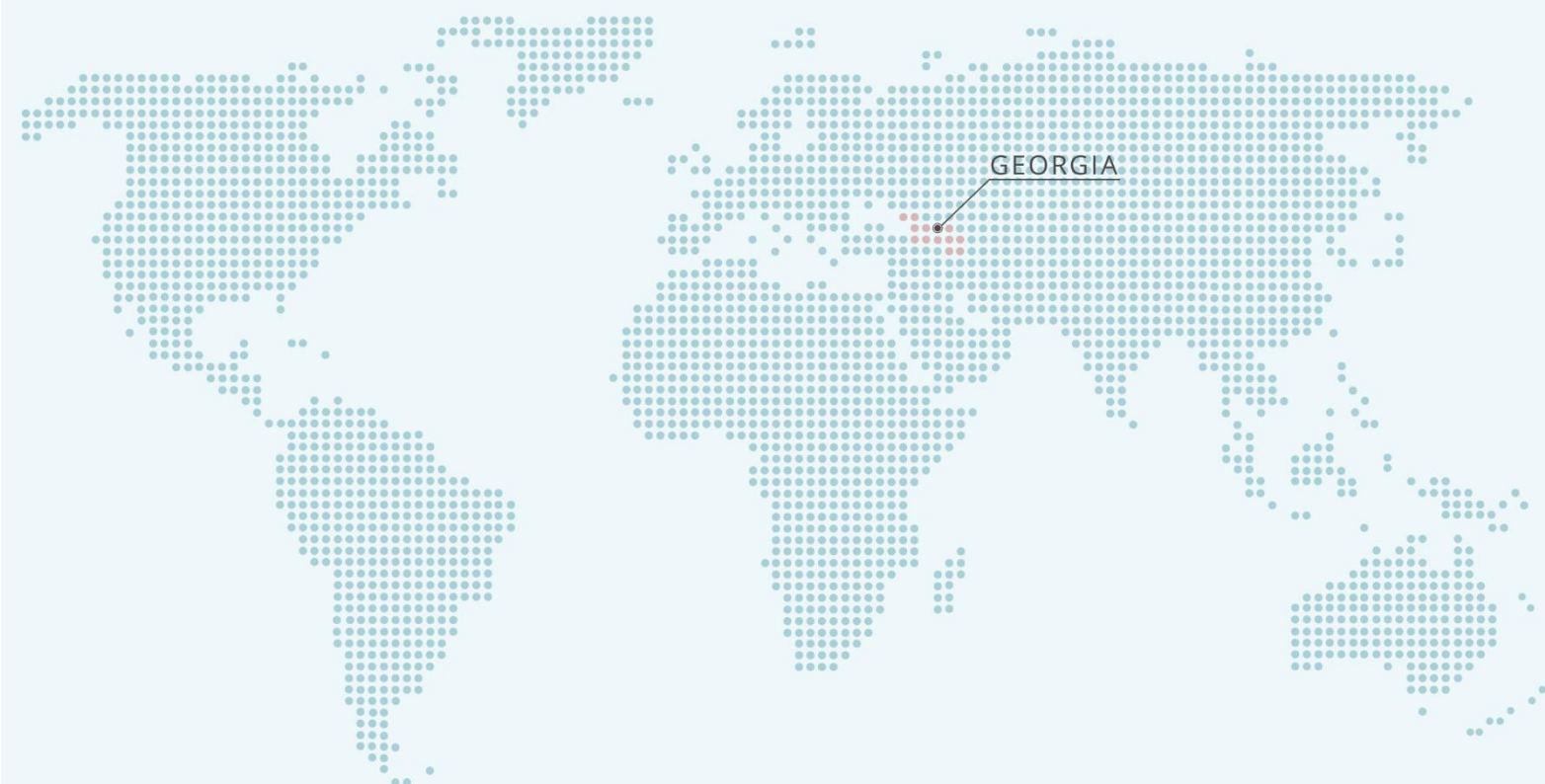


# COUNTABLE INDICATORS SYSTEM FOR ASSESSMENT OF THE UHC PROGRAM AND OTHER STATE PROGRAMS



**Global Alliance  
for Health  
and Social Compact**

## Objectives covered

Elaboration of countable indicators system for assessment of the UHC program and other state programs

## **CONSULTANCY ASSIGNMENT**

According to the Agreement of State Procurement of Advisory Services between Ministry of Labour, Health and Social Affairs of Georgia and Global Alliance for Health and Social Compact, dated 07 April 2015

## **FINAL REPORT**

Objectives covered	Elaboration of countable indicators system for assessment of the UHC program and other state programs
Implementation	Global Alliance for Health and Social Compact
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## Introduction

For the past two decades, Georgia's health system had been undergoing a transformative change. However, at many times, country lacked a framework to measure and evaluates impacts of those transformations.

Furthermore, only in recent years, did the public sector explicitly linked expenditures to performance and impact that set a ground for evaluation and measurement. This was done through introduction of program budgeting as a part of public expenditure framework. However, application of this framework is weak and not operationalized within public sector, including Ministry of Labour, Health and Social Affairs (MoLHSA).

**This report provides a review of existing set of indicators used by the MoLHSA to measure and evaluate its achievements within public expenditures for health;** evaluates strength and weaknesses of current set of indicators and reporting system; formulates operational set of those indicators, together with reporting guidelines/implementation plan (passports) for indicators; and finally, proposes set of recommendations how to improve and adopt this framework in future.

Indicators are the core element of any measurement, evaluation and assessment. They are the “building blocks” for any systematic monitoring and evaluation framework.

Therefore, this report is aimed to identify a set of “priorities” for the healthcare system for use as an organizing framework for the indicators, drawing on priorities expressed in public health programs, other health sector reforms and management priorities in the sector.

For this purpose, it includes a:

- Review existing indicators, currently in use and develop hierarchy of the indicators
- Develop of a draft set of indicators
- Provide indicator passport and recommendations on data collection practices.

In order to meet the following objectives, each of the indicators is scrutinize to meet the following requirement:

- Be suitable for public reporting
- Reflect the range of activity across the system and thus have a clear responsibilities for reporting
- Focus on outcomes for patients, including equity
- Reflect reform directions
- Encourage positive changes and served as a “scorecard” to assess performance
- Are appropriate to benchmark performance
- Are robust
- Utilize existing information system infrastructure.

With those criteria in mind, there are some indicators that do not directly “answer” the results sets out for the intervention. However, one should keep in mind that data collection and analysis functions need to improve in order to establish better capabilities.

Notably, the current report, per the assignment, does not cover all health system domains; rather it concentrates on state healthcare programs that provide of preventive and curative services to individuals.

## **Section I: Health Systems Priorities in Georgia**

Currently Georgia does not have a health sector strategy. However, there are number of documents that state County’s priorities in the health sector. For the purpose to identify which priorities are set by Government, we have reviewed the State Healthcare Concept and Government of Georgia’s strategy for 2020.

### **Strategic Objectives outlined in Health System’s Concept**

State healthcare system concept document outlines direction for health systems development in the country. It lists 10 priorities domains. Below is an excerpt from the document:

1. Health in all policies – general state multi-sectoral approach.
  - Prevention and control of communicable and non-communicable diseases;
  - Education of population;
  - Health of young generation and elderly population;
  - Healthy environment;
  - Water and food safety;
  - Preparedness for emergency situations and catastrophes;
  - Risk factor reduction and health promotion;
  - Reduction of injuries;
  - Improvement of health of individuals in institutions of confinement;
  - Support development of medical education and biomedical sciences;
  - Health services for internally displaced persons – refugees;
2. Development of the healthcare sector governance.
3. Improvement of healthcare financing system .
4. Development of quality medical services.
5. Development of human resources in the healthcare sector.
6. Development of health management information systems.
7. Support of maternal and child health.
8. Improvement of prevention and management of priority communicable diseases.
9. Improvement of prevention and control of priority non-communicable diseases.

## 10. Development of public health system.

Overall, the document is general, and should be considered as a foundation of strategic directions in health sector.

### Strategic Objectives outlined in Government Strategy 2020

The Government of Georgia strategy 2020 gives more specific set of objectives and indicators for health system in the country. Below is the list of those priorities with targets and indicators assigned by 2020. We consider that those should be treated as overarching targets for the national system.

Indicator	Baseline	2017	2020
% of population served by State Healthcare Programs	50	100	100
Per capita PHC visits	2.3	4	8
Share of out-of-pocket payment in Total Healthcare Expenditures	70	≤50	≤30
Share of pharmaceutical expenditures in OPP expenditures	60	≤40	≤20
Life expectancy at birth	74.7	74	76
0-5 child mortality rate per 100 life birth	12.4	10	8
Maternal mortality rate per 100 000 lifebirth	22.8	12.3	8

### International Reporting Requirements

Notably, Georgia is a subject to number of international requirement to report and collect data on certain indicators. MoLHSA should keep a repository of those requirements and oversee the reporting process. Currently, those obligations are shared among different agencies.

**One of the key emerging and comprehensive requirements is to report on set of targets and indicators for Health2020.** This report does not intend to provide review or a summary of these reporting obligations, as it is already stipulated in the methodological guide by WHO.

One consideration to keep in mind in the process of improving current set of indicators and reporting practices to eliminate excessive data reporting and attempt to replace some of the existing program evaluation indicators with that of Health2020. However, currently this seems unreasonable, as most of the State Healthcare Programs do not directly target Health2020 domains.

## Section II: Existing Performance Evaluation framework in Georgia

Currently, country's health system evaluation framework consists of a few core elements, which are summarized below:

### Program Budgeting/Medium-term Expenditure Framework

Georgia public budgeting system started piloting program budgeting, which established medium-term expenditure framework for all public expenditures in 2010. Ministry of Labour, Health and Social Affairs of Georgia was one of the pilot ministries to test the working of Program Budget Methodology.

From 2012, the whole state budget is program based and Ministry of Finance issues regulations related to the composition and reporting of the program budget.

However, based on the information provided by MoLSHA, the system is again undergoing program budget pilot – obviously mostly targeted at improvement of the set of indicators.

Process of Program Budget requires that government first sets a **Strategic Objectives** and then the executive branch of the government should start implementation of programs, which are directly related and contribute to the achievement of those objectives. It is possible to have programs that have no direct impact on the strategic objective, but are essential for the functioning of other programs that directly contribute towards achievement of the objective.

Program Budget entails that each programs has achievable outcomes. Programs are then sub-divided in sub-programs, which have outputs.

Program budget defines different types of program – regulatory, administrative, service provision and infrastructural. **Programs reviewed as part of this report are all service provision type. According to program budgeting methodology, they should have quantitative and qualitative indicators.**

Notably, according to the Ministry of Finance guidance on program budgeting, program can have 4 types of indicators, out of which only the first two are applicable to state healthcare programs:

- **Quantitative:** provide answer to the question “how many”
- **Qualitative:** measures quality of services provided
- **Cost indicators:** evaluates results achieved in relation with the costs;
- **Effectiveness:** describing how cost are related to results achieved
- **Efficiency:** marginal change.

**Indeed, none of the State Health Programs have indictors, other then quantitative. At some point, country should establish more complex framework, although with the understanding that this will involve costs and need for addition data collection and analytical capacity.**



Each ministry develops list of indicators and then reports on their progress in achievement of those indicators.

There is a weak link of measuring achievement of the indicators and mechanism for reacting – what if those indicators are not met? – is missing.

Furthermore, most of the programs that are implemented by the government agencies are continuous by their nature. For example, administrative programs, which include paying salaries to the government officials, continue from year to year and there is weak link to those expenditures and outcomes, or outputs of those expenditures.

State Healthcare Budget has number of program. Here we only review health programs and there are three programs (which are then subdivide into different programs):

- Universal Healthcare Program
- Public Health Program
- Provision of Medical Services in Priority Areas.

### **Health System Performance Assessment**

Health System Performance Assessments are done bi-annually in the country in accordance with the Government of Georgia decree. The methodology is sound and follows WHO recommendations. This is a very sound framework to monitor performance of the system in line with the good international practice and local expert evaluation.

However, reporting process does not seem to be regular. Sometimes it is done every 3 years. This questions reliability of this instrument to be used for reporting purposes.

It would be strongly advised to put those activities and production of the report high on policy agenda and allocate budget funding for the production of the report.

### **Additional Data Sources and Reporting Practices**

There are number of other reports produced in the country that could be considered as a part of the National Evaluation Framework. This includes annual report produced by the National Center of Disease Control and Public Health reporting morbidity and mortality statistics, as well as healthcare utilization and resources. This report does not cover issues for NCDC annual report, although, those need to be analyzed specifically to ensure due reporting and quality of case definitions used in the report.

Furthermore, Ministry of Labour, Health and Social Affairs of Georgia produces National Health Report annually. The report itself can be improved in number of parameters, which will require institutionalization of the reporting process and allocating dedicated staff and funds to produce high quality reports.

National Health Accounts also provide important piece of information and routine monitoring capabilities of the system's progress. Like National Report and HSPA, production is mandated by the Government of Georgia decree. However, there are no

dedicated funds for the reporting and staffing and funding needs for the production should be revised.

SSA had a practice to produce statistical yearbook as well, providing more detailed information about services rendered/covered from programs implemented by the SSA. However, statistical yearbook has not been produced for last few years and statistical information is not routinely available.

### **Section III: Reporting Systems within National Health Programs**

National health programs have streamlined reporting system. The system is electronic. During the assessment some of the key challenges that were identified in the reporting system are:

- Delay – information is processed with significant delay and most often information is not used well for planning;
- Presentation – analysis of the data are not done in a standardized fashion and information is not well presented;
- Analytical functions – since most of the data collected currently under health programs are quantitative, analytical tools are simple; however, if MoLHSA will seek more complex indicators, limited analytical capabilities will become an obstacle;
- There is lack of integration of different sources of information, for example, routine statistical data and program data. There are some examples of this cooperation, but it needs to be enhanced. Furthermore, although, this report only covers indicators within health program, the system will need to develop indicators in other domains as well – clinical quality, health status, cost-effectiveness, etc. and it will become even more essential to have some supra-agency analytical facility;
- Quality of information – we did not have a chance to check quality of the data behind indicators. However, the simple fact that reporting system is not backed up with data quality monitoring system, signifies a potential that information might be flawed and MoLHSA should explore option to monitor quality of the information.

### **Section IV: Review of Existing Targets and Indicators within State Healthcare Programs**

Existing healthcare program have Expected Results framework and outcome and output indicators for a whole programs, as well as output indicators for its sub-programs.

## Expected Results and Indicators from State Health Program (Level II)

Below is the summary of level II Expected Results and Indicators. **Based on the program budgeting methodology of the countries, those are to be the direct measures of achievement of country's strategic objectives.** The table also provides comments/recommendations to be addressed. Notably, Expected results and indicators in Program Budget document are not directly linked as provided in the table below. Moreover, wording of the statements do not sufficiently reflect the idea, some action words are missing, etc. We reworded those statements to match the titles they belong to. Furthermore, different annexes to the state budget project (defining program budget for health), list slightly different set of expected results and indicators. We believe that this is technical error, but needs to be streamlined.

In the table below, those differences will be listed in different colors (Table 1):

**Table 1: Expected Results and Indicators from Program Budget**

Expected results	Indicators	Comments
Population has universal coverage	Number of population to whom state provided medical services	This is a vague definition as “services provided” could refer to ambulance, PHC, hospitalization, etc. The indicator does not have a denominator; Indicator should be worded as “share of population”; It should refer to services that best measure coverage (e.g. PHC)’ “Number of” does not exclude that individuals who receive many services as counted as many individuals
Affordability of medical services is increased <i>The “results” lack 3 additional and essential dimensions of care:</i>  1. <i>Geographic access;</i> 2. <i>Equity in access</i> 3. <i>Quality</i>	Per-capita out-of-pocket payments	The measure directly addresses expected results, and there is a routine data collection of the information through NHA. We suggest adding indicator in additional 3 dimensions, as listed in “results” column. Geographic access and quality/satisfaction could be measured from HUES (bi-annual), as well as equity.
Immunization coverage is increased	Incidence rate of vaccine-preventable diseases	Immunization coverage per se is not the expected results, rather then indicators serve to be better wording of expected results
Incidence of Infectious/communicable diseases is decreased		Wording needs to be adjusted and indicator developed.
Incidence of Hepatitis C is decreased	Incidence of Hepatitis C per 100 000	
Life expectancy of individuals with cancer is increased	Share of patients with breast and cervix cancer who died within the first year diagnosed	
Maternal and child health is improved	Maternal mortality rate per 100 000 life-birth Infant mortality rate per 1000 life birth	
Incidence of HIV/AIDS and TB is decreased	% of late AIDS diagnoses	

	Prevalence and incidence of TB per 100 000	
Healthy lifestyle is supported		Needs indicators to be set.
Reduce mortality		Rather viable expected result, although, indicators, such as increase life-expectancy seems to be better measure of health system functioning
Reduce mortality and morbidity due to communicable and non-communicable diseases		Need to have a list of traceable conditions, which are not identified
Avert mortality due to vaccine-preventable diseases		“Expected result” is better worded, although not all vaccine-preventable diseases immediately pose life threatening conditions, therefore, morbidity and mortality could be a better measure
Reduce morbidity due to TB, HIV/AIDS and other dangerous pathogens		List of traceable conditions for other dangerous conditions need to be identified
Eliminate Hepatitis C		Suited to Georgia’s strategy on Hepatitis C elimination.

### **Expected Results and Indicators within State Programs (Level III)**

Expected results and indicators within state programs should provide measures of Level III set of indicators. Those should be output indicators, which should generate input towards Level II indicators. Notably, Level III indicators have streamlined reporting and information system that supports their routine collection. Therefore, using those indicators does not require additional investment in health information infrastructure, they are traceable from year to year and reporting guidelines are in place (although, not explicitly stated and this would be true in most of the cases).

Those programs also have a hierarchical structure – there are three programs and two of them have sub-programs. Sub-programs are given in *italic*.

Notably, some of the wording does not exactly reflect “results” or “indicators” wording and needs editing and revision. Numbering in the table was added to be the consultant to facilitate mapping and identify missing indicators.

Those are summarized in the table 2 below:

**Table 2: Expected Results and Indicators from State Healthcare Programs**

Name of the Program	Expected Results	Indicators	Baseline	Comments
Universal Healthcare Program	<ol style="list-style-type: none"> <li>1. Reduce mortality</li> <li>2. Number of population that received state funded healthcare services</li> </ol>	<ol style="list-style-type: none"> <li>2. Provision of medical services through state funding is sustained and continues.</li> </ol>	<ol style="list-style-type: none"> <li>2. Number of individuals who received state funded healthcare services</li> </ol>	<p>There is no indicator for “reduced mortality”;</p> <p>Case definitions of “state funded” – refers to only UHP or other programs as well – is missing;</p> <p>Case definition of “number of individuals who received” is missing – what services? Is there double counting?</p>
Public Health Program	<ol style="list-style-type: none"> <li>1. Reduce mortality and morbidity from communicable and non-communicable diseases</li> <li>2. Reduce maternal and child health mortality</li> <li>3. Reduce morbidity due to TB, HIV/AIDS and other socially dangerous pathogens</li> <li>4. Improve functioning of epidemiological surveillance system</li> <li>5. Reduce morbidity due to vaccine preventable diseases</li> <li>6. Eliminate Hepatitis C</li> </ol>	Missing	Missing	

<i>Early Detection of Diseases and Screening</i>	1. Breast cancer screening of females 40 to 70 2. Cervical cancer screening for females 25 to 60 3. Prostate cancer screening for males 50 to 70 4. Early detection of developmental problems among children 0 to 6 5. Primary diagnosis of epilepsy	1. Coverage of 3.5%  2. Coverage 2.5%  3. Coverage of 1.7% 4. Number diagnosed: 650 5. Number diagnosed: 1450	1. 21 000 (2,46%)  2. 23 000 (2.01%)  3. 6 100 (1.4%) 4. Number diagnosed: 628 5. Number diagnosed: 1448	Program provides high-evidence based screening for colorectal cancer and indicator is missing. International evidence suggests that prostate cancer screening “does more harm than good”, therefore, increased coverage is not the best possible target.
<i>Immunization</i>	1. Improve immunization coverage	DPT dose 1: 96% DPT dose 3: 90% MMR dose 1: 90% MMR dose 2: 90%	DPT dose 1: 92.4% DPT dose 3: 78.8% MMR dose 1: 93.4% MMR dose 2: 79.2%	The program also includes other components, such as provision of anti-rabies vaccine and immunoglobulin, for which targets are not identified.
<i>Epidemiological Surveillance</i>	Control of infectious and parasitic diseases	1. Prevention of infectious and parasitic diseases	Unclear	The program results and indicators are unclearly structured and does not respond to program’s content. Program provides for the readiness of epidemiological response.
<i>Safe Blood</i>	1. Increase number of unpaid donations 2. Ensure safety of blood products	1. Number of unpaid donations: 60% 2. Maintain 100% screening of donors	1. Number of unpaid donations 16 500 (29%) 2. 100% of donors are screened	
<i>Prevention of Occupational Diseases</i>	Protection of workers health by prevention and identification of occupational diseases	2. 25 enterprises are examined	1. 5 enterprises are examined	Indicator includes addition text, which is unreadable.



<i>Management of infectious diseases</i>	<ul style="list-style-type: none"> <li>1. Reduce mortality among patients hospitalized with infectious diseases</li> <li>2. Increase access to in-patient treatment for individuals with communicable diseases through access to diagnostics and hospitalization</li> </ul>		<ul style="list-style-type: none"> <li>2. Number of patient who have undergone in-patient treatment: 14 480</li> </ul>	Results, indicators and baseline not compatible/unclear
<i>Tuberculosis</i>	<ul style="list-style-type: none"> <li>1. Patients are supplied with necessary diagnostic services and quality medications</li> <li>2. Financial incentives are provided to improve adherence for patient on long-term outpatient treatment</li> <li>3. Reduce TB prevalence</li> </ul>	<ul style="list-style-type: none"> <li>3. Reduce TB prevalence by 5%</li> </ul>	<ul style="list-style-type: none"> <li>1. Number of patient that have access to necessary diagnostic services and quality medications: 24 830</li> <li>2. Financial incentives: 225 patients</li> <li>3. TB prevalence: 96:100 000</li> </ul>	
<i>HIV/AIDS</i>	<ul style="list-style-type: none"> <li>1. Voluntary screening for MARPs</li> <li>2. Provision of out- and in-patient treatment</li> <li>3. Reduce mortality due to HIV/AIDS</li> </ul>	<ul style="list-style-type: none"> <li>1. Sex workers Screening: 80%</li> <li>2. Provision of in-patient and out-patient treatment: 90%</li> </ul>	<ul style="list-style-type: none"> <li>1. Sex workers screening: 42.1%</li> <li>2. Provision of in-patient and out-patient treatment: 82%</li> </ul>	
Maternal and Child Health	<ul style="list-style-type: none"> <li>1. Maternal mortality rate</li> <li>2. infant mortality rate</li> <li>3. Coverage with antenatal care</li> <li>4. Number of high risk pregnant that underwent treatment</li> <li>5. provision of drugs</li> </ul>		<ul style="list-style-type: none"> <li>2. IMR: 10.5</li> <li>3. Antenatal coverage: 179 100</li> <li>4. Number of high risk pregnant that underwent treatment: 2760</li> <li>5. 947 individuals</li> </ul>	

<i>Treatment of Drug Abuse</i>	1. Number of individuals in the treatment 2. Number of patients with alcohol intoxication under the treatment	1. Number of patients under the treatment 2. Number of patient in the treatment	1. Number of MAT beneficiaries: 3 020 2. Number of patients with alcohol intoxication that were re-hospitalized with the same diagnosis within 1 month	
<i>Health Promotion</i>	Coverage of target population with social media	Number of videos, campaign planned and flyers printed	Coverage with social media	
<i>Management of Hepatitis C</i>	1. Rate of successful completion of treatment 2. Reduce Hepatitis C incidence and prevalence	1. Patients in the treatment: 20000 2. Rate of cured: 95%	1. Patients in the treatment: 3000 2. Rate of cured: 90% 3. Hepatitis C incidence rate: 4.5	
Provision of Medical Services in Other Priority Areas	1. Improve quality of life for patients with mental health problems 2. Reduce mortality among beneficiaries 3. Increase Utilization of PHC	1. 100% of patients have access to MH services 2. Mortality rate among beneficiaries 3. 100% coverage with PHC services in rural areas	1. MH Prevalence: 2547 MH incidence: 260 2. Mortality rate among beneficiaries 3. Utilization of Rural Doctor: per capita visits: 1.7	Mortality rate among program beneficiaries was never calculated Quality of life is not necessarily improved by having access; while 100% coverage rate is too ambitious Indicators with rural PHC services do not match
<i>Mental Health</i>	1. Quality of life for patients with metal health problems is improved 2. Patients with Metal Health problems have access to out-patient and in-patient treatment		1. MH prevalence: 2547 MH incidence: 260 2. Number of beneficiaries of in-patient care: 4800	

			Number of beneficiaries for out-patient care: 22 453	
<i>Diabetes Care</i>	1. Number of beneficiaries of diabetes care program 2. Reduce number of complications due to diabetes	1. No of Children: 1000 2. No of beneficiaries of specialized out-patient care services: 6500	1. No of Children: 795 2. No of beneficiaries of specialized out-patient care services: 5000 3. Number of beneficiaries: 24 383	Results and indicators do not match
<i>Pediatric Oncohematology</i>	Number of beneficiaries	Improve quality of life of children with oncohematological diseases	No of beneficiaries: 134 No of cases: 19.4 thousand	Results and indicators do not match
<i>Dialysis and Kidney Transplantation</i>	1. Coverage of patients with terminal kidney failure with dialysis services 2. Provision of dialysis care		1. Coverage with dialysis: 100% 2. No of patients on hemodialysis: 2319 No of patients with peritoneal dialysis: 181	Results and indicators do not match Impossible to measure
<i>Palliative Care</i>	1. Provision of out-patient palliative care 2. Provision of in-patient palliative care 3. Provision of drugs	Incurable patients are covered with adequate level of care	1. No of out-patient care beneficiaries: 625 2. No of in-patient care beneficiaries: 592	Indicator is not measured by the data provided in the baseline
<i>Rare Diseases and Substitution Treatment</i>	1. No of beneficiaries 2. No of conditions covered	Provide adequate treatment for children with rare diseases	1. No of beneficiaries for out-patient care: 149; Cases: 669	Results and indicators do not match
<i>Ambulance</i>	1. Number of calls served	Beneficiaries have access to timely and quality care	1. Referral transpiration cases: 31000 2. Ambulance visits: 476 200	Results and indicators do not match

<i>Rural Doctor</i>	1. Visits to rural doctor 2. Number of rural doctors and nurses	Share of utilization of PHC services Number of visits of target population	1. No of visits: 1 417 626	Using “per capita” rate would be more appropriate “Share of utilization” is not clear
<i>Referral Care</i>	No of cases funded	No of beneficiaries is stuffiest/adequate	No of patient: 7314 No of cases: 9230	Not clear what is “adequate number of beneficiaries”
<i>Medical Check-up for Army Recruits</i>	Army recruits undergo medical check-up	Ensure good health of army recruits	No of individuals to be recruited: 7687	Unclear

As seen from the table above, we can summarize few of the major issues:

- Not all the expected results have matching indicators to measure the progress
- Wording needs revision (this is not reflected with English language translation)
- Indicators do not directly measure the results
- There is no explicit guide for how indicators are calculated.

## **Section V: Suggested List of Indicators and Implementation Guidelines**

Based on the analysis above, we have formulated a matrix of indicators, streamline objectives and indicators from different strategies domains and developed hierarchical structure for them. You would find those in the Annexes below:

1. Annex 1 and 2: Set of indicators
2. Annex 4, 5 and 6 provides indicator passports with definitions, reporting and implementation guidelines.

### **Indicator Passport**

In order to operationalize evaluative framework, each indicator identified should have a clear rational, measurement and reporting guidelines. Those can be summarized and Indicator Passport.

There are number of different ways to develop Indicator Passport. For example, below (Table 3) is an example of a set of essential information for an indicator passport, with the sample.

### **Implementation Considerations**

Implementations of the Programs, including reporting and evaluation methodologies are currently covered by the Law of Georgia on State Budget. Nevertheless, implementation is weak.

Furthermore, we could not identify a written mechanism for monitoring and evaluation of Strategy 2020, or Health Systems Concept.

HSPA has a set methodology also regulated by the Government Decree.

Overall, in the reporting practices, there are number of flaws that need to be addressed immediately:

- Evaluation should have high political commitment: this process should be an important part of MoLHSA's work;
- There should be a dedicated team and resources for monitoring, data collection improvement and analysis. Those functions are currently scattered among different institutions; especially, analytical function is weakened by this arrangement. At some point, if the MoLHSA want to have a stronger set of indicators, those capacity should be established.

- Country should explore possibilities to dedicate more funds to operational research activities, or encourage other institutions to do so. Overall, it is hard to find evaluations or operational research findings related to national program implementation. Routine quantitative data collection is not sufficient to see issues with implementation and evaluate impact.

**Table 3: Sample for Indicator Passport**

#	<u>Indicator Name</u>	<u>Purpose</u>	<u>Indicator Description</u>	<u>Data Types</u>	<u>Source</u>	<u>Currency</u>	<u>Data Quality</u>	<u>Interpretation:</u>	<u>Comparative Potential:</u>	<u>Detailed Calculation Methodology</u>
		Performance Dimension and Sub-Dimension	Numerator and denominator	For each of the numerator and denominator note survey or Admin	Organization, File, Key data contact	Most Current Year, Range of Available Years, Reporting Period (i.e. Annual, Quarterly	Dimensions of data quality including accuracy (validity), completeness ( <b>coverage</b> ), etc.	What it means and any assumptions or caveats that should be considered.	References to any publications or other jurisdictions that have used this indicator.	Exact information required to replication, including all inclusions/exclusions adjustments etc.
1	The Share of public health expenditure in fiscal year, that is not reflected in the Medium Term Expenditure Framework (MTEF) in all public health expenditure defined by the Budget Law	<i>Improve Health System Stewardship</i>	<p><b><u>Numerator:</u></b> Public health <u>expenditures</u> that are not reflected in MTEF</p> <p><b><u>Denominator:</u></b> All public health <u>expenditures</u> defined by the Budget Law</p>	Administrative (both)	<p>Georgian Law on State Budget.;</p> <p>Basic Data and Directions (BDD)</p>	<p>BDD (2005-2007)</p> <p>Georgian Law on State Budget (2006-2008)</p>	Both documents (BDD and Georgian Law on State budget) are documents and are of <b>High</b> quality.	<p>BDD includes 4 years budget estimations/projections (by priorities and dimensions/sub-dimensions)</p> <p>It is important to check if macro-economic parameters (inflation %, GDP increment etc.) are reflected in the budgets.</p>		Document will describe the process of budget preparation. As BDD includes budget projections for 4 years period, those 4 years' budgets will be compared against appropriate BDDs.

## Indicators and Passports

### Annex 1 and 2: Set of indicators

Strategic Level (Government Strategy 2020)					Health System Performance Assessment Framework (Level I)			Medium-term Strategic Objectives (Level II)		
Indicator	Baseline	2017	2020	Improved Health System Management and Organization	System Assessment Sub-component	#	Assessment Indicators	Expected Results	Program Domain	Indicators (Level II)
					Supporting implementation of the evidence-based policy cycle	1	In the current financial year the share of government allocations for health care not included in the medium term expenditure framework			
					Improvement of health system regulation	2	Share of medicines subject to state quality control in the total number of medications			
					Emergency and disaster preparedness	3	a) Rate of health care facilities that have developed preparedness plans			
							b) Number of medical professionals trained in disaster preparedness			
					Improvement of intersectoral coordination mechanisms	4	Share of decisions made in cooperation with different intersectoral agencies in the total number of			



							health-related decisions			
					Development of E-Health and information system	5	Rate of health care providers involved in the health care reporting system (that have submitted reports)			
						6	Comparing maternal and children (under 1 year, under 5 year) mortality study and routine source data			
					Supporting development of health care sciences	7	Share of allocations for studies in the total health expenditures and public spending			
<b>Indicator</b>	<b>Baseline</b>	<b>2017</b>	<b>2020</b>	<b>Improving Effectiveness of the Health Financing System</b>	<b>System Assessment Sub-component</b>	<b>#</b>	<b>Assessment Indicators</b>	<b>Expected Results</b>	<b>Program Domain</b>	<b>Indicators (Level II)</b>
					Improving effectiveness of the health financing system	8	Total health expenditure / public spending as a share of GDP; change to the structure of health sector revenues: public/ private/donor			
						9	State spending on hospital and out-patient services and public health as compared to overall public spending on health			
						10	Share of total funds allocated for state-funded health insurance programs as			

							compared to the overall state funds for state programs			
<b>Indicator</b>	<b>Baseline</b>	<b>2017</b>	<b>2020</b>	<b>Improving Organization of Medical Service Delivery</b>	<b>System Assessment Sub-component</b>	<b>#</b>	<b>Assessment Indicators</b>	<b>Expected Results</b>	<b>Program Domain</b>	<b>Indicators (Level II)</b>
					Hospital sector development	11	a) Dynamics of bed capacity indicator			
							b) Dynamics of bed occupancy			
							c) Dynamics of the average indicator of length of stay			
					PHC development	12	a) Annual visits to PHC facilities (or at hospital level) per capita; share of the number of the first contacts with PHC vs. total number of contacts			
							b) Share of expenditures on out-patient care at hospital level in the total expenditures on out-patient care			
					Organization of ambulance services	13	Emergency calls to ambulance service per capita			
					Health care in institutions of the penitentiary system	14	The rate of renovated doctor's and dentist's offices at penitentiary system institutions vs. the total number of doctor's and dentist's offices			

Indicator	Baseline	2017	2020	Human Resources	System Assessment Sub-component	#	Assessment Indicators	Expected Results	Program Domain	Indicators (Level II)
					Motivated and qualified medical staff	15	a) Geographical distribution of medical staff (doctors and nurses)			
							b) Correlation of numbers of doctors and nurses			
							Human resource structure			
						16	a) Ratio of visits per full-time physician and the number of physicians at hospital and out-patient levels			
							b) Average monthly salary for medical professionals			
Indicator	Baseline	2017	2020	Improving Geographic and Financial Access to Effective Health Care	System Assessment Sub-component	#	Assessment Indicators	Expected Results	Program Domain	Indicators (Level II)
% of population served by State Healthcare Programs	50	100	100		Geographic and physical access to effective health care	17	a) Percentage of population who can travel to medical facility in 30 minutes by using regular transportation means	Necessary Medical Services are Geographically Accessible	Rural Doctor Program Ambulance Program	Per capita PHC visits
							b) Rate of health care facilities where doctors are available at least 5 days a week			Per capita PHC visits in rural areas
Per capita PHC visits	2.3	4	8		Improving of affordability of health care	18	Percentage of health insurance policy holders (individual or corporate) in the overall size of population	Population has universal access to essential healthcare services	All Healthcare Programs	Share of Population Registered with PHC Services under UHP

						19	Percentage of population who, due to financial limitations, had to refuse basic medical interventions in times of need			Share of Rural Population Registered with PHC Services under Rural Doctor Program
Share of out-of-pocket payment in Total Healthcare Expenditures	70	≤50	≤30			20	Percentage of “out of pocket” health payments vs. overall health spending by service types			
					Improving access to medicines	21	a) Percentage of drug expenditures incurred by the population within their private health expenditures b) Percentage of consultations, when the medicines were prescribed to a patient but were not purchased due to their high cost (computed on the basis of all consultations)			
Share of pharmaceutical expenditures in OPP expenditures	60	≤40	≤20			22	Margin of average markup on drugs in Georgia			
<b>Indicator</b>	<b>Baseline</b>	<b>2017</b>	<b>2020</b>	<b>Improving Quality and Safety</b>	<b>System Assessment Sub-component</b>	<b>#</b>	<b>Assessment Indicators</b>	<b>Expected Results</b>	<b>Program Domain</b>	<b>Indicators (Level II)</b>
					Supporting evidence-based clinical practice	23	Dynamics of number of approved guidelines and protocols			

						24	Number of doctor's liability cases reviewed by the Council of Professional Development			
					Patient safety and medical service quality control	25	Percentage of complicated deliveries (peritonitis developed after Caesarean section, obstetric trauma) in total number of deliveries			
						26	Nosocomial infection rate: share of positive results in studied cultures			
<b>Indicator</b>	<b>Baseline</b>	<b>2017</b>	<b>2020</b>	<b>Ensuring Equity and Financial Protection</b>	<b>System Assessment Sub-component</b>	<b>#</b>	<b>Assessment Indicators</b>	<b>Expected Results</b>	<b>Program Domain</b>	<b>Indicators (Level II)</b>
					Ensuring equal distribution of the load of health care financing system; financial protection of the population from catastrophic health expenditures	27	a) Percentage of household health expenditures of household's total spending and solvency	Equity in Access of Necessary Medical Services in Ensured	UHP	OOP by income quintile (HUES)
							b) Share of population with catastrophic health expenditures			
<b>Indicator</b>	<b>Baseline</b>	<b>2017</b>	<b>2020</b>	<b>Protecting Patient Rights</b>	<b>System Assessment Sub-component</b>	<b>#</b>	<b>Assessment Indicators</b>	<b>Expected Results</b>	<b>Program Domain</b>	<b>Indicators (Level II)</b>

					Development of Mediation Service	28	Share of different types of health insurance policies (state, individual or corporate) and visits to health care facilities in the overall number of visits			
					Reducing information barriers to access to medical services	29	Percentage of the population informed about their health care benefits			
<b>Indicator</b>	<b>Baseline</b>	<b>2017</b>	<b>2020</b>	<b>Improving health promotion, establishment of healthy lifestyle, disease prevention and early disease detection</b>	<b>System Assessment Sub-component</b>	<b>#</b>	<b>Assessment Indicators</b>	<b>Expected Results</b>	<b>Program Domain</b>	<b>Indicators (Level II)</b>
					Raising population awareness of the of main risk factors and public health risks; increasing involvement in screening and early disease detection programs	30	Tobacco, alcohol and drug abuse rate			
						31	Distribution of HIV/AIDS Cases by Modes of Transmission			
						32	Awareness of women of reproductive ages about the modern methods of contraception			

						33	a) Antenatal care coverage (%), 4 visits	Maternal and child health is improved	Maternal and Child Health Programs	Antenatal care coverage % (4 visits)
							b) The ratio of births attended by qualified medical professionals			
						34	Measles vaccination coverage among children under 2 years	Morbidity and mortality due to vaccine-preventable diseases is reduced	Immunization	Immunization Coverage
						35	a) Rate of low birth-weight newborns			
							b) Physical activity/obesity			
						36	The rate of women who had cervical Pap-test and mammogram			
								Eliminate Hepatitis C	Hepatitis C	a) Share of population with Hepatitis C who underwent treatment b) Share of population with Hepatitis C successfully treated
Indicator	Baseline	2017	2020	Improving Clinical Outcomes and Increasing Satisfaction	System Assessment Sub-component	#	Assessment Indicators	Expected Results	Program Domain	Indicators (Level II)

				Improving clinical outcomes	37	a) Overall results of pulmonary tuberculosis MGB+ treatment vs. Cases in correctional institutions	Morbidity and mortality due to TB and HIV/AIDS is reduced	TB	TB incidence rate	
						b) The ratio of multidrug- resistant tuberculosis of the number of new and treated cases of pulmonary tuberculosis MGB+ and treatment outcomes		HIV/AIDS	HIV incidence rate	
						38		a) Percentage of late detection of HIV infection of the number of new cases	HIV/AIDS	% of late detection of HIV infection in the number of new cases
						39		a) Percentage of malignant cancer detected at the 1 <sup>st</sup> and 2 <sup>nd</sup> stages	Early Detection and Screening	Coverage of breath, cervix and colorectal cancer screening
					b) Mortality caused by infraction during the first 24 hours			Share of patients who died in the first year of cancer diagnoses		
					Patient satisfaction	40	The level of satisfaction of the population with medical services			
Indicator	Baseline	2017	2020	Improving Population Health	System Assessment Sub-component	#	Assessment Indicators	Expected Results	Program Domain	Indicators (Level II)
Life expectancy at birth	74.7	74	76		Reducing morbidity and	41	Average life expectancy at birth			



0-5 child mortality rate per 100 live birth	12.4	10	8	mortality rates associated with specific conditions (e.g.: maternal and children health, non-communicable diseases, etc.)	42	Infant, under- 5 and maternal mortality	Life expectancy at birth is increased  Morbidity and mortality due to preventable causes is reduced	All Healthcare Programs	Life expectancy at birth IMR MMR
					43	Mortality rate per 100 000 persons for the 5 most common disease groups (IDC 10) ICD			
					44	a) Incidence rate per 100 000 persons for the 5 most common disease groups (IDC 10).			
						b) Incidence and mortality caused by blood circulatory system diseases			
						c) incidence and prevalence of mental and behavioural disorders			
						d) incidence and mortality caused by traumas, food poisoning and consequences of external causes			
Maternal mortality rate per 100 000 livebirth	22.8	12.3	8						

Name of the Program	Expected Results	Status	Indicators	Source
Universal Healthcare Program	Reduce mortality	Removed		
	Improve health status of the population	New	Increase life expectancy at birth	NCDC
	Increase access to essential medical services	Changed	Share of total population registered with PHC service providers under the UHP	SSA

			No of beneficiaries that received state funded healthcare services for defined line of services	SSA
	Increase affordability of essential medical services	New	Share of OOP in THE	HUES/NHA
Public Health Program	Reduce mortality and morbidity from communicable and non-communicable diseases	Removed		
	Reduce maternal and child health mortality	Unchanged	MMR IMR	NCDC
	Reduce morbidity due to TB, HIV/AIDS and other socially dangerous pathogens	Unchanged	TB prevalence rate HIV/AIDS prevalence rate No of cases of EDPs	NCDC
	Ensure functioning of epidemiological surveillance system	Unchanged	Regional and municipal epidemiological information system is fully functioning (Reports and case notifications meet country's regulations)	NCDC
	Reduce morbidity due to vaccine preventable diseases	Unchanged	Immunization coverage rates	NCDC
	Reduce prevalence of Hepatitis C	Changed	Hepatitis C incidence & prevalence rate	NCDC
<i>Early Detection of Diseases and Screening</i>	Ensure early diagnosis of cancer	Changed	Screening coverage rates	NCDC
	Ensure access to specialised child development services for children from 0 to 6	Changed	No of patients	NCDC
	Ensure access to epilepsy diagnosis services	Changed	No of patients	NCDC
<i>Immunization</i>	Improve immunization coverage	Unchanged	DPT dose 1 coverage	NCDC
			DPT dose 3 coverage	NCDC
			MMR dose 1 coverage	NCDC
			MMR dose 2 coverage	NCDC

<i>Epidemiological Surveillance</i>	Ensure functioning of epidemiological surveillance system	Changed	Regional and municipal epidemiological information system is fully functioning (Reports and case notifications meet country's regulations)	NCDC
			Proportion of surveillance units with routine laboratory data analysis and interpretation	NCDC
			No of malaria cases	NCDC
<i>Safe Blood</i>	Increase number of unpaid donations	Unchanged	Number of unpaid donations	NCDC
	Ensure safety of blood products	Unchanged	share of donors screened (100%)	NCDC
<i>Prevention of Occupational Diseases</i>	Provision of targeted studies of occupational health systems in selected enterprises	Changed	No of enterprises studied	NCDC
<i>Management of infectious diseases</i>	Reduce mortality with infectious and parasitic diseases	Changed	Mortality rate with infectious and parasitic diseases	NCDC
<i>Tuberculosis</i>	Reduce TB prevalence and incidence rate in the country	Changed	TB prevalence rate (incl. MDR TB separately)	NCDC
			TB incidence rate (incl. MDR TB separately)	NCDC
	Provide quality treatment for patients with TB		Treatment default rate	NCDC
			No of beneficiaries (or samples) examined in each component	NCDC
<i>HIV/AIDS</i>	Reduce morbidity and mortality due to HIV/AIDS	Changed	Share of MARPs screened	NCDC
			HIV related mortality rate in PLWHA	NCDC
			% of PLWHA with TB	SSA, NCDC
Maternal and Child Health	Improve maternal and child health	Changed	MMR	NCDC
			IMR	NCDC
			Antenatal care coverage (4 visits)	NCDC, SSA

<i>Treatment of Drug Abuse</i>	Reduce illegal drug consumption	Changed	Coverage of drug abusers with MAT programs (based on size estimations studies)	SSA, NCDC
	Provide quality treatment for patients with alcohol abuse	Changed	Share of patients re-hospitalized with the same diagnosis	SSA
<i>Health Promotion</i>	Coverage of target population with social media		Number of videos, campaign planned and flayers printed	NCDC
<i>Management of Hepatitis C</i>	Reduce prevalence of Hepatitis C	Changed	Rate of successful completion of treatment	SSA
			Reduce Hep C incidence	NCDC
Provision of Medical Services in Other Priority Areas	Increase access of PHC services in rural and remote areas	Changed	Per capita PHC utilization by rural population	NCDC
	Ensure access to mental health services		No of beneficiaries for out-patient services who have had at least 2 visits (annually)	NCDC
	Beneficiaries have access to timely and quality ambulance care		No of beneficiaries served	SSA
<i>Mental Health</i>	Ensure access to mental health services	Changed	No of beneficiaries for out-patient services who have had at least 2 visits (annually)	SSA
			Rate of urgent MH re-hospitalization (annually)	SSA, NCDC
			No of beneficiaries per each component	SSA
			Share of patients with 3 month of longer length-of-stay among all in-patients	SSA
<i>Diabetes Care</i>	Ensure access to drugs and specialized services for patients with diabetes	Changed	No of beneficiaries for drug components (children/adult)	SSA

<i>Paediatric Oncohematology</i>	Improve quality of life of children with oncohematological diseases	Changed	Case fatality rate	SSA
<i>Dialysis and Kidney Transplantation</i>	Improve quality of life for patients with terminal organ failure		No of patients on diesis services	SSA
			Fatality rate of patients on dialysis	SSA
			Fatality rate/organ rejection rate of post-transplantation patients	SSA, NCDC
<i>Palliative Care</i>	Terminal patients have access to palliative care and pain management services	Changed	Share of population who can access palliative care services when needed (regional distribution)	SSA
			No of beneficiaries for in-patient and out-patient services	SSA
			No of beneficiaries for pain management drug component	SSA
<i>Rare Diseases and Substitution Treatment</i>	Ensure quality treatment and access to drugs to children with rare diseases	Changed	No of children with rare diseases served by in-patient and out-patient care providers	SSA
			No of beneficiaries of rare disease drugs	NCDC, SSA
<i>Ambulance</i>	Beneficiaries have access to timely and quality ambulance care	Changed	No of beneficiaries served	NCDC
			Share of calls served within stratified timing framework	NCDC
<i>Rural Doctor</i>	Increase access of PHC services in rural and remote areas	Changed	Per capita PHC utilization by rural population	NCDC
			Number of visits of target population	NCDC

<i>Referral Care</i>	Increase affordability of additional medical services for individuals	Changed	No of beneficiaries	MoH
<i>Medical Check-up for Army Recruits</i>	Ensure good health of army recruits	Changed	All army recruits undergo essential medical check-up	SSA

## Annex 4, 5 and 6: Passports

#	<u>Indicator Name</u>	<u>Purpose</u>	<u>Indicator Description</u>	<u>Data Types</u>	<u>Source</u>	<u>Currency</u>	<u>Data Quality</u>	<u>Interpretation:</u>	<u>Detailed Calculation Methodology</u>
		Connected to HSPA Performance Dimension and Sub-Dimension	Numerator and denominator	For each of the numerator and denominator note survey or Admin	Organization, File, Key data contact	Most Current Year, Range of Available Years, Reporting Period (i.e. Annual, Quarterly	Dimensions of data quality including accuracy (validity), completeness (coverage), etc.	What it means and any assumptions or caveats that should be considered.	Exact information required to replication, including all inclusions/exclusions adjustments etc.
1	% of population served by State Healthcare Programs	8. PROTECTING PATIENT RIGHTS/Development of Mediation Service	Numerator: population served by State Healthcare Programs Denominator: Total number of population	Administrative	Numerator: SSA/ISSSoG Denominator: GEOSTAT	2014, Annual	High	For calculation needed number of people who have private/corporate insurance and are not UHC beneficiaries (ISSSoG)	Total population - number of people who have private/corporate insurance and are not UHC beneficiaries
2	Per capita PHC visits	3. IMPROVING ORGANIZATION OF MEDICAL SERVICE DELIVERY/PHC development	Numerator: Number of ambulatory care visits Denominator: Total number of population	Administrative	Numerator: NCDC&PH Denominator: GEOSTAT	2014, Annual	High	Visits in PHC facilities: rural doctors, ambulatories, Polyclinics	Number of ambulatory care visits / Total number of population

3	Share of out-of-pocket payment in Total Healthcare Expenditures	5. IMPROVING GEOGRAPHIC AND FINANCIAL ACCESS TO EFFECTIVE HEALTH CARE/Improving of affordability of health care	Numerator: Out-of-pocket (OOP) health payments Denominator: THE	Administrative	NHA	Annual	Meddium	Out of pocket expenditure is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. It is a part of private health expenditure.	out-of-pocket payment / THE *100
4	Share of pharmaceutical expenditures in OPP expenditures	5. IMPROVING GEOGRAPHIC AND FINANCIAL ACCESS TO EFFECTIVE HEALTH CARE/Improving access to medicines	Numerator: Denominator:	Administrative	NHA	2014, Annual	Average		pharmaceutical expenditures / OOP expenditure *100



5	Life expectancy at birth	11. IMPROVING POPULATION HEALTH/Reducing morbidity and mortality rates associated with specific conditions		Administrative	GEOSTAT	2014, Annual	High	Life expectancy is the average number of years of life remaining to a person at a particular age and is based on a given set of age-specific death rates, generally the mortality conditions existing in the period mentioned. It is calculated by the analysis of life tables (also called a mortality table or actuarial table)	
6	0-5 child mortality rate per 100 live birth	11. IMPROVING POPULATION HEALTH/Reducing morbidity and mortality rates associated with specific conditions	Numerator: Total number of deaths of children under the age of five Denominator: Total number of live births	Administrative	GEOSTAT	2014, Annual	High	Under-five mortality rate is the probability of a child born in a specific year or period dying before reaching the age of five, if subject to age-specific mortality rates of that period	Total number of deaths of children under the age of five * 1000/Total number of live births

7	Maternal mortality rate per 100 000 livebirth	11. IMPROVING POPULATION HEALTH/Reducing morbidity and mortality rates associated with specific conditions	Numerator: Total number of maternal deaths Denominator: Total number of live births	Administrative	GEOSTAT	2014, Annual	Meddium	a maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes	Total number of Total number of maternal deaths (direct and indirect) * 100000/Total number of live births
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SSA

Social Service Agency

ISSS

Insurance State Supervision Service of Georgia

GEOSTAT

National Statistics offices of Georgia

NCDC&PH

National Center for Diseases Control and Public Health

NHA

National Health Accounts

## Health System Performance Assessment Framework (Level I)

#	<u>Indicator Name</u>	<u>Purpose</u>	<u>Indicator Description</u>	<u>Data Types</u>	<u>Source</u>	<u>Currency</u>	<u>Data Quality</u>	<u>Interpretation:</u>	<u>Detailed Calculation Methodology</u>
		Performance Dimension and Sub-Dimension	Numerator and denominator	For each of the numerator and denominator note survey or Admin	Organization, File, Key data contact	Most Current Year, Range of Available Years, Reporting Period (i.e. Annual, Quarterly	Dimensions of data quality including accuracy (validity), completeness (coverage), etc.	What it means and any assumptions or caveats that should be considered.	Exact information required to replication, including all inclusions/exclusions adjustments etc.
<b>1. IMPROVING HEALTH SYSTEM MANAGEMENT AND ORGANIZATION</b>									
1	In the current financial year the share of government allocations for health care not included in the medium term expenditure framework	Supporting implementation of the evidence-based policy cycle	Numerator: Public health expenditures that are not reflected in MTEF Denominator: All public health expenditures defined by the Budget Law	Administrative	Georgian Law on State Budget; Basic Data and Directions (BDD) document	Numerator : 2014; annual Denominator: 2014-2017; annually for 4 years	High	BDD includes 4 years budget estimations/projections (by priorities and dimensions/sub-dimensions)	Public health expenditures that are not reflected in MTEF / All public health expenditures defined by the Budget Law *100  As BDD includes budget projections for 4 years period, those 4 years'

									budgets will be compared against appropriate BDDs.
2	Share of medicines subject to state quality control in the total number of medications	Improvement of health system regulation	Numerator: Number of controlled drugs Denominator: Total number of circulated drugs	Administrative	RAMA;	2014, Annual	Medium	% of pharmaceuticals are controlled by RAMA annually from total number of circulated drugs	Amount of controlled drugs / Total number of circulated drugs *100
3	a) Rate of health care facilities that have developed preparedness plans	Emergency and disaster preparedness	Numerator: Number of health care facilities (Hospitals) that have developed preparedness plans Denominator: Total Number of Hospitals	Administrative	Numerator: MoLHSA; Denominator: RAMA/NCDC &PH	2014	High	Hospitals readiness for Emergency and disaster preparedness	Health care facilities (Hospitals) that have developed preparedness plans / Total Number of Hospitals *100

	b) Number of medical professionals trained in disaster preparedness			Administrative	MoLHSA	2014	High		
4	Share of decisions made in cooperation with different intersectoral agencies in the total number of health-related decisions	Improvement of intersectoral coordination mechanisms	Numerator: Number of decisions made in cooperation with different intersectoral agencies denominator: Total number of health-related decisions	Administrative	MoLHSA	2014	Medium	Describes Intersectoral coordination	Number of decisions made in cooperation with different intersectoral agencies / Total number of health-related decisions *100
5	Rate of health care providers involved in the health care reporting system (that have submitted reports)	Development of E-Health and information system	Numerator: Number of healthcare providers included in the sectoral reporting system Denominator: Total number of healthcare providers	Administrative	NCDC&PH/RA MA	2014; annual	High	% of providers involved in the reporting process annually In 2014 Dental Polyclinics are not included in the licensing and therefore will be left out of the analysis.	Number of healthcare providers included in the sectoral reporting system / Total number of healthcare providers *100

6	Comparing maternal and children (under 1 year, under 5 year) mortality study and routine source data		a) Differences in numbers of annual death b) Differences between rates of annual death	Administrative and survey results	GEOSTAT; NCDC&PH; RHS; RAMOS; UN IGME; MMEIG	Admin data 2014; RHS - 2010; RAMOS 2014; UN IGME 2014	Medium	Difference between estimates in annual birth/death reported by Reproductive Health Survey vs. routine reporting to SDS	The difference between the data from different sources
7	Share of allocations for studies in the total health expenditures and public spending	Supporting development of health care sciences	Numerator: Public Expenditure on health research and development denominator: Public expenditure on health		MES	2014	High		Public Expenditure on health research and development / Public expenditure on health * 100

## 2. IMPROVING EFFECTIVENESS OF THE HEALTH FINANCING SYSTEM

8	Total health expenditure / public spending as a share of GDP; change to the structure of health sector revenues: public/private/donor	Improving effectiveness of the health financing system	Numerator: a) Total health expenditure; b) Public health expenditure Denominator: GDP  Numerator: c) Public health expenditure d) Private health expenditure; e) Donor expenditure on health Denominator: THE	Administrative	NHA; GEOSTAT					a) Total health expenditure / GDP *100; b) Public health expenditure / GDP *100; c) Public health expenditure/THE *100 c) Private health expenditure / THE *100; d) Donor expenditure on health /THE *100;
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9	State spending on hospital and out-patient services and public health as compared to overall public spending on health		Numerator: a) State spending on hospital; b) State spending on out-patient services; c) State spending on public health denominator: overall public spending on health	Administrative	NHA				a) State spending on hospital / overall public spending on health *100 b) State spending on out-patient services / overall public spending on health c) State spending on public health / overall public spending on health
10	Share of total funds allocated for state-funded health insurance programs as compared to the overall state funds for state programs		Numerator: total funds allocated for state-funded health insurance programs denominator: state funds for state programs	Administrative	Georgian Law on State Budget;	2014	High		Total funds allocated for state-funded health insurance programs / state funds for state programs *100

### 3. IMPROVING ORGANIZATION OF MEDICAL SERVICE DELIVERY



11	a) Dynamics of bed capacity indicator - Hospital bed per 100000 population	Hospital sector development	Numerator: Total number of hospital beds denominator: Midyear population	Administrative	NCDC&PH/RA MA	2014	Medium	Hospital beds are defined as all beds that are regularly maintained and staffed and are immediately available for use. They include beds in general hospitals, mental health and substance abuse hospitals, and other specialty hospitals. Beds in nursing and residential care facilities are excluded.	Total number of hospital beds * 100000/Midyear population
	b) Dynamics of bed occupancy		Numerator: Total number of bed-days spent by patients in a hospital denominator: Total number of hospital beds	Administrative	NCDC&PH	2014	High	Average number of days when hospital bed was occupied as % of available 365 days	(Total number of bed-days spent by patients in a hospital *100) / (Total number of hospital beds *365)

	c) Dynamics of the average length of stay		Numerator: Total number of bed-days spent by patients in a hospital denominator: Total number of all hospital discharges in the given hospital	Administrative	NCDC&PH	2014	High	Average length of stay (ALOS) refers to the average number of days that patients spend in hospital.	Total number of bed-days spent by patients in a hospital /Total number of all hospital discharges in the given hospital
1 2	a) Annual visits to PHC facilities (or at hospital level) per capita; share of the number of the first contacts with PHC vs. total number of contacts	PHC development	a) Numerator: total number of primary health care or ambulatory care contacts denominator: Midyear population  b) Numerator: first contacts in PHC facilities denominator: total number of primary health care or ambulatory care contacts	Administrative; Survey	NCDC&PH; HUES	2014	High	An outpatient contact is one episode of examination/consultation performed by a physician or by a nurse in the presence of a physician, in relation to one outpatient at one time and location, normally at the physician's office or the patient's home	The total number of primary health care or ambulatory care contacts / Midyear population  b) First contacts in PHC facilities / total number of primary health care or ambulatory care contacts

	b) Share of expenditures on out-patient care at hospital level in the total expenditures on out-patient care		Numerator: Expenditures on out-patient care at hospital level denominator: expenditures on out-patient care	Administrative	NHA	2014	Medium	Share of PHC visits expenditure in hospitals. Assessment of PHC as a gatekeeper function  HUES is conducted every 3 years	Expenditures on out-patient care at hospital level / Expenditures on out-patient care
13	Emergency calls to ambulance service per capita	Organization of ambulance services	Numerator: Emergency calls to ambulance service denominator: Midyear population	Administrative	NCDC&PH	2014	High		Emergency calls to ambulance service /Midyear population
14	The rate of renovated doctor's and dentist's offices at penitentiary system institutions vs. the total number of doctor's and dentist's offices	Health care in institutions of the penitentiary system	Numerator: renovated doctor's and dentist's offices at penitentiary system denominator: Total number of doctor's and dentist's offices at penitentiary system	Administrative	Minister of Corrections of Georgia	2014	Medium	Assessment of Health infrastructure in penitentiary system	Renovated doctor's and dentist's offices at penitentiary system *100 / Total number of doctor's and dentist's offices at penitentiary system

#### 4. HUMAN RESOURCES

1 5	a) Geographic distribution of medical staff (doctors and nurses)	Motivated and qualified medical staff	Numerator: Number of doctors in concrete regiondenominator: Population the same regionNumerator: Number of nurses in concrete regiondenominator: Population the same region	Administrati ve	NCDC&PH; GEOSTAT	2014	High	The geographical distribution of human resourcesProviders that are not included in the reporting system will be left put opf the analysis	Number of doctors in concrete region *100000 /Population the same region
	b) Correlation of numbers of doctors and nurses		Numerator: Total number of nurses denominator: Total number od doctors	Administrati ve	NCDC&PH	2014	High	Number of nurses per one doctor	Number of nurses / Number of doctors
	c) Human resource structure		Numerator: Number of doctors by speciality denominator: Total number of doctors	Administrati ve	NCDC&PH; RAMA	2014	High	distribution of human resources by speciality	Number Number of doctors by speciality / Number of doctors

16	a) Ratio of visits per full-time physician and the number of physicians at hospital and out-patient levels		Numerator: Number of hospitalized patients in year denominator: Number of Doctors at hospital  Numerator: Number of out-patient visits per day denominator: Number of Doctors at out-patient level	Administrative	NCDC&PH	2014	High	Assessment of Doctors productivity	Number of hospitalized patients in year / Number of Doctors at hospital  Number of out-patient visits per day / Number of Doctors at out-patient level
	b) Average monthly salary for medical professionals			Administrative	GEOSTAT	2014	High	Decomposed by governmental and nongovernmental employee	
5. IMPROVING GEOGRAPHIC AND FINANCIAL ACCESS TO EFFECTIVE HEALTH CARE									
17	a) Percentage of population who can travel to medical facility in 30 minutes by using regular transportation means	Geographic and physical access to effective health care	Numerator: population who can travel to medical facility in 30 minutes by using regular transportation denominator: interviewed population	Survey	HUES	2014	High	Assessment of physical access to effective health care  HUES is conducted every 3 years	

	b) Rate of health care facilities where doctors are available at least 5 days a week			Survey	HUES	2014	High	HUES is conducted every 3 years	
18	Percentage of health insurance policy holders (individual or corporate) in the overall size of population	Improving of affordability of health care	Numerator: Number of health insurance policy holders (individual or corporate) denominator : Midyear population	Administrative	ISSS	2014	Meddium	Assessment of financial access to effective health care	Number of health insurance policy holders (individual or corporate) *100 / Midyear population

19	Percentage of population who, due to financial limitations, had to refuse basic medical interventions in times of need		Numerator: occurrences of acute sickness in last 30 days, where no consultation was undertaken because it was too expensive/not enough money denominator: Total number of population who reported they are in need to receive medical services	Survey	HUES	2014	High	HUES is conducted every 3 years	
20	Percentage of “out of pocket” health payments vs. overall health spending by service types		Numerator: out of pocket health payments by type of services denominator: Total out of pocket health payments	Administrative	NHA	2014	Meddium	What services as required for the patient pays the biggest share of out of pocket	Out of pocket health payments by type of services *100 / Total out of pocket health payments
21	a) Percentage of drug expenditures incurred by the population within their private	Improving access to medicines	Numerator: Private expenditure on drugs denominator: Total provate expenditure	Administrative	NHA	2014	Meddium		Private expenditure on drugs *100 / Total provate expenditure

	health expenditures								
	b) Percentage of consultations, when the medicines were prescribed to a patient but were not purchased due to their high cost (computed on the basis of all consultations)		Numerator: consultations where medicine was prescribed but not purchased because it was too expensive denominator: all consultations	Survey	HUES	2014	High	HUES is conducted every 3 years	
2 2	Margin of average markup on drugs in Georgia		Numerator: denominator:	Survey	Curatio International Foundation	2013	Meddium	Special survey, not conducted from 2013	

## 6. IMPROVING QUALITY AND SAFETY



2 3	Dynamics of number of approved guidelines and protocols	Supporting evidence-based clinical practice	Numerator: Number of protocols approved reporting years	Administrative	MoLHSA	2014	High	Weak indicators to assess Supporting evidence-based clinical practice; better to use The share of implemented guidelines in number of approved guidelines	
2 4	Number of doctor's liability cases reviewed by the Council of Professional Development	Patient safety and medical service quality control	Numerator: Number of doctor's liability cases reviewed by the Council of Professional Development	Administrative	RAMA	2014	High	Weak indicators Patient safety and medical service quality control	
2 5	Percentage of complicated deliveries (peritonitis developed after Caesarean section, obstetric trauma) in total number of deliveries		Numerator: a) Number of peritonitis developed after Caesarean section; b) obstetric trauma) denominator: total number of deliveries	Administrative	NCDC&PH	2014	Meddium		<p>a) Number of peritonitis developed after Caesarean section * 100 /total number of deliveries</p> <p>b) Number of obstetric trauma * 100 / total number of deliveries</p>

26	Nosocomial infection rate: share of positive results in studied cultures		Numerator: Number of positive results denominator: Number of studied cultures	Administrative	NCDC&PH	2014	Meddium	Need more accurate indicators	Number of positive results *100 by culture / Number of studied cultures
7. ENSURING EQUITY AND FINANCIAL PROTECTION									
27	a) Percentage of household health expenditures of household's total spending and solvency	Ensuring equal distribution of the load of health care financing system; financial protection of the population from catastrophic health expenditures	Numerator: denominator:	Administrative	NHA	2014	Meddium		
	b) Share of population with catastrophic health expenditures		Numerator: denominator:	Survey	HUES; HBS	2014	Meddium		
8. PROTECTING PATIENT RIGHTS									

28	Share of letters from different types of health insurance policies (state, individual or corporate) and health care facilities in the overall number of letters	Development of Mediation Service	Numerator: Number of letters from different types of health insurance policies (state, individual or corporate) and health care facilities denominator: overall number of letters	Administrative	State Mediation Agency (abolished)	2014	High	Need renovation	Number of Complaints letters from different types of health insurance policies (state, individual or corporate) and health care facilities *100/ overall number of letters
29	Percentage of the population informed about their health care benefits	Reducing information barriers to access to medical services		Survey	HUES	2014	High		

#### 9. IMPROVING HEALTH PROMOTION, ESTABLISHMENT OF HEALTHY LIFESTYLE, DISEASE PREVENTION AND EARLY DISEASE DETECTION

30	Tobacco, alcohol and drug abuse rate	Raising population awareness of the of main risk factors and public health risks; increasing involvement in screening and early disease detection programs	Numerator: a) Number of Tobacco usser; b) alcohol consumption c) number of drug abused denominator: a) b) 15 years old and more population; c) Midyear populaion	Survey	STEP, ESPAD, WHO/EURO HFA data base	2011	High	Not available modern data; need special survey	
31	Distribution of HIV/AIDS Cases by Modes of Transmission		Numerator: number of HIV/AIDS Cases decomposed Modes of Transmission denominator: HIV/AIDS cases	Administrative	NCDC&PH	2014	High	Modes of Transmission of HIV/AIDS Cases	Number of HIV/AIDS Cases decomposed Modes of Transmission *100 / HIV/AIDS cases
32	Awareness of women of reproductive ages about the modern methods of contraception			Survey	RHS	2010	High	Survey conducted every 5 years	

33	a) Antenatal care coverage (%), 4 visits		Numerator: Number of pregnant women who have 4 Antenatal care visits denominator: Number of pregnant women	Administrative	NCDC&PH/SSA	2014	High		Number of pregnant women who have 4 Antenatal care visits *100 / Total number of pregnant women
	b) The ratio of births attended by qualified medical professionals		Numerator: Number of births attended by qualified medical professionals denominator: Total number of births	Administrative	NCDC&PH/SSA	2014	High		Number of births attended by qualified medical professionals *100 / Total number of births
34	Measles vaccination coverage among children under 2 years		Numerator: The number of children under 2 years who underwent measles vaccination denominator: children under 2 years	Administrative	NCDC&PH/SSA	2014	High		The number of children under 2 years who underwent measles vaccination *100 / children under 2 years
35	a) Rate of low birth-weight newborns		Numerator: Number of low birth-weight newborns denominator: Number of newborns	Administrative	NCDC&PH/SSA	2014	High		Number of low birth-weight newborns *100/ Number of newborns

	b) Physical activity/obesity		Numerator: a) number of population with low weight b) normal weight c) Excess weight; d) Obesity denominator: total number of population decomposed by age	Administrative	NCDC&PH/SS A	2014	High		Body mass index (BMI) by age (Low weight (BMI <18.5); Normal weight (BMI = 18.5-24.9); Excess weight (BMI = 25.0-29.9); Obesity (BMI >30.0))
36	The rate of women who had cervical Pap-test and mammogram		Numerator: a) number of women aged 25-60 who had cervical Pap-test b) number of women aged 40-70 who had mammogram denominator: a) Number of women aged 25-60 b) Number of women aged 40-70	Administrative	NCDC&PH/SS A	2014	High		a) number of women aged 25-60 who had cervical Pap-test *100 /Number of women aged 25-60  b) number of women aged 40-70 who had mammogram *100 / Number of women aged 40-70
10. IMPROVING CLINICAL OUTCOMES AND INCREASING SATISFACTION WITH CARE									

37	a) Overall results of pulmonary tuberculosis MGB+ treatment vs. Cases in correctional institutions	Improving clinical outcomes	Numerator: Number of recovered cases Denominator: Total number of TB cases undergoing treatment  Numerator: Number of completed treatment cases Denominator: Total number of TB patients' undergoing treatment	Administrative	NCDC&PH/SSA	2014	High		
	b) The ratio of multidrug-resistant tuberculosis of the number of new and treated cases of pulmonary tuberculosis MGB+ and treatment outcomes		Numerator: denominator:						

38	a) Percentage of late detection of HIV infection of the number of new cases		Numerator: Number of late detected new HIV infection denominator: Number of new HIV infection	Administrative	NCDC&PH/SS A	2014	High	Late detection rate of HIV infection gives us a percentage of AIDs patients vs. all newly registered cases of HIV/AIDS	
39	a) Percentage of malignant cancer detected at the 1 <sup>st</sup> and 2 <sup>nd</sup> stages		Numerator: a) new cases of malignants at 1th stage; b) new cases of malignants at 2th stage; denominator: total number of new cases of malignants	Administrative	NCDC&PH/SS A	2014	High	Detection of malignant tumors at early stage of their formation, when the treatment forecast is more reliable and survival rate is high, helps with the improvement of clinical outcome	a) new cases of malignants at 1th stage *100 / total number of new cases of malignants; b) new cases of malignants at 2th stage *100 / total number of new cases of malignants
	b) Mortality caused by infraction during the first 24 hours		Numerator: number of patients, who died within the first 24 hours of the hospitalization denominator: number of patients hospitalized within the first 24 hours of the disease	Administrative	NCDC&PH/SS A	2014	High		



40	The level of satisfaction of the population with medical services	Patient satisfaction		Survey	HUES	2014	High	Survey conducted every 3 years	
<b>11. IMPROVING POPULATION HEALTH</b>									
41	Average life expectancy at birth	Reducing morbidity and mortality rates associated with specific conditions (e.g.: maternal and children health, non-communicable diseases, etc.)		Administrative	GEOSTAT	2014, Annual	High	Life expectancy is the average number of years of life remaining to a person at a particular age and is based on a given set of age-specific death rates, generally the mortality conditions existing in the period mentioned. It is calculated by the analysis of life tables (also called a mortality table or actuarial table)	

4 2	Infant, under- 5 and maternal mortality		Numerator: a) Total number of deaths of children under the age of five; b) a) Total number of deaths of children under the age of 0-1; b) Denominator: Total number of live births  c) Numerator: Total number of maternal deaths Denominator: Total number of live births	Administrative	GEOSTAT	2014, Annual	High		a)Total number of deaths of children under the age of five * 1000/Total number of live births  b) Total number of deaths of children under the age of 0-1 * 1000/Total number of live births  Numerator: Total number of maternal deaths Denominator: Total number of live births
4 3	Mortality rate per 100 000 persons for the 5 most common disease		Numerator: Number deaths by 5 most common diseases groupdenominator: total population	Administrative	GEOSTAT	2014, Annual	High		

	groups (IDC 10) ICD								
44	a) Incidence rate per 100 000 persons for the 5 most common disease groups (IDC 10).		Numerator: Number new cases of 5 most common diseases group denominator: total population	Administrative	NCDC&PH	2014, Annual	High		
	b) Mortality caused by blood circulatory system diseases		Numerator: Number of deaths by blood circulatory system denominator: Total number of population	Administrative	NCDC&PH	2014, Annual	High		Number of deaths by blood circulatory system *100000 / Total number of population

c) incidence and prevalence of mental and behavioural disorders		Numerator: a) new cases of mental and behavioural disorders b) all registered cases mental and behavioural disorders denominator: Total number of population	Administrative	NCDC&PH	2014, Annual	High		a) new cases of mental and behavioural disorders $\frac{\text{a) new cases of mental and behavioural disorders}}{\text{Total number of population}} \times 100000$ b) all registered cases mental and behavioural disorders $\frac{\text{b) all registered cases mental and behavioural disorders}}{\text{Total number of population}} \times 100000$
d) Mortality caused by traumas, food poisoning and consequences of external causes		Numerator: Number of deaths by traumas, food poisoning and consequences of external causes denominator: Total number of population	Administrative	GEOSTAT; NCDC&PH	2014, Annual	High		Number of deaths by traumas, food poisoning and consequences of external causes $\frac{\text{Number of deaths by traumas, food poisoning and consequences of external causes}}{\text{Total number of population}} \times 100000$

Universal Healthcare Program									
1	life expectancy at birth	Improve health status of the population		Administrative	GEOSTAT	2014, Annual	High	Life expectancy is the average number of years of life remaining to a person at a particular age and is based on a given set of age-specific death rates, generally the mortality conditions existing in the period mentioned. It is calculated by the analysis of life tables (also called a mortality table or actuarial table)	
2	Share of total population registered with PHC service providers under the UHP	Increase access to essential medical services	Numerator: population registered with PHC service providers under the UHP Denominator: Total population	Administrative	SSA	2014	High		population registered with PHC service providers under the UHP *100 /Total population

3	No of beneficiaries that received state funded healthcare services for defined line of services		Numerator: Number od cases decomposed by components of UHP	Administrative	SSA	2014	High		Number od cases decomposed by components of UHP
4	Share of OOP in THE	Increase affordability of essential medical services	Numerator: out of pocket health payments by type of services denominator: Total out of pocket health payments	Administrative	NHA	2014	High	What services as required for the patient pays the biggest share of out of pocket	Out of pocket health payments by type of services *100 / Total out of pocket health payments
Public Health Program									

5	MMRIMR	Reduce maternal and child health mortality	Numerator: a) Total number of deaths of children under the age of five; Denominator: Total number of live births b) Numerator: Total number of maternal deaths Denominator: Total number of live births	Administrative	NCDC&PH	2014	High		a) Total number of deaths of children under the age of five * 1000 / Total number of live births b) Total number of maternal deaths * 100000 / Total number of live births
6	TB prevalence rate HIV/AIDS prevalence rate No of cases of EDPs	Reduce morbidity due to TB, HIV/AIDS and other socially dangerous pathogens	Numerator: No of registered Denominator:	Administrative	NCDC&PH	2014	High		

7	Regional and municipal epidemiological information system is fully functioning (Reports and case notifications meet country's regulations)	Ensure functioning of epidemiological surveillance system	Numerator: Denominator:	Administrative	NCDC&PH	2014	High		
8	Immunization coverage rates	Reduce morbidity due to vaccine preventable diseases		Administrative	NCDC&PH	2014	High		DPT dose 3 coverage; MMR dose 2 coverage
9	Hepatitis C incidence & prevalence rate	Reduce prevalence of Hepatitis C		Administrative	NCDC&PH	2014	High		
Early Detection of Diseases and Screening									



10	Screening coverage rates	Ensure early diagnosis of cancer	Numerator: a) number of women aged 25-60 who had cervical Pap-test b) number of women aged 40-70 who had mammogram denominator: a) Number of women aged 25-60 b) Number of women aged 40-70	Administrative	NCDC&PH	2014	High		<p>a) number of women aged 25-60 who had cervical Pap-test *100 / Number of women aged 25-60</p> <p>b) number of women aged 40-70 who had mammogram *100 / Number of women aged 40-70</p>
11	No of patients	Ensure access to specialised child development services for children from 0 to 6		Administrative	NCDC&PH	2014	High		No of patients access to specialised child development services for children from 0 to 6
12	No of patients	Ensure access to epilepsy diagnosis services		Administrative	NCDC&PH	2014	High		No of patients with access to epilepsy diagnosis services
Immunization									
13	DPT dose 1 coverage			Administrative	NCDC&PH	2014	High		

14	DPT dose 3 coverage	Improve immunization coverage		Administrative	NCDC&PH	2014	High		
15	MMR dose 1 coverage			Administrative	NCDC&PH	2014	High		
16	MMR dose 2 coverage			Administrative	NCDC&PH	2014	High		
Epidemiological Surveillance									
17	Regional and municipal epidemiological information system is fully functioning (Reports and case notifications meet country's regulations)	Ensure functioning of epidemiological surveillance system		Administrative	NCDC&PH	2014	High		Reports and case notifications meet country's regulations
18	Proportion of surveillance units with routine laboratory data analysis and interpretation		Numerator: surveillance units with routine laboratory data analysis and interpretation Denominator: surveillance units	Administrative	NCDC&PH	2014	High		surveillance units with routine laboratory data analysis and interpretation / surveillance units

19	No of malaria cases			Administrative	NCDC&PH	2014	High		
Safe Blood									
20	Number of unpaid donations	Increase number of unpaid donations		Administrative	NCDC&PH	2014	High		
21	share of donors screened (100%)	Ensure safety of blood products		Administrative	NCDC&PH	2014	High		
Prevention of Occupational Diseases									
22	No of enterprises studied	Provision of targeted studies of occupational health systems in selected enterprises		Administrative	NCDC&PH	2014	High		
Management of infectious diseases									
23	Mortality rate with infectious and parasitic diseases	Reduce mortality with infectious and parasitic diseases	Numerator: Deaths with infectious and parasitic diseases Denominator: Total population	Administrative	NCDC&PH	2014	High		Deaths with infectious and parasitic diseases *100000 / Total population
Tuberculosis									

24	TB prevalence rate (incl. MDR TB separately)	Reduce TB prevalence and incidence rate in the country	Numerator: Total No of Registered cases of TB Denominator: Total Population	Administrative	NCDC&PH	2014	High		Total No of Registered cases *100000 / Total Population
25	TB incidence rate (incl. MDR TB separately)		Numerator: New cases of TB Denominator: Total Population	Administrative	NCDC&PH	2014	High		New cases of TB *100000 / Total Population Decomposition by MDR TB separately)
26	Treatment default rate	Provide quality treatment for patients with TB		Administrative	NCDC&PH	2014	High		
27	No of beneficiaries (or samples) examined in each component			Administrative	NCDC&PH	2014	High		
HIV/AIDS									
28	Share of MARPs screened	Reduce morbidity and mortality due to HIV/AIDS		Administrative	NCDC&PH	2014	High		
29	HIV related mortality rate in PLWHA		Numerator: No of Deaths in PLWHA Denominator: Total population	Administrative	NCDC&PH	2014	High		No of Deaths in PLWHA *100000 / Total population

30	% of PLWHA with TB		Numerator: PLWHA with TB Denominator: PLWHA	Administrative	SSA, NCDC	2014	High		PLWHA with TB *100 / PLWHA
Maternal and Child Health									
31	MMR	Improve maternal and child health	Numerator: Total number of maternal deaths Denominator: Total number of live births	Administrative	NCDC&PH	2014	High		Numerator: Total number of maternal deaths *100000 /Total number of live births
32	IMR		Numerator: Total number of deaths of children under the age of 0-1; Denominator: Total number of live births	Administrative	NCDC&PH	2014	High		Total number of deaths of children under the age of 0-1 * 1000 / Total number of live births
33	Antenatal care coverage (4 visits)		Numerator: Number of pregnant women who have 4 Antenatal care visits denominator: Number of pregnant women	Administrative	NCDC&PH, SSA	2014	High		Number of pregnant women who have 4 Antenatal care visits *100 / Total number of pregnant women
Treatment of Drug Abuse									

34	Coverage of drug abusers with MAT programs (based on size estimations studies)	Reduce illegal drug consumption		Administrative, Survey	SSA, NCDC	2014	High		
35	Share of patients re-hospitalized with the same diagnosis	Provide quality treatment for patients with alcohol abuse	Numerator: No of patients re-hospitalized with the same diagnosis Denominator: No of hospitalized patients	Administrative	SSA	2014	High		No of patients re-hospitalized with the same diagnosis * 100 / No of hospitalized patients under the drug abuse treatment program
Health Promotion									
36	Number of videos, campaign planned and flyers printed	Coverage of target population with social media		Administrative	NCDC & PH	2014	High		
Management of Hepatitis C									

37	Rate of successful completion of treatment	Reduce prevalence of Hepatitis C	Numerator: No of successful completion of treatment Denominator: all Patients receiving treatment	Administrative	SSA	2014	High		No of successful completion of treatment *100 / all Patients receiving treatment
38	Reduce Hep C incidence		Numerator: No of New cases of Hep C Denominator: Total Population	Administrative	NCDC&PH	2014	High		No of New cases of Hep C *100000 / Total Population
Provision of Medical Services in Other Priority Areas									
39	Per capita PHC utilization by rural population	Increase access of PHC services in rural and remote areas	Numerator: number of visits to rural doctors Denominator: Population in rural area	Administrative	NCDC&PH	2014	High		Number of visits to rural doctors / Population in rural area
40	No of beneficiaries for out-patient services who have had at least 2 visits (annually)	Ensure access to mental health services		Administrative	NCDC&PH	2014	High		

41	No of beneficiaries served by ambulance care	Beneficiaries have access to timely and quality ambulance care		Administrative	SSA	2014	High		
Mental Health									
42	No of beneficiaries for out-patient services who have had at least 2 visits (annually)	Ensure access to mental health services		Administrative	SSA	2014	High		
43	Rate of urgent MH re-hospitalization (annually)		Numerator: No of rehospitalization Denominator: all MH in-patients	Administrative	SSA, NCDC	2014	High		No of rehospitalization * 100 / all MH in-patients
44	No of beneficiaries per each component			Administrative	SSA	2014	High		
45	Share of patients with 3 month of longer length-of-stay among all in-patients		Numerator: No of patients with 3 month of longer length-of-stay Denominator: all MH in-patients	Administrative	SSA	2014	High		No of MH patients with 3 month of longer length-of-stay *100 / all MH in-patients
Diabetes Care									



46	No of beneficiaries for drug components (children/adult)	Ensure access to drugs and specialized services for patients with diabetes		Administrative	SSA	2014	High		No of program beneficiaries who receive insulin (children/adult)
Paediatric Oncohematology									
47	Case fatality rate	Improve quality of life of children with oncohematological diseases	Numerator: No of deaths by oncohematological diseases Denominator: No patients with oncohematological diseases who are receive services by the program	Administrative	SSA	2014	High		No of deaths by oncohematological diseases *100 / No patients with oncohematological diseases who are receive services by the program
Dialysis and Kidney Transplantation									
48	No of patients on dialysis services	Improve quality of life for patients with terminal organ failure		Administrative	SSA	2014	High		No of patients on hemo and peritoneal dialysis by age and region

49	Fatality rate of patients on dialysis		Numerator: Dialysis deaths Denominator: No patients on dialysis	Administrative	SSA	2014	High		No of Dialysis deaths *100 / No patients on dialysis
50	Fatality rate/organ rejection rate of post-transplantation patients		Numerator: a) No deaths of post-transplantation patients b) No of organ rejection people Denominator: post-transplantation patients	Administrative	SSA, NCDC	2014	High		a) No of deaths of post-transplantation patients b) No of organ rejection people post-transplantation patients
Palliative Care									
51	Share of population who can access palliative care services when needed (regional distribution)	Terminal patients have access to palliative care and pain management services	Numerator: population who can access palliative care services Denominator: population who needs palliative care services	Administrative	SSA	2014	High		Population who can access palliative care services *100 / population who needs palliative care services

52	No of beneficiaries for in-patient and out-patient services			Administrative	SSA	2014	High		No of beneficiaries who receive in-patient and out-patient paliative care
53	No of beneficiaries for pain management drug component			Administrative	SSA	2014	High		
Rare Diseases and Substitution Treatment									
54	No of children with rare diseases served by in-patient and out-patient care providers	Ensure quality treatment and access to drugs to children with rare diseases		Administrative	SSA	2014	High		
55	No of beneficiaries of rare disease drugs			Administrative	NCDC&PH, SSA	2014	High		
Ambulance									

56	No of beneficiaries served	Beneficiaries have access to timely and quality ambulance care		Administrative	NCDC&PH	2014	High		No of beneficiaries receive ambulance services
57	Share of calls served within stratified timing framework		Numerator: calls served within stratified timing framework  Denominator: Total calls served	Administrative	NCDC&PH	2014	High		Calls served within stratified timing framework *100/ Total calls served
Rural Doctor									
58	Per capita PHC utilization by rural population	Increase access of PHC services in rural and remote areas	Numerator: number of visits to rural doctors Denominator: Population in rural area	Administrative	NCDC&PH	2014	High		Number of visits to rural doctors /Population in rural area
59	Number of visits of target population			Administrative	NCDC&PH	2014	High		Number of visits of target population under rural doctor program
Referral Care									

60	No of beneficiaries	Increase affordability of additional medical services for individuals		Administrative	MoHLSA	2014	High		No of beneficiaries who receive health service under referral program
Medical Check-up for Army Recruits									
61	All army recruits undergo essential medical check-up	Ensure good health of army recruits		Administrative	SSA	2014	High		

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