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AN ANALYSIS OF RECENT HEALTH SYSTEM REFORMS IN GEORGIA: FUTURE IMPLICATIONS OF MASS PRIVATISATION AND INCREASING THE ROLE OF THE PRIVATE HEALTH MARKET

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1. Summary

At the beginning of 2007 the Georgian government initiated the mass privatisation of hospitals and gave private health care actors greater functions (e.g. private insurance companies were contracted to insure the people living under the poverty line). This decision is innovative in the history of Georgian health care reform; however, it is highly controversial and poses many unanswered questions. This policy paper aims to analyse these reforms based on international experience and give recommendations to the government in order to minimise risks and losses associated with the reforms. In particular, it aims to

- analyse recent health care reforms in Georgia, while paying particular attention to the advantages and disadvantages of mass privatisation and questions concerning private health insurance;
- compare it with similar reforms in other post-communist Central and Eastern European countries (with Poland as the main point of reference);
- present recommendations to the government in order to minimise risks and losses associated with the health care reforms.

2. Background

In the 1990s Georgia experienced a sharp economic decline, political instability and military conflicts. During this period, the health care resources and infrastructure deteriorated. The major health indicators worsened very much even compared to the Soviet times.

Since then the government has made many attempts to reform the health care system and adjust it to new realities (introducing social health insurance, giving some autonomy to hospitals, etc.). However, these efforts have not improved the situation and have actually failed, as a number of symptoms shows. Firstly, hospitals and clinics have remained in need of capital repair and renovation, ill equipped and without modern technology. Secondly, most of the health providers have not had any kind of medical training for a long time. Finally, the managerial capacity of the Ministry of Labour, Health and Social Affairs (MoLHSA), as well as other governmental entities, has also remained weak and there has not been any strong decision-maker in the system.

All the above-mentioned factors (and also some other) have caused limited access to quality health care services for the majority of population, particularly for the poor and vulnerable population groups. Annual visits to the doctor have dropped from 8 to 2 since 1990 and 37% of population has resorted to self-treatment or have taken drugs without a prescription (MoLHSA, 2006).

After the “rose revolution” in 2003, the new government started numerous economic reforms. The State Minister of Reforms Coordination (SMoRC) has been the main person to lead these reforms. He declared to “remove all the obstacles that are holding back investment” and open the whole economy to privatisation. The World Bank even named Georgia to be a leading global reformer in 2006. However, the same report enumerated several areas that needed significant improvement.

During the last few years the government has started to undertake some cardinal steps in reforming the health care system as well. At the beginning of 2007, the government initiated the mass privatisation of hospitals and gave private health care actors greater functions (e.g. private insurance companies were contracted to insure the people living under the poverty line). This paper aims to analyse these reforms based on international experience and give recommendations to the government in order to minimise risks and losses associated with the reforms.

3. Current Situation

There is no doubt that changes in the health care sector of Georgia are necessary. During the last few years the representatives of the MoLHSA declared many times that they had a clear, consistent and tested strategy and that the implementation was already underway. During this period the MoLHSA was the main body, which with the support of various international and local experts tried to implement health care reforms. Many international donors (EU, DFID, etc.) spent millions of dollars not only on the expertise but also on upgrading the health infrastructure. The main focus of these reforms was related to the introduction of the institution of family medicine and making a family doctor a gatekeeper for entry into the system. It was anticipated that family doctors would treat 80% of their patients without referring them to other specialists. The MoLHSA declared that "prevention is better than care" and planned to concentrate 30-35% of health funding on primary health care. The large regional hospitals were also the main recipients of public financial resources. The MoLHSA planned to rationalise or privatise district (rayon) level medical facilities.

Since the second part of 2006, the State Minister of Reforms Coordination (SMoRC) has been particularly interested in health sector reforms. Since then, his office has actually taken a lead in health reform processes. However, the main principles of these reforms somehow contradict the previous strategies of the MoLHSA. The SMoRC declared that a new plan of health system reform was developed on the basis of identified problems (which includes excessive and poor infrastructure, inadequate and low quality services, absence of sound economic principles and market mechanisms in the system, no competition, corruption). The main directions of this plan are: optimising of the number of excessive infrastructures, hospital beds and medical personnel, investing in medical facilities (the so-called project of 100 new hospitals in Georgia) and ensuring effective regulations.

According to the government's "General Plan of Development of Hospital Sector" new hospitals (majority with 15 or 25 beds) will be built in every district centre and at resorts. All these hospitals will be equipped with standard beds, plus one high-tech ward in order to save lives. Regional hospitals will have 50 or more beds (standard beds as well as high-tech wards). The primary health care services will be integrated in these hospitals. Therefore, all the hospitals will have outpatient departments. Primary health care posts in the villages will be financed by the State on a per-capita basis beginning from 2008 (SMoRC, 2007).

In 2007, private insurance companies started to be contracted by the State to insure the population living below the poverty line. A pilot project is underway in the Tbilisi and Imereti regions. The private insurance companies have been contracted for a year; however in the future the government plans to give them permanent contracts (without time limits). So far, 181,122 persons (about 72,400 families) have been insured in Tbilisi and Imereti

and the total amount of the government's spending for this purpose equals 15,095,400 lari (a monthly premium is about 7 lari (about 4.3$) per person). Additionally 473,000 persons (about 189,200 families) will be privately insured in the near future (MoLHSA, 2007). Therefore, the total number of people living in extreme poverty and having private insurance will be 654,122, which is about 14.5% of the Georgian population. However, the officially recognised number of people living in poverty is much higher and composes about 35% of the Georgian population (MoLHSA, 2007).

4. Key Issues

The government's two new initiatives, i.e. a hospital privatisation plan and increasing the role of private insurance companies, are among the most radical steps in the history of Georgian health care reform. Thus, they raise many questions to be answered.

The hospital privatisation plan means that old hospitals will be handed over to private investors who will build completely new health facilities and will be responsible for their management (according to the standards/regulations set by the State) for about seven years. The Ministry of Economic Development has already conducted several tenders for this purpose. Among the winners are leading Georgian pharmaceutical companies. The main characteristics of this policy are described in the graph below, which follows the framework developed by the International Network Health Policy and Reform

Degree of Innovation	traditional		innovative
Degree of Controversy	consensual		highly controversial
Structural or Systemic Impact	marginal		fundamental
Consultation and Transparency	very low		very high
Transferability	strongly system-dependent		system-neutral

It is evident that there are some risks that are closely associated with the recent reform processes. These include questions concerning conventional market failure in the health sector. Ensuring the quality of services as well as accessibility and equity issues needs to be taken into consideration.

In general, all major stakeholders (except for the SMoRC) are expressing concerns over some aspects of the recent health care reforms. However, only few speak about them loudly. The main reason for this silence is political.

- **Parliamentary Committee of Health Care and Social Issues:** The members are well aware of the recent health care reforms and acknowledge the problems associated with it. However, there are only a few experts in the Committee who can argue on the pros and cons of the reform in depth;
- **State Minister of Reforms Coordination (SMoRC)** is the main initiator of the recent reforms in the health care system;

- **Ministry of Labour, Health and Social Affairs (MoLHSA):** the role of the MoLHSA to lead health care reforms has strongly diminished over the last year. The latest changes in the Ministry staff (in particular, firing the Deputy of Minister, who was considered as the main reform person in the MoLHSA) further proved this opinion. Actually, the MoLHSA's capacity to lead/implement health care reforms is weak and their statements very much depend on the SMoRC's decision;
- **Donors** supporting Georgian health reforms are concerned with some aspects of the recent initiatives of the government (e.g. the EU is concerned that PHC posts that have been renovated/rehabilitated with their funds will be sold to the private sector);
- **Health providers (working in hospitals)** in general are not well aware of the reforms details. However, hospital medical personnel realise very well that they can lose their jobs and this is their main concern;
- **PHC providers** as many other stakeholders do not understand the reforms' details well. Before 2007 they knew that in order to maintain their jobs retraining in family medicine was absolutely necessary. However, nowadays PHC providers are more sceptical toward the retraining programme.
- **Health and Social Programmes Agency (HaSPA)** is the successor of the State United Social Insurance Fund, which was recently abolished. The role and functions of HaSPA have very much diminished compared to its predecessor. Their main task is to implement vertical health programmes financed from the State budget and contract private insurance companies. The HaSPA also has many concerns related to the recent health care reforms and their implementation.
- **Private insurance companies** are very enthusiastic about the government's health care reform and currently compete to attract more people living below the poverty line (whose families have vouchers from the government). However, they are also aware the risks associated with insuring poor population groups (this group usually has many elderly and sick persons which increase the risk of 'adverse selection' and that ultimately will destroy risk pools if the premium from the State is not increased);
- **Patients,** in general, are afraid that private companies that cover their investment costs and make profit will charge them more and health care will become less accessible**;**
- **Leading Party:** "National Movement" supports the changes in the health care system and considers that we will have tangible results soon;
- **Opposition parties** are against the recent health care reforms and have severely criticised it;
- **NGO sector.** Most NGOs also are not well aware of the details of health care reform. In general, they are afraid that the mass privatisation and private insurance will decrease accessibility to health services and violate human rights (both of patients and of health providers).

5. Assessment of Probable Consequences of the Reform

5.1. Lessons from International Experience

The resources for health care services are always scarce. Therefore, the main question for every society is: how much and which kind of health care needs to be provided. There are

three options: free market, a command system, and a mixed system. The free market would allocate health care resources according to consumers' purchasing decisions, while the command model would use a plan to allocate health care according to some pre-determined criterion such as 'need.' The mixed system would combine parts of the free market with elements of the command model. The question is how to decide which of these systems is the most suitable in any given case. There are two criteria that economists use to assess the performance of an allocation system. The first is **efficiency** and the second is **equity** (The UK Office of Health Economics, 2007). The balance needs to be found between these criteria. Thus, the question is how to improve efficiency to the extent that it simultaneously meets society's values, such as equal access to health services or social solidarity in health care financing.

Most of the European countries' health care systems (including that of Poland) belong to the class of social insurance systems that finance the bulk of their health care through income-based premiums. Universal access is usually considered to be a fundamental feature of the health care systems of European Union (EU) member states. Some Georgian reformers have argued that in spite of significant economic reforms in EU countries, their health systems have shifted little from "the socialist principles" to the market economy. However, a review of the literature and meetings with many stakeholders have led the author of this paper to the conclusion that there are certain social values (such as social harmony, solidarity, etc.) that are very important for the European societies. Therefore, these values are come to mind first when, for example, Polish politicians and health authorities think about the future organisation and reform of their health care system.

Health reform debates in many countries outside the EU regularly look to the European experience as a model to be copied or as a showcase for methods of preserving access in contexts of marketisation and privatisation. In the EU, universal access is indeed a governing principle. It is affirmed in several countries' constitutions and health service founding documents, and has been incorporated into the EU Charter of Fundamental Rights. The first paragraph of Article 35 reads "Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices" (Council of the European Union 2001).

The changes that are happening currently in the Georgian health care system have little in common with the European values. They are much more similar to the US model of health care organisation, which is among the most market-oriented systems in the world. The share of the private sector is very substantial in the USA, which according to many authors leads to higher expenditures in terms of an increased percentage of GDP for health care (in the USA expenditures on health as a percentage of the GDP amount to 16%, which is the highest rate in the world). However, it does not mean that the US government spends little for the health; about 45% of the total health spending is funded by the government (OECD Health Data, 2006). In Georgia, the total expenditure on health as is 5.8% of the national GDP and the government's general expenditure on health is also low and comprises only 30% of the total health expenditure (WHO, 2005). These facts also need to be taken into consideration while deciding on the future directions of the reforms. Greater involvement of the private sector does not lead to the reduction of overall health care spending. It also does not relinquish the state from funding a substantial part of health care costs. However, Georgian reformers do not pay much attention to these facts and claim that they are going to have their own "Georgian model" of health system organisation and it will not be an exact copy of the American one or other models.

In general, the health market has its own rules and they are common in all countries and societies (regardless of the type of their health system). The way in which the health market works is rather different from the conventional market forces of demand and supply. The free market assumes perfect information, many buyers and sellers, a uniform product and freedom of entry and exit in the long run. However, it is not the case in the health market, where asymmetry of information, uncertainty, imperfect competition and externalities are common. Leaving it entirely to the market (without strong regulation by the State) can produce some serious negative results in the future.

Therefore, while undertaking future health care reforms, it needs to be considered how and to what extent the free market can effectively operate in health care. This is a very crucial point, because "in transition economics, economic policymakers often do not have a good understanding of what the government's role in the health care sector should be. (…) Policymakers assume that health sector can follow the same policies as in other economic sectors, because they do not recognize the serious market failures that exist in health care market. They typically don't recognize that the government must play a significant role in ameliorating these market failures" (International Monetary Fund, 2007).

Health policymakers often do not pay attention to some prerequisites for successful revenue mobilisation for the health sector in transition economies. "These prerequisites include creating new organizations, developing management know-how, and setting up information systems and regulatory measures to set the rules for market competition" (International Monetary Fund, 2007).

Another lesson from international experience is that health care reform should be done step by step. One of the mistakes of the health system reform in Poland in 1999 was an attempt to implement several huge reforms at once (Krajewski-Siuda and Romaniuk, 2007). The significant changes in the health care system imply new tasks for the managers who are very often unprepared. The frequent change in the ministerial staff is another problem hampering the successful implementation of the reforms (Krajewski-Siuda and Romaniuk, 2007). A similar danger appears in Georgia, where shifts of responsibility appeared over the reform and continuity was lacking between various reform ideas.

5.2. Privatisation of Hospitals

Privatisation has been described as the process in which "non-government actors become increasingly involved in the financing and provision of health care services." This can result in changes in roles, responsibilities and ownership within the health sector (Muschell, 1995). Inefficient allocation of scarce resources, the poor performance of the public sector and changes in prevailing ideology often lead to an increased role of the private sector (Zwi and Mills, 1995). Against the background of all these problems, privatisation has been seen as a way to improve resource allocation, efficiency and quality as well broaden consumer choice (Kumaranayake, 1998). That was the Georgian government's position while announcing mass privatisation of hospitals.

The government's plan of "100 new hospitals" represents an innovative, albeit challenging form of public-private partnership. Therefore, the question is how this partnership can be made effective and sustainable. Experience has shown that none of the Central European countries managed to privatise all their hospitals. In these countries the privatisation was done primarily in the area of primary health care and outpatient specialist services. The

Czech Republic is a good example – during the 1990s there was a strong political effort to privatise hospitals in the country, which, however, proved unsuccessful. Hospital privatisation met serious financial as well as political obstacles (particularly, after Social Democrats came to power in 1998) (Jaros et al. 2005). This question needs very careful consideration. Most importantly, the policy can unfavourably affect the patterns of health care utilisation and the overall structure of health expenditures:

According to Kumaranayake "a shift towards privatization may also lead to an inappropriate mix of health care services. For patients with imperfect knowledge, items such as pharmaceuticals and injections are visible indicators of the quality of service. Thus, one would anticipate that private practitioners may try and signal quality through these mechanisms and this can lead to irrational prescribing practices" (Kumaranayake, 1998).

This is especially alarming in Georgia, where leading pharmaceutical companies will own many private hospitals. It can be expected that they will try to sell as many "their pharmaceuticals" (especially, expensive ones for maximum gain) as possible in "their hospitals". Here it should also be mentioned that in all districts both secondary and primary health services have been contracted to the same private companies. This creates a risk that primary providers will have an incentive to refer patients unnecessarily to secondary levels, which will drive up costs for the State as well as for private insurers. Therefore, sets of strong government regulations (to safeguard against market failures such as a monopoly) are absolutely necessary.

On the other hand, the integration of different levels of care might have some positive effects as well. A managed care organisation (MCO) is a good example. Some MCOs (particularly American ones) are fully vertically integrated. This means that the same agency owns and manages services in primary, secondary, acute, post-acute and sometimes long-term care units. The important idea is that by owning resources or being financially responsible for buying the entire continuum of health care services, MCOs are not motivated to refer patients to a higher level of care, or to keep profitable patients in care when there is no longer a medical need to do that. These organisations are mainly financed on a capitation basis that is used both at the organisational level and in relation to individual doctors. This motivates them to be effective in order to maximise their financial surplus (Kowalska, 2005). In the future, if MCOs evolve in Georgia (as they have become the dominant health care delivery vehicle in the USA) and the government decides to contract them, the success of these arrangements will very much depend on the payment mechanisms and the terms of contracts between the State and insurer.

There is also another threat that can cause inefficiencies in health care provision by the private sector and lead to cost-escalation. This could happen because of the unnecessary use of high technology equipment and over-reliance on laboratory tests. The traditional models of price competition suggest that as competition becomes more intense the prices will drop. It must be remembered, though, that quality is a crucial factor in health care, particularly for patients seeking private health care (Aljunid, 1995). Quality competition often (but not always) is associated with a larger investment in high technology equipment and hotel aspects of care. This is how people usually think, particularly those who are outside the health sector and not directly involved in the health management.

However, **evidence rarely suggests that quality competition actually leads to improvements in process quality.** Patients (and not only patients, many Georgian

politicians as well) usually prefer hospitals, which have high-tech equipment and a modern building. Knowing about these aspects private providers may invest in equipment and renovations in order to "signal" to the potential patients the quality of service. Thus, quality competition is often associated with the excessive accumulation of high technology (Kumaranayake, 1998). For example, South Korea with a substantial degree of private sector activity has three times the number of CAT scanners per population than Canada (Zwi and Mills, 1995). However, no one can argue that South Korea has higher quality health care services and better health indicators than Canada. The same situation is in Bangkok, Thailand where the share of the private sector in health care is also high. This city has a CAT scanner per population ratio that is higher than that for most industrialised countries, with the exception of Japan and United States (Kumaranayake, 1998).

Many experts also have concerns regarding the management of hospitals by the Georgian private sector. None of the private companies committed to build and manage new hospitals have had experience in this field before. Generally, hospital management is a complex and resource-intensive field. That requires having an appropriate **regulatory framework** that ensures the quality of the health care services provision in the short and long terms. However, the SMoRC aims to have as few regulations as possible. Generally, this approach is correct and it promotes economic development in many fields but not in health care (particularly in the private sphere). Even the World Bank, which promotes the private delivery of specific services to improve quality and decrease costs, posits a significant role for regulation in achieving these positive benefits from privatisation:

> Strong government regulation is also crucial, including regulation of privately delivered health insurance to encourage universal access to coverage and to discourage [perverse] practices that lead to overuse of services and escalation of costs..... As less developed countries take steps to encourage a diversified system of health service delivery, they need to strengthen government's capacity to regulate the private sector. Regulations are required to ensure that quality standards are met, that financial fraud and other abuses do not take place, that those entitled to care are not denied services, and the confidentiality of medical information is respected (World Bank, 1993).

It may be observed how regulations are connected with private sector activities in the United States, which has the most market-oriented health care system in the world. As Phelps (1992) discovered, the health sector remains one of the most strongly regulated sectors in the American economy. Muschell (1995) also thinks that the problems associated with privatisation may not result in a diminished role for government but rather one which reinforces the regulation and monitoring in health service provision.

5.3. Private Health Insurance

Private health insurance is going to be the main source for health-care financing in the country. The government's plan is to contract private insurance companies and grant them public finances as insurance coverage for those living in extreme poverty (around 15% of the population as determined in the rank-based poverty database). As it was already mentioned, the State United Social Insurance Fund was abolished. Its successor (Health and Social Programmes Agency) has had limited roles and responsibilities. Therefore, according to the government's plan Georgia will have only private health insurance in the future and

the State will finance health insurance only for the poor population group. However, this decision is associated with some risks, which need to be addressed.

The free market in health care requires an effective health care insurance market. Unfortunately, the health care insurance market itself is often not efficient. **Moral hazard** and **adverse selection** both cause significant market failure.

Moral hazard can affect any insurance market but is a particularly serious problem for health care insurance. As it was already mentioned above, the state will only finance insurance for the poor and vulnerable population groups (contracts to private insurance companies for this purpose). The insurance package includes outpatient as well as inpatient (hospital) care. As many surveys suggest, financial problems generally result in the long-term lack of access health care services. Thus, the risk that these people will use health services more than they would otherwise is very high. This certainly will result in the escalation of costs for private insurance companies. As a result, they will demand higher premiums from the State or will go bankrupt. This problem is common for every insurance market, but it is going to be even more acute for Georgia. Many other countries have used patient co-payments and/or limits on the primary provider's power to refer patients to costly services. In the case of Georgia, poor people are already unable to afford co-payments so regulation to limit the power of providers to refer patients to more costly treatments is more preferable. However, this requires establishing a strong governmental monitoring institution, which is highly unlikely to happen (at least from the current government's point of view).

It is also worth mentioning that not only patients but also doctors are affected by moral hazard. They know that the costs of treatment are covered by insurance so the temptation is to over-treat and over-prescribe medicines for their patients **(**The UK Office of Health Economics, 2007). To address this risk other countries used various payment methods: e.g. health providers are reimbursed according to mixed salary and capitation formula, or are paid according to the pre-defined diagnosis group. The latter, diagnosis-related control is extremely complex and expensive to administer, so it would seem wise to introduce provider payment regulation based on a salary-capitation formula.

Adverse selection is another factor in market failure. This happens when insurers are unable to accurately predict the service costs of enrolees. Thus, private insurers usually try to enrol young and healthy individuals in order to justify the cost or to set higher premiums for persons suffering from ill health. In the Georgian case, adverse selection is already a serious problem. Therefore, the probability that the risk pool will ultimately be destroyed is very high.

As it was mentioned before, private health care markets often rely on competition to regulate prices, but this has proved insufficient in all cases (private markets in developed economies cost more than twice as much as public markets). Competition has often led to reductions in costs, but these are countered by the 'consolidation' of suppliers and insurers, who create monopolies and distort the market further. No nation has yet found a sufficient way to regulate this consolidation, which is why private health markets are so much more expensive. The government's only options are to intervene to reduce monopoly tendencies as much as possible, or to opt for a public market instead of a private one (Findings of Oxfam International Working Group, 2007).

Another risk associated with increasing the role of private insurance companies is associated with the accessibility issue. This often results in increased inequities in the provision of health care. A good example is Chile, where the transfer of government revenue to the private companies caused about two-thirds of the country's population to be excluded from the private insurance schemes (Hsiao, 1995).

6. Recommendations

- In spite of Georgia's recent positive economic development, the government's expenditure on health still remains low and should be increased;
- Changes in the health care system should be done gradually, step by step. In this context, it is very important to strengthen the human and technical capacity of the MoLHSA as well as other implementing organisations;
- The new health system should be based on certain values which will be acceptable for the general public. It is a crucial point for the success of the reform and needs an effective public information campaign;
- International experience suggests that the free market is not effective in health care. The role of private sector and market forces should be considered carefully;
- The government's hospital privatisation plan poses many questions. Strong government regulations are absolutely necessary in this context;
- The government should reduce monopolistic tendencies as much as possible. Ownership of primary and secondary health care facilities by the same private company (particularly by pharmaceutical company) illustrates the risk of creating a monopoly. In this context, the other alternative forms of the integration of care should be considered;
- The State will contract private insurance companies and provide them with public finances as an insurance cover for those living in extreme poverty (around 15% of the population as determined in the rank-based poverty database). However, official statistics suggest that the number of poor people is much higher (about 35%). The State should take care of this population group as well;
- Giving public funds to private insurance companies to insure the extremely poor population group is not a simple solution of the accessibility problem. Steps should be taken to mitigate the risks associated with the insurance.

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