



# Promoting Civil Society Monitoring of Secondary Healthcare Reform

During October 2007 - May 2008, Transparency International Georgia implemented the project *Promoting Civil Society Monitoring of Secondary Healthcare Reform* with funding from the Eurasia Partnership Foundation. The proposal was designed to follow on the heels of the government's initiation of hospital sector privatization and had two main objectives: promote the effectiveness of the healthcare system in Georgia and improve the capacity of civil society to monitor the reform of secondary healthcare in Georgia.

Through the project, TI Georgia reviewed and monitored the implementation of select privatization agreements, trained journalists about the intricacies of secondary healthcare reform throughout the country, and provided recommendations to the Ministry of Reform Coordination and the Ministry of Economic Development, the two ministries responsible for secondary healthcare reform implementation.

## Right to Health

Health is a very broad and subjective concept and is influenced by a variety of geographic, cultural, and socio-economic factors. According to the World Health Organization's (WHO) constitution, health is described as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." The constitution also says, "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." The phrase "the highest attainable standard of health" is commonly referred to as the right to health and has since been endorsed by a wide range of international and regional human rights instruments.

Article 25 of the Universal Declaration of Human Rights states, "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond his control."

The International Covenant on Economic, Social, and Cultural Rights (ICESCR) was the first human rights treaty to require states to recognize and exercise the right to health with the state's own available resources and through international assistance and co-operation. The General Comment on the right to health adopted by the Committee on Economic, Social and Cultural Rights (CESCR) further elaborates the content of CESCR Article 12 and emphasizes that the right to health must be understood as a right to the enjoyment of a variety of facilities, goods and services, and conditions necessary for the realization of "the highest attainable standard of health." The International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women, and the Convention on the Rights of the Child and regional human rights instrument such as the revised European Social Charter, which

is also ratified by Georgia, all recognize the right to health. Additionally the right to health has been recognized by the Commission on Human Rights as well as in the Vienna Declaration and Programme of Action.

While the international protection of the right to health is essential, implementation of the right to health happens at the national level. Provision and protection of health is enforced by the Constitution of Georgia (Article 37), the laws on health, public health, the rights of patients, and other normative acts. The right to health is interrelated, interdependent, and indivisible from other social, economic, cultural, civil, and political rights. Health services must be available, affordable, physically and culturally accessible without discrimination, and fairly distributed according to the principles of equity and quality.

The primary goal of a healthcare system is the promotion of better health for the population. The World Health Report 2000<sup>1</sup> identified three overall goals of a healthcare system: achieving good health for the population, ensuring that health services are responsive to the public, and ensuring fair payment systems. The hospital has a central role in achieving these goals.<sup>2</sup> This sector plays an important role not only in the provision of healthcare services but also in education and research.

Reform strategies aimed at accountability, cost effectiveness, sustainability, and quality improvement must be based on scientific evidence and best practice models. Obviously, hospitals do not exist in isolation and are facing greater challenges as changes occur to health needs, socio-economic conditions, and public and political expectations. Efficient hospital performance requires a balance between the effective utilization of main capital and the opportunities for medical intervention offered by advances in technology and new knowledge.

## History of Healthcare in Georgia

Georgia's healthcare system shared the legacy of a Soviet model healthcare system. The Semashko All-Union Research Institute of Social Hygiene and Public Administration in Moscow drew up normative planning standards that were applied across the Soviet Union. Hospitals were funded and medicine was practiced across these healthcare systems in such a way as to keep beds full. Soviet satellite states were heavily influenced by those standards and share three main characteristics: the large number of hospital beds, slower throughput of hospital patients, and a fiscal burden placed upon shrinking health sector budgets by the dominance of hospitals.<sup>3</sup>

In 1991, when the country became independent from the Soviet Union, secondary healthcare was bloated far beyond the country's needs in terms of both infrastructural and human resource capacity. The subsequent lack of financial resources led to the general deterioration of the sector and the economic crisis and lack of electricity affected the physical infrastructure. Staff salaries were extremely low and the healthcare system was vastly overstaffed.

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<sup>1</sup> The World Health Report 2000. Health systems: improving performance. Geneva: World Health Organization, 2000

<sup>2</sup> McKee M, Healy J, eds. Investigating in hospitals (chap. 7). In Hospitals in a Changing Europe. Buckingham: Open University, 2002; 119

<sup>3</sup> Eurohealth, Managing change, The hospital sector in central and eastern Europe, Reforming hospitals in countries of the former Soviet Union. Volume 7 Number 3, Special Issue, ISSN1356-1030.

In the mid-1990s, the Georgian government began reform of the health sector with the support of international organizations to halt the further deterioration of the general health of the population. In 1994-1995 the Georgian government requested World Bank assistance to develop and finance a plan for rationalizing and optimizing Georgia's hospital sector assets. The resulting master plan for hospital restructuring, finalized in 1998, assessed the quantity and capacity of hospitals nationwide and, according to the Law on Privatization,<sup>4</sup> classified them into three groups. Group "A" consisted of hospitals that were best left in the public domain; Group "B" consisted of hospitals that could be privatized provided they maintained a healthcare function; and Group "C" consisted of hospital sector assets that could be sold as real estate (i.e., need not be maintained as healthcare facilities).<sup>5</sup>

One key aspect of the World Bank plan was the establishment of a dedicated body for addressing legal aspects of hospital sector optimization, developing severance packages for hospital personnel, and administering a "hospital restructuring fund"<sup>6</sup> to accumulate investments from the privatization of Group "B" facilities and reinvest them in healthcare infrastructure and equipment.

During this period, USAID assisted the Government of Georgia in developing its hospital accreditation system in order to contribute to improving the country's medical services. USAID partner Abt Associates, Curatio International Foundation, and CARE International also assisted the government of Georgia as it makes the transition to a healthcare system in which the private sector played an increasingly dominant role in healthcare service delivery and financing. Other international state and non-governmental organizations have also supported the healthcare reform processes.<sup>7</sup>

Nevertheless, the previous attempts of the Georgian government failed to improve sector capacity at the expected rate in the provision of healthcare resources and utilization. The reason is that the healthcare system is an indivisible part of the social and economic infrastructure of the country. The government was unable to exert much financial leverage with public financing, some policies put in place to support restructuring have backfired because of the government's inability to act as a regulatory agent, and political pressures have made it enormously difficult to close or sell healthcare facilities. Therefore the effective management of hospitals, quality control, and public accessibility to secondary and tertiary care remained a subject of concern.

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<sup>4</sup> The Georgian Law on Privatization in effect at that time allowed three types of privatization of healthcare facilities: auctioning, competitive bidding, and direct sale.

<sup>5</sup> These plans, developed in 1998-1999, were strongly opposed by the opposition parties during 2002-2003 (including by Mr. Vladimer Chipashvili, then Member of Parliament) and were halted. After Mr. Chipashvili became the Minister of Health following the change in government after the Rose Revolution, he invited two companies—Conseil Sante and Scandinavian Care—to provide assistance in developing the Second Hospital Rationalization Plan.

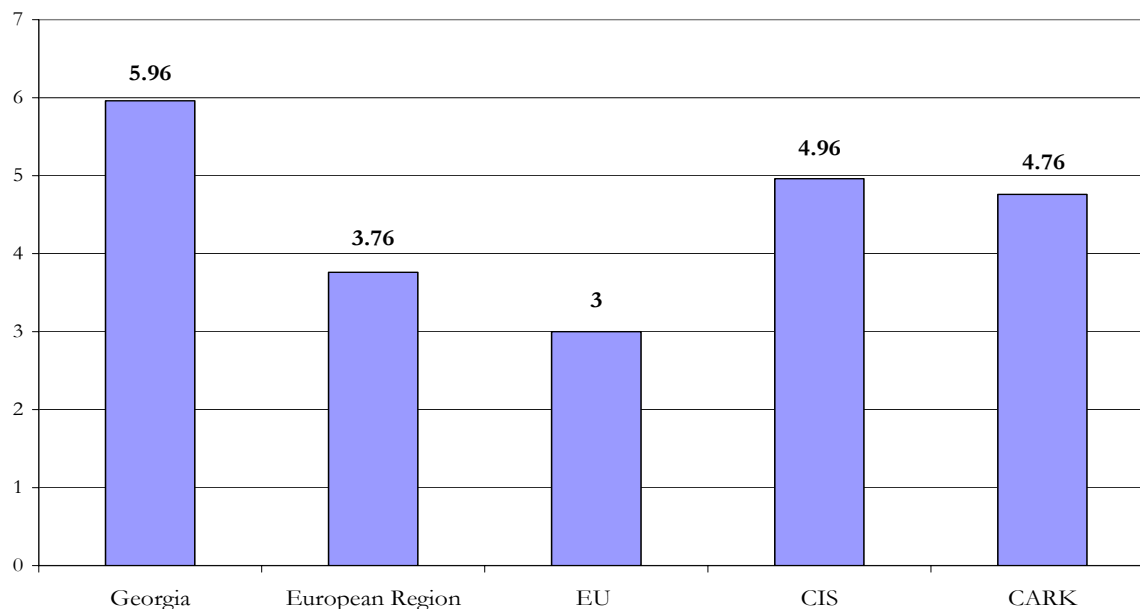
<sup>6</sup> The World Bank even provided financial resources in the amount of up to 5 million USD under the structural adjustment credit.

<sup>7</sup> For additional information please visit the web-page of the Ministry of Health, Labor, and Social Affairs. <http://www.moh.gov.ge>.

## The State of Secondary Healthcare in Georgia in 2001-2006

According to the data provided by the WHO,<sup>8</sup> there were 269 hospitals in Georgia in 2006 or 5.96 hospitals per 100,000 people. This rate was higher than those of other geographic areas. For example, in the European Region (East and West European Countries) there are 3.76 hospitals per 100,000 and 3 per 100,000 in the EU. It is also relatively high in comparison with rates for the Commonwealth of Independent States (CIS) (4.96 per 100,000) and the Central Asian Republics and Kazakhstan (CARK) (4.76 per 100,000) (see Chart 1).

**Chart 1: Hospitals per 100,000 People in 2006**

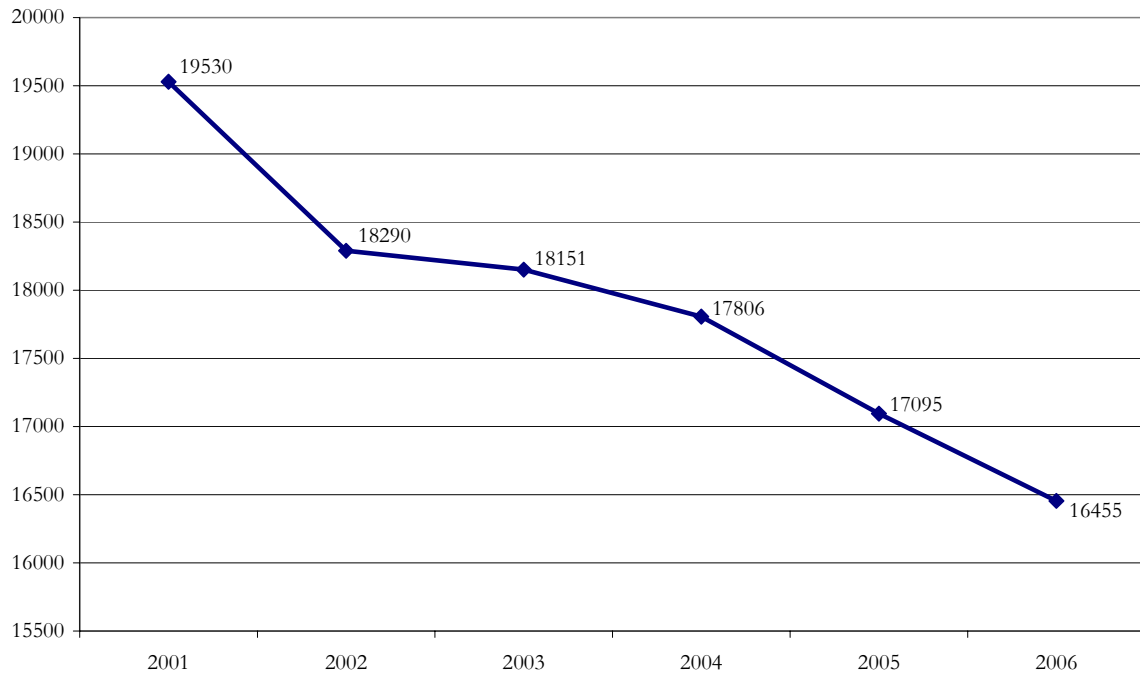


The number of hospital beds declined from 2001 and 2006. In 2001 the total number of hospital beds in Georgia was 19,530, translating into 429.6 beds per 100,000 people.

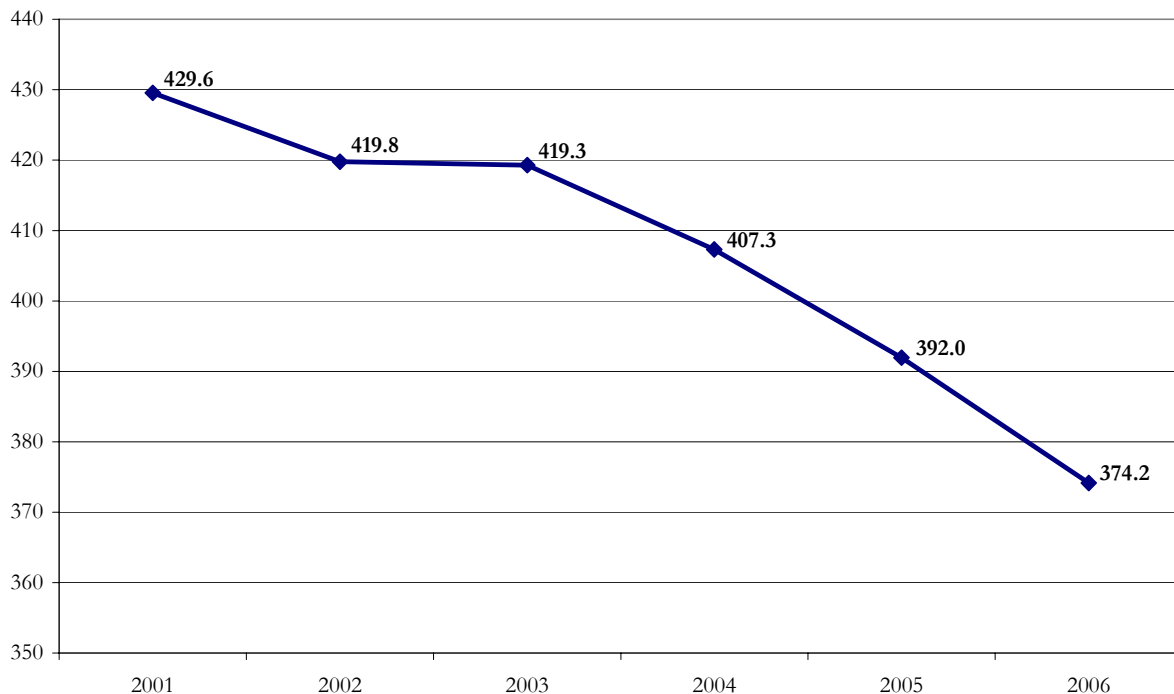
In 2006 the number of beds fell to 16,455, i.e. to 374.2 beds per 100,000 people. In general, bed decline was observed throughout the countries of the former Soviet Union and not only in Georgia during these years (see Charts 2 and 3).

<sup>8</sup> European Health for All databases (HFA-DB), World Health Organization; regional office for Europe. Updated November 2007

**Chart 2: Total Number of Hospital Beds in Georgia**



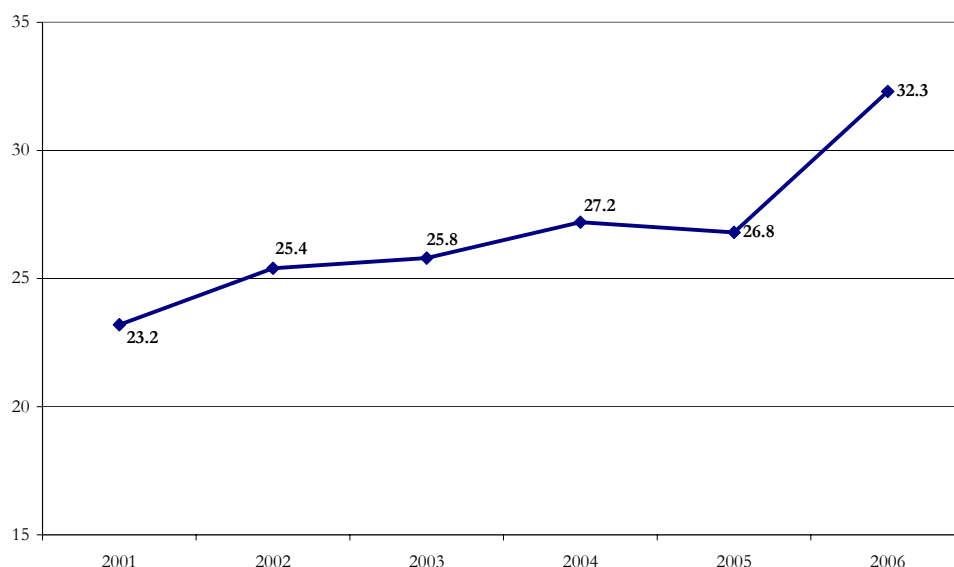
**Chart 3: Hospital Beds per 100,000 in Georgia**



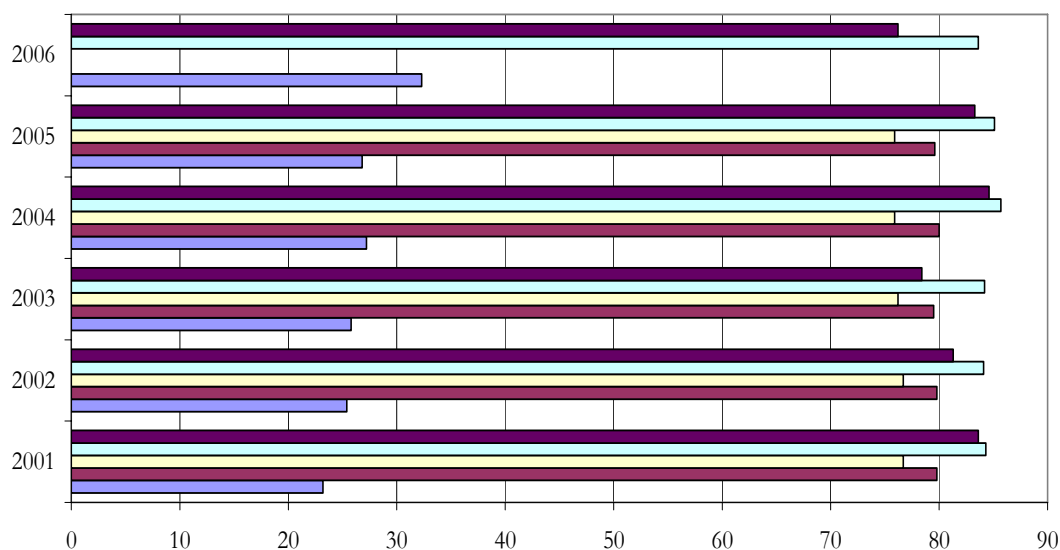
Regardless of the decrease in the number of beds in hospitals in Georgia from 2001 to 2006, bed occupancy rates in acute care hospitals remained low. In 2006, Georgia had one of the lowest hospital admission rates compared to its European neighbors. In 2006, the bed occupancy rates were as follows: Georgia - 32.3%; the EU - 75.85%; the European region - 79.6%; the CIS - 83.61%;

and the CARK - 76.16%. One of the main reasons for the low occupancy in Georgia could be financial access barriers for the population (see Charts 4, 5, and 6).

**Chart 4: Bed Occupancy Rate in Acute Care Hospitals Only (Georgia)**

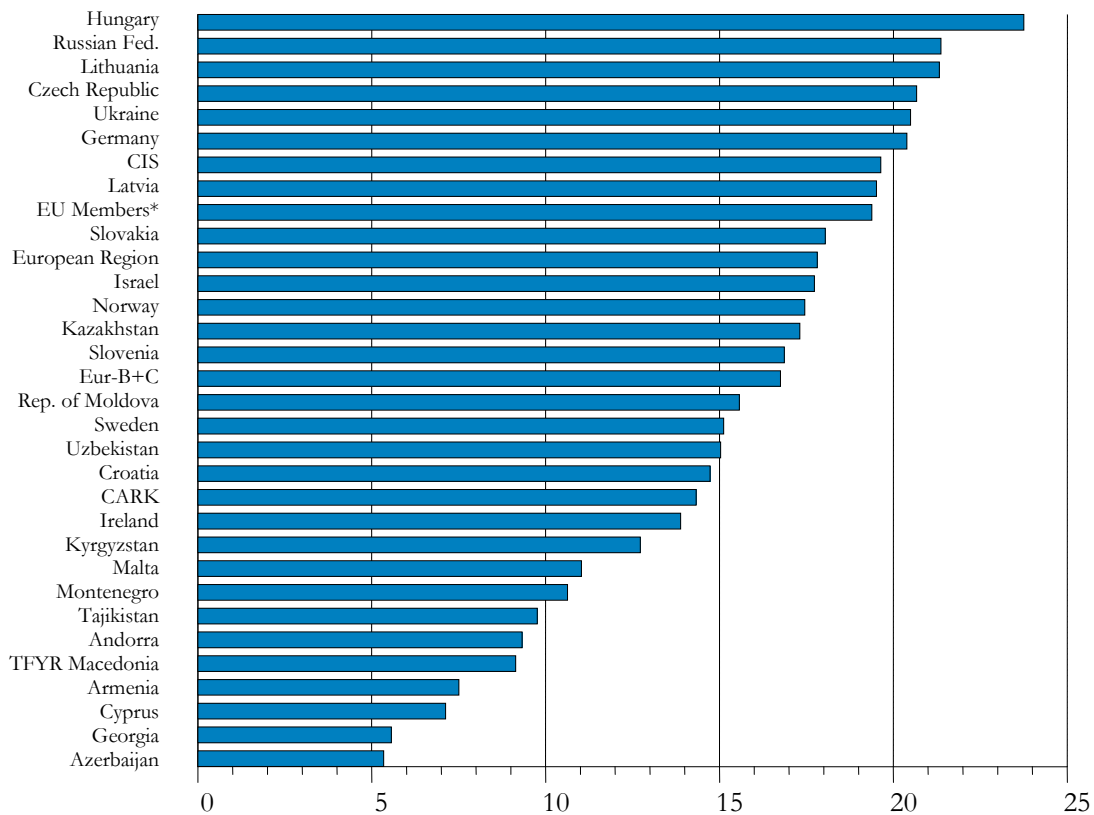


**Chart 5: Bed Occupancy Rate in %, Acute Care Hospitals Only**



	2001	2002	2003	2004	2005	2006
■ CARK	83.6	81.3	78.4	84.6	83.3	76.2
□ CIS	84.3	84.1	84.2	85.7	85.1	83.6
■ European Union	76.7	76.7	76.2	75.9	75.9	0
■ European Union	79.8	79.8	79.5	80	79.6	0
■ Georgia	23.2	25.4	25.8	27.2	26.8	32.3

**Chart 6: Bed Occupancy Rate per 100,000 People, Acute Care Hospital Only (2005)**

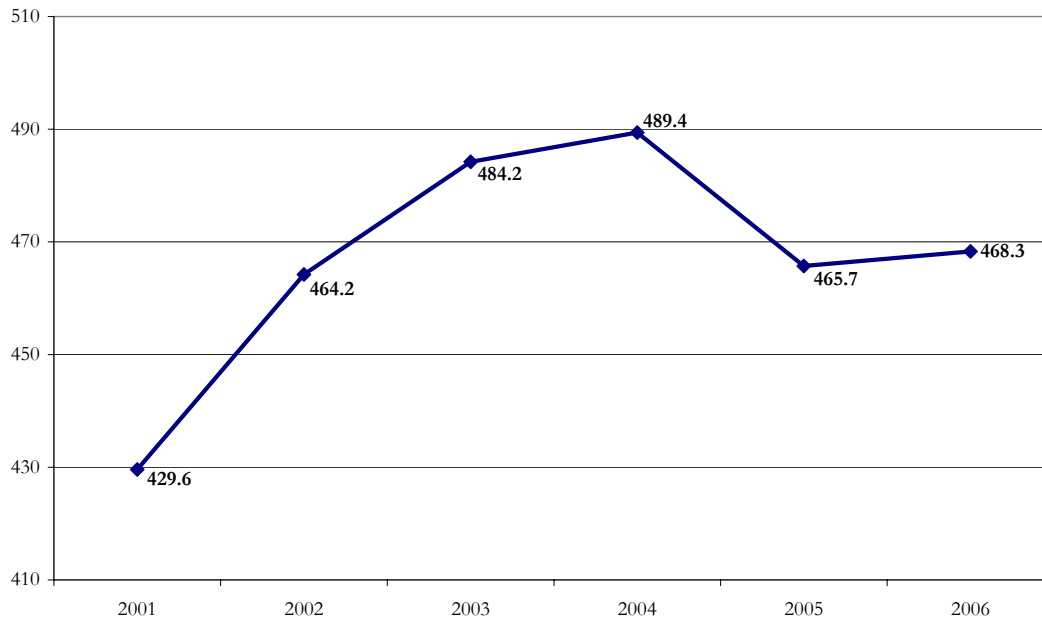


\*EU members since 2004 or 2007

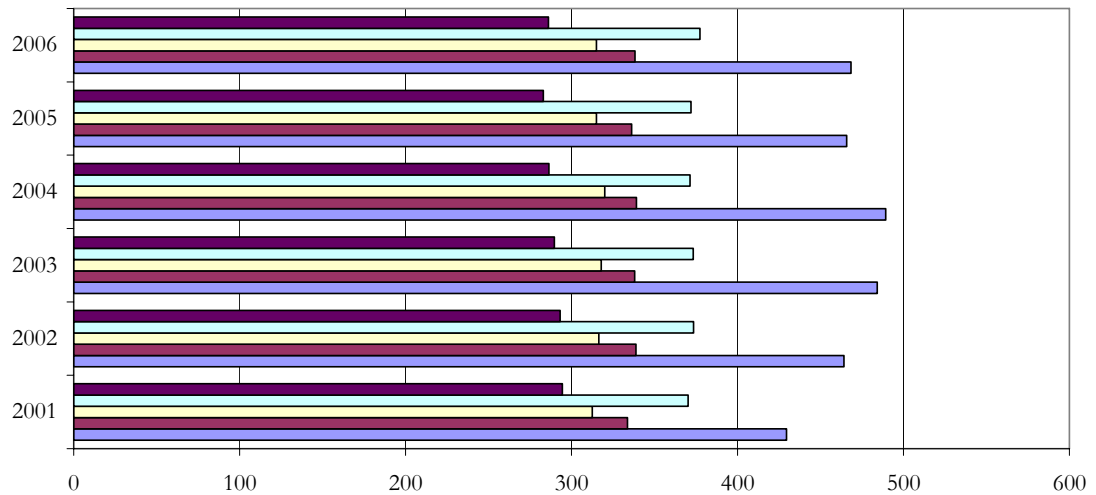
From 2001 to 2006, the Georgian health sector employed a large number of personnel. As in other former Soviet healthcare systems, the number of medical specialists exceeded the number of general practitioners and family doctors in Georgia.

Reforms initiated in Georgia in this period did not result in a significant decrease of medical personnel. Rather, from 2001 to 2006, the rate of physicians per 100,000 people actually increased. Starting from 2001 and until 2006 this number was lowest for the CARK countries and highest for Georgia, compared to the European Region, the EU and the other CIS countries (see Charts 7 and 8).

**Chart 7: Physicians per 100,000 People (Georgia)**



**Chart 8: Rate of Physicians per 100,000 People**

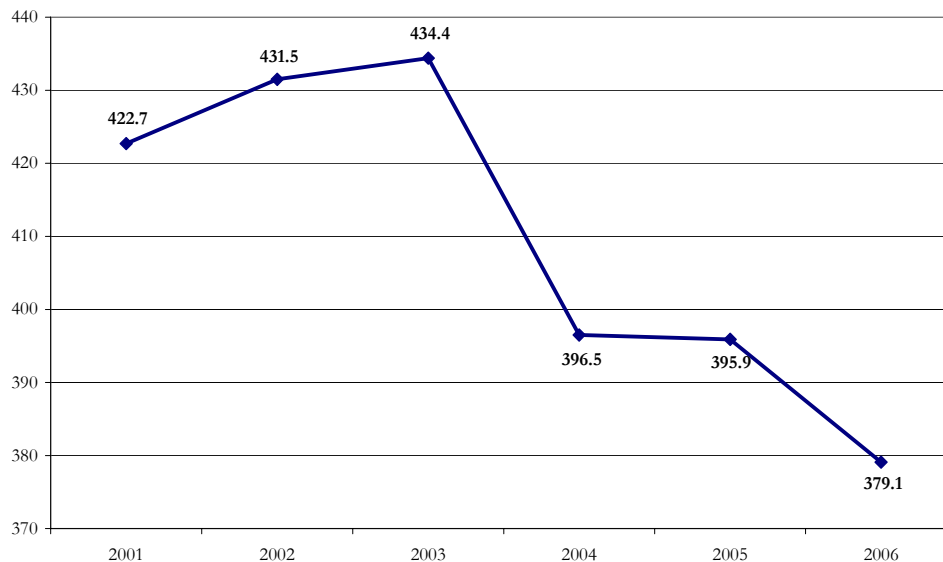


	2001	2002	2003	2004	2005	2006
■ CARK	294.4	293.1	289.6	286.4	282.9	286.0
□ CIS	370.2	373.6	373.3	371.5	372.0	377.4
■ EU	312.5	316.4	317.9	320.0	315.0	315.0
■ European Region	333.8	338.8	338.1	339.0	336.2	338.2
■ Georgia	429.6	464.2	484.2	489.4	465.7	468.3

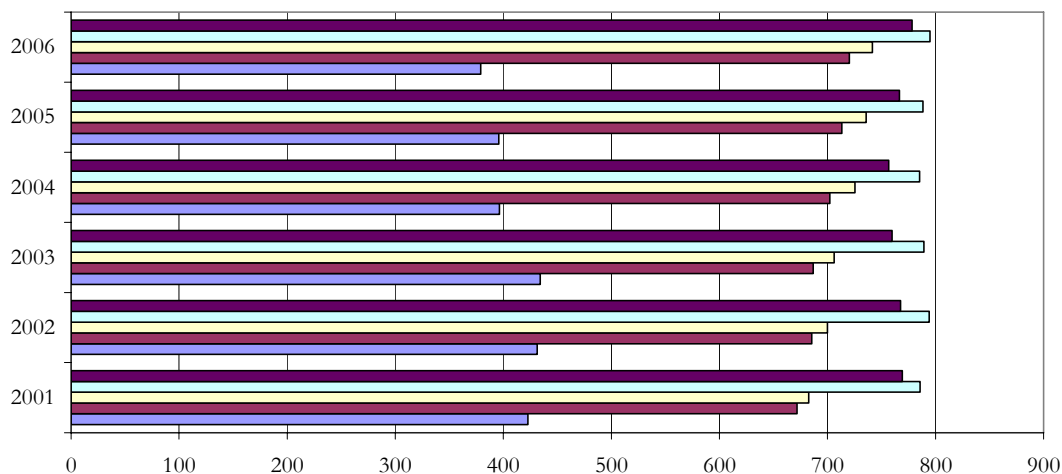
One more important indicator for assessing the state of secondary healthcare in Georgia is the number and qualification level of nurses. Under the Soviet model, nurses were relatively poorly

qualified and acted mainly as doctors' assistants.<sup>9</sup> The rate of nurses per 100,000 people in these years declined. In 2006 Georgia had almost two times fewer nurses than did the countries from the neighboring regions. The ratio of physicians to nurses during those years in Georgia was 1 : 1.2. The ratio recommended by the WHO is 1 : 4 (charts 9 and 10).

**Chart 9: Nurses (PP) per 100,000 people (Georgia)**



**Chart 10: Rate of Nurses per 100,000 people**



	2001	2002	2003	2004	2005	2006
■ CARK	769.2	767.7	759.8	756.6	766.7	778.3
□ CIS	785.8	794.2	789.3	785.2	788.3	794.9
□ EU	682.7	699.9	706.2	725.6	736.0	741.6
■ European Region	672.0	685.5	686.8	702.1	713.3	720.3
■ Georgia	422.7	431.5	434.3	396.5	395.9	379.1

<sup>9</sup> Today the role of nurses is being strengthened and different programs are offered with the support of international organizations to improve the qualification level as well as their role in the provision of healthcare services.

## Post-Revolution Healthcare Reform

The post-Rose Revolution government identified the hospital sector rehabilitation as one of the primary targets of the healthcare reform in Georgia. In January, 2007 Prime Minister Zurab Noghaideli signed a document approving the government's "Hospital Development Master Plan." According to this Plan, following its implementation (after three years) Georgia would have 100 new hospitals with 7,800 new beds (4,185 of them in Tbilisi and 3,615 in the regions<sup>10</sup>). The hospital rehabilitation program was named "100 New Hospitals" and it entailed transferring ownership of almost all state-owned hospitals in Tbilisi and the regions to the private sector through privatization. The government chose to turn the deteriorated healthcare industry over to the private sector with the idea that this would lead to increased competition, higher investments into the sector, and finally, the provision of better medical services. Although the timeframe for the Hospital Development Master Plan was three years, the hospital privatization had to be completed in one year.

Since the first stage of the hospital sector reform focused on privatizing existing hospitals, the responsibility for its implementation was signed over to the Ministry of Economic Development, which is responsible for administering privatization processes in Georgia. The Ministry of Labor, Health, and Social Affairs remained responsible for issuing licenses to the hospitals.

According to the Deputy State Minister for Reform Coordination Mr. Vakhtang Lezhava,<sup>11</sup> the government's reform plan guaranteed access within a half-hour's driving distance to basic medical care for 80 percent of the population. It also called for a systematic shift of emphasis from specialized hospitals (a Soviet legacy) to general (combined) healthcare facilities.

Importantly, the state is receiving no financial dividends from the privatization of its hospital sector assets. Rather than bidding on existing hospital facilities, investors propose to the government the number of hospitals they plan to build (and the number of beds they plan to provide) anew either (1) on the territory of existing, state-owned hospital facilities or (2) on non-agricultural land provided by the Ministry of Economic Development of Georgia in cooperation with the Tbilisi City Hall or appropriate city council.<sup>12</sup> Initially investors must use the purchased land to build hospitals, but after seven years they are free to convert the land and hospital facilities for other uses. The property is being sold in lots, with some land/facilities in Tbilisi and some in less attractive, more remote regions. A positive result of this "mixed bag" approach is that significant investment is being made in the establishment of modern facilities and the provision of healthcare services in previously neglected parts of the country.

## The Process of Hospital Privatization

The tender announcements were posted in the investment business weekly "Mesakutre" [Proprietor] and on the Ministry of Economic Development website ([www.privatization.ge](http://www.privatization.ge)). They were scheduled at intervals of approximately every few weeks. Results of the competitions were

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<sup>10</sup> The Ministry of Labor, Health, and Social Affairs determined the optimal number and types of new beds per locality.

<sup>11</sup> Currently he is the Deputy Minister of Economic Development.

<sup>12</sup> The decision as to where the new hospital should be built is made by the Ministry of Economic Development, not the investor.

publicized via the same outlets. According to the tender announcements and competition results posted on the Ministry website, the criteria for investor selection appeared to be evolving as the privatization program progressed. For the first four tenders (concluded between 11 January and 30 March 2007) the sole criterion for investor selection was the quantity of beds proposed for purchase. While the selection criterion was not specified in the tender announcement, it was made explicit in each of the corresponding result postings. Using the quantity of beds as the only criterion for investor selection directly contradicted one of the main goals of the hospital rehabilitation process – optimizing the number of hospital beds in order to ensure better financing per bed and contribute to improving quality of medical services.

In the announcement of the results of the fifth tender, the government described a more elaborate set of criteria for investor selection, specifically *maximal bank guarantee* and *terms of construction completion*. In an April 19, 2007 address, then-Minister of Economic Development Giorgi Arveladze publicly announced that these two criteria would be added to investor selection process.

According to the government, the bank guarantee was added as a security measure, to ensure that bidding investors possessed financial resources necessary for meeting their commitments (to build and equip new hospitals). As the Ministry of Economic Development explained, the government calculated the cost for one new, general profile hospital bed at approximately 42,000 USD and designated 15,000 of those 42,000 USD (slightly more than one-third) as the minimum bank guarantee required per bed (i.e. an investor committing to 100 beds would be required to present bank guarantee equal to 100 beds x 15,000 per bad = 1.5 million USD). Reviewing the tender processes following adding of the bank guarantee to the selection criteria shows that for a number of investors participating in these tenders the bank guarantee amounts submitted by them significantly exceeded the minimum amount required by the government (in some cases this number was 22-25 times larger). In these tenders the government selected those bidders that bid the highest bank guarantee amounts, even though, naturally, bidding larger bank guarantees does not require the bidding companies to fully invest these amounts into the hospital construction and operation.

Concerning the second criterion – terms of construction completion – according to the European standard, a minimum of five-six years is required to build and equip a new hospital. The designation of speed of completion of construction as a criterion for investor selection disregarded this standard, as it pushed investors to commit to completing the new constructions in minimum time possible in order to defeat their competitors.

Tender announcements Nos. 6 and 7 were the first to include a list of new “conditions,” including maintenance or repair of existing departments of the privatized facilities, purchase of certain types of medical equipment, demolition of certain buildings, and finally—removal and resettlement of refugee families that had been residing on the grounds of state-owned hospitals.

Currently there are 15 hospital sector development projects in place.<sup>13</sup> As part of these projects, 193 hospitals are intended to be privatized, out of which 18 are in Tbilisi and the other 175 in the regions. As of February 2008, three privatization contracts are signed: Project Nos. 1, 5, and 8.<sup>14</sup> Project Nos. 9, 10, 11, 12, 13, 14, and 15 are being worked out at the moment. Project Nos. 3 and 7 have been submitted to the government for consideration.

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<sup>13</sup> According to official information by Ministry of Labor, Health, and Social Affairs.

Project No. 1 includes Zugdidi Healthcare Facilities and the Hematology and Transfusion Scientific Research Institute. According to the signed agreement, the investor must build a general profile hospital with 100 beds in Dighomi, renovate several Zugdidi healthcare facilities, and establish a blood bank. Various sanctions will be imposed on the investor should the contract be violated.

Project No. 5 includes LTD M. Tsinamdzgvrishvili Cardiology Scientific Research Institute, LTD Tbilisi 4<sup>th</sup> Clinical Hospital, LTD M. Guramishvili Pediatric Clinic, LTD Tbilisi Maternity House, and LTD Radiology Clinic. The official winner is Block Georgia; however, TI Georgia found that medical personnel have already noted the involvement of the pharmaceutical company Aversi Pharma in the management process. The main selection criteria were bank guarantee and speed of construction. According to the agreement, the investor must build a general profile hospital with 190 beds in Sanzona in 17 months. This agreement also includes a detailed medical appliance list.

Project No. 8 includes the Georgian National Center of Ophthalmology and Neurology, Shalva Koridze Maternity House, and the Scientific-Practical Recreation Plastic Surgery and Thermal Affects Center. The official winner is Unimsheni, though similarly to Project No 5. TI Georgia found that medical personnel have already noted the involvement of the pharmaceutical company Aversi Pharma in the management process. According to the agreement, the investor must build a fully equipped general profile hospital with 150 beds in Ortachala in 23 months. Again, the main selection criteria were bank guarantee and speed of construction.

## **Health Personnel Assessment of the Hospital Privatization Process**

In order to assess stakeholder views on the reform of secondary healthcare, TI Georgia held meetings with the representatives of different international, state, and non-governmental organizations, with Georgian state structures, and with hospital heads and medical personnel. Thirteen out of 18 hospitals based in Tbilisi were visited in this process. The analysis is based on face-to-face interviews with and questionnaire responses from administrators and medical personnel in thirteen out of the eighteen hospitals in Georgia. A total of sixty-four respondents were interviewed for this research.

The main areas of interest for both the interviews and survey were as follows:

- Outcomes of the secondary healthcare reform as assessed by the surveyed medical personnel
- Awareness level of the surveyed medical personnel about the process of the hospital sector privatization
- Main sources of information about the hospital sector development master plan and its implementation
- Medical personnel's familiarity with the goals and objectives of the hospital sector development master plan
- Medical personnel's assessment of the process of the hospital sector privatization: its compatibility with the set goals and objectives, transparency, and outcomes
- Medical personnel's opinions about the sustainability of new hospitals and investors' commitments to providing healthcare services over the long-term
- Medical personnel's opinions about the agreements signed between the state and

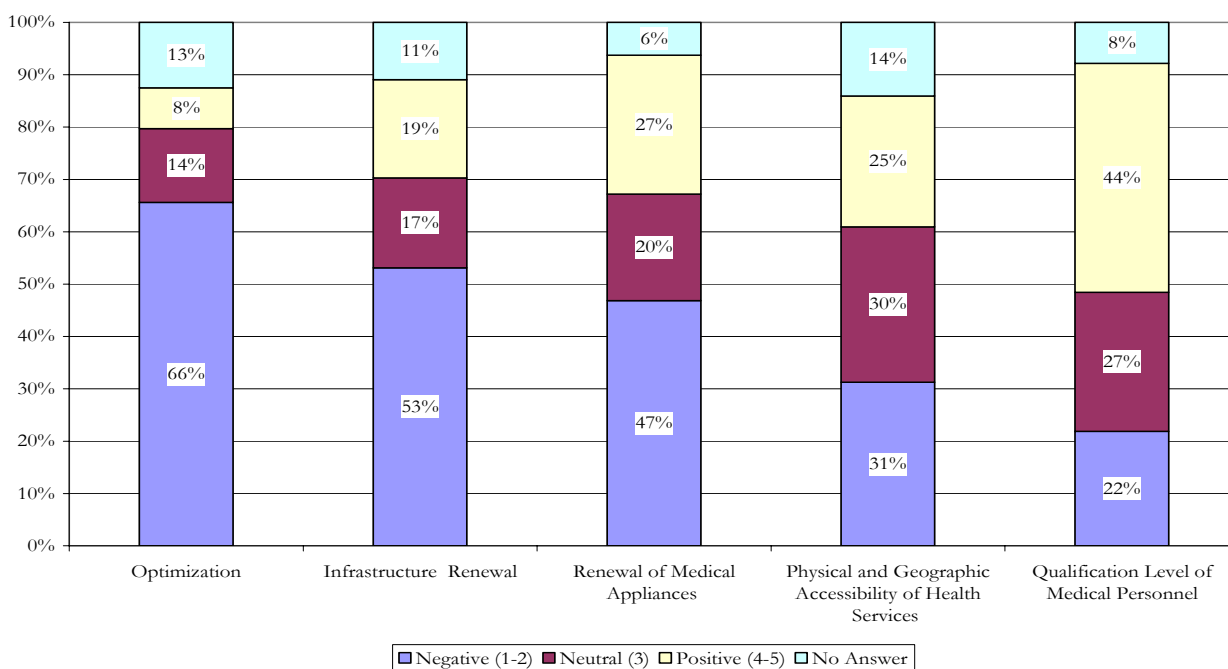
- investors
- Medical personnel’s assessment of and opinions about the regulatory mechanisms in the healthcare sector
- Medical personnel’s suggestions regarding hospital quality management issues

## Results of the Research

### *Secondary Healthcare Reform in 1996-2003 as Assessed by Medical Personnel*

Medical personnel recognized the need to reform secondary healthcare in order to optimize the number of hospitals in the country and the number of medical personnel in those hospitals and improve hospital performance. They considered that despite the reforms taking place in Georgia, the capacity of the sector has not been improved at the expected rate. The average evaluation of the reform processes that took place from 1996 to 2003 in terms of optimization, infrastructure, and medical appliance renewal, physical and geographic accessibility of health services, and qualification level of medical personnel was 2.6 out of total five points, five being highest. The respondents were most critical of the process of hospital optimization and infrastructure renewal: 66% said that the optimization process did not take place and 53% said that infrastructure renewal was at a very low level. The medical personnel were relatively less critical about the renewal of medical appliances: 47% said that it was sufficient, while 27% said that it was largely unsatisfactory. Most positive assessments were given to physical and geographic accessibility of medical services and to qualification of medical personnel. Twenty-five percent of surveyed hospital heads and physicians said that physical and geographic accessibility of medical services was satisfactory, while 31% said opposite. As for the qualification of medical personnel, 44% of the respondents thought that its quality was high as opposed to 22% who said that it was low.

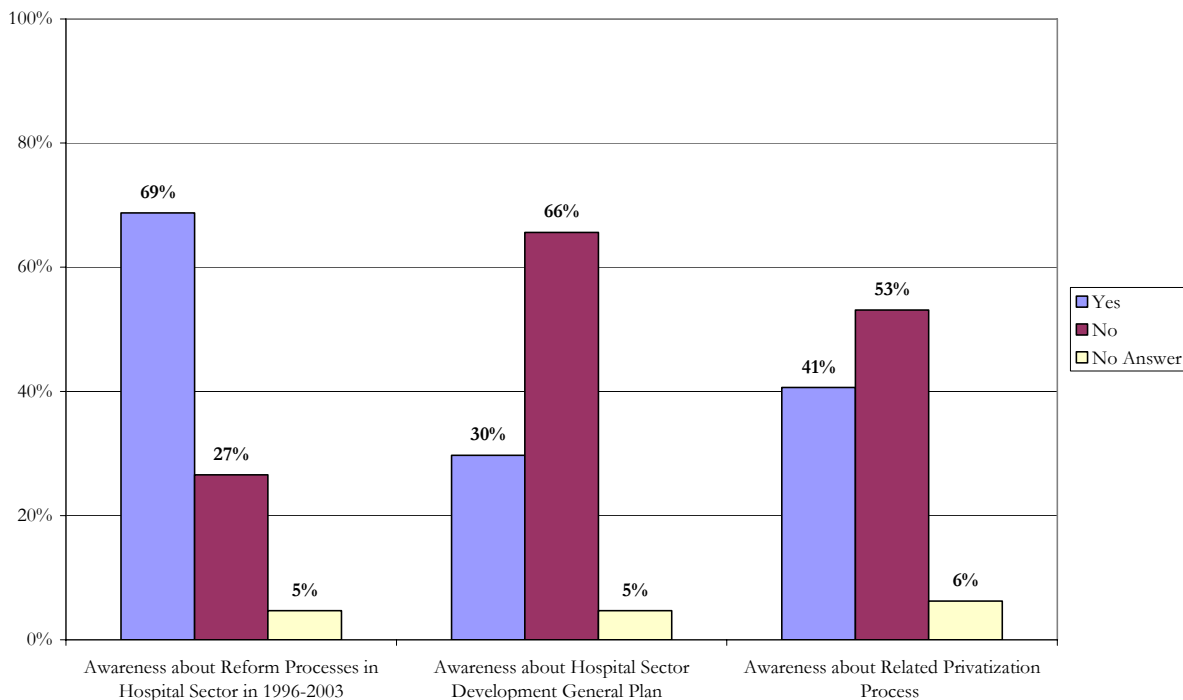
**Chart 11: Secondary Healthcare Reform in 1996-2003 as Assessed by Medical Personnel**



### *Respondents' Awareness of Healthcare Reform Processes before and after 2003*

The survey asked questions about the medical personnel's awareness of the healthcare sector reform processes prior to and following the government change in 2004. Sixty-eight point seventy-five percent of respondents indicated that they had been aware of the reform processes taking place in the country in 1996-2003. This number decreased to 41% when the respondents were asked to comment on their awareness of the post-revolution reform processes. The number decreased further when the medical personnel spoke about their awareness of the hospital privatization process in particular. As the survey showed, only 29.7% of the respondents were adequately informed about the privatization process.

**Chart 12: Awareness Level of Respondents**



### *Main Sources of Information about the Post-2003 Healthcare Reform*

Respondents that indicated that they had information about the current hospital sector reform initiative were asked to indicate the main sources of information on the topic. These sources were the media (58%), hospital administration, (58%) and the Ministry of Health, Labor, and Social Affairs (36%). The Ministry of Economic Development and the investors involved in the process were rarely cited by respondents as a source of information about the privatization process with only 12.5% naming the Ministry of Economic Development and 3% the investors.

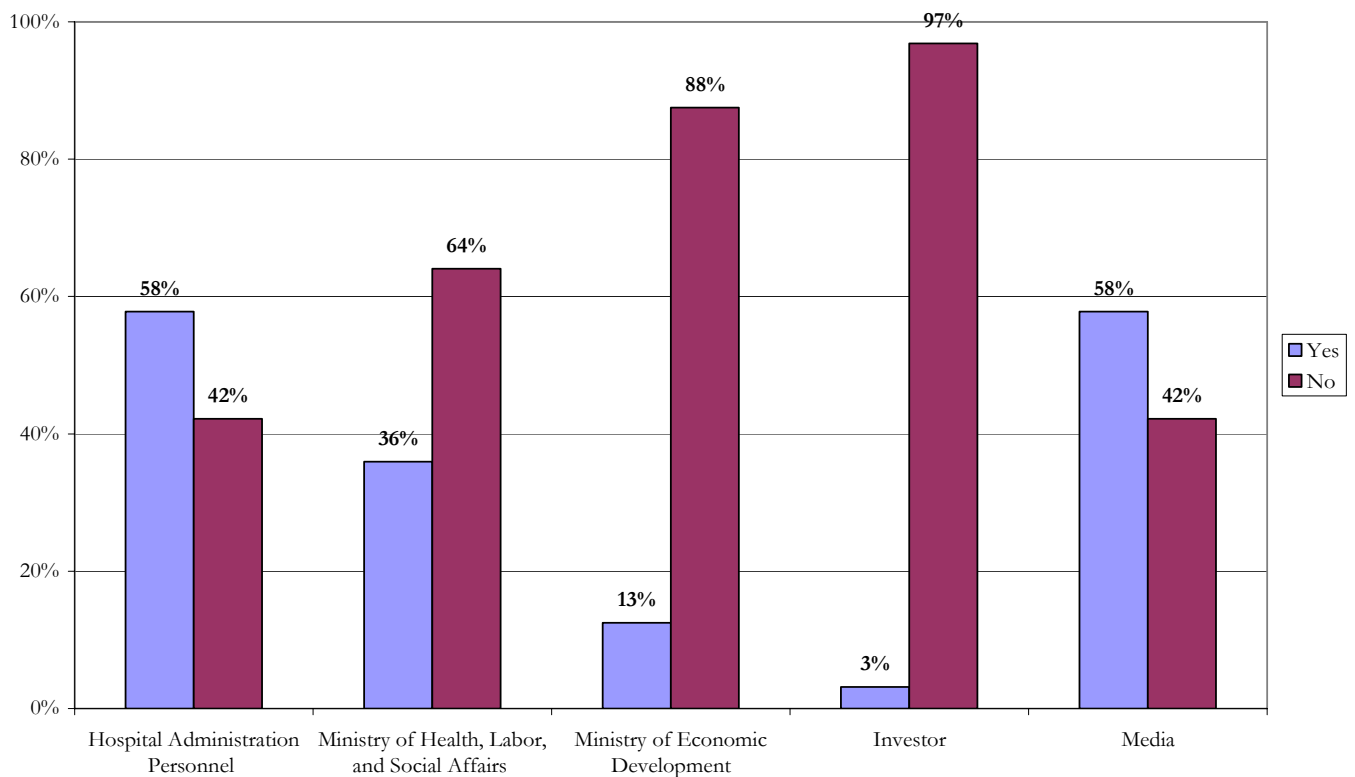
Although 36% of the surveyed hospital heads and personnel said that they received reasonable information about the healthcare sector privatization from the Ministry of Labor, Health, and Social Affairs, the vast majority highlighted that it was essential to increase communication between this Ministry and the hospital staff. This need was also identified in reference to the different state entities involved in the healthcare reform process, including the Ministry of Health and the Ministry

of Economic Development.

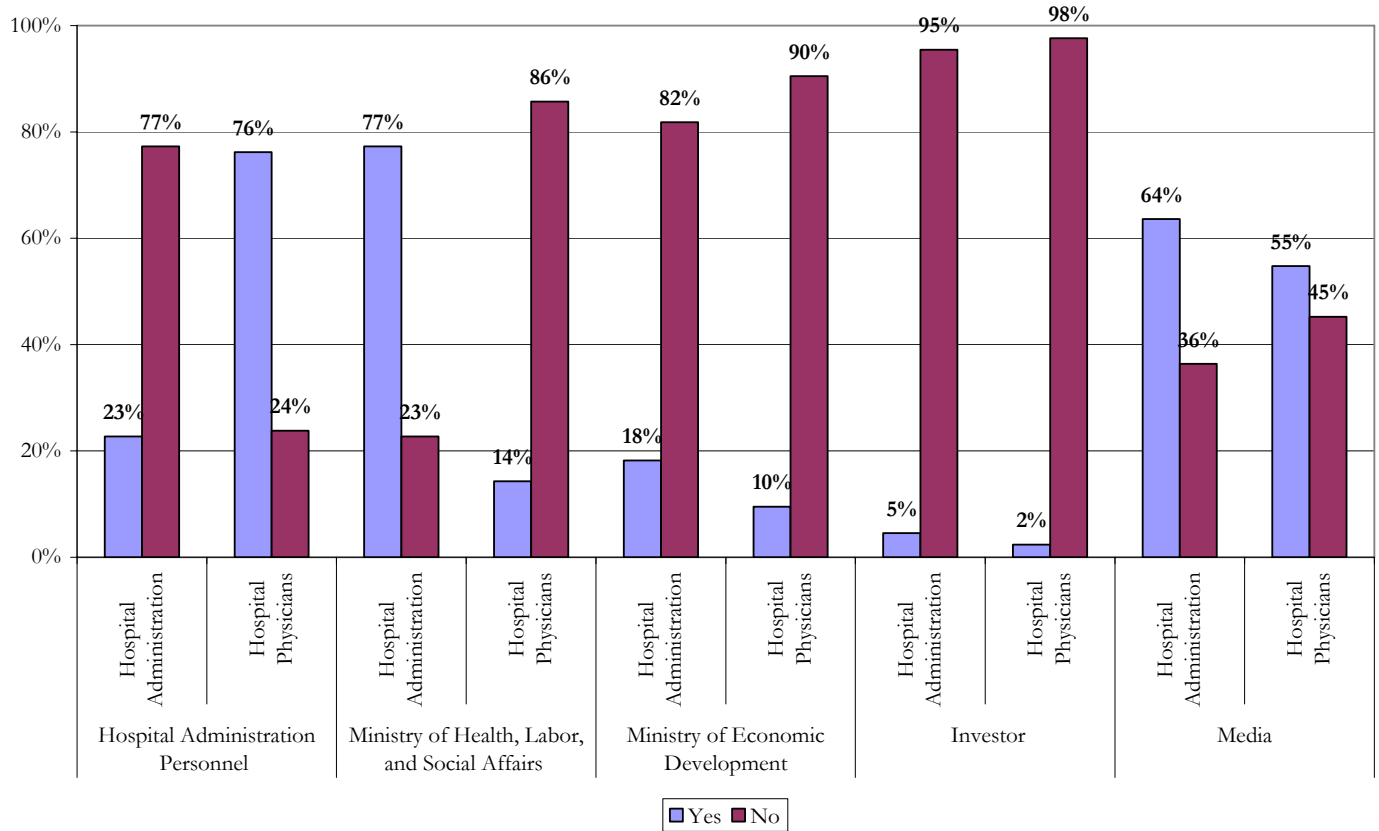
The medical staff called for more frequent meetings among the major stakeholders in this process. They were particularly interested in meeting with the bidding investors in order to learn about their objectives vis-à-vis the hospital sector and the means and mechanisms for meeting these objectives.

It should be noted that the hospital administration responded more positively to the question about the Ministry of Labor, Health, and Social Affairs' communication with the hospital administration on the issue of hospital privatization (77% responded positively) than physicians (86% responded negatively). However, the two were similarly critical of the Ministry of Economic Development's and the investors' availability for either a dialogue or the requested information. Eighty-two percent of hospital heads were critical of the Ministry of Economic Development and 95% were critical of the involved investors. Ninety percent of personnel were of the same opinion about the Ministry of Economic Development and 98% of the investors. The media turned out to be the major source of information for both of them at about the same level.

**Chart 13: Main Sources of Information about the Hospital Sector Development Master Plan and Its Implementation**



**Chart 14: Breakdown of Chart 13 by Hospital Administration and Personnel**



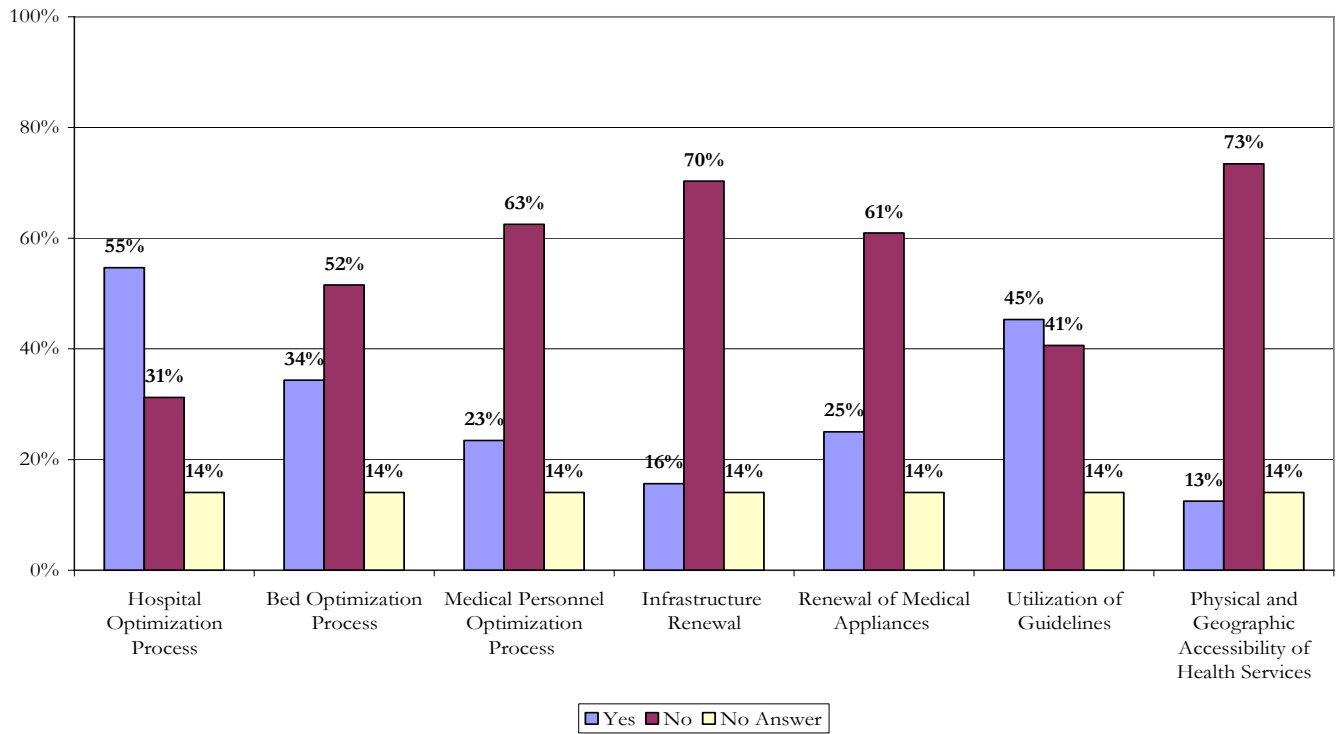
*Discussion Topics to date*

To date, there have been some meetings held between the Ministry of Labor, Health, and Social Affairs and hospital staff. According to the interviewed medical personnel, these meetings mostly concerned:

- hospital sector optimization (named by 55% of respondents),
- the utilization of medical guidelines (named by 45% of respondents),
- the bed optimization process (named by 34% of respondents),
- and the renewal of medical appliances (25% of respondents).

In responding to this question, many respondents added that the statements made during these meetings and the promises given did not translate into subsequent action.

**Chart 15: Consultation and Meeting Topics between the State Structures and Medical Personnel**

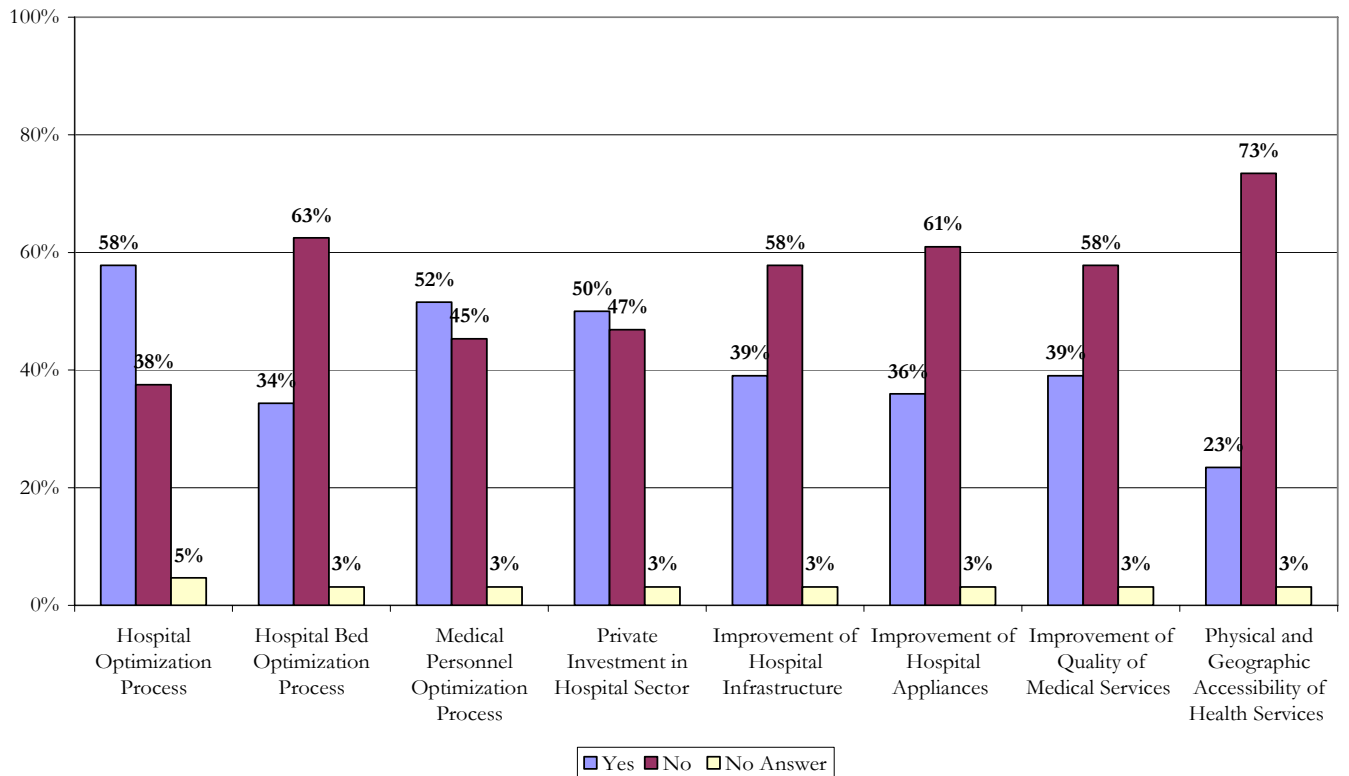


*Main Goals and Objectives of the Hospital Sector Development Master Plan according to Medical Personnel*

In order to assess the respondents' opinions about the main goals of the Hospital Sector Development Master Plan, as identified in the Plan itself and pursued by the responsible state agencies, TI Georgia asked the interviewed hospital heads and medical personnel to name what they thought was the most important part of the Plan for the government.

Fifty-eight percent of the respondents stated that the government was most interested in optimizing the hospital sector; 52% said that they were mostly in favor of optimizing the number of medical personnel; and 50% named promoting private investment into the healthcare sector as the government's top goal. At the same time, 73% of the respondents said that the Master Plan does not ensure physical and geographic accessibility of medical services; 63% stated that it barely supports optimization of hospital beds; 61% said that it does not guarantee the improvement of hospital sector appliances; and 58% were not confident in its compatibility with the goals to improve hospital infrastructure or the quality of medical services.

**Chart 16: Medical Personnel’s Opinions about the Major Goals of the Hospital Sector Development Master Plan**



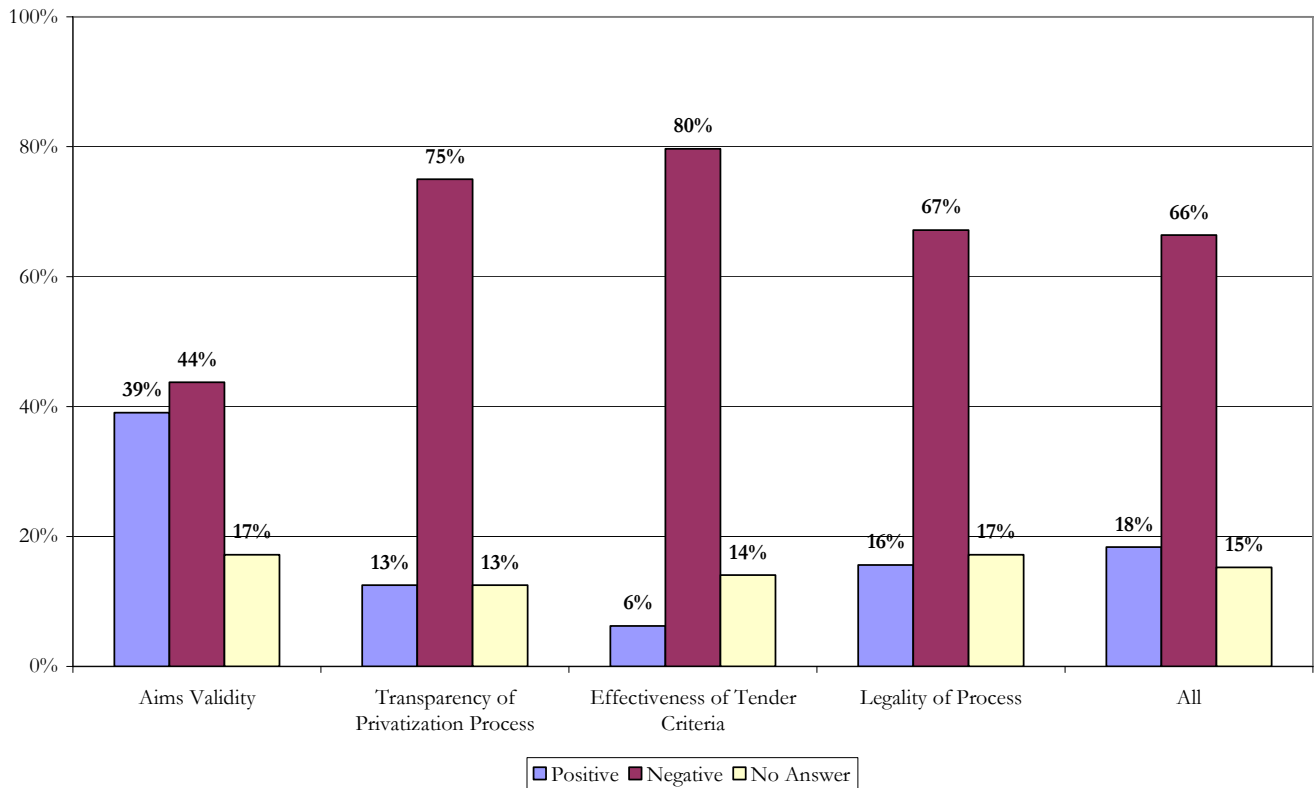
*Respondent’s Evaluation of the Privatization Process: Its Goals, Transparency, Effectiveness, and Legal Aspects*

In general, the number of the surveyed medical personnel who assessed the process of the hospital sector privatization positively, taking into consideration its different aspects, was very low (18%). On the contrary, 66% assessed this process negatively.

Out of four different elements of the privatization – aims validity, transparency, effectiveness of tender criteria, and the associated legal procedures – the effectiveness of tender criteria was considered to be the most problematic (80% of the respondents said that the criteria was ineffective); the lack of transparency of the process was regarded as the second most problematic (named by 75% of the respondents); and the legal procedures involved were highlighted as third most problematic (named by 66% of the respondents).

The goals of the privatization process were assessed more positively.

**Chart 17: Current Hospital Sector Privatization Process as Assessed by Hospital Personnel**



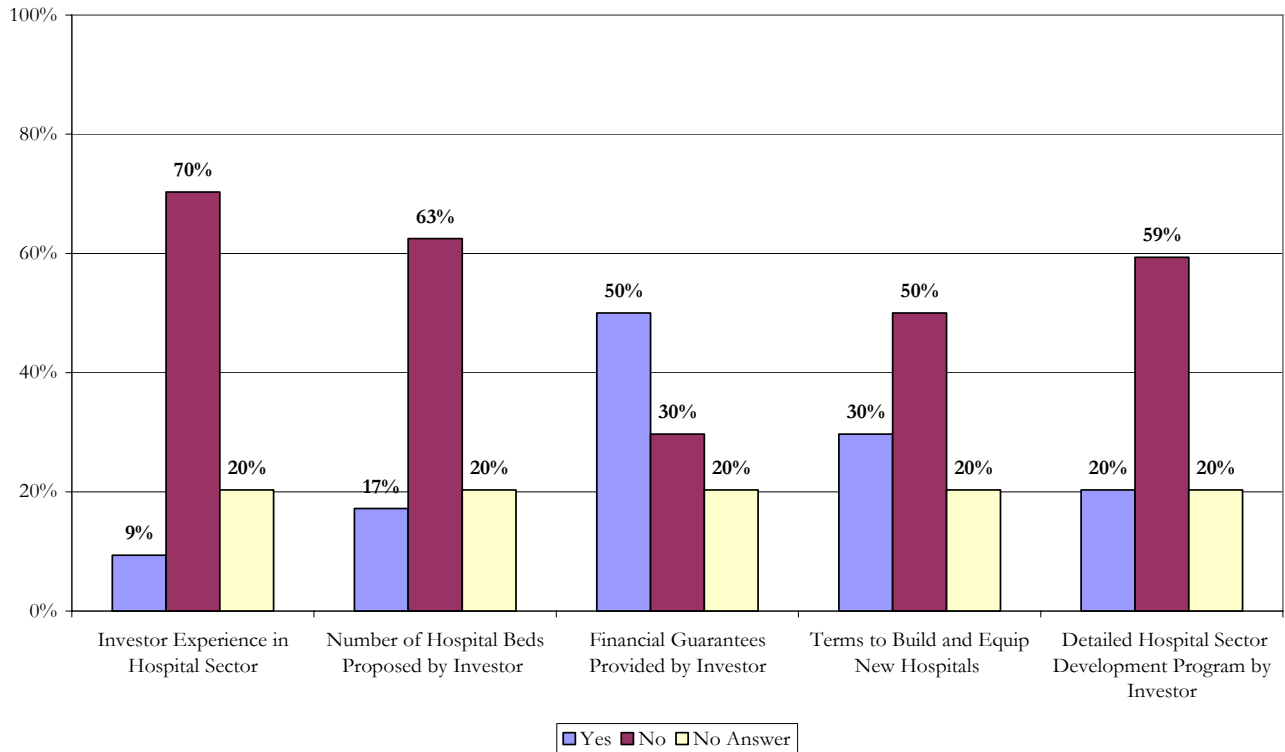
*Respondents' Familiarity with the Selection Criteria in the Hospital Privatization Process*

To learn about the respondents' familiarity with the tender criteria in the process of the hospital sector privatization, TI Georgia asked the following question: "According to your observation, what are the main criteria used for identifying the winning investor?"

The results were as follows: 50% of the surveyed hospital staff stated that the government paid most attention to the financial guarantees provided by the bidding investors and 30% said that the primary criterion was the speed of the hospital construction/reconstruction as suggested by the investors.

In contrast, 70% of the respondents said that the government disregarded the participant investors' experience in the health sector; 63% said that the government was not paying much attention to the number of beds offered; and 59% said that the government overlooked the importance of a detailed development program presented by the potential investors.

**Chart 18: Respondents Familiarity with the Selection Criteria**

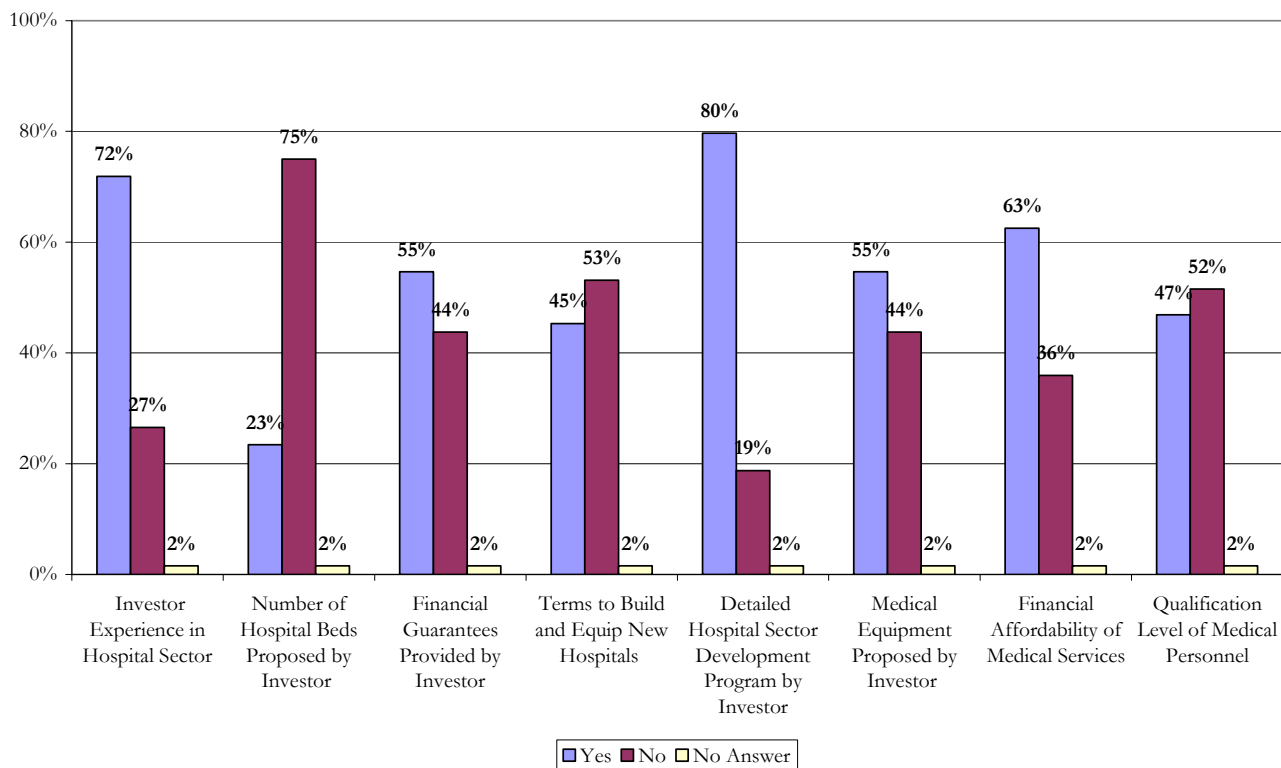


*Criteria Proposed by Medical Personnel*

The criteria used by the government for privatizing the state hospitals did not coincide with the criteria proposed by the majority of the respondents for ensuring the effective implementation of the hospital sector reform. The hospital staff stressed that the selection process could be improved by redirecting attention toward: (1) a detailed hospital development program offered by the bidders (80%) – this should include production efficiency, a hospital management system, medical personnel employment, etc., (2) investors’ experience in the sector (72%), (3) guarantees for financial affordability of medical services offered by the privatized hospitals (63%), (4) financial guarantees provided by the investors (55%), (5) medical equipment proposed by the investors (also 55%), (6) qualification level of medical personnel to be secured by the investors (47%), (7) speed of construction/reconstruction (45%), and (8) number of beds offered (23%).

On the other hand, 75% are against using the number of beds as one of the main criteria for selecting the winner, and 53% were against using speed of construction/reconstruction as a criterion.

**Chart 19: Criteria to Be Used for Identifying Winning Investor according to Respondents**



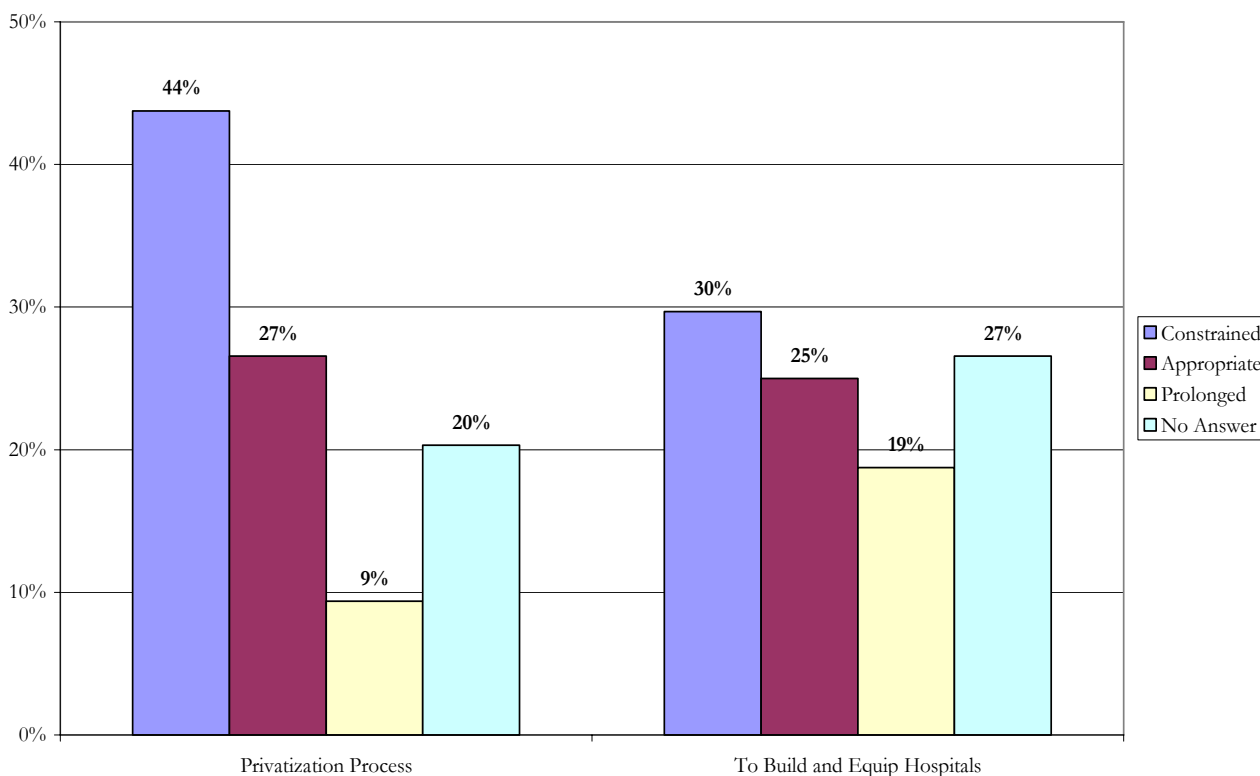
*Timeframes of the privatization process and building of hospitals*

One of the main criteria for investor selection in the privatization process was the speed of construction of new hospitals. The government originally planned to set a two-year deadline for completion of new hospital construction, but later expanded it to three years.

The European standards for building and equipping a new hospital from start to finish are a minimum of five to six years. Nevertheless, 34% of the respondents considered that the timeframes for the privatization process are either sufficient or even too long; and 44% considered that the time allocated for finalizing the hospital construction and equipment is either sufficient or prolonged. On the other hand, 44% think that the privatization process is too short and 30% think that the time given for constructing the hospitals is constrained.

However, according to the medical personnel, what is more important in terms of the hospital sector reform is not the timeline associated with the privatization process and the hospital construction but further accountability and responsibility of the investors in terms of the quality of healthcare provided by the new hospitals.

**Chart 20: Privatization Timeframes**



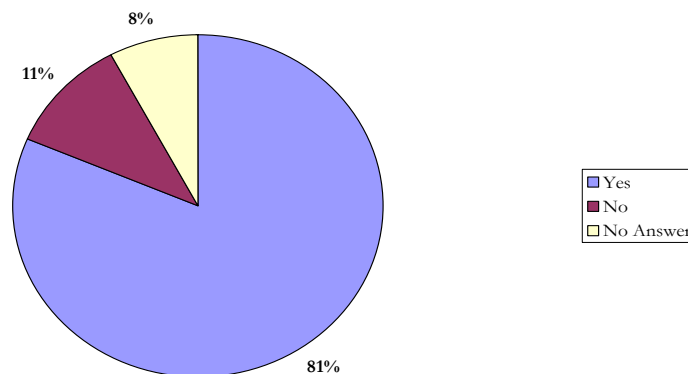
*Sustainability of new hospitals and investors' commitment to providing healthcare services over the long-term*

According to the terms of the tender contracts, the new facilities must function as hospitals for seven years from the date of the conclusion of the tender agreement. After seven years, investors are free to use the former state-owned property for any purpose they deem desirable. The stipulation raises two major questions. First, what incentive will investors have to continue providing healthcare services after seven years? Thus far the winning bidders in the hospital privatization program have been real estate developers (whose long-term commitment to healthcare development in Georgia is unclear) and pharmaceutical companies. The government assumes that this will be regulated by the market – after building and operating high-quality hospitals, these hospitals will become profitable and thus it will be in the interests of their owners to continue their operation after the completion of the seven-year period. However, concerns remain about the possibility of a poorly functioning secondary healthcare system due to inadequate financial planning and/or ineffective regulation of the sector on the part of the government. At this point it is unclear how the cost will be recovered and who will assume the responsibility for providing healthcare to the Georgian public should this happen.

The vast majority of the respondents to TI Georgia's survey expressed concern about the actual outcomes of the healthcare sector reform upon the completion of the privatization process. Their main concerns were associated with the likely unprofitableness of the new hospitals, especially in the regions. According to the Master Plan, most of these (regional) hospitals will be supplied with just 15-25 beds. Even in the regional centers, most new hospitals will have the capacity of less than 150 beds.

Small rural hospitals will provide only the most basic emergency and urgent care services. In these facilities, just one of the fifteen or twenty-five beds will be equipped for more comprehensive care. Eighty-one percent of the respondents expressed fears that without a proper regulatory system in place, investors would most probably try to expand their facilities for providing more lucrative types of care (i.e., increase their number of “general profile” beds) at the expense of minimizing the share of less lucrative types. In the end, patients in need of less lucrative types of care, such as chronic cardiovascular, oncological, or psychiatric disorders and infectious diseases, could be left entirely without local access.

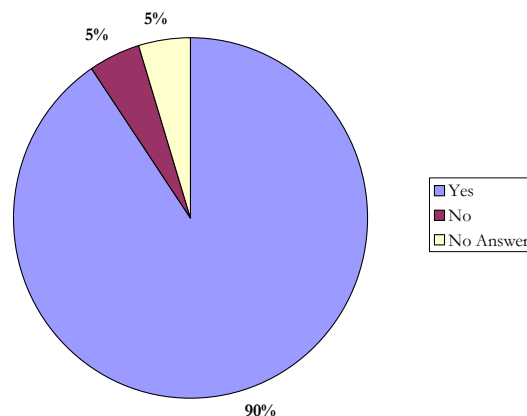
**Chart 21: Possibility of Decreased Opportunities for Care for Less Lucrative Diseases**



*Affordability of medical services after the privatization process*

An important concern in terms of the transfer of ownership of the state-owned hospitals in Tbilisi and the regions to the private sector is connected with the prices of medical services following the privatization. It is argued that the privatization will increase the costs of medical services. Ninety percent of the interviewed hospital staff shared this concern.

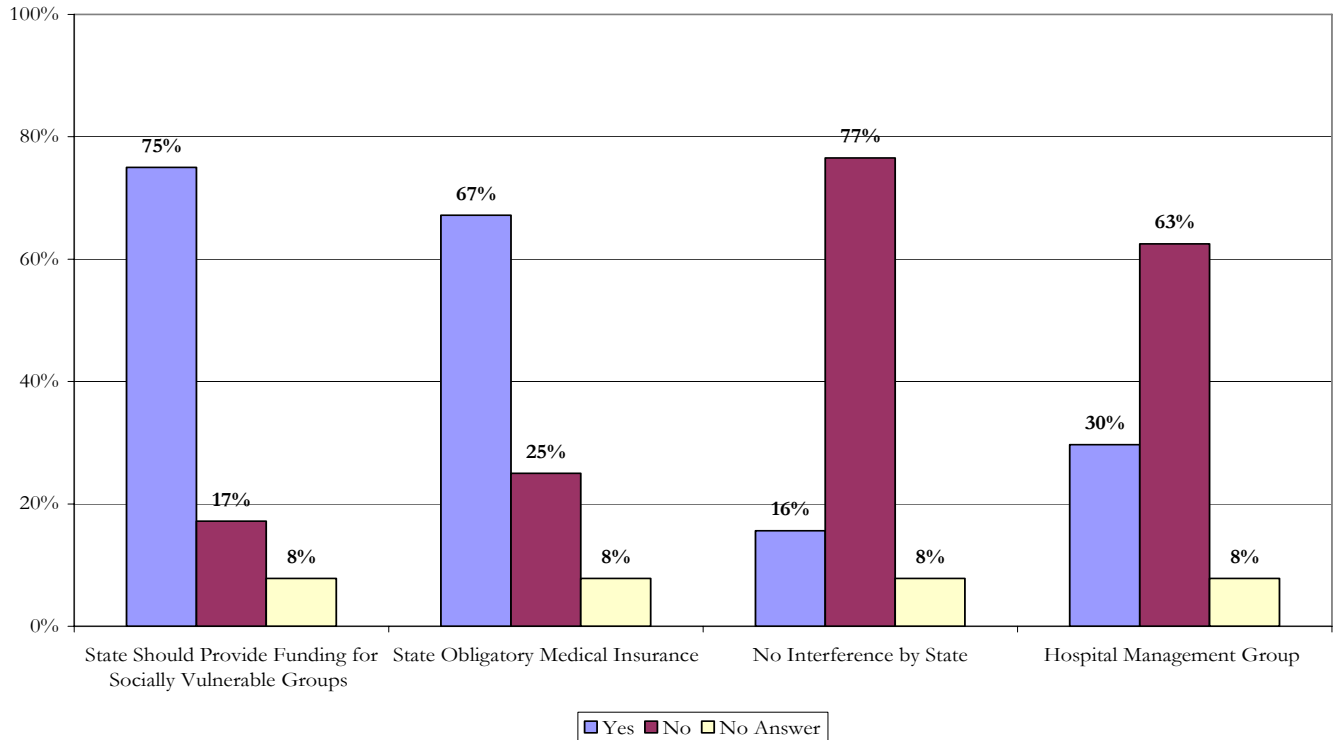
**Chart 22: Possibility of Increasing of Prices on Medical Services as a Result of Hospital Privatization**



The respondent's opinions about how to avoid or address financial overburdening of the consumers varied. The following suggestions were offered by the hospital heads and personnel involved in the research:

- Seventy-five percent of the respondents said that the increased prices had to be coupled with increased state financing of socially vulnerable groups. However, another concern related to the new “targeted financing” strategy of the state is that it will benefit the most vulnerable (poverty-stricken, elderly, etc.) parts of the society, while pushing privately run healthcare services out of reach of the majority of the population, i.e. those who do not qualify as socially vulnerable by the state's current standards but still have very low incomes. Currently, an estimated 40% of Georgian citizens fail to qualify for state support but cannot afford to purchase private insurance. This group might be left without access to even some of the most basic healthcare services.
- Sixty-seven percent of the respondents said that there should be obligatory state insurance.
- Thirty percent of the respondents consider that the new hospital management groups (new owners) must provide economic plans and estimations that will prevent the significant increase of fees for medical services.
- Sixteen percent of the respondents said that the state should play no role in this process. In their opinion, this system will be most effectively regulated by the principles of a market economy.
- Five percent of the respondents indicated there is a need to combine public financing of the sector with private health insurance. According to them, properly developed state and private medical insurance systems and relevant legislative frameworks are the most efficient ways to avoid an increased financial burden on the consumers. However, there is concern that Georgia's health insurance industry is still too small to assume responsibility for financing the healthcare needs of the majority of the population.

**Chart 23: Regulatory Mechanisms for Increased Prices on Medical Services**



*Regulatory Mechanisms for Ensuring Quality Healthcare*

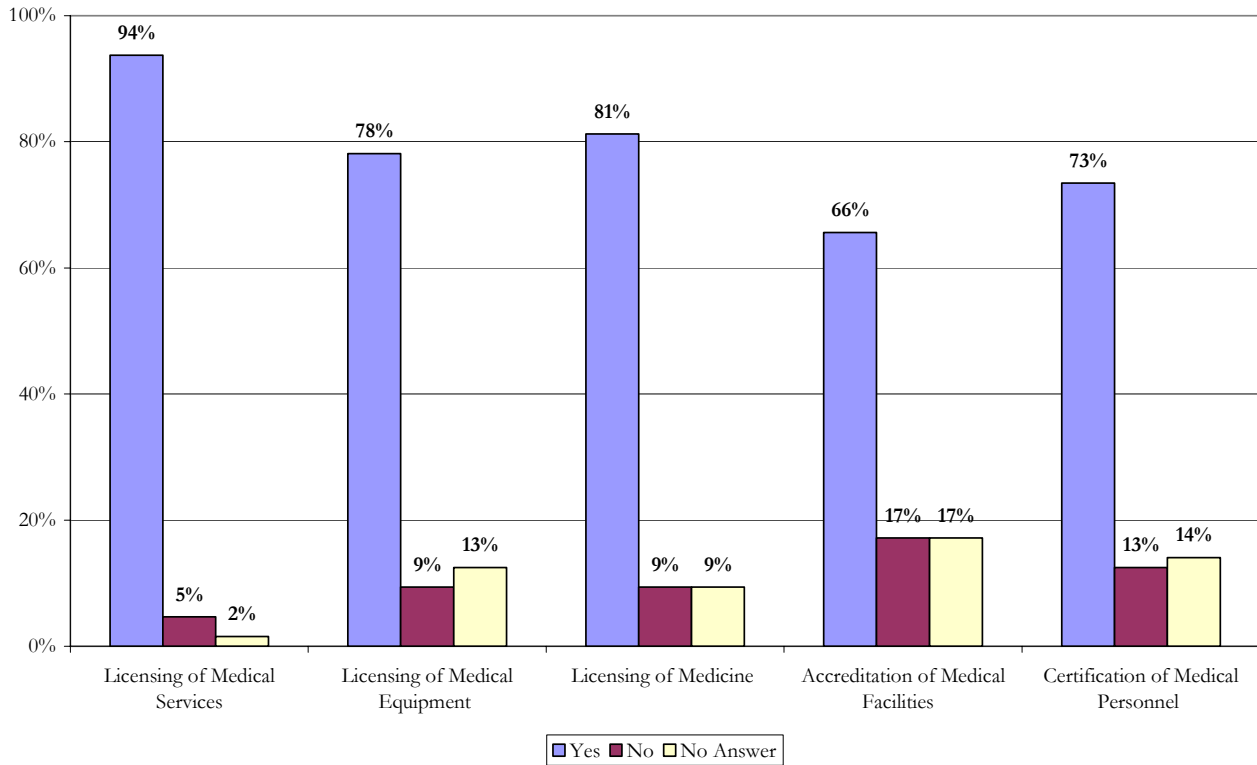
Worldwide government engagement in the regulation of the healthcare sector and its fulfillment of the “stewardship function” are considered to be important aspects in the provision of healthcare services.<sup>15</sup> In general, the healthcare sector is one of the most regulated sectors in all countries, including developed ones.

According to the interviewed medical personnel, licensing of hospitals, medical appliances, and medicine along with accreditation strategies and certification of medical personnel are important elements of quality healthcare provision. Ninety-three point seventy-five percent of the respondents stressed the importance of licensing of medical services, 81.3% highlighted the need for licensing of medicines, 78% supported licensing of medical equipment, 73% voted for certification of medical personnel, and 66% stressed the significance of accreditation of medical facilities.

Importantly, the hospital privatization program contains no specific provisions on regulating or monitoring different types of services to be rendered in the new facilities. At the same time, as it was mentioned by most medical personnel, the technical standards of medical appliances that are being required from investors at the given moment are not sufficient to provide high quality healthcare. According to the government, the regulatory policies in the healthcare sector are under reconsideration at the moment.

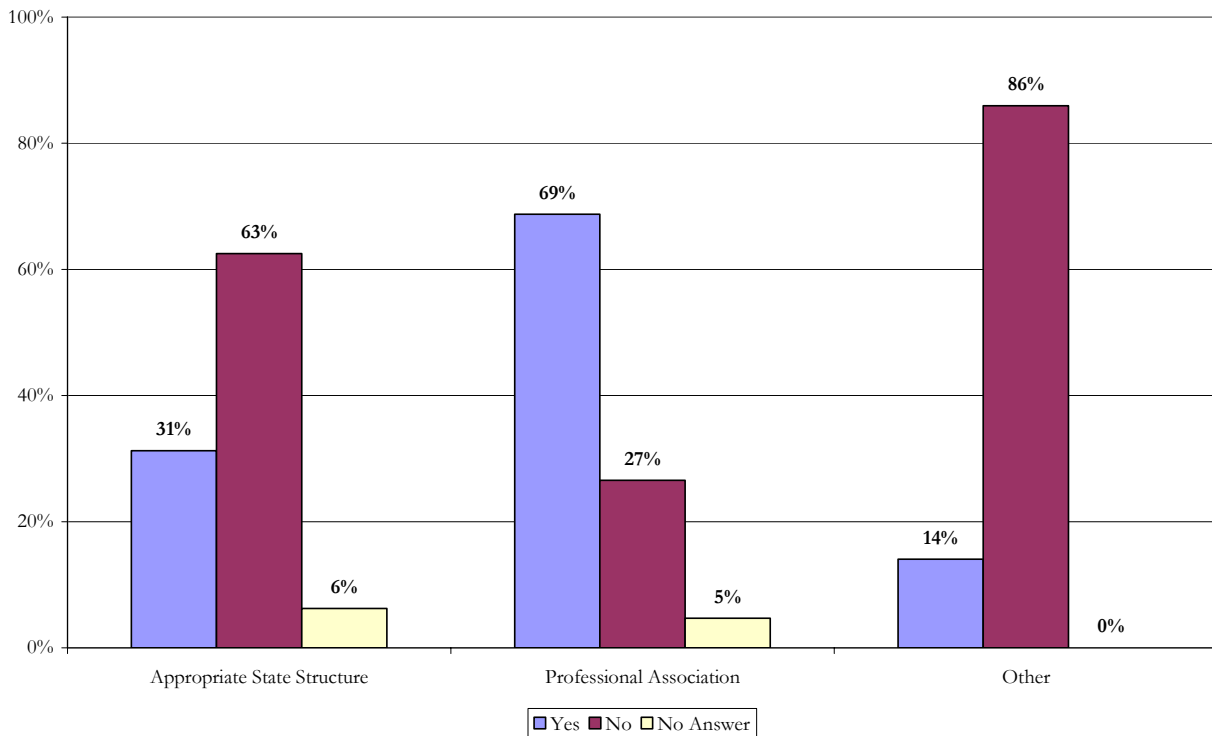
<sup>15</sup> The economics of public and private roles in healthcare: Insights from institutional economics and organizational theory. Preker, Alexander S. and Harding, April.

**Chart 24: Means of Monitoring Medical Services According to Respondents**



TI Georgia also asked the respondents to present their thoughts about the role the government should or should not play in regulating the healthcare sector in Georgia. Thirty-one percent of respondents believe that the Georgian government should retain the ultimate responsibility for the performance of the healthcare system. In their opinion, the state must define the standards and guidelines/directives in relation to the hospitals' facilities (physical capital), medical personnel (human capital), and scientific approach (intellectual capital). Sixty-eight point seventy-five percent of respondents thought that this responsibility should be outsourced to the professional associations in this field. Fourteen percent of the respondents indicated that the standards and guidelines should be set with the involvement of both actors.

**Chart 25: Suggested Regulatory Bodies**



## Conclusions and Recommendations

### *Increased Involvement of Other Agencies and Stakeholders*

The privatization process should not be treated as solely an economic process administered by the Ministry of Economic Development, especially that this privatization is regarded as one of the primary steps of Georgia's healthcare reform. The Ministry of Health (together with the hospital staff) must be involved in the process in order to ensure that this first stage of the healthcare reform process puts down a solid ground-block for future efforts in this field.

The state agencies responsible for the reform of secondary healthcare should involve stakeholders in the design and implementation of the reform. All parties can contribute to defining better selection criteria. Hospital personnel should be allowed and encouraged to meet with investors. They should also be provided with investors' proposals so that they can analyze the investors' objectives and the mechanisms offered to achieve these objectives, and assist the involved state agencies in the process of selection.

### *Refined Selection Criteria*

Clearer criteria in the hospital privatization process are needed and should be defined together with

the Ministry of Health and other stakeholders. More attention should be paid to investor experience in the sector and the proposed hospital construction, development, and management plans. Eighty percent of the respondents expressed concern about the selected investors' complete lack of experience in the sector and the limited detail in their submitted proposals, which focused mainly on the technical details on how many beds they planned to operate, how soon they would complete the construction process, etc.

There should also be more consistency in applying the set criteria to promote the greater efficiency, transparency, and fairness of the privatization process. As mentioned in the report, the criteria were evolving throughout the privatization process and in some cases were not clearly defined at the onset of certain privatization deals.

The profitability of regional hospitals (15-25 beds) needs to be reconsidered. Currently there are doubts about whether or not these hospitals will manage to be profitable, considering the small number of beds and the socio-economic conditions in the regions these days. This is of great concern because of the stipulation that after seven years, owners will no longer be required to run hospitals. Respondents fear that after seven years and no profits, owners will transform hospitals into other more lucrative businesses and leave segments of the population without access to healthcare.

Following the previous recommendation, the seven-year condition regarding hospital function needs to be reconsidered. Whether or not the new infrastructure will retain a healthcare-related function over the long-term will depend largely on the quality of the private investors. For this reason, there is concern about the level of experience investors have in the healthcare sector, the lack of detail required in the plans submitted to the Ministry of Economic Development, and the state's current capacity and willingness to regulate the sector.

#### *Improved Communication from and among Responsible Agencies*

Despite the recognition of the need for reform and support for the objectives of the reform of secondary healthcare, there is concern about the enforcement mechanisms and implementation process. One of the reasons to the negative attitude toward the current reform lies in the lack of information and the lack of transparency of the process (75% said the process is not transparent). The awareness level among hospital administration and personnel about the current hospital reform was very low (only 30% informed about the privatization process). There is a poor communication with the Ministry of Economic Development and the Ministry of Healthcare (especially with the Ministry of Economic Development). The main source of information for respondents is the media (58%) and the media coverage of this process is too superficial and inconsistent.

To address this problem, information provision and two-way communication between stakeholders and implementers needs to be improved. Formal communication mechanisms between the Ministry of Health and hospital sector representatives should be established. There should be greater follow-up to official meetings and communication between formal meetings. Systems should be created in order to allow stakeholders to assess how problems are addressed after and outside of official meetings (many respondents said that although there were some meetings between the Ministry and the healthcare sector personnel, nothing happened after these meetings and the promises made there were not fulfilled). The Ministry needs to improve its reporting in order to increase its

accountability.

### *Effective Regulation of the Healthcare Sector*

The healthcare sector is the most regulated sector through the world, even in the most liberal countries. The interviewed stakeholders believe that some form of regulation is needed to ensure the success of the reform and sustainable, affordable, and high-quality healthcare, especially after seven years. In their opinion, the state must devise effective regulatory mechanisms, including control standards/guidelines for facilities, infrastructure, equipment, and medical personnel. It is ultimately the state's responsibility to ensure that effective, affordable, and sustainable healthcare is being provided in Georgia.

Regulations should also be implemented to ensure that less lucrative types of healthcare are not done away with in favor of more lucrative types.

The state should also consider how to address the likely price increase for medical services in the privatized hospitals. Through TI Georgia's research, various options were proposed:

- a) Increased state assistance for socially vulnerable groups, though this will not address the estimated 40 percent of Georgian citizens who fail to qualify for state support but cannot afford to purchase private insurance;
- b) Mandatory insurance, though there is doubt that Georgia's health insurance industry can assume responsibility for financing the healthcare needs of the majority of the population;
- c) Combining public and private health insurance schemes;
- d) Requiring more detailed information from investors about how they will maintain affordable prices for medical services;

### *Evaluation of Success of Privatization and Compliance with Agreements*

Privatization agreements need to provide more detailed descriptions of the obligations of both parties, as well as quality indicators and sanctions in case of failing to meet the obligations.

In addition, a government monitoring mechanism needs to be developed with a clear definition of involved state institutions, a distinct distribution of functions among those state institutions, and requirements regarding the transparency of the process.

The monitoring plan must include clear evaluation criteria, bed occupancy, turn over rates, financial affordability, infrastructure, equipment, personnel professionalism, etc.