CHAPTER 9

Healthcare – Unleashing the Power of Public-Private Partnership

Abstract This chapter describes how the government partnered with private enterprises to renew the country's healthcare system. Before the reforms, health insurance was a foreign concept for the vast majority of Georgians. In 2006, less than 1 percent of the population was insured. At the same time, most healthcare facilities were in a state of ill repair, and the medical staff was insufficiently trained. In response, the government divided the country into healthcare clusters and requested bids from insurance companies to provide basic coverage for the neediest in a given cluster. The winning bidder was obligated to renovate or rebuild and operate the hospitals in that area. By 2012, more than half the population was insured and more than 150 new or renovated hospitals were opened. What is more, competition between providers also resulted in higher incentives for medical personnel to perform well and grow professionally.

Keywords Insurance · Healthcare · Public-private partnerships · Obamacare · Special insurance program (SIP)

Until recently, health insurance was an unfamiliar concept for the vast majority of Georgians. In 2006, less than 1 percent of the population was insured. Most healthcare facilities were in a state of ill repair, and the medical staff was insufficiently trained. In response, the government

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divided the country into healthcare clusters and invited bids from insurance companies to provide basic coverage for the neediest in a given cluster. The winning bidder was mandated to renovate or rebuild and operate the hospitals in that area. The scheme, set up as one of Georgia's biggest public-private partnerships to date, was a big success. By 2012, more than half of the population was insured. What is more, competition between providers also resulted in better service for patients and in higher incentives for medical personnel to perform well and grow professionally.

9.1 The Solidarity Challenge

Worldwide, governments have come up with various approaches to tackle healthcare. Even developed countries are struggling to find the right setup. The latest, and perhaps most prominent, experiment to bring affordable healthcare to the masses is "Obamacare" in the United States. It is widely criticized, and the jury is still out on its long-term impact. The underlying challenge is one of solidarity. The young and healthy are reluctant to spend much on insurance; they regard it as a waste of money. But any insurance system solely dependent on contributions from the elderly and infirm alone will have a funding problem. And few governments, except perhaps for those in countries with valuable natural resources, can afford to finance healthcare without some form of continuous contribution from the population. What is more, completely free healthcare is an incentive for patients to collude with providers and request treatment beyond what is necessary. If healthcare is fully paid for, corrupt individuals will always find a way to take advantage of the system by charging the government extra costs. When they are confronted, they will manipulate public opinion by saying that the government is cutting corners at the expense of the well-being of the population.

In Georgia, the problems in 2009 went beyond this fundamental financing challenge. Most healthcare facilities had been built in the 1960s and 1970s and were not properly maintained because of insufficient funds. Much medical equipment was outdated, hospitals were overstaffed, but most medical personnel were not sufficiently trained. While the approach the government came up with may not have solved all of these structural problems at once, it was still a big step in the right direction for the healthcare system in Georgia.

9.2 The Special Insurance Program

In 2010, the Georgian government started its "special insurance program" (SIP). In parallel, state-owned healthcare facilities were privatized. All facilities were categorized based on a single question: were they commercially viable? If they were, they were to be privatized right away. If they weren't, they were either kept under state ownership (e.g., essential clinics to treat infective diseases) or made part of the second stage of the SIP, although that second stage was never fully implemented.

The SIP was a joint effort by the state and all private insurance companies; Georgia did not have any public or state-owned insurance companies. Its primary target group was that part of the population that had been identified by the welfare program as most in need (see previous chapter). At the first stage of the SIP, the government defined the minimum insurance package and gave insurance vouchers covering that minimum package to the neediest families. Families were free to redeem their voucher for minimum coverage with any of the private insurance companies. All monthly payments were picked up by the government. The fact that the group of those insured under this scheme did not only include the elderly or the sick but everyone in the lowest wealth bracket made the voucher relatively cheap; initial calculations regarding the package and the price of the voucher were carried out by the Ministry of Healthcare in consultations with actuaries and private insurance companies.

9.3 Initial Setbacks

Unfortunately, the government's expectation that the scheme would create competition among insurance companies and increase the quality of service, or encourage companies to offer additional services beyond the minimum package, did not come true. The miscalculation the government made was to assume that the poorest had sufficient knowledge of what insurance was and that they would not trade the voucher for cash. While vouchers were numbered and named to prevent beneficiaries from selling their vouchers to others, there was no mechanism in place to stop insurance companies from offering cash instead of better service in exchange for the vouchers. As a result, many of the neediest effectively sold their vouchers to insurance companies rather than redeem them for improved service or extended coverage. Companies even employed so-called "marketing" agents that would go door to door and offer cash in exchange for the voucher.

Competing companies adopted different "marketing" approaches. Some of them hired local doctors as their representatives, while others hired schoolteachers, who were opinion leaders in many rural areas at the time. Some even went as far as enlisting the services of representatives of local governments to attract as many voucher holders as possible. For an insurance company, the voucher was a guarantee of steady income from the government. This made it well worth the comparatively small expense of a cashback to voucher holders, most of whom had no idea how the system worked.

At the time, the whole concept of insurance was completely new for Georgia. Most Georgians only had a vague idea how they would benefit from being insured. The government ran an extensive communications campaign to educate the population about these benefits, but the campaign failed to reach most of its target audience. The insurance companies took advantage of the ignorance of many voucher holders and made the cash kickback the norm. The poor preferred to give their vouchers to those companies that offered cash in exchange, rather than to those who offered better service or coverage. The government's plan to define the basic insurance package and then have private insurance companies compete with each other by offering additional services to voucher holders failed.

9.4 Healthcare Clusters

To put an end to the semi-corrupt practices, the government devised a large-scale public-private partnership program, pursuing a dual objective: provide healthcare services to the poor and build new, state-of-the-art healthcare facilities, or upgrade existing facilities. As a first step, the whole country was divided into relatively small healthcare clusters. For each cluster, the government determined the number of necessary hospital beds as well as the number of voucher recipients. As a next step, the government announced a tender among private insurance companies for every cluster to insure all voucher holders in that cluster. The winning company would be required to build new hospitals (or renovate existing hospitals which were transfered from state to the insurance company for free) as deemed necessary for that cluster within 18–24 months, equipped with state-of-the-art technology as specified by the Ministry of Healthcare, and adjust the number and qualification of medical employees.

An auction was held in each cluster, and the contract went to the company that offered the lowest cost per insured person. In most clusters, the government signed over the existing hospital to the winning company – complete

with land, buildings, equipment, and staff – for free. The company would then have to refurbish or re-build, re-equip, and re-staff the hospital. In the vast majority of cases, the existing infrastructure was in such a poor repair that only the land could be used.

Except for insufficiently qualified employees who lost their jobs, everybody won:

- *The state*. The government successfully privatized healthcare facilities that had been mismanaged before: hospitals that were overstaffed, did not provide adequate service, yet kept asking for additional funds from the government. The most difficult decision – to reduce inefficiency and let go part of the medical personnel – was shifted to private sector players, who took care of it efficiently and effectively.
- *Private insurance companies*. Insurers received additional funds for the insured and were given an opportunity to enter a new market, effectively becoming healthcare providers. The transformation was co-financed through the PPP program. All the insurance companies had to do was to calculate the costs of the facilities they would be required to build, add these costs to the cost of providing insurance services to the insured in the specific cluster, and come up with the price per insured individual.[1]
- *Medical staff*. While the total number of hospital employees shrunk, those who stayed were given higher salaries (based on their performance), a better work environment, better training, and better equipment to work with.
- *Patients*. The population was given much better service in newly built or fully refurbished hospitals. One hundred fifty new hospitals were put into operation over the course of 18 months, some of them newly built, others newly renovated.

As a whole, the resulting contracts constituted one of the biggest public-private partnerships between the government and private sector in Georgia.

In Tbilisi, the capital, the situation was slightly different. The privatization tender was held among insurance companies only to insure the poor, not to build any new hospitals, as a different hospital development plan was put together for the capital city. Tbilisi itself was also broken down into clusters, and every hospital was privatized based on open tenders or bought out by the existing staff. Where there was a lack of interest from

the private sector, the government adopted a different approach. The Ministry of Healthcare itself refurbished some buildings and gave them to state-owned hospitals under the condition that the staff would buy out these hospitals at a minimum price per square meter, payable in installments, and bring in new equipment. Despite initial disputes, a few dozen hospitals were privatized in this fashion and moved to newly renovated buildings.

9.5 Human Resource Development

Of course, the cluster-based partnership with private companies did not solve every problem overnight. Training was the biggest challenge. The level of training medical personnel had previously received was very low. The new setup provided a better environment for them to grow professionally. In the past, most of the hospitals had been owned by the state. There was no competition among the hospitals and, hence, no need to attract and develop the best doctors. The privatization of most of the hospitals brought competition for patients, and this triggered a war for talent too. Hospitals made investments to attract the best doctors and to improve the qualification of their medical personnel.

Many healthcare experts believe in the magic of regulation and pre-reform Georgia was no exception. Regulation and licensing was widely regarded as the key to highly qualified staff. While this might work in some countries, it didn't work in Georgia. Because of corrupt practices and government inefficiencies, the regulatory approach was not effective. Only the introduction of competition among different healthcare providers brought a significant improvement. When the state is the only (or main) provider of healthcare and salaries of doctors are regulated, doctors have no incentive to invest in their professional development. The income gap between the best doctor and the worst one usually does not reflect the relative levels of their qualification and performance. Often, regulated salaries are tied to tenure rather than performance. Good doctors are irked by this injustice and often develop their own private practice, partly illegally, alongside their duties as state employees in public hospitals. Less ambitious doctors simply stop making an effort to grow professionally or provide superior service to patients. This effect can, to some extent, be compensated for with performance-based bonuses, but many countries have not introduced such schemes to the healthcare sector. But if the healthcare sector is privatized and companies are under pressure to attract the best personnel,

doctors have an incentive to perform well, to grow professionally, and to make names for themselves in their respective areas of specialization. This is exactly what happened in Georgia since the reforms outline previously.

Privatization also helped to take care of a problem that was quite specific to Georgia. Georgians are naturally proud. Everybody wants to be a doctor, and nobody wants to be a nurse. And as the healthcare sector was just as corrupt as any other sector in pre-reform Georgia, most of the medical staff could simply buy a doctor's license. As a result, Georgia had more doctors than nurses before the privatization of the healthcare sector. But the managers of the private companies that participated in the cluster-based auctions knew very well that they would have no use for vast numbers of insufficiently trained, questionably licensed doctors. Some of them were let go, and some of them volunteered to retrain with special programs.

9.6 Resolving Conflicts of Interest

Eventually, a new problem arose from a structural conflict of interest. In most clusters, hospital operations and insurance were in the hands of the same company. Without proper precautions, this could easily have resulted in poor service. Especially in rural areas, insurance companies were tempted to cash in on their privilege as the only provider of healthcare services and maximize profits by providing inadequate service. The government used a combination of three measures to prevent this from happening:

- *Granularity.* The clusters were defined in a way that made it easy for private patients to go to a competitor's hospital in the neighboring cluster. Since most companies were trying to serve not only state-insured patients but private patients as well, this acted as a powerful incentive to provide good service.
- *Protocols.* Additionally, the government put in place protocols that specify the minimum service level and a price for that level of service. These protocols were based on international best practices and local price levels. Beneficiaries who choose to obtain medical services from a private provider pay the difference between the price specified by the protocol and the private bill.
- *Supervision.* Finally, the medical regulator was strengthened to help resolve three types of potential conflict: customers dealing with insurance companies, hospitals dealing with insurance companies, and hospitals dealing with customers.

Specifically, the regulator protects beneficiaries from local monopolies, i.e., areas in which the hospital owned by the insurance company is the only medical facility. If there are numerous complaints from beneficiaries in a given cluster, the regulator will conduct an investigation and, if need be, annul the license of any hospital or any doctor. The regulator also has the authority to force an insurance company to allow beneficiaries to go to another hospital if they are willing to pay the difference between the protocol price and the price asked by the competing hospital. And the regulator has a right to resolve disputes between an insurance company and a hospital, typically regarding delayed payments from insurance companies to hospitals.

Protocols and regulatory oversight also partially helped to take care of one of the last remaining issues in Georgia's healthcare sector at the time: the cost of emergency surgery. Under the new scheme, emergency surgery carries a higher price tag than planned procedures. When this regulation took effect, the number of emergency heart operations increased threefold, while the number of planned heart operations decreased accordingly. Doctors were simply filling out the forms in a way that would maximize their profits. Protocols and strict regulatory oversight was an attempt to prevent these practices. However, practice showed that the only way for minimizing the abuse of state financing in the healthcare is 80/20 co-financing structure of the insurance scheme. The co-financing must be done at the moment of receiving healthcare services, not necessarily during obtaining insurance packages. For the poorest, additional financing scheme must be put in place that subsidizes most of the 20 percent co-financing obligation. Only with co-financing scheme the patient has all the right incentives not to follow proposed schemes of the hospitals and carefully study the costs rather than feel free to let the doctors work their documents to earn more money on the back of state finances.

9.7 The End State

In 2012, the status of the Georgian healthcare system was as follows. With the exception of the capital, the vast majority of hospitals was privatized and managed by one of the five major insurance companies that had participated in the cluster-based auctions. A handful of healthcare facilities had been

singled out as not commercially viable but medically indispensable. Examples include an HIV clinic, a treatment center for infective diseases, and a tuberculosis clinic. The government decided to keep these facilities under state ownership and provide them with additional funds to update their infrastructure and improve the service.

By 2012, the five insurance companies had already built or fully renovated more than 100 hospitals. The size of these hospitals varied, depending on the healthcare requirements in a given cluster. Most hospitals were small (10–25 beds), but there were also a few larger ones with more than 50 beds. In some regions, other private providers emerged and started competing with the hospitals operated by the five insurance companies. In some cases, these new competitors were the successors of decommissioned former state-owned hospitals that had been bought out by their staff, an approach similar to the process that had been adopted in Tbilisi. By the end of 2012, there were more than 20 companies that owned hospitals across Georgia. Some of them big, some of them small, some of them offering universal healthcare, others specialized in one way or another. By 2012, most of the unnecessary staff in the healthcare sector had already been laid off. Competition among hospitals for the best doctors was fierce, and doctors were highly motivated to grow professionally. Many of them participated in specially devised training programs.

In 2006, less than 1 percent of Georgian population had health insurance. By the end of 2012, more than half of the population was insured. About 25 percent of the insured were privately participating in the SIP, while the rest was covered by the government's basic insurance policy. The insurance policy covered all medical expenses for the poor, 80 percent of the cost of medical treatment for everybody else and 50 percent of the cost of drugs (up to USD 100 USD per year). The 80-percent coverage turned out to yield the best tradeoff between service quality and efficiency. It discourages beneficiaries from receiving unnecessary services and helps minimize collusion between doctors and patients to cheat the insurer.

Most recently, the Georgia Healthcare Group (GHG) went public on the London Stock Exchange. At the time of the IPO in November 2015, the company had been in the healthcare business for less than a decade. But thanks to good management and favorable conditions in Georgia's healthcare market, the IPO was a big success.

9.8 Later Developments

The original plan was to liberalize the healthcare sector completely at the next stage. Once insurance companies had recovered their investments in newly built hospitals, the cluster system should have been dismantled, allowing all voucher holders to choose any insurance company, depending on who offers the best service. Thanks to a much more knowledgeable population, it might have worked the second time round. The government elected in 2012, however, chose a different path and decided to insure every citizen of Georgia, regardless of wealth and age – a bold and a popular move, but it remains to be seen whether the effects of this move will financially sustainable in a long term.[2]

In any case, the reforms undertaken between 2010 and 2012 are widely recognized as a major breakthrough moment for the Georgian healthcare sector, especially for the population, who now receives better and more reliable treatment than ever before in the country's history.

Notes

1. Actually, due to their lack of experience, some of the private companies miscalculated the revenue streams and had to be merged with others to absorb the impact. Some even went bankrupt.
2. http://www.georgiapolicy.org/2016/03/georgia-is-moving-forward-on-welfare-reform/ (retrieved in May 2016).