

Review Paper

Impact of Healthcare Reform on Universal Coverage in Georgia: A Systematic Review

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ABSTRACT

To ensure universal health coverage, Georgia has implemented reforms of its health care system. A market based approach and privatization of public facilities were the major characteristics of the reform process. In this paper a systematic review was carried out to analyze the outcomes of the reforms in terms of sustainability in health care financing, equity, efficiency, quality and cost control.

The evidence shows that because of a lack of strategic policy making capacity, the reforms were not successful. Subsequent changes in the reforms have undermined the sustainability in health financing, efficiency, equity and quality of healthcare. Massive privatization of the health sector without effective regulatory mechanisms has led to an impending risk of market failure.

To improve efficiency and effectiveness in the health care sector in terms of improving universal health coverage, healthcare quality, financial protection of the general population and sustainability in health financing, improvement in the regulatory framework and a public-private mix regulatory system is a priority.

Keywords: Health system reform; Financing; Efficiency; Equity; Quality

Highlights:

- The political decisions towards achieving universal health coverage were not adequately successful.
- The frequent changes in healthcare reform barrier to sustainability in health financing.
- Absence of healthcare cost and quality control threatens market failures.
- High OPP with instability in health financing is related to inequity in healthcare.

Introduction

As in all fifteen Soviet Republics, health care financing in Georgia was a tax-based and centralized system providing universal health care coverage. After the collapse of the Soviet Union in 1991, the ability of the Georgian government to maintain this system diminished. Georgia was not in a position to tackle the sudden political and socio-economic changes. During the initial transitional phase, the government took initiatives to reform all public sectors including health care. Since then the country has been facing multiple challenges to ensure universal access to health care. This is witnessed by the fact that about 90% of health care expenses are currently financed through out-of-pocket payments (OPP). The rapid transformation of the tax-based financing into financing through OPP was accompanied by reduced accessibility, affordability and utilization of healthcare facilities. Consequently, the changes were accompanied with increases in morbidity and mortality. This resulted in general dissatisfaction among the population and mistrust of the health care system[1,2].

The core financial reforms in the health care sector have focused on privatisation along with a radical shift of the strongly hierarchical and centralized system towards a liberal market-based health care system. During the first stage of the reform, Georgia implemented a system of social health insurance, which in the second stage was abolished and replaced by a system of private health insurance. However, the reform process was not successful to achieve universal access to health care and the transition process is still unfinished.

This paper focuses on the health care reform in the Georgian healthcare sector. The paper aims to review empirical evidence on the outcomes of the reform and to provide an evidence-based appraisal of the reform. To achieve this aim, the paper first outlines the content of the reforms. Then, the impact of the reform on the efficiency and quality of health care provision, as well as on equity in health care, is analyzed based on a systematic review of evidence in previous publications. Finally, the paper provides conclusions. The results presented here are relevant for policy making in Georgia but are also useful for other low- and middle-income countries that are contemplating ways to ensure universal coverage for their populations.

Reform in the Georgian health care sector

Though the socio-economic and political situation in Georgia changed during the post-Soviet period, some citizen charters of the Soviet system that shaped the social, cultural and moral perspective of the people have remained unchanged. The population demand to retain the Semashko model of tax-funded universal free-of-charge healthcare services and for the preservation of the highly bureaucratic governance system are two examples out of others.

After becoming independent Georgia experienced a gradual economic recession, which had already started in the last decade of the Soviet era[3-6]. The government faced multidimensional challenges including ensuring basic life-needs of the citizen, political instability caused by the economic crisis, corruption, bureaucracy and weak governance[7,8]. As a result, the government funding of the health care system dropped. In 1991, total health expenditure (THE) was reduced to 1% of GDP. The insufficient resources for the health care sector coupled with a highly expensive health care system and weak governance in health care seriously challenged the aim to provide universal coverage of basic health care needs. Most of the huge health care infrastructure required extensive repair and renovation. This shortfall was worsened by the shortage of equipment and diagnostic facilities. All those factors reduced access to health care services as well as the government's ability to assure healthcare provision with good quality and adequate access[9,10].

First stage of the reform

Given the above mentioned shortcomings, in 1994, the government took initiatives for a health care system reform. In 1995, the government amended the Constitution and implemented the first stage of the health care reform. This reform stage was a devolution type of reform as the regional governments were given the responsibility to allocate resources, to contract with providers, to monitor service quality, and for budgeting, planning and implementing of local health care programmes. However, the shortage of resources and weak governance became prominent barriers to the success of the reform[9]. Practically, the planning, management, administration and decision making process in the healthcare system suffered from interference from the central government, which made the reform process ineffective.

The introduction of social insurance was an important step during the first stage of the reform. A State Health Fund was created in 1995 to pool payroll contributions from employers and employees (at the rate of 3% and 1% of monthly salaries respectively). A government contribution covered for the unemployed, children and pensioners. The State Health Fund became the State Medical Insurance Company (SMIC) in 1997. In the same year, the government formed the Insurance State Supervision Service (ISSS) of Georgia to regulate the insurance system through an independent body[9-14].

The government designed the Basic Benefit Package (BBP) to cover basic health care needs of the population. The services included in the BBP were jointly funded by the SMIC, the municipality health fund and the Ministry of Labor, Health and Social Affairs (MoLHSA)[9,15-17]. Services covered by the BBP were usually free of charge, but included co-payments for some selective diseases such as cancer treatment. The aim of the BBP was to ensure health care for the general population. However, it was an expensive and ambitious programme for the newly independent Georgia. Underfunding, inadequate health care management and corruption became barriers to the successful implementation of the BBP and thereby, reduced general access to health care services.

The first stage of the reforms, including the SHI and the BBP, were stopped in 2004. In the same year, the government took initiatives to develop a private health insurance system along with the privatization of public health care facilities. The SMIC was reorganized and a new agency named the Health and Social Program Agency (HeSPA) was formed. One of the purposes of the HeSPA was to implement the State Health Insurance programme. Later, in 2011, the HeSPA also was abolished and the MoLHSA took over its responsibilities.

Second stage of the reform

As the first stage of health reform was not successful in improving universal access to health care, the government initiated a second stage of health reform in 2004. The main characteristics of the second reform stage were: re-centralization followed by privatization, reforms of the primary health care sector, provision of private health insurance and a reorganization of the hospital sector.

A remarkable element of the second stage of the health care reforms was the withdrawal of all authority from the local governments to the central government. The government took full authority of the health care budgeting and decision making related to health service provision and purchasing. However, the maintenance of the expensive health care infrastructure and excess staff were beyond the ability of the government. Added to that was the strong lobby and influence of the powerful private health providers that motivated the government to sell health care facilities to the private sector. Ultimately, the second stage of the health care reforms turned into a massive privatization of the health sector where nearly 100% of the government health facilities were sold to private owners by 2010.

The decision to privatize nearly all public health facilities was motivated by the obsolescence of the health care infrastructure, as well as by the over staffing, low motivation and responsiveness of staff in these facilities. Also the financial crisis, weak governance, population dissatisfaction, a new easy licensing and accreditation system and strong influence of affluent private investors on the government played a role in the privatization decision[15]. Large and influential pharmaceutical companies, who had already established a monopoly in the drug market, became the major owners of the privatized health care facilities. Due to the lack of regulatory control over the costs, the resulting monopolies in health care increased prices leaving the general population increasingly at risk of catastrophic health expenditure.

Private insurance was regulated by the Law of Insurance

and Civil Code. At the beginning there were three health insurance companies. Since then, a private insurance market has emerged as an expanding actor in the Georgian health care system. Also, during this period of the health care reform, private health care providers established private insurance companies and/or pharmaceutical companies. The goal was to maintain market competition, transparency, accountability and sustainability of the insurance market. The expansion of the private health insurance market in Georgia was implemented without assessing the needs and demands of the population, and without sufficient guaranties for financial aid for those who cannot afford to pay for health care and without formulating adequate control mechanisms over insurers to protect clients. As a result, cream skimming was not uncommon due to a lack of control and reliance on self-control of insurance companies.

In 2007, the government decided to buy insurance for the most vulnerable population groups of the country at private insurance companies. The government started a special programme for this purpose called "the State health insurance programme". Initially the government insured only people below the national poverty line, but later in 2009, other population groups that were included as priority populations in that programme were Internally Displaced People (IDPs), orphans, teachers, national actors, painters and laureates of Rustaveli prize.

The privatization of health care facilities and the financing system in the health care sector was initiated without a national consensus[9,15]. As a result, the total system was under threat of reversal after a political transition. Ultimately, this financial reform did not contribute to an improved universal access to health care services.

Current stage of the reforms

As a result of the health care reform, THE increased substantially. In 2011, it was 9.9% of GDP. General Government health care expenditure as a percentage of THE increased from 19.8% in 2009 to 22.1% in 2011[18]. In 2011, Private Health Expenditure (PvtHE) as percentage of THE, was 77.9%, of which contributions from the private insurance companies and OPP were about 4.4% and 89.2%, respectively. The high percentage of OPP indicates that the population is at the potential risk of health catastrophe[19].

By 2012, nearly 38% of the county population was insured by the State, and 8.43 % citizens enjoyed private and corporate insurance respectively and the rest approximately 54% remained without any health insurance[20].

In 2013, a new wave of the reform started. The government started the State health program "Health for All". The government maintained the already existing State Health Insurance program and from February 2013, the Universal Health Care (UHC) Program was launched for more than two million citizens. With the implementation of the new program the government gave a health care guarantee for the entire population. The goals of UHC are: to increase geographic and financial access to primary health care; to rationalize expensive and high-tech hospital services by increasing PHC utilization; and to increase financial access to urgent hospital and outpatient services[20].

The first stage of the UHC program stipulated services of primary healthcare doctors/local (district) doctors and management of emergencies both at the inpatient and the outpatient level. More than 80% of clinics nationwide were involved in the realization of the UHC program countrywide. From February 28 until July 1 of 2013, three blocks of services were provided under the UHC: urgent outpatient assistance, urgent hospital assistance, scheduled outpatient and policlinic services. The second stage of the UHC program started on July 1, 2013. Contrary to the first stage, the Ministry of Health offered six blocks of medical services to citizens: primary health care services, urgent outpatient assistance, extended urgent hospitalization, planned surgeries, treatment of oncological diseases, and child delivery. Besides, the volume of primary healthcare and emergency inpatient services has increased significantly[20].

Methodology

To review the empirical evidence on the outcomes of the health care reforms in Georgia, a desk research is conducted. For the analytical appraisal of the health care reforms the following indicators are used: financial sustainability, allocative and technical efficiency, equity in access and finance, transparency and accountability, utilization and quality of care. The main motivation of using these indicators is to identify key actors and to analyse their roles in the healthcare system of Georgia. To identify the challenges for health financing and universal access to health care and to determine interventions that may help to overcome barriers to the implementation of the reforms.

The following keywords and word combinations are used for the literature search: Georgia, health care reform, financing, efficiency, equity, quality, Georgia health care, Georgia health financing, see annex 1 for the exact combinations. Synonyms and variations in spelling are considered. The search for relevant publication with the above mentioned keywords is conducted in the following databases: PubMed, Sciencedirect and Google Scholar. Literature is searched in September, 2014.

The language of publications is limited to English, Georgian and Russian. The search process excludes publications that provide only a general discussion of the effect of the health care reforms in Georgia without presenting relevant data, as well as publications prior to the implementation of such reforms that do not discuss its design or potential effects. Grey literature studies and informational papers are also captured. Publications are identified as relevant if they present empirical evidence and the results of original analysis on the quality, equity, efficiency and sustainability effects of the Georgian healthcare reforms (micro- and macro-level parameters). Quality of the selected articles is assessed by CASP criteria.

Publications from before the healthcare reforms are taken into account to outline the determinants, expectations and concerns related to the implementation of each step of the reform. Publications after the actual implementation of the Georgian healthcare reform are reviewed to analyze to what extent prior expectations and concerns are realized.

Results

Description of the publications included in the review

The initial search yielded 57 articles and reports in English, and articles and 10 in Georgian. Most of the articles and reports only provided a description of the reform focusing on the implementation stages. They included discussions and authors' personal perceptions about achievements and challenges of the ongoing reform but no empirical evidence. These articles and reports were excluded from the review. Only 38 articles and reports in English and 3 in Georgian met the relevance criteria (provided empirical evidence) and were included in the literature review.

The characteristics of the publication included in the review are presented in the Table 1 and Annex 1. As indicated in Table 1, the number of evidence-based publications on healthcare system reforms in Georgia has been growing since 1995. In English publications, attention is given to the entire reform period started from 1991. The Russian articles are mainly focused on the analysis of the Soviet healthcare system before Soviet era. The Georgian publications focus on the last stage of the reform. They mostly present policy documents, unpublished papers for MoLHSA and health insurance companies as well as the national reports of MoLHSA.

Most publications aim to study the micro and macro parameters of the healthcare system. To assess the impact of the health care reform is also stated as a primary objective of some studies. As indicated in Table 1, we divided the major findings reported in the publications, into the following sub-groups: financial sustainability, allocative and technical efficiency, equity in access and finance, transparency and accountability, utilization and quality of care. Each sub-group is discussed separately.

Effects on financial sustainability (system funding)

Our review suggests that the development of the health

Table 1: Characteristics of evidence-based publications included in the review.

	Number of publications	References
Year of publication		
1989-2000	7	1, 4, 5, 6, 7, 11, 17
2001-2014	34	2, 3, 8, 9, 10, 12, 13, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41
Reform period addressed		
1991-1995	4	1, 6, 11, 17
1996-2003	12	2, 7, 8, 9, 10, 12, 13, 15, 17, 36, 37, 38
2004-2014	24	12, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 32, 33, 34, 35, 39, 40, 41
Type of publication		
Journal article	9	1, 2, 3, 6, 7, 10, 13, 27, 34
Report	25	3, 8, 9, 11, 12, 15, 16, 17, 20, 21, 23, 24, 25, 26, 28, 29, 30, 33, 33, 35, 36, 37, 38, 39, 40
Policy note	1	14
Unpublished manuscript	1	41
Type of empirical data		
General statistics	19	1, 7, 9, 11, 14, 15, 16, 17, 18, 19, 20, 21, 23, 24, 25, 26, 30, 34, 35
Survey data	14	1, 8, 9, 12, 13, 27, 28, 29, 33, 36, 37, 38, 39, 40
Mass media/publication review	2	5, 22
Aim of the study		
Macro parameters	10	3, 4, 5, 7, 9, 14, 15, 16, 24, 25
Micro parameters	24	1, 3, 4, 5, 7, 8, 9, 10, 11, 12, 14, 15, 16, 18, 21, 23, 26, 27, 28, 29, 30, 32, 34, 35
Reform impact	19	2, 6, 7, 9, 12, 13, 15, 16, 21, 28, 29, 32, 33, 35, 36, 37, 38, 39, 40
Classification of major findings		
Financial sustainability	25	3, 4, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 21, 22, 23, 26, 27, 28, 29, 32, 34, 36, 37, 38, 39
Effects on efficiency	12	7, 9, 12, 15, 16, 20, 21, 22, 28, 29, 34, 39
Equity of care	14	8. 9, 12, 13, 14, 15, 16, 22, 23, 27, 28, 33, 34, 35, 36, 37, 41
Quality and use of care		9, 13, 15, 16, 23, 28, 29, 33, 36, 37, 40, 41

insurance market in Georgia is still facing multiple challenges due to frequent policy changes and the transition periods that accompany the above mentioned changes. The direction and priorities of the reforms depend on the ruling party and this corroborates the principal –"new lords, new laws". The high level of OPP indicates the inability of the public and private sector to ensure solidarity in the funding of the system. The population is unable to pay premiums for private insurance and moreover, consumers' trust in the private insurance companies is very low. Given the resource constraints people face, the utilization of health care services fell radically during the last two decades. The state could not maintain adequate service provision throughout the country[21]. The situation changed dramatically in 2012, when the aim of the reform process shifted from the establishment of a market-regulated health care system[22] to the achievement of universal coverage[23]. With the purpose to protect the population, the new government doubled the budget of the MoLHSA in spite of the fact that the economic growth in the country was just 2.3% in 2013[24]. THE as a percentage of GDP in Georgia is typical for lower-middle income countries[25]. However, the State has implemented the new health program "Health for All" with the aim to ensure the basic needs of all population groups irrespective of economic status[26]. The literature provides no information about the effectiveness of the implemented basic benefit package.

The "Health for All" has been implemented through various insurance companies. The Social Service Agency is responsible for monitoring the program[26]. Previously, the private health insurance companies were actively involved in the hospital sector development project (HSDP) and in the state insurance program (SIP). After the implementation of the "Health for All", the administrative body was changed. And the administration of the SIP is carried out by the State not by the health insurance companies themselves. Within one year after the starting of universal coverage, one of the insurance companies announced bankruptcy due to debts towards of the health facilities. Another insurance company reported that the economic value of the insurance company has fallen by 35 percent in 2013. The same paper is predicting the gradual replacement of private health insurance companies and full exclusion of them from the State Insurance Program in 2014[27]. Some experts suggest that the private health insurance companies involved in the State Insurance Program will face financial difficulties and that the State will have to support them to avoid bankruptcy[27,28]. As a result, the private insurance sector will be forced to leave the Georgian hospital sector and the state may confront with the task to (re-)nationalize a big part in hospital sector[27].

Effects on efficiency and cost control

The results of our review indicate that the introduction of the private health insurance mechanism in Georgia did not establish a purchaser-provider separation. The regulation of purchaser-provider relationships has not been updated and this is a significant gap in current health legislation. Specifically, a health care provider is providing services through the State health insurance program. Private health insurance companies purchase the healthcare benefit package for the State program "Health for All" as well as for the population under the poverty line and for voluntary schemes from their own health facilities. On the one hand, the State is purchasing health care services indirectly through the health insurance companies; on the other hand, the health insurance companies purchase health services from the facilities. The MoLHSA is contracting out the health insurance companies through tenders[24].

In the first stage of the reform in Georgia, the low official reimbursement rates and patient unawareness of the official hospital costs created an environment conducive to the shift of a large part of the real hospital costs to the patients, resulting in illegal patient charges[29]. During the second stage of the health care reform, the key focus of the efficiency-oriented changes was to downsize the huge infrastructure of the health care system because of the high maintenance costs. As a result, the utilization of hospital services and the average cost per patient stay decreased due to a reduction in the length of stay[15,16,21]. Following massive privatization, old health facilities were sold and replaced by health centers with multiple services provision. In 2012, hospital beds reduced by 9.9% compare to previous years[30].

The optimum use of human resources is the indicator as well as objective of efficiency in healthcare. Some documents show that across the regions of Georgia, physicians' productivity increased from 25 patients to 29 patients annually per fulltime-equivalent physician during 2005-2007. At the same time, physicians' productivity failed to meet any reasonable standards and ranks, and it remained the lowest in the European and CIS region[16]. Several reports have indicated that cost-control was not an objective throughout the reform process. Fee-for-services reimbursement varied widely between facilities. Since there was no cost-control mechanism, private investors were able to increase costs to maximize profits. Moreover, in the private market there are mergers between pharmaceutical companies and health facilities. As a result, suppliers induced demand of health care services was quite common in the private health market. As a consequence, there is the potential risk of impoverishing health expenditures for patients[15]. We did not find publications that described the implementation of cost-containment mechanisms or that specifically addressed problems with allocative and technical efficiency.

Effects on equity

The publications in our review suggest that during the reform period, the situation with regard to equity changed dramatically since free access to healthcare services was no longer a key health policy principle. During the early 1990s, insured individuals lacked the right to choose their own providers and facilities. Due to information asymmetry and corruption, health care services were affordable only for a small elite group of people[31]. In 2006, the State implemented the Medical Assistance Program (MAP) to provide health insurance to the poor population[15]. The program was launched with the aim of improving equity and reducing the burden of catastrophic health expenditure for the poor population. Generally, the program was effective but the burden of the pharmaceutical cost was still high. A study showed

that due to the exclusion of pharmaceutical cost from the basic benefit package (BBP), the overall utilization of healthcare services did not increase[15]. Changes in the eligibility criteria for BBP also proved to be a hurdle to improve service utilization[15]. From the beginning of the MAP, most of the poor population was covered by the program. The State developed a proxy-means-tested system for identification of poor households. Later due to budget constraints, the government changed the eligibility for the MAP[32-34].

In the second stage of the reform after the implementation of the private health insurance, the insurance companies freely manipulated the selection criteria and risk-rated premiums concentrating on their own profits. Thereby, cream skimming was common[15]. Moreover, there was a scope to improve access to healthcare service information in the private sector (both at health facilities and insurance companies), which is important for transparency, accountability and survival of the healthcare market in the state that intends to create a market for health care. Also, information asymmetry negatively influenced accessibility and utilization of health care services. People were discouraged to obtain insurance voluntarily and the risk of impoverishment remained because of unpredicted and unbearable health care expenses[15]. OPP created barriers for access to health care services. In the recent past when only one third of the population was covered by the various State Healthcare Programs, the majority of the households devoted a higher share of their monthly expenditure to health care. Some studies showed that OPP was the result of declining economic status and worsening health outcomes of households[15]. OPP appeared as a burden for middle income households[35-38]. The implementation of the HMO model increased inequity in the health care system. The population did not have a chance to choose the health provider freely. They were obliged to get services from the local healthcare providers. The situation changed after the implementation of universal health care. According to the order of the Ministry of Health, every person is free to choose his or her own health provider.

Effects on quality of care

Among the inheritance of the Soviet area was a low medical quality of care especially in the regions. Since that period, one of the purposes of all stages of the healthcare reform was to improve the quality of health services. But so far the evidence shows, no significant changes in the quality of care since the start of the health care reform[31,38].

The market-based health care system had a negative effect on quality of health care during the second stage of the healthcare reform. The lack of regulation and the abolishment of the accreditation system diminished the importance of quality of care for the health providers[15,16]. Some studies showed that consumers perceived quality of care as poor and stated the necessity to improve the quality of services, especially at the primary care level[39,40]. Since the implementation of the "Health for All" program, the MoLHSA has taken steps to improve quality of care. For example, by applying an evidence-based approach, an assessment of maternity care services was conducted throughout the county. As a result, perinatal service providers have been graded by their functional capabilities and a reorganization of the referral and emergency system has started[41]. However, according to experts' opinion, this did not help to improve the quality of care[28]. The experts are also conservative about future changes in quality levels[28]. We did not find publications that described healthcare quality.

Discussion and Conclusion

Independence was a sudden political, social and economic turning event for Georgia. Politicians tried to cope with the challenges in all state sectors including health care. This paper has reviewed the available empirical evidence on the effects of the Georgian healthcare reforms. We acknowledge the limitations of our review since we might have missed relevant studies that have not yet been reported. Nevertheless, the publications that we reviewed provide several points relevant to healthcare policy making in Georgia.

The review indicates that population-centered political decisions towards achieving better health were not stable and successful. This was associated with the lack of strategic health policy making, lack of economic strength, quick transition of healthcare provision from the inherited centralized to a private market without control mechanisms, changes in the socio-cultural structure and lack of national consensus. As a result, the frequent changes in the healthcare reform processes have undermined sustainability in health financing, efficiency and equity and quality of healthcare provision, and have resulted in market failures in terms of cost control and access to information, as well as in weak clients' trust in the healthcare sector.

As suggested by our results, the BBP and SHI system in the first stage of the reform were ambitious in terms of financial sustainability and regulatory capability. The government shifted most of the responsibility for healthcare provision to the market by transforming the inherent centralized healthcare system into a market-based system, privatizing the public health facilities and establishing the insurance system. This however resulted in reduction of accessibility and affordability of healthcare services. The root factor of that unsuccessful reform was clearly an asymmetry among government decision making and political foresight in terms of financial and regulatory capacity. In 2012, the new government took the political decision to achieve the "Health for All" objectives, which does not differ from the health reform objectives of the previous governments. Further, the government doubled the health budget despite the limited GDP growth (2.3%) in 2013. Based on above mentioned examples such as frequent changes of health policy, it is not unusual to doubt the financial sustainability of the Georgian healthcare sector. Again, sceptics predict the exclusion of private insurance companies from the state insurance programme, which may result in public-private tension rather than partnership in health with further instability in the public health financing.

Another crucial factor that seems to be associated with the instability in public financing of the healthcare sector is the unsuccessful reform towards a purchaser-provider split. As suggested by our review, there was in fact integration since

during the second stage of reform, the influential monopoly owners of the pharmaceutical companies became the owners of the private facilities. Further, the healthcare market in Georgia, as in the other sectors of the economy, follows the principles of open market economy free from any government control. Hence, the healthcare costs in the private market are the autonomy of the monopoly healthcare providers. This might be associated with the high OPP even while THE as percentage of GDP in Georgia is considerably higher than in many other LMICs.

Further, the publications reviewed suggest that equity in the Georgian healthcare sector has yet to improve even after decades of health reform initiatives. Though the government took initiatives to secure the poor population from impoverishing health expenditure, it was not adequately successful because of the financial constraint, lack of cost control in the private market and supplier induced demand. However, while the clients' right to choose their own provider was restricted in the HMO model in Georgia, it has been established in the recent "Health for All" reform strategy. Thus, it means that some improvement might be in the nearest future. Our review also indicates problems with health care quality. Low quality of healthcare services was in fact inherited from the Soviet era but so far there is no evidence that quality improvement has become a key objective during the reform stages. Moreover, in the private healthcare market, regulated competition is necessary for quality care. The influence of mergers and monopoly in the private market in Georgia has hindered healthcare quality. The abolition of the accreditation system and the lack of regulatory control also contributed to the lack of quality health care. Without the implementation of evidence-based strategic regulation, the current reform model might be least contributory to improve health care quality. Because of the lack of strategic policy making capacity in Georgia, the health reform initiatives of Georgia has not been successful. Due to the lack of regulatory control over private market, there exists information asymmetry, absence of regulated market competition and cost control; hence resulting in market failures. High OPP with instability in the public health financing is related to inequity in the healthcare sector. While the healthcare market is privatized, an effective partnership between public and private parties is necessary. However, the present reform strategy may turn to public-private tension that may again result in the inadequate achievement of the current reform strategy.

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CONFLICT OF INTERESTS

None.

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