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Issues paper – Private sector

Private-public partnership in Georgia

A case study of contracting an NGO to provide specialist health services

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Executive summary

Over the last few years, there has been increasing discussion on the theory and practice of working with private health providers and on the institutional context within which they operate.

Central and local government, civil society institutions and community-based organizations have all developed a variety of strategies to improve health services for poor people. These strategies have included financing methods and use of health insurance, provider payments, contracting, regulation, health worker training, accreditation, branding and other strategies designed to influence both supply and demand behaviour.

These strategies are producing useful data on specific private sector models, but they are not yet able to answer more systemic and fundamental questions about the private sector and its interaction with the public sector. As a result, there is still a lack of sound evidence on non-government providers worldwide, and available data is, at best, patchy.

This case study provides details of a partnership that emerged in Georgia following the initiation of health sector reforms in 1995. It mainly focuses on describing the details of how and why the public purchaser – the State Medical Insurance Company (SMIC) – contracted a non-governmental provider – the Jo Ann Medical Centre (JAMC) – to deliver a set of health services in Georgia. The case study is discussed with proper attention to the context within which this arrangement developed.

The nature of the services provided was paediatric cardio-surgery, which can hardly be considered a basic essential health service. Notwithstanding this, the case study provides a sufficient body of evidence to facilitate policy discussions about public–private partnerships (PPPs) and their potential role in reaching the poor. It provides examples of possible arrangements that could have a positive impact on the utilization of services by poorer sections of the community.

In addition, this case study documents how policy decisions in the health sector are not always guided by the principles of pragmatic thinking. All too often, there is a tendency to focus narrowly on what evidence-based resource allocation decisions are made. Not enough attention is paid to how these decisions are made.(Thompson 2002). This case study seeks to illustrate some of the social, political and ethical dynamics that influence policy-makers, and the decisions they do make, in the health sector.

Analysis of this particular PPP suggests several critical factors that shape the success of the partnership. These can be grouped into four main areas:

- The overall legal and regulatory environment within which the partnership emerges;
- The specific legal and regulatory environment within the health sector that affected various aspects of the partnership;
- The institutional capacity of relevant state agencies (purchasers as well as providers) to implement their functions and state policies adequately;

and

- Technical details of partnership design and implementation.

While all these factors are important when considering engaging the private sector in service provision for the poor, the evidence of this study proves that two are most vital: explicit public policy to subsidize service provision for the poor; and specifying the technical details for policy implementation through the contracting mechanism.

1 Introduction and methodology

1.1 Background and purpose

This case study was commissioned by the DFID Health Systems Resource Centre as one of a series of papers to strengthen the evidence base in support of strategies to strengthen public–private sector collaboration in improving health services for poor people. The case study presents an example of a contracting relationship between the public sector (SMIC) and a non-governmental provider (JAMC) that emerged in Georgia following the initiation of health sector reforms in 1995.

The objective of this study is to examine one specific experience where the public sector contracted JAMC for paediatric cardiac-surgery. JAMC operates as a not-for-profit organization. It was established with support from foreign foundations and donors. This study particularly focuses on the impact of this PPP arrangement on the poor measured by accessibility and quality of services as perceived by the consumer and documented through a patient satisfaction survey. A second purpose of this study is to articulate new thinking and evidence about the private sector that can be translated into policies for a broader audience.

The nature of the curative services provided by JAMC consists of paediatric cardio-surgery, which can be hardly considered a basic, essential health service. Nonetheless, this case study provides a sufficient body of evidence to facilitate policy discussions about PPPs and their potential role in reaching the poor, and provides examples of arrangements that could have a positive impact on poorer people using services.

Description of the health sector reform process and legislative environment in Georgia helps to explain the legal context within which public and private partners must work in the health care market. The following section describes the historical development of paediatric cardio-surgery in Georgia, and how it came about that a private service provider could work in this field.

The subsequent sections provide details of the policy-making, tendering and contract award processes, and contract implementation and monitoring of provider performance.

The impact of the PPP is evaluated using the results of patient surveys and other hard data. The study concludes with discussion and conclusions that seek to present the

critical factors that helped the Government of Georgia to engage successfully with the private sector and manage to deliver services to poorer sections of the community.

1.2 Methodology

The study methodology included: in-depth interviews with key informants (policy-makers, purchasers and provider); a small-scale mail survey of randomly selected patients from discharge lists; and a review of existing literature/documentation that was available in the public domain and from the purchaser and the provider.

The mail survey was used to obtain patient information and patient satisfaction with services. The survey questionnaire included modules and questions on:

- Household demography and detailed household monthly expenditure in the format that is used in the Living Standard Measurement Survey (LSMS) by the State Department of Statistics (SDS) of Georgia. This module was included in order to detect households' poverty status with the methodology adopted in the country. Thus, monthly per capita consumption derived from the survey was compared with the national average calculated by the SDS and used for poverty line determination in the country;

- A patient satisfaction module to evaluate the quality of services offered by JAMC as perceived by the patients;

- A module designed to evaluate out-of-pocket expenses of patients for the medical treatment received at the hospital. Survey questions already tested on another project in the country by the authors were used (Gotsadze et al. 2001).

The data was computerized and analysed in SPSS 10.0.

2 Health systems in Georgia

2.1 The health sector reform process

Under the Soviet system, health service financing and provision was the government's responsibility, and all facilities were managed by the central government. Following independence in 1991, the Georgian Government initiated major health sector reforms in 1995, separating out the functions of financing and provision of health services, and establishing central and regional/municipal-level financing agencies. This approach separated the roles of central and local governments in health service financing, and granted full autonomy to health care providers who were now released from direct central government control.

As a major organized purchaser, the state defined volumes and types of services to be provided with public funds and determined rates for reimbursements under public programmes. Public purchasers introduced selective contracting for provider selection/contracting arrangements. The reform process also created the opportunity for a number of private providers as well as financiers (private insurance companies) to emerge in the health care market pays between 66 and 87 per cent.

The government continued to test various approaches to further improve the system of health care financing/provision. Several different models of PPP were initiated (For example, SMIC contracted a private company to provide quality maternity delivery and referral services; the municipal health fund contracted out management responsibility to a private insurance company).

2.2 Financing

Georgia moved away from direct budget line health care financing to a financier–provider split from the very beginning of the health sector reform process. New earmarked resources, as well as funds from central and municipal budgets, were mobilized and new financing mechanisms to reimburse providers were introduced. Provision for private, direct, out-of-pocket payments at the point of service was also established with relevant legislation.

The state established SMIC and municipal and regional health funds to collect and administer public resources for the health sector. SMIC collects mandatory health premiums[1] and also receives central budget transfers on behalf of the unemployed.

From accumulated resources, SMIC finances the Basic Benefit Package (BBP)[2] for the entire population. Municipal/regional health funds receive revenues from local budgets and finance programmes that are developed in the municipality/region.

Compared to other Soviet republics, Georgia suffered one of the sharpest economic declines between 1990 and 1995. Economic output fell by up to 78 per cent (Bonilla-Chacin et al. 2003), capacity utilization in the industrial sector dropped to about 20 per cent of previous levels, disruptions in the agricultural sector occurred, and all former trade links collapsed. By the end of 1993, annual inflation had reached 8,400 per cent (Both 2002). This economic crisis resulted in the collapse of government revenues, which also affected resources for the health sector that fell to US$0.8 per/capita per annum (World Bank 1996). Thus, from 1994, private spending became the major source of health sector financing. According to recent reports, the population in Georgia pays between 66-87 per cent of the national health bill (Gotsadze *et al*. 2003).

The situation in Georgia, while extremely serious, was not exceptional. Similar economic trends and a shift towards private spending were observed in other transitional countries in the former Soviet Union, and are described elsewhere (see, for example, Berman 1997; Bonilla-Chacin et al. 2003; Hotchkiss et al. 1998; Lewis 2000; Preker et al. 2002).

2.3 Legislative framework

In order to fully understand the environment in which the PPP arrangement between government and JAMC emerged, it is critical to provide information about the legislative environment existing in Georgia.

Between 1995 and 2001, Georgia adopted a number of laws and regulations in support of health sector reforms that also created a conducive environment for PPPs. General as well as health sector-specific legislation defined state responsibilities and mechanisms for contracting private for-profit and not-for-profit providers. The most relevant legislation that allowed the state to enter into a contractual relationship with JAMC included:

- **A law on state medical insurance** which established the state purchasing agency SMIC and determined the sources of funding and the rights of the agency to purchase health services for the population from public and private providers that legally operate in the health care market of the country;

- **A law on state procurement** which regulates the conduct of state purchases and mandates open competition and the creation of equal opportunities for the public and private sector on the national market;

- **Licensing regulations for health care providers** which were introduced as a

result of health sector reforms. A new licensing process sets the rules for health care providers to seek official government permits to enter the market. Regulation treats public and private entities equally;

and

- **The Civil Code and Law on Health Care** which contain provisions allowing charities with not-for-profit status to be formed and to offer medical services to the public.

In Soviet times, all medical facilities (hospitals, outpatient centres, dental clinics, pharmacies etc.) were owned by the state and were managed by the Ministry of Health (MoH) and their regional departments. Reforms in Georgia transformed all medical providers, including hospitals, into separate legal entities. Their legal status was changed from budget institutions to state (Treasury) enterprise. These changes separated health facilities from the national budget, and introduced contracting mechanisms between purchaser and provider, creating autonomy for providers. This was followed by the removal of up to 120,000 health care employees from the state budget (World Bank 1996). These health care professionals are no longer civil servants but are contracted directly by the private facilities.

Separating hospitals from the MoH but still maintaining public ownership was the first step planned within the reform process. In 1999, changes in general legislation[3], forced the MoH to proceed with the 'corporatization' of hospitals. All hospitals became incorporated as limited liability companies (LLCs) or joint stock companies (JSCs), established under the Law on Entrepreneurship. However, changes enacted in general and health legislation also allowed medical institutions to become non-governmental and not-for-profit entities.

2.4 Health policy priorities

Within this environment, the state intended to focus scarce public resources mostly on public health, offering a more limited number of curative care services.[4] However, the process of BBP formation became a subject of significant political influence from curative service providers (e.g. various clinical groups influenced the government to include their services in BBP in order to guarantee steady revenues from the public purchaser for their services). Also societal pressure and demand for personal care forced the Ministry of Labour, Health and Social Affairs (MoLHSA) and SMIC to increase the number of programmes that paid mainly for personal curative services in the BBP.

Children's health was recognized as a political priority, and a children's programme was developed that was included in the BBP from the very beginning. This programme finances outpatient and inpatient service provision for children. However, due to a lack of public funds, the central financier (SMIC) only assumed responsibility for all children

under the age of three. Responsibility for financing services for 4–15 year olds became the liability of local financiers and municipal/regional health funds.
Paediatric cardio-surgery was included in the children's progamme as a service to be paid for by the public purchaser in 1998. According to the financial coverage policy for paediatric cardio-surgery, any child under the age of three was fully covered by SMIC. Payments for children over the age of three incurred a co-payment of between 20–25 per cent.[5] However, for poor/vulnerable households, co-payments were covered by a programme for the vulnerable. This programme is managed by SMIC using dedicated financial resources for poor/vulnerable people and families (MoLHSA 2002). After the reforms, it became obvious that limited public resources could not meet the needs of the population, especially the disadvantaged. Thus, the state needed to develop a mechanism for the provision of targeted assistance to the most poor/vulnerable.

In this environment, where the economy mainly operates informally, means testing as a mechanism to target the subsidies did not seem feasible. It was well known that the real income of Georgian households was much higher than any officially declared income (World Bank 1999). Thus, the government developed 16 criteria (for example, single pensioners, single (female) parent families, single woman-headed households, people with significant disabilities, people who have been displaced as a result of armed conflicts etc.) to determine eligibility and vulnerability of individuals and or households for public subsidies.

With the help of local social welfare offices, SMIC regional branches issued a medical insurance policy for the vulnerable to all eligible individuals. This insurance policy entitles them to receive additional curative services that are limited to a positive list of services established for this programme. On average, up to 10 per cent of the general population and 110,000 internally displaced individuals[6] benefit from the subsidies under this programme (Ministry of Health of Georgia 2000). This was the explicit state policy to subsidise the poor, the implementation of which is discussed below.

2.5 Development of paediatric cardio-surgery in Georgia

During the Soviet era, paediatric cardio-surgery was only performed in Moscow and all republics had to refer patients to this service provision centre. The services were financed from respective republican budgets. Financial allocations for such services were scarce relative to the demand, and waiting time for treatment was long. Therefore, by 1987 the number of registered 0–14 year-old children in Georgia with congenital cardiac diseases awaiting surgery had reached alarmingly high levels: 3,088 (MoLHSA 2002). This significant unmet need was causing increasing mortality among these children. According to the State Statistical Department of Georgia, every year between 230 and 250 children were born who required surgical treatment due to congenital cardiac problems,[7] and among those, 14 per cent died before reaching their first birthday if the operation was not performed in time (MoLHSA 2002).

After the dissolution of the Soviet Union, various donor organizations and international foundations sought to address the needs of children suffering from congenital heart abnormalities in the region. With the help of an American non-profit organization, Global Healing, Georgian surgeons received lengthy training in the United States and St Petersburg, Russia. In addition, American medical teams were brought to Tbilisi to provide on-job training to Georgian doctors. A team of clinicians for paediatric cardio-surgery was formed. MoLHSA allowed JAMC to renovate an empty department in the under-utilised medical facility without charging any fee for renting the space. Global Healing raised private and public donations that amounted to more than US$4 million and invested in brand-new equipment for the hospital, which was renovated with private funds. On 16 September 1996, the non-profit Jo Ann Medical Centre[8] opened its doors to patients.

In 1997, JAMC performed a total of 36 operations financed through donations from Global Healing and from patients. Demand for the services was significant, but the actual cost of the surgery was high, a factor that prevented people from seeking treatment. Decreasing financing from donors, who were not willing to finance recurrent costs at the Centre, and the inability of patients to afford the high cost of treatment, forced JAMC management to seek alternative funding sources. At the end of 1997, the outpatient department at JAMC had already registered 300 children who required surgical intervention. Most of these patients were from poor families and unable to meet the cost of surgery. As a result, JAMC management approached the MoLHSA, and SMIC provided them with the list of patients and a request to include paediatric cardio-surgery in the state financed benefit package. Their request was granted.

2.6 Why a priority?

Why was paediatric cardio-surgery considered a priority? In order to answer this question it is important to analyse the critical social, political and ethical dynamics and attitudes that influenced this policy decision.

The request to include paediatric cardio-surgery in the publicly financed BBP was made at a time when public spending was so negligible that it could barely meet the basic health care needs of the nation. At the same time, the proposed cardio-surgery programme had a much lower cost-effectiveness ratio than other essential programmes in the BBP. So the proposal certainly was not made on the basis of pragmatic arguments around resource allocation. Based on the cost-effectiveness analysis, the donor community assisting the MoLHSA with the health sector reforms opposed inclusion of paediatric cardio-surgery in the BBP (BBP Working Group 2000).

Unfortunately, in general there is limited knowledge about the effectiveness of many health care interventions currently practised. Nor do many countries know much about the real costs of interventions – effective or otherwise. While the movement for evidence-based practice is accelerating and sources of information are growing, much

of this information is of more use to industrialized countries and is less focused on the health problems of lower income countries (England 2000). Georgia was no exception to this rule. In 1997, investments made in the health sector were not delivering any tangible results. Public financing was not significantly improving the health of the nation.

In this context, JAMC presented a list of 300 children to the government who needed urgent medical attention. This enabled MoLHSA and SMIC to take into account the values and views of the specific consumers that ultimately constitute the moral and legal basis upon which the financing of public sector health care rests. In an interview undertaken as part of this study, one high-ranking policy-maker commented:

> *"With most investment decisions we only knew potential beneficiary groups. In the case of JAMC, we were presented with up to 300 children by name, address and health problem. We were asked to help individuals and not a population group. We could even tell which individuals' lives would be saved. Morally, I was not in a position to say no."*

Additionally, in 1997, three years after the initiation of reforms, JAMC was the only centre of excellence that had emerged with almost no assistance from the government and mainly through the investment of foreign donors. Thus, a quite sophisticated field of medicine (paediatric cardio-surgery) was developed, the hospital was equipped with help of donor organizations, and, most importantly, critical human resources were trained/developed that had not previously existed in Soviet Georgia. Furthermore, JAMC was the sole provider of paediatric cardio-surgery services not only in Georgia but also in the neighbouring countries of the South Caucasus and Central Asia. It was obvious that donor investments would have been wasted if state support for paediatric cardio-surgery had not been provided in a timely way. So the Centre itself became the first significant and tangible deliverable of the reforms initiated by MoLHSA. As a result, MoLHSA used JAMC to demonstrate the success of the sector reforms, which were being criticized by political opponents.

During one interview, a senior MoLHSA official said:

> *"Seventy years of Soviet rule never allowed the country to develop the field of paediatric cardio-surgery. We had a case when foreign donors helped the country and invested in the most important area in this field – human resources. They also helped us with the needed infrastructure. As a nation, we will always require these services ... I doubt whether in the immediate future Georgians will be in a position to afford to pay the cost of this surgery abroad. Thus, saying no to the JAMC meant destroying what had been already accomplished … letting hundreds of children die from congenital heart problems not only now but also in the future. JAMC's request was moderate. They were not asking for much. We hoped that along with economic growth, the relative share of funds devoted to*

paediatric cardio-surgery would always be moderate in an overall public spending on health. All of these factors probably made us accept the proposal and finance the programme, although within our limits."

3 Contract tendering processes, management and monitoring

3.1 Tendering processes and criteria

As set out in the State Purchasing Law, MoLHSA developed the programme for paediatric cardio-surgery and SMIC entered into a contractual relationship with JAMC. In 1998, the first contract was arranged without tendering since JAMC was the only provider of services on the national market and international tendering was not considered. The contract was developed through direct negotiation between SMIC and JAMC.

Up until the end of 2002, JAMC was the only provider of paediatric cardio-surgery in Georgia. In 2002, the for-profit cardio-surgery clinic Open Heart Ltd was established[9] and staffed by junior doctors. Operations were performed on a fee-for-service basis by invited foreign doctors, who visited the country several times a year. The range of operations performed by Open Heart was more restricted than that offered by JAMC.

Due to the provisions of the Georgian Law on State Procurement and anti-monopoly legislation, SMIC had to announce a tender for the paediatric cardio-surgery package for 2003. Tendering documents were prepared, which included requirements placed on applicants, a formal contract, a list of requested documents and proposal evaluation criteria/procedures. The package was developed in accordance with the Law on State Procurement and approved by a special commission created from the representatives of the MoLHSA, the State Procurement Agency[10] and SMIC.

Announcements about the tender were made through the mass media. Only two applicants submitted a bid: Open Heart and JAMC. The proposals, which included technical and financial application, were opened publicly. The bidding process consisted of a qualification and a proposal review stage.

Selection was conducted according to the criteria developed by a special commission. The proposals were evaluated against these criteria, which included the following:

- Quality of offered services (weight factor 0.50)[11]
  - Volume and type of services evaluated with the help of the facility statistics and

number and complexity of conducted surgical operations
- Quality of rendered services evaluated with outcome indicators for surgical/diagnostic interventions
- Staff experience expressed in years
- Staff qualifications based on training received
- Technical condition of the institutions, including facility structural conditions, diversity of equipment available, complexity of treatment and diagnostic procedures offered by the bidder. All these factors were evaluated through the on-site visit conducted by the tender committee.

- Payment type and frequency requested by the bidder – pre-payment amount, quarterly or monthly payment etc. (weight factor 0.2);

- Proposed price per case in accordance to the standards set by the state usually called Diagnostic Related Groups (DRG)[12] (Gamkrelidze *et al.* 2002) – (weight factor 0.2);

- Financial status of the organization based on an independent audit report (weight factor 0.1).

As mentioned above, Open Heart could not provide treatment for the required range of diagnostic categories. Thus, their proposal only partially covered the medical services required by SMIC. For this reason, Open Heart's proposal was rejected at the qualification stage and the contract was awarded to JAMC.

3.2 Management and monitoring

The responsibilities of the two parties (SMIC and JAMC) to the agreement were detailed in a contract that clearly identified:

- Price per case to be paid by SMIC;

- Billing and payment terms and procedures;

- Annual and respectively quarterly ceilings for the total contract value. The latter was determined with the help of the JAMC database of the registered patients from which the expected case mix for the coming year was derived. Cost per case was established by state regulations that allowed for an estimated annual ceiling for the contract;

- Monitoring responsibilities and rights of SMIC;

- Special provisions for 3–14 year olds from poor families to be financed from the programme for the vulnerable. These provisions created incentives for the

provider to offer services to the poor with a greater likelihood of recovering co-financing from the state purchaser.

Based on these contractual provisions, JAMC invoiced SMIC on a monthly basis. The billing procedures were programme specific. For example billing was separately performed for 0–3 year old children because the programme that paid for the services of this age group was different from the billing for 3–14 year olds (since this latter age group was subject to 20–25 per cent co-payments). As stated above, the 3–14 year olds from low income groups were exempted from the co-payments and the cost of treatment was covered by the programme for the vulnerable. Thus, the provider had no incentive to refuse the treatment of poor people. Rather, the provider had higher guarantees to recover co-payment from SMIC since the financier was the state entity.

The billing process was designed in a way that information detailed on the invoices allowed SMIC to monitor the following:

- Overall utilization of services by age groups;
- Type of conditions treated by JAMC and price per case. This information was used by SMIC to determine case mix for the facility and use it as a basis for the next year's contract;
- Number of eligible 3–14 year olds (subject to co-payments to be covered from the programme for the vulnerable) who received the treatment, and their share in overall patient load;
- Treatment outcomes per case and age group.

Thus, SMIC was able to gather all the critical information that would enable them to: plan the next year budget; monitor the service utilization by various age/population groups; track the case mix of JAMC; and monitor the outcome of treated cases. According to SMIC records (see Table 1), utilization of services by the poor in the 3–14 year old age group was significant, and it increased from 55 per cent in 1999 to 93 per cent and 82 per cent in 2000 and 2001 respectively.

Table 1: Service utilization by age and economic status

Year	Number of operations performed every year	Number of operations performed on 0–3 year olds	Number of operations performed 3–14 year olds	Number of operations performed on 3–14 year olds from poor families
1997	36	n/a	n/a	n/a
1998	99	n/a	n/a	n/a
1999	119	55	64	35 (55%)
2000	113	67	46	43 (93%)
2001	137	80	57	47 (82%)
2002	225	*	*	*

Source: SMIC

* In 2002, co-payments for 3–14 year olds were removed and SMIC financed the full cost of treatment for every patient. Thus, SMIC does not possess breakdown by age figures for 2002.

4 The results of the private-public provision arrangement

The results of this PPP arrangement could be judged against several criteria. However, we consider two to be critical: the impact of the arrangement on the provider; and the impact of this arrangement on the population, particularly the poor.

4.1 Impact on the provider

The overall volume of service provision under this paediatric cardiac-surgery programme is increasing, although at a very low rate relative to need.[13] This slow increase in service provision has been largely determined by scarce public resources rather than by the inability of JAMC to deliver higher volumes of service. All those interviewed agreed that JAMC's capacity to perform the operations is much higher than the state can actually finance. However, services are not demanded or requested by people when the state is unable to meet at least part of the cost. This is simply because people cannot afford it.

Nevertheless, increased utilization provided more work for the JAMC staff, which was critical to sustaining and further developing their capacity. This arrangement also helped JAMC to retain critical human resources. This is an important component of JAMC's capacity to function and continue to offer high quality services.

More revenue[14] from increased utilization was also essential to sustain and further develop the capacity for delivering services throughout the country and in the region of South Caucasus. Everybody involved in decision-making from MoLHSA and SMIC agreed that without this arrangement it would have been impossible to sustain either service provision or the institution itself. Generated revenue was invested in human resource training and also in new equipment. Through this investment, quality improvements through modernizing clinical technology were achieved. Incoming revenue also helped the facility to enjoy the benefits of economies of scale and boost institutional efficiency through cost reduction and rationalized spending. With a higher volume of working capital, JAMC started purchasing in bulk and saved on the cost of supplies/drugs.

4.2 Impact on the population

A mail survey was conducted to evaluate the impact of this PPP arrangement on the population. Of the 60 questionnaires that were mailed, 34 completed questionnaires were returned – a 57 per cent response rate. The results of the questionnaire analysis produced comparable results to SMIC reports about benefits received by the poor. The survey showed that 73.5 per cent of JAMC patients were extremely poor and 17.6 per cent from poor households. Only 8.8 per cent belonged to the wealthier group. (For the purposes of this study, the extremely poor were defined as people living on US$2.00. or less per day,15 and the poor were those living on US$4.30 or less per day (Falkingham 2003; World Bank 2000).)

Out-of-pocket expenditures were only made for diagnostic services[16] and for co-payments. All other services received at JAMC were provided free of charge. The services received by the poor were totally free. No single patient from those surveyed reported making informal payments to hospital staff and/or for pharmaceuticals.[17] The cost of diagnostic services consumed 53 per cent or less of the household monthly budget for 67.6 per cent of patients. For 17.6 per cent of patients, these costs were in a range of 53–100 per cent of the household's monthly spending. In five cases (14.7 per cent), the diagnostic expenses exceeded monthly household budgets.

While the costs of diagnostic services may seem significant, the level of diagnostic costs needs to be interpreted cautiously. According to the household survey conducted in Georgia in 2000, out-of-pocket expenditures for simple outpatient services consume more than 20 per cent of poor households' monthly budget and take approximately 14 per cent from wealthier households. And any case of hospitalization is a significant expense, equivalent to at least one month's total household expenditure. But for the lowest income group (the poor), a hospitalization on average accounts for three months' expenditure (Gotsadze 2001). So, relative to this situation in Georgia, the actual costs that were borne by the patients for diagnostic services at JAMC are not that burdensome.

The survey also revealed the mean expenses per household group detailed in Table 2. While the actual cost of the diagnostic services was lower in extremely poor households than for the poor, the findings were not statistically significant. However, the survey did show that wealthier households actually paid less than the poor.

Table 2: Actual spending for diagnostic services by different income groups (Gel*)

Income groups	Mean	N	Standard deviation
Extremely poor	192.52	25	246.14
Poor	243.33	6	193.18
Rich	140.00	3	151.00
Total	**196.85**	**34**	**227.59**

The patient satisfaction module provided data to evaluate the degree of satisfaction among those treated. Results of the analysis are presented in Table 3. Findings show that the degree of satisfaction is quite high. Almost all respondents were positive about the personnel, the facility and the services they received at JAMC.

Table 3: Patient satisfaction

Statement	N	Mean	Std. deviation
Doctors are good about explaining the reason for medical tests and surgical operations	34	1.24	0.43
I think the hospital has everything needed to provide complete medical care for my child	34	1.41	0.66
The medical care which was provided to my child was just about perfect	33	1.24	0.44
I would recommend this hospital to other patients	34	1.26	0.45
I feel confident that my child can get the medical care that he/she needs without being set back financially	31	1.39	0.50
When my child went for medical care, medical personnel were careful to check everything when treating and examining her/him	34	1.35	0.65
The doctors treated my child in a very friendly and courteous manner	34	1.24	0.43

* Gel are Georgian lari, the national currency. 1 Gel = US$1.00.

Statement	N	Mean	Std. deviation
Doctors usually spent plenty of time with my child	32	1.38	0.49
My child is able to get medical care whenever he/she needs it	32	1.19	0.40
I would recommend the surgeon and cardiologist who treated my child to my family members and friends	33	1.15	0.36
Sometimes doctors make me wonder if their diagnosis is correct	34	4.38	0.65
I had to pay for my child's medical care more than I could afford	28	4.36	0.68
Doctors acted in a too impersonal manner towards my child	34	4.59	0.50
Those who provide my child with medical care sometimes hurry too much	33	4.42	0.66
Doctors sometimes ignored what I told them	30	4.27	0.78
I have some doubts about the ability of doctors who treated my child	34	4.65	0.49
I found it hard to get an appointment for medical care right away	33	4.42	0.66
I am dissatisfied with some things about medical care provided to my child	34	4.65	0.49

(1 = fully agree and 5 = fully disagree)

5 Discussion and conclusions

5.1 Implementing policy through contract specifications

The success of this arrangement can be mainly attributed to two critical factors: the explicit public policy to subsidize service provision for the poor through the programme for the vulnerable; and the technical specifications in the contract that enabled policy implementation.

It may seem obvious that reducing the financial access barrier for 3–14 year olds from poor households was critical to increasing access to and utilization of services. However, available evidence is not sufficient to attribute the increased utilization solely to this factor. Poor households had to pay for diagnostic services prior to benefiting from public subsidies. The burden of such payments relative to what people pay for simple outpatient treatment in the Georgian health market is not that significant. Thus, poor households seem to be willing to bear the cost of diagnostics on condition that the actual surgical treatment is financed by the public purchaser.

The public purchaser managed to implement state policy on subsidizing the poor with the help of a well-designed contracting mechanism. The contractual provisions helped the purchaser to shift some risks to the provider through case-based reimbursement. The ceiling established for the contract forced the provider to stay within the limits of available funds but also provided enough flexibility to self-manage the case mix load. The fixed total value of the contract, low relative to the demand, also forced the provider to prioritise among the patients. According to JAMC staff, those patients in greatest need on the waiting list received the services first.

A predetermined rate of reimbursement, case-based billing and formats of invoices were critical elements through which SMIC possessed an effective tool for monitoring the utilization and the quality of JAMC's performance.

Finally, the contracting mechanism used in this partnership had a positive influence on provider behaviour and managed to eliminate incentives for JAMC to refuse treatment to poor households.

This case study also provides an argument in favour of out-sourcing health service provision to the private sector, even if to a monopolistic provider. Paediatric cardio-

surgery originally emerged as a service in the private domain, initially facilitated with the assistance of donor funding. However, up until 2002, JAMC was the only facility that offered such services to the Georgian market. So between 1998 and 2002, JAMC had a monopoly on the market and was in a position to influence the policy-making process – which they did, successfully. Nevertheless, arrangements designed by the government managed to deliver services to the poor – and the poorer segments of society benefited most. If well planned, well designed and efficiently implemented, such a PPP can benefit the poor even when the providers are in a monopolistic position in the market.

This case study provides evidence that there is potential for constructive engagement between the public and private sector in health care, and for achieving and maintaining service provision to poor households.

5.2 Conclusions and lessons learned

What can we learn from this case study? It seems that several factors contributed to the successful implementation of this PPP. These critical factors could be grouped into four major areas:

- **The overall legal and regulatory environment** which includes supportive general legislation and the nature of public sector reforms, where purchasing and provision functions are well defined and separated, and market mechanisms developed, and where the state regulates the public sector purchasing process (tendering, contracting, reimbursement etc.) and allows the public and private sector to compete for public funds on equal grounds;

- **The specific legal and regulatory environment in the health sector** addressing:
  - The purchaser and provider split and clear roles for purchasers and providers in the health care market;
  - Clear market entry regulations, where the state has a system to accredit and license the health service providers, and where regulations treat public and private providers equally;
  - Explicit public financing policies to subsidize service provision for poor households and effective mechanisms of delivery of these subsidies;

- **Institutional capacity** that emerged and was developed throughout the reform process, including purchaser capacity to contract providers effectively, and provider capacity to offer the quality services to the market and be able to enter into contractual arrangements with the purchaser;

- **Technical specifications of the contract** relating to:
  - Tender process design and bid evaluation procedures;

- Contract design and implementation;
- Effective contracting as a means to manage the provider and deliver subsidies to the poor including:
  - output-based versus input-based contracting, which provides a significant degree of flexibility to the autonomous provider to manage generated revenue;
  - case-based reimbursement that shifts part of the financial risk to the provider;
  - an annual ceiling of the contract, which forces the provider to be conscious about utilization volumes, and to a degree provides incentives to prioritize among the treated patients;
  - clearly defined billing and reporting mechanisms, which allow the public financier to monitor the utilization by poor/non-poor groups, case mix treated by the provider and outcome quality of rendered services.

There is no 'one size fits all' recipe for such a partnership, and local context will always determine the intentions, design and implementation of any PPP. Nevertheless, in any environment, explicit state policy/desire to reach the poor, and a well-structured and effective contract along with capable people/institutions to enforce the contractual terms, seem to be the most important factors in determining the relative success of any PPP. Certainly, this was the case in this partnership.

Notes

1. This premium was for 4 per cent of payroll, 3 per cent being employer share and 1 per cent employee share for those employed in the formal sector.
2. BBP is composed of several programmes, and includes mainly curative services.
3. On 19 February 1999, the Georgian Parliament adopted amendments to the Law on Entrepreneurs that eliminated 'Treasury Enterprise' as one of the legal forms of organized economic activity.
4. Paediatric cardiac-surgery certainly does not fall under the list of basic primary health care services, and it also falls outside the limited list of curative services. The reasons why this service is paid from public sources are explained later in this report.
5. According to the type of operation, co-payment rates varied. For example, for open heart surgery the rate was 20 per cent and for close heart surgery the co-payment rate was 25 per cent.
6. There are up to 250,000 internally displaced individuals in the country.
7. 0.8–1.2 per cent of all newborns; that is, comparable to other European countries.
8. The Centre was named after Global Healing's first president, Jo Ann McGowan, who initiated the project for paediatric cardio-surgery in Georgia. She died shortly after the Centre was opened, and grateful Georgian colleagues named the Centre after her in recognition of the incredible work that she carried out in Georgia.
9. Georgian legislation does not require a certificate of need in order to establish a medical provider. However, every provider is mandated to obtain a licence, which officially allows him or her to offer services to the public.
10. The State Procurement System of Georgia is based on the Georgian Law on State Procurement passed by Parliament in December 1998. The main coordinating and monitoring body for public procurements established by the law is the Public Procurement Agency (PPA), which is supervised by a Board of Supervisors. The President of Georgia appoints the Chairs of the PPA and the Agency Board.
11. A weighted scoring system was used to evaluate the proposals. Each criterion was scored on a 0–10 scale and multiplied with the weight factor. A total score for the proposal was established by each member of the tender commission and the overall score was calculated for each proposal. Researchers were not able to obtain exact instructions/rules for score application, thus a degree of subjectivity seems to have been an implicit part of the scoring system used by the tender commission.
12. DRG in the Georgian context is a slightly modified version of the DRG system used in the USA. The basic price for each DRG is established by the state and providers have the freedom to supply their price up to this limit.
13. At the end of 1997, JAMC had a list of 300 patients waiting to have the operation but only 99 operations were performed in 1998.
14. From 1998 to 2002 the volume of revenue increased by 1.4 million Gel.
15. In its 2000 report on poverty in Central and Eastern Europe, the World Bank proposed to use higher poverty lines given the region's cooler climate, which necessitates additional expenditure on heat, winter clothing and food. This line of US$2.15 a day was therefore proposed for extreme poverty. A higher threshold of US$4.30 was also used, recognizing that what may be considered as subsistence

needs inevitably varies with the level of country's development (Falkingham 2003).

16. Diagnostic services conducted prior to the surgeries that are to confirm the diagnosis are not covered by the public purchaser and are paid for by the patient themselves.

17. It is well documented elsewhere (Both 2002; Gamkrelidze et al. 2002; Lewis 2000; World Bank 1999) that most patients in Georgia face informal charges while hospitalized. The expenses are mainly made to hospital staff and for pharmaceuticals and consumables that patients have to buy in the pharmacy and bring along to the hospital.

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