

Privatization and Management Development in the Healthcare Sector of Georgia

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Abstract

Healthcare reforms in Georgia parallel some of the major changes made by other Central and Eastern European countries. This is especially true of efforts to privatize the health sector and secure capital investments from Western Europe. Privatization of Georgian healthcare requires an understanding of the Soviet-era healthcare system and ideological orientation. Many of the issues and problems of privatization in Georgia require new knowledge to enhance equity outcomes, improve financial performance, increase access to care and encourage healthcare competition. Training existing and future healthcare leaders in modern management theory and practice is paramount. A university-based health-management education partnership model was developed and implemented between several universities in the United States and Europe, along with two Georgian universities, to address workforce demands, changing market conditions, management knowledge and leadership competencies. Health-management education concentrations were developed and implemented along with several short courses to meet market demand for trained leaders and managers.

Background and Overview

Georgia, in the Trans-Caucasus region, has historically been a proud nation desired and influenced by the Greek, Roman, Persian, Byzantine, Turk, Mongol, Ottoman and Russian empires. Because of its geo-strategic location, Georgia has long been considered a bridge between Europe and Asia. Georgia is a country with approximately 4.6 million inhabitants. The country has an independent and progressive population; traditions and entrepreneurial spirit permeate society in general and support the reforms and characteristics of its healthcare system. The government has declared privatization of health facilities a priority, and, since 1994, several initiatives have been implemented as new services and systems find an efficient and effective way to operate in a rapidly changing economy.

Georgia has initiated healthcare privatization and governmental reforms in an effort to improve the health status of the population, ensure fairness in financing reforms and improve access to care. The United States Agency for International Development (USAID) and the American International Health Alliance (AIHA) have initiated health-management education partnership programs in Georgia to build collaboration and cooperation among universities in preparing future healthcare leaders. Key efforts embraced by the Ministry of Labour, Health and Social Affairs (MOHLSA) include appropriate improvements in physical infrastructure, capital investments that improve access to care and service quality, private sector involvement, development of private health insurance and strengthening the role of MOHLSA (National Institute of Health 2003).

The new reforms offer significant opportunities for improvement of health services in Georgia through the development of new capital infrastructure to replace outdated and inefficient medical facilities, an expansion of private sector investment in healthcare, improved quality and efficiency of healthcare services through market mechanisms and provider competition, and targeted public financing for the poor. However, many challenges have been identified and must be addressed early in the process of these reforms to avoid significant failures that could negate these opportunities, undermine the reform process and erode confidence in the government sponsoring the reforms. Some of these challenges are macro-economic and budgetary and relate to the fact that many citizens will not qualify as poor and therefore will not be covered by public sources. Also, Georgia's high number of unemployed workers and its self-employed working population will not have access to employer-subsidized voluntary health insurance plans.

The Soviet Period

Any serious attempt to understand the privatization of Georgian healthcare must begin with a consideration of Soviet-era healthcare. The stark contrasts between the authoritarian direction of health services under Soviet rule and modern day efforts at privatization highlight the extent of radical economic policy change within the country.

As one of 15 republics within the former Union of Soviet Socialist Republics (USSR), Georgia spent most of the twentieth century as an "essentially monocratic, highly centralized and ideological oriented" state (Verulava and Kalandadze 2001: 167). At a Soviet conference in June 1918, a resolution was passed calling for free medical care for the entire population of the USSR (Roemer 1991). The following month the Ministry of Health Protection was established. Three years later, Georgia became part of the Soviet Union.

For more than 70 years, centrally directed healthcare was the standard in Georgia and the other republics that made up the USSR. The physical facilities of the health delivery system were owned by the state, physicians and other healthcare professionals were employed by the government and the system of free care was financed by centrally collected tax revenues. Although centrally controlled by government, the quality of care often varied by region. Primary care was emphasized in the delivery system, with little emphasis on preventive care.

Like the other Soviet republics, Georgia placed a strong emphasis on physician training and education, maintaining educational ties to pre-eminent medical education facilities in Moscow where postgraduate training was provided for many of Georgia's medical and surgical specialists. The nation's tradition of physician training is evidenced by the fact that Georgia has one of the

world's lowest ratios of physicians to population (1:243) (The Economist 2007). However, the prolific production of physicians, coupled with severe funding problems, led to very poor physician compensation levels and lower socio-economic status for medical practitioners in Georgia, as well as in other Soviet republics. As a result, many physicians began to move away from the practice of medicine and seek other vocational activities such as teaching, administration and sales. In periods of relative prosperity during the Soviet period, the strong central direction from Soviet authority, as well as somewhat stabilized financing provided by centrally collected and disbursed tax revenues, allowed Georgia and other Soviet republics to maintain adequate healthcare economic sectors.

1991 and the Aftermath

When the USSR collapsed in 1991, Georgia and the other Soviet republics were cast into political and economic turmoil. With centralized tax revenues no longer available to support the Georgian healthcare sector, the healthcare system deteriorated rapidly. Per capita spending on healthcare dropped from approximately 13 US dollars in 1990 to 1 US dollar in 1994. During this period, immunization of children dropped significantly, infant mortality rates increased by 13%, maternal mortality increased significantly relative to other developed nations, and mortality due to cardiovascular diseases rose by 35% (Verulava and Kalandadze 2001).

Early attempts at dealing with the Soviet Union's collapse were mostly unsuccessful in the hospital industry. While public hospitals remained in place and Georgian-trained physicians and nurses remained in the newly independent economy, the loss of public support from Soviet-directed public funding left the system on the verge of ruin. The first serious effort at health sector privatization grew out of the "rose revolution" of 2003 when Mikheil Saakashvili, a US-educated lawyer, assumed the nation's presidency. With other Western-educated government advisors assuming prominent roles as economic policy makers, the push for large-scale economic privatization began in earnest. As early as 1994, a number of privatization methods had been introduced, including auction, tender, lease and direct sale of government-owned facilities in major capital-intensive industries (Asian Development Bank 2007). Telecommunications, energy and hospitals have been the major industries designated for the privatization efforts.

Privatization and the Healthcare Sector

The trend to privatization has been widespread in developing countries. This is especially true in Eastern European countries emerging from the Soviet socialist system. In theory, privatization should increase efficiency and productivity and improve financial markets, but there is also a risk that privatization can deplete national wealth and cause a decline in social welfare (Kikeri et al. 1992).

The debate about whether privatization is a positive move in health services policy has been discussed for more than two decades. In the 1980s and early 1990s, developing countries introduced considerable reforms to privatize and decentralize health services (Akins et al. 1987; Viveros-Long 1986). The analysis, which is still valid today, looked at privatization from several different perspectives. The three most important areas are provision of health services, financing of healthcare and regulation of all the healthcare sector components. Examples of public-private schemes and ideas are documented in the literature in the area of regulation and establishment of accreditation bodies for hospitals (World Health Organization [WHO] 1999); implementation of reforms with private, non-governmental entities taking a leading role and responsibility (Saltman and Figueras 1997) in the area of health financing, where private insurance schemes and even social and community-based health insurance models are utilized (WHO 1999); and in the area of health services delivery (National Institute of Health 2003). There are countless examples, embraced by industrialized nations like the United Kingdom, for the provision of services for the elderly and for child and reproductive health programs provided and financed by non-profit private organizations (Institute for Public Policy Research 2001; Walters et al. 2002; Uplekar et al. 2001).

Theoretically, privatization of healthcare services cannot be seriously considered until a national economy develops to a sufficient level of sophistication. Until then, the government must finance

delivery of health services and also provide those services directly to the population by owning clinics and hospitals and employing physicians and other providers directly. Since Georgia had been part of the former Soviet Union, it has inherited a Soviet-model health system, developed from an ideology that saw the delivery of healthcare as the responsibility of government.

When the Soviet Union collapsed and the former Soviet states became independent nations again, Georgians had to learn to live without the extensive support of the central government in Moscow. Most of these newly independent CEE nations saw their economies rapidly deteriorate to the point where they would be considered “developing.”

Privatization of several economic sectors, including healthcare, became an attractive concept to these newly independent nations. By privatizing healthcare finance and delivery, Georgia could benefit in two significant ways:

1. Privatized healthcare could be an important catalyst for expanding gross domestic product as the private sector invests in healthcare delivery, including the development of private health insurance capacity, as private market forces gain momentum to the economic benefit of the nation.
2. Increased private investment relieves the government of its economic burden of financing and delivering healthcare services. This frees up government budgets so that public funding can be devoted to other national economic needs that are less conducive to privatization, such as infrastructure improvements, public education and national defense.

In healthcare, expanded privatization also leads to the need for management development. Under publicly provided healthcare, physicians and other clinicians assume leadership and management roles, often by default. Private investment requires management skills rarely found in clinically trained individuals. Intensive management education efforts are needed to develop the individuals who will manage in the private sector.

The evolution of privatization in healthcare requires a management perspective that is difficult for many clinically trained professionals to appreciate, since their professional education did not address these skills. As competitive private markets develop over time, and organization of the health sector requires investment capital from domestic and international sources, healthcare managers require more specialized education in the management disciplines of human resources administration, organizational operations, marketing and financial management. Skills in these disciplines take on increasing importance for managers of clinical organizations like hospitals and clinics. They are also important for private health insurance companies, whether these are internationally focused firms expanding into Georgia who need Georgian nationals as in-country managers, or domestic insurance company start-ups. As Georgian governmental and educational leaders have come to realize, privatization requires management skills not found in centrally planned government-controlled economies.

As part of a project named 100 Hospitals, private companies, including real estate developers and pharmaceutical companies, are taking over public hospitals with no payment to the government, but with pledges that the new owners will upgrade the physical facilities and improve hospital quality (Lomsadze 2008). Physicians and nurses, severely undercompensated following the Soviet collapse and prior to privatization efforts, have seen their average salaries increase by 20% to 25% when employed by the newly privatized hospitals (Lomsadze 2008). The health ministry reports that hospital revenues have increased by 25% to 35% since the introduction of privatization (Lomsadze 2008).

Georgia has seen the effects of privatization in transferring the ownership and management of state-owned business to private firms. Public policies have been revised to enhance competition, and new regulations have been enacted to improve social services, especially in the healthcare sector. However, privatization has also contributed to unemployment of healthcare workers, and many healthcare system reforms have not improved the overall level of public health. The significant question facing Georgia is whether the social benefits of privatization can be realized during the next decade of governmental reforms. Many would contend that privatization has created an imbalance

between rich and poor. Privatization has usually been opposed in public sectors such as education and healthcare. Here again, the Soviet model provided universal coverage, and the new private markets have not developed significantly to provide access to primary care and increased quality of care for the majority of citizens. Out-of-pocket expenditures for healthcare have increased, and private insurance reforms have only recently been enacted and implemented (MOLHSA 2008). Healthcare coverage for the poor and vulnerable population remains a problem requiring public, government-supported programs.

Health Management Education Partnerships

The Ministry of Education and Science (MES) and MOLHSA in Georgia recognized that substantial educational efforts are required to achieve the ambitious healthcare reforms articulated by the Government of Georgia (GoG). Educational efforts require not only short-term courses, but also postgraduate (master's degree) programs that address core competencies of healthcare management and administration, hospital and clinic administration, healthcare planning, health economics, healthcare financing, health insurance, epidemiology and public health. While the accelerated development of a private sector as envisioned by the reform process will create an immediate demand for these specialties, the Georgian health education sector is not equipped to respond to this demand without considerable outside assistance. Furthermore, physicians with little or no management training currently occupy leadership positions in the healthcare sector. These senior medical directors (head doctors) have no formal training in organizational design, finance, marketing, ethics, health policy, organizational behaviour, operations management or human resources management. This lack of knowledge makes privatization difficult, and many reform efforts will not be sustainable without a trained workforce. Preparing future managers and leaders will take time, and new changes will not be easily embraced, adopted and implemented. Future MBA- and MHA-trained employees will fill mid-level management positions but not key leadership positions. Thus, the transition and impact of better-educated healthcare leaders may take another decade to realize sustainable outcomes. To accomplish the intense educational training, an international academic partner institution was formed to assist in development of the course content, curriculum, new courses and faculty.

With USAID support, the AIHA assisted the GoG's national healthcare reform efforts, with the goal of further strengthening Healthcare Management Education (HME) capacity in the country. The HME project utilized a partnership methodology to strengthen the capacity of leading existing MBA programs in Georgia by linking with a counterpart university in the US. The partners targeted the development of an international-quality health services specialization/concentration, building on the existing Master of Business Administration (MBA) curriculum. The US partner assisted the selected academic institution(s) in Georgia in developing faculty, curriculum, course content and materials for graduate master's programs with a health administration track; developing related short certificate courses and modules for practising healthcare managers and administrators; and developing case-based teaching models and practical internships to ensure maximum adaptation of training for practical experience. These targets were achieved through technical assistance, faculty exchanges, extensive training and promotion of international learning standards. In addition to developing and managing the "twinning" partnership, AIHA project staff worked closely with the MOLHSA and MES, as well as with private sector interests, governmental and regulatory bodies, and USAID and other international donor organizations to assure utilization, appropriate institutionalization and sustainability of the educational programs.

To ensure maximum impact and the sustainability of the project, special priority was given to the selection of Georgian partner institutions. Pre-existing capacity with respect to an established MBA program was a pre-requisite for selection of the Georgian partner institution. Based upon thorough assessment and consultations with potential partner institutions and the GoG, the AIHA identified and proposed institutions with pre-existing strengths and capacity and a strong interest in partnering with an American university in the development of a healthcare-management program.

The HME partnership chose the University of Scranton (UoS) as the lead partner, as well as

other select European universities and US universities such as the University of Central Florida and Saint Louis University, which have international teaching experience. An HME partnership model was used to build collaboration and cooperation between the UoS, the Caucasus University (CU) and the University of Georgia (UoG). Faculty from the Caucasus School of Business (CSB) and the UoG selected faculty to co-teach with UoS faculty in special healthcare-related courses during the 2007–2008 academic year. Two concentrations were developed: hospital administration and health insurance management. The initiative focused on building workforce capacity and sustainability in HME through course and curriculum development, faculty education, program development, co-teaching and student outcomes. The expanded partnership is continuing efforts to reinforce the critical mass and sustainability of health-management education and practice in Georgia.

Faculty from the CSB and UoG were trained and mentored to offer the healthcare concentrations in the MBA programs of study. Approximately 18 faculty members from Georgia were paired with faculty from the UoS to co-teach healthcare courses, with the expectation that the Georgia faculty would be able to teach the courses independently at CSB and UoG during the 2008–2009 academic year. Students for the courses were selected from CSB and UoG MBA students who were eligible to pursue an MBA healthcare concentration in Hospital Administration or Health Insurance Management. Approximately 40 current or recently graduated MBA students were selected equally from CSB and UoG. All students received healthcare concentration certificates in the 2007–2008 academic year (approximately 20 in each of the two areas of concentration). The AIHA, UoS, CSB and UoG worked with healthcare providers in Georgia to strategically place students in applied settings for fieldwork experience. Both concentrations included six courses (18 credits), and these were offered at the UoG and CSB as an MBA concentration at each university. Each concentration had six specific three-credit courses (18 credits) to provide the necessary knowledge, skills, abilities and competencies required for the concentration. A credit system model was discussed with Georgian partner institutions and adjusted as required to ensure that the program fit into the existing MBA programs at the CSB and UoG to meet the requirements of MES accreditation.

The MBA curriculum, including the new health-related concentrations, was designed for 60 credits and has the following structure:

MBA foundation courses	=	15 credits
MBA core courses	=	27 credits
MBA concentration (health)	=	18 credits
Total credits	=	60 credits

A. *Hospital Administration.* This 18-credit (six courses) concentration was designed to prepare hospital managers and executives to work in small, medium and large hospitals in Georgia. Students trained in this concentration are able to work in many different areas of hospital management and operations to provide healthcare services. Specific courses included:

- 1.1 Management of Health Care Services & Systems (three credits)
- 1.2 Principles of Managed Care (three credits)
- 1.3 Healthcare Organizational Leadership (three credits)
- 1.4 Managing the Modern Hospital (three credits)
- 1.5 Quality Assurance and Improvement (three credits)
- 1.6 Management of Human Resources (three credits)

B. *Health Insurance Management.* This 18-credit (six courses) concentration was developed to prepare students to work in the health insurance industry in Georgia. Participating MBA students combined core management courses with courses in insurance applications and risk management. These six courses were a separate concentration in the MBA curriculum. Three courses overlapped with the hospital management concentration. Students gained the knowledge, skills, abilities and competen-

cies for corporate and public sector risk management. MBA graduates work with insurance companies in benefits management, risk management or different types of consulting. Specific courses included:

- 2.1 Health Economics & Insurance (three credits)
- 2.2 Principals of Managed Care (three credits)
- 2.3 Healthcare Organizational Leadership (three credits)
- 2.4 Marketing Health Insurance Products & Services (three credits)
- 2.5 Quality Assurance & Improvement (three credits)
- 2.6 Financial Strategies & Risk Management (three credits)

Each course was taught over a 10-day period so as to provide 45 contact hours per three-credit course. UoS faculty taught the initial course. The UoS faculty member was assisted by selected Georgian faculty from the CSB and UoG. UoS faculty worked with their Georgian counterparts during the course to familiarize them with course materials and improve their pedagogical skills. After the course was completed, UoS faculty continued to mentor and work with their faculty counterparts via e-mail and video conference. Faculty development went hand in hand with curriculum development and involved developing new faculty members, improving faculty skills and expanding professional development opportunities. The partners worked on strengthening knowledge of content areas as well as pedagogical skills, using a training-of-trainers approach in workshops, team-teaching at the Georgian institutions and one-on-one instruction, follow-up and mentoring via e-mail and video conferencing.

Existing faculty from the CSB and UoG identified faculty who could teach courses in the hospital administration concentration and health insurance management concentration. Faculty had to be qualified to teach specific courses. If existing faculty were not qualified, new faculty were recruited to teach in each concentration. Each of the Georgian institutions (CSB and UoG) needed nine faculty (one for each course in each concentration – three courses overlapped).

A central element of the HME partnership was the assessment of current curricula and adaptation and development of curricula and related materials for graduate and continuing education, as well as undergraduate programs to meet the demands of the developing reform process. In addition to producing specific new curricula, the Georgian partners gained skills related to the process of overall curriculum development, including developing program structure, individual course syllabi, teaching materials and lesson plans. The curriculum helped to standardize goals and objectives for the educational institutions as well as ensure that specific reform needs were met.

An advisory group was developed to provide direct advice and feedback to university faculty and HME partners. This group was composed of hospital directors, banking executives, pharmaceutical executives, insurance company executives and USAID, AIHA and other governmental representatives. Several focus groups with healthcare providers from Tbilisi, Georgia, were consulted regarding internship and residency fieldwork opportunities. Input from outside stakeholders was used to modify the content of short courses and to add content to university courses. Fieldwork also served to build relationships between the public and private sectors. The demand for education and training for hospital and insurance company managers increased as individuals in key positions became aware of educational opportunities at both universities. Some of the curricula and materials were modified in a manner that allowed the material to be taught in non-degree short courses offered by the CSB and UoG.

An important component of the HME partnership agenda was the establishment of adequate library and learning resources to provide administrators, policy makers, students and the healthcare community with accurate and timely information on health policy and management. As part of the new partnership, the AIHA worked with the Georgian partner institutions, the international donor community and the private sector to ensure that adequate learning resources for faculty and students were made available to enable healthcare professionals to connect globally through the Internet, participate in continuing medical education and satellite-based video conferencing and education

programs with their UoS counterparts, continuously improve knowledge and skills through access to online journals, participate in e-learning courses and conduct distance learning classes with their UoS partners and other partner institutions around the world.

The HME partnership outcomes achieved in 12 months included:

- MBA concentration developed in Hospital Administration at the CSB and UoG
- MBA concentration developed in Health Insurance Management at the CSB and UoG
- Six courses with 18 credits for each concentration developed and implemented
- Related curricula, teaching and student materials developed and utilized
- Modified curricula, teaching and student materials for non-degree short courses developed
- Eighteen Georgian faculty trained in specialized courses through co-teaching and observation
- Program completion by 40 qualified MBA graduates (approximately 20 specialized in Hospital Administration and 20 in Health Insurance Management)
- Two new MBA concentrations at the CSB and UoG accredited by the Ministry of Education
- Four in-service education sessions conducted for faculty

Lessons Learned

Sustainable privatization requires continuous evaluation and assessment to design new approaches to meet new market conditions. Assessing changes in healthcare financing is key to understanding the direction and possible strategies that support effective policy development and health services implementation. Several criteria have been proposed by the WHO and include level of funding (amount, reliability and effect on other mechanisms); efficiency (technical, allocative, administrative and quality); equity (distribution of burdens and benefits); viability (consumer acceptability, acceptability to professional organizations and political acceptability); and health impact (change in health status) (WHO 1993).

Outcome assessments of HME training efforts suggest that formal academic preparation is needed in Georgia. Although short courses and continuing-education classes for head doctors are important, a trained workforce with competent healthcare leaders may take years to realize. This will jeopardize privatization efforts and make sustainable gains in quality of care, access to care and financial efficiency difficult. Furthermore, the private sector is not willing to provide free fieldwork training to university students. The concept of internships and administrative residencies is new in Georgia. Finally, finding faculty who are competent to teach specific courses is difficult. This is especially true in the areas of health policy, ethics, health law and medical economics.

Within all of these variables, developed and developing countries continue exploring formulas for public-private interaction. Business providers and insurers push for new service development and system designs beyond the traditional medical care boundaries, with more emphasis on public health, home care, prevention, retail medicine, lifestyle, nutrition and environmental health. This new universe of healthcare ventures requires strategies that enable

providers to move beyond the traditional competitive landscape of the healthcare marketplace.

The educational program partnership effort resulted in several important lessons learned. Some of the most salient include:

- Respect the culture in which you are working and its historical traditions. Georgia and other Eastern European nations have travelled a much different road in the past. Private enterprise is a concept to be learned and appreciated. Many citizens of the former Soviet republics remain nostalgic about the period of centrally planned economies. Faculty in these academic partnerships should read the history of the peoples and nations in which they are teaching in order to understand the uniqueness of the host country and its people.
- Be flexible in your approach to teaching. US or Western European faculty will find the teaching environment somewhat different from that of their own universities. For instance, the vast majority of MBA students at the Georgian universities are part-time enrollees attempting to balance their

educational, employment and family responsibilities. Classes were scheduled to begin at 2 pm and run until 9 pm each day including Saturdays and Sundays, meaning that students often came directly from work, even on weekends. On some occasions, they would arrive late and leave early because of the pressure of work commitments in a developing economy. It was not unusual for students to have to step out of the classroom to take cellphone calls from their offices.

- Try to develop close personal relationships with the administration and faculty of the host institutions. Diplomacy is crucial in academic partnerships like the one the authors encountered in Georgia. Fortunately, faculty from each of the three US universities had extensive international teaching experience and UoS faculty had worked with some of the Georgian administrators and faculty before embarking on the HME partnership. These close personal friendships enhanced the partnership effort.
- Appreciate the state of the macro-economy. The US was entering the great recession just as the HME partnership was beginning. As a physician–student remarked to a UoS faculty member, “When the US sneezes, many developing economies catch pneumonia.” It is inevitable that the measures of success, such as participation, outcomes and sustainability, will be correlated to the economic performance of the host country. It is within the nation’s macro-economic context that the educational endeavours will take place.

Future Efforts

The HME partnership has made significant contributions to Georgia’s modernization and privatization efforts. In one sense, the demand for healthcare leaders, administrators and managers is what economists refer to as a derived demand. It is derivative of the demand for modernization and privatization in the developing economies of Georgia and the other former republics of the Soviet Union. As their public policies favour privatization efforts, they simultaneously induce demand for initiation and expansion of health management privatization. The continued success of the health-management education efforts will depend on the successful push for privatization of the healthcare sectors of Georgian and other national economies.

While privatization efforts in the Georgian healthcare sector have gained momentum, the coming years will be challenging for entrepreneurs and government policy makers. Young professionals who are asked to make managerial commitments to the privatization efforts must see progress if they are not to become disillusioned and attempt to transfer their newly acquired management skills to some other sector that is perceived as more progressive, or leave Georgia for opportunities in Western Europe.

Some of the most obvious challenges to be addressed are:

1. *Greater perceived geopolitical stability in the South Caucasus Region.* The military hostilities that broke out between Georgia and Russia in August 2008 created a worldwide sense of political instability in the region. The tensions between the breakaway republics (South Ossetia and Abkhazia) and the rest of the nation permeate much of the political dialogue and contribute to the notion of instability. Even after the cessation of armed hostilities, the intensity of political opposition within the country seems particularly harsh when compared to other established democracies (Schildts 2008). Since foreign capital is more attracted to political and economic stability in countries in which it seeks to invest, the perceived lack of stability may hamper future inflows of foreign capital necessary for large-scale privatization.
2. *The synchronization of Georgian commercial law with private market evolution.* Many business laws have been intentionally simplified to avoid overwhelming the “as yet rudimentary nature of the market” (Guledani 2005). However, corporate, tax and securities law must mature to meet the reasonable expectations of domestic and foreign investors necessary for successful privatization development. As the private market evolves, so must Georgian business law.
3. *Private health insurance utilization and underwriting capacity expansion.* Private investment capital for health sector expansion, whether domestic or foreign, must see the possibilities for acceptable rates of return if it is to feel comfortable being employed in the privatization of the healthcare

sector. The unpredictability of revenue flows will cause investors to be wary of committing investment capital for hospital construction and other capital-intensive projects. As in the US, serious consideration should be given to making insurance coverage mandatory to facilitate revenue streams that can amortize investments. If Georgian insurers lack the capacity, foreign health insurers should be encouraged to write coverage in Georgia.

4. *The creation of lending facilities to spur privatization.* As a sovereign nation, Georgia should explore the expansion of its borrowing capacity from international financial institutions as a way of lowering the cost of capital for investors willing to commit to private health sector development. By using the faith in and credit of the government as borrower in the debt markets, Georgia might be able to provide lower-cost financing to domestic and foreign investors who would then find it more attractive to commit the borrowed capital to private investment projects.

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