

Health Reforms Need Marketing - Analyzing Current Georgian Healthcare Model through Reform Marketing Matrix (RMM)

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Abstract

Supported by German Academic Exchange Center, well known by the abbreviation of DAAD, invited by a famous professor of Health Economics, Dr. I.-Mathias Graf von der Schulenburg, Kakhaber Djakeli spent interesting research period at Leibniz University, Hanover (LUH), at the Institute of Insurance Business Administration and the Center of Health Economics Research in Hannover (CHERH) in the summer of 2016. This author had been researching Georgian Health Reforms and health economics for a long time at the LUH, and this article is a continuation of this tradition. The co-author, Tamar Jakeli, who is a young researcher interested in reform management, conducted analytical research of Georgian Health Reforms and their marketing at her university, Lafayette College, in Pennsylvania (USA). Both authors believed that a marketing approach that assessed Health model and reform was needed. As a result, they developed the model of RMM.

As a research approach, the famous Delphi method was used in order to gain expert views and opinions on the issue of reforming. The information obtained through this primary research method enabled us to establish prerequisites for the successful establishment of the Reform Marketing Matrix (RMM). Using the Delphi method, completed in two stages, 37 health experts were asked to answer questions electronically.

Keywords: health marketing, health reform, health reform management, health systems, reform marketing

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Introduction

We would like to ask the reformers: Why cannot you market and sell reforms, especially health reform, just like you sell soap? This idea implies that sellers of "commodities such as soap are generally effective, while "sellers" of social causes are generally ineffective" (Kotler & Zaltman, 2008). Why do health reforms take place? Many different answers can be given to this difficult question. Firstly, the societies in which old systems are no longer working are pushed to think about health reform. Secondly, people's demand for a national health system has increased because they want to live long and well. Thirdly, some political leaders want to show to their nations that they are better equipped to rule the country than the previous leaders, therefore, they aim at improving the health system (Parsons, McLaren, & Tadjewski, 2008).

How do we improve human capital of the country if not through health and education improvement? Health reformers have to think not only about the systems they are changing, but also about the national traditions; the core compe-

tences of doctors, medical universities and their professors; the image of political leaders; the pivotal details of health systems; the country's budget; the demands of the population; the media's position; and other important details.

Health reformers must act like military strategists, such as Epaminondas, Moltke, or Eisenhower. Health reforms are well received when the leaders have planned every detail elaborately. Especially in countries undergoing transition, however, the leaders only consider one side of the coin. The other side, which has not been considered earlier, often creates unintended negative consequences.

This article analyzes the Georgian health reforms. Before being occupied by the Russian Empire in 1801, Georgian kingdoms - Kingdom of Kartl-Kakheti, Kingdom of Imereti - had not built healthcare systems. The Russian Empire then established some hospitals but not a system. During the first independence in 1918-1921, Georgia was fighting against invaders, so the country could not build a

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health system for the entire nation. The Soviets occupied Georgia in 1921. The Soviet Union was known as a global budgeting financier of basic health benefit package for their population. Georgia, as a one of the Soviet Republics, was a part of the state-controlled Semashko Health model. Now, many argue that the Soviet Semashko Health model was very similar to the British Beveridge model of healthcare. But we can find more differences between these models than similarities.

In the early 90s, the Soviet Union with its health system finally demised. The nations that had been dreaming of freedom finally achieved independence and started their long fight to build states. But what is a state without health?

The First and the Second Health Reforms in Independent Georgia

Independent Georgia engaged in health reform three times, in 1994, in 2007, and in 2012-2013 and continued in 2014, respectively. All these reforms had their reasons.

The first reform: “At the time of its independence, April 9, 1991, Georgia appeared to be relatively well off republic with fairly good growth potential” (Collins, 2005). But the country’s ties to the Soviet Union and its main descendant, the Russian Federation, were cut and already in 1993 the model of Semashko was totally removed. The principles that had guided the Soviet System, such as territorial planning of polyclinics and the Feldsher stations, were finally abolished in Georgia. Encouraged and financially supported by the World Bank, the Georgian government in 1994 started first healthcare reform: a) to create the legal basis for new health system; b) to decentralize its management; c) to make transition to program based funding; d) to prioritize importance of primary health care; e) to encourage the transition to principles of health insurance, support privatization process and set up the rules of accreditation and licensing of health facilities and medical personnel; f) to reform the medical education.

Many things happened in the period of first reform, and decentralization and privatization efforts started. More than 400 state health institutions were privatized, and the number of hospital beds decreased from 57000 to approximately 44000. The medical insurance law was confirmed by the parliament of Georgia, but in that “dark ages of transformation” (author’s title of that period) insurance companies were still being born, so they could not influence the process positively. To collect healthcare payments and funds for the state insurance program, Georgian government created the State Medical Insurance Company (SMIC) (Djakeli, 2014). In theory, the basic healthcare, and the primary and essential hospital care could be covered by the state funded programs. But in reality the reform failed because of the state’s weakness. Formal and informal out-of-pocket payments constituted a large part of the total healthcare expenditures - 74.7% in 2003 (World Health Organization, 2009). 39 programs were funded by the State Medical Insurance Company. In 1999, nearly 700 health care providers carried out work on 1300 contracts (with the State

Medical Insurance Company - SMIC) (Gamkrelidze, Rifat, Gotsadze, & Maclehose, 2002). “After more than a decade of reform implementation, however, the results have been disappointing” (Collins, 2003). Accordingly, due to the shortage of funding, state medical standards approved by the Ministry of Labor, Health and Social Affairs (MOLHSA) failed and lost their reputation in the healthcare market of the country. In 1999, Georgia spent 0, 59 percent of its GDP on health care. The WHO’s unified index for health system’s performance – the DALE (Disability Adjusted Life Expectancy) for “health expenditures” per capita ranked the country as 125th. In 2002, the Georgian health system almost collapsed owing to a lack of state funding” (Federal Office of Migration BFM, 2011). “In the health sector, an impressive array of plans and reform initiatives coincided with abysmally low spending (0.6 percent of GDP in 1999) – lower than most low-income African countries” (European Stability Initiative, 2010, Georgia’s Libertarian Revolution Part Three: Jacobins in Tbilisi). The main causes that led to the failure of the health reform were identified as following: a) widespread corruption in the healthcare system and in the country, b) failure of the country’s economy, c) poor and irrational reform-strategy, d) poor structure and non-linkages to healthcare delivery. The first health reform ethics according its character was only utilitarian.

The second reform: The idea design for the second health reform was started in 2006 under the influence of Prime Minister and the think-tank of the Georgian government Mr. Kakha Bendukidze. The main goal for second health reform in independent Georgia was to ensure financial accessibility to the Medical services especially for the vulnerable population. The liberal thoughts of Milton Friedman helped Georgia in this case. His book, called “Capitalism and freedom” (Friedman, 1982), had influenced Mr. Bendukidze to such an extent that he offered the Georgian government Friedman’s liberal ideas for Health Financing (Djakeli, 2014). As we know, Milton Friedman advocated for the vouchers. The Government of Georgia decided to give the Health voucher to vulnerable populations or to those who could not afford the payment for the healthcare themselves. The recipient of the voucher could select a private insurance company and give them the voucher in exchange for health insurance. Many people soon became insured by private insurance companies. For voucher holders, the country paid insurance premium, with an initial amount of 10 GEL per person. The sum of insurance premium paid by the country to private insurance companies soon increased approximately two times for one person. Accordingly, the vulnerable persons became the most attractive customers for private insurance companies. They soon started to compete to gain the vulnerable populations as customers. The second health reform encouraged: a) more rapid privatization of health care infrastructure, b) targeting of the most vulnerable population groups with comprehensive health insurance coverage, c) channeling of public funding to targeted vulnerable groups through private insurance companies, d) reduction of health sector regulation to an essential minimum, and e) retaining of the most essential public health functions as governmental responsibility (UNICEF Report, 2010). The process of reforms was not easy. It was backed by so called Zero Tolerance policy to bribing and

corruption, started in 2004 by the President of Georgia, Mikhail Saakashvili. Because corruption was abolished, the state budget of Georgia increased rapidly. Leading coalition "United National Movement of Georgia" officially declared that they follow liberalism and ideas of libertarian economy. Therefore, the state regulation policies were weakened in health sector. According to some authors, this was not a positive development, but this is disputed. Insurance companies, that had been receiving health insurance premiums from the government, invested money in the health facilities. "In no other European country does the private sector pay as high a proportion of healthcare costs as in Georgia. The infrastructure and services and the qualifications of medical staff have improved significantly in the last few years. The switch to the family doctor system for basic care is also well advanced in some regions" (Federal Office of Migration BFM, 2011). Through voucher, in 2008 health insurance was given to more than 656 000 vulnerable persons. In 2009 this type of health insurance extended to the refugees too. In 2010 the health insurance, through voucher exchange, was given to 888 368 persons. But private insurance companies in that period calculated their losses, which reached 96% (Verulava, 2014). The achievements of this very interesting second health reform were: a) four years after the initiation of reforms, 1.2 million people (out of approximately 4.6 million total country population) were covered by health insurance by private insurance companies through public funding (UNICEF Report, 2010); b) Georgian state increased insurance culture among people and many from employed population started to look for corporate or individual health insurance at private insurance companies; c) private insurance companies became stronger through state funded health insurance activities; d) Georgian health system began to have the following facilities: emergency centers, centers for outpatient treatment, (outpatient or inpatient) polyclinics, specialist hospitals and birthing centers, medical research institutions (with patient beds), dental surgeries, and pharmacies. Additionally, each town had at least one hospital and one center for outpatient treatment. A family doctor and a nurse were stationed in each village (Federal Office of Migration BFM, 2011). But the main disadvantage of that time was that a large part of the population was left without insurance. The private insurance companies that invested their money into health facilities became monopolists. If we are interested in the ethics of this reform, we can say that it had a liberal character.

The Third Health Reform in the Independent Georgia

In the Parliamentary Elections of 2012, the "United National Movement of Georgia" that had been the leader of Georgian libertarianism for nine years was suddenly defeated. The alliance, non-liberal but democratic "Georgian Dream – Bidzina Ivanishvili," emerged as the winning coalition.

From 23 February of 2013, according to State N36 restriction, the new health reform was started and "Universal Health Care" model was implemented (Acts of Ministry of Labor, Health & Social Affairs of Georgia, 2014). The goal

of these new beginnings was to provide all citizens of Georgia with basic benefit package. In the initial stage of this program, it intended to give the beneficiaries' only minimal package of health care. This minimal package involved family doctor care, consultations, and the urgent need satisfaction of secondary and tertiary care. From 1 July of 2013, the program extended to planned surgeries, urgent ambulatory care, urgent stationary care and limited medical analyses.

An innovative feature of the "Universal Health Care" is that it covers not only the citizens of Georgia but also non-citizens living in or traveling to Georgia. The program allows the beneficiaries themselves to choose the health facility. For planned stationary care, the beneficiaries must apply to the Social Service Agency and get a guarantee paper.

The WHO, USAID and World Bank experts in 2014 made their assessment of annual achievements of the State Program "Universal Health Care". The American Development Agency's health project also supported research about the satisfaction of the customers. The survey was conducted by telephone. 96.4% of the survey participants were mostly satisfied by the hospital and the urgent ambulatory care.

The program financing has rapidly increased. It went from 365 million GEL to 634 million GEL in 2013 and now in 2016 it has already reached 800 million GEL.

The Georgian government is saying that it has established universal instrument for people to utilize health services. They believe that 3,4 millions of the citizens are covered by this universal model. Corporate health insurance covers 546 thousand citizens of Georgia, and 560 thousand citizens receive health insurance from the state. By 5 May of 2014, approximately 2.3 million beneficiaries were registered for this program. 383 707 cases were fixed, among them urgent ambulant care cases – 229 480, urgent stationary care – 81 495, planned surgery – 27 030 cases and cardio surgery 1 107 cases, chemotherapy, hormone and laser therapy cases – 12 308, birth cases – 31 867. The state also made assessment of this universal health care model and established the following picture:

- Research of population shows that 96,4% of all respondents are satisfied by hospital care, urgent ambulatory care;
- 80,3% of beneficiaries are satisfied by planned ambulatory care;
- In the component of planned ambulatory survey, 84,1% of respondents are saying that they have free choices and program is strong due to financial support from government;
- 78.2% in the survey component of urgent ambulatory, planned hospitalization say that program has the advantages of free choice and financial support;
- Out-of pocket payments have drastically declined in Georgia due to this program;
- The biggest reason of non-satisfaction with the program comes from "long waiting lists";
- The ethics of the reform is strongly communitarian.

What is Consumer-Driven Health Care and How it Works in Private Sector

How do we assess health systems according to their customer centricity? Let us first revisit private health system changes and determine what needs evaluation. Private health system changes or reforms enable us to better understand customer-oriented health reform marketing. They are planned for employees, and assessed according to the logic of rational man and the rules of marketing.

In 2009, the company Intel, trying to tame soaring health care costs, encouraged its employees to be more involved in the purchasing process of their own healthcare. The company thus implemented new model of healthcare. Intel offered its employees:

- Higher-deductible plans with lower premiums,
- Tax-advantaged accounts,
- Tired-provider options,
- Optional annual health checks, with ability to reduce premiums or deductibles,
- Health coaches,
- Free fitness classes.

But all these measures did not work until Intel implemented a new type of approach – purchasing power in markets where the company had operations in order to influence healthcare providers, health plan administrators, insurers and other employers to rise above their competing self-interests and build entire health Care System (McDonalds, Mecklenburg, & Martin, 2015).

The company started to use lean improvement method in healthcare to manage costs and quality. The results were significant: “treatment costs of certain medical conditions fell by 24% to 49%, patients could access care and return to work faster, patient satisfaction improved, and more than 10,000 hours’ worth of waste in health care suppliers business process was eliminated” (McDonalds, et al., 2015, p. 41). The healthcare model being implemented by Intel, called “Healthcare Marketplace Collaborative Model” or

HMC has the potential to be a game changer. According to its ethics, this model is much more communitarian than any health models implemented in private or public sector.

Perhaps some readers would think that Health Plans were also the same. In fact, health plans were not the same. Some plans were not rational and involved more unnecessary visits. “Without strong pressure, they would not make enough effort to provide the highest-quality, lowest-cost care possible” (McDonalds, et al., 2015).

The steps that Intel has implemented to establish Healthcare Marketplace Collaborative Model are the following:

- It made explicit what each player – Employer, Provider, Insurer, Physician leader - can do well to work effectively for every member of HMC (Figure 1: HMC model);

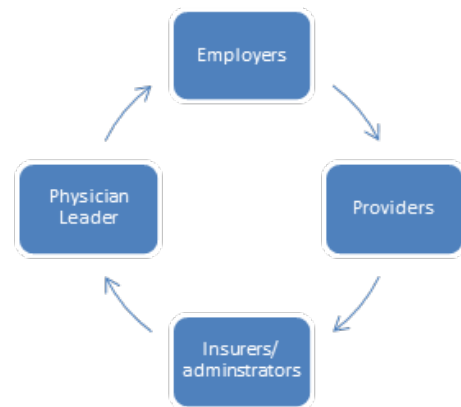


Figure 1. HMC Model
Source: McDonalds, et al., 2015, p. 41

- HMC model established a shared aim - one big goal that is interesting for all stakeholders;
- Rather than develop new protocols, common for autocrats, Intel offered to use traditional easy metrics and lean lingo, value stream systems, which made the system more accessible and affordable (Figure 2: Traditional approach).

Table 1. HMC

Success Measures	Lower back pain	Shoulder, knee & hip pain	Headache	Breast problems	Upper respiratory illness	Diabetes	Screening
Same-day access	93%	86%	100%	26%	100%	100%	100%
Patient satisfaction	98%	98%	92%	94%	100%	96%	96%
Evidence-based medicine	92%	81%	N/A	100%	N/A	N/A	N/A
Rapid return to function	99%	97%	N/A	42%	N/A	N/A	N/A
Savings in direct costs	23,5%	37,7%	49,1%	N/A	N/A	N/A	N/A
Initiated	2010	2010	2011	2012	2012	2013	2012
Duration	35MOS	35MOS	24MOS	38MOS	18MOS	10MOS	14MOS
No. of patients	499	343	657	86	111	47	151

Source: McDonalds, et al., 2015

To measure results, the HMC chose five metrics that addressed the aim of better, faster and more affordable care (Figure 3: The HMC Process).

Goals were set like this:

- 85% of patients calling for appointment could get it in one business day;
- 100% percent of patients would refer a friend to the clinic;
- 100% percent of patients would receive research based medical treatment;
- 90% would meet targets for number of days to resume normal daily routine (Table 1).

The differentiation of HMC from the traditional method can be shown also graphically:

General Question - How Do We Assess Customer Oriented Reforms, Especially in Health Sector?

Generally health reforms are implemented to increase the population's well-being. In several ways, it is different from other types of reforms. But what is similar between the health care and for example, military reforms is that often we are prepared to fight the last war, not the next. Yet, the health reformers must be prepared to fight the next war. That's why health reformers need marketing.

Because reforms are made for people, we can involve into this process more marketing than we are currently utilizing. The interesting part of health reforms is how to create value. The reform must be branded because it is for people.

The customer-centricity of health reforms is needed. If reform is customer centered, than the entire health system will be customer-centered too. We know how it is important to be customer oriented in business. For example "over the past decade, many companies have refocused their

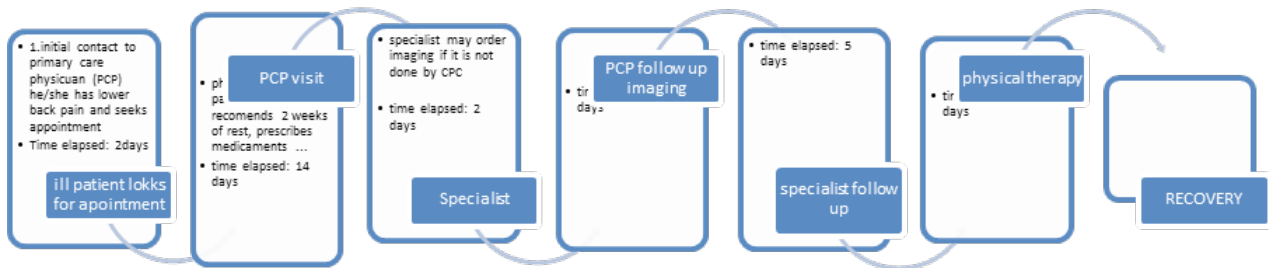


Figure 2. Traditional Approach
 Source: McDonalds, et al., 2015

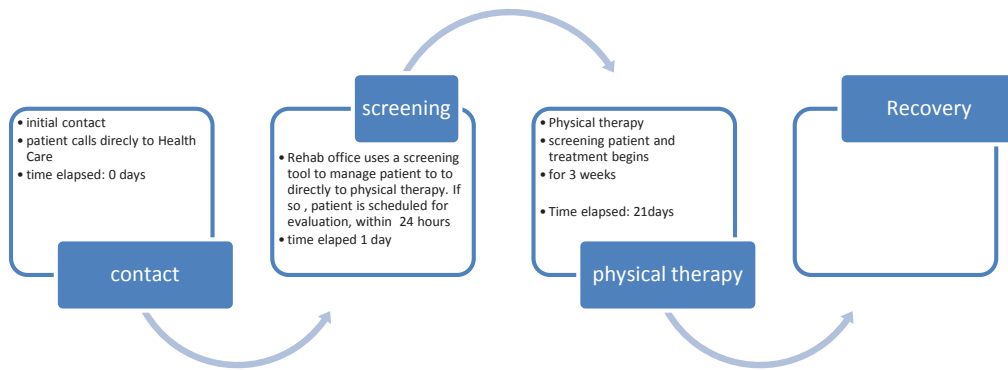


Figure 3. The HMC Process
 Source: McDonalds, et al., 2015

What can be adopted from these models? We can guess that high accessibility, affordability and smartness of health system are much appreciated in corporate life. The same assessment criteria can be used by countries to make their health systems much more effective, smart and accessible for people. Additionally, in order to measure success of health reformers and to assess the health systems established by them, the same marketing criteria can be utilized, in combination with reform ethics and reform knobs.

structures on customer segments rather than products – about 30% of the Fortune 500 firms, including Intel, IBM, and American Express, have done so” (Harvard Business Review, 2015). In addition, “the researchers theorize that younger people have had fewer chances to define themselves professionally, so they see an immediate benefit to being identified with a respected brand” (Harvard Business Review, 2015, p.24). So reforms and especially Health Reforms must be brands. People must elaborate some emotional appeal to reforms as they have established some attitude to brands.

To find methods to evaluate health systems, established by health reformers, we can once again recall private sector and Intel’s approach. Taking into consideration Intel’s approach to more customer- driven insurance, we can say that a new, more marketing oriented method of health system reforming must be utilized.

About main drivers of health system changes, either in country or in company the following idea is agreeable: “Four broad forces are driving health reform in countries around the world. The first is raising costs in health care. In addition, there are rising expectations, as citizens demand more, both from government in general and from rising costs and higher expectations are occurring at a time in history when governments confront limits on the capacity to pay the costs of health care. These have arisen both for developing countries that have faced political instability and economic turmoil, and countries that have experienced many years of relative peace and prosperity. These limits represent the third driving force at play. The current worldwide reform debate is also influenced by a fourth driving force: growing skepticism about conventional approaches to the health sector” (Roberts, Hsiao, Berman, & Reich, 2002).

These authors (Roberts, et al., 2002) also suggest 5 control knobs to evaluate health reforms, which are:

- Financing – the money raising method, including taxes, insurance premiums, direct payments;
- Payment model to health providers;
- Organization, their structure, roles and functions, and how these providers operate internally;
- Regulation;
- Behavior includes efforts to influence what individuals do in relation to health and health care;
- Including both patients and providers (Roberts, et al., 2002).

So taking into consideration these 5 knobs, implemented by Roberts, Hsiao and others, we will add them marketing orientation through 4A-s some ground philosophy of the nation, country, and representing readiness for reforming of health.

The New Health Reform Marketing Model (RMM)

“Judging health sector performance requires ethical analysis. ...we introduce three major ethical perspectives as a basis for making such judgments: utilitarianism, liberalism, and communitarianism” (Roberts, et al., 2002). So in PMM model the ethical analysis and decisions of society have their important place. To use this model we need some steps:

- Before we start health reform analysis through RMM, we should study its utilitarianism, liberalism or communitarianism;

- 5 knobs of reform have their vertical formation in RMM. We add one more knob, which is – controlling. So five knobs became six in our matrix;

- 4A’s have their horizontal formation in RMM;

- Before filling this matrix, we need research tools and experts who present their opinions on the 5 knobs and their 4 A’s in reality;

- From 1 to 5 degrees, experts have a chance to evaluate accessibility of financing. If financing is well-accessible, experts write number 5, if accessibility is good to excellent, experts write 4, if accessibility of financing is average then experts write 3, if it is poor experts write 2, and if accessibility of financing is bad, experts write 1;

- The same can be said about acceptability, affordability, awareness for 5 knobs, started from financing, ending with controlling;

- We add one more question about experts’ opinion about general public and its accessibility, acceptability, affordability and awareness to ethical directions of reform, for example – utilitarianism, liberalism and communitarianism. This question was added because in the 21st century there are some cases when nations do not fully share liberal values. How can health reforms be carried out in such countries?

- In RMM experts of health market assess not only reforms but systems established as a result of these reforms;

- Finally we calculate the total ranking of reforms, and establish total range of health systems (Table 2).

Table2. Reform Brand Measuring Matrix – elaborated by author (source: author)

	Utilitarianism				Calculations
	Accessibility	Acceptability	Affordability	Awareness	
Financing					
Payment					
Organization					
Regulation					
Behavior					
Control					
Utilitarianism					
Total ranking					

Liberalism				
	Accessibility	Acceptability	Affordability	Awareness
Financing				
Payment				
Organization				
Regulation				
Behavior				
Control				
Liberalism				
Total ranking				
Communitarianism				
	Accessibility	Acceptability	Affordability	Awareness
Financing				
Payment				
Organization				
Regulation				
Behavior				
Control				
Communitarianism				
Total ranking				

The Delphi Research of Health Reforms in Georgia Using Reform Measuring Matrix (RMM)

The Research had two goals: first, to understand the nature and meaning of Health Reforms of Georgia and the second, to calculate their ranking through RMM.

As a research approach, the famous Delphi method was used in order to gain expert views and opinions on the issue of reforming. The information obtained through this qualitative method enabled us to establish prerequisites for the successful establishment of the RMM. Using Delphi method, completed in 2 stages, 37 health experts who write about health were asked to answer questions electronically.

The Delphi marketing research method summarizes opinions and judgments obtained to formulate opinion. "This method is useful to a wide range of problems, provides a focused interaction between people who are geographically dispersed, and also allows exchange of ideas between people from different disciplines. The research conducted through the Delphi method provides quantitative and qualitative results" (Denisa & Dado, 2013). The rate of questionnaires' return was 66% percent.

Ranking of Health Reforms According Research Results

Experts participating in our Delphi survey evaluated each reform's knobs. This was done according to their accessibility, acceptability, affordability and awareness. Experts tried to grade them according to the assessment criteria of 1 to 5 degrees. Five was excellent assessment. In the second stage of Delphi research, the researchers once again sent experts not only their own assessments but the assessments of their colleagues participating in the same survey. So experts had a chance to think about their opinion and change something if they wanted. In the final stage we received final versions of expert's assessments about reforms knobs and their 4 A's. The researchers calculated deviant for each 4A. To calculate utilitarian health reform's degree, for example, asimple formula was used:

$$\text{Total Ranking of reform (S)} = \text{S financing} + \text{S Payment} +$$

S Organization + S Regulation + S Behavior + S Control + S Utilitarianism (Table 3).

Table3. Reform Brand Measuring Matrix (source: author)

Utilitarianism					Calculations
	Accessibility	Acceptability	Affordability	Awareness	
Financing F	A(F)	ACCEPT(F)	AFF(F)	Aw(F)	S Financing
Payment P	A(P)	ACCEPT(P)	AFF(P)	Aw(P)	S Payment
Organization O	A(O)	ACCEPT(O)	AFF(O)	Aw(O)	S Organization
Regulation R	A(R)	ACCEPT(R)	AFF(R)	Aw(R)	S Regulation
Behavior B	A(B)	ACCEPT(B)	AFF(B)	Aw(B)	S Behavior
Control C	A(C)	ACCEPT(C)	AFF(C)	Aw(C)	S Control
Utilitarianism U	A(U)	ACCEPT(U)	AFF(U)	Aw(U)	S Utilitarianism
Total ranking					

Experts participating in the research have assessed health reforms in the way (Table 4):

Table 4. Three Health Reforms in Georgia and their Assessment

1st Reform 1994-1997		Utilitarianism				Calculations
Reform 5+1 knobs	Accessibility	Acceptability	Affordability	Awareness		
Financing	0	0	0	1	1	1
Payment	1	1	1	1	1	4
Organization	1	1	1	1	1	4
Regulation	1	1	1	2	2	5
Behavior	2	1	1	2	2	6
Control	2	2	1	2	2	7
Utilitarianism	2	2	2	1	1	7
Total Ranking	9	8	7	10	10	34
2nd reform 2007-2012		Liberalism				
Reform 5+1 knobs	Accessibility	Acceptability	Affordability	Awareness		
Financing	5	5	5	3	3	18
Payment	3	3	3	3	3	12
Organization	4	4	5	4	4	17
Regulation	4	4	5	4	4	17
Behavior	3	3	5	3	3	14
Control	3	3	3	3	3	12
Liberalism	2	2	2	2	2	8
Total Ranking	24	24	28	22	22	98
3rd reform 2012-2016		Communitarianism				
Reform 5+1 knobs	Accessibility	Acceptability	Affordability	Awareness		
Financing	4	4	4	4	4	16
Payment	5	5	5	5	4	19
Organization	4	4	4	4	4	16
Regulation	4	5	5	4	4	18
Behavior	4	5	4	4	4	17
Control	4	4	5	5	5	18
Communitarianism	5	5	5	5	5	20
Total Ranking	30	32	32	30	30	124

So, the first health reform received the score of 34. The second health reform, which had more liberal appeal, received 98. The third health reform, however, received the highest score of 124.

Discussion – The Criteria for Marketing Exchange Incorporated in the Reform

As we know, exchange is the main concept of marketing since 1950. Buurma, backed by the concept of Koster (Koster, 1991), established nine general criteria for the marketing exchange (Buurma, 2008). Based on their criteria, I identify and suggest three different bands of criteria, different for utilitarian, liberal, or communitarian type of health reforms (Table 5).

Table 5. Criteria for Marketing Exchange for Health Reforming According Utilitarian, Liberal and Communitarian Ethics

Utilitarian character of health reforming	Liberal character of health reforming	Communitarian character of health reforming
Parties involved by rational choice	Parties involved by best choice	Parties involved by communitarian choice
More government responsibility and less mutuality	100% mutuality	Balanced mutuality
Reform goals and objectives backed by government and politics	Reform goals and objectives backed by free choice of suppliers, financiers, demanders, controllers, general public and media	Reform goals and objectives balanced between communities and their majoritarian and plural groups
Non to lose-not to lose philosophy	Win to win philosophy	Nothing to lose and win to win philosophy
Propaganda type of communication	Interactive free communication	Free traditional communication
Legitimacy: on power of political winner	Legitimacy: on free choice and rights of plural groups/persons	Legitimacy: on good faith, traditional points of view, communal/national values
Rights and obligations: prescribed by administration and followed by people	Rights and obligations: as free agreement between sides and their ambassadors	Rights and obligations prescribed by communities, people
Claims of parties: sanctions are disposed inside the system	Claims of parties: sanctions are disposed by civil court	Claims of parties: sanctions are disposed by civil court or state administration

Policy Recommendations

According to the research and established concepts, we can have the following suggestions:

- The customer-centricity of Health Reforms is in great need. If reform is customer centered, then the entire health system will be customer-centered too;

- Because reforms are carried out for people, we can involve more marketing in this process than we are currently utilizing. The interesting part of health reforms is how to create value. The reform must be branded because it needs to appeal to the people;

- The case of Intel about the implementation of new Health System is not meant to suggest, however, that companies like this can or should take the place of government to carry out health reform properly. Nor is it meant to suggest that private organizations, profit or nonprofit entities are without problems. Only it seems reasonable that they plan their activities according to the market, using their business, marketing, and branding skills. As Intel knows its workers well, Health reformers must too know their people. The social behavior of citizens should not be treated in isolation by the health reformers. So the health reformers must understand what kind of population they have: more liberal, more utilitarian, or more communitarian?

- The theory of social motivation and perception (Koschnick,1995), combined with the concept of 4 A's, extends the health reform process according to the socialization process, especially as it is examined by person, his/her family, friends, relatives, and community members;

- Reform Marketing Matrix RMM has its advantages only if the general public and their leaders decide to build cus-

tomers/patient/people oriented national health system;

- Power of global mass demand can be used by the next political leaders to establish more liberal systems of health care, based on collaborative approaches between providers, financiers, payers and controllers like it was done by Intel Corporation. The Reform Marketing Matrix can help the next reformers to put marketing into reforms and achieve greater goals.

Conclusion

Reformers around the world must touch the hearts of their customers, who are of course their people. How can they do this? An increasing number of nonprofit organizations have begun to use marketing logic as a means to furthering their goals, products, services and ideas. Even churches have been advised by marketers on how to increase their membership and raise money. For social events, Advertising Council of America has carried out social campaigns like: "keep America beautiful", "join the Peace Corps", "buy stocks", "go to college", and etc. Marketing knowledge and social branding have become crucial for success.

If we plan health reform according to the tools of marketing, social marketing and nonprofit marketing, we will have great results. First of all, we will plan health reform for the customers.

It is obvious that social behavior of citizens cannot be treated in isolation by the health reformers. During the initial planning, health reformers must know their society: what kind of population they have - liberal, utilitarian, or communitarian.

Our approach is not only a measuring tool of health reforming, it is also a planning tool. The Reform Marketing Matrix (RMM) can help reformers plan well, and measure their success during the reforming process.

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