Beka Natsvlishvili
Ivane Javakhishvili Tbilisi State University
E-mail: beka.natsvlishvili@yahoo.com

From Public Servant to Entrepreneurial Physician: Neoliberal Reform and the Transformation of Medical Professionalism in Georgia

Abstract

This article examines how neoliberal healthcare reforms have transformed medical professionalism in Georgia by reshaping the institutional position, professional self-understanding, and everyday working conditions of physicians. The study focuses on the post-Soviet transformation of the Georgian healthcare system, where the Soviet Semashko model of centralized public provision was gradually replaced by a market-oriented system characterized by large-scale privatization, expanded private service delivery, and public financing organized mainly through the state's purchaser role. Although the Universal Healthcare Program expanded public coverage after 2013, most healthcare institutions had already been privatized, creating a hybrid arrangement in which public funds flow largely through private providers. Drawing on eighteen semi-structured interviews with physicians and clinical managers working in private and state medical institutions in Georgia, the article explores how doctors interpret commercialization and how these institutional changes affect professional identity, career strategies, clinical decision-making, and professional autonomy. The findings show that commercialization has encouraged a shift from the model of the physician as a state-serving professional toward a more entrepreneurial form of medical professionalism. Physicians increasingly describe specialization choices, professional development, workplace mobility, reputation building, and visibility in terms connected to income, competitiveness, patient flow, and market value. Medical expertise remains central, but it is increasingly reinterpreted as a form of professional capital that must be continuously developed, strategically positioned, and made visible within a competitive healthcare market. The article also shows that commercialization affects clinical practice through financial incentives and managerial forms of control. Per-case remuneration, clinic-level revenue expectations, DRG-related cost constraints, and internal financial monitoring introduce economic considerations into the environment of clinical judgment. These mechanisms do not mechanically determine physicians' behavior, but they narrow the practical space in which professional autonomy is exercised. At the same time, the interviews do not support a simple narrative of ethical decline. Many physicians continue to emphasize patient welfare, professional responsibility, and clinical judgment, and some describe resisting financially advantageous but clinically unnecessary interventions. The article therefore argues that commercialization does not simply eliminate medical professionalism; rather, it reconfigures it. Physicians operate within hybrid institutional environments where professional commitments coexist with economic incentives, organizational constraints, and market-oriented expectations. Differences in interpretation appear to reflect not age alone, but physicians' different institutional experiences and working environments, including earlier state-centered healthcare arrangements and contemporary commercialized private-sector settings. The Georgian case contributes to sociological debates on neoliberalism, professional change, and post-socialist healthcare reform by showing that healthcare commercialization reshapes not only ownership, financing, and service delivery,

but also the social meaning of medical work and the conditions under which professional ethics and autonomy are practiced.

Keywords: Healthcare commercialization; Medical professionalism; Professional autonomy; Neoliberalism; Georgia

Introduction

Over the past three decades, many healthcare systems have undergone market-oriented reforms that privatized infrastructure, expanded private provision, and introduced financing mechanisms based on competition and efficiency. These reforms changed not only the governance and financing of healthcare, but also the institutional environment in which medical professionals exercise autonomy, responsibility, and clinical judgment (Saltman & Figueras, 1997; Light, 2000; Harvey, 2005).

Georgia represents a particularly important case of this transformation. Before independence, the Georgian healthcare system operated within the Soviet Semashko model, where healthcare institutions were state-owned and physicians worked as public servants in a centralized system designed to provide universal access (Field, 1967). After the collapse of the Soviet Union, and especially after the Rose Revolution of 2003, reforms transferred much of the healthcare infrastructure into private ownership and reduced the state's role as a direct provider of services. The Universal Healthcare Program introduced in 2013 expanded public financing, but because most providers had already been privatized, the state largely became a purchaser of services while private clinics dominated provision (Richardson & Berdzuli, 2017). Reimbursement in this system is largely organized on a per-case basis, while regulatory oversight has remained relatively limited, leaving private providers substantial autonomy in organizing services and pursuing economic strategies (Richardson et al., 2025). Recent research also suggests that the Georgian health workforce has developed largely through market dynamics rather than coordinated state planning (Aladashvili et al., 2025).

These changes altered the structural position of physicians. Contemporary Georgian doctors increasingly work in commercialized organizations where clinical practice is intertwined with market incentives and institutional revenue pressures. This tension is especially important in healthcare because the doctor-patient relationship is characterized by informational asymmetry: patients usually lack the specialized knowledge required to assess the necessity, quality, or appropriateness of medical interventions (Arrow, 1963). When financial incentives enter such settings, commercialization becomes not only an institutional or economic issue, but also a problem of professional ethics and patient trust.

This article argues that healthcare commercialization in Georgia has contributed to a transformation of physicians' professional ethos, shifting their role from state-employed public servants toward a more entrepreneurial form of medical professionalism. Although studies of Georgia's healthcare system have examined policy reforms, financing mechanisms, and sectoral performance (Gorgodze et al., 2025; Bauhoff, Hotchkiss, & Smith, 2011; Natsvlishvili, Kapanadze, & Japaridze, 2022), less attention has been paid to how these reforms reshaped physicians' professional identity and ethical framework. Based on eighteen in-depth interviews with physicians from different specialties, institutional settings, and professional experience groups, the article examines how doctors interpret commercialization and how it affects autonomy, ethical reasoning, and everyday clinical decision-making.

Literature Review and Theoretical Framework

This study interprets Georgia's healthcare transformation through sociological perspectives on neoliberal governance and professional work. Neoliberalism is understood here not only as a set of economic policies, but also as a framework for organizing institutions and social relations according to competition, market coordination, and individual responsibility (Eagleton-Pierce, 2016). Brown (2015) similarly argues that neoliberal rationality extends market principles into domains previously governed by social or democratic values, encouraging institutions and individuals to interpret activity through efficiency, competitiveness, and market value.

Healthcare has been a central arena of these changes. Privatization, private provision, and competitive financing arrangements have often been justified by appeals to efficiency and responsiveness, yet they also place clinical work in organizational contexts shaped by financial incentives, provider competition, and managerial oversight (Saltman & Figueras, 1997; Light, 2000; Relman, 2007). These shifts matter because medicine has historically been understood as a profession grounded in specialized knowledge, autonomy, and a normative commitment to patient welfare. Parsons (1951) argued that medical authority rests on trust in physicians' discretionary judgment, while Freidson (2001) described medicine as governed by the "logic of professionalism," where decisions are expected to be guided by expertise rather than market or bureaucratic control.

Market-oriented governance may therefore reshape professional autonomy without eliminating it. Physicians increasingly work in environments where professional expertise coexists with financial incentives and institutional performance expectations (Light, 2000; Feiler, Hordern, & Papanikitas, 2018). Power's (1997) concept of the "audit society" is useful for understanding how professional activities become subject to measurement, verification, and performance monitoring. In healthcare, these mechanisms include reimbursement systems, financial indicators, and managerial evaluation.

Neoliberal reforms also affect how professionals understand themselves. Foucault's concept of neoliberal governmentality describes individuals as "entrepreneurs of the self," responsible for investing in their own capacities in competitive environments (Foucault, 2008). Becker's (1964) theory of human capital similarly treats education and skills as investments that increase productivity and earning potential. In Georgia's post-socialist context, these perspectives help explain how extensive privatization and market-oriented reform reshaped not only healthcare institutions but also physicians' professional self-understanding, career strategies, and working conditions (Bauhoff, Hotchkiss, & Smith, 2011; Natsvlishvili, Kapanadze, & Japaridze, 2022).

Methodology

Research Design

This study uses a qualitative research design to examine how physicians interpret healthcare commercialization and how these institutional changes influence professional identity, career strategy, autonomy, and everyday clinical practice. Qualitative interviews were appropriate because the study focuses on physicians' own interpretations of institutional change and the meanings they attach to ethical and organizational pressures in commercialized healthcare settings.

Participants and Sampling

The empirical material consists of eighteen semi-structured interviews conducted with physicians practicing in Georgia in 2025. Participants were selected through purposive sampling to capture diversity

across institutional setting, specialty, professional role, age, and professional experience. Thirteen respondents worked in private clinics and five in state clinics. Fourteen were primarily practicing clinicians, while four held clinical director or managerial roles, enabling the study to include perspectives from both clinical practice and organizational management.

In terms of specialty and position, the sample included four surgeons, three traumatologists, three ophthalmologists/oculists, two cardiologists, one therapist, one neurologist, and four clinical directors. This distribution made it possible to examine how commercialization is perceived across fields differently exposed to surgical intervention, patient volume, reimbursement mechanisms, and market competition. Respondents ranged from 30 to 85 years old: five were between 30 and 39, seven between 40 and 59, and six were aged 60 or older. These age groups are not used for statistical generalization or as a simple generational division. Rather, they indicate different contexts of professional socialization and institutional experience. Some respondents began their careers during the late Soviet or early post-Soviet period, while others entered the profession after the consolidation of market-oriented reforms. This variation is important because the article interprets differences in respondents' accounts as shaped by institutional experience and working environment rather than by age alone.

Data Collection and Analysis

Interviews were conducted between January and March 2025 and lasted between 45 and 90 minutes. They focused on career trajectories, workplace environments, specialization choices, competition, financial incentives, managerial oversight, professional autonomy, and ethical decision-making. Interviews were recorded, transcribed, and anonymized. Respondents are identified only by role or specialty, institution type, and age.

The material was analyzed using thematic analysis following Braun and Clarke's approach. Transcripts were read repeatedly, coded for themes related to commercialization and professional change, and then grouped into broader analytical categories. The findings section presents the main patterns identified across the interviews: public provision and market differentiation, self-investment, professional visibility, financial incentives in clinical decision contexts, and managerial control.

Ethical Considerations and Limitations

Participation was voluntary, and all respondents were informed about the aims of the study and consented to the use of anonymized quotations. Because the study is based on a small qualitative sample, the findings are not statistically representative of the entire medical workforce. The aim is instead to develop an interpretive understanding of how physicians in different institutional settings experience commercialization. The consistency of themes across interviews nevertheless suggests that the patterns identified reflect important dynamics in Georgia's commercialized healthcare sector.

Findings

This section presents the thematic analysis of eighteen interviews with physicians and clinical managers in private and state medical institutions in Georgia. Respondents described a shift from medicine associated with public service and collective responsibility toward a more market-oriented and competitive professional environment.

The findings are organized around five themes: public provision and market differentiation, self-investment, professional visibility, financial incentives in clinical decision contexts, and managerial control over the conditions of medical work.

Healthcare Between Public Provision and Market Differentiation

The interviews reveal an important transformation in how physicians interpret the institutional foundations of the healthcare system. While many respondents continue to describe healthcare as a universal social good, their narratives simultaneously reflect the growing normalization of differentiated services within medical provision. In practice, the principle of equal access to healthcare is increasingly reconciled with the acceptance of different levels of service depending on patients' financial resources.

Several respondents emphasized that essential healthcare should remain universally accessible, while also acknowledging the legitimacy of additional services offering greater comfort or convenience.

> "Essential healthcare must be accessible to everyone. […] But if someone wants comfort, why not. Conditions cannot be the same for everyone."
>
> *(Ophthalmologist, 85 years old)*

A similar perspective appeared in the following account, where the respondent rejected the idea that healthcare itself should become purely commercial but nevertheless accepted the existence of enhanced services for those willing to pay.

> "Healthcare should not be commercial… but at the same time, if someone prefers luxury, they should have the possibility to pay for it."
>
> *(Therapist, 47 years old)*

These narratives illustrate how physicians reconcile two potentially contradictory principles: the commitment to universal access and the acceptance of differentiated service provision. While respondents consistently emphasized that basic medical care should remain available to all citizens, the presence of private services providing faster access, additional privacy, or improved comfort was often viewed as a legitimate feature of contemporary healthcare organizations.

This logic becomes particularly visible in private medical institutions, where service provision increasingly resembles customer-oriented models found in other sectors. As one clinical director explained:

> "This is a regular private outpatient clinic. State insurance has nothing to do with it. We have reception staff, we provide services, we have personal assistants who help patients with appointments and other issues. […] If someone does not want to stand in line, if someone wants more privacy… if they have the money, what is the problem? I do not see inequality here."
>
> *(Clinical director, private clinic, 59 years old)*

Such accounts suggest that the commercialization of the healthcare system is not necessarily interpreted by physicians as a complete abandonment of universal healthcare principles. Rather, many respondents describe the contemporary system as a hybrid arrangement in which publicly financed healthcare coexists with differentiated services organized through private institutions.

Differences in interpretation should not be understood simply as age-based. They reflect different contexts of professional socialization and current institutional practice: physicians with experience of earlier state-

centered arrangements more often described commercialization as a departure from public responsibility, while those embedded in private-sector settings more often treated differentiated services as normal.

Taken together, these observations indicate that commercialization has reshaped not only the institutional organization of healthcare but also physicians' interpretations of fairness, access, and the role of private services within the medical system.

The Entrepreneurial Physician: Investing in Human Capital

The interviews suggest that the commercialization of the healthcare system has also reshaped how physicians understand their professional development and career trajectories. In contrast to the Soviet healthcare system, where the number of medical specialists and career progression were largely regulated through centralized planning, respondents described the contemporary medical labor market as strongly influenced by market dynamics. Under these conditions, specialization choices, career strategies, and professional development increasingly reflect considerations related to income opportunities, working conditions, and professional reputation.

Several respondents noted that medical specialization is now frequently evaluated in terms of its economic potential rather than solely according to professional interest or the needs of the healthcare system. As one clinical manager explained, young physicians often select specialties associated with higher earnings and more favorable work schedules, while less profitable fields struggle to attract new doctors.

> "Together with the clinic we established a university and we offer residency programs in twenty specialties. Everyone wants the same fields - you can guess which ones - radiology, angiology, cardiac surgery, where the money is. When incomes became higher, nobody wanted internal medicine anymore. We do not have therapists or family doctors… our residents say openly: I want a specialty with a high salary. They know they will not have night shifts, they will perform procedures, they will have weekends free, and maybe even spend holidays in Mallorca."
>
> *(Clinical manager, private clinic, 58 years old)*

This account illustrates how market considerations increasingly shape physicians' career decisions. Rather than being guided primarily by institutional planning or collective healthcare needs, specialization choices are often aligned with expectations of financial return and lifestyle advantages.

The interviews also indicate that physicians frequently invest their own resources in professional training and specialization in order to strengthen their position within a competitive medical labor market. Professional development is often described as a continuous process of self-investment aimed at improving professional opportunities and long-term career prospects.

> "Competition between doctors must exist. Doctors invest the money they earn in their own development. Those who do not do this remain on a salary of 2000 GEL. Those who invest in themselves are constantly studying and improving. Modern medicine has increased competition. Yes, a doctor is a businessman. Doctors are businessmen everywhere - in America, in Norway, everywhere. We all work to earn a living."
>
> *(Clinical director, private clinic, 59 years old)*

In this perspective, education, specialization, and skill acquisition are increasingly understood as forms of professional capital that must be continuously developed. Medical careers are therefore described less as

stable professional trajectories within a publicly organized system and more as ongoing processes of individual investment and professional positioning within a competitive environment.

At the same time, one respondent with experience of earlier professional norms expressed reservations about the increasing individualization of professional development and the growing role of competition within the profession.

> "When I tell younger doctors to train someone who is interested in surgery, they answer: I will teach my own child, not a competitor. In the past, if doctors learned something new, they shared it with colleagues. Now they think: this knowledge is my interest; I will benefit from it… I have even heard that some doctors ask for serious money just to teach someone."
>
> *(Ophthalmologist, private clinic, 80 years old)*

For this respondent, the increasing emphasis on individual career advancement appears to contrast with an earlier professional culture characterized by stronger norms of collegial cooperation and knowledge sharing. The concern is not simply that physicians now pursue professional development, but that knowledge itself may become treated as an individually owned competitive resource.

Taken together, these accounts suggest that the commercialization of the healthcare system has contributed to the emergence of a more entrepreneurial understanding of medical professionalism. Physicians increasingly approach their careers as strategic investments in human capital, seeking to strengthen their professional position through specialization, continuous training, and the development of professional reputation within a competitive healthcare sector.

Competition and Professional Visibility

The commercialization of the healthcare system has also reshaped the competitive environment in which physicians operate. As the previous section showed, competition is often linked to physicians' self-investment in training, specialization, and professional development. In this subsection, however, the analytical focus shifts from self-investment to another dimension of competition: the growing importance of professional visibility, reputation, and patient attraction within a commercialized healthcare market.

In a healthcare system dominated by private institutions, clinical expertise alone may no longer be sufficient to secure professional success. Physicians increasingly have to become visible to patients, maintain public recognition, and present themselves as attractive professional figures within a competitive medical marketplace. This logic is clearly expressed by one clinical director, who describes advertising not as something external to medical work, but as a normal strategy for increasing recognition and patient flow.

> "I do not consider doctors' advertising on the internet to be self-advertising. It serves to increase recognition, popularity, and patient flow. As for banners, yes, young doctors mainly use them. I do not need this, but if I needed it, I would probably use it. In the end, I work in order to earn a living. If healthcare is commercialized, a doctor should be well dressed, well groomed, always neat, and happy, so that patients look at them adequately."
>
> *(Clinical director, private clinic, 58 years old)*

This account shows that professional visibility is linked not only to reputation, but also to popularity, patient attraction, and management of the doctor's public image. Commercialization thus expands the meaning of professional competence: doctors are expected not only to know and treat, but also to appear credible and accessible.

The unequal consequences of this visibility requirement are emphasized by another respondent, who argues that commercialization does not benefit all physicians equally. In his account, doctors who are able to advertise and promote themselves may consolidate stronger financial and professional positions, while equally competent but less visible doctors may be disadvantaged.

> "Commercialization has harmed doctors more than patients. Some doctors have advanced, but many others have not. Those who succeeded were the ones who promoted themselves well. A surgeon may be very good, but another surgeon of the same level who did not advertise may remain less visible."
>
> *(General surgeon, state clinic, 35 years old)*

This account highlights the structural inequality created by visibility-based competition. Professional success becomes partly dependent on the ability to advertise, attract attention, and convert visibility into patient flow and financial stability. As a result, commercialization may reward not only clinical competence but also the capacity for self-promotion.

However, attitudes toward these developments vary among physicians. While some respondents accepted self-promotion as a normal part of contemporary medical practice, others expressed discomfort with the increasing importance of advertising within the profession. This discomfort was especially visible among physicians whose professional understanding was shaped by earlier norms of medical authority and collegial recognition.

> "In the Soviet period advertising was considered shameful. A good doctor did not need advertising. When I saw some of my former students on advertising banners, I felt embarrassed."
>
> *(Ophthalmologist, private clinic, 80 years old)*

These contrasting views suggest that commercialization has introduced new expectations regarding professional competition and visibility. Whereas earlier professional cultures placed greater emphasis on reputation built through clinical expertise, collegial recognition, and long-term trust, contemporary physicians increasingly operate in an environment where professional success is also linked to public visibility, self-presentation, and patient attraction.

Taken together, these accounts show that competition operates on more than one level. It encourages physicians to invest in their professional development, but it also pressures them to become visible and recognizable in a crowded medical marketplace. In this sense, commercialization reshapes not only how physicians develop their skills, but also how professional value and recognition are produced within the healthcare system.

Financial Incentives and Clinical Decision Contexts

The interviews also indicate that the commercialization of the healthcare system has introduced financial considerations more directly into the organizational environment in which clinical decisions are made. Physicians described how payment arrangements, institutional expectations, and reimbursement structures increasingly shape the context of everyday medical work. In private healthcare institutions, remuneration is often linked to the number or type of medical procedures performed, creating conditions in which professional activity becomes closely connected to organizational revenue generation.

One respondent illustrated how such payment structures influence the practical circumstances under which clinical decisions occur:

> "Because of the large number of clinics, the harmful side of commercialization is that every morning I go out like a hunter and think about where to hunt. Today I refused to perform an operation worth 8000 GEL and discharged the patient instead. My salary would have been 1500 GEL from that case. I work per case. I did this because I saw that the patient was improving and the operation was not necessary. But this is not right, is it? If I were thinking only about my family, I should have performed the operation. The correct system would be one where I simply receive a salary and do my work without feeling like a hunter."
>
> *(Microsurgeon, private clinic, 56 years old)*

This account illustrates how payment systems can influence the environment in which physicians act. When income is linked to procedures, doctors become aware of the economic consequences of clinical decisions, even when they ultimately prioritize medical judgment. The case shows that commercialization creates a decision context in which judgment is exercised under economic pressure.

Other respondents described similar situations in which the structure of healthcare financing creates incentives for medical interventions. In particular, the combination of private healthcare provision and publicly financed programs may generate institutional pressures to perform procedures that are financially advantageous for clinics, even when their clinical necessity is questionable.

> "Young doctors opened clinics. In ophthalmology almost everything is financed. A patient comes and says they were told they need cataract surgery. I look through the microscope and see that it is at a very early stage. In reality, it is not surgical. They send the patient for funding, the funding is approved, and they implant an artificial lens. But it did not need to be done. Glasses could have been prescribed, but they perform the operation anyway. Whether it is needed or not, they do it. My conscience and ethics do not allow me to operate when the disease is at an initial stage."
>
> *(Ophthalmologist, private clinic, 59 years old)*

This account shows not only how financing arrangements may create incentives for unnecessary medical interventions, but also how physicians may resist such incentives on professional and ethical grounds. The respondent explicitly contrasts the clinic's financial interest with the requirements of clinical judgment, professional conscience, and medical necessity. The example is therefore important because it demonstrates that commercialization does not simply eliminate professional ethics; rather, it places physicians in situations where professional standards must be actively defended against organizational and financial pressures.

These narratives show that financial incentives do not mechanically determine physicians' behavior. Rather, they form part of the institutional context within which doctors must balance professional standards, organizational expectations, patient needs, and the economic consequences of clinical decisions. The ethical tension emerges precisely because clinical decisions are made in settings where professional responsibility and revenue-generating opportunities may point in different directions.

Taken together, these accounts suggest that commercialization does not only influence healthcare institutions or professional careers. It also reshapes the economic and organizational conditions surrounding clinical decision-making, introducing financial considerations into everyday medical practice while simultaneously making professional ethics and clinical judgment more difficult, but also more visible, as practical commitments.

Managerial Control and Professional Autonomy

While the previous subsection focused on financial incentives in clinical decision-making, this subsection turns to broader organizational mechanisms: managerial systems through which healthcare institutions monitor performance, control costs, and shape the practical boundaries of professional autonomy. Respondents described reimbursement mechanisms, financial monitoring, institutional planning, and revenue-oriented evaluation as increasingly important conditions of medical work.

One institutional change discussed by several respondents is the introduction of diagnosis-related group (DRG) payment systems. Although such mechanisms are intended to regulate healthcare expenditures and improve efficiency, physicians sometimes perceive them as limiting their professional autonomy. In particular, respondents noted that standardized tariffs and cost restrictions may influence decisions regarding treatment methods, medical materials, and the practical range of options available to doctors.

> "I want to have freedom of choice as a doctor. If the cheaper option is chosen, the doctor may receive a higher percentage of payment because expensive implants leave less profit for the clinic. In this case, both the clinic and the doctor may become interested in choosing the cheaper option."
>
> *(Traumatologist, private clinic, 38 years old)*

This account shows how reimbursement systems and cost-control mechanisms may enter the practical space of clinical judgment. The respondent does not describe professional autonomy as formally abolished; rather, he points to a situation in which the doctor's freedom of choice is narrowed by financial calculations built into the institutional setting. When treatment options are associated with different financial outcomes for both the clinic and the physician, economic considerations may become intertwined with professional judgment.

Respondents also described the influence of broader financial expectations within private healthcare organizations. In some institutions, physicians reported that clinic management evaluates medical work not only through clinical outcomes, but also through revenue indicators, patient volume, and the intensity with which offices or departments are used. One ophthalmologist described this logic directly:

> "This is a private hospital. We calculate how much revenue should be generated per square meter. If this office is not busy enough, they will tell me: take care."
>
> *(Ophthalmologist, private clinic, 85 years old)*

This quote illustrates how professional activity may become subject to spatial and financial productivity criteria. The physician's office is not treated only as a site of clinical care, but also as an organizational resource that must generate sufficient revenue. In this context, the doctor's professional position becomes linked to the clinic's expectations regarding patient flow, workload, and the financial productivity of medical space.

A similar form of managerial control appears in the discussion of departmental financial targets. One neurologist explained how financial planning was incorporated into the everyday routine of clinical departments:

> "Every morning the conference started with financial plans. For example, the neurology department had a plan of thirty thousand GEL per month. Then they calculated the percentage of how much had already been achieved."

(Neurologist, private clinic, 30 years old)

This account shows that financial targets may become integrated into the ordinary organizational routines of medical work. The morning conference, which might otherwise be expected to focus primarily on clinical issues, is described as beginning with financial planning and the monitoring of progress toward monthly revenue targets. In this way, managerial oversight does not operate only through direct commands, but also through the normalization of financial indicators as part of everyday professional communication.

Taken together, these narratives indicate that financial monitoring and institutional planning have become integrated into healthcare governance. While physicians formally retain clinical authority, their work increasingly takes place within frameworks shaped by financial accountability, performance expectations, and revenue-oriented evaluation.

Commercialization therefore affects professional autonomy not only through market competition or payment incentives, but also through internal governance structures that organize, measure, and assess medical work.

Discussion

The findings show that healthcare commercialization in Georgia has reshaped medical professionalism not by replacing professional norms with market logic, but by reorganizing the institutional conditions under which judgment, career development, and ethical responsibility are exercised. Physicians continued to invoke patient welfare and clinical judgment, yet described working in environments shaped by competition, financial incentives, patient flows, and managerial oversight. This points to a hybrid form of medical professionalism in which professional values remain active but must be negotiated within commercialized organizations.

The Georgian case is important because commercialization developed through a specific configuration: public financing expanded through the Universal Healthcare Program, while provision remained concentrated in private institutions. Public financing therefore did not restore a state-centered model. Instead, it channeled public funds through a privatized provider landscape in which the state remained primarily a purchaser of services, while private clinics organized the everyday conditions of medical work. This helps explain why physicians experience reform not only as a policy change, but as a practical transformation of professional activity.

The study contributes to debates on neoliberalism and professional change by showing how market-oriented reform operates at the level of professional self-understanding. Specialization, training, mobility, reputation, and visibility are increasingly described in relation to income, competitiveness, and market value. The entrepreneurial physician emerges not simply because doctors adopt business-oriented values, but because the institutional environment rewards self-investment, visibility, and strategic positioning. Medical expertise therefore remains central, but it is increasingly treated as professional capital that must be cultivated and made visible.

The findings also show that autonomy is constrained in ways that go beyond direct bureaucratic control. Per-case remuneration, clinic-level financial interests, DRG-related cost constraints, revenue targets, and managerial monitoring do not mechanically determine physicians' behavior, but they introduce economic considerations into clinical judgment. At the same time, the interviews do not support a simple narrative of professional decline. Respondents described resisting unnecessary but profitable interventions and

expressed discomfort with advertising and revenue planning. Commercialization therefore appears less as the disappearance of professionalism than as its reconfiguration under more difficult institutional conditions.

Finally, differences in interpretation should be understood less as a strict generational divide than as differences shaped by professional socialization and current institutional location. Physicians with experience of earlier state-centered arrangements more often described commercialization as a departure from public service and collegial responsibility. Respondents embedded in commercialized private-sector settings more often treated competition, visibility, and market-oriented practice as normal features of contemporary medicine. The main contribution of the study is to show that, in a system where public funds flow through private providers, physicians remain responsible for patient welfare while working in organizations structured by competition, revenue generation, and performance monitoring.

Conclusion

This article examined how healthcare commercialization in Georgia influences physicians' professional identities, career strategies, autonomy, and everyday clinical practices. Drawing on qualitative interviews, it showed that privatization, market competition, financial incentives, and managerial governance reshape several dimensions of medical professionalism.

Physicians increasingly work in environments characterized by competition for patients, self-investment, visibility, reputation building, and financial monitoring. These conditions influence specialization choices, career trajectories, professional recognition, and clinical decision-making. Mechanisms such as per-case remuneration, reimbursement rules, financial targets, and managerial oversight redefine the practical boundaries of professional autonomy.

The findings suggest that commercialization does not simply replace professional norms with market logic. Rather, physicians operate in hybrid institutional environments where commitments to patient care coexist with economic incentives, organizational constraints, and market-oriented expectations. These transformations are interpreted differently by physicians shaped by different institutional experiences and working environments, rather than by age alone.

The Georgian case demonstrates that extensive healthcare commercialization reshapes not only ownership, financing, and service delivery, but also the institutional conditions and social meaning of medical professionalism. Professional ethics and autonomy remain important, but they are practiced within organizations increasingly structured by competition, revenue generation, and managerial control. This is the article's central contribution to the literature on neoliberal reform and professional change.

ბექა ნაცვლიშვილი
დოქტორანტი
ივანე ჯავახიშვილის სახელობის თბილისის სახელმწიფო უნივერსიტეტი

საჯარო მოხელიდან მეწარმე სუბიექტამდე: ნეოლიბერალური რეფორმა და სამედიცინო პროფესიონალიზმის ტრანსფორმაცია საქართველოში

აბსტრაქტი

წინამდებარე სტატია შეისწავლის, თუ როგორ გარდაიქმნა ნეოლიბერალური ჯანდაცვის რეფორმების შედეგად, ექიმების ინსტიტუციური მდგომარეობის, პროფესიული თვითაღქმისა და ყოველდღიური სამუშაო გარემოს ცვლილების საფუძველზე, სამედიცინო პროფესიონალიზმი საქართველოში. კვლევა აანალიზებს საქართველოს ჯანდაცვის სისტემის პოსტსაბჭოთა ტრანსფორმაციას, რომლის ფარგლებშიც მოხდა საბჭოთა ცენტრალიზებული სისტემის, სადაც როგორც ჯანდაცვის შემსყიდველი, ისე მიმწოდებელი სახელმწიფო იყო, ბაზარზე ორიენტირებული მოდელით ჩანაცვლება. ეს პროცესი ხასიათდება ჯანდაცვის დაწესებულებების ფართომასშტაბიანი პრივატიზაციითა და მოგებაზე ორიენტრებული დაწესებულებების კონცენტრაციით. 2013 წლის საყოველთაო ჯანდაცვის რეფორმის შედეგად დაიწყო მოსახლეობის დიდი ნაწილის მკურნალობის ხარჯების ბიუჯეტიდან დაფინანსება. ჩამოყალიბდა ჰიბრიდული მოდელი, სადაც სახელმწიფო ბიუჯეტი, კერძო, მოგებაზე ორიენტირებული კლინიკების პირისპირ აღმოჩნდა. ამ გარემოებამ გაზარდა ექიმების წინაშე არსებული არასაჭირო სამედიცინო მანიპულაციის მორალური რისკი. სტატია ეფუძნება საქართველოში კერძო და სახელმწიფო სამედიცინო დაწესებულებებში მომუშავე ექიმებთან და კლინიკურ მენეჯერებთან ჩატარებულ თვრამეტ ნახევრადსტრუქტურირებულ ინტერვიუს და აანალიზებს, თუ როგორ განმარტავენ ექიმები ჯანდაცვის კომერციალიზაციას და როგორ აისახება ეს ინსტიტუციური ცვლილებები პროფესიულ იდენტობაზე, კარიერულ სტრატეგიებზე, კლინიკურ გადაწყვეტილებებზე და პროფესიულ ავტონომიაზე. კვლევის მიგნებები აჩვენებს, რომ კომერციალიზაციამ ხელი შეუწყო ექიმის, როგორც საჯარო სიკეთის მიმწოდებელი პროფესიონალის, მეწარმე სუბიექტისთვის დამახასიათებელ თვისებებთან ადაპტაციას. ექიმები სპეციალიზაციის არჩევას, პროფესიულ განვითარებას, შრომით მობილობას, საჯარო პროფესიულ სივრცეში საკუთარი თავის პოზიციონირებას სულ უფრო ხშირად აღწერენ შემოსავალთან, კონკურენტუნარიანობასთან, პაციენტთა ნაკადთან და საბაზრო ღირებულებებთან დაკავშირებული ტერმინებით. სამედიცინო ცოდნა კვლავ ცენტრალურ მნიშვნელობას ინარჩუნებს, თუმცა იგი სულ უფრო მეტად განიმარტება როგორც პროფესიული კაპიტალი, რომელიც მუდმივ განვითარებას და ბაზარზე სტრატეგიულად განთავსებას საჭიროებს. სტატია ასევე აჩვენებს, რომ კომერციალიზაცია კლინიკურ პრაქტიკაზე მოქმედებს ფინანსური სტიმულებისა და მენეჯერული კონტროლის ფორმებით. შემთხვევაზე მიბმული ანაზღაურება, კლინიკის შემოსავლებთან დაკავშირებული მოლოდინები, DRG-თან დაკავშირებული ფინანსური შეზღუდვები და შიდა ფინანსური მონიტორინგი ეკონომიკურ გათვლებს კლინიკური განსჯის გარემოში შეაქვს. ეს მექანიზმები ექიმების ქცევას მექანიკურად არ განსაზღვრავს, თუმცა ავიწროებს იმ პრაქტიკულ სივრცეს, სადაც პროფესიული ავტონომია ხორციელდება. ამავდროულად, ინტერვიუები არ ადასტურებს პროფესიული ეთოსის გაქრობას ან ეთიკურ დაღმასვლას. ექიმების ნაწილი კვლავ ხაზს უსვამს პაციენტის ინტერესს, პროფესიულ პასუხისმგებლობასა და კლინიკურ კეთილსინდისიერებას, ხოლო ზოგიერთ შემთხვევაში აღწერს ფინანსურად მომგებიან, მაგრამ კლინიკურად არასაჭირო ჩარევებზე უარის თქმის პრაქტიკასაც. შესაბამისად, სტატია ამტკიცებს, რომ კომერციალიზაცია სამედიცინო პროფესიონალიზმს კი არ აუქმებს, არამედ მის რეკონფიგურაციას ახდენს: ექიმები მოქმედებენ

ჰიბრიდულ ინსტიტუციურ გარემოში, სადაც პროფესიული ვალდებულებები თანაარსებობს ეკონომიკურ სტიმულებთან, ორგანიზაციულ შეზღუდვებთან და ბაზარზე ორიენტირებულ მოლოდინებთან. ინტერვიუებში იკვეთება განსხვავებული დამოკიდებულებები სხვადასხვა პროფესიული გამოცდილების მქონე ექიმებს შორის. ეს განსხვავებები მხოლოდ ასაკით არ აიხსნება; ისინი უფრო მეტად უკავშირდება ექიმების ინსტიტუციურ გამოცდილებასა და პროფესიულ სოციალიზაციას, მათ შორის ადრინდელ სახელმწიფოზე ორიენტირებულ ჯანდაცვის მოდელსა და თანამედროვე მოგებაზე ორიენტირებულ სისტემაში მუშაობის გამოცდილებას. საქართველოს შემთხვევის შესწავლა ხელს უწყობს ნეოლიბერალიზმის, პროფესიული ცვლილებისა და პოსტსოციალისტური ჯანდაცვის რეფორმის შესახებ სოციოლოგიურ დისკუსიას, რადგან აჩვენებს, რომ ჯანდაცვის კომერციალიზაცია ცვლის არა მხოლოდ საკუთრებას, დაფინანსებასა და მომსახურების მიწოდებას, არამედ სამედიცინო პრაქტიკის სოციალურ მნიშვნელობას და იმ პირობებს, რომლებშიც პროფესიული ეთიკა და ავტონომია ხორციელდება.

საკვანძო სიტყვები: ჯანდაცვის კომერციალიზაცია; სამედიცინო პროფესიონალიზმი; პროფესიული ავტონომია; ნეოლიბერალიზმი; საქართველო

AI Disclosure

ChatGPT was used only for editorial and language-related assistance during the preparation of the manuscript, including language polishing, structural refinement, and technical formatting review. The research design, empirical analysis, interpretation of findings, and final scholarly conclusions are the author's responsibility.

References

Aladashvili, G., Kirvalidze, M., Tskitishvili, A., Chelidze, N., Tvildiani, N., Pkhakadze, G., Bossert, T. J., Lunze, K., & Nadareishvili, I. (2025). Strengthening health workforce in Georgia: Identifying gaps and integrating evidence-based strategic planning. The International Journal of Health Planning and Management, 40(4), 993–1001. https://doi.org/10.1002/hpm.3922

Arrow, K. J. (1963). Uncertainty and the welfare economics of medical care. The American Economic Review, 53(5), 941–973.

Bauhoff, S., Hotchkiss, D. R., & Smith, O. (2011). The impact of medical insurance for the poor in Georgia: A regression discontinuity approach. Health Economics, 20(11), 1362–1378. https://doi.org/10.1002/hec.1665

Becker, G. S. (1964). Human capital: A theoretical and empirical analysis, with special reference to education. University of Chicago Press.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Brown, W. (2015). Undoing the demos: Neoliberalism's stealth revolution. Zone Books.

Eagleton-Pierce, M. (2016). Neoliberalism: The key concepts. Routledge.

Feiler, T., Hordern, J., & Papanikitas, A. (Eds.). (2018). Marketisation, ethics and healthcare: Policy, practice and moral formation (1st ed.). Routledge. https://doi.org/10.4324/9781315186351

Field, M. G. (1967). Doctor and patient in Soviet Russia. Harvard University Press.

Foucault, M. (2008). The birth of biopolitics: Lectures at the Collège de France, 1978–1979 (M. Senellart, Ed.; G. Burchell, Trans.). Palgrave Macmillan.

Freidson, E. (2001). Professionalism: The third logic. University of Chicago Press.

Gorgodze, T., Zoidze, A., Catalan, J. M., & Gotsadze, G. (2025). Financial protection and universal health coverage in Georgia: An analysis of impoverishing healthcare costs using household income and expenditure surveys. BMJ Global Health, 10(7), e019150. https://doi.org/10.1136/bmjgh-2025-019150

Harvey, D. (2005). A brief history of neoliberalism. Oxford University Press.

Light, D. W. (2000). The medical profession and organizational change: From professional dominance to countervailing power. In C. E. Bird, P. Conrad, & A. M. Fremont (Eds.), Handbook of medical sociology (5th ed., pp. 201–216). Prentice Hall.

Natsvlishvili, B., Kapanadze, N., & Japaridze, S. (2022). Social consequences of privatization of healthcare. Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files/bueros/georgien/19905.pdf

Parsons, T. (1951). The social system. Free Press.

Power, M. (1997). The audit society: Rituals of verification. Oxford University Press.

Relman, A. S. (2007). Medical professionalism in a commercialized health care market. JAMA, 298(22), 2668–2670. https://doi.org/10.1001/jama.298.22.2668

Richardson, E., & Berdzuli, N. (2017). Georgia: Health system review. Health Systems in Transition, 19(4), 1–90. https://eurohealthobservatory.who.int/publications/i/georgia-health-system-review-2017

Richardson, E., Tvaliashvili, M., Gviniadze, K., & Roubal, T. (2025). Health Systems in Action (HSiA) Insights: Georgia, 2024. European Observatory on Health Systems and Policies, WHO Regional Office for Europe. https://eurohealthobservatory.who.int/publications/i/health-systems-in-action-georgia-2024

Saltman, R. B., & Figueras, J. (1997). European health care reform: Analysis of current strategies. WHO Regional Office for Europe.