Comments/suggestions on a draft primary care reform strategy for Georgia

Strengthening primary care services is a high level priority for the Government of Georgia. A draft strategy has been elaborated to guide the PHC development in 2016-2023. The paper provides some reflections on the draft strategy. Also the strategy has many strengths the reader focused on weakness and interventions which does not seem feasible or politically and socially acceptable in the Georgian context.

1.1 Situation analysis

The strategy is based on in-depth situation analysis of current status of primary care services. It identifies key challenges to be addressed during the strategy cycle. (See figure 1 for a summary findings).

Figure 1. Challenges in PHC system in Georgia

Governance

- MoLHSA role in PHC governance should be strengthened
- The deficit of qualified PHC managers

Financing

- Underfunding of PHC services due to imperfect mechanism of cost calculation and sifting of resources towards hospital services
- Price of services does not include the needs related to equipment and physical infrastructure
- Duplication/parallel system in PHC provision (UHC and Rural doctors programs)
- Payment/remuneration mechanisms are not equitable and adjusted to the health risks, age groups, geography.
- No performance driven motivation
- No active purchaser role for Social Service Agency
- No competitive environment between primary care providers for health zones/patients list

Service delivery

- Weak institutional capacity to provide quality services
- Low utilization rate
- Severely limited gatekeeping capacity and does not serve as an entry point into the health system
- Limited role in prevention and control of NCDs, limited role in health education and promotion
- Lack of inter disciplinary team work in PHC service delivery
- Lack of multidisciplinary team work
- Lack of quality improvement mechanisms : guidelines are available but not implemented
- PHC physical infrastructure is in a poor shape
- Lack of workplace SOPs

Human resources

- Health education system makes little emphasis on prevention and rehabilitation, as well as on primary care diagnosis and treatment
- Insufficient integration of specialty services into FM scope of work
- Human resources are not generated in line with the health care needs
- Irregular numerical, geographic and professional distribution and mismatch between the existing and requested numbers
- Very low number of nurses
- Insufficient motivation system

Situation analysis omits organization of PHC services and does not describe existing models of care in urban and rural areas. No comparison is made to international experience on that regard. The key challenge here is a lack of institutional separation of primary from secondary care services. Primary care services are not legally separated from hospitals and specialized outpatient care providers. Many primary care and hospital services operate under one administrative umbrella (mainly in urban areas). In this circumstances no mechanism exists to exercise PHC gate keeping role as medical establishments are interested in the high utilization of profit generating and costly hospital services. The current set up of the Georgian health care system hardly allows for addressing this issue adequately. However, it still should be mentioned for assessing potential risks in allocation of already scarce public resources.

1.2 The strategy outline

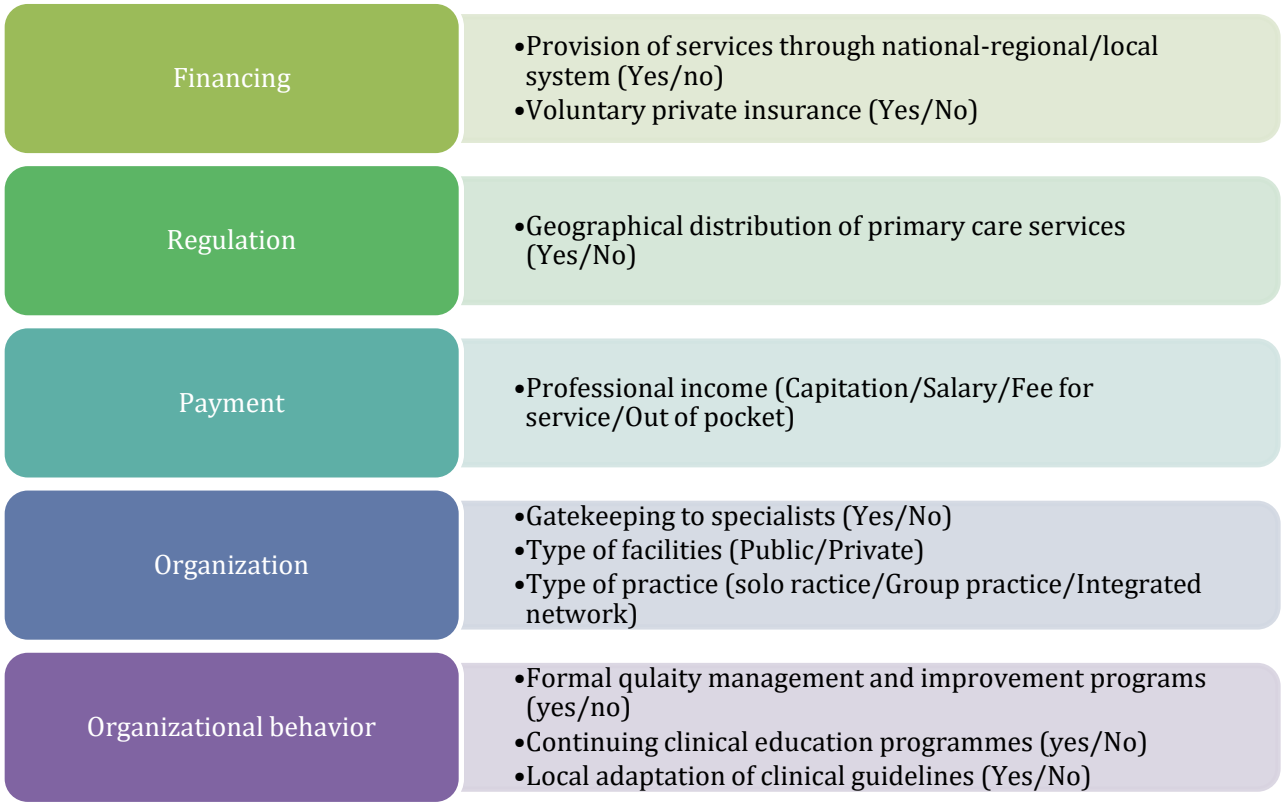
The strategy is organized around 5 strategic objectives. Those are in line with identified challenges. Proposed interventions are of proven effectiveness and if implemented, will lead to substantial improvement in PHC delivery and subsequently health outcomes. (See table 1 for easy reference).

Although the strategy is based on a solid technical information and offers reasonable solutions to identified challenges, There are some issues which in my opinion should be revisited:

1. If the government intends to formalize the PHC development “strategy” (I would suggest to name it as a roadmap), then the sensitive language should be adjusted for some statements. The document requires additional technical input to convert it into the Governmental position statement on primary care development. Although many specific characteristics of PHC system can be elaborated later on in various decrees and normative documents, it is critical to define the general framework right now. The common framework for classification of primary care models is presented below on figure 2. We may try to answer the following questions (figure 2) and somehow form a general shape of the model. Beside this the most important thing is the role of FM providers in PHC service delivery. Do we intend to promote the family medicine based primary care system versus no based on specialized services? If so, then this should be clearly articulated in the strategy/ policy statement/roadmap.

2. Strong emphasis on allocating 70% of the state funding to hospitals and 30% to primary care does not seem well justified in this context when many parameters of the PHC service delivery model are unclear. Bottom-up costing is required to define the required resource envelope and plan for a gradual increase of allocations in line with the capacity strengthening and broadening of the scope of services.

Figure 2. Common Framework for classification of primary care models



3. The strategy proposes to elaborate **a primary care policy**. This sounds somewhat odd as usually national strategies serve as policy frameworks in the areas of interest. I may misunderstand what is meant here by "PHC policy" but many people may do so. It's worth to clarify.

4. The list of proposed normative documents to be elaborated (see table 2 below). No doubt, that PHC reform will require updated/strengthened regulatory framework. The highest priority in my opinion is revisiting the UHC program for (1)harmonization of village doctors program with UHC, if this has not been done yet (2) introducing coefficients for tariff adjustment for age and geography (3) exploring opportunities for introducing pay for performance-the later is envisioned for TB and HIV services with the GF support. All these will require a substantial technical input. I believe it's not feasible to do this with internal resources neither through working groups (which are advisory only). MoLHSA should consider mobilizing technical assistance for this purpose. I would suggest consulting the USAID mission to see if they can help. The ongoing "Good Governance Initiative Program" and "Governance For Growth" may have some space to accommodate these needs if not now, from the new fiscal year starting on October 1st.

Table 1. PHC Strategy outline

	Strategy Objectives
Objective 1	**Improving governance and organizational capacity in primary care**
1.1.	Develop the policy framework in primary care and align it with declared priorities in the health sector
1.2.	Improve the governance framework in primary care
1.3.	Implementation of the integrated eHealth system at the level of primary care
1.4.	Improve the collaboration mechanisms with inter-sector partners in developing a sustainable primary care system
Objective 2	**Adequate insurance of human resources for primary health care**
2.1.	Adequate training of primary care personnel, thus ensuring a proper balance on inflow and outflow of professionals in family medicine
2.2.	Develop an effective mechanism for motivating the primary care personnel
2.3.	Cover immediate and short-term needs in PHC personnel (both physicians and nurses) through a re-specialization program based on a special PHC certification curriculum
Objective 3	**Improving financing, resource allocation and systems of payments to primary health care providers**
3.1.	Develop funding policies aimed at increasing equity, in line with declared priorities in health sector
3.2.	Ensure a sustainable, effective and performance-promoting method of payment to primary health care institutions
3.3.	Establish a framework for contracting primary care services, including a framework for strategic procurement
3.4.	Increase transparency in allocating and using financial resources in primary health care
Objective 4	**Improving quality of primary health care services**
4.1.	Create an essential framework, based on accreditation, for primary care providers to regularly and consistently evaluate and improve their processes and environment against patient experience and nationally and internationally recognized standards
4.2.	Assure the provision of primary health care by high quality, knowledgeable and experienced in their area of clinical practice personnel
4.3	Institute the quality and Safety Measurement Framework in provision of primary health care
Objective 5	**Improving Accessibility to family medicine**
5.1.	Assure Integrated Disease Management at primary health care level
5.2.	Cover population needs in primary health care based on the principle of efficacy, opportunity and universal health coverage
5.3.	Increase access to affordable pharmaceuticals by improving the system of drug reimbursement and its centeredness on primary health care according to WHO recommendations and international best practice.

We've made an attempt to prioritize the activities, to identify those which should be implemented in the immediate future followed by medium to long term priorities (See figure 2).

Figure 3. Priority areas and interventions

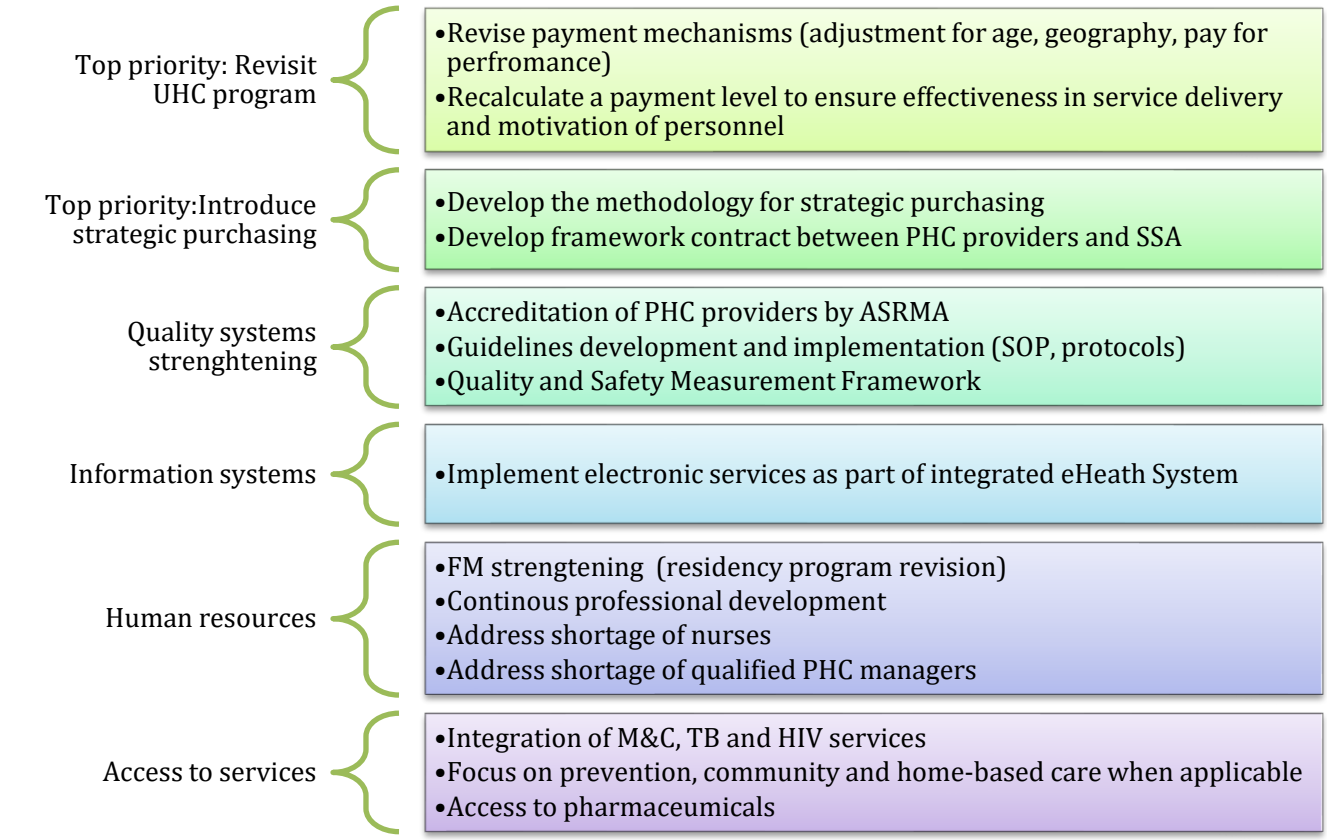


Table 2. List of Normative documents

Normative framework to enable implementation of PHC Policy	Priority	Notes
1. Normative acts on organization and services delivery in primary care	High	Governmental decree which the will be reflected into the UHC program
2. Normative framework to increase the role of MoLHSA in governance with a focus on accountability, access, efficiency and quality Normative framework on PHC governance model based on integrated health system	-	Mandate of MoLHSA is already quite strong, the issue is with the lack of governance mechanisms
3. Extend the role of PHC consultative committee in the area of measurement and monitoring strategy	Low	May improve transparency and accountability but again needs mechanisms in place otherwise the normative act would not change anything.

4. Normative framework on inclusion on PHC providers into eHealth	High	
5. Normative framework for establishment "one-stop-service" at primary care(medical-social collaborative management)	Medium	
6. Normative framework for re-specialization in FM	-	Already in place
7. Normative framework for accreditation	High	Requires policy decision
8. Normative framework for licensing of PHC personnel	-	This is not fully clear to me, PHC personnel is licensed according to the Georgia legislation
9. Regulatory framework for organizing and coordinating the delivery of services in family medicine practices	-	Do not we want to have the primary care based on FM model? Unclear how this differs from point 1.
10. Procedures for registering the population with the primary care facility	-	To me this is also a part of point 1
Note: This list derives from the strategy draft. However, intensive national consultations will be needed to define the purpose and specific content for these regulations. Policy decisions should be made first on (1) accreditation of PHC providers (2) introducing licensing mechanisms These are two big areas which, if decided, should be developed		