DFID Georgia PHC Development project
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Development of Family Medicine based PHC system

Support and assistance in development and implementation of the concept of health reform was provided by:

- ❑ The Government of USA
- ❑ UK (DFID, KNOW-HOW FUND), Germany, Japan
- ❑ Netherlands, Canada, Sweden, Denmark
- ❑ The World Bank
- ❑ WHO
- ❑ UNDP/UNICEF

Georgia health strategy is based on development of primary care as a priority direction. It focuses on development primary medical care and prevention rather than treatment-oriented system.

According to the Decree of the President of Georgia #179 from May 7, 2000 on "Urgent Measures on Implementation of the Conceptual Principles of Georgia Social Development" was approved National Health Policy of Georgia and Strategic Health Plan (2000-2009). Main element of the Plan is improvement the quality of primary care by the development of family medicine institution based primary care system.

On purpose to support development of primary care in Georgia the Know-How fund project "In-service training for general practitioners in Georgia" was implemented during 1997-1999. The Project has fulfilled the following activities:

- 16 FP trainers have been trained, this created an important capacity for training other general practitioners;
- Specialty "Family Physician" was included in the list of physicians and pharmacists (Decree of the Minister of Health № 425/O, 27.10.1997, on "Awarding the State Certificate and License to the High and Middle-level Medical and Pharmaceutical Personnel").
- 47 FP have been re-trained. Thus, together with 8 GP trainers, trained on the initial stage of the Project, 55 GPs were certified;

- Curriculum (930 hours) and appropriate training materials for GP training were developed and approved;
- FP Certification Program has been developed.

UK Department for International Development had strong political support from the Ministry of Health and Municipal Health Department. The second DFID Project was designed in 1999 with input from the GoG and the WB. The purpose of the Project is to develop and implement a sustainable new model of Primary Health Care through Family Medicine to improve quality, access and participation. This in turn will contribute to the goal of the Project, which is to improve the health status of the (poor) population of Georgia.

The Project will assist the Georgian Primary Health Care Reforms through four key outputs:

- Output 1: FM demonstration sites functional. The Project will develop five FM demonstration sites. This urban model of FM will provide the platform for the national roll-out of the FM model
- Output 2: New financing model for PHC implemented. The Project will develop and test alternative options for financing PHC
- Output 3: Human Resource Capacity for new PHC model established. This will be achieved through multidisciplinary training of Trainers for primary care nursing, primary care management and general practice.
- Output 4: Risk pooling scheme for essential primary care drugs developed and implemented in demonstration sites. This output will co-ordinate very closely and integrate with the PHC financing model established in output 2.

According to the Project memorandum financial support from the Ministry of Labour, Health and Social Affairs (MOLHSA) of Georgia and Tbilisi Municipal Health Department (TMHD) implies:

1. Participation in refurbishment and equipping of NFMTC and two demonstration sites in Tbilisi (TMHD);
2. Funding of salary fund of demonstration sites staff for the first year of the Project before the new financial model will be implemented (TMHD);
3. Training of GPs, nurses and managers (MOLHSA);
4. Financing of pilot project for implementation of primary care model-family physician institute (MOLHSA).

Project activities were determined by the priority problems of primary care, particularly, institutional organization of primary care and development of flexible and rational financing model and training of primary care staff. The Project includes four main components:

1. **Establishment of National Family Medicine Training Center and 5 operational family medicine demonstration sites in Tbilisi, that, in turn implies:**

- Refurbishment;
- Equipping at modern level (furniture and medical equipment);
- Development of basics for accreditation of general practice;
- Identification of team composition;
- Determination of roles, duties and competencies of team members;

- Design of job descriptions;
- Development of local guidelines and protocols;
- Establishment of educational clinics for health promotion and individual and group training (for adolescents, healthy population, pregnant and children, elderly, high risk and chronic patients and their families) and their provision with necessary visual, materials, booklets, posters, etc.;
- Carrying out social marketing for patients enrolment;
- Active involvement of patients/community in health care.

2. **The implementation of a sustainable and affordable financing model for primary health care, that, in turn implies:**

- Study of possible options for primary care financing through household surveys;
- Determination of possible roles of for consumer contribution to health care;
- Identification of possible roles for public funds;
- Development of mixed public-private financing model.

This component ties in very tidily with the World Bank, who is studying options for financing of the health system as a whole.

3. **Increased Ministry of Labour, Health and Social Affairs capacity to train PHC staff, that, in turn implies:**

- Support for establishment of national and regional training centers;
- Development of basis for accreditation of general practice as training institution;
- Training of GP/FP trainers for Tbilisi and regions;
- Training of practice nurses and practice nurse trainers for Tbilisi and regions;
- Training of practice managers and practice manager trainers for Tbilisi and regions;
- Development of curricula for training family medicine staff (physician, nurse, manager);
- Development of training materials for training family medicine staff (physician, nurse, manager);
- Development of legal basis for training and re-training of family medicine staff;
- Establishment of continuous medical education in family medicine.

4. **Development and implementation of population-based risk pooling in order to cover the costs of essential PHC drugs at the FM demonstration sites. This component of the Project works very closely with the financing component and explores two key issues namely:**

- Identifying the source of funds to be pooled to cover essential primary care drugs;
- How the providers (or drug suppliers) will be paid.

Project progress:

Key achivements up to date are as follows:
Output I:

- ❑ FM centers opened at the end of April
- ❑ Organizational structures established within FMCs
- ❑ Legislative framework developed and approved by the Ministerial decree (15.04.2002)
    a) Statute for Family Medicine Practice (center/department is developed;

b) Statutes and competencies were developed for:
- Family Physicians
- General Practice Nurse
- General Practice Manager

- ❑ Open enrolment commenced based on SM activities
- ❑ Clinical guidelines developed for 5 conditions and piloted in NFMTC, 5 more are being developed; Protocols for diabetes, hypertension, CHD, asthma, well-person and new person health check, elderly health check, child surveillance, antenatal care, family planning and health promotion (disease-orientated, high risk-orientated, health orientated) clinics have been developed. These will be implemented when the new Ambulatory Care Programme is introduced. Seminars and "patient schools" will be held regularly to inform and educate patients. Training materials for the implementation of these protocols into practice has been developed at the NFMTC trough project support. These are used in training of doctors.
- ❑ MIS working group is developing new systems. Project has been providing TA to assist FMC to establish new MIS

Output II: New financing model for PHC implemented

- ❑ Alternative options for financing PHC identified
- ❑ An options paper produced and submitted to MoLHSA;
- ❑ Primary care financing proposal developed (based on a weighted capitation model).
- ❑ Paper agreed by FMC chiefs and TMHD representation.
- ❑ The new ambulatory care programme was ratified by city parliament at the beginning of May.
- ❑ Implementation starts in September 2002.
- ❑ The new model will be implemented in the 5 demonstration sites

Output 3:Human Resource Capacity for new PHC model established

- ❑ NFMTC and 4 FM training centers fully operational
- ❑ 5 PHC Manager trainers, 8 PHC Nurse trainers trained
- ❑ Training programme for Family physicians, nurses and managers approved by the MoLHSA in April 2002. Following documents have been developed:
  - GP retraining program;
  - Practice Nurse retraining program;
  - Practice Manager retraining program;
  - Statute of GP trainer;
  - Statute of Practice Nurse trainer;
  - Statute of Practice manager trainer;
  - Statute of family Medicine training practice.

- ❑ 43 FP in Tbilisi and 10 Doctors in Mtskheta PHC center (financed By USAID/AIHA) completed training course 48 doctors have successfully passed summative assessment
- ❑ Second cohort of PHC nurses (24 PHC nurses and 6 Nurse trainers) selected. Training started in May at 5 FMTCs
- ❑ Multidisciplinary training introduced
- ❑ 1st cohort of 8 regional FP trainers (Batumi [3], Kutaisi [3], Gori [2]) trained

- Further 6 Trainers from Batumi and Kutaisi selected. This training started in March 2003.
- With support of National Health Management Center was prepared and published first Georgian textbook "**Family Medicine**";
- Within the program 13 GP trainers provided 10-day training course for 90 physicians in western regions (Guria, Imereti, Samegrelo).

Current infrastructure for training of FM human resources

DEVELOPMENT OF NETWORK OF POSTGRADUATE TRAINING CENTRES IN FM

There are plans to develop a Postgraduate Centre for FM at the Institute for Postgraduate Training in Tbilisi, which has now been renamed as the Academy of Postgraduate Training. This fits well with the intended strategy of DFID Project to assist the GoG in the development of a network of postgraduate development centres for FM training. It is envisaged that the National FMTC and the four polyclinics with form a network with the Regional Centres. These will be linked to the new Academy of PG Training (APGT).

The Minister of LHSA, Prof Gamkrelidze, requested assistance in a number of areas to support the development of the new Academy including:

a. International TA to identify roles and relationships of the Academy and Postgraduate Training Centre;
b. International TA to estimate true cost of training doctors and trainers and develop a framework that can be used by the MoLHSA
c. International TA to train faculty from the new Academy in Family Medicine and education methods.

Accreditation of Medical Schools

The framework for the accreditation process and the basis for appropriate legislation were developed by the Project. This has been approved by the MoLHSA and has been submitted to the MoE for approval. No activities have taken place.

Output IV: Risk pooling scheme for essential primary care drugs developed and implemented in demonstration sites

- ❑ The programme to be called “drug reimbursement scheme”
- ❑ Draft concept paper for discussion being developed
- ❑ Essential drug list developed, analysed and approved by the PHC team
- ❑ PHC drug formulary development: activities planned, involvement of FMC’s agreed
- ❑ Involvement of pharmacies discussed by the FMC directors

Review of existing information systems in PHC

There is a clear need to develop new information systems for the Georgian Health System and particularly in primary care.

Currently each polyclinic has a catchment population allocated to them. Patients, hence, have no choice and have to attend the polyclinic to which they are allocated. The polyclinics provide municipality, federal (MoLHSA Public Health programmes) and SMIC programmes to these patients. TMHD makes per capita payments to these polyclinics based on their catchment populations. Similarly payments are made by SMIC and the PHD to the polyclinics based on the number of patients. However, the exact number and socio-demographic mix of the population is not accurately known as no census has taken place for over 10 years. Hence, payment is made for a far larger number of patients then that exist in reality. This phenomenon is well documented in other health systems and the non-existing patients often referred to as “ghost patients”. The inflation of numbers of patients inevitably results in excess per capita payments being made to polyclinics, and misuse of public funds as these patients do no exist. Population movements are not captured by the existing data collection systems.

With the new FM model and the ACP the patients have choice and hence can register with a FMC (or polyclinic) of their choice. Per capita payment will then be made. Hence, money follows the patient. This creates an incentive to improve quality as this normally leads to attracting more patients. However, the current information systems are not able to accurately capture information regarding patient registration and movements and will have to rely on the returns made by the polyclinics.
The DFID Project is providing international TA for this area.

Project Cascade and Collaboration with International Agencies

USAID

- USAID is financing the PHC development project in Mtshketa-Mtianeti Region. Project is conducted through Milwaukee international health training centre. The training programme for 10 PHC doctors in Mtskheta is based on the curriculum developed within DFID Project. The programme was successfully implemented by the trainers trained within DFID Project

- GP trainers are involved in the clinical guideline developing committee established by USAID.
- IMC-International Medical Corps implemented the training programme (short modular courses-128 Hours) for 130 PHC physicians in western Georgia through GP Trainers trained within DFID project.

WHO

NFMTC in agreement with the Liaison officer Rusudan Klimiashvili and Deputy Director of Public Health Department Dr. V. Doborjginidze have produced proposals for WHO future activities in PHC. The following areas were identified as priorities:

- Developing handbook in paediatrics for Family Physicians;
- Developing clinical guidelines in paediatrics for Family Physicians: This has been agreed with chief paediatrician of Georgia-Professor K. Pagava;
- Developing handbook in psychiatry for Family Physicians;
- Developing general practice nurse training handbook;
- Developing the training manual for GP and Nurse Trainers;
- Implementation of ICPC2;
- Introducing the training courses in adolescent health, TB management for PHC doctors.

Curatio International foundation

FP trainers trained within DFID project were involved in the project financed by USAID and implemented through international foundation Curatio-Safe motherhood initiative. They've participated in the following activities:

- Designing the training curriculum
- Developing training materials for trainers and trainees for PHC internists in Kachketi region
- Providing training for PHC physicians (Internists-21 trainees) in Kackheti region

Donor Co-ordination:

Meetings were held with the World Bank and ICRC. DFID is collaborating with WB closely. However it is critical that additional capacity is developed in-country to better co-ordinate donor activities. DFID is well placed to do this. Ideally a full time well trained person with no links to local stakeholders should be funded by DFID and based at the MoLHSA to co-ordinate donor activities.

In addition to the WB, DFID and EU the ICRC are planning primary care related activities in Western Georgia. It is critical that these activities are brought under the umbrella of national PHC development programme and not be designed as a separate vertical project. The same consideration should be given to WHO vertical programmes that need to be seamlessly integrated into the horizontal PHC reform programme that is currently being implemented. RA met the regional director for ICRC during the visit to brief him of the DFID Project and stressed the important issue of integration.

Bridging Extension:

The current DFID Project is due to end in July 2003. The proposed DFID Project (which will be designed jointly with the EU and the WB) which is at PCN stage is unlikely to start by then. Given the strong momentum in PHC reforms a “bridging extension” to the current project would be highly appropriate to enable a seamless transition from the current DFID Project to the next WB-DFID-EU Project. Such an extension would be of a time and cost extension and provide ongoing support to the MoLHSA

Such an extension could finance activities that have been identified by the MoLHSA as necessary for maintaining the momentum of development in PHC but also enabling a seamless transition between the current DFID Project and the start of the next with WB Health II. These include: (a) Development of software for registering and tracking patients at the FMCs with linkages to the TMHD, PHD of the MoLHSA and the SMIC; (b) TA to estimate true cost of training doctors and trainers; (c) TA to develop FM faculty at the Postgraduate Medical Academy; (d) Poverty mapping exercise leading to development of a Rapid Strategic Plan (this was an activity that was included in the WB PPF and necessary prior to the start on the WB Health II Project but as the PPF was cancelled the activity was not undertaken; (e) Establishment of a Donor Co-ordination Unit at the MoLHSA