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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BBP	Basic Benefits Package
CDC	Center for Disaeses Control (USA)
CIDA	Canadian International Development Agency
CIS	Commonwealth of Independent States
CMSI	Center for Medical Statistics and Information
DFID	UK Department for International Development
DFID/OPM Project	Georgia Primary Health Care Reform Project, funded by DFID and implemented by OPM
EC	European Commission
EU	European Union
EU/GVG Project	Project implemented by GVG and EPOS Health Consultants; EU Support to Primary Health Care Development: Reform of the Health Care Financing System in Georgia (also referred to as “the Project”)
FAP	Feldsher akushersky punkt, Russian acronym for health post
FGD	Focus Group Discussion
FM	Family Medicine
FMC	Family Medicine Centre
FTE	Full-time equivalent
GEL	Georgian Lari
GHSPIC	Georgian Health and Social Policy Implementation Centre
GoG	Government of Georgia
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HP & PR	Health Promotion and Public Relations Working Group,
HTA	Health technologies assessment
IEC	Information, Education, Communication
IT	Information Technology
MoE	Ministry of Economics
MoF	Ministry of Finance

MoLHSA	Ministry of Labour, Health and Social Assistance
NDC&MSC	National Diseases Control and Medical Statistics Centre
NGO	Non Governmental Organization
NFMTC	National Institute of Health and Social Affairs
NTCFM	National Family Medicine Training Centre (in Tbilisi)
OPM	Oxford Policy Management
PHC	Primary Health Care
PHCen	Public Health Centre
PHD	Public Health Department
PR	Public Relations
Project	EU funded project Reform of the Health Care Financing System in Georgia
Road Map	Road Map for Primary Health Care Reform in Georgia, adopted by MoLHSA in November 2004 and establishing the structure of a PHC Co-ordination Board, PHC Management Committee and four Working Groups
SC/SCF	Save the Children/Save the Children Federation
SDC	Swiss Agency for Development and Cooperation
SDS	State Department of Statistics
SHP	State Health Program
STD	Sexually Transmitted Diseases
SUSIF	State United Social Insurance Fund
TB	Tuberculosis
ToR	Terms of Reference
UNICEF	United Nations Children Fund
USAID	US Agency for International Development
WB	World Bank
WHO	World Health Organisation

1 Project Synopsis

Project Title:	Reform of the Health Care Financing System
Project Number:	EuropeAid/116064/C/SV/GE
Country:	Georgia

Overall Project Objective

Establishment of new efficient and effective financing system for ensuring accessibility and affordability of PHC services for the Georgian population.

Specific Project Objectives

1. To provide sustainable and affordable access to Primary Health Care services through the implementation of new financial and solidarity mechanisms at national and regional level.
2. To improve the capacity of the financing and managing institutions (including SUSIF) to ensure that health benefits reach the whole population and especially vulnerable groups
3. To guide the reform of financial mechanisms and administrative processes with "best methods and practices" from pilot initiatives implemented at regional level (Kakheti Region).
4. Multi donor co-ordination with the World Bank and DFID, ensuring a harmonised approach and co-ordinated assistance towards sustainable financing of the PHC services and PHC policy development.

.**Planned Outputs:**

1. New solidarity strategy defined and developed.
2. New financial mechanisms and administrative processes defined and implemented.
3. A regional Health Financing Masterplan is developed.
4. Training needs on health insurance management are analysed. Sustainable training programmes on health insurance management are planned and implemented.
5. Seminars and workshops at central and regional levels to assist MoLHSA in building a supportive environment for the introduction of new health insurance policy and practices are organised; an Information, Education and Communication strategy is developed.
6. Study tours to one or two countries in transition (or new EU member states) and to one "old" EU country are implemented.
7. Technical specification of necessary equipment and software is prepared.

Project Activities:

The project activities are grouped according to the following components:

- Component 1: Technical Assistance, divided into four work streams:
    - Macro financial issues, e.g. institutional mapping and corresponding financial flows; PHC budget
    - Micro financial issues, e.g. contracting, calculating costs and tariffs, accounting and HMIS
    - BBP for PHC

- Implementation: see components 2 - 5

- Component 2: Pilot Activities in Kakheti Region
- Component 3: Capacity Building/Training
- Component 4: Information, Education and Communication
- Component 5: Coordination of Activities
- Others: Study Tours; Technical Specifications of Necessary Equipment.

Target Group:

Ministry of Labour, Health and Social Affairs; major stakeholders of financial issues; pilot region Kakheti; selected Primary Health Care providers; training centres and trainees; general public.

Project Starting Date: 17th June 2004

Project Duration: June 2004 – June 2006 (24 months)

2 Summary of Project Progress since the Start

The project commenced in June 2004. The reporting period of this Progress Report covers the whole period from the project start until 30th April 2005. According to the different components the project's progress can be summarised as follows (for details, see chapter 4):

1. **Component 1: Technical Assistance**
   - Macro financial issues have been analysed with particular regard to institutional mapping and macro financing, including a first set of recommendations
   - Micro financial issues cover the analysis of accounting and management issues as well as a first draft of a calculation model for costs and the development of tariffs. First real data simulations have been calculated
   - Two options for the development of a BBP for PHC have been developed and discussed, including a first set of recommendations
   - Health/medical needs have been analysed, comparing Kakheti with Georgia as a whole whenever possible. Resulting recommendations concerning PHC development have been drafted
   - A strategy paper on solidarity issues in PHC in Georgia has been developed, a leaflet has been produced, and the press have been informed

2. **Component 2: Pilot Activities in Kakheti**
   - A project office has been established in Telavi for Kakheti Region
   - Major stakeholders as well as some providers have been contacted for fact finding and informing them about the planned PHC reform.

3. **Component 3: Capacity Building / Training**
   - Capacity building / training needs have been defined, identified and assessed. Resulting recommendations have been drafted as well as a first action plan showing different options for starting the PHC reform in 2005

4. **Component 4: Information, Education, Communication (IEC)**
   - An IEC strategy for supporting PHC financing reform has been drafted and discussed with MoLHSA and the relevant working group

5. **Component 5: Coordination**
   - Several coordination meetings with international donors/implementing agencies have taken place in order to harmonise timing and content/financing support of the different projects
   - Additional coordination meetings with the MoLHSA and the EC delegation have been conducted
   - Regular internal meetings support coordination of the different components within the project

6. **Others**
   - Technical specification for the equipment needed: the technical hardware specifications have been developed and included in the drafted procurement documents. Software solutions are still under consideration and evaluation. Discussion of "service centre" and PHC manager options are ongoing

3 Summary of Project Planning for the Remainder of the Project

The project activities for the whole duration of the project have been specified in the Inception Report (form 1.4 Overall Plan of Operations). Meanwhile – in November 2004 – the Minister of LHSA offered to all stakeholders involved in PHC reform a new plan of action ("Road Map"). This "Road Map" provides for:

- 2 stages for the PHC reform – a "crash programme" and a long-term programme
- the establishment of 4 working groups to develop the proposals for both stages
- a detailed time-table for the development of proposals for both stages (final version for the "crash programme" proposals by 30th March 2005; final version for the stage 2 proposals by 15th April 2005).

The consultant has accordingly adapted the activities of the past months and especially the project planning for the remainder of the project to this staging and the corresponding timetable. Therefore we would like here to underline the overall project planning taking into account these developments.

In line with the Road Map and as agreed with the EC Delegation, the consultant will phase the implementation of new financial and managerial mechanisms for PHC financing in the following four stages:

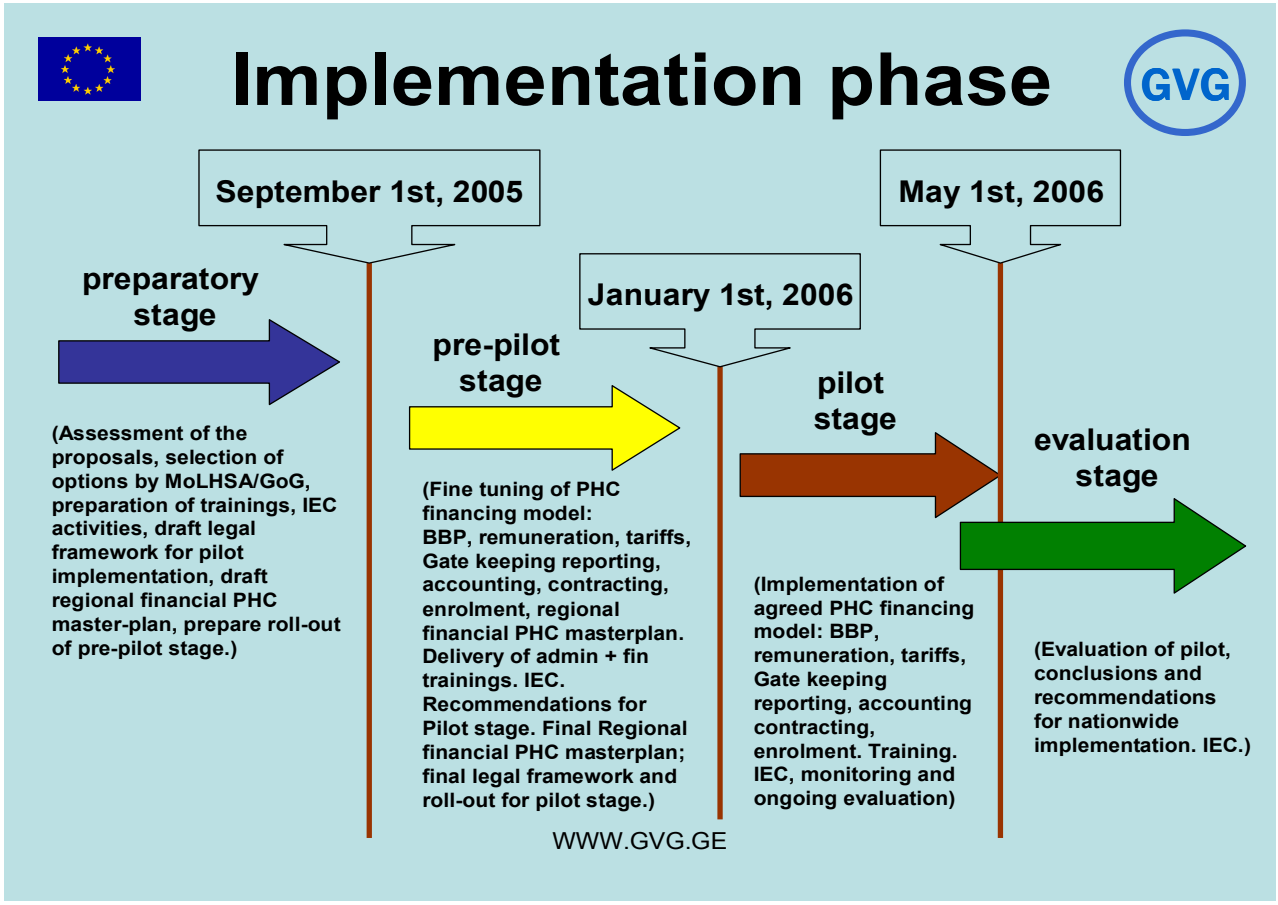

Figure 1: Implementation Phasing

Preparatory stage: the consultant will continue to work closely with the Working Groups supervised by the National PHC Coordinator and continuously feed draft policy proposals into these groups for discussion and further development.

1. During the course of the preparatory stage the regional financial Masterplan, as outlined at the workshop held on 30th November 2004, will be further developed, discussed with the beneficiary and agreed upon. Based on both the analysis of the current out-patient system and the planned new PHC system the regional financial Masterplan will also reflect the according transition process from the old – SUSIF financed - out-patient system to the new PHC system in economical terms. According to the philosophy "money follows the patient" the utilisation of the new PHC system and the old system will be compared and according the shifts of financial resources, e.g. from SHC towards PHC, will be calculated as a decision basis for the future development. Not knowing the pace of this transition process until final implementation of PHC nationwide, 2 scenarios will be projected: 5 years and 10 years. Close collaboration with the development of MTEF (TA by OPM) is ultimately necessary.
2. In parallel, the project will follow the developed IEC strategy in terms of an information campaign for supporting the PHC reform.
3. All necessary procurement procedures for equipment and software must be started at short notice to ensure functional stakeholders (purchasers and providers (to date it is not clear who will be the provider)) in terms of equipment and software.
4. Financial and administrative trainings will be prepared for the target groups: providers, managers, financing administrations (MoLHSA and its regional department, SUSIF and its regional department). Coordination with PHC reform projects in Adjara and Imereti shall be ensured. On the proposal of the EC Delegation all out-patient providers in Kakheti will be provided with basic administrative and financial Training. Those out-patient providers their staff is already retrained in family medicine and will become new PHC providers will receive a more specified and intensive administrative and financial training during the Pre-Pilot or Pilot stages due to their availability and involvement in other training or retraining courses.
5. After preparation of the training curriculum and training materials the trainers will be selected and trained in basic administration and financial issues (module 1).
6. The assessment and consensus-finding process will be supported by a joint workshop of all PHC Working Groups in June 2005. Depending on the pace of the PHC reform this workshop will serve as a basis for both accelerating the Working Groups' activities and for preparing consensus.
7. A draft legal framework for both the new PHC system and the pilot phase will be developed. The according list of pending decisions to be taken by the MoLHSA and/or GoG has been addressed to the EC Delegation dated 13th April 2005.
8. Roll-out of pre-pilot stage will be prepared and agreed with the relevant stakeholders and counterparts.

The following pre-conditions have to be fulfilled in due time:

- The final design of new PHC system is adopted by the MoLHSA;
- The consensus on PHC financing model is reached and new model is adopted by GoG;
- The procurement procedures for equipment (hardware) of stakeholders are ongoing;
- Training curriculum and program are legalised;
- Adequate trainers are selected and contracted;

The **Pre-pilot stage** will start in September 2005:

9. The new PHC financing model will be fine tuned with regard to BBP, remuneration, tariffs, gate keeping, reporting, accounting, contracting, enrolment, regional financial PHC Masterplan.
10. As all details of the new PHC financing model are defined by this stage the extensive training program (module 2) for different stakeholders (PHC staff of new PHCens, Managers and central and regional financing Administrations) will be developed.
11. Training of trainers in module 2 will be conducted.
12. We plan to conduct the trainings for the involved representatives of the purchasers from the regional level (i.e. Kakheti) and from the national level. Further more basic financial and administrative training for all outpatient doctors and nurses is planned to start during this period. After clarification (by MoLHSA and EC Delegation) about which staff will be retrained an additional financial and administrative training will be conducted for this target group. This specialised training (module 2) will focus on the new mechanisms and procedures necessary for running the new PHC system.
13. IEC component will inform about final decisions on the new PHC model and support the PHC reform according to the IEC strategy.
14. After procurement all necessary IT equipment will be installed and functional.
15. Evaluation of pre-pilot stage will be prepared.
16. Recommendations for the pilot stage (implementation in Kakheti) will be developed.
17. Roll-out of pilot stage will be prepared and agreed with the relevant stakeholders and counterparts.

The following pre-conditions have to be fulfilled in due time:

- The final content of BBP is agreed and adopted by the MoLHSA;
- Pilot facilities in agreement with the EC Delegation and MoLHSA are selected;
- Trainees (PHC staff, managers, financing administration) are available (are not involved in other trainings) and wiling to undergo the training;
- All necessary equipment is procured in time;

Pilot stage: It is advisable to start the implementation with the fiscal year 2006. Thus we **plan** implementing the pilot stage from 1st January 2006. It will become fully fiscally-effective.

18. The new PHC financing mechanism (e.g. BBP, remuneration, tariffs and gate-keeping) will be implemented in all those facilities which are functional in terms of basic medical equipment and where new family medicine based PHC is introduced between January 1st and March 31st 2006.
19. Training activities will be continued.
20. The IEC component will support the PHC implementation.
21. Monitoring and progress-based ongoing evaluation of implementation will be conducted.

The following pre-conditions have to be fulfilled in due time:

- The new PHC system is established and functional (i.e. new PHC facilities have retrained staff in family medicine and are providing full range of BBP services to population);
- Corresponding and appropriate public financing is allocated for new PHC facilities;
- Financing institutions are ready (retrained) to administrate new PHC financing system;
- The legal framework allows pilot activities in Kakheti;

The **Evaluation stage** will start on 1st May 2006:

22. The consultant will carefully evaluate the experience of the pilot stage and draw up conclusions arising from the Kakheti experience for implementing PHC reform in whole Georgia. The experience from the parallel activities in Adjara and Imereti will be taken into consideration.
23. The IEC activities will support the evaluation stage, e.g. by press conferences, press releases.
24. A Final conference will address the findings and recommendations to the target groups.

The following pre-conditions have to be fulfilled in due time:

- The piloting stage is conducted successfully and gives the evidence for final evaluation and preparing of recommendations for nationwide implementation;

4 Project Progress in Reporting Period

BACKGROUND / POLICY DEVELOPMENT

Since 1995, Georgia has been facing an ongoing process of health care reform, because the existing Semashko system failed after the Soviet Union disappeared. In conditions of a very difficult social-economical situation, the Government of Georgia (GoG) decided as a first priority to reform the Primary Health Care (PHC) system in order to shift utilisation of services by population from expensive secondary and tertiary care to more affordable primary care.

The PHC reform meant transformation of an ambulatory-polyclinic system (a duplicated or even triplicated system with a mixture of GPs and specialists – therefore a mixture of primary and secondary care) to a real PHC system with a family medicine specification. MoLHSA planned to optimise the existing network in accordance to international standards and local needs.

In 1997-2002, two DFID pilot projects were conducted for PHC development. In the framework of these projects, 5 family medicine centres (one of them the National Family Medicine Training Centre) have been established, more than 70 FM physicians, nurses and practice managers trained (part of them became trainers in their corresponding fields), training curricula and treatment guidelines prepared, etc. The evidence and experience of these projects proved that:

- Facilities have to be refurbished and re-equipped, because for promotion of a new PHC system / Family Medicine and for attracting the population to PHC services and facilities, it is very important to have also a new image. No patient will believe any explanation that a new system is established if he comes to the same old, dirty and deteriorated ambulatory. Another issue is that in an old facility it is impossible to provide the full set of services which are considered in the PHC package.
- Physicians and nurses have to be trained in specific management-financial issues and also must receive special training in Family Medicine, because without a new image, new skills and knowledge, FM physicians and nurses cannot rebuild the trust of the population which has been quite lost due to existing conditions and practice in ambulatories. It is very important that FM guidelines and curriculum dramatically change the responsibilities and roles of physician and nurse and their interaction. There is also a very big difference in disease and health management; therefore without appropriate training an FM team cannot provide the full range of services and cannot manage the new tools (accounting, reporting, contracting, etc.).

On the basis of the experience of these pilot projects, MoLHSA decided to begin a large multilateral programme on PHC reform. Several international organisations (WB, EU, DFID, USAID, etc.) are supporting GoG for successful implementation of these efforts. In 2003 a Memorandum of Understanding on PHC Reform between all major stakeholders was signed. So now it has been agreed to reform the existing PHC system by means of optimisation of the existing ambulatory-polyclinic system, refurbishment, equipping of selected facilities, and training of FM physicians, nurses and practice managers and implementation of a new financial system for PHC (Including a Basic Benefit Package of services). In line with all the above-mentioned factors, since June 2004 the EU-funded GVG/EPOS project on “Reform of the Health Care Financing System in Georgia” has been conducted.

In the following, we address practical changes in the project’s environment which have occurred since the ToR were prepared:

- The future situation of SUSIF is under discussion. It is still uncertain whether SUSIF will become a more insurance- or fiscal-oriented administration. Our proposed financial mechanisms are not dependent on this issue as long as SUSIF remains a strong public

purchaser and a sufficient allocation of financial resources to SUSIF is assured by health insurance schemes, by a public health service, or by a combination of both.

- Identification and registration of the poor and vulnerable population is to be addressed by the project. Since autumn 2004, the GoG has been considering this issue. The GoG's tools for identification and registration are supposed to be functional by the end of 2005. MoLHSA's target is to lift the extreme poor part of the population (the 17% of population with a monthly household income < 62 GEL) above this level, which is defined as the extreme poverty line. The statistical database required for this is under preparation. We have discussed with MoLHSA the idea to start the pilot project on poverty in the regions of Imereti, Adjara and Kakheti, and MoLHSA is considering this proposal. The up-to-date situation will be assessed by us during the preparatory stage, so that we may use the results for our project.
- A strong theoretical solidarity strategy has been developed by the project. Solidarity mechanisms are an integral part of the proposed remuneration mechanisms for PHC in Georgia.
- The format of coordination has changed. Since the PHC Management Committee was dismissed in 2004 and the Road Map for PHC Reform has been issued by MoLHSA, coordination takes place through the four Working Groups established by the National PHC Coordinator. Issuing the Road Map is supposed to result in an acceleration of the reform process, and for the first time an official time schedule for the PHC reform is available. The project has adapted its tasks accordingly. The deadlines of our work have been adjusted to the deadlines set out in the Road Map.
- The EU has conducted and finalised preparation of two new projects focussed on FM training and refurbishment of PHC facilities in Kakheti. Up to 57 functional PHC facilities with FM trained staff are expected to be in place in Kakheti Region until the end of 2006.
- The WB is preparing a PHC Masterplan and refurbishment of some 66 selected PHC facilities in Adjara and Imereti. This is planned to be finalised by September 2005.

Due to joint cross-portfolio decisions, the State will take responsibility for the health of the population in the framework of a universal Basic Benefit Package (BBP), which will be free of charge for all the population, and with some additional programmes for target groups. MoLHSA will finance PHC (including Public Health activities), emergency care and urgent hospital care for all the population; also some programmes for target groups and diseases (pregnancy and delivery of women, TB, infectious diseases, psychiatry, etc). All other responsibilities will be delegated to municipalities. The feasibility of this policy is uncertain or even unrealistic. The consultant has already identified a financial gap.

Funding of health care shall be changed from social insurance-based to be budget-funded. Despite promises by the Minister of Finance regarding favourable funding for the social sphere, for the year 2005 the significant increase in the State Budget touches only funding of social policy (pensions and other benefits) and not health care. It is also unwise to make assumptions based on the personal will of one politician as opposed to having clear annual allocations (based on a % of State budget or GDP, etc) which do not depend on the good-will of any individual.

MoLHSA is implementing new methodology and new tools for evidence-based policymaking (Medium Term Expenditure Framework, National Health Accounts, etc.) which aim to increase the performance of the HC system and the efficiency of public funds spent on these HC activities.

MoLHSA is also trying to increase its role in co-ordinating the reform efforts of different stakeholders (international and local) and accordingly to strengthen the sense of ownership of Georgian counterparts. Taking into account the lengths of procedures for implementation of donor-funded international projects, the Minister of LHSA recently offered all stakeholders involved in PHC reform a new plan of action (the "Road Map"), which considers 2 stages – a "crash programme" and a long-term programme.

For the "crash programme" the Minister asked the counterparts (EU, WB, DFID, etc) to mobilise their efforts and begin as soon as possible (spring of 2005) with facility refurbishment and staff training in approximately 100 small rural ambulatories in 3 regions (Adjara, Imereti, Kakheti) – specifically in those ambulatories which might be on the list of any future selection. In parallel, the PHC reform programme will continue implementation activities relating to mid- and long-term planning.

To increase the speed of theoretical investigations and elaboration of practical recommendations, a very important step has been made by establishing the four working groups, where all interested parties participate and will come to a consensus and elaborate options for decision-makers, finding solutions for many uncertainties and questions which currently remain open-ended.

The consultant has contributed to the PHC Reform Process with the policy paper on PHC Reform in Georgia which has been provided to the Minister in Georgian Language.

Please, refer to ANNEX 1 for the "Strategy: GVG Project – Implementation Process – Revised and Updated -" and to for the working paper "A Comprehensive View of PHC reform in Georgia", issued 28th February 2005.

PROJECT PROGRESS:

During these months the entire international team was mobilised. Local experts for most project components could finally be contracted after a lengthy selection and approval procedure.

A main project office has been established in Tbilisi in the premises of MoLHSA (compare Inception Report) and a second project office has been established in the pilot region of Kakheti. A local coordinator for Kakheti has been selected and contracted. Thus the office in Kakheti is now fully functional and collaboration with the regional counterparts will be intensified.

During the reporting period the team has participated in several workshops and seminars organised by donors, other implementing agencies and by local authorities. Co-ordination meetings and workshops with MoLHSA and its PHC coordinator, with the EC Delegation and the other projects it supports, as well as with other international donors and implementing agencies – e.g. World Bank, WHO, and OPM – were necessary for generating and developing a common approach to the implementation of Georgia's PHC reform. The coordination of all PHC reform activities is a major issue for Georgia and has to be continuously addressed and supported.

Four working groups of the MoLHSA's PHC reform programme were established in November/ December 2004: (i) Human Resources and Service Production (HR and SP), (ii) PHC Financing (HF), (iii) Health Management Information System (HMIS) and (iv) Health Promotion and Public Relation (HP and PR). The consultant has participated in their meetings and supported their work.

The consultant's international and local experts have held interviews and working meetings with all major stakeholders at both national and regional level. Several field trips to Kakheti region have taken place.

A project web-site (www.gvg.ge) was launched and has been maintained since August 2004 (compare Inception Report).

In summary, the project has made considerable progress during the reporting period. The consultant has initiated or completed all planned activities and developed working papers (see Annexes) on the respective issues: e.g. Implementation Process; Proposals for PHC in Georgia.

However, some activities and outputs planned for December 2004 were postponed until January / February 2005. The reasons for this delay were threefold:

- The process of selection, approval and contracting of local experts was quite a lengthy procedure (approval of vacancy advertisements, interviews, selection process together with

MoLHSA, approval of selections, contracts). Even though the procedures started in September 2004, most local experts were only contracted in November / December.

- Due to the Minister's decision to establish 4 working groups, the project awaited their establishment in November / December 2004 instead of duplicating and establishing its own project working groups as planned for October.
- The Road Map specifies clear dates for submission of proposals (in different phases between January and April 2005). The contractor has adapted the project pace to this time schedule.

The identification of the partner institutions (funding agencies and providers) in Kakheti started immediately after the summer vacation period.

Please, refer also to Form 2.2 "Project Progress Report"; Form 2.3 "Resource Utilisation Report", and Form 2.4 "Output Performance".

In the respective project components the following progress was made:

4.1 Component 1: Technical Assistance

Result 1: New solidarity strategy defined and developed

On the basis of an analysis of policies and strategies on solidarity and health needs in Georgia and in other countries (activities 1.1, 1.2, 1.3) several working papers (activities 1.3, 1.5, 1.6 and 2.1 respectively) have been developed. These working papers analyse the situation in Georgia, assess problems and shortcomings, describe international approaches and make initial recommendations for a new solidarity strategy in Georgia.

These papers have been presented in brief at two workshops (see activity 1.7). During the next few weeks the draft recommendations will further be discussed with the beneficiaries and the working groups (activities 1.7 and 1.8) and subsequently consolidated into final recommendations for a new solidarity strategy in Georgia (activity 1.9).

Activity 1.1 Review existing health policy, strategy and legal docs

The health policy, strategy and legal documents related to the Basic Benefit Package for Primary Health Care (BBP) and to the respective solidarity mechanisms have been reviewed. As a result of activities 1.1 and 1.2 the existing health policy and strategy in Georgia is described in two working papers focussing on Solidarity Mechanisms and on BBP for PHC and in a working paper on Health Needs (see activities 1.3 and 1.5).

Please, refer to for the working papers "Medical/Health Needs Assessment in Kakheti" and "Elements of a Solidarity Strategy". Issued 28th February 2005.

Activity 1.2 Interviews with administrative officials

The consultant has held numerous interviews with administrative officials and stakeholders from many involved parties. This process will be ongoing throughout the project's duration.

Please, refer to ANNEX 3 for the "List of Meetings"

Activity 1.3 Review and evaluation of existing medical/health needs

Medical/health problems have been reviewed and evaluated on the basis of existing statistical data. Special attention was given to groups of the poor population and vulnerable people. This target population is characterised by particular health and health care needs. The following major health problems have been identified and serve as a basis for deriving the health needs:

- The demographic situation in the country as a whole and in Kakheti region has significantly worsened. Changed age (ageing population) and sex (more males than females up to the age of 20 – females increasingly predominant in older age groups) characteristics pose significant challenges to the country's healthcare system, which have important implications for primary health care.
- The problems of women's reproductive health include high levels of maternal mortality, a large number of abortions, poor availability of information and services for family planning and the growing incidence of STDs. Embolia, bleeding and septicaemia (infections) account for a significant percentage of maternal deaths. Abortion remains a major cause of maternal mortality in the country. Infant mortality continues to be high. The leading causes are infections, congenital anomalies, obstetric trauma, etc. There is great potential to reduce infant mortality through promoting exclusive breastfeeding and preventing preterm birth/low birth weight. As for morbidity, the highest incidence has been reported for respiratory diseases, neurological disorders, and infectious and parasitic diseases.
- Diseases of respiratory, cardiovascular, psycho-neurological profile and infectious diseases account for the majority of incidence and prevalence of the population's health problems in all regions including Kakheti.
- Diseases of the circulatory system – mainly ischemic heart disease and stroke - are the leading cause of mortality and morbidity in Georgia. Kakheti seems to have higher rates for diseases of the circulatory system compared with other regions. Blood pressure is directly related to mortality from coronary heart disease and stroke. Therefore, it is extremely important to ensure effective prevention and adequate case management of hypertension at primary care level.
- Cancer is the second major cause of mortality in Georgia. Over the last decade, there has been a steady increase in the incidence/prevalence of malignancies of various types and locations (lung, breast, cervical, and prostate cancers). Of particular concern is that the proportion of cancer cases detected at later stages has significantly increased, which indicates that serious problems exist at the primary care level, where cancer cases should be detected at early stages. Kakheti seems to have higher rates of malignancies compared with other regions. Smoking cessation/control and breast/cervical cancer screening programmes need to be promoted at primary care level to tackle this problem.
- Georgia has been recording increases in the prevalence/incidence of respiratory, endocrine and digestive system diseases. The prevalence of endocrine diseases is one of the highest in Kakheti compared to other regions. A high prevalence of goitre and diabetes mellitus calls for relevant preventive and curative measures to be taken at primary care level to ensure adequate control of these disorders. Available evidence suggests that neurosis and depression are prevalent in the population, which also has important implications for primary care.
- Georgia appears to have one of the highest rates of TB of any of the former Soviet republics. Treatment defaulting is one of the major causes of the failure of TB control programmes. Treatment failure, prolonged treatment and period of transmission are common and increase the likelihood of drug resistance. TB incidence in Kakheti is

comparable with other regions. There is an urgent need to promote and institutionalise a DOTS programme at primary care level to ensure effective TB control.

- Increasing magnitudes of STDs, Hepatitis C and HIV/AIDS call for immediate action to ensure adequate preventive measures are implemented at primary care levels.
- Kakheti is an endemic region for malaria – almost all cases reported in the country are registered in Kakheti. This has important implications for primary health care in Kakheti and calls for immediate action.

Activities 1.3 and 1.4 are closely linked and feed into activity 1.9.

Please, refer to the working paper "Health Needs Assessment in Kakheti". Issued 28th February 2005.

Activity 1.4 Approach to identify and register the target population

As already mentioned in the Inception Report, the approach of identification and registration of the poor population is of less importance than originally planned, because MoLHSA is addressing this process. The project has discussed with MoLHSA starting their pre-test also in Kakheti (at the end of 2005). This hopefully would generate synergies between the different policies concerning PHC and equity. However, the vulnerable parts of the population remain a focus for the project's work (compare for example activity 1.5).

Please, refer to the working papers "Medical/Health Needs Assessment in Kakheti" and "Elements of a Solidarity Strategy". Issued 28th February 2005.

Activity 1.5 Review international practice on solidarity and advice on BBP

International practices on solidarity have been carefully analysed with particular regard to both financial issues and BBP. The working paper on Solidarity strongly considers international experience. Our recommendations tackle both major obstacles – informal payments and limited access to health care – by recommending a comprehensive BBP and by discussing complementary community-based health financing schemes, among other measures. The consultant carefully analysed the current solidarity mechanisms in Georgia, identifies different policy options and finally recommends two main policies: (i) development of BBP according to the characteristics of PHC: PHC is comprehensive care. A negative list of services excludes those PHC services which will not be covered by public funds. (ii) Large informal payments create strong barriers for the poor population in accessing the public health care system. Evidence in Georgia and abroad shows that community-based health financing schemes as additional funding can significantly decrease informal payments and thus ensure access to the health care system for the whole population. Thus community-based financing schemes may serve as a tool for socialising in economic terms the informal payments. However, the long-term sustainability of community-based health financing schemes still has to be proved for Georgia. Pilot projects funded by donors other than the EU are ongoing, and their evaluations have to be awaited.

As a further measure to reduce/eliminate the practice of "informal" payments and enhance access to care for vulnerable groups in the population, the consultant proposes defined co-payments targeted at the better-off.

We recommend the option with a well-defined patients' charge for (nearly) all. The other options would not significantly decrease the costs of PHC practices, since less than 10% of these are variable ients exemted from public funding will nc

pass the PHC level as currently occurs. The final option does not guarantee the rights of inhabitants to PHC care and we do not recommend it mainly for this reason.

Based on our choice, we have elaborated our recommendation in substantial detail. We propose a Basic Benefits Package (BBP) for PHC that contains a generally-accepted set of immunisations, a comprehensive set of preventive examinations for all age categories and curative services including laboratory tests. Services in the personal interest of a person, cosmetic treatment and acupuncture are of course excluded from the BBP.

For the moment, we have set aside the question of partial coverage of the cost of drugs. It would be highly desirable to include partial coverage of drugs in the BBP, but further analysis is needed. We assume that, for the patient, all immunisations and preventive services included in the BBP will be free of charge. For each curative treatment, we assume a fixed co-payment per visit which also covers laboratory tests.

Please, refer to the working paper "Elements of a Solidarity Strategy". Issued 28th February 2005.

Activity 1.6 Review and recommend financial and administrative process and flows

Sound financial and administrative processes and flows between the institutions involved in the PHC process are crucial for the functioning of the system. By reviewing the legal documents and through interviews with administrative officers, the information on financial decision-making and administrative procedures as regards main stakeholders was collected and analysed. The serious difficulties in getting structured information should be noted. On-going changes and a corresponding lack of clarity regarding the legal status, functions and rights of important public institutions could also be observed.

On the basis of the analysis in 1.1 and 1.2, the consultant has carried out a first analysis of the institutions involved in public PHC financing and PHC provision and provided an initial set of recommendations concerning the future interaction of the stakeholders involved (see activity 2.1). The development of the planning/priorities setting and purchasing functions by particular institutions was proposed. Recommendations for coordinated approaches towards property management and rationalisation of the providers' network, as well as for collection/analysis of the information necessary for PHC planning/implementation, were prepared.

One of the preconditions to achieve these objectives is consolidation of financial funds for PHC at central level instead of fragmentation of funds in several state or municipal programs. So that for the PHC we propose horizontal instead of vertical consolidation of public financial means. It relates also to alternative health care networks (railways, police etc.). If there is no justification for example due to state security reason we propose to merge alternative PHC networks with the public network and to consolidate financial funds as well.

The public purchaser should be dominant purchaser of PHC services. Other should play a marginal role not to interfere with objectives of the public purchaser. Other purchasers may be Public Health Departments purchasing some public health services, military authorities purchasing examinations of draftees etc.

Please, refer to the working paper "Analysis of institutions involved in PHC Financing" (April 2005) and to the working paper "Remuneration Mechanisms and Tariffs Calculation for Primary Health Care in Georgia", issued 28th February 2005.

Activity 1.7/2.7 Workshop on evaluated implications

The project has so far implemented three workshops. In these workshops the team presented the analyses carried out so far and the initial recommendations as attached to this Progress Report:

- The internal workshop dated 30th November 2004 was aiming at
  - Ensuring agreement on a common project approach
  - Clarifying the status quo of the project and the next steps
  - Listing decisions needed for the next steps
  - Drafting the Financial Masterplan for Kakheti
  - Drafting the implementation plan for Kakheti.

  The results of the workshop are represented in the various drafted working papers attached to this Progress Report as annexes. Furthermore, the elements of the Regional Financial Health Financing Masterplan have been drafted (see also Activity 3.5) as well as a proposal for the implementation phase.
- On 14th December 2004 the team presented the activities and results of the reporting period, the implementation plan and the planned activities of the IEC component to MoLHSA and the EC Delegation.
- On 26th January 2005 the GVG/EPOS project conducted a first informational workshop in Telavi to brief Kakheti stakeholders about the pending organisational and financial changes in the primary care system and to make an inventory of the subjects required for more elaborate workshops and other means of communication later in 2005. This workshop focused on the following issues: description of FM; organisation of FM; financial aspects of FM; administration of FM; projects on PHC reform in Georgia.

Furthermore the GVG/EPOS project has actively participated in the four working groups established by MoLHSA (service development and human resources; financing; health management; IEC and health promotion) in terms of making presentations and discussing questions and comments arising.

Please, refer to ANNEX 4 “Workshops and presentations”

Activity 1.8 Consensus finding

The working groups established by MoLHSA (see Activity 2.5) serve as an excellent basis for finding consensus between the stakeholders involved, e.g. SUSIF, MoLHSA, NFMTC. In addition and in preparation for the workshops (1.7), bilateral communication with the stakeholders contributes to building consensus on the new solidarity strategy and the new financial and administrative mechanisms.

Accordingly, both the “IEC” and “Training“ components are supporting and generating consensus about the PHC reform.

Activity 1.9 Draft new solidarity strategy

First elements of a new solidarity strategy have been drafted and communicated with the beneficiary (see also activities 1.1 and 1.5). These include in particular policy recommendations. Consolidated recommendations for a new solidarity strategy in Georgia will be further developed in the next reporting period.

Result 2: New financial mechanisms and administrative processes defined and implemented

Besides the activities concerning the new solidarity strategy (result 1), financial and administrative processes were the second main focus of technical assistance / policy development during the reporting period.

Analyses have been carried out (activities 1.1, 1.2, 2.1 and 2.2) and basic recommendations have been developed:

- concerning the future interaction of the stakeholders involved in public PHC financing and PHC provision (activity 2.1)
- concerning the contracts of polyclinics / ambulatories with SUSIF and other public purchasers (activity 2.4)
- a list of qualitative criteria for a new remuneration mechanism for PHC in Georgia (activity 2.4)
- concerning the approach of the design of appropriate remuneration mechanisms and calculation of corresponding tariffs (activities 2.5.1 and 2.6)
- a remuneration mechanism mix (activity 2.6) and development of the relevant calculation formulas.

These draft recommendations have been and will be further discussed with the beneficiaries and the working groups (i.e. activity 2.7) and will be further detailed and consolidated into recommendations for financial mechanisms (activity 2.5.1) and a new PHC remuneration system (activity 2.6) as a basis for the (pilot) implementation.

The new PHC financial and administrative mechanisms will be linked to the PHC reform process through the activities of the components “IEC”, “Training”, and “Coordination”.

Activity 2.1 Review and clarify: procedure, role, function, responsibility of institutions involved

Clear roles and responsibilities of the institutions involved and clear procedures (interactions) between them are essential for the successful implementation of new financial and solidarity arrangements and for supporting the PHC reform in Georgia.

On the basis of a review and interviews (see also Activities 1.1 and 1.2), the consultant has carried out a first analysis of the institutions involved in public PHC financing and PHC provision. A draft analysis includes the mapping of these institutions (chart), their relations and the money transfers. The legal status, the organisation, tasks, functions, financial flows and other aspects concerning these institutions have been analysed. The current picture shows a fragmentary and complicated interaction of the stakeholders. Further ongoing discussions and uncertainty about the future development of SUSIF have a significant impact on the role, function, and responsibility of all the administrations involved.

A first set of recommendations has been drafted concerning the future interaction of the stakeholders involved at three levels in order to improve their performance:

- To implement a consistent approach towards the PHC development on the basis of a comprehensive PHC running model.
- To identify the institutions taking overall responsibility for PHC planning and the purchase of PHC services. As an option, clear functions, responsibilities and rights in these fields could be granted to MoLHSA (including its regional branches) and to SUSIF.

- To re-orient the PHC planning/implementation from an historic and providers-driven approach to a population needs and medical technologies assessment.
- To elaborate and implement a long-term (e.g. at least for three years) PHC development and financing strategy.
- To elaborate and implement a separate PHC development programme with identification of concrete and measurable priorities/goals/ tasks/benefits.
- To assess the lessons from application of numerous planning and reimbursement methods in the field of PHC.
- To improve collaboration between the main stakeholders.
- To assure information support for decision-making (covering the providers' performance evaluation, financial management, information and epidemiological surveillance analysis).

Please, refer to ANNEX 5 for the "Analysis of Institutions involved in PHC Financing". Issued in April 2005.

Activity 2.5 Establish working group

Working groups are indispensable to ensure the availability of a broad range of insights and a sustainable basis for consensus on proposals of the project.

Members of the project team have attended several working group meetings. The working papers and proposals attached to this Progress Report have been or will be presented and discussed with the working groups. In order to submit a coherent strategy which fits into the Government policy; the results of these discussions will be included in the further development of the project strategy. It is our ultimate goal to feed the strategy developed by the project into the measures proposed to MoLHSA regarding the outputs 1 and 2 of the Road Map for Primary Health Care Reform in Georgia by 30th March and 15th April respectively for firm decision. The National PHC coordinator has issued a proposal paper for the MoLHSA, which derived from the PHC working groups.

However, by the end of April 2005 we did not receive firm decisions about the new PHC system. We addressed a list of pending decisions for MoLHSA/GoG to the EC Delegation for supporting us in this respect.

Please, refer to ANNEX 2 for the "List of pending decisions".

Furthermore regular Round Table meetings of the implementing projects (i.e. OPM, Abt, GHSPIC, and GVG) were established in April 2005. These meetings are supposed to update each other about status of the projects, next steps, and problems. Close cooperation, e.g. monthly meetings, with the National PHC Coordinator is expected.

Activity 2.2 Analyse financial flows

Financial flows between institutions involved in public PHC financing and PHC provision at national, regional and municipal level have been analysed and compiled in a report. The financial data collection and, in cases where information is not available, an estimation of the scope of the inflows to PHC were used as a basis for elaboration of the financial master plan. The approaches and regulations applied for elaboration of the State Outpatient programme were analysed. A list of publicly paid activities/services through channels other than the State Outpatient programme was drafted for further consideration.

The issues of mobilisation and integration of resources under a particular PHC implementation programme were addressed. In the current situation, the PHC budget still cannot be satisfactorily identified. Thus for the coming period, further detailed analysis / projection of the PHC financing options, having regional PHC sustainability in mind, is considered and proposed for discussion in the Financing Working Group. (See activity 2.1)

Activity 2.3 Analyse and identify main shortcomings and obstacles to reform

Main shortcomings and obstacles to reform have been analysed and form an integral part of the working papers attached to this Progress Report. However, we would like to summarise them as follows:

There are some general obstacles and shortcomings indicated in the "Road Map" issued by MoLHSA:

- *a complex combination of high public expectations with severe economic difficulties,*
- *an unstable situation with frequent changes in government,*
- *a context in which the main stakeholders (doctors, citizens, universities, etc.) have not been properly involved in the process of reform,*
- *a series of well-meant reform initiatives which have either not been properly implemented and/or are not necessarily compatible with each other,*
- *a severe institutional weakness as a result of which MoLHSA has found it difficult to play a proper leadership in the process so far.*

There is thus a need to make demonstrable progress, otherwise the reform will become stuck.

Beside these overall problems, there are some particular organisational and financial issues which might be seen as obstacles or shortcomings for PHC financing reform:

- No clear plan for optimisation of the ambulatory system in Georgia and especially in Kakheti – there is no final decision on the number of facilities which will be contracted in future after optimisation and thus no exact data on catchment area of medical teams. It is therefore very difficult to calculate exactly the co-payment rates.
- If the health social insurance system is transformed to a budget-financed HC system, it is necessary to analyse in depth what will be the solidarity mechanisms for support of (vulnerable) target groups
- MoLHSA is introducing a new identification and registration system for the vulnerable, but first data regarding the number of vulnerable population might be obtained only at the beginning of 2006. It is therefore very difficult to calculate exactly tariffs for co-payments and exemptions from these payments, as well as sources for covering existing gaps in PHC financing
- Considering the mechanism for attracting the population to the PHC system, several obstacles have been identified:
  - The population will not increase visits to PHC facilities which are not refurbished, not equipped and where staff are not re-trained, as they lost trust in them in the past (according to one household survey, poor quality of care, poor physical and technical infrastructure, poor sanitary conditions, lack of possibility for laboratory tests, lack of knowledge of medical staff, etc account for nearly 50% of the reasons why the population do not go to PHC facilities) ;

  - The only way to attract people to visit even such deteriorated facilities is to include provision of drugs in the BBP, but the question then is, how to finance this?

- GoG is planning to introduce a universal BBP, but as only a part of PHC facilities will be refurbished, equipped and staff trained, not all PHC centres can provide all the PHC services included in the BBP; this will cause inequity and asymmetry for the population and mistrust towards the government. The BBP will be only a declaration of intent for people without access to renovated facilities.
- Due to their right of free choice of a physician in areas where two or more providers are available, the population will choose those facilities, which are refurbished and equipped, with professionals who have been retrained and where they can receive the full package of services. Enrolment of the population for some medical teams might therefore decrease to virtually zero, whereas for others it could increase to the maximum figure allowed. This will cause many problems even for those teams with the maximum demand for enrolment, since a huge increase in demand will lead to a decrease in quality, increase in referrals, longer waiting lists, etc. Thus the main aim of reform – provision to the whole population of accessible, affordable, quality HC services – could be undermined.

Activity 2.4 Select criteria for financial mechanisms

A list of qualitative criteria for a new remuneration mechanism for PHC in Georgia has been developed, which aims to:

- be consistent with the health policy objectives of the country
- be consistent with the legal status and organisation of providers
- be consistent with solidarity schemes
- provide incentives for an appropriate volume and structure of care
- provide incentives for quality of care
- provide disincentives for an inappropriate choice of patients
- give the ability to calculate tariffs / ensure the availability of data
- ensure administrative simplicity
- allow fraud elimination / the ability to audit claims

Activity 2.1 also deals with the financial flows between the institutions involved in PHC and with payment mechanisms (remuneration of services).

Please, refer to working papers “Remuneration Mechanisms and Tariffs Calculation for Primary Health Care in Georgia” (issued in February 2005) and “Analysis of Institutions involved in PHC Financing” (April 2005).

Activity 2.5.1 Develop options for financial mechanisms

Possible financial mechanisms have been developed and compiled in the respective working papers (see activities 2.1 - 2.6).

PHC in Georgia suffers from several problems. Health facilities are under-funded and medical personnel badly paid, but on the other hand inhabitants do not use PHC services - usually they treat themselves or if not, they by-pass the PHC level. There is an excess capacity of PHC facilities which would be under-utilised even if inhabitants used PHC as in other countries. The PHC level is not organisationally separated from the secondary level in Georgia.

We started our analysis of the problem from the bottom up. We have elaborated a comprehensive cost model of a PHC practice and we have found that normal functioning of a PHC practice

requires annually about 5,500 Lari for operations and about 2,000 Lari for depreciation and maintenance of premises over and above the current level of funding.

Increased salaries for medical personnel, which we considered in evaluation of the cost model, account for some 3,000 Lari of this funding gap. At the same time, we came to the conclusion that on average less than 10% of the total annual costs of a PHC practice are variable costs which depend on the number of patients visiting the practice.

We have analysed six options as to how to cover this funding gap. A simple increase of public funding seems not to be feasible, given the current macroeconomic situation in Georgia. Optimisation of the network of PHC facilities would help and should be done, but this realises only some 1,800 Lari annually per practice to cover the gap.

After that, the only options which remain are those which depend on patients bringing money into the PHC system. Either all patients (with the exemption of vulnerable people) will pay some well-defined charge when visiting a PHC practice; or only a part of PHC services will be publicly funded; or some major groups of inhabitants (for example, adults under 65) will be excluded from public funding. Another option would be that the public purchaser (SUSIF) contracts only part of the capacity of PHC providers: only patients who visit during office hours would be covered by public funding, while others would have to pay the full cost of services.

We recommend the option with a well-defined patients' charge for (nearly) all. The other options would not significantly decrease the costs of PHC practices, since less than 10% of these are variable costs. There is also a great risk that patients exempted from public funding will not bring in the expected money to cover the fixed costs of practices, since they will either not use or will by-pass the PHC level as currently occurs. The final option does not guarantee the rights of inhabitants to PHC care and we do not recommend it mainly for this reason.

Activity 2.6 Elaborate tariffs and new payment formulae for PHC

The future remuneration system should enforce a sound and objective-oriented health policy and reflect criteria defined on this basis (see activity 2.4). The special needs of poor and vulnerable population groups and the population living under specific conditions – such as those living in rural and high mountain areas – must be taken into consideration. New tariffs and payment formulae will be developed as an integral part of a sound contracting system based on the new health financing policy of the Government of Georgia. The result of this activity will be a new reimbursement, payment and tariff scheme for PHC services with a focus on BBP.

We recommend following the "seven steps" approach to the design of appropriate remuneration mechanisms and calculation of corresponding tariffs:

1. Requirements, assumptions and decisions relevant to the design of the remuneration system are formulated and well documented
2. Costs are calculated for specified types of PHC units
3. An appropriate mixture of remuneration mechanisms is chosen that best meets the criteria
4. For the portfolio of remuneration mechanisms, specific preparations have to be made
5. The structure of patient's charges is specified as well as cost sharing that should be covered by patient's charges and target patients groups. Elasticity of demand will be considered.
6. Indicators of volume and quality of PHC are specified to complement contractual provisions of remuneration mechanisms
7. The designed portfolio of remuneration mechanisms and the calculated tariffs are verified

Options for remuneration mechanisms applicable for PHC have been identified and evaluated. Based on the criteria selected we recommend a capitation-based PHC remuneration system. According to the above mentioned approach we identified and documented requirements regarding

to salaries of medical personnel, space requirements for medical premises and requirements for equipment of PHC. The comprehensive cost model for different types of PHC units (mobile practice, solo practice, group practice, laboratory, and nurse post) was built up and filled with data derived on Georgian experience.

Regarding remuneration system as a core universal mechanism for PHC per capita remuneration is recommended for Georgia. This mechanism will be complemented / adjusted by particular measures in order to address negative incentives built into the capitation mechanism.

Regarding tariff calculations, the consultant recommends a limited (combination of two or maximum three options) selection of the following **remuneration mix**:

- Budget based on consumption of input factors, e.g. staff, materials
- Per capita remuneration for each person explicitly or implicitly registered at a primary health care practice
- Remuneration for each visit to a primary health care physician
- Remuneration per patient with a distinctive pathology (i.e. patients with long-term diseases requiring supervision by a physician)
- Remuneration per service (intervention) for each single intervention (one or more during one visit)

Options for remuneration mechanisms applicable for PHC have been identified and evaluated. Based on the criteria selected we recommend a capitation based mechanism as a core universal mechanism for PHC remuneration in Georgia. This core mechanism is supplemented by fee for service for preventive service as one option. Remuneration for depreciation and maintenance of PHC services is also considered in two options. Firstly it can be included in the remuneration by capitation or it can remunerated by budget at public owners of PHC premises (the Georgian state or municipalities).

The proposed options for remuneration mix are complemented / adjusted by particular measures in order to address negative incentives built in the capitation mechanism. Age adjusters and social adjusters are proposed and calculated with intention to prevent adverse selection of inhabitants by PHC providers.

To cover the identified gap of current public remuneration of PHC services an uniform and simple system of user fees was designed and calculated. The user fee applies for each non preventive visit (with exemption for vulnerable people).

The relevant calculation formulas were developed and basic tariffs, risk adjusters and users fee were calculated according to them.

There are some risks associated with the proposals above. It may turn out that the fees calculated will be prohibitive for a major part of population and they will therefore continue to avoid or try to by-pass the PHC level. For this reason as well, it is necessary to include some coverage of drugs to make PHC more attractive for inhabitants.

It might also occur that some PHC providers will continue to ask for unofficial payments, even though official co-payments are intended as a substitution for these. A strong contractual policy by the public purchaser will have to play a decisive role in this respect. As a partial remedy, we propose to finance part of the income/salary of medical personnel from patient's co-payments.

The proposal we are submitting for discussion is considered by the Project team as the most feasible and in full accordance with the reform goals to improve the health status of Georgian inhabitants and to use public money in the PHC system more efficiently. Nevertheless, based on discussions with our Georgian counterparts, we are able to modify and to calculate rapidly the impact of other options to the same level of detail.

Please, refer to the working paper "Remuneration Mechanisms and Tariffs Calculation for Primary Health Care in Georgia", issued 28th February 2005.

Activity 2.7/1.7 Presentation

See activity 1.7

4.2 Component 2: Pilot Activities in Kakheti Region

As described in section 3. "Summary of Project Planning for the Remainder of the Project" of this report, pilot activities / implementation will be implemented in various stages which are clearly defined. The stages are:

- Preparatory stage
- Pre-pilot stage
- Pilot stage
- Evaluation stage

It is of utmost importance that, as at national level, the Kakheti counterparts designate staff who will be responsible and have the capacity for the implementation exercise during the project and beyond.

The EU financed refurbishment and re-training project will be ongoing until the end of 2006. The current out-patient system and the new PHC system will be functional in parallel for a certain period of time. The GVG pilot activities in Kakheti must be linked and coordinated with the national level. This means that also at the national level structural changes have to be implemented (parallel to the current system which will continue working for the rest of the country and partly in Kakheti). The project will thus on an ongoing basis support the implementation of the necessary structures at national level: advice, training and the provision of equipment are the most important instruments.

During the reporting period the identification of partner institutions in Kakheti has started. A project office in Telavi has been established and a local coordinator for the region has been contracted (activity 3.0). The health / medical needs of the population in Kakheti have been analysed (activity 3.1)

The contracting between polyclinics/ambulatories and SUSIF and other public purchasers and the book-keeping system has been reviewed and some initial recommendations have been developed (activities 3.2 and 3.3).

A first set of elements for the Masterplan for future development of PHC financing has been drafted (activity 3.4).

Please, refer to the working paper "Capacity Building for Primary Care Reform in Kakheti", issued 28th February 2005.

Result 3: A regional health financing Masterplan is developed

Activity 3.0 Identification of partner institutions, setting up the pilot office in Kakheti

Identification of the partner institutions in Kakheti started immediately after the summer vacation period. The project started cooperation with PHC funding agencies and health care providers in Kakheti. During the reporting period the project team had meetings with the following stakeholders in Kakheti: Regional Department of MoLHSA, Governor's Office of Kakheti, SUSIF Regional Department Kakheti, Public Health Department, and selected out-patient health care providers. Furthermore some NGOs and a set of local/regional journalists have been contacted for preparing the IEC activities.

The project office in Kakheti has been functional since 20th December 2004. The office is staffed permanently with local staff and will be complemented on a regular but not permanent basis with international experts. The GVG/EPOS office in Kakheti was officially inaugurated on 26th January 2005.

Activity 3.1 Review and analyse existing health / medical needs of population in Kakheti

The draft report on health / medical needs includes specific data and information about the situation in Kakheti, including recommendations arising. See also activity 1.3.

As was stated under activity 1.3, medical/health problems have been reviewed and evaluated on the basis of existing statistical data and the results of surveys and population-based studies. Whenever possible, data were analysed for Kakheti separately.

The overall, demographic situation, morbidity, and mortality in Kakheti are comparable to other regions. There are nevertheless some peculiarities, namely Kakheti has higher rates for diseases of the circulatory system (mainly ischemic heart disease and stroke) and malignancies compared with other regions. Similarly, the prevalence of endocrinal diseases (manly goitre and diabetes mellitus) is one of the highest in Kakheti.

Kakheti is an endemic region for malaria – almost all cases reported in the country are registered in Kakheti. This has important implications for primary health care in Kakheti and calls for immediate action.

Please, refer to the working paper "Health Needs Assessment in Kakheti", issued 28th February 2005.

Activity 3.2 Evaluation of management, accounting, HR, contracting capacities in Kakheti

The contracting between polyclinics/ambulatories and SUSIF and other public purchasers has been reviewed and some initial recommendations have been developed.

Each provider has 5 contracts with each public purchaser. We strongly recommend streamlining the contracting.

A book-keeping system is available at the providers' level and on the purchasers' level. This system shows particular deficiencies with regard to completeness and transparency. For improving book-keeping and accounting The Tax Code Law of Georgia regulates the accounting systems of the polyclinics and ambulatories. Their financial concerns enfolded the double bookkeeping system. The standard forms are mandatory and based on international standards of bookkeeping. Polyclinics and ambulatories have to use the following standard forms:

- Balance sheet
- Profit and Loss account
- Single Accounts (Wages, heating, water, gas, etc.)
- Journal

- Cash account book
- Tax declaration form
- Cash receipt
- Registration of the catchments population

At the current situation the administration of the polyclinics and ambulatories prepare all necessary forms and accounts. The physicians are not in charge with this process.

In general the bookkeeping and accounting system follows the Tax Code Law of Georgia and the international standards.

For improving bookkeeping system and accounting in the Primary Health Care System the following recommendations shall be considered:

- Clear guidelines are needed to simplify the system
- All transactions, including co-payments, must be documented. No net-transaction can be allowed.
- The yearly balance sheets as well as the profit and loss calculation sheet have to be based on all transactions during the fiscal year.
- The FM-Teams should prepare only the Journal including the profit and loss calculation. Group practices with more than 5 doctors and 5 nurses must use the fully bookkeeping and accounting system as well as polyclinics and ambulatories. The tax code has to be accordingly adapted.

The reimbursement system is regulated in the contracts between the providers and the public purchaser (SUSIF). The providers prepare the request of payments and the remuneration of the personnel costs, maintenance, etc. SUSIF checks the requested payments in order to settle the payments. The Treasury proves the payment orders of SUSIF and transfers the amounts to the bank accounts of the providers.

The capacities assessment is an integral part of the report on Capacity Building for PHC Financing reform in Georgia (see Component 3). The assessment of the training needs (see Activity 4.3) shows that the most important and urgent need exists among the primary care providers who will be the future family physicians and nurses, managing their own family medicine practices. The need for training SUSIF staff is very limited under present circumstances, and uncertain for the future, because the future role of SUSIF and the future financing model are not yet fully known.

In 2006 our project will pilot new PHC solidarity mechanisms. The training of primary care providers in the principles and management of family medicine, focussing on financial management, even before their official retraining programme in family medicine would start, is an important contribution for this pilot implementation.

The existing retraining programme for family medicine has modules that can be used for a fast-track programme of training in the principles of management of family medicine; these modules have proved their value in the past. There would be no need to design a new curriculum. The availability of trainers has to be checked. According to quantitative capacity restrictions of trainers we assume to train trainers through our project. Our project could help to update module 2 for physicians and module 16 for nurses if new developments make this necessary. In any event, the consultant will update/enlarge module 2 to meet future needs. The results can later feed as one element into the EU-retraining project for family physicians, which is currently being prepared.

Please, refer to working paper “Capacity Building Needs for Primary Care Reform in Kakheti”, issued 28th February 2005.

Activity 3.3 Recommendation/options for efficient financial mechanisms and processes

The development of options for efficient financial co-ordination mechanisms and administrative processes is ongoing, hand in hand with the evaluation activities under 3.2.

Activity 3.5 Preparation of Masterplan

A first set of elements for the Masterplan for future development of PHC financing has been drafted:

1. Identify PHC Budget
    a. State funds
    b. Municipal funds
    c. SUSIF funds
    d. Private insurance
    e. Co-payments
    f. Others
2. Institutional Setting
    a. Legal status of PHC facilities
    b. Legal status of PHC staff
3. Define PHC Service Provision
    a. BBP for PHC
    b. Extra PHC services
    c. Referral system
4. PHC performance and utilisation
    a. Accreditation and licensing
    b. Contracts
    c. Quality assurance of services
    d. HMIS
5. Financial Mechanisms
    a. Funding system
    b. Remuneration system
    c. Investments
6. Implementation Steps
    a. Who?
    b. When?
    c. How?

Note: legal aspects are an integral part of the Regional Financial Masterplan.

This Regional Financial Masterplan will be complemented by simulations of the transition process from the old out patient system toward the new PHC system in terms of financial implications based on the utilisations of the medical facilities.

4.3 Component 3: Capacity Building/Training

Result 4: Training needs on health insurance management are analysed; sustainable training programmes on health insurance management are planned and implemented

The project focuses on the reform of the health care financing system towards sustainable financing of the Primary Health Care Services. Accordingly all training activities focus on health financing management in the context of the primary health care reform.

The objectives of the training activities are:

- To facilitate the pilot implementation activities of the project in Kakheti
- To increase the administrative and management capacity of the institutions involved at all levels
- To contribute to the building-up of sustainable training structures for health financing management in Georgia.

The planned activities (see Inception Report) therefore consisted of:

- Assessment of training needs (activities 4.1 and 4.2)
- Review of existing programmes and facilities (activity 4.3)
- Development and implementation of a train-the-trainer programme (activities 4.4 to 4.7)
- Development and implementation of a training programme in management-financial issues for "end-users" (in Kakheti and at national level) to support the pilot implementation process in Kakheti
- Evaluation and adaptation of the programme for use at the national level.

Several factors outside the project have influenced the previous activities and future planning in this field:

- The Minister of LHSA has published the Road Map for PHC Reform. The donor-supported primary care projects will have to adapt their activities to this programme – the planning for our project has in fact been adapted to the time plan of the Road Map.
- The new organisational model of primary care and the new financial mechanisms for primary care have not yet been decided. This means for example that it is not clear who will be the future primary care managers, who should receive management training and which type of financial management they should be trained in.
- The future role of SUSIF is unclear.
- A new EU-supported project for the retraining of primary care staff is being planned. Its implementation may start after the contracting planned for mid-2005.

During the reporting period, capacity building needs and training needs have been analysed (activities 4.1 and 4.2). The availability of training programmes, training centres and trainers has been assessed (activity 4.3). The preliminary results of these activities have been described in Annex 9: working paper on "Capacity Building for Primary Care Reform in Kakheti". Please note that this Annex 9 presents the information as available at the beginning of December 2004. Since then, this information has been updated. The combined information from this analysis has – in combination with the above-mentioned developments outside the project – led to the approach to activities 4.4, 4.5 and 4.6 described below.

Activity 4.1 Definition of capacity building needs

An analysis of capacity building needs related to the implementation of the BBP for PHC and to the respective financial and administrative mechanisms has been carried out and been summarised in a working paper. The analysis covers both PHC funding agencies at national and regional level and health care providers at regional level:

- primary care physicians
- regional SUSIF staff for health services

- staff of the Regional Department of MoLHSA
- regional staff of the Department of Public Health
- national staff of some departments of MoLHSA and SUSIF.

PHC Providers

At present, primary care in Kakheti is almost completely managed by secondary care institutions, i.e. by polyclinic directors. There are only 5 independent ambulatories in Kakheti (out of 111); they are larger than average and even offer some narrow specialist care. Primary care should become independent from secondary care in the near future, and in most settings primary care physicians will have to manage their own affairs. That means *they* should be trained, not the polyclinic directors and their financial assistants.

Management is a very broad term that means much more than (financial) administration. A manager of primary care must make sure that the following tasks are being performed according to plan: administrative and financial aspects of the provision of the standard package of health services, management of finances (business plan, contracts with purchasers, financial administration of revenues and different types of expenditures, tax issues, etc.), maintenance of the material infrastructure (premises and equipment), management of human resources (doctors and nurses, employment issues), collecting, analysing and providing data and information (patients' lists, data on the number of office visits and home visits, coverage of preventive services, epidemiological data, etc.).

The training of primary care providers in these issues, even before their official retraining programme in family medicine would start, has been considered.

Regional and National Funding Agencies:

Primary care managers interact with the following professionals who are also potential target groups for capacity building and training in management and (financial) administration:

- regional SUSIF staff for health services
- staff of the Regional Department of MoLHSA
- regional staff of the Department of Public Health.

This potential target group numbers at most 15 people.

National staff of some departments of MoLHSA and SUSIF are also potential candidates for training in financial management.

SUSIF and MoLHSA staff will have to be trained in the administration of the enrolment process, payment of primary care providers by capitation payments, and quality control via a minimum set of indicators. They will have to learn how to provide feedback to family medicine practices on their performance in comparison to regional and national averages. This performance will be measured by indicators such as average consultation rates, referral rates, prescription rates, and coverage of preventive activities.

Activity 4.2 Assessment of training needs

On the basis of activity 4.1 the immediate training needs for the different target groups have been analysed and been defined for some of them (compare also activities 4.1 and 4.3):

The most important and urgent need exists among the primary care providers who will be the future family physicians and nurses, managing their own family medicine practices.

The need for training SUSIF staff is very limited under present circumstances, and uncertain for the future, because the future role of SUSIF and the future financing model are not yet known. The minimal requirements for training in family medicine financing for existing SUSIF and other staff in Kakheti are at most one or two workshops for a maximum of 15 staff.

The requirements for training in primary care financing for national staff of SUSIF and MoLHSA are not clear at the moment.

Activity 4.3 Review of existing training centres and programmes

From the beginning it was clear that the project – whenever possible – would take into account existing training programmes and existing training facilities and would use their staff. These possibilities have been assessed and are part of the report on "Capacity Building Needs for PHC Reform in Kakheti". The analysis carried out during the reporting period has shown that:

- The existing retraining programme of NFMTC for family medicine has modules in the principles and management of family medicine. Our project should help to update and enlarge the existing modules for physicians and nurses.
- SUSIF does not organise in-service training courses for its national and regional staff; they "learn by doing". Many of its staff at national and regional level have the certificate in public health management from the National Institute of Health and Social Affairs, although SUSIF is not involved in the design or teaching of this curriculum.

Activity 4.4 Draft curriculum for training in Kakheti

The project approach was to implement intensive training for a group of trainers who would then carry out the training for the different target groups and who would be the nucleus for nationwide replication of the training beyond the duration of the project. New developments and changes in the environment have led to the following approach.

- During 2005 and 2006, the project will train involved representatives of financing administration from the regional level (Kakheti) and from the national level. Furthermore, all out-patient doctors and nurses from Kakheti will be trained in basic financial and administrative issues. After clarification on the retrained staff, an additional financial and administrative training will be conducted for this target group. This specialised training (module 2) will focus on the new mechanisms and procedures necessary for running of the new PHC system.
- The existing retraining programme for family medicine that will be given to the staff by the new EU funded training project has a management module, part of which will be used as a theoretical basis for developing the new administrative and financial skills of the staff of the pilot facilities. However, the curriculum for the *practical* aspects of self-management in PHC ambulatories must be developed from the beginning. These practical management topics have been mentioned above under activity 4.1. Trainers will be trained who can teach this new curriculum.
- The training of PHC staff of new PHCens, Managers and central and regional financing administrations will take the form of workshops, for which a format will be developed (module 2) during the Pre-Pilot stage. The workshops will cover topics such as data requirements, administration of the enrolment process, payment of primary care providers by capitation payments and quality control.

- The requirements for training in primary care financing for national staff of SUSIF and MoLHSA are not yet clear.

Activity 4.5 Draft training materials

For the development of training materials according to the curricula, see activity 4.4.

Activity 4.6 Selection of potential trainers

Please refer to activities 4.4 and 4.5

4.4 Component 4: Information, Education and Communication (IEC)

Result 5: Seminars and workshops at central and regional levels assist the MoLHSA in building supportive environment for the introduction of new health insurance policy and practices organised; an IEC strategy is developed

A draft IEC strategy has been produced (activity 5.3) and was issued to the EC Delegation by 28th February 2005. The objective of the draft IEC strategy is defined as to assist the Ministry in building a supportive environment among the public and professionals at both national and Kakheti regional level for the introduction of PHC and health insurance reforms. The draft strategy focuses on the needs of three key target groups:

- the "internal public" – policy-makers (including Members of Parliament), Ministry, SUSIF, regional staff etc who need to be PHC reform "champions" – to build an internal consensus on and understanding of the reforms
- the "professional public" – health managers and professionals, opinion-formers, the media, NGOs etc who need to be "allies" of the reform– to build an external consensus on and understanding of all aspects of the reforms, including the BBP
- the general public – including both patients and non-patients, and vulnerable groups – to inform them of their rights and the practical impacts of the reforms

The draft strategy sets out plans to inform and educate these groups through such activities as:

- information seminars/workshops and events
- media education (not just provision of information – journalists need to be taught basic facts about health care so they better understand the reforms) and activities
- public information materials and activities

The draft strategy assumes close co-operation with stakeholders and other PHC reform projects, co-ordinated by the Health Promotion and PR Working Group. It also envisages that implementation in Kakheti Region will be undertaken with the assistance of a suitable NGO.

The draft strategy covers:

- an analysis of the PR capacities and activities of the main stakeholders at national and Kakheti level (activity 5.1)
- provision for incorporation of the "content needs" (activity 5.2)
- identification of the main target groups (activity 5.5)
- a timeframe for the selection of participants for seminars/workshops at both national and Kakheti regional level (activity 5.5)
- preparation of a range of information materials, including a PHC Reform Manual to be provided to all seminar / workshop participants (activity 5.4)
- proposals and a timetable to roll out the programme of seminars/workshops – starting with the "internal" public, then the "professional" and general publics – from March 2005 (activity 5.4)
- evaluation of all IEC activities in spring 2006, with their effectiveness gauged through a range of measurements including an evaluation survey. The evaluation report will include adapted material and serve as a handbook for nationwide replication of the activities after the project (activity 5.7)
- proposals for the organisation of two final conferences at the end of the project – one in Kakheti and one at national level. The results of the project will be presented at these to decision-makers and the media, with recommendations for follow-up based on experience from the pilot activities (activity 5.7.a)
- a range of media education and information activities throughout the project, at both national and Kakheti regional levels (activity 5.8).

Furthermore, the IEC experts have produced a leaflet explaining the project's objectives and activities, for distribution to all stakeholders and interested parties at both national and regional level.

Please, refer to the "Information, Education and Communication Strategy (Draft)", issued 28th February 2005.

Activity 5.1 Inventory of already existing public information and PR activities and products

The PR capacities of the main stakeholders at national and Kakheti level have been analysed, plus the existing and previous PR activities and materials concerning PHC reform of these and other actors, such as NGOs and donor-funded projects.

This assessment has been incorporated into the draft IEC strategy, together with recommendations on how to co-ordinate and maximise the effectiveness of the human and material resources available for public information / PR purposes.

Activity 5.2 Definition of the "IEC content needs" with regard to components 1, 2 and 3

The draft IEC strategy makes provision for incorporation of the "content needs" based on two factors:

- the results of the strategic activities of components 1, 2 and 3 and decisions on these by the Ministry, in accordance with the timetable set out in the Road Map for PHC Reform;

- research into the information needs of the key target groups, which will be conducted in Spring 2005

Activity 5.3 Based on the research results, define a strategy for Information, Education and Communication

A draft IEC strategy has been produced and is attached to this Report (see Annex 10).

The draft strategy has been submitted to the Working Group on Health Promotion and Public Relations and will be revised following discussion with the key stakeholders and other PHC reform projects. A final version should be agreed, according to the timetable set out in the Road Map, no later than the end of March 2005, with implementation starting immediately thereafter.

The objective of the draft IEC strategy is defined as to assist the Ministry in building a supportive environment among the public and professionals at both national and Kakheti regional level for the introduction of PHC and health insurance reforms. The draft strategy focuses on the needs of three key target groups:

- the "internal public" – policy-makers (including Members of Parliament), Ministry, SUSIF, regional staff etc who need to be PHC reform "champions" – to build an internal consensus on and understanding of the reforms
- the "professional public" – health managers and professionals, opinion-formers, the media, NGOs etc who need to be "allies" of the reform – to build an external consensus on and understanding of all aspects of the reforms, including the BBP
- the general public – including both patients and non-patients, and vulnerable groups – to inform them of their rights and the practical impacts of the reforms

The draft strategy sets out plans to inform and educate these groups through such activities as:

- information seminars/workshops and events
- media education and activities
- public information materials and activities

The draft strategy assumes close co-operation with stakeholders and other PHC reform projects, co-ordinated by the Health Promotion and PR Working Group. It also envisages that implementation in Kakheti Region will be undertaken with the assistance of a suitable NGO.

Activity 5.4 Prepare materials for seminars/workshops to introduce the new health insurance policy

Preparation of a range of information materials is proposed in the draft IEC strategy, including a PHC Reform Manual to be provided to all seminar/workshop participants.

Activity 5.5 Select participants for seminars/workshops in pilot region Kakheti

It is essential to have a group of participants including health administration, municipalities, health care providers and the population. Main target groups have been identified in the draft IEC strategy and a timeframe established for selection of participants for seminars/workshops at both national and Kakheti regional level.

Activity 5.6 Implement seminars and workshops and round tables to introduce the new health insurance policy at national and regional levels

The draft IEC strategy includes proposals and a timetable to roll out the programme of seminars/workshops – starting with the "internal" public, then the "professional" and general publics – from April 2005.

Activity 5.7 Evaluate and replicate seminars/workshops at national level

All IEC activities will be evaluated in Spring 2006, with their effectiveness gauged through a range of measurements including an evaluation survey. The evaluation report will include adapted material and serve as a handbook for nationwide replication of the activities after the project.

Activity 5.7a Final conference to present project results

It is proposed to organise two final conferences at the end of the project – one in Kakheti and one at national level. The results of the project will be presented at these to decision-makers and the media, with recommendations for follow-up based on experience from the pilot activities.

Activity 5.8 Carry out regular press conferences (including a press conference at the end of the project)

The draft IEC strategy envisages a range of media education and information activities throughout the project, at both national and Kakheti regional levels.

Activity 5.9 Provide communications support and advice to other project components

The IEC experts have produced a leaflet explaining the project's objectives and activities for distribution to all stakeholders and interested parties. Advice and assistance will be provided throughout the project to the project team on PR and design matters, including compliance with the EC's visibility guidelines.

4.5 Component 5: Coordination Activities

PHC reform in Georgia is a co-ordination challenge for MoLHSA and for the donors/implementing agencies. The National PHC Co-ordinator recently has established 4 working groups for synthesising all findings and recommendations in order successfully to support and drive forward the PHC reform. See also activity 1.8.

The PHC reform in Georgia is supported by several international donors and implementing agencies. The main donors are: European Union, World Bank, DFID, and USAID. Wherever there are joint areas of activities, the consultant has sought coordination with their projects.

Please, refer to ANNEX 3 and 4 for the "Meetings" and "Workshops and Presentations"

The EU is planning to support the PHC reform from 2005 with projects (re-)training future Family Physicians and refurbishing PHC facilities. A project team had been in Georgia preparing the necessary ToR. Several meetings have been held with this team, with particular regard to avoiding conflicts concerning timing and content. However, a harmonisation of our project with the future EU funded projects seems questionable having the different time frames in mind.

The World Bank plans to support the PHC reform for example by investing in regional PHC training. A final harmonisation between EU, World Bank and MoLHSA of "when" and "where" to start PHC implementation activities (e.g. training centres, list of selected PHC facilities) is planned by the beginning of 2005. A corresponding agreement and decision is required as the basis for any further progress of the PHC reform.

OPM (Oxford Policy Management) is acting as the DFID implementing body for PHC support in Georgia. Many useful analyses and recommendations have been prepared. Several meetings have taken place for coordinating the work streams. Concerning financial aspects it seems that GVG's work is more implementation-orientated than OPM's work. During the coming months the recommendations of both projects have to be more harmonised through bi-lateral meetings and the 4 working groups. In the field of IEC and Health Promotion, close and fruitful collaboration has taken place. The results arising are reflected in the draft IEC Strategy (see Annex 10).

USAID has recently started a new PHC reform project: Georgia Co-Reform Project – Cooperation in Health Care System Transformation. The overall project strategy is founded on the provision of technical assistance to strengthen the policy development and institutional capacity required by the Government of Georgia. The USAID project will focus on synthesising the lessons learned in the PHC reform including GVG, OPM, and World Bank. A risk to our project can be seen if USAID was to develop a new PHC vision for Georgia which does not fit to our approach. During the coming months, the recommendations of both projects have to be more closely harmonised through bi-lateral meetings and the 4 working groups.

4.6 Study Tours

Result 6: Study tours to one or two countries in transition (or new EU member states) and in one "old" EU country are implemented

Activity 6.1 Study visit for policy-makers and administrators/implementers; contacts beyond project

The project team proposed to implement a study tour to two countries (one "old" and one "new" EU member state) for two groups of 8-10 people each (a) policy-makers and (b) administrators / implementers of the reform. The groups will include key personnel from both national and Kakheti regional level. It was agreed with the EC Delegation and the National PHC Coordinator to study PHC in Lithuania and Denmark from 17th May through 27th May 2005. The list of participants and the draft agenda have been agreed with the National PHC Coordinator and the EC Delegation. The EC Delegation has approved the study tour as suggested by the project. All necessary preparations are ongoing.

The study tour will be implemented at an early stage, when key participants are available, in order to inform and influence the policy-making and reform implementation process. While the two groups will travel together, they will have partly separate day-time programmes, with the opportunity to share their experiences with each other.

The first group will examine how policy is made, applied, and further developed regarding the health insurance and finance systems in the selected EU countries which have functioning PHC systems; it will also explore how health reform policies are communicated and covered by the media. The study visit will thus contribute to the further development of detailed plans to implement the PHC reform in Georgia.

The second group will study in-depth the work of functioning PHC structures, with particular emphasis on the financial mechanisms and administrative systems.

4.7 Technical Specification for Necessary Equipment

Result 7: Technical specification for necessary equipment and software is prepared

For the pilot implementation in Kakheti region – and later on, for Georgia as a whole – an IT-supported information system will be a big step forward regarding the availability of data material, of permanent patient records and the installation of a database, which is needed for each tracing and follow-up and for the functioning structure of a stable financing system.

The final output of the equipment-related activities will be the technical specification, guidance, supervision and training in relation to delivery of hard- and software to the institutions who will participate in the pilot implementation at regional and central level.

Thus all activities are targeted at providing basic equipment to facilitate this pilot implementation process:

- Activities 7.1 – analysis, 7.5 – system design – and 7.7 – monitoring indicators – provide the basis of
- activities 7.2 and 7.3 (requirements and technical specification) which then are the basis of
- the tendering process at the EC Delegation.
- Activities 7.4 and 7.6 will support and follow-up the equipment purchase and delivery.

The equipment should be designed for the easiest solution possible, so that the user training of doctors and nurses will be as easy and short as possible.

So far, initial analyses on current information exchange mechanisms have been carried out and the main requirements for the new system have been identified. The communication lines in the pilot region have been analysed. A first draft of the technical specification for the necessary equipment has been developed and inserted into the procurement documents. Software solutions are under evaluation: a software package from a Canadian company has been evaluated and discussed. The Centre of Disease Control is working with this software in a test run and checking whether it is a feasible solution. The software is already translated into Georgian.

A system similar to the system proposed for Kakheti is also being implemented in the Ukraine. Regarding effectiveness, this system is designed to work for at least a minimum period of 3 years. Regarding the components, the system is designed for minimal user errors and the data transfer is done automatically. That means the doctor or the nurse can use it without a complete knowledge about how PCs work. The proposed solution is different from the proposals of other organisations (e.g. USAID), but the Consultant is convinced that a simpler system will be more effective and sustainable.

Please, refer to the “Draft IT Procurement Tender Documents”

As an alternative to providing each PHC provider with IT equipment, the establishment of so-called “service centres” is also under consideration. The role and function of these service centres have to be developed and the resulting transfer of information has to be elaborated. In case the HMIS working group recommends this solution to MoLHSA and MoLHSA chooses this option, the consultant will specify the IT requirements at short notice.

Activity 7.1 Review current information exchange mechanisms

First analyses on current information exchange mechanisms have been carried out. The technical conditions for communication in the pilot region have been analysed.

Activity 7.5 Design of the IT systems

Even though activity 7.1 is not yet completed, the main requirements for the new system have already been identified.

Activity 7.2 Prepare technical specification

A first draft of the technical specification for the necessary equipment has been developed and inserted into the procurement documents. This draft has been given to the EC Delegation at the beginning of December 2004.

Software solutions are under evaluation: a software package from a Canadian company has been analysed and discussed. The software is already translated into Georgian. The Centre of Disease Control is working with this software in a test run and checking whether it is a feasible solution.

Activity 7.3 Specify IT-requirements

As input to the procurement of equipment within the planned EC refurbishment project, a first draft of the procurement documents has been developed. The documents include the equipment to be purchased for immediate use within the framework of this project.

A first analysis of the technical conditions for communication in the pilot region has been carried out. At present only two big fibre optic lines are available. One is the submarine optical fibre cable system line from Poti (West Georgia) to Russia and the other line follows the cities Zugdidi, Khobi, Abasha, Senaki, Samtredia, Kutaisi, Zestaphoni, Khashuri, Gori, Kaspi, Mtskheta, Tbilisi and divides itself in 2 lines below the city Rustavi. One line is the TAE Main Line to Baku and the other one follow the cities Bolnisi and Dmanisi down to Yerevan and later into Iran. The Kakheti Region is not touched by high speed data transfer lines.

An alternative solution could be mobile internet. “Mobile internet” and “mobile office” are just empty phrases if they are not supported by high speed, reliable, secure and cheap communication. GPRS (General Packet Radio Services) was developed to meet these requirements and has already been successfully implemented by many leading mobile operators worldwide: a mobile handset sends a request, a base station receives the request and, from international packages out of the data file, seeks free links and transmits the data packages.

One channel can handle 14.4 Kbps. GPRS allows one to increase this rate two or three times or more – up to seven-fold, according to the number of channels used. At the same time, the base station changes the data format from GSM into the TCP/IP format for internet. So again the process flows as follows: A handset requests to a BTS (Base Transmit Station), the BTS to a BSS (Base Station Subsystem) combined with a PCU (Packet Control Unit). Accessing a SGSN (Serving GPRS Support Node) from there to GGSN (Gateway GPRS Support Node). The next step is the MSC (Mobile Switching Centre) integrated into an NSS (Network Sub System).

5 Project Planning for Next Reporting Period

The project planning for the period of 1st May 2005 to 16th June 2005 is based on the activities in Form 1.6 “Plan of Operations for the Next Reporting Period”.

During the next reporting period numerous activities will be carried out and finalised in order to prepare the implementation of the pilot activities in Kakheti (please refer also to component 2 and activity 2.9 respectively in sections 3.1 and 5.2 of this report) and on a national level (activity 2.8), which is scheduled to start from September 2005.

5.1 Activities

5.1.1 Component 1: Technical Assistance

Result 1: New solidarity strategy defined and developed

Result 2: New financial mechanisms and administrative processes defined and implemented

- The review of existing health policy, strategy and legal documents (activity 1.1) and interviews with administrative officials (activity 2.2) will be ongoing activities during the next reporting period and the entire duration of the project.
- The draft recommendations on
    - the development of a BBP (activities 1.5, respectively 1.3 and 3.1), with particular regard to drugs,
    - the inclusion of the vulnerable parts of the population (activity 1.4),
    - the procedures, roles, functions and responsibilities of the involved stakeholders involved in public PHC financing and PHC provision (activity 2.1) and their
    - adequate interaction with particular regard to financial and administrative processes and flows (activities 1.6 and 2.2)

    will be further developed as well as discussed and agreed with the beneficiary.

    The proposed
    - criteria and options for financial mechanisms (activities 2.4 and 2.5.1),
    - the remuneration mix, tariffs and user fees
    - the relevant adjustments for calculation formulae (activity 2.6)

    will be further verified, discussed with beneficiaries and adjusted, if necessary.
- Within the next reporting period these proposals will be consolidated into a set of recommendations for financial and administrative system and processes (activities 2.5.1 and 2.6) necessary for the implementation of this strategy.
- This consolidation process will be carried out in continuous discussion and co-operation with the beneficiary and the working groups. This process will be supported by implementing a special workshop, preferably integrating all four working groups (activity 1.7/ 2.7 and 1.8).
- According to the time schedule of the Road Map for urgent and medium-term measures agreed concrete measures were supposed to be finalised by 30th March and 15th April respectively for presentation to MoLHSA for firm decision. A delay has meanwhile occurred. (According to our knowledge this process is still ongoing)
- GVG/EPOS has submitted proposals for the PHC reform for discussion with the working groups. Agreed concrete measures are supposed to be finalised – according to the time schedule of the Road Map –by 30th March respectively 15th April for presentation to the MoLHSA by the working groups for firm decision. According to the pending decisions more precise proposals are to be delivered by GVG/EPOS after the decisions have been made by MoLHSA/GoG.

5.1.2 Component 2: Pilot Activities in Kakheti Region

Result 3: A regional health financing Masterplan is developed

During the next reporting period the activities in the pilot region will focus on:

- Identification of the partner institutions and the responsible individuals for the pre-pilot phase in Kakheti and at national level will be finalised (activity 3.0). (see also sections 3. "Summary of Project Planning for the Remainder of the Project" and 5.2 "Important Observations for Project Success" and 5.3 "Proposals for Adjustment of Overall Project Planning" of this report).
- Complementary to the activities on the national level (activities 1.6, 2.1, 2.2, 2.4, 2.5.1, and 2.6), the evaluation of the management, accounting, human resources and contracting capacities in Kakheti (activity 3.2) will be finalised by June 2005.
- Hand in hand with these evaluation activities, recommendations/options for efficient financial mechanisms and processes (activity 3.3) will be further developed.
- The recommended options will be presented at workshops (activity 3.4) and discussed with the relevant regional and national stakeholders to formulate a consensus for the Masterplan and the pilot implementation process.
- On this basis a Draft Masterplan for future development of PHC financing will be developed in the first half of the year 2005 (activity 3.5). This Masterplan will include the above-mentioned findings and recommendations and be supplemented by a strategy to balance expenditures and resources. This Masterplan will form the basis for the pilot implementation in Kakheti.

5.1.3 Component 3: Capacity Building/Training

Result 4: Training needs on health insurance management are analysed. Sustainable training programmes on health insurance management are planned and implemented

The capacity building / training activities during the next reporting period will focus mainly on starting the preparations of both the pre-pilot and pilot stages (see also sections 3. "Summary of Project Planning for the Remainder of the Project" and 5.2 "Important Observations for Project Success" and 5.3 "Proposals for Adjustment of Overall Project Planning" of this report).

At the same time first steps to prepare the pilot phase will be taken in order to implement the respective training programmes starting in September 2005, thereby increasing the administrative and management capacity of the involved institutions and building up sustainable training structures for health financing management in Georgia.

Accordingly the activities during the next reporting period comprise:

- Finalisation of the assessment of capacity building and training need assessment (activities 4.1 and 4.2) of PHC providers, of SUSIF staff in Kakheti and at national level, of MoLHSA staff (including the regional department in Kakheti) and of regional staff of the Department of Public Health;
- Agreement with beneficiaries, EC Delegation and relevant training centres on concrete terms for using existing training programmes and facilities (activity 4.3) for the training of PHC providers;
- Adaptation and/or preparation of the relevant financial and administrative modules of existing training programmes for PHC providers;

- Final clarification of whether a train-the-trainer approach will be chosen for staff of MoLHSA and SUSIF – at both national and regional level – and for the regional staff of the Department of Public Health;
- Development of a training programme (activities 4.4, 4.6, 4.8, 4.9, 4.10 and if necessary 4.5 and 4.7) of staff of funding agencies in financial-administrative issues in Kakheti and at national level;

5.1.4 Component 4: Information, Education and Communication (IEC)

Result 5: Seminars and workshops at central and regional levels assist the MoLHSA in building supportive environment for the introduction of new health insurance policy and practices organised; an IEC strategy is developed

On the basis of the results of the strategic activities of components 1, 2 and 3 and decisions on these by the Ministry, in accordance with the timetable set out in the Road Map for PHC Reform, the draft IEC strategy will be finalised by March 2005 (activity 5.3). Further initial IEC activities will be implemented during the next reporting period. According to the draft IEC strategy, the activities thus focus on:

- definition of the "IEC content needs"; research into the information needs of the key target groups will be conducted in early 2005 (activity 5.2);
- preparation of a range of information materials to be provided to all seminar/workshop participants (activity 5.4); concrete proposals – including a PHC Reform Manual – have already been made in the draft IEC strategy;
- selection of participants for seminars/workshops at both national and Kakheti regional level according to the target groups and timetable proposed in the draft IEC strategy (activity 5.5);
- implementation of first seminars / workshops – starting with the "internal" public, then the "professional" and general publics – from March 2005;
- implementation of first media education and information activities, at both national and Kakheti regional levels (activity 5.8);
- continuous advice and assistance will be provided to the project team on PR and design matters, including compliance with the EC's visibility guidelines (activity 5.9).

5.1.5 Study Tours

Result 6: Study tours to one or two countries in transition (or new EU member states) and in one "old" EU country are implemented

During the period 17th – 27th May one study visit to Lithuania and Denmark for two groups will be implemented (activities 6.1, 6.2, 6.3 and 6.4). It will examine how policy is made, applied, and further developed regarding the health insurance and finance systems in these two EU countries with functioning PHC systems; it will also explore how health reform policies are communicated and how the media covers such matters. Representatives and members from the Ministry of Health, Health Care Authorities and Administration of Georgia will visit several institutions in both countries and will get familiar with the mechanisms and legal basis of the PHC centres. Furthermore, they will visit clinics and insurance funds and will discuss with the policy makers and actors of the health care systems in Lithuania and Denmark the background of their systems and the further steps. The study visit will thus contribute to the further development of detailed plans to implement the PHC reform in Georgia. Participants will include a group of key policy-makers regarding PHC reform as well as one group of administrations and implementers of the main counterparts.

5.1.6 Technical Specification for Necessary Equipment

Result 7: Technical specification for necessary equipment and software is prepared

The activities during the next reporting period will focus on the provision of necessary equipment to the PHC funding agencies and PHC providers in Kakheti. As of to date it is not decided yet who will become provider and which will be the lowest level of using IT (PHC managers/service centres or PHC doctors and nurses?) Assuming the pending decisions will be decided in due time we are prepared to fine tune our according activities as follows:

- Finalisation of the review of current information exchange mechanisms (activity 7.1) and
- Completion of the IT-system design in June 2005 (activity 7.5) as well as
- Finalisation of the development of monitoring indicators for the new system (activity 7.7).
- Finalisation of the technical specification – especially with regard to the proposed software and the inclusion of internet solutions (activities 7.3 and 7.2) in June 2005; in this context, clarification of some contractual and tender procedures with the EC Delegation is required.
- The tendering process will be implemented within the framework of another project and is envisaged to be finalised by April 2005.
- The delivery process will be supported by this project (activity 7.4).
- Training in use of the system will be provided to the pre-pilot end-users prior to September 2005

5.2 Important Observations for Project Success

Compare also section 3 of this report.

5.2.1 Implementation

New EU-supported projects for the retraining of primary care staff and refurbishing facilities are being planned. The terms of reference for these projects have been prepared, the tenders have been published, and the signatures of the contracts are planned for June 2005. Having in mind the time need for mobilisation of the project teams and the summer months, full implementation will probably realistically start by September 2005. The first cohort of family medicine deoctors and nurses will be re-trained from spring 2005 on. The date of refurbished PHC facilities is not known yet.

Training:

During both the training needs assessment phase (Nov/Dec) and in subsequent discussions with the EC delegation and MoLHSA, different approaches for implementing PHC in Kakheti were proposed by the EC Delegation: that training of PHC providers and refurbishment of pilot PHC facilities shall be the exclusive task of the planned new EU projects.

Following the proposal of the EC Delegation all out-patient doctors and nurses and managers from Kakheti as well as financing administrations (MoLHSA and its regional department, SUSIF and its regional department) will be trained in basic administrative and financial training. Those out-patient doctors and nurses who are already retrained in family medicine and will become new PHC teams will receive a more specified and intensive administrative and financial training during the Pre-Pilot or Pilot stages due to their availability and involvement in other training or retraining courses.

Equipment:

Having new functional PHC facilities which are equipped and have retrained staff in family medicine and are providing full range of BBP services to population are the preconditions to our pilot stage.

Concerning equipment, we assume that the proposed information technology will be available and functional in due time. This is a prerequisite for improving inter-organisational communication beyond sending papers by regular mail from provider to purchaser and vice-versa.

5.2.2 Working Groups

All working groups have been established in November / December. Thus the results so far are very limited. According to the time frame set out in the Road Map, major decisions must be prepared and communicated during the first quarter of 2005 and final decisions for the mid/long-term perspective must be finalised by the end of April 2005. Indeed, initial recommendations concerning short-term policies have been passed to MoLHSA in January 2005.

Furthermore, we see a risk in operating this inter-dependent structure of working groups under the circumstances which exist in practice: the question of political will for PHC reform, the political and administrative/legal uncertainties facing PHC reform, numerous international donors and implementing agencies with slightly different approaches and implementation time frames.

5.2.3 Systemic Aspects

The consultant, like other international donors and implementing agencies, follows MoLHSA's health care reform policy in focussing health care reform activites particularly on PHC. However, the health care system consists of different portfolios. The most simplified description would be as described in Table 1:

Table 1: Portfolios in Health Care

	Outpatient care	Inpatient care
PHC	1	2
SHC	3	4

The consultant has pointed out the relevance of the inter-dependence of outpatient and inpatient care on the one side and of PHC and SHC on the other side. Several issues in developing coherent and sustainable health policies have to be considered: a sound referral system between PC and SHC and a refined financing system (funding, (re-)allocation of funds, remuneration, incentives etc.) are prominent examples to be thought out carefully for every field in Table 1. Otherwise frictions will occur and hinder the success of any health care reform on all levels. We are missing this cross-portfolio policy management, however.

Furthermore, we have been considering the role of parallel health care networks. On 16th December 2004 the first joint meeting of the MoLHSA with representatives from the Ministry of Defence, Ministry of Interior and others took place in order to exchange health policies. For Georgia, a relatively small and poor transition country, we recommend to unify health care policy across all portfolios as far as possible, with particular regard to HMIS. Additional collaborations may be developed at a later phase of the health care reform.

5.3 Proposals for Adjustment of Overall Project Planning and their Consequences

5.3.1 Implementation

The consultant proposes the following milestones for implementing the new mechanisms:

1. Preparatory Stage will be finalised by 1st September 2005: selection of options by MoLHSA/ GoG, preparation of trainings, train the trainers (module 1);
2. 30th November 2005: start evaluation of pre-pilot stage
3. Pre-Pilot Stage will be finished by December 31st 2005: fine tuning of PHC financing model, training in basic management and financing issues; train the trainers (module 2).
4. From 1st January 2006 on the new financial mechanisms (e.g. remuneration, BBP, tariffs, gate keeping reporting, accounting, contracting, enrolment) will be piloted in new functional PHC facilities. Training of out-patient providers becoming new PHC providers in more specific and intensive administrative and financing issues. Monitoring and progress-based ongoing evaluation of implementation;
5. The evaluation stage will start by May 1st 2006: begin evaluation of implementation and preparation of national policy recommendations.

Concerning training, it has to be clarified as soon as possible how the planned EU projects for PHC training and refurbishment can be linked to our ongoing project without wasting resources. Moreover, in addition to finding a technical solution to this problem, the political will of the Minister of LHSA has to be considered – i.e. his wish to demonstrate the first successes of PHC reform in 2005.

5.3.2 Working Groups

To support the development of consolidated results from the working groups, we strongly recommend conducting a joint workshop of all working groups. Our project is prepared to support this workshop with substantial financial and personal resources. After meetings with both the National PHC Coordinator and the EC Delegation, a progress workshop will be conducted by the National PHC Coordinator in June 2005. Also a follow-up second consensus workshop will be scheduled in close cooperation with the National PHC Coordinator.