Report to the Department for International Development

PRIMARY HEALTHCARE DEVELOPMENT IN GEORGIA:

Establishing new Family Medicine Centres in Tbilisi

Support to the health sector in Georgia

Monitoring visit

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Responsibility

Although this report has been commissioned by the British Government under British aid arrangements, the British Government bears no responsibility for and is not in any way committed to the views and recommendations expressed herein.

1. Executive summary

Keywords: PHC training, systems development, health financing.

Background and purpose of the visit

John James visited Georgia 17 –22 December 2001 to review the progress of this DFID project supporting the introduction of family medicine services in Georgia. In this phase of the project, primary care nurse and manager trainers have been trained (in addition to the general practitioner trainers trained in the previous phase), and five family medicine centres will deliver comprehensive primary care services in Tbilisi. The project has supported the refurbishment and equipping of these centres. In addition, the consultant was to develop a workplan to ensure the family medicine centres opened in early 2002.

Activities and findings

The consultant worked intensively with the Director of the NFMTC, the Director of GP training and the project co-ordinator. He also held meetings with the Director of the NHMC, the FMC polyclinic chiefs, the project financing consultant and the DFID health adviser in the British Embassy. He had lengthy telephone discussions with the Deputy minister of Health (now appointed as Minister of Health). The FMCs are now fully equipped. Three FMCs are fully refurbished; work is in progress on the remaining two, and should be completed in January 2002. A three -month workplan to ensure the FMCs open in April 2002 was agreed. The workplan is detailed in this report. Key areas for development were: establishing a legal basis for the delivery of the new primary care services; appointing all new staff for the FMCs; agreeing management and information systems; ensuring adequate funding for the new services so FMC staff are rewarded for the additional services that they will provide. More work on finalising the training syllabuses for the primary care nurses and managers in required. The workplan was presented to the FMC chiefs, who agreed with the proposals. However, all expressed concern that without the guarantee of additional funding, the FMCs would not be able to function. Options for ensuring that there would be adequate funds were debated. It was agreed that the NFMTC would request additional funds from the Municipality to reward the FMCs for providing more comprehensive services.

Following the introduction of new regulations, the post of local project co-ordinator – now held by Dr Vazha Dobordjginidze – has been advertised nationally. Four (of the nine) applicants will be invited for interview in January. The selection process was agreed between the consultant and the DFID health adviser in the British Embassy, and approved by the Deputy Minister of Health.

The consultant presented the outline proposals and conclusions to the Deputy Minister of health. He accepted them, and again voiced his support and commitment to the project.

Dr Amiran Gamkredlidze was appointed Minister of Health on 23 December 2001.

Discussion

Dr Amiran Gamkredlidze has been committed to this project since its inception. His appointment as Minister of health should further ensure the project's success. The FMCs should open in April 2002, provided the workplan timetable is adhered to. It is important that the FMC chiefs participate in the workplan activities and share the workload – otherwise the burden will be borne by the Director of the NFMTC, the Director of GP training and the project co-ordinator. The trio's commitment to the project is impressive – but they would benefit from more support from the other FMC chiefs. Ensuring that there will be adequate funds to ensure reasonable salaries for FMC staff should secure their support; this issue is of vital importance, and must be addressed as a matter of urgency.

2. Background and purpose of the visit

The background to the project has been described in earlier reports. The purpose of this visit was to review project progress since the last monitoring visit in September 2001[1], to agree a workplan to ensure that the family medicine centres open in early 2002 thereby identifying areas for UK consultant support, and to agree a shortlist for the post of local project co-ordinator.

3. Activities and findings

Developments since September 2001.

All five FMCs have been provided with medical equipment and furniture. The refurbishment of three FMCs is complete; it is anticipated that the remaining two will be completed by the end of January. President Shevadnadze attended the formal opening of the National Family Medicine Training Centre (polyclinic 17) in October.

The 5 manager trainers and the eight nurse trainers successfully completed their training courses (in October and September respectively). Draft training syllabuses have been prepared by the UK consultants.

The NHMTC has published the first Georgian textbook on Family Medicine, and it has been approved by the Ministry of Education as the official textbook for the specialty of family medicine. Five additional doctors have been accepted on the 12 month family medicine training course which started in May this year, bringing the number of doctors currently being trained to 43.

A local project co-ordinating group has been established. Its members comprise the FMC chiefs, the Deputy director of the Municipality, the Director of the NFMTC, and the local project co-ordinator. The group meet on a weekly basis, and the minutes are circulated widely. A family medicine financing working group has also been established; the manager trainers are working with George Gotsadze, finance consultant to the project, who leads the group. They are working on the development of the new family medicine model.

Following the resignation of Dr Levan Kobaladze from his post of local project co-ordinator in August, Dr Vazha Doborjginidze was appointed in his place. However, newly introduced regulations require that all local appointments made by International organisations must be through open competition. This post was accordingly advertised in November. Nine candidates applied, and a shortlist is to be drawn up. The interviews will be held at the end of

[1] Georgia primary health care development project: progress report May to September 2001. James J, Atun R. Report to DFID September 2001. IHSD London

January attended by the project co-director, a representative from DFID, and a representative from the MoH.

Dr Amiran Gamkredlidze was appointed Minister of Health for Georgia on 23 December. He previously held the post of Deputy Minister of Health. Dr Gamkredlidze was involved in the original design of this DFID project, and has provided invaluable support to the project ever since its inception. In his new post he will be in a strong position to ensure the success of the project, and that family medicine services are introduced throughout the country.

Activities

A workplan to ensure the FMCs open in April *Annex 2*

The consultant worked intensively with the local project co-ordinator, the Director of the NFMTC and the Director of GP training in devising the workplan. The workplan was presented to the polyclinic chiefs at the project co-ordinating group, and modified in the light of their comments.

The workplan is set out in annex 2. It details the activities that must be undertaken before the FMCs open. It was clear that the preparations would take at least three months, so it was agreed that the opening date should be early April 2002. As described above, it is anticipated that the FMCs will be fully refurbished, equipped and furnished by the end of January 2002 (6 months later than originally planned). The key areas that require more work are: establishing a legal basis for the FMCs, the primary health care team, and the training activities that will be undertaken; finalising the FMC staffing requirements, agreeing job descriptions and appointing and training staff; ensuring that FMC staff have a good salary; introducing comprehensive management and information systems (MIS); the design and implementation of effective clinical protocols; finalising the nurse and management training courses, and introducing the training courses. They are discussed below.

Establishing a legal basis for family medicine activities

Work on preparing the necessary legal documents that must be ratified by the MoH is under way, and they should (with support from the UK consultants) be completed by mid January. After a two week consultation period, the final drafts will be presented to the MoH. Formal ratification should be granted mid – February.

FMC staff

There was considerable discussion over the proposals for FMC staffing levels. It was accepted that the ratio of doctors to nurses should be 1:1.5, and that the FMCs should be under the direction of the parent polyclinic chief doctor, working on a part time (? 50%) basis. There is a legal requirement for independent institutions to employ an accountant and an

economist (neither posts were considered necessary by the consultant). There was disagreement over the need for a driver (for out of hours home visits). There was recognition for the need for specialists to joint the FMC team. As FMCs are to provide care for children and adults as well as obstetric and gynaecological services, all FMCs will need to appoint an obstetrician/gynaecologist and a paediatrician (with the exception of paediatric FMC 9). Some polyclinic chiefs felt the need for a cardiologist as well. It is essential that job descriptions for all staff are drawn up (deadline February 2002). So far, only the GPs and managers have been appointed; the remaining staff should be recruited by the beginning of March, to allow a month of staff training before the FMCs open in April.

Financing issues

This issue is a matter of concern all the FMC doctors and polyclinic chiefs. It had been envisaged that all family doctors and nurses would receive a higher salary than district doctors and nurses, in recognition of their specialist training and that they will be providing better and more comprehensive services. As these include out of hours services, they will be working longer hours. Target salaries were 300 gel for doctors, and 200 gel for nurses (this compares with the national average of 80 gel and 40 gel for doctors and nurses respectively). In the original memorandum of understanding signed between DFID and the Municipality, it was agreed that the Municipality should set aside a sum of $200,000 to ensure that the pilot FMCs were able to function for the first 12 months. This in part was in recognition that the FMCs would initially have very few registered patients, with the result that their income (part dependent on capitation payments) would be very low. The polyclinic chiefs felt that this money should be used to guarantee these target salaries for the first year, to allow the FMCs to build up their patient numbers and develop their services.

At this time, proposals for a new payment system for primary care services are under development. Outlines of these proposals, which being prepared by George Gotsadze, project finance consultant, will be published early next year. They focus around a basic capitation payment, free services for children under 14 years and adults over 65 years, additional payments for specific services (preventive services, management of chronic diseases etc), fee for services for those aged 15 – 64, and an affordable fee for attendance at the polyclinic/ FMC. It is clear, however, that these payments will be low.

A simple exercise was carried out, to establish whether FMCs could generate enough income to pay the high salaries proposed for the doctors and nurses (and all other FMC staff). The figures used were based on the proposals for the NFMTC, part of polyclinic 17. 10 of the 17 doctors will be able to transfer their patients to the FMC, because they are working as district doctors already, and have their own patients. Based on the per capita payments (currently 4 gel), this should generate a gross income of around 100,000 gel. However, regulations limiting salary payments to 35% of net profits, taxation and social security payments reduce the net monthly income for salaries to around 1,600 gel. This will provide an average income of just 30 gel ($15) for the FMC staff. In order to achieve the overall target salaries proposed

(11,000 gel per month), gross income would have to be quadrupled. It is reasonable to suppose that the income could be doubled – but a fourfold increase is unrealistic. The target figures are too high – salaries of 200 gel and 100 gel for doctors and nurses respectively are more realistic estimates.

In discussion with George Gotsadze, it was clear that the Municipality would not agree to simply pay guaranteed salaries to FMC staff; furthermore, this mechanism would not allow meaningful evaluation of the pilot FMCs. One option discussed was to request the Municipality to grant additional funds for research and development activities in the FMCs. Family medicine staff could be contracted to do the work (which would be of great benefit to developing family medicine) on a part time basis. This could augment staff salaries – an additional 100 gel for doctors and 60 gel for nurses, perhaps. However, the project co-ordinator explained that regulations did not allow the Municipality to provide funds for research – this was the sole remit of the MoH. He considered the best option was to request additional funding to provide new services, rather than research the feasibility of providing them. These would include health promotion and preventive services. Examples are listed in the table

Table: Examples of the additional services to be provided by the FMCs:

- Health prevention/ promotion services
  - Healthy lifestyle
  - Well woman clinics
  - Healthy person checks
  - Elderly person checks
- Chronic disease management programmes
  - Diabetes
  - Hypertension
  - Asthma

It was agreed that the NFMTC team would draft an application to the Municipality, requesting the sum of $100,000 dollars over a 12 month period. This sum should ensure that the staff salaries are increased. This would provide the FMCs with the opportunity to develop and evaluate these services – this will be important information when evaluating the impact of FMC services.

These issues were discussed with Dr Amiran Gamkredlidze, who committed himself to ensuring that there would be adequate finance to ensure the FMCs could function effectively.

The introduction of MIS

MIS has been under consideration by the GP, manager and nurse trainers for the past 12 months, but there have been no clearly presented conclusions. MIS is essential for the day-to-day running of the FMCs, and should generate the data needed to evaluate the impact of the family medicine services. It was agreed that a MIS working group should be established immediately, and that the group should produce draft MIS proposals by the end of January 2002. The consultant emphasised the importance of developing effective systems, rather than preparing lists of data that should be "computerised".

Protocol development

A number of evidence based protocols have been developed, but they have not been tested in the clinical environment. The protocols will be piloted in the polyclinics in mid January, evaluated, and in the light of the findings, formalised for use in the FMCs. Doctors', nurses' and managers' roles in using the protocols will be clearly defined; they will attend a one week training course before the FMCs open

Social marketing

This is a key area if patients are to be recruited to FMCs. Bio- Ethics, and NGO under contract to Oxfam, is working with the NFMTC in developing a social marketing strategy for both patients and doctors. They also represent patient rights. An early meeting between NFMTC staff, DFID (British Embassy) and Curatio has been planned. It is hoped that Bio-Ethics will produce leaflets, posters and contract nurses to visit communities to inform them about the proposed services. Doctors should be informing their patients about FMCs on an opportunistic basis during consultations in their polyclinics. The programme should start without delay

Training programmes

The family doctor programmes are already well established. However, the nurse and manager training courses are still in draft form. The final versions should be completed (by

the UK consultants) by mid January, before being reviewed by the NFMC team and submitted to the MoH for validation. Once validated, the MoH will pay the salaries and the tuition fees of those undergoing these training courses. It was agreed that family doctor and nurse training should start two weeks after the FMCs open. As the manager trainers will be new to their posts, manager training should not start until September 2002.

Appointment of the local project co-ordinator

As described above, there were nine applicants for the post of local project co-ordinator. Their curriculae vitae were reviewed against the requirements listed in the job description, and a matrix drawn up (annex III). Of the nine, only two met all the criteria, but two well qualified applicants were also short-listed. The shortlist was discussed and agreed with the DFID officer in the British Embassy and the Minister of health. The candidates will be informed of the decision, and the four successful candidates will be invited for interview at the end of January

Memorandum of understanding between the local project office, the DFID project mangers and the FMC polyclinic chiefs

The local project officer and the director of the NFMTC were concerned that the polyclinic chiefs were not participating fully in the development of the proposed family medicine services because they were concerned that the funding for the services had not been finalised. This suspicion was confirmed during the project co-ordination group meeting that the consultant attended – two polyclinic chiefs declared that they would not be prepared to deliver family medicine services unless additional finances were guaranteed – and they appeared reluctant to participate in the activities agreed in the workplan presented at the meeting. Accordingly the project co-ordinator drafted a memorandum of understanding outlining the activities that the polyclinic chiefs were to deliver under the project agreement. This is to be signed by the polyclinic chiefs in the next week.

4. Discussion

Preparations for opening the FMCs

Provided the activities outlined in the workplan, the FMCs should open on 1 April. However, there is concern over the commitment of the polyclinic chiefs (with the exception of the director of the NFMTC) who appear unwilling to participate in the activities until a generous financial package is guaranteed (by the Municipality). The consultant emphasised the importance of working together as a team, but anticipates that most of the work will be carried out by the NFMTC director, the Director of training and the project co-ordinator (with support from the UK consultants). This is regrettable – it is unlikely that the memorandum of understanding will stimulate greater participation from them.

Social marketing for family medicine services must start as soon as possible

Financing family medicine services

As outlined above, this is a matter for concern for all. It is clear that the salaries of the FMC staff will need to be enhanced – the preferred option would be ask for additional payments for the health promotion, health prevention and chronic disease management services that will be provided by the FMCs. These could then be provided free of charge –in the hope that patients will be encouraged to attend for these services. These additional payments would be short-term only; by the second year it is anticipated that greater patient numbers will result in the FMCs generating an income which will allow for higher staff salaries.

Two of the pilot FMCs have very few doctors (and in one, just one of the four doctors has a registered patient list); the running costs of both clinics will be disproportionately high, so the likelihood of their becoming self-supporting institutions appear doubtful.

Developing a viable financing mechanism for primary health care services is an urgent priority. The project co-ordinator and his team must work actively in this area with the Ministry of health and the Municipality.

5. Summary of recommendations

Ensuring FMCs open in April

- Workplan activities must be supported – and supervised by the project co-ordinator
- Polyclinic chiefs must be encouraged to participate in the discussions and activities
- UK consultants should support NFMTC team in drafting legal documents
- MIS. A MIS co-ordinating group should be established immediately, and produce draft proposals by the end of January 2001.

Ensuring adequate financing for FMCs

- NFMTC team and project co-ordinator to draft proposal for increased payments to FMCs (for additional services) to Municipality
- Close working with MOH and Municipality to ensure payments granted
- Work on developing new financing mechanisms for family medicine services are essential; NFMTC team and project co-ordinator should have greater involvement with the project finance consultant, George Gotsadze

Family medicine training programmes

- UK consultants to finalise training programmes for nurse and manager training programmes to ensure they are ratified by the MoH by the end of February

- Training programmes for GPs and nurses to be delivered by the FMCs two weeks after they open

Position of local project co-ordinator

- Candidates to be informed of shortlist
- Four candidates to be interviewed end of January (representative from DFID, MoH and Dr Rifat Atun
- List of questions, and scoring matrix to be developed, and sent to DFID representatives in the British Embassy

ANNEX 1

ACTIVITIES AND MEETINGS

Intensive meetings were held on a daily basis with the local project co-ordinator, the Director of the NFMTC and the Director of GP training.

In addition, meetings were held with

- The polyclinic chiefs of the five FMCs
- The deputy director of Tbilisi Municipal health department
- Dr George Gotsadze, Curatio organisation, DFID finance consultant
- Dr Otari Versadze, Director NHMC
- Dr Kakha Khimshiashvili DFID project officer (Health, agriculture)

Telephone discussions were held with:

- The Deputy Minister (now Minister) of Health, Dr Amiran Gamkredlidze

ANNEX II

DRAFT WORKPLAN FOR FAMILY MEDICINE CENTRES: PROPOSED OPENING 1 APRIL 2002

		Dec-01		Jan-02				Feb-02				Mar-02				Apr-02		
	Done	**Wk3**	**Wk2**	**Wk1**	**Wk2**	**Wk3**	**Wk4**	**Wk1**	**Wk2**	**Wk3**	**Wk4**	**Wk1**	**Wk2**	**Wk3**	**Wk4**	**Wk1**	**Wk2**	**Wk3**
FMC																		
Refurbish		>>>	>>>	>>>	>>>	>>>	>>>											
Equip and furnish	>>>																	
Legal basis documents prepared																		
Drafts prepared:																		
FMCs		>>>	>>>	>>>	>>>													
Training centres		>>>	>>>	>>>	>>>													
GPs, nurse, managers		>>>	>>>	>>>	>>>													
Trainers		>>>	>>>	>>>	>>>													
Drafts circulated CG						>>>	>>>											
Submitted to MoH								>>>	>>>									
FMC staff																		
Job descriptions DNM		>>>	>>>	>>>	>>>													
Draft DNM approved						>>>	>>>											
Agree staffing needs		>>>	>>>															
Appoint nurses										>>>	>>>							
Appoint specialists										>>>	>>>							
All other staff appointed										>>>	>>>							
Staff training												>>>	>>>	>>>	>>>	>>>	>>>	>>>
Viable Finance for FMCs																		
Negotiate Municipality, MoH		>>>	>>>	>>>	>>>	>>>	>>>	>>>	>>>	>>>								
Additional salaries for staff		>>>	>>>	>>>														
Work with Curatio		>>>	>>>	>>>	>>>	>>>	>>>	>>>	>>>	>>>								
FMC staff receive salaries												>>>	>>>	>>>	>>>	>>>	>>>	>>>
Patient registration																		

Social marketing strategy developed with “Bio-ethics” group (Oxfam sponsored)				>>>	>>>	>>>	>>>											
Implement social marketing								>>>	>>>	>>>	>>>	>>>	>>>	>>>	>>>	>>>	>>>	>>>
Patient registration														>>>	>>>	>>>	>>>	>>>

Clinical protocols

Design protocols	>>>																	
Pilot protocols						>>>	>>>											
Modify and finalise								>>>	>>>									
Train DNM in protocols											>>>	>>>						
Develop more protocols																	>>>	>>>

Management and information systems

Establish working group		>>>	>>>															
WG prepare MIS draft				>>>	>>>	>>>	>>>	>>>										
MIS draft circulated									>>>	>>>								
MIS plan finalised											>>>	>>>		>>>				
MIS plan implemented													>>>	>>>	>>>	>>>		

FMC training

Nurses																		
Draft syllabus				>>>	>>>	>>>	>>>											
Draft circulated								>>>	>>>									
Syllabus finalised										>>>	>>>							
Training plan designed												>>>	>>>					
Training starts																		>>>
GPs																		
Training programme	>>>																	
Training starts																		>>>

	Irma **Khonelidze**	**Archil** **Morchiladze**	**Tamara** **Andjaparidze**	**David** **Khubua**	**Nicoloz** **Natsvlishvili**	**Tamar** **Gabunia**	**Iirina** **Karosanidze**	**Ekaterina** **Sioridze**	**Vazha** **Doborjginidze**
Current position	MOLHSA Programme management	MOLHSA MCH	MOLHSA MCH	World Bank PCU	MOLHSA MCH	NFMTC / NHMC	NFMTC/ NHMC	MOLHSA MCH	NHMC and MOLHSA, Public health
Project Management	No	No	No	Yes: 5 years	No	No	Yes	Yes: 1 year World Bank	Yes: 5 years DFID
Managing PC Institutions and networks	No	No	No	No	No	No	Yes 1989 – date	No	Yes 1986 – date
PH/ health management	No	No	No	No	Yes	No	Yes	Yes	Yes 15 years
Senior management **position**	No	No	No	No	No	No	Yes 1989 – date	No	Yes 1986 – date
Knowledge of PC	Yes	Yes? Hospital Paediatrician	Yes? Hospital paediatrician	Yes? Hospital specialist	Yes? Hospital paediatrician	Yes	Yes	Yes? Obstetrician	Yes 1986 – date
Experience in PC	Yes: Nurse, GP	No	No	No	No	Yes	Yes	No	Yes

Medical degree	Yes Nurse and District doctor	Yes Paediatrician	Yes Paediatrician	Yes Physician	Yes Paediatrician	Yes Family Physician	Yes Family Physician	Yes Obstetrician	Yes Paediatric surgeon
English language	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Work with NGOs, International agencies	No	No	No	Yes	Yes	Yes: DFID AIHA	Yes: DFID AIHA	World Bank	Yes: DFID
Involved in DFID PC project	**No**	No	No	No	No	Yes 1996 - date	Yes 1996 - date	No	Yes Design DFID project, and adviser to DFID 1996 -