INTRODUCTION OF THE FAMILY MEDICINE MODEL

The main objective of the reform of healthcare system in Georgia is to establish the modern and flexible primary healthcare system, which would be based upon the principles and the concept generally recognized across the Europe. The severe health state of the Georgian population, which has worsen during the last 12-15 years in comparison with either the western Europe, as well as the states of the eastern and central Europe, constitutes the clear affirmation of necessity for such transformation and establishment of the efficient model of the primary healthcare. The situation is extra-alarming as regards to the maternal and infant healthcare and management of the tuberculosis, transmissible, parasitical and cardiovascular diseases.

The poor indicators of the population health state are resulted from various factors, including (a) the sever social state, which disqualifies the most of patients from payment of costs per medical services, (b) the poor level of the public awareness regarding the health matters. (c) the lack of confidence of the general public in medical experts, etc. Despite the fact that the financial barrier, which reduces the population's accessibility to healthcare services, is the key factor[1]; however, the mistrust of the population in respect of outpatient services is also important. The current obsolete physical infrastructure of the network of outpatient clinics and polyclinics is lesser attractive for the most of patients. The lack of relevantly trained human resources shall be also noted. Only the minor part of the personnel engaged within the primary healthcare network has passed the specific training, and the skills and competence of the most thereof does not comply with the requirements of the primary healthcare.

Due to all the above, the population actually does not apply to the PHC institutions. During the last years, utilization of the public medical services at the PHC level has reduced drastically (since 1990 and up to present, application rate per capita has reduced from 7-8 visits down to 1.8 visit, and the annual utilization rate per capita is even lesser at rural outpatient clinics). Such utilization rate of services is the lowest across the whole Europe and the Central Asia (according to data of 2002). And the target population coverage rate is also low.

[1] Multi-sectoral study of households. "Save the Children". 2002.

The primary healthcare reform implemented by the Ministry of Labor, Healthcare and Social Affairs with support by the donor organization, considers the various activities, through which the new PHC system is to be established. As far as it ensures for efficient, fair and even distribution of resources existing in the healthcare sector, therefore, instead of the limited package of medical services, it offers to the population the comprehensive and high-quality services, which will be accessible for each citizen despite his/her age, gender and social status.

This program expresses the readiness of the Ministry of Labor, Healthcare and Social Affairs in order to ensure the consistent and sustainable implementation of the primary healthcare reform. Transformation of the system is the long-term and complicated process. The activities at early stage of the reform do not consider the full reorganization of the outpatient clinics and polyclinics. The first changes will concern the rural outpatient clinics. Start up of the new model of provision of medical service in the country and analysis of obtained results will create the solid foundation for planning of subsequent steps.

By means of foreign investments, several rural outpatient clinics have been repaired and equipped in Imereti, Kakheti and Adjara. The personnel engaged therein have been re-trained through the specific training programs. Since 2006, 22, 24 and 15 PHC institutions will be ready for operation in Imereti, Adjara and Kakheti respectively. The re-trained professionals will offer to patients the different and high-quality service, and that will positively affect their health state.

Start up of the rehabilitated entities and study of peculiarities of operation thereof is really important for further implementation of the PHC reform carried on in the state. Ultimate formation of the primary healthcare model in Georgia shall be performed upon consideration of those experiences and hardships gained right at the early stages.

Program Objective

Improvement of the health state of target population.

General (Long-term) Tasks of the Program

- ✓ Growth of utilization rate of the primary healthcare services.
- ✓ Improvement of the quality of medical services at rehabilitation centres.

Growth of utilization rate of the primary healthcare services is the crucial task of the primary healthcare reform in Georgia. The utilization rate do well expresses as how the attitude of

population will change in the nearest future as regards the PHC entities and medical services provided by them.

Specific tasks

- ✓ Growth of accessibility and coverage rates;
- ✓ Provision of the permanence of medical services;
- ✓ Launch of services focused on patients needs and requirements;
- ✓ Raise of the public awareness (knowledge) as regards to healthcare issues.

Ways for realization of the tasks above

- ✓ Launch of a new model of provision of services, which shall be focused on prevention and striking roots of the healthy life-style;
- ✓ Selection and launch of an optimal model of organizational structure and management of rehabilitation centers;
- ✓ Launch of an optimal funding model at institutions considered under the program;
- ✓ Establishment of basics of the healthcare information system in accordance with operational peculiarities of renovated institutions;
- ✓ Provision of the population with information as regards to new services.

Main principles of the program implementation

- ➢ A family medicine team i.e. a family physician and a general practice nurse will constitute a major provider of medical services at rehabilitated PHC centers;
- ➢ Introduction of a new model of primary healthcare will be supported by relevantly trained managers, who will provide family medicine centers with the effective administration;
- ➢ The funding model will provide a patient with an optimal financial accessibility;
- ➢ Within the program frame, the primary healthcare will gain the function of the first contact point i.e. the ‘gate’ for well-established medical services and provide for permanence of services and referrals;
- ➢ A family medicine team will be focused on disclosure of and compliance with patient’s requirements.

Measures considered under the program

Provision of medical services by family medicine centers to the target population envisaged by the program

I. New centers, within the professional competence of a medical personnel, will offer a comprehensive (basic care and preventive) services to patients of all ages and genders. The service package will integrate high priority services.

Within the program frame, the team of a family physician and a general practice nurse will provide the target population with free services as follows:

1. Visits to a physician for patients of all ages and genders;
2. Home visits by a physician and/or a nurse as per necessity (see the regulations for implementation);
3. Home nursing of pregnant women (see the scope and the criteria of mandatory referrals in the regulations for implementation);
4. Surveillance over development of infants and juveniles (see the regulations for implementation);
5. Immunization and vaccination (through the procedure established in the country);
6. Provision of treatment (DOT) to tubercular patients under direct supervision (see the regulations for implementation);
7. The health state examination of the adult population in order to identify the cardiovascular ischemia and the pancreatic diabetes in the high risk groups (see the regulations for implementation);
8. Management of widespread chronic diseases (see the regulations for implementation);
9. Medical examination of seniors (those above the age of 65) (see the regulations for implementation

List clinical and diagnostic tests considered under the program

Medical institutions participating in the program will provide the tests as follows:

- the electrocardiography;
- the otoscopy;
- the ophthalmoscopy;
- the peakflowmetry;
- the measurement of blood pressure.

Laboratory tests through the instant diagnosis method (testers)

- The urine analysis;

- The glucose test in peripheral blood;
- The haemoglobin;
- The pregnancy determination.

For the purposes of the following laboratory tests, it is considered to refer a patient to a laboratory with a relevant capacity:

- the clinical blood analysis;
- the fecal test on concealed hemorrhage;
- the venous blood glucose test;
- the vaginal smear bacterioscopy;
- the creatinine;
- the prothrombin;
- the cholesterin.

The clinical and diagnostic tests will be performed based upon a decision by a physician.

Again based upon a decision by a physician, a patient will apply to the following experts considered within the frame of the state outpatient care program:

1. an endocrinologist;
2. a phthisiatrician;
3. an oncologist.

The primary healthcare centers completed only by a nurse will offer the population services as follows:

1. Visits to a nurse for patients of all ages and both of the genders;
2. Home visits by a nurse as per necessity (see the regulations for implementation);
3. Surveillance over development of infants and juveniles (see the regulations for implementation);
4. Immunization and vaccination (through the procedure established in the country);
5. Provision of treatment (DOT) to tubercular patients under direct supervision (see the regulations for implementation);
6. Raise of patients awareness on treatment and prevention matters (see the regulations for implementation).

List of clinical and diagnostic tests

- the measurement of blood pressure;
- the peakflowmetre.

Laboratory tests through the instant diagnosis method

- the pregnancy test;
- for enjoying all other medical services considered under the program, a patient is referred to the PHC institution participating in the state program of outpatient care, whom the said institution is assigned to.

II. For the purposes of provision of effective organization and efficient operation of medical services, a modern guidelines and protocols of the clinical state management based upon scientific grounds will be introduced;

III. Nursery services of a new type will start operating and that will support implementation of preventive measures;

IV. The special attention will be paid to raise of the care and preventive awareness of patients (seniors, caretakers thereof, children, high risk groups, etc.) in accordance with their individual requirements.

V. For the purposes of study of operation peculiarities of a new model of medical services, relevant forms of records-keeping and accountability will be introduced.

VI. Various activities are planned for the purposes of raise of awareness of patients (e.g. home informational visits, elaboration and dissemination of posters and booklets); that shall be performed with an assistance of donor organizations within target areas prior to commencement of the program and in the course of implementation thereof.

Organizational structure and management of rehabilitation centre

The centers integrated within the community of outpatient clinics and polyclinics carry out the program activities on conditions of institutional and financial independence from the said community:

- A rehabilitated unit existing within the community of outpatient clinics and polyclinics is formed and operated as a department or branch thereof;
- Accounting of funds and costs received by a rehabilitated unit within the program frame is performed separately from funds and costs of the community of outpatient clinics and polyclinics;
- A manager is responsible for administration of a rehabilitated unit, who meets his/her responsibilities in accordance with the established instructions;

- The community of outpatient clinics and polyclinics disposes of funds assigned under an agreement made within the program frame only upon a statement by a department/branch manager. All accounting and record-keeping procedures are effected by a legal entity subject to the Private Law, which maintains an optimized branch or department.

Program budget

The program budget constitutes 1,040,000 GEL, which is assigned for the 6-month period (the program will come into effect on 1st of July 2006). The funds assigned for the said purposes under the Law of Georgia 'On State Budget of Georgia for the Year of 2006' constitutes the funding source of the program.

Budgeting methodology

Calculation of costs has been carried out through the so called 'bottom-up' accounting methodology. By means thereof, the expenditure extent for each primary healthcare team has been determined (see Table 1).

Table 1

a) Annual expenditure of the PHC institutions

	Description	1-team	2-team	3-team	4-team	5-team
1	Salary disbursements	**7,776**	**14,688**	**21,816**	**28,944**	**36,120**
2	Medical purpose items, medicines, test-systems, laboratory services and vaccination	3,440	6,880	10,320	13,760	17,200
3	Utility, communication, office, maintenance and other costs	2,683	3,815	5,216	6,925	8,636
4	Amortization costs	3,323	4,273	5,773	7,654	9,554
	Total	**17,222**	**29,656**	**43,125**	**57,283**	**71,510**
	Average per team	**17,222**	**14,828**	**14,375**	**14,321**	**14,302**

Note: Funding of costs per medical purpose items, medicines, test-systems, laboratory services and vaccination will be provided through capitalization method; the annual cost per capita constitutes 1.72 GEL.

b) Remuneration of labour of a personnel of PHC institutions inclusive of deductions by employers (GEL)

	Description	1-team	2-team	3-team	4-team	5-team
1	A physician	3,360	6,720	10,080	13,440	16,800
2	A nurse	1,800	3,600	5,400	7,200	9,000
3	A manager (1 per every 10 teams)	420	840	1,260	1,680	2,100
7	Other remaining	900	1,080	1,440	1,800	2,200
	Total remuneration of labour	6,480	12,240	18,180	24,120	30,100
8	The social tax	1,296	2,448	3,636	4,824	6,020
	Total	**7,776**	**14,688**	**21,816**	**28,944**	**36,120**
	Average per team	**7,776**	**7,344**	**7,272**	**7,236**	**7,224**

Note: The PHC institutions that include only a physician and a nurse are assigned only salaries thereof inclusive of social taxes thereon.

Institutions participating in the program and the target population

The primary healthcare institutions of Imereti, Adjara and Kakheti, rehabilitated through the financial aid provided by the World Bank and European Union, will participate in the program and be staffed by the re-trained family physicians, nurses and managers.

According to the requirements of the Law of Georgia 'On State Budget', the SUSIF of Georgia will enter in agreements through negotiations with a sole-person (see draft contract in Annex __).

The list of institutions participating in the program attached hereto (see Annex __).

Within the program frame, family medicine centers will provide services to the population residing within their areas of activity (determined basing upon the geographic accessibility principle)[2]. Upon identification of the target population, an institution shall be governed by the formal data of the passport system, however, keeping the formal statistical data, which is approved by a Gamgeoba or a Sakrebulo.

Determination of a number of teams within an activity area is performed through the principle as follows: a team of a family physician and a nurse shall cover 2,000 persons on average.

An exception is allowed in cases as follows:

- In highland and out-of-the-way villages, where a population does not exceed the average standard;
- When facing a personnel lack (upon absence of a physician or a nurse in a team).

Funding methodology

The SUSIF will fund institutions participating in the program through the combined method: by capitalization and budgetary source.

Budget method – Costs of an institution per salaries, utilities, communication, maintenance and amortization are reimbursed at a fixed extent despite a target population. A fixed budget is calculated against a number of teams (see Table 1); an institution shall be funded through the procedure as follows: a number of teams x an average budget of a team __ GEL (alterations may be applied according to actual amortization costs).

Capitalization method – Costs per medical purposes items, medicines, laboratory services and office shall be reimbursed per capita and constitute 1.72 GEL (3,440 GEL/2,000 persons).

Settlement procedure

- In the beginning of a month, however, not later than 15th day thereof, the fund transfers to a PHC institution 1/12 part of an annual amount. By the end of each quarter, not later than 10th day of a subsequent month, a PHC institution submits to the Fund a report on disposal of a received amount.

[2] The master plan of the primary healthcare development in Imereti, Adjara and Kakheti.

Expected outcome

Expected outcome of the program		Assessment indicators	Current situation	Target
	Coverage of a target population	A target population (%), which will be provided with services considered under the program within a period under report		
		Coverage of an infants' contingent with vaccination against the age groups		
		(a) infants under the age of one year	**80%**	**90%**
		(b) re-vaccination by the age of five years	**75%**	**85%**
		(c) re-vaccination by the age of fifteen years	**70%**	**80%**
	Utilization of PHC services	**Applications** (a) to a physician		
		outpatient		
		home visits		
		primary		
		(b) to a nurse		
		outpatient		
		home visits		
		primary		
		(c) utilization of laboratory services		
		testers upon home visits		
		at laboratory		
		(d) referral to an expert		
		an endocrinologist		
		a phthisiatrician		
		a gynaecologist		
		an oncologist		
	Quality of the medical services	Study of patients' satisfaction rate		
		A number of newly disclosed cases of the capillary hypertension		
		A number of newly disclosed cases of the pancreatic diabetes		

	EXPECTED OUTCOMES OF THE PROGRAM	ASSESSMENT CRITERION	CURRENT SITUATION	TARGET
1	**Coverage of a target population**	***1.*** A population residing within a service area. ***2.*** A target population (%), which will be provided with services considered under the program within a period under report. ***3.*** Coverage of an infants' contingent with vaccination against the age groups: **a)** infants under the age of one year **(BCG, DPT-3, POLIO-3, HpB-3**); **b)** the rubeola component vaccine-1 in infants of the age between 1 and 2 years; **c)** re-vaccination at the age between 5 and 6 years **DPT-4, POLIO-4,** the rubeola component vaccine-2; **d)** re-vaccination at the age of 14 years		
2	**Utilization of PHC services**	**Applications** **a) to a physician:** outpatient home visit preventive **b) to a nurse:** outpatient home visit preventive **c) utilization of laboratory services:** testers at laboratory **d) referrals to experts:** an endocrinologist a phthisiatrician a gynaecologist an oncologist		
4	**Quality of the medical services**	**1. Study of patients' satisfaction rate** **2. A number of newly disclosed cases of the capillary hypertension**		

		3. A number of newly disclosed cases of the pancreatic diabetes **4. A number of patients registered:** a) oncological diseases b) cardiovascular system disease c) diabetes d) tuberculosis of the respiratory tract **5. A number of deceased patients:** a) oncological diseases b) cardiovascular system disease **6. Treatment outcome** a) a number of diseases caused by the diabetes b) respiratory tract tuberculosis rate in patients after treatment of **DOTS** - a number of incurable cases - a number of interrupted treatment cases **7. The pregnancy surveillance:** a) a number of pregnant women under surveillance, including before 12 weeks b) a number post-natal women including – passed 4 full visits – delivered at home		