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Quality of primary health care in Georgia

Assessment report

Version: Draft 1
September 2017

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WHO European Centre for Primary Health Care
Health Services Delivery Programme
Division of Health Systems and Public Health

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Abstract

This report presents the findings of an assessment of quality of care in primary health care in Georgia. In the framework of the advancements of the universal health coverage agenda in the country, this work was set out to support the Ministry of Labour, Health and Social Affairs with the operationalization of the Primary Health Care Strategic Plan 2016–2023. The report presents policy directions to strengthening the quality of primary health care.

Keywords

DELIVERY OF HEALTHCARE
HEALTH SERVICES
PRIMARY HEALTH CARE
QUALITY OF CARE
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Abbreviations

CGs	clinical guidelines
CME	continuing medical education
CPD	continuous professional development
FD	family doctor
GP	general practitioner
NCDC	National Centre for Disease Control and Public Health
NCDs	noncommunicable diseases
MOH	Ministry of Labour, Health and Social Affairs
PHC	primary health care
RD	rural doctor
SARMA	State Regulatory Agency for Medical Activities
SSA	Social Service Agency
UHC	universal health coverage

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Insights and overall coordination of the assessment were provided by the WHO Country Office in Georgia under the leadership of Marijan Ivanusa; Rusudan Klimiashvili and Nino Mamulashvili.

Valuable inputs were received by representatives from the following organizations: Ministry of Labour, Health and Social Affairs; National Centre for Disease Control and Public Health; Tbilisi Municipality; Public Health Centre of the Sagarejo region; Tbilisi Family Medicine Training Centre; Tbilisi State Medical University; Georgian Society of Hypertension; Georgian National Nursing Association; Cancer Patients' Association "Winner Women Club"; as well as a wide range of providers – Curatio Private Clinic, Regional multi-profile medical centre in Sagarejo, Sartichala Rural Ambulatory Centre, Iashvili Central Children Hospital and Gudushauri Multiprofile Hospital – and the following development partners: Development Cooperation for the Czech Republic, UNICEF and UNFPA.

The document was technically reviewed by Juan Tello, WHO Regional Office for Europe.

Background

In Georgia, over the past five years considerable policy strides have been made in order to transform services delivery based on a primary health care (PHC) approach and embrace Universal Health Coverage (UHC). These actions are defined in the Georgian Health System State Concept 2014–2020 on UHC and quality control, and the launch of a UHC Programme in 2013, introducing a social health insurance model to extend basic coverage *(1)*.

This assessment was organized in the context of the WHO-EU-LUX UHC Partnership (UHCP). An UHCP action plan covering the period of July–December 2017 envisages WHO support to operationalizing the Primary Health Care Strategic Plan 2016–2030. More specifically, the UHCP activity five calls for the development of mechanisms for quality improvement in primary care as a means of strengthening governance.

This assessment follows an earlier health services delivery-scoping mission in July 2016 and constitutes an effort to further describe and analyse the current situation and initiatives undertaken to strengthen PHC governance and improve PHC quality of care.

The scope of the assessment is aligned with other ongoing WHO technical assistance initiatives. These initiatives and their related findings were fully up-taken in this assessment to ensure harmonization of overall policy directions and complementary of efforts. Emphasis was made to coordinating efforts with the areas of strategic purchasing, tackling noncommunicable diseases (NCDs) and nutrition, continuing endeavours to integrate public health services and response to tuberculosis.

This document is organized into four main sections. The first section provides an overview of key health outcome as drivers for transformation of health services delivery. The second section provides and oversight of the primary health care delivery system in terms of organization and its governance. A third section describes the mechanism for ensuring quality of inputs, processes, outputs and outcomes. Section four provides directions for improvements in terms of concrete policy action-oriented recommendations.

Throughout the report, good practices and innovations in service delivery observed during the field visits have been highlighted.

Methods

This assessment draws on a desk review and on interviews and direct observations during a visit that took place to Georgia from 24 to 28 July 2017.

Documents published in recent years were reviewed and analysed. Some are made publically available (*1,4*); others were shared by the Ministry of Labour, Health and Social Affairs (MOH) (*2,3*). The review of these documents provided a solid understanding of the health status and challenges the health system is currently facing.

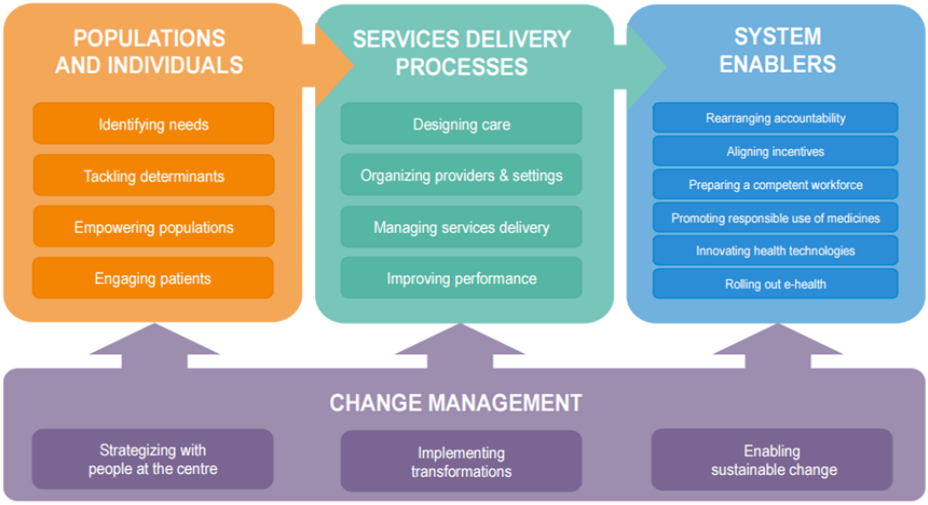
Questionnaires with the aim of filling knowledge gaps were then developed to guide the interviews during the in-country period.

The assessment team was composed by multidisciplinary background on policies, accountability and overall governance and on quality of clinical practice. Through semi-structured interviews, the assessment team sought out first-hand insights of the MOH, national counterparts, providers and professional associations regarding the challenges that the quality of PHC face today and explored options for improvement.

The assessment team met with representatives of the MOH, National Centre for Disease Control and Public Health, Tbilisi Municipality, and a diverse range of health facilities spanning from a children's hospital and a multi-profile hospital to the Tbilisi Family Medicine Training Centre and a rural ambulatory centre. The team also interviewed members of professional associations and patients' clubs and met with representatives of development partners.

The assessment was guided by the principles of the European Framework for Action on Integrated Health Services Delivery and its approach to transforming health services delivery *(7)* (Fig. 1).

Fig. 1. Overview of the European Framework for Action on Integrated Health Services Delivery



Source: *(7)*

The assessment used selected European Framework for Action on Integrated Health Services Delivery variables as per Table 1.

Table 1. Variables reviewed in the assessment applying the European Framework for Action on Integrated Health Services Delivery

Domain	Areas	Variables
Populations & Individuals	Identifying needs	▪ Identifying patient population health needs
Services delivery processes	Designing care Organizing providers and settings Managing services delivery Improving performance	▪ Structuring primary care practices ▪ Determining mix of disciplines ▪ Use of clinical guidelines and protocols ▪ Organization of providers and settings for equitable access ▪ Patient transitions, referrals and discharge ▪ Measuring performance and quality of care
System enablers	Rearranging accountability Aligning incentives Ensuring a competent workforce	▪ Aligning organizational structures ▪ Matching provider incentives to services ▪ Recruiting and training primary care staff

Health status and risk factors

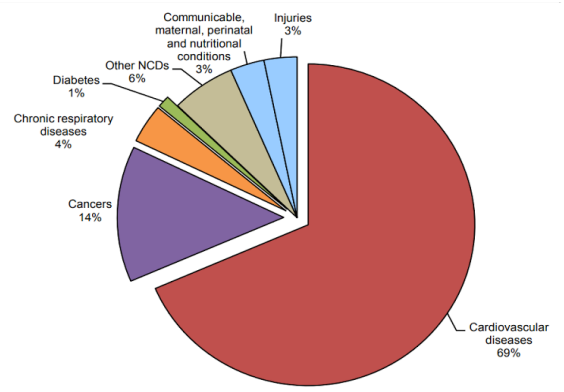
Life expectancy in Georgia has been increasing slowly over the past years, with a growing number of older people living with chronic and co-occurring conditions.

High prevalence of smoking and alcohol use, communicable diseases such as Hepatitis C and tuberculosis co-exist to the increasing burden of noncommunicable diseases.

Noncommunicable diseases

At present, NCDs account for an estimated 93% of total deaths in Georgia. 69% of those are due to cardiovascular diseases (Fig. 2) *(4)*.

Fig. 2. Proportional mortality 2014 (% of total deaths, all ages, both sexes)



Source: (4)

Three cardiovascular conditions are the leading causes of death in Georgia: ischemic heart disease, cerebrovascular disease and hypertensive heart disease, Table 4. A cause of particular concern is the increase in mortality due to hypertensive heart disease (145.6% increased from 2005–2015) *(5)*.

Table 2. Top 10 causes of death by rate in 2015 and change, 2005-2015

Rank	Cause	Change 2005-2015 %
1	Ischemic heart disease	1.4
2	Cerebrovascular disease	-0.9
3	Hypertensive heart disease	145.6
4	Chronic Obstructive Pulmonary Disease	-1.5
5	Alzheimer	42.6
6	Lung Cancer	36.9
7	Diabetes	66.3
8	Stomach Cancer	5.7
9	Chronic kidney disease	45.1
10	Road injuries	40.5

Source: *(5)*

Another relevant increased relates to diabetes. From 2005 to 2015, diabetes increased 66.3% its weight as leading cause of death. High body-mass index and high fasting plasma glucose are top risk factors driving mortality and disability *(5)*.

Tuberculosis and Hepatitis C

Georgia faces persisting challenges for tuberculosis and hepatitis C. The country is among the 18 high-priority countries in the WHO European Region for TB (*11*). In 2015, there were estimated 3.9 deaths from TB per 100,000 (*2*). The mean age of new and relapse tuberculosis cases is 40.8 years (*11*).

There is also a high prevalence of Hepatitis C which has prompted the government to implement a National Elimination Program. Major risk factors for hepatitis C in 2015 were injecting drug use and blood transfusions (*2*).

Main behavioural risk factors: smoking and alcohol use

Risk factors for NCDs in Georgia draw attention to diet, high systolic blood pressure and persistently high levels of adult smoking. In 2016, the WHO STEP-wise approach to noncommunicable disease risk factor surveillance-STEPS pointed towards some concerning patterns: 52% of males reported smoking daily (females, 6%), 35% of men engage in heavy episodic drinking (females, 3%) and 65% of males and females combined are overweight (*9*).

Primary health care delivery system

Georgia is striding to advance the strengthening of PHC. These efforts resume with the Georgian Health System State Concept 2014–2020 on UHC following an *impasse* between 2008 and 2012 created by the privatization of the provision of services. Table 2 shows the main PHC policy documents in the country.

In 2016, as part of the renewed commitments towards PHC and in the context of the Health System State Concept 2014–2020, the Health Council endorsed a PHC Development Strategy 2016–2023. This Strategy aims at strengthening family medicine and developing a responsive, effective and sustainable PHC *(2)*.

Table 3. PHC policy milestones in Georgia

2004-2006	First PHC Master Plan	Framework for reform to improve access to quality basic health care.
2007-2010	Second PHC Master Plan	Introduction of a private PHC system, strengthen regulation, improve access and extend the basic package of services. Not adopted.
2008-up to date	Rural Doctors Programme	Vertical programme that covers around 1.1 million people living in rural areas.
2013-up to date	Universal Health Coverage	Introduction of Universal Health Coverage
2016–2023	PHC Development Strategy	A strategy to strengthen the position of family medicine in the health system.

Source: WHO European Centre for Primary Health Care, Division of Health Systems and Public Health

In a context of multi-profile networks of health providers, the Strategy seeks to strengthen the governance arrangements to holding providers accountable for health outcomes. This is particularly challenging in a context of highly-deregulated provision of services; many institutions and public administration levels delivering and funding health services, a relative small team in the public administration to coordinate initiatives, actors and provide the overarching policy directions.

PHC organization and governance

There is a large range of providers delivering PHC services in different settings. The current scope of PHC services delivered include maternal and child, immunization, reproductive health, screenings, some activities in health promotion and disease prevention at population and individual levels, basic laboratory tests, diagnostics, palliative care, rehabilitation, psychiatric community-based care, health checks, among the most relevant. An overview is depicted in Table 4

National actors involved in the provision and purchasing of PHC services, under the control of MOH are the National Centre for Disease Control (NCDC) and the Social Security Agency (SSA), with a network of subnational branches with mostly an administrative role.

Table 4. Primary health care services, providers and settings

Services	Providers	Settings
Promotion of healthy lifestyles and health literacy	Rural doctors	Rural ambulatory hospital
Vaccination and immunization	Rural doctors Private Family doctors	Rural ambulatory hospital
Preventive check-ups of adults	Specialist	Inpatient at multi-profile hospital
Antenatal care and postpartum care	Specialist	ANC centres Inpatient at multi-profile hospital
Reproductive health	Specialist	Inpatient at multi-profile hospitals
Medical services for acute conditions, including diagnostic procedures, treatment, minor surgical procedures	Specialist	Inpatient at multi-profile hospital
Management of chronic conditions	Rural doctors Some private Family doctors	Outpatient
Diagnosis and prescription	NA	Outpatient
Cardiovascular risk assessment	NA	NA
Medical services delivered at home, including home visits by physician and/or nurse	Rural doctors	Home
Rehabilitation	Specialist	Inpatient at multi-profile hospital
Psychiatric community-based care	Specialist	Residential
Palliative care	Specialist	NA

Source: WHO European Centre for Primary Health Care

Health services are also provided through a large number of disease-oriented, dedicated, vertical programmes. Some of current programmes include tuberculosis, hepatitis C, the rural doctor programme, mental health, diabetes, addictions, among others, see Table 5. The Health Services Department of MOH defines priorities and the annual budget for these programmes. The prioritization criteria are not explicit. Minor adjustments can be made during the programmes implementation.

A SSA unit is in charge of implementing and administrating the programmes. It procures services and medicine through reimbursement to providers for services delivery or to individuals through vouchers. The unit can also contract services directly from a pool of pre-qualified providers. Follow-up of the programmes is limited to financial and administrative compliance. There is no evaluation of the quality of the services provided. Access to data is therefore limited to financial aspects rather than performance. Municipalities, in agreement with MOH, also implement thematic programmes that complement the MOH ones.

Examples of *dedicated programmes* include:

- *UHC Programme*. It has granted access to services for vulnerable groups. It is gradually rolling-out and expanding its scope to include a long list of medicines as of July 1st. The overall health outcomes, quality of services delivered and patients' experience has not yet been fully assessed.

- *Disease-oriented programmes* ensure either services and/or medication for specific diseases and health conditions. Some of current programmes include tuberculosis, hepatitis C, rural doctors, mental health, diabetes, addictions.

- *Rural doctors*. This programme includes contractual arrangements with individuals, paid monthly a flat amount. The flat amount covers all practice costs. In 2015, there were about 1270 rural doctors-entrepreneurs *(2)*, they are highly autonomous and send yearly reports to the NCDC about aggregate health outputs. Their (co-)location varies from municipality-owned health facilities to private hospitals where they work side by side with specialists.

Table 5. Dedicated health programmes

Universal health coverage	Rural doctors	Disease-oriented	Thematic
It covers planned out-patient, emergency in- and out-patient services, elective surgery, cancer treatment and obstetrical care. It now also includes medicines for priority diseases.	Set up in 2008 to upgrade facilities and health workforce skills in primary care facilities in about 900 villages. It covers around 1.1 million people living in rural areas.	Diabetes Tuberculosis HIV Hepatitis C	Maternal and child Immunization

Source: WHO European Centre for Primary Health Care

Taken together, the myriad of providers and actors involved have an impressive range of knowledge, skills and capacity to deliver PHC services. However, their responsibilities are not clearly defined resulting in inefficiencies, lack of accountability for outcomes and critical gaps in services delivery. The existence of parallel health services programmes creates the need for coordination and a large administration that translate in inefficiencies.

During a visit to *Sartichala Rural Ambulatory Centre*, it was observed that rural doctors are carrying out chronic disease management activities capitalizing on their familiarity with their catchment population and their living conditions (see Box 1). Investing in improving capacities of rural doctors by, for example, training them in delivery of proactive NCDs interventions such as risk stratification and individual services for patients at risk of chronic diseases could proof effective in helping close the NCD service delivery gap.

Box 1. Rural doctors and chronic disease management

In Sartichala Rural Ambulatory Centre, rural doctors and nurses have a better ability to provide longitudinal care to their attached populations. As expressed by one of the rural doctors, the familiarity with life circumstances and health needs of their population gives a better ability to tailor services to those needs and guide patients through the system. For example, care for patients with type 2 diabetes mellitus or chronic obstructive pulmonary disease -COPD was mostly done by rural doctors. The reasons for this were two-fold. Firstly, rural doctors were more familiar with principles of family medicine and existing clinical guidelines, which require treatment of uncomplicated cases. Secondly, awareness of the resource constraints in the population prevent rural doctors from unjustified referrals to specialists and diagnostics – a practice common among –urban- FDs.

Given the current burden of NCDs, there remain critical gaps related to tackling NCDs in primary health care for example, cardiovascular risk stratification, early detection, diagnosis and management of chronic conditions, lifestyle and behaviour changes counselling services.

People-centredness

There is a formal definition of patient rights in Georgia since 2003 *(1)* and are included in specific legislation. Patients can complain directly to the MOH and financial sanctions are imposed to facilities upon review and confirmation of the complaints related to patient safety. However, providers were observed to have a heterogeneous approach to patient complaints at the facility level, from having complaint boxes to relying in relationships of trust between patients and providers to voice complaints. A more systematic approach needs to be promoted to ensure the implementation of the principles enshrined in the patient's charter.

The involvement of people in planning of PHC seems limited. There are a few patients' organizations such as the breast cancer survivor's Winner's club that has the plan of approaching patients soon after their diagnosis to provide them with advice and support. This example of patient groups' involvement with the health care system represents a promising first step; further efforts should focus on the inclusion of patients' perspectives in the planning and delivery of PHC services. Under the UHC, patients have a choice in selecting their providers; they are allowed to switch GP providers every two months. However, the information needed to make decisions in the selection of providers (such as quality indicators) is limited and not widely accessible to the general public *(1)*. Ensuring access to information to compare among providers is needed to enable patients to make better decisions about the care they receive and drive health service delivery performance.

The fragmentation of the health care system and the existence of parallel health service delivery systems (i.e. vertical programmes, UHC) translate into a difficult navigation of the system from the patient perspective. Patient pathways for maternal and child health services are among the clearest, but for all other conditions patients need to navigate a complex system of different and distant points of care and administrative procedures. For example, until recently patients that visited rural doctors needed to then be referred to a UHC provider to gain access to affordable medicines *(2)*.

Accountability of health providers

Health providers have gained increasing autonomy since the reforms initiated around 2007 *(1)* and this has resulted in a situation of fragmentation in the health services delivery system. Primary health care services are provided by a myriad of actors with the involvement a numerous stakeholders, in different settings and paid with diverse mechanisms.

Overall, PHC providers are rarely held accountable for their performance. Information about providers is mainly limited to financial reimbursement for services rendered. Inspection, supervision and feedback are absent.

Rural doctors are contracted by MOH and paid a monthly salary. They are poorly coordinated with other providers, work without supervision or feedback. The only information they provide is an aggregate health services annual report. Despite these conditions, they appear to uphold an approach to services more in line with the principles of PHC: they feel accountable to their population, manage patient needs and diseases in a more holistic way resulting in lower referrals to specialists. An explanation to this is the fact that they operate in a context of less accessibility to specialists and inpatient care.

Conversely, *urban family doctors* are employed by private providers contracted by the SSA and paid by capitation. Contractual arrangements include urban family doctors (FDs) and other different medical specialties and diagnostics. Urban FDs are mainly accountable to the organization they belong to. Their scope of practice is narrow and, usually, do not manage diseases. As a result, a high volume of cases that could be managed by FDs is reported to be treated by specialists. Besides the inefficiencies in the use of resources, this raises concerns about the competencies of FDs, who are not diagnosing, treating and managing common chronic conditions, and, of specialists that deal mostly with "common conditions" rather than with complicated cases.

Performance, data and feedback learning loops

The NCDC is mandated with the collection of epidemiological data and overall surveillance of the population's health, published in a health statistics yearbook. It focuses primarily on communicable diseases and there is no disaggregation for PHC.

Overall, the generation and use of data to inform, evaluate and improve performance of policies, providers, managers and clinical practice remains weak. Data from health providers is mainly reported for administrative purposes. The possibility to share information among providers and institutions is very limited consequently feedback loops are absent and analyses for policy, managerial or clinical decisions are done only on ad-hoc basis.

A positive example of use of data for performance measurement and feedbacks was observed at the Tbilisi Family Medicine Training Centre (see Box 2)

Box 2. Management for performance at the Tbilisi Family Medicine Training Centre

The Tbilisi Family Medicine Training Centre has a catchment area of more than 45,000 persons. The Centre adopts a unique emphasis on the role of family doctors and primary care teams, with a 1:1 ratio of family doctors to nurses and Centre-wide effort to ensure the principles of preventive medicine, comprehensive and coordinated care are upheld.
The Centre's management has worked to instil a culture of continuous quality improvement of clinical processes and targets for service outcomes with regards to access and patient satisfaction. A set of indicators have been developed drawing from performance measures applied in the United Kingdom; using results of these measures for managing the Centre's performance.
These indicators are linked to pay-for-performance bonus that sums up to the base salary of FDs. The Centre's management regularly analyses performance to provide feedback to practitioners and to inform their continuous professional development.

Regulatory capacity

The main regulatory actor of the health system is the MOH. The MOH sets standards for quality assurance mechanisms such as licenses, permits and technical regulations in line with international requirements and the participation of professional associations. Under the MOH, the State Agency for the Regulation of Medical Activities (SARMA) is the institution in charge of enforcing standards. SARMA's capacity to carry out inspections and enforce providers' compliance with standards is limited. This is partly due to lack of personnel.

Currently, there are no standards (licenses, permits and technical regulations) for PHC. For example there are no basic medical equipment and infrastructure requirements for FDs. The PHC infrastructure is not in an optimal state particularly in the rural areas as was observed during the visits. There are a few technical regulations that apply to family medicine such as

gynaecology and ophthalmology. However, inspections are usually conducted for facilities where high-risk services are delivered, family medicine services were reported to be inspected only when co-located with high-risk services in the case of multi profile hospitals, for example.

Facilities that provide services under the UHC need to meet additional standards. In October 2017 new standards will be issued. Currently, there is no accreditation of PHC institutions.

Capacity at subnational level

Actors at subnational level include regional departments of health contracting out health programmes for their catchment population and municipal public health centres supporting the implementation of vertical programmes such as immunizations. The public health centres are funded by the municipalities but report to the NCDC, which is itself under the MOH. There are also local SSAs with administrative functions. Table 6 lists actors at different levels.

Actors at subnational level are hardly under the purview of the MOH. This limits MOH's possibilities to implement policies.

Table 6. Key actors by national and subnational levels

National	Subnational level	
	Regions and municipalities	**Practitioners, providers, patients, families**
MOH SSA NCDC PHC Consultative Committee SARMA Tbilisi Family Medicine Training Centres Georgian Hospital Association Patients' clubs Professional associations (e.g. Georgian Society of Hypertension and Georgian National Nursing Association) Development partners	Municipal governments Municipal Public Health Centres Regional SSA branches Tbilisi State Medical University	Urban primary care clinic Urban polyclinic Urban multi-profile hospital Rural hospital Women Consultancy Centres/ANC centres Managers Health Professionals and allied Patients and families

Source: WHO European Centre for Primary Health Care, Division of Health Systems and Public Health

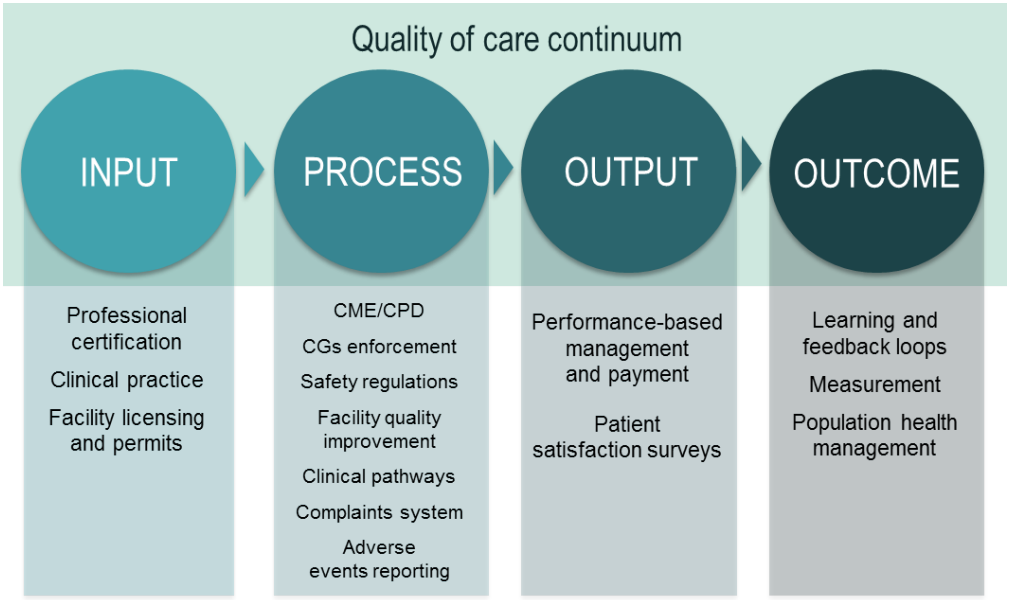
Quality in primary health care

Relevant to primary health care and to this assessment, is a draft health system quality improvement strategy developed but yet approved *(3)*.

Taken together, there are a number of mechanisms in place and innovative practices for improving quality of care, in particular the inputs, processes, and outputs of care. Overall, these efforts face constraints to be applied systematically and lack cycles of feedback loops, follow-up or time-based elements for regular updating. This paper draws upon important regulatory advancements on facility licensing and permits and minimum quality and safety requirements established, predominantly over the past five years.

To assess the quality of PHC, the existence of mechanisms across a quality of care continuum was identified (Fig. 4).

Fig. 3. Quality of care continuum



Source: WHO European Centre for Primary Health Care, Division of Health Systems and Public Health

Setting and enforcing standards

The MOH sets standards for quality assurance mechanisms such as licenses, permits and technical regulations in line with international requirements and the participation of professional associations. There exist standards for professionals, facilities, pharmaceuticals, laboratories, infectious disease control and high-risk services e.g. blood bank, pathology, ophthalmology, clinical practice.

The State Agency for the Regulation of Medical Activities (SARMA) of the MOH is the main implementer of the mechanisms to ensure the quality of inputs to the system. SARMA's current role in PHC quality assurance is overall limited, with lack of PHC-related standards. Developing standards for PHC facilities is recognized as a priority as detailed in the PHC Development Strategy. A Professional Development Council is in charge of professional certification and the MOH Department of Healthcare acts as the secretariat of the Council.

Professional certification. The MOH's regulatory division is responsible for the development of standards for health workforce. The Professional Development Council under the MOH is the implementing body in charge of issuing certifications for doctors. This certification is not time-bounded and there is currently no re-certification process in place. Concerns were raised anecdotally on the standards of certification exams. These tests are currently developed as multiple-choice questions and are to the exclusion of practical skills testing. Diplomas and specialization certifications were described to inform initial contracting and employment of practitioners at health facilities.

Facility licensing and permits. There are three main regulatory mechanisms for health facilities: licensing, permits and technical regulations. The MOH regulatory division develops standards for health facilities. These are currently to the exclusion of PHC centres. Licensing of facilities and the issuing of permits are conducted by SARMA. The issuing of technical regulations to deliver medical practice requires the submission of information on technical standards and can also include inspections to assess these standards in practice. These mechanisms are currently delivered as one-off tasks, for example, issuing initial licensing without a time-bounded element, permits without check or only reactive inspection due to complains, etc. Facilities that provide services under the UHC Programme need to comply with additional standards. There are currently no accreditation programmes for facilities.

Clinical practice. There are about 35 clinical guidelines (CGs) specific for primary care and there is a general awareness on their existence. At present, there are no standardized procedures for developing CGs', periodically updating, distributing and training professionals. The development of the existing CGs has benefitted from the involvement of professional associations, including Family Doctors Association and Physician Association. Some private providers have implemented internal clinical protocols based on national or international standards. Compliance to CGs is not audited, unless there is a complaint and further investigation by the MOH or by the insurer. Availability of CGs at primary care and referral health facilities and their easy accessibility on MOH website represents one of the potential strengths for quality assurance.

High-risk services. There are technical regulations for high-risk services such as ophthalmology, gynaecology. SARMA makes in-person inspections to assure compliance. These inspections do not currently apply to PHC.

A summary of existing mechanisms for quality assurance of inputs, highlighting the lack of mechanisms for PHC is presented (see Table 7).

Mechanisms for ensuring quality of care processes

Continuing medical education/Continuing professional development. The law mandating continuous medical education (CME) and continuous professional development (CPD) was rescinded in 2007. As a consequence of this gap in the regulatory framework, the quality of trainings is not standardized and trainings are not informed by practitioner actual needs rather than the management interests. Similarly, there is no evidence that the trainings are implemented in alignment with health outcomes and MOH's priority. There is currently no oversight over CME/CPD that ensures that these learning systems are in place and/or are happening on a regular basis.

Table 7. Summary of quality assurance of inputs

	Professionals	Inpatient facilities	Outpatient facilities/services	PHC
Enter market practice	**One-off certification** No re-certification	**Licenses** activities (e.g. pathology, blood bank) and **permits** for indefinite time issued by SARMA	Some **technical regulations** regarding the infrastructure	NONE
Service delivery	No accreditation programmes	Internal minimum quality and safety requirements (i.e. Quality committees)	**Technical regulations** for high risk services (e.g. surgery, OB/GYN)	NONE

Source: WHO European Centre for Primary Health Care, Division of Health Systems and Public Health

Facility managers have autonomy to tailor CME/CPD to their priorities. A variety of arrangements were recorded in terms of the scale, frequency and modality of these initiatives. The National Family Medicine Training Centre, for example, has designed courses and ad-hoc trainings for FDs and nurses working at the Centre. Professional associations are also active in developing content and implementing CME/CPD. This includes a high-level of activity by the national nursing association in supporting nursing CME/CPD in services. FDs expressed particular interest for trainings on patient counselling on NCD risk factors.

Building on existing CME/CPD initiatives will be key to promote a bottom-up approach to quality. Further alignment of these CME/CPD initiatives with national health priorities is needed to multiply the positive effect and achieve faster results in terms of health outcomes. See Box 3 for an example of existing CME/CPD innovations.

Box 3. CME/CPD innovations at the Gudushauri Multiprofile Hospital

The chief nurse of the critical care unit at the Gudushauri Multiprofile Hospital felt there was a need to supporting her nursing staff with continuous learning opportunities to maintain their competencies in caring for patients. The chief nurse, realizing she needed support to gather all the most up-to-date knowledge reached out to the Georgian Nursing Association. The Georgian nursing association prepared a 10-module programme in general nursing to run over the course of 2-years. Modules cover topics such as monitoring medications and polypharmacy, providing antenatal care, infection control, emergency care, monitoring and managing diabetes, patient centred communication, and documentation. Nurses take the classes in their free time within the 1-3 month time frame that the courses are made available. Nurses pay a total of 10 *lari* (approx. 4 USD) per month to subsidize the training. The programme is now moving into its second year. The chief nurse has worked closely with hospital management and the Human Resources Department to organize the space and times of the trainings. As soon as the training period comes to an end, the hospital will evaluate the project and look into a long-term training and funding scenario. Their hope is to tailor the trainings to specific areas of care emergency medicine, paediatrics, anaesthesiology and critical care.

Source: WHO European Centre for Primary Health Care, Division of Health Systems and Public Health

Clinical guidelines enforcement. External routine system for auditing compliance to CGs is absent. However, it was observed that some private providers adopt protocols based on national or international CGs supported by internal quality improvement mechanisms that ensure compliance at facilities level. Compliance to CGs in primary care is not audited, unless there is a formal complaint in which case an investigation is made by MOH or by the private provider network.

Hospitals quality improvement mechanisms. There are a number of internal quality improvement mechanisms in place at national, regional and district hospitals *(8).* Each hospital has a designated quality committee/department responsible for implementing regular clinical audit processes aimed at improving patient care and outcomes through the systematic audits of the services provided. This is done through checks and reviews of patient clinical histories. In addition, adverse events, outcomes and patient complaints are also reviewed. The results of these reviews by case or event are duly recorded in reports of the meetings and are communicated internally to clinical director/heads of clinical departments and doctors for appraisal/punitive purposes, learning process and implementation of change. There is currently no measurement neither follow up to assess the impact of these mechanisms on quality improvements.

Other quality improvement mechanisms include routine checks of medical records, reviews of complicated cases and data submission for reporting to the NCDC conducted by heads of departments and randomly by hospital manager and/or clinical directors. Finance departments conduct administrative checks of medical records to assess the amount of delivered services against claims ones. Human resources departments report checks of doctors' diplomas and specialization certificates to determine their eligibility for practice.

The described quality improvement mechanisms at the hospital level provide a strong platform to build a similar system in PHC.

Box 4. Peer review meetings

During visits to three hospitals: Iashvili Central Children Hospital, Gudushauri Multiprofile Hospital and Sartichala Rural Ambulatory Centre it was noted that all hospital medical staff participate in regular (weekly) peer review meetings resulting in collegial well-informed consensus regarding conclusions, lessons learnt and operational decisions. Existence of such a platform was consistently described at all three hospitals visited. This mechanism complemented by functioning QI structural units represents one of the major strengths of the approach to quality in Georgia. Further development and fine-tuning at the hospital level may be needed but most importantly of a tailored version by PHC is required.

Source: WHO European Centre for Primary Health Care, Division of Health Systems and Public Health

Clinical pathways. There is no clear distinction of the scope of services that should be delivered by FDs or by narrow specialists. This distinction will be deducted from CGs recommendations and by competencies of each FD. There is no mechanism for assessing the appropriateness of referral to specialists.

Complaints system. A national patients' charter is in place as well as a mechanism to capture patient complaints. There is also a national toll-free number for patients to file complaints about the care received. These mechanisms, however, are not standardized and

neither systematically implemented across facilities. During the field visits, it was observed that only some facilities have complaint boxes and advertise the toll-free number. Complaints received predominately refer to issues related to coverage of services and disputes of access to services due to residence or registration lists.

Adverse events reporting. Reporting of adverse events is a key mechanism to ensure patient safety. It includes reporting of side effects of medicines and vaccines, medical device adverse incidents, defective, counterfeit or fake medicines or medical devices. At present, a mechanism for reporting of adverse events is not in place. The 'Yellow Card Scheme'[1] – an international standard vital in helping countries to monitor the safety of all health products to ensure they are acceptably safe for patients and those that use them – is not applied. In the facilities visited, there was no practice of reporting adverse drug reactions, except for discussion at the quality committee. Some facilities are reporting adverse events to pharmaceutical companies.

Mechanisms for ensuring the quality of outputs and outcomes

Performance-based management and payment. There are vertical initiatives monitoring outputs in PHC, e.g. immunizations, but a comprehensive and standardized monitoring scheme is missing. The current payment model in place for PHC is mostly based on inputs e.g. salaries to FDs and nurses, number of patients enrolled with PHC providers. This is to the exclusion of output and outcome factors such as sex, age, burden of disease, quality of care, patient experience or population health. In the context of the initiatives of the Global Fund, there are intentions to pilot result-based payment for tuberculosis services. Also, the Tbilisi Primary Care Training Centre has mechanisms that monitor medical practice that are considered to financially reward FDs as part of a pay-for-performance initiative.

Patient satisfaction surveys. Information about patients' experiences and satisfaction are not systematically collected. For some private facilities are collecting data on patients' satisfaction and experience. Measures at present look predominately to waiting times.

Outcome measurement. An overall system to report on population health outcomes is absent. Currently, measurement of population health is conducted by the NCDC as part of the organization's population health surveillance. This reporting line looks primarily to rates of communicable diseases. Findings of this surveillance are published in an annual health statistics yearbook. Ad-hoc assessments for health outcomes are also reported, e.g. the WHO STEPwise approach to Surveillance -STEPS for noncommunicable diseases risk factors, the Childhood Obesity Surveillance Initiative –COSI and the National Reproductive Health survey.

[1] The Yellow Card Scheme is based upon the ICS E2B (R2) international standard and routinely used in EU, USA and many other countries reporting all adverse drug reactions to international database centre and laboratory in Uppsala (Sweden).

Policy directions for improvements

Opportunities for strengthening the primary health care delivery system

Modern health systems are characterized by diffuse lines of accountability. Georgia is no an exception and faces common governance challenges stemming from multiple and relatively autonomous private providers difficult to be held accountable for outcomes, lack of enforcement mechanisms, weak subnational capacity to implement policies and a missing culture of learning loops driven by performance at policy, managerial and clinical practice level. A multi-stage process for strengthening PHC governance is shown in Annex 1.

Defining the scope of practice

Overall PHC actors have the needed competencies for delivering PHC services and understanding of the underpinning principles of holistic approach to health care. However, they don't constitute a network of providers guided by share vision of PHC as there is not PHC identity that would allow defining roles and responsibilities and hold providers accountable for outcomes. Fragmented PHC service delivery systems hinder performance in terms of quality and efficiency. This results in a narrow PHC scope of practice and services delivery gaps particularly related to NCDs.

In the current situation of multiplicity of actors at different levels of government and across public and private sectors, defining the PHC scope of practice will allow to establish roles and responsibilities for actors to be held accountable and ensure that there are no gaps or duplications in the delivery of services.

The PHC Consultative Committee can play a key role in defining the scope of practice for PHC and the set of competencies for PHC health care personnel.

Strengthening accountability for performance

A map of current services along the continuum of care, settings and actors with accountability linkages is needed to prioritize areas where accountability arrangements are the weakest and may have the greatest negative impact on health services delivery.

PHC needs to be reorganized into multidisciplinary teams making use of the health care personnel available through the parallel PHC service delivery systems (i.e. UHC, rural doctors and other disease specific vertical programmes) and then be held accountable for performance indicators.

In many cases, FDs and specialists are located in the same premises, which provide a unique opportunity to strengthen interdisciplinary collaboration around specific and measurable health gains.

PHC performance indicators need to be developed by the MOH with the participation of professional associations and other PHC actors. Capacity to monitor performance indicators is needed at the national and subnational levels. The PHC Consultative Committee may be well-positioned to track progress against targets *(1)* and at the subnational level the Public Health Centres at the rayons could play the role of monitoring performance of PHC, if capacity is built. They conduct immunization and communicable diseases and sanitary surveillance; capacity could be increased to include performance monitoring of priority conditions.

Strengthen accountability linkages for rural doctors by requiring the reporting of performance indicators data to the MOH via Public Health Centres. At the same time, supervision and CPD need to be implemented to address areas of improvement.

Continue piloting pay for performance schemes to find an effective scheme to align desired performance and incentives for all PHC actors, individuals as well as organizations.

Improving data access to enable feedback loops

Limited use of data for learning and driving performance improvements in policy, management and clinical practice creates an obstacle to accountability. No feedback mechanisms are in place.

Improved information sharing by establishing common/shared health records in outpatient care and guaranteeing access to timely and appropriate information by those who deliver PHC will both strengthen the virtual PHC teams and contribute to building a platform for continuous feedback and learning to improve performance.

The type of information currently collected and reported at the facility level, mainly about volume, can be expanded slowly to include performance indicators about the four priority conditions identified by the MOH and for which essential medicines are provided to the most vulnerable segment of the population.

Currently data flow on one direction from facilities to the MOH via NCDC and its regional centres. Public Health Centres at the rayons can play a role in feeding the information back to the facilities for benchmarking and learning. Information can be discussed at bi-monthly meetings with PHC managers and Public Health Centre director.

Information generated about PHC performance will need to be analysed at the MOH level, for example by the PHC Consultative Committee and can then inform decision making and priority setting.

Increasing regulatory capacity

Good regulatory capacity exists but enforcement is limited as inspections, supervision, audits and overall feedback are absent. There is lack of regulations targeting PHC.

Standards for PHC need to be developed according to international standards.
Human resources planning for SARMA is needed to ensure sufficient personnel is available to enforce PHC compliance with standards and technical regulations.

Building capacity at subnational level

The capacity of the subnational level to implement policies is limited. Many actors are involved without coordination locally as all report to the national level. There is also limited presence of MOH's subordinate units at subnational levels. Subnational oversight function on population health management is missing. Regions, municipalities, SSA branches, public health centres, rural doctors, disease-oriented programmes, other regional, municipal and national programmes and private for profit and non-profit initiatives working without direction and community orientation also hinder PHC quality and efficiency.

Strengthening or expanding the role of some subnational level actors such as the public health centres will be needed to provide oversight of performance measurement, enable information exchange and establishing learning loops.
A “champion rural doctor” can be identified in facilities in charge of monitoring and reporting performance indicators to the MOH via the rayon Public Health Centre. The “champion rural doctor” can also serve as the main liaison between the Public Health Centre and the facility to disseminate and lead the translation of policies and programmes.

Opportunities for improving quality in primary health care

Overall, the health system in Georgia exhibits a range of mechanisms to assure, manage and improve quality. While some mechanisms related to assuring the quality of inputs and processes need to be strengthened; others need to be introduced, specifically those related to ensuring quality of outputs and outcomes. However, these mechanisms are mostly not systematically applied in PHC.

Strengthening mechanisms to assure quality of PHC inputs

There exists a relatively solid foundation of mechanisms to assure the quality of inputs and processes that can be leveraged to include PHC. Some of the proposed measures are listed below.

- **Human resources for health**. Setting standards for professional certification; licensing health professionals by competencies; introducing time-bounded licencing and recertification.

- **Clinical practice**. Standardizing clinical practice; developing a regulatory framework that details the processes for the timely development, adoption, dissemination, implementation, monitoring and updating of CGs.

- **Health facilities**. Developing ad-hoc or extending current standards and regulations to include PHC facilities; licensing and issuing permits for PHC; introducing time-bounded licensing and permits; implementing inspections to facilities by SARMA, for surveillance of standards overtime, including mandate to revoke licenses based on findings.

Improving and consistently applying mechanisms for quality of PHC processes

- **Continuing medical education/Continuing professional development.** Aligning CME/CPD to national priorities and improving its supervision; developing a mandatory CME system for PHC with designated point person in the MOH to oversee implementation and take stock of existing practice, resources and training centres; ensuring stakeholder involvement, including associations and universities in the development improvement and implementation of PHC trainings; diversifying modalities for trainings and resources including online e-learning and decision aids. Introducing accreditation criteria that require on-site PHC specific learning opportunities, such as journal clubs, developing PHC learning plans, lunchtime lectures, peer teaching on topics related to practice, peer-to-peer reviews of cases and inter-professional role playing. These initiatives can be financed using funds of accreditation fees. Expanding skills could also look to improving inter-professional practice, improving prevention and management of disease in the community.

- **Enforcement of clinical guidelines**. Introducing internal and external mechanisms for monitoring compliance to CGs; designing pathways including criteria for referrals and hospitalizations; developing a CGs implementation checklist. The checklist should address at least: facility governance arrangements to support the implementation of CGs, awareness and dissemination, clinical education and quality and safety. Improving processes for counter-referral and patient follow-up in primary care, including transfer of discharge letters.

- **Establish patient safety regulations**. Introducing international standards for patient safety measures; investing in systems for monitoring administrative errors, diagnostic errors, medication errors and transitions of care; ensuring the consistent use of quality committees including systematic examination of clinical priorities, assessment of clinical outcomes and clinical learning.

- **Mechanisms for patient's complaints**. Disseminating formal mechanisms in facilities to gather patient complaints and patient experience while strengthening the capacity of the MOH to follow-up.

- **Report adverse events**. Establishing conditions system to stimulate the reporting of adverse event through anonymous reporting; ensuring an adverse drug reaction monitoring programme is introduced in line with international standards. The interested parties should include all medical establishments, Pharmacological Committee of MOH, professional medical organizations and Uppsala Monitoring Centre - WHO Collaborating Centre of the Programme for International Drug Monitoring.

Continuing piloting and standardizing mechanisms for assuring PHC quality outputs

The development of a culture of performance monitoring and feedback is needed both at the system and provider levels, with special emphasis in analysis, reporting and feedback.

- **Performance-based management and payment**. Continuing and expanding the piloting of results-based financing in PHC, including planned application to tuberculosis services. Continuing piloting total quality management in PHC facilities.

- **Patient reported information**. Standardizing mechanisms for collecting and analysing patient reported experiences on measures such as patient-centeredness of care, coordination, comprehensiveness and continuity of services.

- **Establishing mechanisms for improving quality of PHC outcomes**

- **Learning and feedback loops**. Establishing mechanisms for feedback and learning, driving the health workforce to focus on health outcomes. Building upon existing practices such as the model for clinical care coordinators for improving maternal and child health in pilot facilities coordinated by UNFPA.

- **Outcome measurement**. Standardizing the coding requirements and harmonize the use of ICD-10 coding for patient records at both PHC and hospitals and for data reporting to the NCDC; enabling data aggregation regionally to inform regional health strategies. Strengthening accountability for outcomes of PHC facilities.

Final remarks

Accelerating the responsive capacity at pace with changing health and social needs in Georgia seems an imperative. Health needs and the burden of diseases have drastically changed and the system appears strained to keep pace.

There are proven cost-effective interventions both at population and individual levels that call for efforts to invest in developing a PHC approach, also in line with global and regional commitments.

The UHC Programme is a window of opportunity for improving PHC governance and quality as it calls attention to services delivery. It presents an opportunity for the alignment and consolidation of vertical efforts into a horizontally integrated platform of services with a higher resolutive and quality capacity.

A model of care based on a strengthened PHC approach that puts people at the centre can facilitate this. For this to be achieved, a collective understanding and buy-in on a people-centred approach to services delivery is needed to adjust people's perceptions and professional practice.

Increasing the resolutive capacity of the first level of care will ensure sustainability of the UHC programme efforts, generating internal efficiency gains in the long run.

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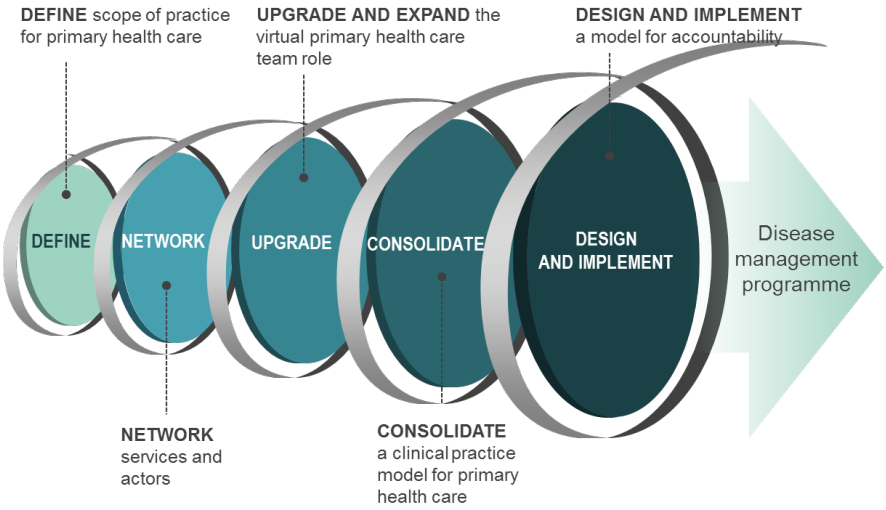
Annex 1. Multi-stage process for strengthening primary health care governance

This annex presents an example of how the recommendations above mentioned can be operationalized by focusing on a priority disease/s and implementing a long-term concurrent multi-stage process as shown in Fig. 4, below.

An expanded scope of PHC that defines roles and responsibilities of actors currently involved in delivering PHC services could be achieved by establishing virtual PHC teams that network existing actors through concrete tools e.g. patient pathways, health records, discharge plans and creates a *niche* for family doctors e.g. care/case managers, coordinators. Focusing on performance of priority disease/s, for example, could facilitate the development of the system capacity to regulate PHC, align incentives and update the health workforce competencies, also at subnational level.

Fig. 4. Multi-stage process for strengthening primary health care governance



Source: WHO European Centre for Primary Health Care

- ***Manage networks of actors and services***. Tools need to be applied to connect virtual primary health care teams around previously agreed on outputs and outcomes, examples of tools are patient pathways and discharge plans. Increasing the capacity to manage services, a key process for translating policies into practice, will be important to provide guidance and supervision to the virtual PHC teams. This oversight role needs to exist at the facility level and at the subnational level.

- ***Upgrade and expand the virtual PHC team role***. The introduction of new services is possible, especially to fill critical service delivery gap in NCDs prevention and treatment. To this end, the competencies of providers will need to be upgraded, new standards developed and incentives aligned around the new service. For example, competencies around screening, health literacy and healthy lifestyles will be needed to address NCDs.

- ***Consolidate a clinical practice model for PHC***. With upgraded and expanded PHC teams, a clinical practice model for PHC can be consolidated by harmonizing basket of services, competencies, scope of practice (rural/urban; private/public) and standards. The

clear delineation of scope of practice for PHC actors based on clinical guidelines and protocols will promote standardization across the parallel PHC service delivery systems and guarantee improved performance and increased efficiency. The regulatory underpinnings of this clinical practice model will be needed, with the development of standards and mechanisms to regulate and enforce them. Financial incentives will also need to be aligned to achieve desired performance of the clinical practice model for PHC.

- ***Design and implement a model for accountability***. Based on the initial mapping of current actors and accountability linkages, an accountability framework is to be designed and implemented to improve governance of all PHC actors around results and health outcomes. Setting out clear accountability arrangements, making sure they are well resourced and are provided with guided will be necessary. There are three important processes that need to be guaranteed within the accountability model: setting performance targets (at the national and facility level), generate performance information and ensure feedback loops for accountability. Three key processes:

    - Setting of performance targets both at the health system level and at the facility level.
    - Generating and disseminating performance information to stakeholders. Engaging regional and local actors will be important to monitor accurate information production and sufficient information flow.
    - Making feedback timelier to improve performance and learning through effective accountability chains.

  For individual PHC providers appropriate reward structures, increased employment status and improved supervision and reporting can contribute to a solid accountability framework. Building on existing values regarding PHC providers' responsibility for their catchment population will be key to strengthen accountability linkages.

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