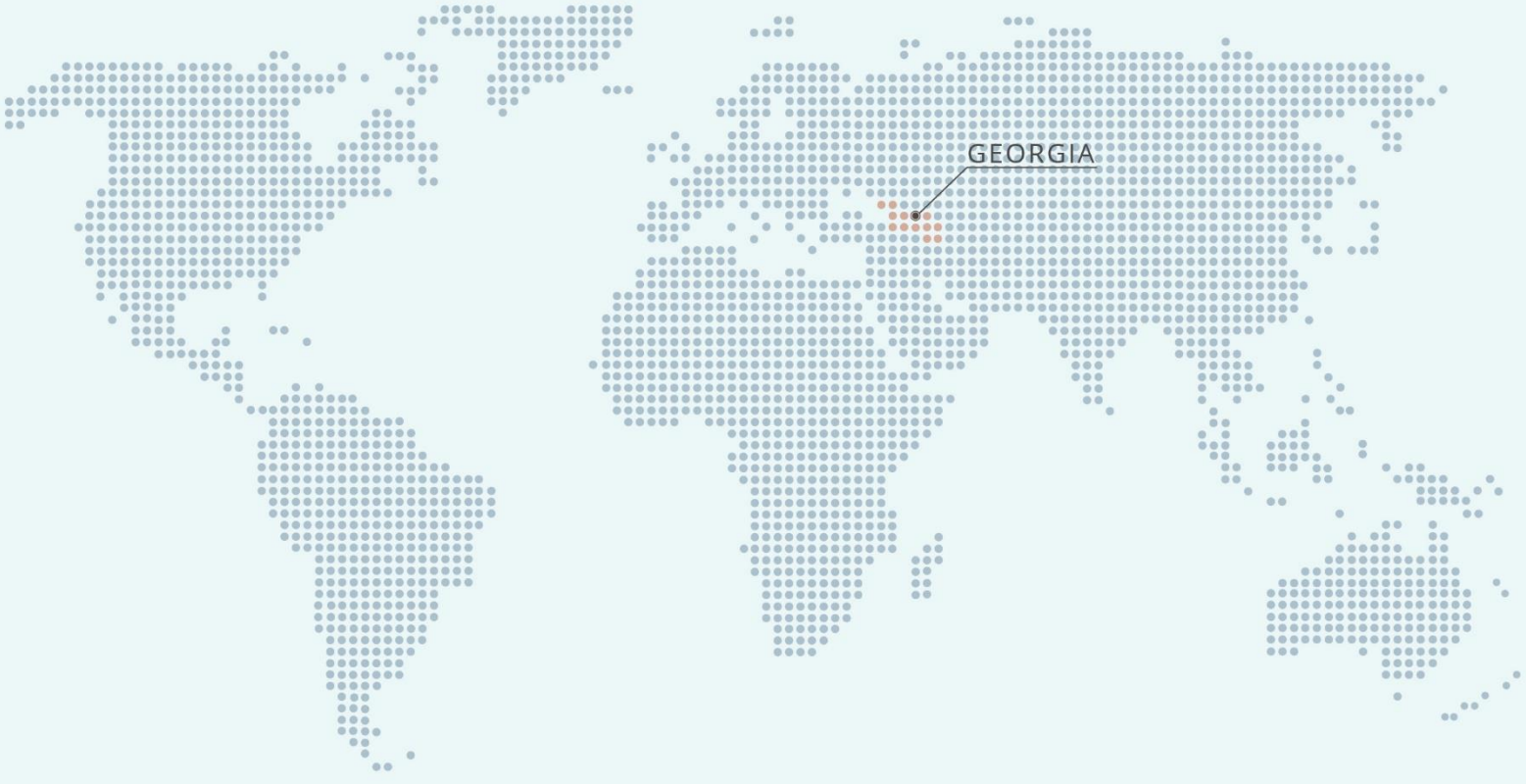
Primary Healthcare System's Development Strategy



Global Alliance
for Health
and Social Compact

CONSULTANCY ASSIGNMENT

According to the Agreement of State Procurement of Advisory Services between Ministry of Labour, Health and Social Affairs of Georgia and Global Alliance for Health and Social Compact, dated 07 April 2015

Objectives covered	Elaboration of primary healthcare system's development strategy and its implementation plan
Implementation/Development	Global Alliance for Health and Social Compact
Date of report	March 28, 2016

Global Alliance for Health and Social Compact

For further information on this report and the project please contact:

Global Alliance for Health and Social Compact

22 Billet Street Taunton, Somerset TA1 3NG
United Kingdom of Great Britain and Northern Ireland

UK Tel / +441823321177
UK Fax / +441823423400

E-mail: office@gahsc.net

Dr. Tatiana Paduraru

Content

Introduction ……...…… 5

Description of the current situation and pending problems 5

Necessary measures to attain the objectives and expected results 16

Impact assessment 24

Stages of implementation 27

Reporting and monitoring procedures 28

Action plan 30

INTRODUCTION

1. Primary Health Care System Development Strategy for the period 2016-2023 (hereinafter referred to as Strategy) is a component part of the implementation of the Georgian Healthcare System State Concept 2014-2020, oriented towards the primary health care system development.

2. The goal of the Strategy is to strengthen the position of family medicine in the health system of Georgia and develop a strong, responsive, efficacy and sustainable primary health care system that improves health care for all Georgians, especially those who currently experience inequitable health outcomes, by keeping people healthy, preventing illness, reducing the need for hospital services and improving management of chronic conditions.

3. The Strategy is in line with the objective of restructuring the health care system initiated 5 years ago and stems from the identification of the existent priority problems and outlines the methods of their approach and intervention, that, in case of sustainable and appropriate implementation, will ensure better outcome for the performance of the primary health care system and for the population health, even in the situation of scarce resources.

4. The Strategy has been developed on the basis of the best international practices for the development of primary health, as well as the basic documents of the World Health Organization, European Commission, World Bank and other international organizations from the sector of healthcare policy.

DESCRIPTION OF THE CURRENT SITUATION AND PENDING PROBLEMS

5. Reforms on primary health care services were initiated in Georgia in 2000. The First Primary Health Care Master Plan 2004-2006 provided the framework for reform aimed to provide universal access to quality basic medical care through a publicly owned and managed system. It also included plans to re-train all medical staff delivering primary health care and to rehabilitate PHC facilities. The designed policies assumed that financing

for primary health care would be covered through the state budget and by service fees, further moving towards a fixed per-person tax system.

6. In 2006, the Ist PHC Master Plan was reassessed in the framework of embarking on a major privatization program for health services, thus aligning health policy in line with the broader national economic policy to promote greater private-sector involvement. This radical health reform was implemented with minimal consultation with medical community, civil society groups and development partners.

7. In 2007, the IInd PHC Master Plan for the period 2007–2010 designed a major guideline for primary health care reform – (i) to introduce a private PHC system, based on insurance; (ii) to strengthen the role of the Ministry as regulator and policy-maker, thereby improving efficiency, effectiveness and quality of the health system; (iii) to differentiate urban and rural models of PHC, with about 900 PHC facilities in rural areas and an unlimited number in cities and regional/district centers, all of which are to be private; (iv) to fund publicly primary care provision in rural/mountainous areas, where the private sector would be unlikely to provide adequate coverage and (v) to fund the full package of PHC services for the poorest people (all those living below the poverty line). Finally, the Master Plan was not adopted.

8. In the period 2008-2012 the primary health care was not highlighted as a main policy intervention in the framework of the three strategic objectives that aimed to strengthen the health system. The primary health care provision reproduced defining elements of the system based on private provision and purchasing, which would work in a competitive environment. However, the health sector specific characteristics that make it distinct from the conventional market approach based on supply and demand for goods and services triggered the need for change.

9. With the effective introduction of the universal health coverage program in 2013, primary health care, represented by family medicine, has registered an upward trend in delimiting its field of competence within the health system. The competencies and responsibilities of the family medicine have been analysed and extended, generating an increase in efficiency by providing a greater volume of medical consultations and home visits, recording a larger number of patients and ensuring a better coverage in primary care.

10. Despite a low funding level and lack of necessary resources, Georgia has succeeded in making important steps towards the creation of a favourable environment for family medicine and reforms implemented in the primary health care sector. Family medicine has become a specialty by law, and the primary healthcare is declared a priority and holds the position of an “outpost” of healthcare system.

11. The various reform initiatives described above have resulted in the improvement of certain aspects of the organisation and provision of primary care services. However, the socio-economic context, epidemiological and demographic trends, geographical complexity and systemic deficiencies in implementation have limited the obtainment of desired results. Characteristics of primary care and regional comparisons indicate on insufficient achievements and the need for further improvements.

12. Being the most cost-efficient form of health care with the biggest impact on population health status and providing accessibility and continuity, the primary healthcare is still confronted with a number of serious problems.

Governance in the Primary Health Care System

13. Effective governance is an important prerequisite for provision of high quality primary health care services and for adequate ensuring with qualified primary health care personnel and modern equipment. Design of the appropriate governance models in the primary health care allows for the mobilization of the necessary financial resources, application of tools for priority setting, as well as rational and efficient utilization of the available resources in order to achieve the desired outcomes. Many of the developed policy interventions and plans cannot be fully implemented as they are not sufficient legally underpinned. In this respect, the strengthening of the MoLHSA role in governance of primary health care with a focus on volume of services, accountability, access, efficiency and quality is essentially required.

14. The deficit of qualified PHC managers, both for macro- and micro-level, is registered in the sector that would ensure positive evolutions and achievements in effectiveness, quality of and satisfaction with primary health care services. The reforms initiated in middle 2000's provided autonomy to health care providers, however, the skills in such modern managerial techniques as project planning and management, forecasting, financial management, negotiations, contracting and resource management are still weak. In order to make the primary health care system functional, it is necessary to train current managers and provide for the scheduled training of the new managerial staff of modern formation and advanced performance.
15. The weaknesses in the governance and financing dimensions of the primary health care have been identified by majority of persons interviewed within the consultancy assignments as the most significant barriers in the development of the primary healthcare, because the PHC institutions are not stimulated to introduce modern practices with a view to improving the quality and volume of services. It is necessary that in the shortest possible timeframe, this sector be strengthened and used to the maximum extent for obtaining the highest efficiency in allocating the financial resources intended for the healthcare system and enhancing the quality of the health services by implementing the mechanisms of motivating the primary health care providers, including by applying the stimulating payments depending on the performance.

Funding and mechanisms of payment for Primary Health Care

16. Funding is one of the main pillars that determines the sustainable functioning of the primary health care system and creates favorable conditions for satisfying the needs and requirements of the population in high quality and adequate volume services. Adequate application of allocation targets and payment mechanisms, including combination of them in linkage to types and packages of PHC services, allows for enhanced equitable access of the population to PHC services, ensures the rational and efficient use of resources and favors positive motivation of the PHC providers.

17. Although along with the implementation of the UHC Program, the degree of financial stability of the health system has increased and the access of the population to health care services has improved, a series of problems have not been yet solved.

18. The primary health care is under-funded mainly due to directing of the funds to the inpatient care. The current applied inpatient payment mechanism - bundle fee-for-service - is considered efficient in the case of services that require the stimulation of demand and supply of these services, in terms of their importance for public health (for e.g., screening services aimed at detecting oncologic diseases, cardiovascular diseases, malnutrition in children, etc.) and not in reimbursement of hospital cases. Consequently, hospital care is reaching a dramatic share > 80% of the total expenditures of the UHC Program, being to the detriment of primary health care (approx. 12% in 2014 and approx. 8% in the first 6 months, 2015).

19. Another critical source of leakages of primary health care funds is represented by duplication and/or parallel systems in primary health care provision - specific PHC services in vertical programs, including drug provision, and Rural Doctor Program - thus failing to assure efficient and effective use of resources to achieve declared objectives.

20. There is no a "gold standard" for financing the primary health care. Analysis of the international practices concludes about an "acceptable" level of 30% of health expenditures for the primary health care. This determines the need to strengthening and pooling the health system resources and build capacities for primary health care.

21. The applied payment mechanisms are not equitable and adjusted to the health risks, age group, area covered by family physicians (urban, rural, geographically remote/disadvantageous areas), number of people registered in the family physician's list and other medical-social criteria and need to be improved in order to stimulate provision adequate type and volume of primary health care. Different payment methods under UHC Program and Rural Doctor Program crease uneven financial flows for PHC services in rural and urban areas. The international practice shows better outcomes in case of systems that assure provision of services in rural and disadvantageous areas according to adjusted coefficients in the framework of the same payment/remuneration system, rather through the parallel ones.

22. The main purchaser in the health system - Social Service Agency (SSA) - is acting more as a passive claim administrator rather than an active purchaser of primary health care

services. In practice, there is no a competitive environment between primary care providers for health zones/patients lists.

23. The lack of norms related to allocated resources use, imperfect mechanism of cost calculation for primary health care services, etc. undermine the financial security of the service providers and PHC personnel motivation, including in the private sector, to conduct an activity framed entirely in the required standards. Neither realistic tools for efficacy enhancement, quality and performance in primary care provision, nor mechanisms of PHC personnel motivation to improve safety and accountability have been implemented.

Provision of Primary Health Care

24. The role and institutional capacity of primary care to provide quality services for entire population is low. Over the past five years, a network of primary care facilities has been established, but with limited possibilities in covering the needs of the entire population in essential health services of a high quality. As a consequence, a part of the population that can solve their health issues at the primary care level, is forced to turn to more costly hospital structures, which results in an irrational use of resources for health.

25. Primary care has a limited role in the prevention and control of non-communicable diseases (cardiological, oncological,etc.), which currently represent the main causes of high mortality of population. This network needs to be developed by further improving the governance and financial dimension, including the payment mechanism which should take into account demographic, geographic and achieved performance aspects.

26. According to WHO Health for All Database, the registered number of outpatient contacts per person per year in the health system (2.1 – 2011, 2.3 – 2012 and 2.7 – 2013) is significantly lower comparative to CIS countries (8.89 in 2013), WHO European Region (7.55 in 2013) and EU member countries (6.92 in 2013). Consequently, the registered primary health care contacts, as share of outpatient contacts, is generating warning signs. These data conclude that primary health care has severely limited gatekeeping capacity and does not represent the entry point into health system. The interviewed within the consultancy assignments decision-makers, health managers and physicians described

hospital as an outpatient as the first point of consultation when ill, as well as emergency care most often, rather than family doctor.

27. The primary health care contacts in rural areas is even lower. Several factors account for these low utilization rates. For instance, the qualitative assessments evidence that the pre-hospital emergency medical care (EMC) is being used for minor complaints and discouraging effective use of PHC institutions when medical attention is required. Majority of family physicians are employees of EMC institutions. But perhaps the main reason is the reduced role of primary care in accessing affordable pharmaceuticals through drug reimbursement program (under one umbrella).

28. Currently, separate primary health care delivery exists at different level of administration (i.e. primary health care in Tbilisi municipality) and different health programs (UHC Program and Rural Doctor Program); and each system is financed and operated by different governance units – local public authorities, UHC Program, vertical programs, etc. Having parallel health delivery systems creates tremendous duplication within the health sector.

29. Duplication and parallel primary health care represent a solid barrier in establishing an adequate package of PHC services. This aspect is complemented by the decoupling of primary care from the rest of health services, which results in serious discontinuities in monitoring the evolution of patients' health.

30. In the practice of the family doctor an insufficient capacity is observed in promoting health by providing the population with information and means of intervention on health determinants, which would shift focus towards preventive health services, as well as towards increasing in the population of the level of education on health with a view to adopting healthy behaviours. This fact is due both to insufficient resources and to motivation means which place a reduces emphasis on this type of interventions. Moreover, the current health education system sporadically offers knowledge and skills in this area, promoting at the level of primary care medical diagnosis and therapeutic procedures with very little emphasis on prevention and rehabilitation.

31. The lack of an approached based on interdisciplinary team work impedes the strengthening of primary care capacity in providing health care to a higher percent of patients even within the community. This would require the vertical integration of the primary care team and specialty services. Among regulations that are necessary to be developed for this purpose are administrative procedures, specific services such as direct access to diagnosis facilities, discharge and individual assistance schemes, integrated assistance and common care protocols, especially for chronic diseases. In this regard, primary care teams could take over in a more efficient way much of health care responsibilities that are currently assigned to specialist services, including to the ones delivered at the hospital level.

32. Regional disparities in economic development and certain geographic challenges result in an uneven distribution of primary care facilities, with focus on the urban area and on more prosperous rural areas. The impact of the reduced number of medical personnel, as well as of the insufficient qualified staff in a series of key areas in primary care is emphasises by the type of organization and ”tradition”, which does not stimulate and disregards multi-disciplinary team work and integrated management of diseases at the level of PHC, which might otherwise reduce the workload on the medical staff.

33. Another area for improvement is the one concerning the insurance of the quality of services delivered within the primary health care. Although professional associations of doctors have been among the most active in developing clinical guidelines, their implementation has remained in many cases unfulfilled, and the primary health care system as a whole hasn’t created the necessary framework for undertaking specific actions for ensuring quality. The low quality of the PHC services is caused, to a great extent, by the lack of programs that would determine the service providers to satisfy the needs of the beneficiaries to the maximum, by the fragmented approach of the quality management, by the mechanisms still insufficiently developed of performance-driven motivation of providers.

34. The process of accreditation has not become compulsory for providing services. The possibilities of contracting as an instrument of improving the allocation of resources on the basis of the population needs and motivating the providers with a view to obtaining the best results in quality and efficacy are not applied. Besides that, the set of performance

indicators for payment of providers proceeding from the attained results is also underdeveloped.

35. The PHC infrastructure do not correspond to the required standards of providing high quality services and is in a poor state, except those developed and renovated within the assistance projects of international agencies. PHC institutions in rural areas are more likely to be of poor quality and the participation of the local public authorities in the development of the healthcare infrastructure is still minimal.

36. The above mentioned situation is determined primarily due to lack of mechanisms of including in the price of services the needs related to equipping and infrastructure, thus limiting the possibilities for long lasting institutional development and dependence on specific state-run financing programs. Medical equipping does not derive from service delivery, but is dependent on special financing programs. The situation is similar to private PHC providers as well, since allocated funds for primary health care have been insufficient to allow for own investments. Moreover, funding patterns and payment mechanisms have offered few incentives to private providers to make investments in the PHC infrastructure. In addition, the public-private partnerships in providing primary health care services are not used at full extent.

Resource Management

37. The misbalances in human resources planning, training and management considering limited financial resources lead to unwanted inadequate generation of PHC personnel of high quality, knowledgeable and experienced in their area of clinical practice. Elements of current planning is based primarily on the ability of educational institutions of the education itself and less on health care needs that healthcare professionals should respond.

38. The analysis of human resources for PHC highlights four broad categories of problems related to:

a) irregular numeric distribution meaning the mismatch between the existing and the requested number of PHC personnel;

b) irregular distribution of capacities, meaning the mismatch between the professional training level and the capacities, in terms of both quantitative and qualitative dimensions, requested by the primary health care system;

c) irregular territorial distribution of the PHC personnel, urban/rural disproportion and inadmissible ratio and distribution of family physicians and nurses;

d) migration of the most qualified and trained medical staff from the national healthcare system.

39. The number of nurses per capita, according WHO Health for All Database, is twice lower than the CIS countries and approx. three times lower than WHO European Region and European Union average.

40. Another factor affecting the performance of PHC personnel is the insufficient motivation system. This includes both revenues obtained by medical personnel and issues related to unsatisfactory working conditions, as well as the reduced possibility of professional promotion based on objective criteria. From the viewpoint of the PHC managers and personnel, the lack of clear definition of workplace standard operation procedures, inappropriate PHC governance model, and low involvement in the decision-making process represent serious barriers for professional and managerial growth.

GENERAL AND SPECIFIC OBJECTIVES

41. The receptiveness of the primary health care system towards the population needs that depends on the degree of involvement of the citizens in the process of establishing the healthcare policy remains a serious problem. The involvement of the beneficiaries in planning, priority setting, implies not only the right to opinion, but also the transparency of the process of service provision, because the new model recommended by the World Health Organization aspired to, is patient-centred, guaranteeing maximal security both for beneficiaries and service providers.

42. Over the last years Georgia has registered significant progress in reforming its primary health care system. The first phase of the reform process was oriented towards stopping the decline in healthcare system conditioned by the financial crisis over the last decade of the previous century. The second phase was marked to a great extent by the introduction of market-driven mechanisms in health financing and provision. The next phase provides for the mobilization of all resources for structural changes that would result in increased efficiency and quality of the primary health care system.

43. The Strategy, in order to solve the identified problems and achieve the declared goal, defines the following general and specific objectives:

General objective 1. Improving governance and organizational capacity in primary care

1.1 Develop the policy framework in primary care and align it with declared priorities in the health sector

1.2 Improve the governance framework in primary care

1.3 Implementation of the integrated eHealth system at the level of primary health care

1.4 Improve the collaboration mechanisms with inter-sector partners in developing a sustainable primary health care system

General objective 2. Adequate insurance of human resources for primary health care

2.1 Adequate training of primary care personnel, thus ensuring a proper balance of inflow and outflow of professionals in family medicine

2.2 Develop an effective mechanism for motivating the primary health care personnel

2.3 Cover immediate and short-term needs in PHC personnel (both physicians and nurses) through a re-specialization program based on a special PHC certification curriculum

General objective 3. Improving financing, resource allocation and systems of payment to primary health care providers

3.1 Develop funding policies aimed at increasing equity, in line with declared priorities in the health sector

3.2 Ensure a sustainable, effective and performance-promoting method of payment to primary health care institutions

3.3 Establish a framework for contracting primary care services, including a framework for strategic procurement

3.4 Increase transparency in allocating and using financial resources in primary health care

General objective 4. Improving the quality of primary health care services

4.1 Create an essential framework, based on accreditation, for primary care providers to regularly and consistently evaluate and improve their processes and environment against patient experience and nationally and internationally recognized standards

4.2 Assure the provision of primary health care by high quality, knowledgeable and experienced in their area of clinical practice personnel

4.3 Institute the Quality and Safety Measurement Framework in provision of primary health care

General objective 5. Improving accessibility to family medicine

5.1 Assure Integrated Disease Management at primary health care level

5.2 Cover population needs in primary health care based on the principle of efficacy, opportunity and universal health coverage

5.3 Increase access to affordable pharmaceuticals by improving the system of drug reimbursement and its centeredness on primary health care according to WHO recommendations and international best practices

NECESSARY MEASURES TO ATTAIN THE OBJECTIVES AND EXPECTED RESULTS

44. In order to develop the policy framework in primary care and align it with declared priorities in the health sector the following activities are planned:
    a) Develop normative acts required for the implementation of the Strategy for the development of primary health care, including amendments and completions to related normative acts
    b) Elaborate and approve the normative framework on organization and service delivery in primary health care

c) Coordinate the activities in the area of primary health care with World Health Organizations, bilateral international organizations and development partners
d) Realize bilateral agreements/projects in the area of primary health care.

45. In order to improve the governance framework in primary health care the following measures shall be undertaken:
    a) Develop the normative framework to increase the role of the MoLHSA in governance of primary health care with a focus on accountability, access, efficiency and quality
    b) Train Social Service Agency personnel in the field of governance of all areas of primary health care
    c) Develop and approve the normative framework on PHC governance model based on Integrated Health System
    d) Extend the role of PHC Consultative Committee in the area of measurement and monitoring strategy to identify how the primary care system is performing in reference to its goals and objectives.

46. Implementation of the integrated eHealth system at the level of primary health care shall be achieved as follows:
    a) Develop the normative framework to include in the Integrated eHealth System all types of institutions involved in primary care provision
    b) Connect all types of institutions involved in primary health care provision to the Integrated eHealth System
    c) Train health authorities, managers and personnel from primary health care in utilization of Integrated eHealth System
    d) Implement a communication and awareness campaign on patient-oriented tools and eServices in PHC as part of Integrated eHealth System.

47. Improvement of the collaboration mechanisms with inter-sector partners in developing a sustainable primary health care system shall be achieved through the following actions:
    a) Develop and implement a Inter-sectorial Communication Plan for primary health care development

b) Establishment by local pubic authorities of primary health care facilities according to the Register of family medicine practices
c) Improve the institutional framework for collaboration and participation in decision-making on PHC with physician associations, PHC providers, local authorities, etc.
d) Establish agreements with local public health authorities on ensuring basic infrastructure for primary health care provision
e) Develop and approve the normative and institutional framework to ensure a sustainable inter-sectorial "one-stop service" at primary health care level (medical-social collaborative management, etc.).

48. In order to adequately train primary care personnel, thus ensuring a proper balance of inflow and outflow of professionals in family medicine, the following interventions shall be realized:
    a) Develop and apply a human resources for PHC planning methodology based on morbidity patterns, demand for services and perspectives of development of health system
    b) Develop medium- and long-term state plans for primary health care personnel
    c) Review the education curricula in family medicine according to international standards and needs of the health system for higher and middle personnel at undergraduate, postgraduate and continuous medical education levels
    d) Develop of the system of the residency in family medicine by position as a policy intervention to covering the necessities in health personnel in rural area and/or other regions with imbalances in the distribution of health personnel
    e) Improve the mechanism of collaboration between the medical education institutions and clinical training bases for a more efficient and increasing the practical training of PHC personnel
    f) Institutionalize eLearning tools in continuous medical education of primary health care personnel.

49. The development of an effective incentive framework for primary health care personnel shall be achieved as follows:

a) Develop and approve the methodology for establishing the maximum rates of expenditures for remunerating the personnel (employees) of primary health care institutions included in the Universal Health Coverage Program
b) Develop the methodology for motivating the PHC personnel from the rural and disadvantaged areas as an integrant part of the wage mechanism.

50. In order to cover immediate and short-term needs in PHC personnel (both physicians and nurses) through a re-specialization program based on a special PHC certification curriculum the following activities shall be undertaken:
    a) Estimate immediate needs in primary health care personnel according to designed family medicine practices
    b) Develop and accredit the training curricula in family medicine for physician and nurse re-specialization
    c) Develop and approve the normative framework for re-specialization in family medicine
    d) Train and certificate physicians and nurses in family medicine according to re-specialization curricula/program
    e) Distribute generated family physicians and nurses to family medicine practices.

51. In order to develop funding policies aimed at increasing equity, in line with declared priorities in the health sector, the following activities are planned:
    a) Improve and adjust the normative framework for an adequate financing of the primary health care, including setting expenditure targets for primary health care (at least 30% form the UHC Program budget), complemented with targeting inpatient expenditures at lower rates
    b) Pool resources for all primary health care services provided under the Universal Health Coverage Program and vertical programs in a Primary Health Care Sub-program within UHC Program.

52. Insurance of a sustainable, effective and performance-promoting method of payment to primary health care institutions shall be achieved through the following actions:
    a) Develop the methodology for implementing payment mechanisms in primary health care – per capita, expressed in points, according to doctor's list with registered persons;

fee-for-service, expressed in points, payment through global budget and payment for performance

b) Adjust *per capita* payment to the structure of the health risks, age group, area covered by family physicians (urban, rural, geographically remote/disadvantageous areas), number of people registered in the family physician's list and other medical-social criteria

c) Develop the methodology on planning resources allocated for primary health care institutions as a sum between the amount allocated *per capita* depending on age groups and urban/rural area, amount allocated for medical services the payment for which is made on the *fee-for-service* basis, amount allocated for achieving performance indicators, amount allocated through global budget and the amount allocated for reimbursing prescribed drugs

d) Develop the methodology of calculating the point granted for per capita, fee-for-service, performance and prescription of reimbursed drugs.

53. In order to institute the framework for contracting primary care services, including the framework for strategic procurement, the following activities shall be carried out:

a) Develop and adopt the normative framework to instituting contractual relationships in primary health care services procurement

b) Develop the methodology and procedures for contracting medical facilities for primary health care services provision

c) Develop and adopt the normative framework to instituting strategic purchasing in primary health care

d) Develop the methodology for strategic purchasing in primary health care

e) Develop Framework Contract between Social Service Agency and primary health care providers

f) Estimate the needs (human resources, etc.) of the Social Service Agency to implement the contract system in provision of primary health care services

g) Organize capacity building activities for Social Service Agency personnel to implement the contract system, including strategic purchasing, in provision of primary health care services

h) Organize capacity building activities for service providers to estimate the amount of services in contracting/strategic purchasing

i) Develop and approve the system of tariffs for healthcare services delivered within the primary health care system
j) Develop and implement primary health care services coding system.

54. The increase of transparency in allocating and using resources in primary health care shall be achieved through:
    a) Develop and approve Methodological Norms on the management of financial resources allocated for primary health care from UHC Program funds by contracted institutions
    b) Develop and implement procedures and tools for monitoring and reporting on primary care services contracted by the Social Service Agency within the UHC Programe, including through the eHealth Integrated System
    c) Develop and distribute annual reports on the allocation and usage of financial resources in primary health care

55. In order to create an essential framework, based on accreditation, for primary care providers to regularly and consistently evaluate and improve their processes and environment against patient experience and nationally and internationally recognized standards, the following measures shall be implemented:
    a) Review and complete the standards for primary health care per component of PHC practice according to international standards
    b) Amend the normative framework for accreditation of primary health care institutions
    c) Review procedures and tools for accreditation of primary health care institutions
    d) Organize capacity building activities for Agency for State Regulation of Medical Activities (ASRMA) in the field of accreditation of primary health care facilities
    e) Organize facilitating activities and preparation for accreditation for the primary health care providers
    f) Estimate the needs (human resources, etc.) of the Agency for State Regulation of Medical Activities to implement the accreditation of primary health care institutions
    g) Develop and implement the Primary health care facilities Accreditation Plan
    h) Implement electronic services, as part of Integrated eHealth System, for accreditation of primary health care providers – eAccreditation.

56. In order to assure the provision of primary health care by high quality, knowledgeable and experienced in their area of clinical practice personnel, the following actions shall be undertaken:
    a) Develop the standards for primary health care personnel licensing according to international standards
    b) Develop and approve the normative framework in the field of licensing of primary health care personnel based on a five-year cycle
    c) Develop the procedure and tools for licensing of primary health care personnel
    d) Organize capacity building activities for Agency for State Regulation of Medical Activities (ASRMA) in the field of licensing of primary health care personnel
    e) Estimate the needs (human resources, etc.) of the Agency for State Regulation of Medical Activities to implement the licensing of primary health care personnel
    f) Develop and implement the Plan on Licensing of Primary health care Personnel
    g) Implement electronic services, as part of Integrated eHealth System, for licensing of primary health care personnel – eLicensing
    h) Review and align the clinical guidelines in family medicine
    i) Develop and implement the clinical standardized workplace protocols for family doctors
    j) Develop and approve the standard operations procedures – SOPs (set of competencies) for medical personnel providing primary health care.

57. For instituting the Quality and Safety Measurement Framework in provision of primary health care, the following measures shall be undertaken:
    a) Implement, as part of National Health Quality Strategy, the set of quality and safety indicators in primary health care provision
    b) Include and adapt on a regular basis the set of quality and safety indicators into the contracting and pay for performance system to link clinical and financial accountabilities in primary health care
    c) Establish regular annually safety and quality data collection through Integrated eHealth System
    d) Map safety and quality profiles of primary health care institutions applying PHC Quality Scorecard.

58. In order to assure Integrated Disease Management at primary health care level, the following activities are planned:
    a) Establish the clinical conditions and/or population groups for Integrated Disease Management (IDM) at primary health care level (i.e. Integrated Management of Childhood Illnesses, etc.)
    b) Elaborate the regulations to implement the Integrated Disease Management (IDM) at primary health care level
    c) Develop the IDM guidelines and training curricula in Integrated Disease Management
    d) Develop and distribute IEC and counselling materials on Integrated Disease Management
    e) Develop the monitoring and evaluation procedures for Integrated Disease Management
    f) Clinical implementation of the Integrated Disease Management at primary health care level
    g) Ensure reporting on a regular basis of IDM implementation as part of health information system in place.

59. The coverage of population needs in primary care services based on the principle of efficacy, opportunity and universal health coverage shall be achieved through the following:
    a) Map and establish the family medicines practices
    b) Approve and update on a regular basis the Register of family medicine practices
    c) Develop and approve the methodology for attributing the family medicine practices
    d) Develop the regulatory framework for organising and coordinating the delivery of services in family medicine practices, including financial implications
    e) Develop and approve the procedures for registering the population with the primary health care facility
    f) Review and update the regulatory terms for registering the patients and introducing them in the lists of family physicians
    g) Improve the scheduling of patient visits, including of home visits, by implementing the eAppointment
    h) Promote and inform the population on the procedure of patient scheduling, including through eAppointment

i) Build a public-private mix in primary health care provision in a framework of common standards for public and private sectors
j) Elaborate methodology of primary health care delivery at home.

60. In order to increase access to affordable pharmaceuticals by improving the system of drug reimbursement and its centeredness on primary health care according to WHO recommendations and international best practices, the following activities shall be realized:
    a) Elaborate and approve the Drug Reimbursement Program, including amend and complete related normative acts
    b) Develop and approve procedures and tools for reporting in drug reimbursement
    c) Implement the eReceipt system in drug reimbursement
    d) Organize facilitating activities and preparation for drug reimbursement for the primary health care providers
    e) Implement at country-level the drug reimbursement program.

IMPACT ASSESSMENT

61. At the global level, the assessed impact is represented by the significant improvement of the governance, financing and provision of primary health care, as well as coordination capacity with other levels of health system, with effect on the increase of system efficacy and efficiency. The assessed financial impact is related to: ensuring of the financial protection of the population in accessing primary health care and drugs; enhancement of the efficacy of the system of health care services by streamlining the distribution of financial resources; ensuring of the transparency of the healthcare system; increase of the level of financing of the primary health care system. The assessed non-financial impact shall result in the following: improvement of the population state of health; enhancement of the access and equity to the necessary primary health care services; improvement of the quality of the rendered PHC services; ensuring of the PHC system responsiveness; streamlining the use of the primary health care system resources; correlation of the consumption of the PHC services with the population needs. The definitions of the indicators and the methods of assessment shall comply with the international technical standards promoted by the World Health Organizations, Eurostat, by the Global Fund to Fight AIDS, Tuberculosis and Malaria, Global Alliance for Vaccines and Immunization

and other international organizations activating in the health sector. In order to identify the existent inequalities in the healthcare system, the collected data shall be structured by sex, age, social and economic status, geographic situation and the residence area (urban and rural). The monitoring of the general objectives shall be conducted on the basis of the outcome indicators, and the attainment of the Strategy goals shall be centred on the following impact indicators:

Basic indicators of the population state of health:

a) Infant mortality;

b) Mortality of children under 5 years old;

c) Tuberculosis-related morbidity and mortality;

d) Cardio-vascular pathology-related mortality within the age groups between 30-39 and 40-59;

e) Malignant tumour-related mortality within the age groups between 20-39 and 40-59.

Medical services equity and accessibility:

a) The share of population that failed to seek the necessary health care due to financial situation;

b) The share of the primary health facilities from the rural localities, where one family doctor covers more than 2000 inhabitants;

c) The number of rural localities where there are primary health facilities, but there is no pharmaceutical support.

Financial protection of population for disease phenomena:

a) The share of the direct expenditures of the population for the healthcare services to the total expenditures of the household;

b) Co-payments for the health care services in the outpatient settings referred to the average salary.

Efficacy of the system of healthcare services provision:

a) The share of expenses for the primary health care to the total allocations for health;
b) Number of treated cases at primary health care level.

Quality of healthcare services:

a) The share of women who gave birth to a child and benefited from the entire package of antenatal services;

b) The share of pregnant women with anaemia to the total number of pregnant women.

Resources of the healthcare system:

a) Number of family doctors/nurses per 10,000 inhabitants;
b) Ratio family doctors : nurses;
c) Number of primary healthcare facilities/institutions per 100,000 people;

d) Number of acute hospital beds per 100,000 people.

Healthcare services consumption:

a) Level of hospitalization of the patients per 100,000 inhabitants;

b) Average number of visits to family doctor during one year per 1 inhabitant;

c) Number of calls for emergency services per 1,000 inhabitants.

62. The successful implementation of the Strategy presupposes a firm political commitment, efficient and visible stewardship, provision with the necessary resources, a good management and planning, an efficient system of monitoring and evaluation at each level, as well as skilled staff. The participation and support of the social partners, non-

governmental organizations, interested associations and community groups are indispensable. A significant role is played by the cooperation with the international structures, both in the form of technical assistance and attraction of investments from donors.

STAGES OF IMPLEMENTATION

63. The implementation of the Strategy will be carried out in two stages:

Stage I (2016 – 2019), comprising the following:

a) Develop and improve the normative framework and other implementation tools;
b) Accelerate structural and operational changes in human resources for primary health care;
c) Improve financing mechanisms for primary health care.

Stage II (2020 – 2023), will make an emphasis on:

a) Implementation of the interventions necessary for achieving the declared general and specific objectives.

64. The Strategy implementation will require development, integration and coordination of several programs identified and defined during the process of Strategy development.

65. Measures related to the development and implementation of the normative framework will be carried out directly by the central public authorities and will not entail additional costs than those provided by the state budget. With reference to the actions of development of the primary health care system resources such as PHC infrastructure, advanced medical and information technologies, strengthening of the medical staff capacities that involve additional implementation costs to those existent, such actions will be financed within the limits of the national public budget means, from technical assistance and foreign investments, public-private partnership projects, as well as from other sources that do not violate the legislation in force.

66. The financial, technical and human resources necessary for Strategy implementation will be assessed and detailed for each stage of the implementation process and for each separate

activity. Besides that, a periodical adjustment of these needs to the Mid-Term Expenses Framework, national development strategies and programs of national and territorial socio-economic development, will be realized.

67. Cooperation agreements from all development partners of the health care system represents the essence of the Strategy implementation success. During the process of implementation, the Ministry of Labor, Health and Social Affairs will cooperate with partners from inside and outside the healthcare system and first of all with the civil society. The contents and manner of Strategy implementation will be largely disseminated in mass-media means so that the whole population and medical community in this field be aware of its goals and contents.

REPORTING AND MONITORING PROCEDURES

68. The Strategy monitoring activities shall have a permanent character, being conducted during the whole implementation period and shall include the collection, processing and analysis of monitoring data, identification of errors or emergency effects, as well as potential corrections of content in the planned policies. The monitoring shall be realized taking into account three sets of indicators (process, outcome and impact) that will allow to supervise and assess the achievement of the general objectives specified in the Strategy and attainment of the general goal.

69. The process indicators will reflect the completion of activities detailed in the Action Plan, outcome indicators will monitor the achievement of the specific objectives and applied measures, and the impact indicators will be used to evaluate the changes registered in the population state of health.

70. The set of indicators monitoring the general objectives can be supplemented or changed during the Strategy implementation. For adequate monitoring and evaluation of the Strategy implementation process several information sources are being planned, the main of them being the data of the National Statistics Office of Georgia, surveys on human development supported by UNDP and World Bank, administrative reports within the

healthcare system. The collection of data for calculating the indicators shall be realized on the basis of the information collected in the State Registry of Population, during the population census, household surveys, and statistics reports on health status and on the basis of the activity results of the health facilities.

71. The Strategy evaluation shall have a systematic character being carried out during the whole period of implementation and shall include the development of the annual progress reports, evaluation report after the first stage of implementation and the final evaluation report after the second stage of implementation all of them being based on monitoring indicators.

72. The progress reports shall refer to the outcomes registered at the respective stage of Strategy implementation – achievement of general and specific objectives, completion of planned activities, attainment of performance indicators specific for each type of activity and formulation of proposals for the improvement and correction of planned measures. The evaluation report after the first stage of implementation shall also contain the aspects of institutional, functional and structural improvements produced as a result of Strategy implementation, the impact on the health of the target groups referred to in the document, level of observing the implementation terms and content from the Action Plan by the responsible institution. In case of non-fulfilled activities, the reasons of non-fulfilment or partial fulfilment shall be specified and efficient measures for achieving the Strategy general objectives will be proposed.

73. In order to ensure transparency of the Strategy implementation process, the annual progress reports, the evaluation report after the first stage of implementation, as well as the final evaluation report will be published in mass media and on the web site of the MoLHSA. The Ministry of Labor, Health and Social Affairs shall ensure a large dissemination in mass-media means of the process of Strategy implementation, as well as offer relevant information to the local and foreign partners.

ACTION PLAN

for implementation of the Strategy for Primary Health Care System Development for the period 2016-2023

Strategic Goal	**Strengthen the position of family medicine in the health system of Georgia and develop a strong, responsive, efficacy and sustainable primary health care system that improves health care for all Georgians, especially those who currently experience inequitable health outcomes, by keeping people healthy, preventing illness, reducing the need for hospital services and improving management of chronic conditions.**			
General Goals	**General objective 1. Improving governance and organizational capacity in primary care** **General objective 2. Adequate insurance of human resources for primary health care** **General objective 3. Improving financing, resource allocation and systems of payment to primary health care providers** **General objective 4. Improving the quality of primary health care services** **General objective 5. Improving accessibility to family medicine**			
Specific Goals	**Activity**	**Timeframe**	**Responsible authority**	**Indicators**
1.1 Develop the policy framework in primary care and align it with declared priorities in the health sector	Develop normative acts required for the implementation of the Strategy for the development of primary health care, including amendments and completions to related normative acts	2016-2017	MoLHSA	Normative acts on implementation of the Strategy for primary health care system development approved
	Elaborate and approve the normative framework on the organization and service delivery in primary health care	2016-2017	MoLHSA	The normative framework on the organisation and service delivery in primary health care approved
	Coordinate the activities in the area of primary health care with World Health Organizations, bilateral	2016-2023	MoLHSA	# of coordination working meetings with World Health Organizations,

	international organizations and development partners			bilateral international organizations and development partners
	Realize bilateral agreements/projects in the area of primary health care	2016-2019	MoLHSA	# of bilateral agreements in the area of primary health care signed
1.2 Improve the governance framework in primary health care	Develop the normative framework to increase the role of the MoLHSA in governance of primary health care with a focus on accountability, access, efficiency and quality	2016-2017	MoLHSA	Normative framework to increase the role of the MoLHSA in governance of primary health care approved
	Train Social Service Agency personnel in the field of governance of all areas of primary health care	2016-2019	Social Service Agency	% SSA staff trained in the field of PHC governance *(Target – 97%)*
	Develop and approve the normative framework on PHC governance model based on Integrated Health System	2016-2018	MoLHSA	Normative framework on PHC governance model based on Integrated Health System approved
	Extend the role of PHC Consultative Committee in the area of measurement and monitoring strategy to identify how the primary care system is performing in reference to its goals and objectives	2016-2018	MoLHSA	Statute of PHC Consultative Committee approved
1.3 Implementation of the integrated eHealth system at the level of primary health care	Develop the normative framework to include in the Integrated eHealth System all types of institutions involved in primary care provision	2016-2017	MoLHSA	Normative acts on regulating utilization of eHealth system in primary health care approved

	Connect all types of institutions involved in primary health care provision to the Integrated eHealth System	2018-2019	MoLHSA	% of PHC institutions operating within integrated eHealth system *(Target – 95%)*
	Train health authorities, managers and personnel from primary health care in utilization of Integrated eHealth System	2016-2017	MoLHSA	# of health authorities representatives, managers and personnel from primary health care trained in utilization of Integrated eHealth System *(Target – to be determined)*
	Implement a communication and awareness campaign on patient-oriented tools and eServices in PHC as part of Integrated eHealth System	2018-2019	MoLHSA	# of users of eServices in primary health care *(Target – to be determined)*
1.4 Improve the collaboration mechanisms with inter-sector partners in developing a sustainable primary health care system	Develop and implement a Inter-sectorial Communication Plan for primary health care development	2016-2017	MoLHSA	Intersectoral Communication Plan for primary health care development approved
	Primary health care facilities established by local public authorities according to the Register of family medicine practices	2017-2019	MoLHSA, MoRDI, Local Public Authorities	# of primary health care institutions founded by local public authorities *(Target – to be determined)*
	Improve the institutional framework for collaboration and participation in decision-making on PHC with physician	2016-2017	MoLHSA	% of proposed policies by medical community and associative sector which were approved through normative acts *(Target – to be determined)*

	associations, PHC providers, local authorities, etc.			
	Establish agreements with local public health authorities on ensuring basic infrastructure for primary health care provision	2017-2019	MoLHSA, MoRDI, Local Public Authorities	# of agreements signed with local public health authorities on ensuring basic infrastructure for primary health care provision *(Target – to be determined)*
	Develop and approve the normative and institutional framework to ensure a sustainable inter-sectorial "one-stop service" at primary health care level (medical-social collaborative management, etc.)	2016-2018	MoLHSA, MoRDI, Local Public Authorities	Normative acts on intersectoral collaboration in primary health care approved
2.1 Adequately train primary care personnel, thus ensuring a proper balance of inflow and outflow of professionals in family medicine	Develop and apply human resources for PHC planning methodology based on morbidity patterns, demand for services and perspectives of development of health system	2016-2017	MoLHSA	Methodology on human resources for PHC planning approved
	Develop medium- and long-term state plans for primary health care personnel	2016-2017	MoLHSA	State plan for primary health care personnel approved
	Review the education curricula in family medicine according to international standards and needs of the health system for higher and middle personnel at undergraduate, postgraduate and continuous medical education levels	2016-2018	MoLHSA	New education curricula in family medicine approved

	Develop of the system of the residency in family medicine by position as a policy intervention to covering the necessities in health personnel in rural area and/or other regions with imbalances in the distribution of health personnel	2016-2018	MoLHSA	# family medicine residents employed in PHC institutions *(Target – to be determined)*
	Improve the mechanism of collaboration between the medical education institutions and clinical training bases for a more efficient and increasing the practical training of PHC personnel	2016-2018	MoLHSA	# of signed agreements between the medical education institutions and clinical training bases *(Target – to be determined)*
	Institutionalize eLearning tools in continuous medical education of primary health care personnel	2018-2019	MoLHSA	# courses graduated by PHC personnel using eLearning tools *(Target – to be determined)*
2.2 Development of an effective incentive framework for primary health care personnel	Develop and approve the methodology for establishing the maximum rates of expenditures for remunerating the personnel (employees) of primary health care institutions included in the Universal Health Coverage Program	2016-2017	MoLHSA	The methodology for establishing the maximum rates of expenditures for remunerating the personnel (employees) of primary health care institutions included in the Universal Health Coverage Program approved
	Develop the methodology for motivating the PHC personnel from the rural and disadvantaged areas as an integrant part of the wage mechanism	2016-2017	MoLHSA	The methodology for motivating the PHC personnel from the rural and disadvantaged areas approved
2.3 Cover immediate and short-term needs in PHC	Estimate immediate needs in primary health care personnel	2016-2017	MoLHSA	Needs assessment in primary health care personnel according to

personnel (both physicians and nurses) through a re-specialization program based on a special PHC certification curriculum	according to designed family medicine practices			designed family medicine practices realized
	Develop and accredit the training curricula in family medicine for physician and nurse re-specialization	2016-2017	MoLHSA, MoES	Training curricula for re-specialization in family medicine for physician and nurse accredited
	Develop and approve the normative framework for re-specialization in family medicine	2016-2017	MoLHSA, MoES	Normative acts for re-specialization in family medicine approved
	Train and certificate physicians and nurses in family medicine according to re-specialization curricula/program	2017-2018	MoLHSA	# of physicians and nurses in family medicine trained according to re-specialization curricula/program *(Target – to be determined)*
	Distribute generated family physicians and nurses to family medicine practices	2017-2018	MoLHSA	% of family medicine practices covered with PHC personnel through re-specialization *(Target – 30%)*
3.1 Develop funding policies aimed at increasing equity, in line with declared priorities in the health sector,	Improve and adjust the normative framework for an adequate financing of the primary health care, including setting expenditure targets for primary health care (at least 30% form the UHC Program budget), complemented with targeting inpatient expenditures at lower rates	2016-2017	MoLHSA, MoF	Allocation to primary health care of at least 30% from the UHC Program budged

	Pool resources for all primary health care services provided under the Universal Health Coverage Program and vertical programs in a Primary Health Care Sub-program within UHC Program	2016-2017	MoLHSA, MoF	Normative acts on pooling financial resources for primary health care approved
3.2 Ensure a sustainable, effective and performance-promoting method of payment to primary health care institutions	Develop the methodology for implementing payment mechanisms in primary health care – per capita, expressed in points, according to doctor's list with registered persons; fee-for-service, expressed in points, payment through global budget and payment for performance	2016-2017	MoLHSA	Methodology on payment mechanism in primary health care approved
	Adjust *per capita* payment to the structure of the health risks, age group, area covered by family physicians (urban, rural, geographically remote/disadvantageous areas), number of people registered in the family physician's list and other medical-social criteria	2016-2017	MoLHSA, MoF	Risk-adjusted coefficients for per capita payment approved
	Develop the methodology on planning resources allocated for primary health care institutions as a sum between of the amount allocated *per capita* depending on age groups and urban/rural area, amount allocated for medical	2016-2017	MoLHSA, MoF	Methodology on planning resources allocated for primary health care institutions approved

	services the payment for which is made on the *fee-for-service* basis, amount allocated for achieving performance indicators, amount allocated through global budget and amount allocated for reimbursing prescribed drugs			
	Develop the methodology of calculating the point granted for per capita, fee-for-service, performance and prescription of reimbursed drugs	2016-2017	MoLHSA	Methodology of calculating the point granted for per capita, fee-for-service, performance and prescription of reimbursed drugs approved
3.3 Institute the framework for contracting primary care services, including the framework for strategic procurement	Develop and adopt the normative framework to instituting contractual relationships in primary health care services procurement	2016-2017	MoLHSA, MoF, MoJ	Normative framework on contractual relationships in primary health care services procurement approved
	Develop the methodology and procedures for contracting medical facilities for primary health care services provision	2016-2017	MoLHSA, MoF, MoJ	Methodology and procedures for contracting medical facilities for primary health care services provision approved
	Develop and adopt the normative framework to instituting strategic purchasing in primary health care	2016-2017	MoLHSA, MoF, MoJ	Normative framework on strategic purchasing in primary health care approved % of PHC institutions contracted based on strategic purchasing *(Target – 40%)*
	Develop the methodology for strategic purchasing in primary health care	2016-2017	MoLHSA	Methodology for strategic purchasing in primary health care approved

	Develop Framework Contract between Social Service Agency and primary health care providers	2016-2017	MoLHSA	Framework Contract between Social Service Agency and primary health care providers approved
	Estimate the needs (human resources, etc.) of the Social Service Agency to implement the contract system in provision of primary health care services	2016-2017	MoLHSA	SSA organizational structure and staffing norms approved % PHC contracting job positions covered *(Target – 90%)*
	Organize capacity building activities for Social Service Agency personnel to implement the contract system, including strategic purchasing, in provision of primary health care services	2016-2017	MoLHSA	% of SSA staff certified in contracting primary health care services *(Target – 100%)*
	Organize capacity building activities for service providers to estimate the amount of services in contracting/strategic purchasing	2016-2017	MoLHSA	% of PHC managers trained on contracting the primary health care services *(Target – 97%)*
	Develop and approve the system of tariffs for healthcare services delivered within the primary health care system	2016-2017	MoLHSA	Tariffs for primary health care services approved
	Develop and implement the primary health care services coding system	2016-2018	MoLHSA	Primary health care services coding system approved
3.4 Increase of transparency in allocating and using resources in primary health care	Develop and approve Methodological Norms on the management of financial resources allocated for primary health care from UHC Program funds by contracted institutions	2016-2017	MoLHSA	Methodological Norms on the management of financial resources allocated for primary health care approved

	Develop and implement procedures and tools for monitoring and reporting on primary care services contracted by the Social Service Agency within the UHC Programme, including through the eHealth Integrated System	2016-2017	MoLHSA	% of contracted PHC institutions reporting electronically to SSA *(Target – 85%)*
	Develop and distribute annual reports on the allocation and usage of financial resources in primary health care	2017-2023	MoLHSA	Annual reports on resource allocation and utilization in PHC published
4.1 Create an essential framework, based on accreditation, for primary care providers to regularly and consistently evaluate and improve their processes and environment against patient experience and nationally and internationally recognized standards	Review and complete the standards for primary health care per component of PHC practice according to international standards	2016-2017	MoLHSA	Standards on primary health care institutions accreditation approved
	Amend the normative framework for accreditation of primary health care institutions	2016-2017	MoLHSA	Normative framework on accreditation of primary health care institutions approved

	Review procedures and tools for accreditation of primary health care institutions	2016-2017	MoLHSA	Methodology on accreditation of primary health care institutions approved
	Organize capacity building activities for Agency for State Regulation of Medical Activities (ASRMA) in the field of accreditation of primary health care facilities	2016-2017	MoLHSA	% of ASRMA personnel certified in accreditation of primary health care personnel *(Target – 100%)*
	Organize facilitating activities and preparation for accreditation for the primary health care providers	2017-2019	ASRMA	% of PHC managers trained on accreditation for the primary health care providers *(Target – 97%)*
	Estimate the needs (human resources, etc.) of the Agency for State Regulation of Medical Activities to implement the accreditation of primary health care institutions	2016-2017	MoLHSA	ASRMA organizational structure and staffing norms approved % accreditation job positions covered *(Target – 90%)*
	Develop and implement the Primary health care institutions Accreditation Plan	2017-2023	ASRMA	Plan on primary health care institutions accreditation approved
	Implement electronic services, as part of Integrated eHealth System, for accreditation of primary health care providers – eAccreditation	2017-2023	ASRMA	% of primary health care centers with accreditation certificate issued electronically *(Target – 95%)*
4.2 Assure the provision of primary health care by high quality, knowledgeable and experienced in their area of clinical practice personnel	Develop the standards for primary health care personnel licensing according to international standards	2016-2017	MoLHSA	Standards for primary health care personnel licensing developed

	Develop and approve the normative framework in the field of licensing of primary health care personnel based on a five-year cycle	2016-2017	MoLHSA	Normative framework on licensing of primary health care personnel approved
	Develop the procedure and tools for licensing of primary health care personnel	2016-2017	MoLHSA	Methodology on licensing of primary health care personnel approved
	Organize capacity building activities for Agency for State Regulation of Medical Activities (ASRMA) in the field of licensing of primary health care personnel	2017-2019	ASRMA	% of ASRMA personnel certified in licensing of primary health care personnel *(Target – 100%)*
	Estimate the needs (human resources, etc.) of the Agency for State Regulation of Medical Activities to implement the licensing of primary health care personnel	2016-2017	MoLHSA	ASRMA organizational structure and staffing norms approved % licensing job positions covered *(Target – 90%)*
	Develop and implement the Plan on Licensing of Primary health care Personnel	2017-2023	ASRMA	Plan on Licensing of Primary Health Care personnel approved
	Implement electronic services, as part of Integrated eHealth System, for licensing of primary health care personnel – eLicensing	2017-2023	ASRMA	% of primary health care personnel with license certificate issued electronically *(Target – 65%)*
	Review and align the clinical guidelines in family medicine	2016-2018	MoLHSA	Clinical guidelines in family medicine approved
	Develop and implement the clinical standardized workplace protocols for family doctors	2017-2023	MoLHSA	% family physicians covered with clinical standardized workplace protocols *(Target – 95%)*

	Develop and approve the standard operations procedures – SOPs (set of competencies) for medical personnel providing primary health care	2016-2017	MoLHSA	SOPs for medical personnel providing primary health care approved
4.3 Institute the Quality and Safety Measurement Framework in provision of primary health care	Implement, as part of National Health Quality Strategy, the set of quality and safety indicators in primary health care provision	2017-2021	MoLHSA	List of safety and quality indicators for primary health care (including meta-data) approved
	Include and adapt on a regular basis the set of quality and safety indicators into the contracting and pay for performance system to link clinical and financial accountabilities in primary health care	2017-2023	MoLHSA	% of PHC centers with quality-related stipulations in the contract with SSA *(Target – 85%)* % of safety and quality indicators into performance payment *(Target – 25%)*
	Establish regular annually safety and quality data collection through Integrated eHealth System	2017-2023	MoLHSA	% of PHC centers submitting electronically safety and quality reports *(Target – 90%)*
	Map safety and quality profiles of primary health care institutions applying PHC Quality Scorecard	2017-2023	MoLHSA	% of PHC centers with annually updated PHC Quality Scorecard *(Target - 70%)*
5.1 Assure Integrated Disease Management at primary health care level	Establish the clinical conditions and/or population groups for Integrated Disease Management (IDM) at primary health care level (i.e. Integrated Management of Childhood Illnesses, etc.)	2016-2017	MoLHSA	List of health conditions for Integrated Disease Management (IDM) approved
	Elaborate the regulations to implement the Integrated Disease	2016-2017	MoLHSA	Regulations on Integrated Disease Management (IDM) at primary health care level approved

	Management (IDM) at primary health care level			
	Develop the IDM guidelines and training curricula in Integrated Disease Management	2016-2023	MoLHSA	% of primary health care personnel trained in Integrated Disease Management *(Target – 85%)*
	Develop and distribute IEC and counseling materials on Integrated Disease Management	2017-2021	MoLHSA	% of person registered in family physician list covered with IEC materials on Integrated Disease Management *(Target – 95%)*
	Develop the monitoring and evaluation procedures for Integrated Disease Management	2016-2017	MoLHSA	Monitoring and Evaluation Procedures for Integrated Disease Management approved
	Clinical implementation of the Integrated Disease Management at primary health care level	2017-2023	MoLHSA	% of PHC centers applying in practice integrated disease management for established health conditions *(Target – 60%)*
	Ensure reporting on a regular basis of IDM implementation as part of health information system in place	2017-2023	MoLHSA	% of PHC centers reporting activity-related IDM indicators *(Target – 50%)*
5.2 Coverage of population needs in primary care services based on the principle of efficacy, opportunity and universal health coverage	Map and establish the family medicines practices	2016-2017	MoLHSA	Register of family medicine practices approved
	Approve and update on a regular basis the Register of family medicine practices	2016-2023	MoLHSA	% of family medicine practices covered with PHC providers *(Target – 95%)*
	Elaborate and approve the methodology for attributing the family medicine practices	2016-2017	MoLHSA	Regulation on attributing family medicines practices approved

	Develop and approve the procedures for registering the population with the primary health care facility	2016-2017	MoLHSA	Regulation on the registration of population with the primary health care facility approved
	Improve the scheduling of patient visits, including of home visits, by implementing the eAppointment	2016-2017	MoLHSA	eAppointment in primary health care functional
	Promote and inform the population on the procedure of patient scheduling, including through eAppointment	2017-2023	MoLHSA	% visits to primary health care institutions based on eAppointment *(Target – 45%)*
	Build a public-private mix in primary health care provision in a framework of common standards for public and private sectors	2016-2018	MoLHSA	% of family medicine practices with private provision of care *(Target – 60%)*
	Elaborate methodology for primary health care delivery at home	2016-2017	MoLHSA	Methodology for primary health care delivery at home approved # of home visits by family nurse per person registered in family physician list *(Target – to be determined after baseline)*
5.3 Increase access to affordable pharmaceuticals by improving the system of drug reimbursement and its centeredness on primary health care	Elaborate and approve the Drug Reimbursement Program, including amend and complete connected normative acts	2016-2017	MoLHSA	Drug Reimbursement Program approved

according to WHO recommendations and international best practices				
	Develop and approve procedures and tools for reporting in drug reimbursement	2016-2017	MoLHSA	Procedures and tools for reporting in drug reimbursement program approved
	Implement the eReceipt system in drug reimbursement	2017-2023	MoLHSA	# of receipts issued by family physicians submitted electronically *(Target – 95%)*
	Organize facilitating activities and preparation for drug reimbursement for the primary health care providers	2017-2019	MoLHSA	% of family physicians informed regarding drug reimbursement procedures *(Target – 90%)*
	Implement at country-level the drug reimbursement program	2017-2023	MoLHSA	# of issued receipts for reimbursed drugs per visit *(Target – 65%)* # of receipts for reimbursed drugs per family physician *(Target – to be determined)*

Global Alliance for Health and Social Compact (GAHSC) represents a brand new business initiative amalgamating consultancy and management, expertise and capacity into solid professional think-tank generating turn-key solutions for health systems.

GAHSC is an international company bringing together leading expertise from a wide range of health system areas including but not limited to public health, healthcare management, health financing mechanisms, healthcare service delivery design and reconfiguration as well as comprehensive monitoring and evaluation.