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Transforming primary health care during the pandemic

FROM CRISIS TO OPPORTUNITY: ADVANCING PRIMARY HEALTH CARE REFORM AMID THE COVID-19 PANDEMIC

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MOTIVATION

The COVID-19 pandemic has created significant challenges for the health system but has also highlighted the importance of comprehensive primary health care services. Although Georgia has implemented reforms to strengthening the family medicine–based primary health care model over the past 30 years, previous steps have not resulted in the desired service delivery capability and outcomes. The pandemic has highlighted this and created an opportunity to renew commitment and efforts to strengthen primary health care services. This vignette highlights Georgia's most recent approach to designing and initiating the implementation of major comprehensive reform efforts during challenging times while continually learning and integrating lessons from the pandemic response into both design and implementation.

TRANSFORMATIONAL POLICIES AND TOOLS

Renewed commitment to strengthening the primary health care system

In December 2019, the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs announced renewed commitment to comprehensively reforming primary health care. Throughout 2020, the Ministry, with the support of WHO, drafted the primary health care roadmap to support phased implementation of primary health care reform. Key components of this effort included: (1) stepwise revision of the primary health care benefits package, giving priority to early childhood development and comprehensive management of noncommunicable diseases; (2) strengthening the model of primary health care to deliver expanded services to the entire emplanelled population, (3) introducing a new costing and payment structure aligned with a performance and quality framework; and (4) giving priority to investment in digital solutions for telehealth and telemedicine to increase access to and improve service delivery in rural and underserved communities.

This initiative responds to weaknesses in the current design of family medicine–based primary health care, which does not adequately align with population health needs, does not meet people's expectations and does not produce desired health outcomes. Due to its fragmented design, narrow service offerings and limited capacity, primary health care doctors refer up to 40% of the people who seek primary health care services to specialists. In addition, many people bypass primary health care and self-refer to more costly specialized care due to access barriers and low confidence in the quality of primary health care. Hence, the current reforms aim to address these weaknesses and other root causes:

- Fragmented management and delivery of primary health care services under multiple separate programmes (Universal Health Care Programme, the Rural Doctors Programme and 29 vertical programmes) has led to poor population awareness of entitlements and access barriers while inhibiting an integrated holistic approach to care and limiting the accountability of primary health care providers for health outcomes and their role in managing the health of the population.
- Lack of health workforce planning and management have resulted in an unevenly distributed and ageing primary health care workforce, with an acute shortage of nurses: the nurse–physician ratio in primary health care is 0.3 to 1 *(1)*.
- Lack of continuing medical education or professional development system or framework or requirements.
- High referral rates aided by proximity to and ease of access to specialists negatively affects the coordination of care pathways and the comprehensiveness of services provided by urban family doctors, resulting in a narrow scope of practice and limited engagement in chronic disease management.
- Weak policy, regulatory and accountability frameworks and misaligned financial incentives undermine the gatekeeping role of primary health care providers and result in low-quality and fragmented primary care, which neglects prevention and care continuity.
- Low public spending skewed towards secondary and specialized care (only 12% of the public health budget was allocated to primary health care in 2018) *(2)* results in chronic underfunding of primary health care.
- Weak financial protection and high out-of-pocket payments as a share of total spending on health (48% in Georgia versus 30% in the WHO European Region as a whole in 2018) leads to relatively frequent impoverishing and catastrophic health spending.
- Escalating costs for medicines are a leading cause of catastrophic health expenditure and account for the largest share of out-of-pocket payments (69% in 2018) *(3)*.

Phased approach

Shifting from an institution- and disease-oriented system with vertical and often uncoordinated programmes that rely greatly on specialist services towards an integrated, people-centred primary health care model requires a well-planned stepwise approach. Given the scale of investment and retooling required for this transition, Georgia is pursuing a stepwise implementation strategy from 2021 to 2025, implementing a revised benefits package and integrating priority service packages into primary health care among early adopters in phases before national expansion.

Strengthening governance and legislative frameworks

Strong leadership and health system governance are key to the effective implementation and sustainability of health reform. A multistakeholder primary health care Coordinating Council established by the Ministry is expected to play an important role in coalition building and engaging key national stakeholders (professional associations, providers, patient organizations and public agencies) and international stakeholders (WHO, European Union, UNICEF, UNFPA, UNDP, United States Agency for International Development and Czech Development Agency), sustaining political commitment and steering the reform implementation process. Other implemented actions for strengthening governance and legislative framework for the primary health care system include selective contracting of primary health care providers, building management and purchasing capacity and strengthening health information systems to support the production, analysis, dissemination and use of reliable and timely information. The newly established Agency for Information Technologies will play a central role in streamlining the health information system in the country.

Redefining priority service packages for universal coverage

Primary health care plays a critical role in disease prevention, early detection and management of noncommunicable diseases, reducing noncommunicable disease-related complications, hospitalization and premature mortality. In Georgia, noncommunicable diseases account for an estimated 93% of all deaths. Thus, the roadmap begins with strengthening existing essential primary health care services and integrating key noncommunicable diseases (hypertension, cardiovascular diseases, diabetes, chronic obstructive pulmonary disease and asthma), mental health and early child development into primary health care among select early adopters with subsequent expansion nationwide.

The aim of the costing model is to identify the resources needed in primary health care to deliver a unified package of primary health care services to the entire population without co-payments, since they may create barriers to utilizing services. The new costing model is based on defining all necessary basic costs required for providing the essential services in the primary health care benefits package and payment rates for providers.

In parallel, it is necessary to continue to address affordability and access to high-quality medicines in primary health care. This includes passing the Law on Medicinal Products (submitted to Parliament in 2020), introducing price regulation for medicines and changes to the outpatient medicine benefits programme, regularly updating the prescription guidelines and monitoring and mandatory disclosure by health care professionals of any benefits received from industry.

Strengthening the model of care to deliver an expanded scope of services

Transforming the primary health care service delivery model from one that is reactive and disease centred towards one that is more proactive and addresses upstream health needs and root causes of disease for the whole population is essential to creating a more people-centred primary health care system. Such a model requires an expanded scope of services, risk stratification tools and integrative approaches for strengthening population health management. Future primary health care should take a more holistic approach to assessing individual health needs and involve collaborative decision-making based on individual needs, preferences and attitudes towards health and health-seeking behaviour. Therefore, in addition to updated clinical guidelines and competencies, introducing non-clinical competencies will be important, such as more person-centred communication with patients and efficient interprofessional communication. The primary health care roadmap envisions a gradual transition towards networks of multidisciplinary primary health care teams, with increased role of nurses and social workers responsible for coordinating services across the care continuum and health outcomes for their empanelled population and social services applied universally to urban and rural practices alike. In this light, the Ministry has given priority to integrating mental health services in primary health care, after the successful piloting of primary health care provider engagement in providing mental health services during the pandemic.

Addressing health workforce challenges

The full-scale implementation of the primary health care roadmap requires a comprehensive, long-range health workforce strategy. The WHO Regional Office for Europe is supporting the Ministry to conduct the first comprehensive health workforce assessment to inform such a strategy. The assessment is encompassing competencies, training needs, skill–mix balance, retention, attractiveness, geographical distribution etc. It will consider both clinical and managerial aspects of primary health care delivery, including reviewing the required competencies and aligning with the new primary health care model to ensure sustainability. Short- and long-term capacity-building interventions, including mandatory continuing medical education and

professional development for doctors and nurses, are planned to be introduced and aligned with the revised protocols, competencies and payment incentives. Achieving the objectives outlined in the primary health care roadmap will also require the increased role, autonomy and competencies of the family nurse (at least one full-time nurse per doctor). Finally, performance measures and accountability mechanisms are planned to be established for all primary health care providers.

Introducing financial incentives to drive performance

Implementing the primary health care reforms requires additional budgetary allocations and better alignment of financial incentives with the desired and measurable outcomes. Based on a detailed provider cost and activity data analysis, a new costing and payment model was developed for the revised primary health care benefits package with a mix of capitated payments, rent allowance and a motivational, results-based payment component for providing the priority services. The model will be applied to rural and urban providers offering the basic benefits package. The new costing model is based on defining all necessary basic costs required for providing the essential services in the primary health care benefits package. As an incentive to reduce high rates of referral and provide services in primary health care for specific priority diseases and populations, motivational add-on payments are proposed for the priority services (noncommunicable diseases and early childhood development). In addition, selective contracting was initiated in 2020 to encourage a transition toward larger network or group practices in urban settings with larger patient panels to increase efficiency and improve quality and sustainability.

eHealth and digital solutions for strengthening primary health care

The shift to digital platforms and telemedicine solutions was given priority before the pandemic but accelerated out of necessity during the pandemic response.

The current health information system is fragmented across multiple eHealth modules, and the management information for the primary health care system remains cumbersome and non-standardized and lacks interoperability with various internal information systems used by primary health care providers. In addition, the personnel must complete duplicate paper-based and electronic forms and yet the data are rarely used for analysis and decision-making. In 2020, the Ministry developed a concept paper on telemedicine in health care as part of the strategic vision for health care sector development, which involves the support of the online interface for both patients and communities as well as within the health sector (vertical, within the primary health care system connecting rural physicians with urban family medicine centres and horizontal, connecting all primary health care professionals with hospital-based specialists). In the same period, the Ministry gave priority to telehealth and telemedicine as the key intervention in the implemented primary health care reform to improve service delivery in rural and underserved communities.

Digital solutions are crucial to both managing and delivering services under the phased primary health care roadmap, including expanding remote services and introducing the empanelment process (patient enrolment registration, a system to maintain and update the individual enrolment database after each enrolment registration period etc.), data exchange between primary health care providers and the Ministry and its subordinate agencies responsible for population empanelment, performance monitoring and payment – the strategic purchaser, the National Health Agency, and the Agency for Informational Technologies. Primary health care providers should have the ability to electronically report on enlisted patients in the target groups and to follow up on patients not receiving care according to the guidelines. Depending on data availability, the platform should also support the monitoring of health outcomes and the analysis of data for (performance-based) financing.

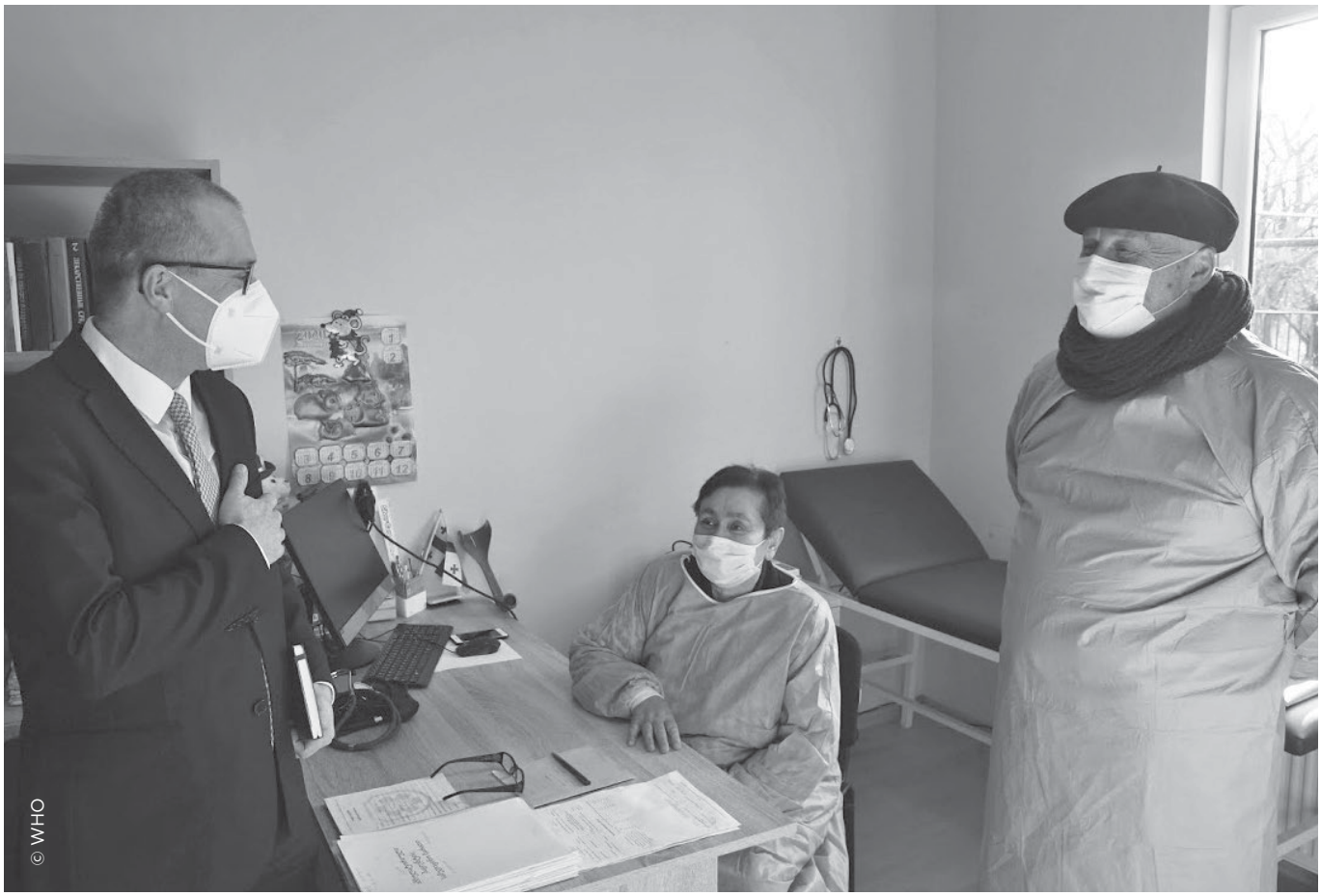
ACCELERATED REMOTE CONSULTATIONS AND DIGITAL TOOLS DURING THE COVID-19 RESPONSE

The COVID-19 pandemic disrupted health care services at all levels of care in Georgia but has also accelerated the transformation of primary health care. Digital solutions helped bring services closer to the people through a remote model of delivery. Key activities included:

- a unified digital platform to support primary health care communication;
- rapid retraining of the entire primary health care workforce in new protocols and guidelines (with support from WHO, UNICEF, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United States Agency for International Development and the Czech Development Agency);

- Internet connections established for nearly 1000 rural ambulatories, providing access to the new platform with capacity for online training, supportive supervision, videoconferences, peer exchange, online consultations, reporting, feedback and monitoring and evaluation and updated protocols, guidance and training;
- online clinics for the remote management of patients;
- patient monitoring, supportive supervision, internal and external quality control and medical audit mechanisms not previously used in primary health care settings were designed and implemented, including modules on peer observation and constructive feedback *(4,5)*;
- telehealth solutions, such as shared medical appointments for expectant mothers *(6)*, virtual patient chatrooms and an efficient task force hierarchy involving medical students and senior doctors, providing opportunities for peer exchange and on-the-job training for medical students and junior doctors *(7)* will remain relevant for primary health care reform in the post-pandemic period; and
- empanelment strengthened through a new digital portal *(8)*.

Before the pandemic, many people did not utilize primary health care services and were not aware of their assigned primary health care provider, but a digital portal (http://ambulatoria.moh.gov.ge) launched in November 2020 enabled people to connect with family doctors and clinics where they were registered if they developed COVID-19 symptoms. Individuals not registered with any primary health care provider were assigned a family doctor in accordance with their place of residence. According to the Ministry, several thousand people were registered for the first time. In addition, between September 2020 and May 2021, the 112 emergency service transferred 322 735 calls to primary health care online clinics from which ambulances were dispatched for only 8555 cases (2.7% of all calls), and 23 592 (7.3%) cases were eventually hospitalized. The COVID-19 response has both increased demand for primary health care services and demonstrated the critical role primary health care plays in the health system. It has highlighted the need for further investment and strengthening of primary health care in Georgia as well as increased awareness regarding the use of enhanced digital tools in enabling the transformation towards a more responsive, accessible and people-centred primary health care model.



EARLY ACHIEVEMENTS, SUSTAINABILITY PROSPECTS AND NEXT STEPS

The COVID-19 pandemic strengthened political commitment to advancing comprehensive primary health care reform with an aim for more people-centred, coordinated, continuous primary health care services that are accessible and affordable. Georgia has taken a whole-system approach starting from expanding the benefit package, adjusting the model of care to deliver these services, addressing health workforce challenges, aligning financial incentives, investing in digital solutions and strengthening governance arrangements.

In response to the pandemic, mixed modalities for service delivery have been introduced, combining face-to-face in-facility consultations with face-to-face at-home and remote (online or telephone) consultations. Moving existing services online enabled the delivery of essential services closer to the people, thereby increasing access to and reducing disruptions in services not only because of the pandemic but also because of physical access barriers and harsh weather conditions in hard-to-reach areas.

Building on the successful application of the behaviour insights approach in planning pandemic response measures, the Ministry plans to consistently use this approach for community empowerment and engagement to ensure effective functioning of the new primary health care model and to use in this process the experiences and skills acquired by the national actors in conducting behaviour insights study during the pandemic.

Moving forward, comprehensive assessments are needed in areas of human resources for health, health information systems and digital health to properly align health system needs with resources and investment.

"IMPLEMENTING THE PRIMARY HEALTH CARE REFORMS REQUIRES ADDITIONAL BUDGETARY ALLOCATIONS AND BETTER ALIGNMENT OF FINANCIAL INCENTIVES WITH THE DESIRED AND MEASURABLE OUTCOMES."

LESSONS LEARNED FOR OTHER COUNTRIES

Several lessons have been learned through this process that can inform the long-term transformation in health care delivery in Georgia and elsewhere.

- **The COVID-19 pandemic served as an opportunity to accelerate primary health care reform** aiming for more people-centred, coordinated, continuous primary health care services, that are accessible and affordable for the whole empanelled population.
- **Sustaining the momentum for implementing the primary health care roadmap and continually giving priority to investment in primary health care requires strong and dedicated leadership, effective coordination and the commitment of sufficient human resources** to manage the complex transition to a people-centred and integrated primary health care model. Significant investments are needed in human resources, infrastructure, essential and supportive services and information technologies, which may be constrained due to the economic and fiscal restrictions as well as increased competing health demands created by the pandemic.
- **For countries with fragmented coverage, comprehensive primary health care transformation is an entry point to implement universal coverage.**
- **Adequate levels of public funding** (including investments in the transformation process itself) and **proper financial incentives for providers** but also for patients in terms of removing financial barriers **are required to accelerate primary health care reform**.
- **Availability of high-quality data and the capacity to collect, analyse and disseminate data-informed policy recommendations are essential to implementing a more responsive and people-centred primary health care model.**
- **The pandemic has revealed a significant demand for mental health services in primary health care**, highlighting the need for strengthening multi-disciplinary care that can meet the health, mental health and social needs of the population.
- **Innovative digital solutions developed during the pandemic response can be successfully and sustainably applied in the post-pandemic period** for both communicable and noncommunicable disease monitoring and management, continuous medical education and supportive supervision and the development of health management information systems, including the unified electronic medical records for primary health care.
- **The recent increase in the use of digital health solutions has shown that there is a need for significant investment in appropriate digital technologies and health workforce capacity to use such tools**, establishment of a regulatory framework for their implementation and systematic promotion of digital solutions among health workers and the population, which is a key focus of the ongoing primary health care transformation process in the country.

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ACKNOWLEDGEMENTS

The authors thank the following people for sharing their insights and resources for drafting the report and for reviewing the document:

Arnoldas Jurgutis, Technical Officer, WHO European Centre for Primary Health Care;

Kaija Kasekamp, Consultant, WHO;

Ketevan Goginashvili, Chief Specialist, Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs;

Irina Karosanidze, Director, National Family Medicine Training Center;

Melitta Jakab, Head of Office, WHO European Centre for Primary Health Care;

Triin Habicht, Senior Health Economist, WHO Barcelona Office for Health Systems Financing; and

Zulfiya Pirova, Technical Officer, WHO European Centre for Primary Health Care.

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