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REVIEW

PRIMARY HEALTH CARE REFORMS IN GEORGIA: THE EXPERIENCE AND CHALENGES

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Abstract

Introduction. Primary healthcare can be considered as a cost-effective mechanism, which is mainly focused on the prevention of diseases and improvement of health.
The objective of the study was to explore the attitudes and values which underlie primary health reform in Georgia, and to investigate the goals of reform and the strategies designed to achieve them.
Materials and methods. The article is based on a documentary analysis, which included official documents and non-official journal publications.
Results. Georgia became one of the first post-Soviet countries where primary healthcare policies were introduced, and the concept of family medicine was formed. During the Soviet period, primary health care was organized within the territorial concept, where patients had no right to choose a family doctor. After the reorientation, patients were granted the right to choose a family doctor, which increased the competition among doctors. Primary health care organizations have become independent legal entities. Contractual relationships have been formed between the medical organization and the healthcare staff. Primary health care organizations were mainly funded by public purchasers based on the capitation remuneration method through federal and municipal health programs, which increased the competition among doctors and

Résumé

Les réformes des soins de santé primaires en Géorgie : expérience et défis

Introduction. Les soins de santé primaires peuvent être considérés comme un mécanisme rentable, principalement axé sur la prévention des maladies et l'amélioration de la santé.
L'objectif de l'étude était d'évaluer les changements structurels et financiers dans le système de soins de santé primaire en Géorgie.
Matériaux et méthodes. L'article est basé sur une analyse documentaire, qui comprenait des documents officiels et des publications de journaux non officiels.
Résultats. La Géorgie est devenue l'un des premiers pays post-soviétiques où des politiques de soins de santé primaires ont été introduites et où le concept de médecine familiale a été formé. Pendant la période soviétique, les soins de santé primaires étaient organisés dans le cadre du concept territorial, où les patients n'avaient pas le droit de choisir un médecin de famille. Après la réorientation, les patients ont obtenu le droit de choisir un médecin de famille, ce qui a accru la compétition entre les médecins. Les organisations de soins de santé primaires sont devenues des entités juridiques indépendantes. Des relations contractuelles se sont nouées entre l'organisation médicale et le

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motivated them to provide high-quality healthcare. Despite the reforms, the primary health care system is facing many challenges. This can be evidenced by the low level of referral of patients to family doctors and their lack of trust in them.

Conclusions. Primary healthcare reform should contemplate the development of the family doctor system, which includes promoting continuing medical education for family physicians, optimizing the geographical distribution and accessibility of primary healthcare services, and increasing remuneration for primary healthcare personnel.

Keywords: primary healthcare, family medicine, healthcare system.

personnel soignant. Les organisations de soins de santé primaires étaient principalement financées par des acquéreurs publics basés sur la méthode de rémunération par capitation par le biais de programmes de santé fédéraux et municipaux, ce qui a accru la concurrence entre les médecins et les a incités à fournir des soins de santé de haute qualité. Malgré les réformes, le système de soins de santé primaires se confronte avec de nombreux défis. Cela peut être démontré par le faible niveau de référence des patients aux médecins de famille et leur manque de confiance.

Conclusions. La réforme des soins de santé primaires devrait envisager le développement du système de médecine de famille, ce qui comprend la promotion de la formation médicale continue des médecins de famille, l'optimisation de la répartition géographique et de l'accessibilité des services de soins de santé primaires et l'augmentation de la rémunération du personnel de soins de santé primaires.

Mots-clés: soins de santé primaires, médecine familiale, système de santé.

Introduction

Primary health care can be defined as the first level of medical care, where patients consult doctors about their health problems and where most of the population's medical and preventive health needs can be fulfilled[1]. Primary health care plays a special role in the organizational arrangement of the health care system. It's the patient's first contact with an organized medical service and doctor, who is a kind of "gatekeeper" in the health care system[2]. The primary care doctor makes the first assessment of the disease and, if necessary, refers the patient to specialist physicians[3].

With the help of primary health care services, patients are under ongoing and continuous monitoring. The doctor observes the patient for a long time, during his lifetime. As a result, the physician is fully aware of the patient's disease, how it has developed and how it is progressing. This allows the doctor to manage the disease.

Another distinctive feature of primary health care is its comprehensiveness, especially, the family physician cares not only for the patient's physical but also for mental and social well-being. Healthcare is a complex system. In this regard, primary healthcare has a coordinating function. The family doctor coordinates patient care and appears to be his or her partner, supporter, guide, and coordinator who can protect patients, and help them select the right medical service. Through the physician coordination function, the patient receives the appropriate service at the appropriate time and place.

After gaining independence, Georgia inherited the Soviet system of primary health care, where the organization, management and delivery of medical services were carried out by state authorities. Funding and administration were bureaucratic and strictly centralized. Primary health care was organized locally within the precinct-territorial concept, mostly, the contingent of patients was evenly distributed among the doctors of the polyclinic and was divided into districts according to the principle of territoriality or place of residence. In this system, the patient did not have the right to freely choose the physician. District physicians did not have a "gatekeeper" function because patients had easy and unrestricted access to outpatient physicians.

In the centralized Soviet health care system, doctors were civil servants. The population of a specific geographical area was served by a district therapist and pediatrician appointed by the Ministry of Health, which coordinated patient's medical services. Prophylactic medicine was not actually implemented. Physicians' main efforts were focused on diagnosis and treatment, therefore, the health care system was mainly focused on hospital medical services[4-5]. The medical education system was characterized by early specialization and less attention was paid to modern primary health care approaches such as family practice and public health. The family medicine profession had low respect among other medical professionals[6,7].

Medical services were provided mainly by the medical specialists of the polyclinic[8]. Rural outpatient clinics provided limited medical care. Thus, the principle of equal access to health care was not implemented during the Soviet system of primary health care[9].

The material base of primary health care facilities, especially in districts and villages, usually did not match with modern requirements. Buildings were unsuitable. Hardware equipment and inventory were out of date. Rural primary health care facilities were in a particularly difficult situation. Damaged buildings were not heated during the cold winter and did not have the supply of medicine and equipment.

During the Soviet period, the remuneration of primary health care staff was carried out by the fixed salary method, which was very low. There were no financial and material incentive mechanisms. Accordingly, primary care staff did not have the motivation to improve their quality and to provide effective service[10,11]. Because of the low wages, informal payment was widespread[12].

Reorganisation of healthcare system in Georgia, which began in 1995, was based on the development of primary healthcare system, aiming at activating preventive medicine.

The objective of the study was to explore the attitudes and values which underlie primary health reform in Georgia and to investigate the goals of reform and the strategies designed to achieve them.

Material and methods

The article is based on a documentary analysis, which included both official and non-official documents. The official papers included legislative and other governmental documents. All health policy documents that could be obtained from World Health Organization (WHO)/EURO, the Georgian Ministry of Health and regional health departments were included in the study. In total, 10 official papers were analysed.

Non-official documents were publications from major health databases (SCOPUS, MEDLINE, PubMed). The following search terms were used: Georgia plus "primary healthcare reform", "primary healthcare system", "family physician". Articles published from 1990 to 2021 were included. Articles were included if they contained descriptions of one or more of the following aspects: (1) the primary healthcare system or primary healthcare reforms in Georgia; (2) organizational structure and reforms of the primary healthcare system. Articles were restricted if (1) they published in Georgian; (2) they merely focused on reforms of the primary healthcare system.

Overall, the literature search resulted in 13 journal articles of potential relevance to the study. After assessing the full text versions in light of the inclusion/exclusion criteria, 9 articles were finally included in the paper.

Results

An important part of the reform, which began in 1995, was the reorientation of hospital-oriented medicine to prevention and primary healthcare. As a result, the national health policy has focused on the priority of primary health care in the country. Primary health care can be considered as health care system's cost-effective mechanism, which is mainly focused on the prevention of diseases and improvement of healthiness. The orientation of the health policy from the Soviet period had to be radically changed to the development of preventive medicine.

Georgia, based on the recommendations of the WHO and the experience of other countries, decided to reform primary health care using the family medicine model. Georgia is the first country among the countries of the former Soviet Union to recognize the specialty of family medicine. The choice was made on the model of the United Kingdom, which was considered as one of the most famous models of European primary health care.

International agencies, especially the World Bank, the WHO, the European Union, the governments of Britain, Sweden and Japan, played an important role in reforming Georgia's primary health care system. The Government of Georgia, with the support of the World Bank, developed and launched a primary health care development project[13].

The Family Medicine Society was brought into being in December 1995. The concept of family medicine was developed, and the position of family doctor was established. In 2000, the Department of Primary Health Care was set up in the Ministry of Health. In 2001, it merged with the Department of Public Health. According to the National Health Strategy, the establishment of national and regional centres of family medicine was planned for 2003, and the formation of a national network of primary health care centres by 2008, which would be staffed with trained primary health care teams.

Family medicine was not recognized as an academic discipline in the communist era[14]. As a result of the reform, its admission as a specialty and its introduction into medical training programs was a significant change. In 1999 license examinations for primary care specialists were conducted. Significant progress has been made in introducing guidelines and recertification procedures.

Since 1996, several pilot projects have been implemented to strengthen the primary health care system. Programs were developed, the main purpose of which was to train physicians as family physicians.

In 1997, the United Kingdom Department of International Development (DFID) launched a family doctor training program that trained family medicine trainers and family medicine specialists. Within the second project of the UK Department of International Development following group of family medicine trainers, primary healthcare nurses and managers started training. This department also initiated the formation of five demonstration centres for family medicine, including the National Family Medicine Training Centre. Since 2002, the World Bank has begun supporting further reforms in the primary health care sector. Training of family medicine staff was planned. A rational and cost-effective medication prescription project was implemented as part of the Primary Health Support Policy with the support of the UK Department for International Development and the WHO.

The second project of the World Bank was launched in 2003, which was aimed at further development of the primary health care network. The United States Agency for International Development (USAID) has launched primary health care projects in the Shida Kartli and Guria regions. With the support of the governments of the European Union, Britain, Sweden and Japan, it has become possible to train hundreds of doctors and nurses specializing in family medicine.

As a result of the reform, since 1995 primary health care, which was initially organized on a precinct-territorial concept, has been replaced by the principle where patients have the right to choose a family doctor, this reform encouraged patient involvement and contentment with both the family physician and the entire primary health care system[15,16]. At the same time, the patient's free choice of family doctor helps to increase competition among family doctors as they try to attract as many beneficiaries as possible.

Primary health care providers in the centralized Soviet health care system, physicians were civil servants because the Ministry of Health was both a purchaser and a supplier of medical services. As a result of the reform, the function of purchasing medical services was transferred to the medical insurance company, while the function of delivery was transferred to the medical organizations with the status of independent action.

Primary health care facilities have become independent legal entities. Accordingly, a contractual relationship was established between the medical organization and the healthcare staff. Consequently, according to the reform, the purchase and supply of medical services are separated, which is considered as a mechanism to improve the efficiency of medical services[17]. This relieved the state of its role as a direct provider of medical services. It had to maintain its influence over the healthcare system through strong regulatory, financial, and licensing mechanisms[18].

Infrastructure development projects have been launched with the support of international organizations. The World Bank, the United States Agency for International Development, the governments of the European Union, the United Kingdom and Japan planned and started the rehabilitation of primary health care facilities and the provision of technical equipment. These projects have made it possible to rehabilitate up to 200 ambulatories and supply them with modern equipment.

Since 1995, because of the reform, primary health care organizations decided to switch to program funding. Polyclinics were mainly funded by State Medical Insurance Company with the capitation method through federal and municipal healthcare programs. Medical staff employed in primary health care facilities in mountainous regions received higher salaries through state programs.

The aim of the reform was to introduce a method of remuneration for primary health care staff, which would include mechanisms for financial and material incentives and, as a result, it would increase motivation to improve the quality of services. To fund primary health care staff, capitation funding method was chosen, within this method doctor tries to increase the number of patients registered with him to receive high pay. Therefore, competition among doctors have been increased, which in turn provides an incentive to provide high quality medical care. This circumstance is facilitated by the right of the insured to voluntarily choose a family doctor[19,20].

25 years passed since the start of healthcare reforms in Georgia, but an effective primary health care system has not been brought into being. The fact that the number of referrals to outpatient medical institutions per capita is 2.3 (up to 7.5 in European countries) indicates the less development of the primary health care system in Georgia. Patients buy medications and engage in self-medication without a doctor's prescription[21]. As a result, the share of medicinal costs in total healthcare expenditures is catastrophically high (around 40%, while in European countries it reaches 10-15%).

The reason for the low development of the family doctor institute is the low trust in primary health care institutions, the lack of a primary health care culture in the country[22]. The family doctor institute and primary health care in our country have not developed to the standards that have existed for several decades in many countries[23].

Discussion, recommendations

Primary health care reform should contemplate the development of the family doctor institute, which includes promoting continuing medical education for family physicians, optimizing the geographical distribution and accessibility of the primary health care system, and ensuring normal remuneration for labour.

At the initial stage of reform, organizational forms of primary health care delivery service should be defined. With experience from many countries, the organizational forms of primary health care are:

- Individual medical practice of the family doctor;
- Family medicine centre, staffed by several family doctors;
- An outpatient clinic or outpatient department of hospitals, where several specialists of different profiles function simultaneously.

Family physicians are independent practicing physicians who form a team with nurses. They have their own offices and bank accounts where they are accrued. It is necessary to stimulate the development of such a scheme. This does not mean reducing the role of outpatient clinics but supporting various organizational schemes of primary health care in the country. Patients should be given the right to choose freely not only between family physicians but also between different organizational schemes of primary health care. This will facilitate competition between both family physicians and different primary care organizational schemes, which in turn will increase the quality of medical care.

Primary health care reform cannot be implemented without proper education of a family doctor / nurse[24]. This requires raising the level of professional training of staff. In this regard, there are family medicine training centres in the country, where family doctors / nurses are trained. However, they are mostly expensive and often have low financial availability. The state, with the support of donor organizations, should ensure the development of the required capacity of appropriate primary health care human resources across the country. Continuing medical education for family physicians should also be promoted by the state.

In mountainous regions, and especially in rural areas where there is a deficit of primary care medical staff, there is a need to reduce regional disparities in the distribution of medical personnel. It is necessary to encourage the employment of staff in certain regions with much higher financial benefits. This will facilitate a more equitable distribution of human resources across the country.

The location of primary health care facilities is determined by the principle of optimal geographical access to medical services, which implies the ability to receive services within a 15-minute access zone. For people living in the mountains, or in villages with small populations, it is expedient to set up mobile primary health care teams that periodically provide on-site primary health care services from the nearest family medicine centre. In this regard, a single-team primary health care provider will be established in rural areas, and a single and multi-team primary health care provider in district centres and large cities.

Primary health care is an effective mean of overcoming intersectoral fragmentation and integrating medical services[25]. Management of vertical state programs (tuberculosis, AIDS ...) is insufficiently coordinated. As a result, duplication of activities, inefficient use of resources, increase in costs are frequent. This requires the integration of vertical state programs at the primary health care level. Integration will help make medical care more cost-effective.

Conclusions

To facilitate the development of the family doctor institute, it is necessary to ensure the normal remuneration of primary health care personnel. It is advisable to introduce combined methods of primary health care reimbursement. The methods of incentive remuneration of physicians for conducting preventive measures are particularly noteworthy.

Primary care is the foundation of a health system. The quality of the population's health, access to services, and efficient spending of scarce resources on health care significantly depend on a well-functioning primary health care system.

Author Contributions:

T.V. conceived the original draft preparation. T.V., and A.J. were responsible for conception and design of the review. T.V., and A.J. were responsible for the data acquisition. T.V. were responsible for the collection and assembly of the articles/published data, and their inclusion and interpretation in this review. T.V., and A.J. contributed equally to the present work. All authors contributed to the critical revision of the manuscript for valuable intellectual content. All authors have read and agreed with the final version of the manuscript.

Compliance with Ethics Requirements:

"The authors declare no conflict of interest regarding this article"

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