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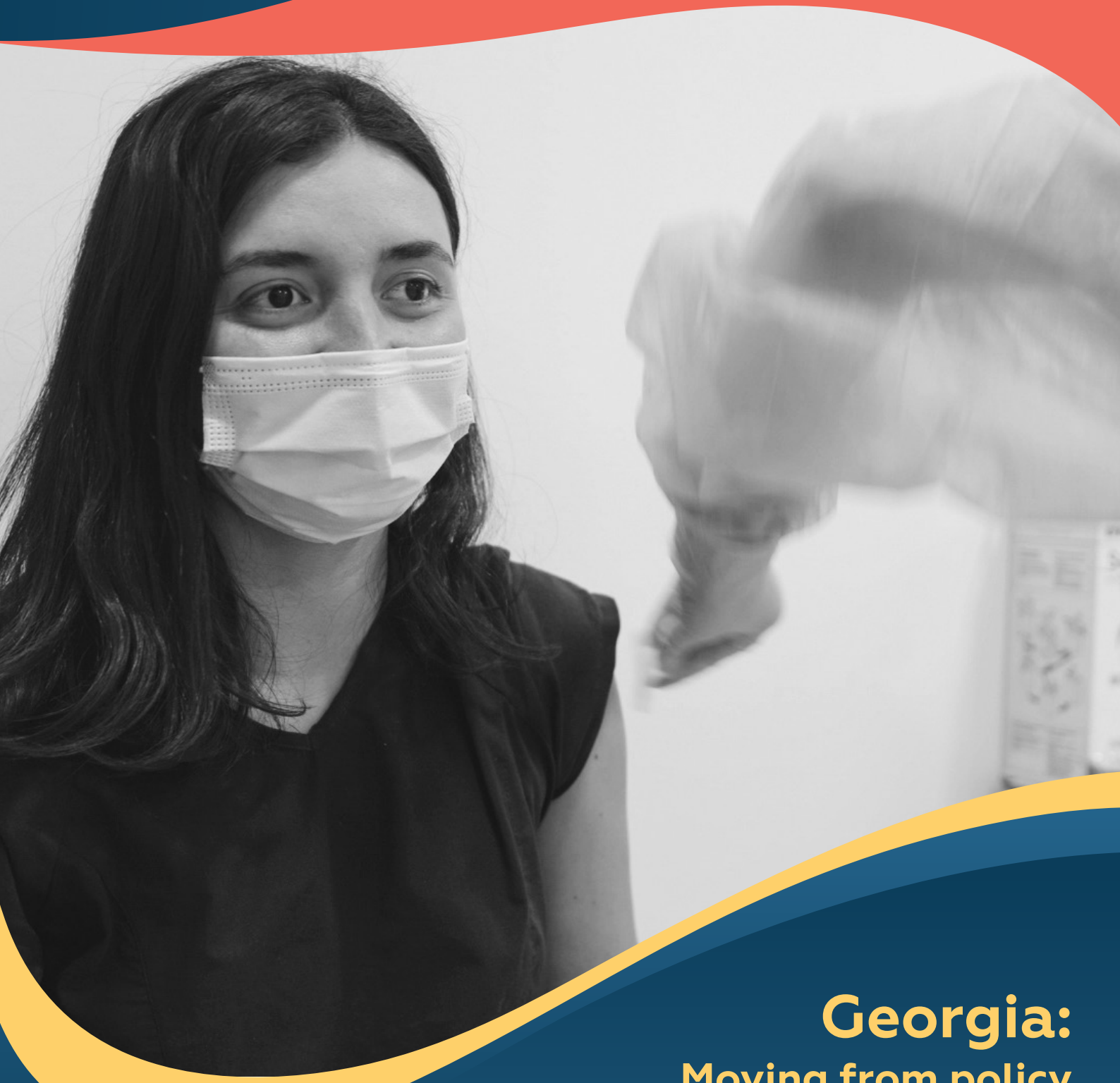

Georgia:

Moving from policy to actions to strengthen primary health care

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Abstract

The COVID-19 pandemic has proven that high-performing and accessible primary health care (PHC) is vital to build back better. Georgia is committed to improving the health of the population and increasing the efficiency of health services delivery by strengthening PHC. This publication from Primary health care policy paper series focuses on Georgia, with the aim of describing the current challenges facing PHC and providing pragmatic policy options for transitioning to a more community-oriented model. A new model of PHC should aim to be more responsive to the needs and expectations of the population and attractive to physicians and patients, especially in rural areas of Georgia. Shifting away from heavy reliance on costly specialist and inpatient services towards the greater utilization of integrated PHC services is no easy task. This requires new approaches to delivering PHC services and aligning health system enablers that support PHC providers as the first point of contact and coordinator of care. To do this, the publication details seven entry points for strengthening the PHC model of care and five policy levers for sustaining the transformation needed.

Keywords

PRIMARY HEALTH CARE
HEALTH WORKFORCE
FAMILY PRACTICE
RURAL HEALTH
HEALTH POLICY
GEORGIA

CONTENTS

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About Primary health care policy paper series

Primary health care policy paper series aims to provide concise, evidence-informed and policy-relevant considerations of pertinent topics related to primary health care (PHC). Country-specific editions of the series aim to capture PHC developments across the WHO European Region for contextualized evidence and policy changes in practice. The series is designed to support the efforts of Member States in their evidence-informed policy-making related to strengthening PHC.

This work is led by the WHO European Centre for Primary Health Care of the WHO Regional Office for Europe. Each paper engages a range of topic and country experts and key stakeholders and draws on international and national data sources, scientific evidence, policy documents and national reporting.

Country in context: Georgia

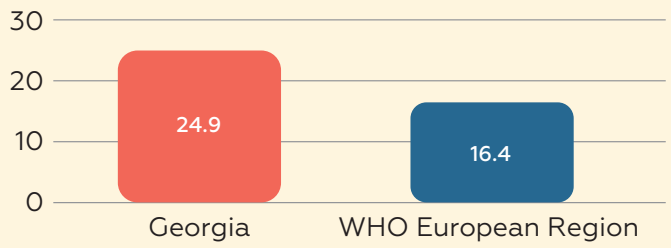
	Georgia	WHO European Region
Population size, in millions[a]	3.7 (2020)	926.1 (2019)
Life expectancy at birth, both sexes combineda	73.4 (2020)	78.8 (2019)
Gross domestic product per capita, purchasing power parity, US dollars (2020)	14 863	35 340

[a]The latest year for which data are available is shown in brackets.
Sources: Health for All Database [online database]. Copenhagen: WHO Regional Office for Europe; 2023 (https://gateway.euro.who.int/en/datasets/european-health-for-all-database, accessed 6 March 2023) and Spending on health in Europe: entering a new era. Copenhagen: WHO Regional Office for Europe; 2021 (https://apps.who.int/iris/handle/10665/340910, accessed 6 March 2023).

Health status

Noncommunicable diseases account for most of the country's burden of morbidity and mortality. The overall mortality rate in Georgia is high, with stroke being the leading cause of death.

Premature mortality from noncommunicable diseases in 2015, age 30–70 years (%)

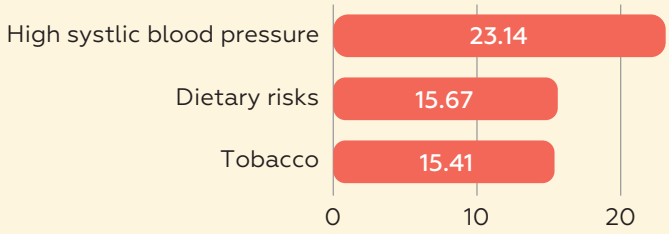


Source: Health for All Database [online database]. Copenhagen: WHO Regional Office for Europe; 2023 (https://gateway.euro.who.int/en/datasets/european-health-for-all-database, accessed 6 March 2023).

Risk factors

High blood pressure is the biggest risk factor as a share of all deaths in Georgia and considerably increases the risk of stroke if left unmanaged. Other important risk factors include dietary risks, tobacco use and, to a lesser extent, alcohol consumption.

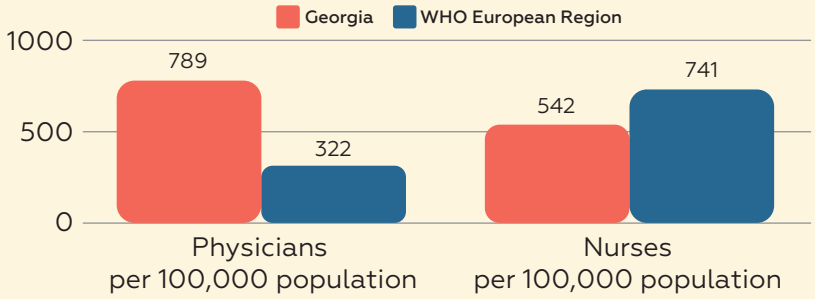
Top risks contributing to total DALYs in 2019, all ages (%)



Source: Global Results Tool [database] Seattle: Institute for Health Metrics and Evaluation; 2019 (https://vizhub.healthdata.org/gbd-results, accessed 6 March 2023).

Health workforce

Georgia has many doctors per capita but an acute shortage of nurses. The age profile and distribution of family medicine doctors across the country is of particular concern, with three times as many doctors per capita in Tbilisi as in other regions.

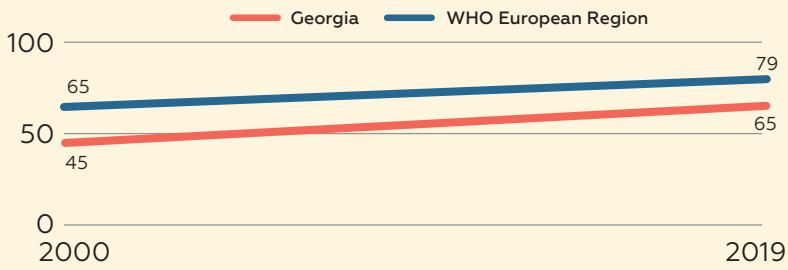


Note: 2014 data for WHO European Region and 2019 data for Georgia.
Sources: Health for All Database [online database]. Copenhagen: WHO Regional Office for Europe; 2023 (https://gateway.euro.who.int/en/datasets/european-health-for-all-database, accessed 6 March 2023) and European Observatory on Health Systems and Policies, WHO Regional Office for Europe. Health systems in action: Georgia. Copenhagen: WHO Regional Office for Europe; 2021 (https://apps.who.int/iris/handle/10665/349232, accessed 6 March 2023).

Health services

Georgia has improved access to essential services, especially for infectious diseases, specifically access to treatment for HIV, tuberculosis and hepatitis C. Challenges remain for access to treatment for chronic conditions and preventable treatments for cardiovascular diseases. Only a fraction of registered beneficiaries (17–23% by facility) use PHC services annually in Georgia.

Universal health coverage service coverage index over time



Source: Universal health coverage [online database]. Geneva: World Health Organization; 2023 (https://apps.who.int/gho/data/node.main.UHC?lang=en, accessed 6 March 2023).

Featured key messages

Policy context

- Georgia's population faces a high burden of noncommunicable diseases. Over the past two decades, the probability of dying from noncommunicable diseases has been consistently above the WHO European Region average, with no sustained trend towards narrowing.

- Primary health care (PHC) plays a critical role in the prevention, early detection and management of noncommunicable diseases. Georgia has continually given priority to strengthening PHC through various reforms and programmes. However, inconsistent implementation, unfinished agendas and lack of alignment across health system enablers have strained the necessary scale and degree of transformation needed for realizing health gains.

- Differing approaches to organizing, contracting and purchasing PHC services between rural and urban areas have limited the capacity of rural PHC practices to date. As a consequence, rural residents tend to access urban PHC services or use ambulances or emergency rooms in cities.

A new model for PHC in Georgia to improve equity in services delivery

- A new model of PHC should aim to address current rural and urban inequities in PHC by transforming PHC practices to provide more responsive and person- and people-centred services tailored to local needs. The transformation needed extends across rural and urban settings and is part of a whole-of-system redesign.

- A multilevel networked model could be considered to strengthen linkages between PHC providers and public health services, to improve population coverage with services needed and to ensure better coordinated care pathways. For example, smaller (local-level) PHC networks could connect rural PHC practices in a common geographical area, providing face-to-face services, coordinated telehealth and links to mobile clinics. Larger (regional-level) PHC networks could connect rural PHC practices and region-specific hospitals for specialist support. These networks could also be linked to and be supported by regional branches of the National Centre for Disease Control and Public Health. The PHC networks under the Georgian Medical Holding would also benefit from introducing regional coordinators.

Seven entry points for realizing a new model of care are proposed

- Redefine the PHC package of services, gradually expanding the scope of PHC services for priority conditions, including preventive care focused on noncommunicable diseases.

- Implement new clinical protocol guidelines and patient pathways for priority noncommunicable diseases, including cardiovascular diseases, hypertension, diabetes, chronic obstructive disease, asthma and mental health.

- Ensure the empanelment of the population (registration with PHC practices within geographical areas), balancing a community focus with an individual's right to choose a provider.

- Reorient PHC to better address the community health needs and support population health management by bridging local public health and PHC services and leveraging practice panel data for risk stratification tools.

- Align the profile of PHC teams with population health needs and the revised package of services, drawing on the expanded profile of competencies made possible through a networked approach.

- Strengthen PHC management and supportive supervision subnationally by introducing a networked approach.

- Revise the system for PHC performance monitoring and quality improvement to leverage available information for learning and continual improvement of processes and care.

Five policy levers to unpin the model of care are identified

- Strengthen PHC governance and management arrangements, in particular to support the local and regional efforts proposed through clearly defined mandates, accountability arrangements, monitoring and feedback, and ensure that changes to the model of care are clearly communicated to the public.

- Increase public investment in PHC to create a revised benefit package that is universally accessible and free at the point of use.

- Invest in health workforce planning and development for a PHC workforce with sufficient numbers and skill mix.

- Give priority to the safe and cost-effective use of medicines by strengthening prescription enforcement and use of electronic prescriptions, expanded outpatient drug benefits for people with chronic diseases, good manufacturing practices, updated legislation and unified protocols and standards.

- Leverage digital solutions to best manage patient panels, provide remote care, exchange data across providers and organizations and inform performance measurement efforts for learning and improvement.

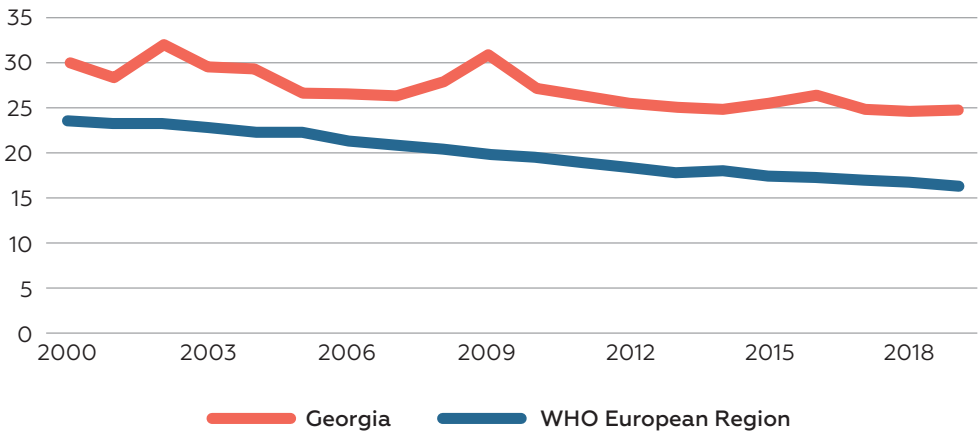
POLICY CONTEXT

Noncommunicable diseases account for the majority of Georgia's burden of disease, with the overall burden of premature mortality from noncommunicable diseases constituting a threat to the country's sustainable development.

In Georgia, noncommunicable diseases are the leading cause of premature mortality *(1)*. In 2019, the probability of dying from cardiovascular diseases, cancer, diabetes and chronic respiratory disease was 24.9%, well above the WHO European Region average of 16.4% (Fig. 1) *(2)*. Moreover, no positive trends in reducing premature mortality from noncommunicable diseases in Georgia have been recorded since 2012 *(2)*.

International evidence consistently indicates that primary health care (PHC) plays a critical role in the inclusive, effective and efficient delivery of health-care services and overall satisfaction with the health-care system *(3,4)*. The available evidence also underscores PHC as vital to the prevention, early detection and management of noncommunicable diseases by way of reducing noncommunicable disease-related complications, hospitalizations and premature mortality *(5,6)*.

Fig. 1. The probability of dying prematurely from any noncommunicable disease in Georgia is consistently above the WHO European average (%)



Probability (%) of dying from cardiovascular disease, cancer, diabetes or chronic respiratory disease (age 30–70 years) over time.
Source: European Health Information Gateway *(2)*.

Georgia has regularly given priority to strengthening PHC in national policies, but incomplete implementation and lack of alignment of system enablers have hindered the sustainable implementation of a PHC services delivery model that is more responsive to the health needs and expectations of the population and the intended health impact of these efforts.

Since 1997, several PHC development concepts and strategies have been proposed to guide the reform of health services delivery towards more equitable, efficient and responsive PHC based on a family medicine model *(7)*. However, these concepts and strategies have been strained to sustain a consistent, long-term vision for the country's health-care system. Lack of proper PHC governance and limited regulatory capacity at the national and regional levels have been cited as causes for this *(1,7)*. Further, insufficient financing and inadequate health workforce strategies have strained the system's readiness to enable the transformations needed.

Despite multiple efforts and investments in developing family doctor competencies, the PHC model of care (Box 1) at present is limited in its design to meet the demand for early prevention and management of noncommunicable diseases faced by the population. Thus, despite policy priorities, the PHC system remains unable to deliver evidence-informed patient pathways and improve PHC performance outcomes *(7,8)*.

Georgia has various PHC models for urban and rural populations in organizing, contracting and purchasing services

Box 1. Key terms

Model of care
Conceptualizes how health services should be selected, designed, organized, delivered, managed and supported by various services delivery platforms *(9)*. A PHC model of care reflects the decisions taken to align services delivery with the principles of PHC.

Rural primary health care practice (Rural Doctors Program)
Primary care facilities in rural areas managed by the Georgian Medical Holding. The proposed model of care aims to ensure that each centre is staffed by at least one family doctor and one nurse.

Universal Healthcare Program
A programme introduced in Georgia in 2013 that extends access to publicly funded health-care services to most of the population.

Urban outpatient health centres
Centres providing primary care and specialized ambulatory care in urban areas that are contracted by the National Health Agency. Urban outpatient health centres are obligated to provide family doctor services, specialized outpatient services and defined laboratory and diagnostic services through Universal Healthcare Program funding. Most of the urban outpatient centres are private.

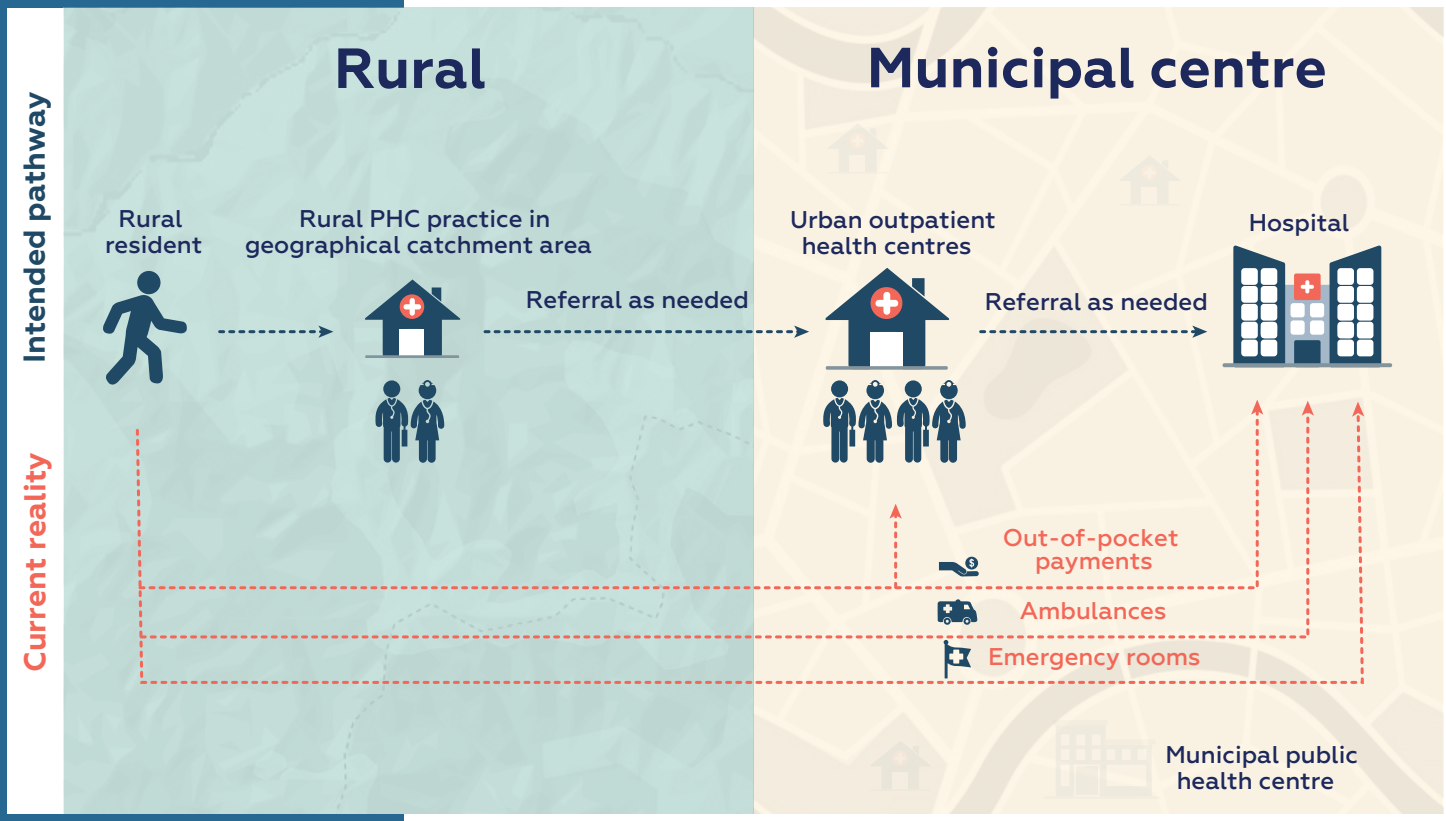
As of March 2022, rural doctors are employees of the state-owned Georgian Medical Holding, which already managed 28 health facilities (including urban and rural hospitals), with affiliated PHC centres through its regional medical centre. At present, the buildings of rural PHC practices remain owned (or leased) by individual municipalities, multiple ministries or (rarely) by individual physicians. A process of reallocating these properties to the Georgian Medical Holding is ongoing. In contrast, urban PHC practices are privately owned and are contracted by the National Health Agency under the Universal Healthcare Program. The introduction of selective contracting in the three largest cities dictates that the size of the population served by urban facilities is no less than 13 000 *(8)*.

The suboptimal organization of care has contributed to unintended care pathways that are especially disadvantageous for rural residents
Consequently, concerning trends over the past decade include inadequate investment in infrastructure, and the health workforce overall and the capacity of personnel have affected professional motivation to deliver more proactive care, especially in rural areas.

Only a fraction of registered beneficiaries (17–23% by facility) use PHC services in Georgia. This is in stark contrast to countries of the Organisation for Economic Co-operation and Development and European Union, where 68% of people with lower income and 72% of those with higher income have consulted a general practitioner in the past 12 months *(10)*. Rural residents in particular have been described as having lost trust in local PHC services *(8)*, opting instead to access urban PHC services directly, pay for specialist services in urban facilities, use ambulances and/or access emergency rooms (Fig. 2). In addition to the financial burden of co-payments, these unintended care pathways result in lost opportunities for people to benefit from preventive services and better coordinated, continual and evidence-informed services. The same challenges arise for privately insured people, who use services provided by private clinics when they are ill, without receiving preventive services at PHC settings. If this is not properly addressed, the absence of preventive services risks resulting in even greater demands on the publicly funded PHC system.

Fig. 2. Small rural PHC practices are unable to address the needs of their catchment population, resulting in unintended pathways for rural residents to access services in municipal centres

Source: the authors.



Accelerating progress demands a new model of PHC in Georgia

A strengthened model of PHC is needed to address the design, organization and performance challenges described. This may enable the current model of PHC to transition from a reactive, disease-centred health services delivery approach to a PHC model that is proactive in preventing noncommunicable diseases and organized around the needs of local residents in both rural and urban areas.

The Government of Georgia has reiterated its commitment to providing integrated, high-quality, accountable, individual and population-level multidisciplinary PHC accessible to all, including the most vulnerable people. The accelerated strengthening of PHC is reflected in Georgia's PHC

Roadmap. PHC-related priorities are also reflected in the National Health Care Strategy of Georgia 2022-2030 *(11,12)*, including activities related to reviewing clinical pathways, the benefit package and telemedicine. Needed now are comprehensive actions to increase the efficiency and results of health services delivery in Georgia through sustained transformation of the PHC services delivery system that have to be enabled by revised health system financing and health workforce policies.

This policy paper has been developed based on a review of international and national evidence. Topic and country experts have conducted a series of studies through field visits, document reviews and workshops since 2020. This publication consolidates the intelligence generated with the following two aims:

- to present an approach and entry points for a PHC services delivery model in Georgia that is aligned with the health needs of the population; and

- to provide key policy actions and system levers for introducing a strengthened PHC services delivery model in a staged policy approach over a four-year period.

STRENGTHENING THE PHC MODEL OF CARE IN GEORGIA

A strengthened model of PHC is proposed that puts people and their needs first, prioritizes a competent PHC workforce, adopts a results-oriented, collaborative approach and is technology-enabled

The transition from heavy reliance on costly specialist and inpatient services to a comprehensive PHC model that corresponds to international practices is a complex and long-term process. It requires both new approaches to the delivery of PHC services and alignment of health system enablers that support PHC providers as the first point of contact and coordinator of care.

The overall objective of a new PHC model of care in Georgia should aim to reduce the national burden of ill health and demand for more expensive health-care services by identifying and addressing the priority health needs of the population through equitable and timely access to evidence-informed preventive, diagnostic, curative, rehabilitative and palliative services.
The redesigned PHC model of care is based on the following principles, each contributing to improving clinical outcomes and reducing unnecessary expenditure. The vision for a strengthened PHC model in Georgia is proposed in full alignment with the Declaration of Astana *(13)* (Box 2). It is also fully aligned with the vision put forward in Georgia's PHC Roadmap and complements this document by providing an elaborated approach to strengthening the model of PHC.

Box 2. Definition of PHC

PHC is a whole-of-society approach to health and well-being that is people-centred rather than disease-centred and includes health promotion, disease prevention, treatment, rehabilitation and palliative care. It addresses the broader determinants of health and focuses on the comprehensive and interrelated aspects of physical, mental and social health and well-being across the lifespan and empowers individuals, families and communities to take charge of their own health in their own communities.
Declaration of Astana *(13)*.

- Person- and people-centred approach that enables services to be tailored to every individual, accounting for each individual's complex needs, including those related to socioeconomic determinants. A people-centred approach also ensures that care is organized around the health needs and expectations of all people, rather than diseases, making individuals, families and communities both active participants and beneficiaries for trusted, high-quality, comprehensive and coordinated services delivered in an equitable manner and involving people as partners in decision-making.

- Uninterrupted improvement of service quality by continually developing professional competencies for family doctors, nurses, social workers and other specialists and introducing scientifically proven national recommendations of clinical practice.

- A results-oriented approach by introducing new quality improvement and performance measurement mechanisms that are aligned with financial and nonfinancial incentives targeted at motivating personnel to achieve better clinical outcomes.

- Strengthening cooperation with public health-care facilities and civil society for integrated population health management and individual health care–related matters through strengthened patient engagement.

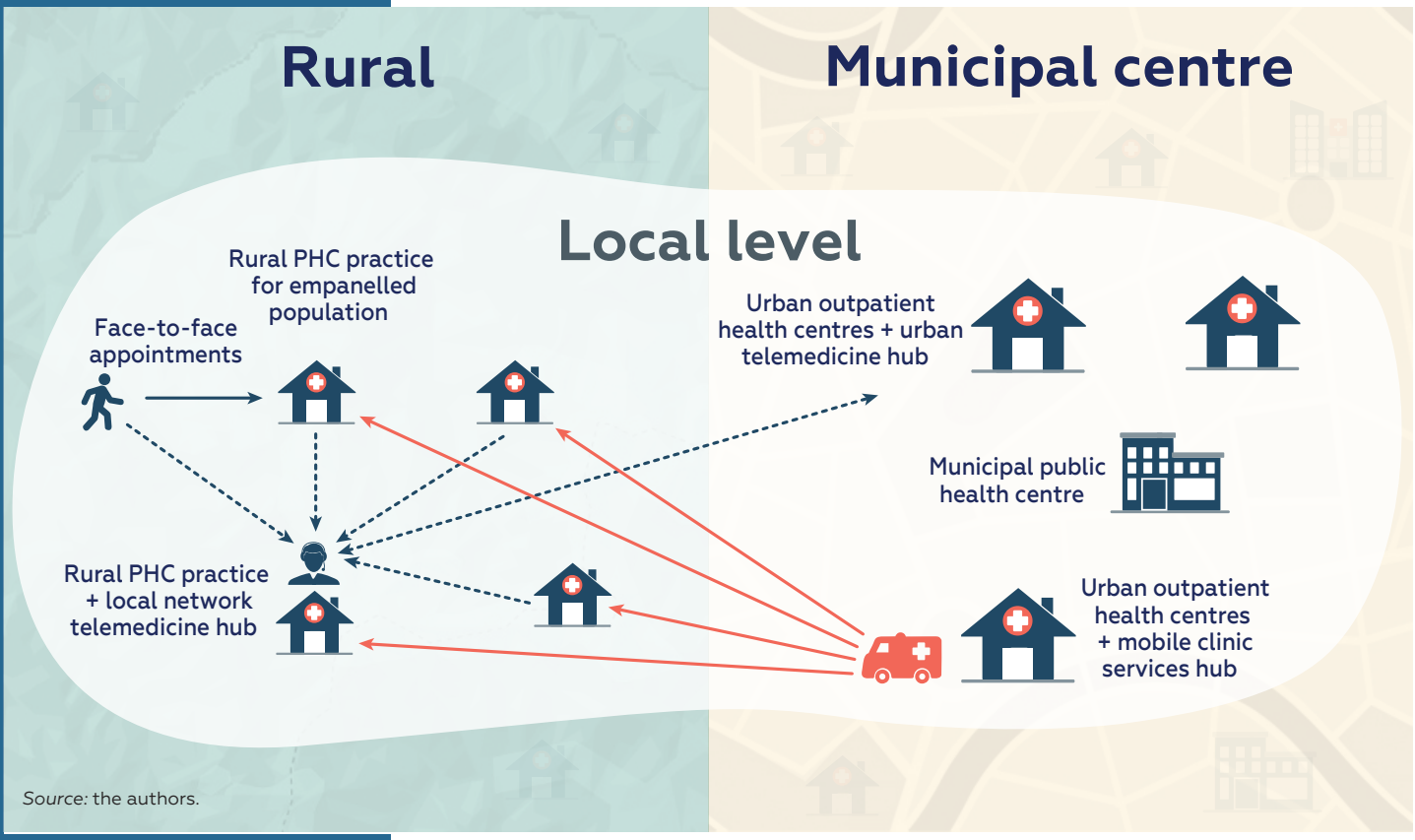
- Supporting the introduction of innovative technologies in PHC (including digital technologies and telemedicine) to facilitate communication and peer support between specialists and family doctors, to support patient engagement in self-management and establish a broad network for managing complex matters and improve data collection, management and utilization.

Advancing the rural model of PHC and strengthening its integration with the urban model of PHC in Georgia is a key entry point for making progress and realizing the intended principles locally

High-quality PHC should be equally accessible to both urban and rural populations. Given the different contexts and PHC organizational models between rural and urban PHC in Georgia, different approaches will be needed to transform the existing models.

PHC networks provide a mechanism for achieving the goals put forward in the PHC Roadmap (such as PHC networks at the local, municipal and regional levels). Such networks aim to better share the resources needed to include more preventive service and population health management tools while also working to strengthen accountability arrangements for improving the health outcomes of empanelled populations. To achieve this, PHC efforts should be synergized with community public health actions. This can be supported by stepwise, gradual engagement with local municipal governments in addressing priority health needs and reshaping municipal public health centres to better support municipalities in local public health policy (Fig. 3).

Fig. 3. Operationalizing a networked approach to PHC services in Georgia

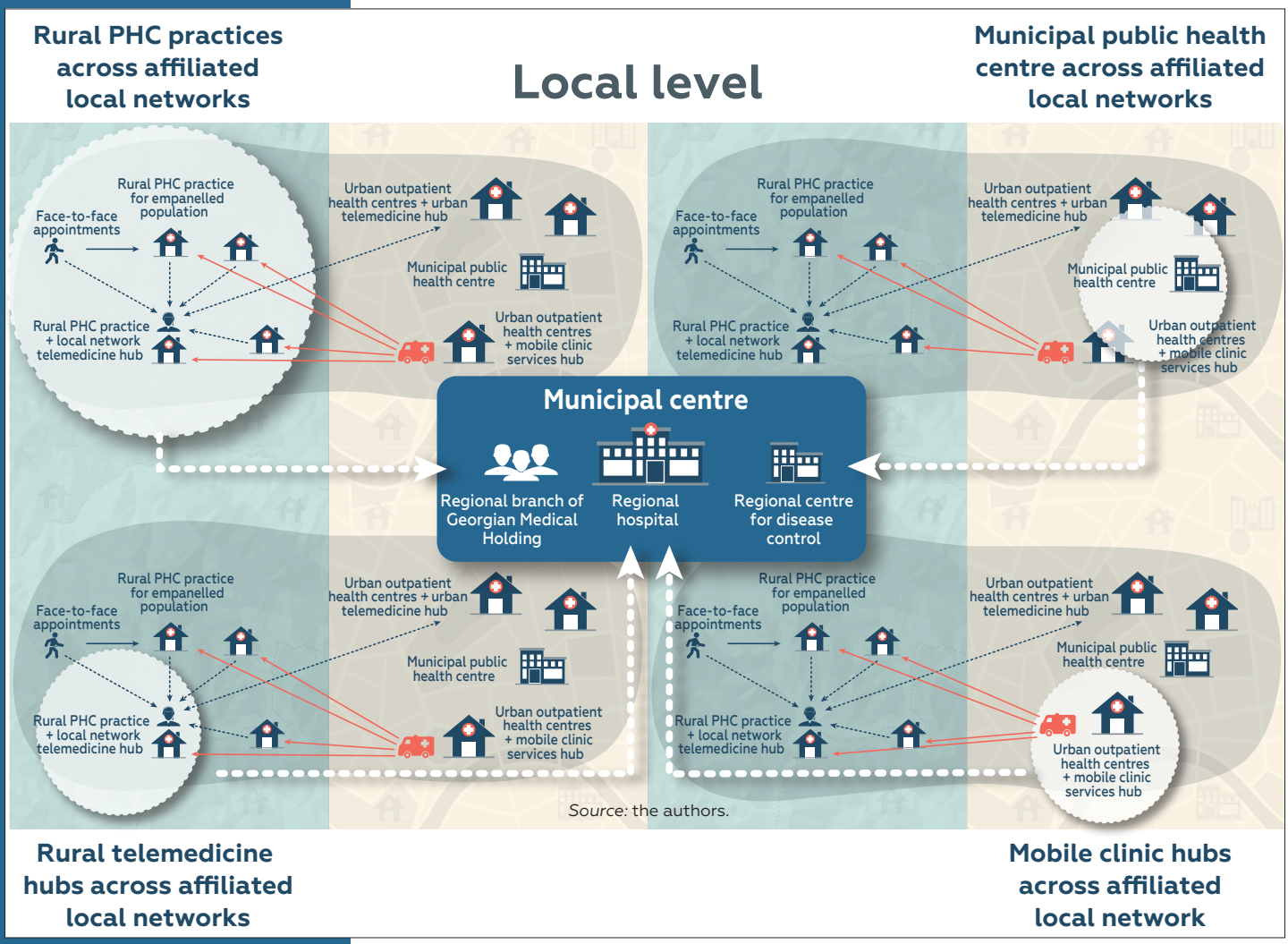


Source: the authors.

The use of a networked approach at the regional level can also strengthen PHC performance monitoring. Identifying good performers could support learning for improvement, spotlight leading practices to demonstrate improved patient experience and outcomes and serve as champions for the new model of care. Further to performance monitoring, health data of the National Center for Disease Control and Public Health can be analysed locally with the support of its regional centres and municipal public health centres as necessary input for managing population health.

Multiplatform delivery of PHC can bring high-quality services closer to people (Fig. 3 and 4) through three main modalities: face-to-face appointments at PHC facilities, telemedicine and mobile services. As an initial phase, face-to-face services could be complemented by telemedicine models to expand access, offering greater convenience and improving quality. Networks can also extend access to laboratory services, with the possibility to transport samples from local to municipal or regional facilities. In the longer term, the networks could be further strengthened through mobile services to reach people with face-to-face services in their homes. Mobile services could be operated by region-level networks and shared across facilities to maximize equal coverage, with more focus on vulnerable population groups (Fig. 4).

Fig. 4. Local and regional hubs could come together, linking up regional branches of Georgian Medical Holding, regional hospitals and branches of the National Center for Disease Control and Public Health



Source: the authors.

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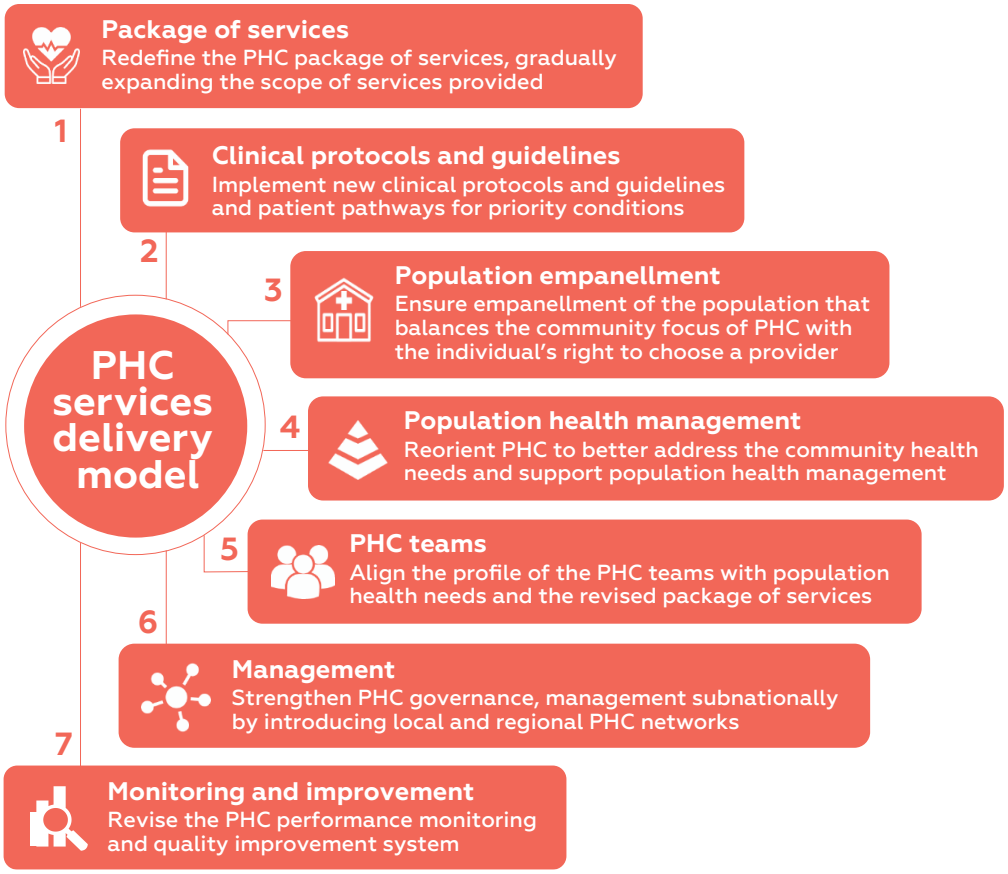
PRIORITY AREAS FOR STRENGTHENING THE PHC MODEL OF CARE

Seven key areas are identified for strengthening the PHC model of care in Georgia

Fig. 5. Seven key priority areas for strengthening the PHC model of care



1. Redefine the PHC package of services, gradually expanding the scope of services provided

A more attractive and responsive PHC system requires a package of services that is tailored to the health needs and expectations of the population *(4)*. A country's PHC package of services should be well defined within the overall benefit package and integrate a comprehensive range of services that are feasible to implement countrywide and equally accessible and affordable for all people.

In Georgia, the introduction of a comprehensive package of services should be well aligned with the population's health needs and the available PHC infrastructure, equipment, workforce and financial resources. As a complex, long-term endeavour, the expansion of the PHC benefit package should follow a stepwise approach. As an initial stage, the focus should be to give priority to health needs that can be addressed by PHC to achieve positive performance outcomes in terms of population health gains and reduce the burden on more specialized levels of care.

Package of services

- To serve as the entry point to personal health services for the vast majority of health problems, the PHC package of services should align with the needs and expectations of the population.
- The current package of services in Georgia risks placing a greater burden on more specialized levels of care by failing to give priority to the prevention and early management of noncommunicable diseases in PHC.
- As a first phase, the expansion of services should include a comprehensive range of preventive services for priority noncommunicable diseases, early childhood development, and mental health.

The Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs, in consultation with various stakeholders, has already set priorities for the gradual expansion of the PHC package of services in two phases. For the first phase (2023–2024), the following services will be given priority: 1) a full set of preventive services focused on priority noncommunicable diseases (cardiovascular risk assessment, early detection and management of diabetes, hypertension, chronic obstructive pulmonary disease and asthma); 2) a holistic service package for early childhood development that addresses the psychosocial needs of families with children 0–6 years old; and 3) integrating essential mental health services into PHC. For the second phase (2025–2026), the expansion of the PHC package of services will focus on managing people with TB and HIV, women's health and antenatal care.

Priority actions

- **Year one.** Redefine the PHC service package within the benefit package in the first phase for priority conditions and provision of new services (teleconsultations between patients and PHC provider and between PHC providers and specialists) and clearly define the scope of services provided by family doctors and general practice nurses and by narrow specialists (secondary outpatient services).
- **Year two.** Ensure access to diagnostics and affordable medicines related to the revised package of services through an expanded outpatient drug benefit package for people with chronic diseases.
- **Year three.** Expand access to a broader range of services to be provided by PHC facilities, including antenatal care, TB and HIV, health education, further development of mental health services and enhance coordination with social services.
- **Year four.** Activate measures for the continual review of the benefit package in alignment with changing population health needs.

2. Implement new clinical protocols and guidelines and patient pathways for priority conditions

Patient pathways should clearly define the goals and expected outcomes for patients and outline the sequence of interventions patients, family doctors, general practice nurses, specialists and other professionals should implement to achieve the desired outcomes in a given period of time *(4)*. Clearly designing care pathways can contribute to minimizing discrepancies in core services, both what is provided and how care is delivered *(14)*.

Although methods for developing guidelines exist and implementation is mandated, no standardized performance measurement system enables guideline implementation to be tracked in practice. There are about

Clinical protocols and guidelines

- Clinical protocols and guidelines and patient pathways play an important role in designing care, supporting the explicit use of best available evidence in care decision-making.
- Existing clinical protocols and guidelines in Georgia are either not fully implemented or outdated, and patient pathways are poorly defined and incentivize accessing urban centres and specialized care.
- PHC services defined in the new PHC benefit package should inform revisions to clinical protocols and guidelines and be accompanied by clearly defined and redistributed tasks.

35 clinical protocols and guidelines for primary care clinical practice, but they are not fully implemented and many are outdated. Some PHC providers have implemented their own clinical protocols based on international standards and have introduced internal quality improvement measures for monitoring how they are implemented in everyday practice *(7)*. However, in most PHC facilities in urban and rural areas, compliance with evidence-informed clinical protocols is not sufficiently implemented in practice. There is currently no nationwide system of quality improvement, and monitoring how clinical protocols are implemented in practice, the Ministry, with support from United Nations Children's Fund (UNICEF) and Caritas Czech Republic, has piloted quality management systems in select regions to support the establishment of a nationwide quality improvement system for PHC. WHO has also supported the development of PHC performance monitoring framework within the training course Strengthening Actionable Primary Health Care Performance Measurement and Management.

Patient pathways are not systematically defined apart from some individual provider-level initiatives. The current co-payment system incentivizes family doctors to refer patients to diagnostic services, resulting in substantial induced demand for unnecessary laboratory tests and other diagnostic services. Patients have a strong incentive to forgo preventive visits or skip annual follow-up visits due to bureaucracy, high out of pocket payments for medicines and diagnostic tests.

Instead patients seek care during acute episodes in hospitals where they face lower or and quality of services are viewed more favorably.

The referral rate from PHC to specialists is 40%, well above rates internationally, typically ranging between 10% and 15% *(15)*. In addition, hospitals are easy to access and provide emergency care and medicines free of charge, encouraging patients to bypass PHC.

PHC clinical protocols and guidelines should be accompanied by clearly defined and redistributed tasks to support the implementation of the benefit package. The implementation of referral standards along with strengthened patient pathways and the alignment of financial incentives are necessary to strengthen the role of family doctors. The population should ultimately view family doctors as coordinators of care with essential family medicine competencies (that are distinct from specialized care) to be recognized as first-contact providers for the whole population.

Priority actions

- **Years one and two.** Implement revised clinical protocols (with additional guidance for delivering remote and telemedicine services) and guidelines for priority noncommunicable diseases (cardiovascular diseases, hypertension, diabetes, chronic obstructive pulmonary disease and asthma) and mental health. Update and implement revised clinical protocols for an expanded package of PHC services, including antenatal

care, TB and HIV. Ensure that patient pathways align with the implementation of the new model of care, including referral systems for priority conditions (direct referrals, remote consultations including patient-provider and provider-provider). Engage patient organizations in implementing and giving priority to promoting patient education and engagement in self-management and patient-centred care. Ensure that reform of PHC financing is linked to the implementation of revised protocols and pathways to reduce the role of specialist care services in the PHC benefit package and create incentives for improved quality of PHC services in alignment with earlier recommendations *(8)*.

- **Years three and four.** Establish a new process for routinely reviewing and updating of clinical protocols and guidelines. Implement a countrywide quality monitoring system that is supported by information technology and enables the implementation and monitoring of clinical protocols and guidelines.

Empanelment of the population

- Empanelment (population registration or rostering) is central to a population health management approach.
- Georgia currently applies the method of voluntary self-assignment to practices in urban areas. People in rural areas are geographically assigned unless they purchase private care.
- Clearer processes for empanelling rural populations are needed, in alignment with urban areas, and should include determining the appropriate panel size, mechanisms for safeguarding patient choice and capacity building to ensure that PHC practices leverage relationships and data for their practice panel optimally.

3. Ensure the empanelment of the population that balances the community focus of PHC with the individual's right to choose a provider

Empanelment, or population registration or rostering, is a foundational component of population health management and a PHC approach to services delivery *(16)*. It is an ongoing and deliberate process of clearly identifying all individuals to be assigned a primary care provider or clinic and actively reviewing and updating data describing a group of people for whom a health-care organization, care team or provider is responsible *(27)*. It requires establishing and maintaining relationships between patients and providers through proactive outreach (such as screening, patronage nurses, proactive management and follow-up with patients) *(28)*, so both are aware of their relationship. When properly managed and applied, empanelment enables health systems to improve the patient experience, reduce costs and improve health outcomes *(5,16,19–24)*.

There are three main methods for empanelment: geographical, insurance-based and voluntary *(17)*. These methods are not mutually exclusive and can occasionally coexist, as is currently the case in Georgia, where a mix of two methods are applied: the voluntary method of self-assignment is used (majority) for the population residing in urban settings, and the insurance method formally applies to 15% of the population enrolled in private insurance schemes. Geographical assignment is intended in rural areas but is not fully realized, since providers do not have complete individualized patients' panels. Due to the absence of universal electronic registration for PHC empanelled patients, many individuals assumed to be residing in the catchment area of a PHC provider may be individually empanelled with urban PHC providers.

Determining the appropriate panel size for rural PHC practices is critical but may not be feasible in the early stages and must take many factors into account, including demand for in-person visits, patient complexity and practice support networks *(25–28)*. The size for urban PHC practices is defined under the Universal Healthcare Program to be 2500 per practice of one team of a family doctor and a nurse. There is no one-size-fits-all process for empanelment, and the size of the empanelled population per PHC facility or team may vary *(25,26,29,30)*. Importantly, large panels have been associated with poor diabetes control and could create access barriers and contribute to provider burnout. Effort should be made to reduce panel size as responsibilities grow under the expanded scope of services. Panels need to be weighted based on age and health needs if indicative panel size numbers are to be set.

Priority actions

- **Year one.** Establish standards for optimal panel size for rural PHC (from 1200 up to 2000 inhabitants maximum) with consideration for the availability of family doctors and general practice nurses, population density, age structure, population characteristics and geographical access. Ensure that standards protect a patient's right to choose their PHC provider within an administrative unit (municipality) and freedom to change for free, in case of changing place of residence or for other personal reasons (limiting the ability to change for free to once per year). Unify the empanelment process for urban and rural areas to ensure that each person is registered with a PHC provider.

- **Year two.** Establish governance mechanisms for the empanelment process, designating responsible institutions for population empanelment, including the task of ensuring transparent processes for population registration and, if necessary, the administrative assignment for unregistered population groups. Introduce a unified electronic registration system for the urban and rural populations.

- **Year three.** Invest in capacity building (time and skills) to support empanelment and panel management and plan for the continual improvement of skills for PHC providers. Invest in training and communication and in the optimized tracking and assessment of population health metrics using electronic medical records. Optimize the panels for urban population not to exceed 2000 patients per PHC team.

- **Year four.** Ensure that panel management includes setting and working towards targets and assessing gaps in chronic disease management, immunization and treatment adherence.

4. Reorient primary health care to better address community health needs and support population health management

A key prerequisite in redesigning the PHC delivery model to one that is more responsive to the needs of the population is commitment to transform a reactive service model to one that is proactive in managing the health and well-being of a given population. Population health management aims to do just that by taking a comprehensive approach to consider the health needs of the population and ensure greater health equity *(31)*. This requires engaging the population, health-care professionals and local governments

Population health management

- Population health management is the foundation of proactive primary care services delivery.
- The current reactive model of care in Georgia is strained to achieve the intended community-level prevention and early detection of health conditions and proactive disease management characteristic of population health management.
- Strengthening linkage between primary care and public health services is key to improving population health management.

in defining and addressing priority health needs, including those of vulnerable population groups. Population health management also requires proactive outreach to underserved populations (people with multimorbidity, low mobility and/or low health care-seeking behaviour) *(31)*. In addition to comprehensively addressing the health needs of people with noncommunicable diseases and multimorbidity, population health management must also consider and aim to address the upstream causes of diseases and mitigate socioeconomic risks.

A stepwise approach is therefore needed to strengthen population health management in Georgia. Strengthening linkage between PHC and public health services is key to improving population health management. In the short term, the focus should be to create the foundation for population health management through empanelment and creating synergy with existing services by bridging local public health and PHC services.

Strengthened and standardized local public health centres and enhanced feedback of health data analysed by the National Center for Disease Control and Public Health can support better understanding of population health needs locally for short-term priority conditions (such as noncommunicable diseases, mental health families). Local public health centres should be equipped to inform affiliated PHC teams on trends for specific priority health needs and gradually increase their capacity in the mid-term to initiate and lead multisectoral public health interventions with municipalities. The introduction of digital risk stratification tools can also support the stratification of the population by diseases and morbidity level and improve understanding of the population by socioeconomic risks.

Priority actions

- **Year one.** Study empanelled populations, create community profiles and leverage digital tools for risk stratification and monitoring population health outcomes for various population groups for introducing a population health management approach.
- **Year two.** Strengthen the capacity of PHC and public health professionals at the municipal public health centres and bridge them in assessing health needs, setting priorities and stratifying risk and developing population targets and systems for tracking and inviting target populations for screening and other proactive health services, especially for vulnerable groups.

- **Year three.** Further expand the capacity of public health specialists by investing in public health training and introducing integrated approaches and tools for gathering and analysing data, defining priority needs and leading joint interventions in addressing priority health needs.

- **Year four.** Engage municipalities to give priority to health in the political agenda, to facilitate multisectoral action and to establish PHC accountability mechanisms for population health outcomes.

5. Align the profile of PHC teams with population health needs and a revised package of services

PHC requires a workforce with a wide range of skills and expertise *(4,32,36)*. The right profile and competences of PHC professionals is essential for implementing the revised PHC benefit package of services and for ensuring more proactive population health management.

PHC teams

- The number, profile, competencies and distribution of the PHC workforce are key in ensuring the intended delivery of primary care services.

- Family doctors and general practice nurses in Georgia need to be supported to both obtain and continually improve a wider range of competencies.

- A workforce development strategy should give priority to the even distribution of a minimum of one family doctor and one general practice nurse per PHC centre across the country with enhanced PHC competencies.

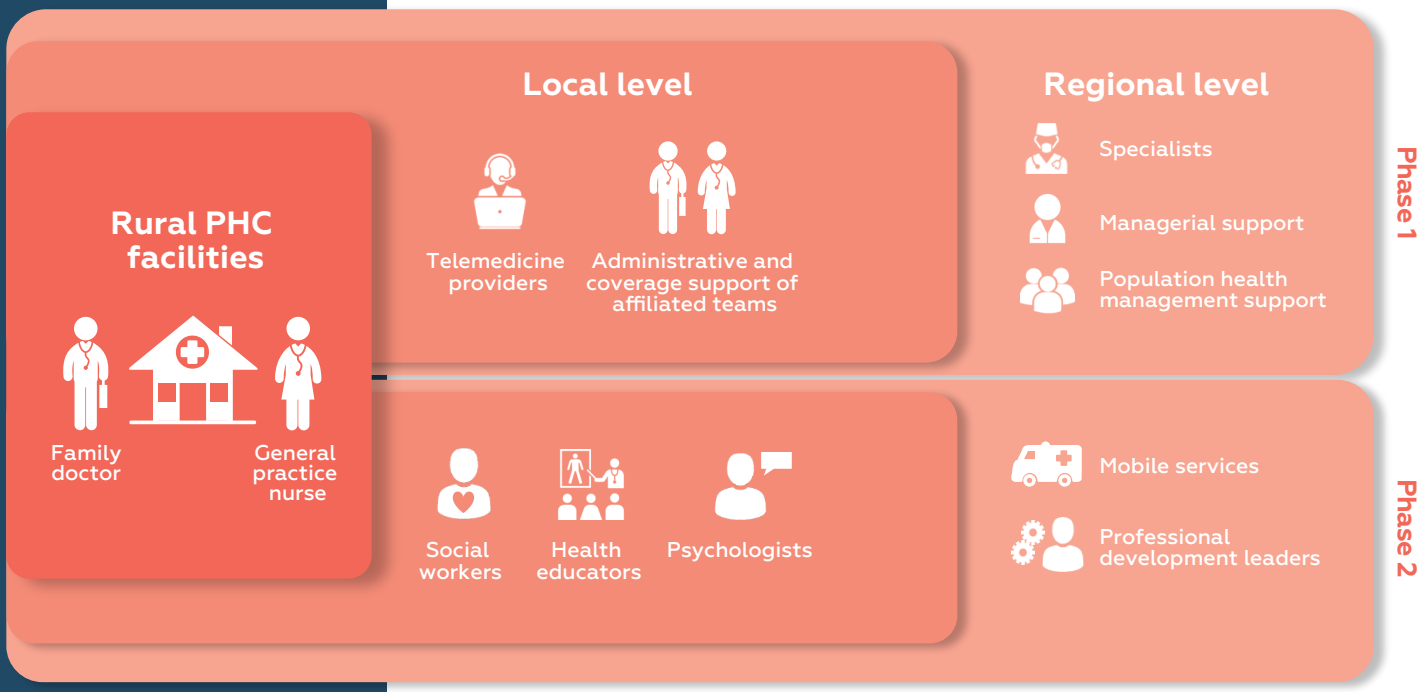
International evidence recognizes the role of general practice nurses in expanding, connecting and coordinating care *(32)*. General practice nurses can carry out many essential PHC tasks related to population health management, education and management of people with noncommunicable diseases and home care, including palliative care. Realizing this requires investing in five core competencies for nurses working in primary care: patient advocacy and education, effective communication, teamwork and leadership, people-centred care and clinical practice, continual learning and research *(32)*.

Ultimately, the proposed networked model of care can support access to a wide range of shared resources, widening rural PHC teams beyond family doctors and general practice nurses. This is foreseen to include, for example, access to specialists and managerial support in the short term and, in the longer term, the support of social workers, health educators and psychologists, among others (Fig. 6).

Priority actions

- **Year one.** Establish a unit within the Ministry with the capacity and mandate to conduct health workforce assessments and strategic planning. Develop a PHC workforce strategy that gives priority to the equal distribution of family doctors with family medicine competencies. Introduce a minimum requirement for PHC teams to have one general practice nurse per doctor. Define clear roles and responsibilities of PHC providers, including laboratory and diagnostics, for most common conditions, and establish referral requirements. Establish the legal, educational, societal and organizational conditions for increasing the professional autonomy of general practice nurses. Develop requirements for competencies and responsibilities for social workers and nurse assistants to be introduced in PHC teams.

Fig. 6. Rural PHC teams should include a range of shared resources for broader, multiprofile teams made possible through networks organized at the local and regional levels



- **Year two.** Upgrade the competencies of general practice nurses in alignment with new services and tasks for priority clinical conditions. Invest in training family doctors in managing noncommunicable diseases, early childhood development and mental health in alignment with the new PHC package of services and the expected new roles and responsibilities.

- **Year three.** Introduce a more systematic approach to continuing professional development for the PHC workforce to continually improve the quality of care provided and enhance patient experiences. Establish a group of PHC professional development leaders within PHC networks to contribute to developing and implementing continuing medical education and other initiatives for innovative capacity building.

- **Year four.** Introduce multidisciplinary ways of working in a networked approach that includes sharing a broader range of human resources to expand teams (such as social workers, psychologists rehabilitation services, health educators and others). New types of social workers working with vulnerable patients in the network could improve the ability of primary care to provide more holistic care and reduce the risk of social problems being medicalized. There should also be family-oriented services for addressing the psychosocial needs of pregnant women and children 0–5 years old and older people.

6. Strengthen PHC management subnationally by introducing a networked approach

Evidence indicates that PHC networks benefit population health management by improving continuity of care and access to an extended range of services through sharing human, laboratory and diagnostic

resources *(31)*. Importantly, networks provide opportunities for integrating PHC with public health, social services and links with other services provided by community and/or nongovernmental organizations that can contribute to improving population health management.

The introduction of PHC networks in Georgia has the potential to increase access to a wider scope of services for the population residing in rural areas. Through clearly defined roles, responsibilities and relationships, networks are also an opportunity to strengthen PHC governance and management. Linking the more than 1200 stand-alone, rural PHC centres via PHC networks has several advantages. These networks can support:

- expanded opening hours and providing 24/7 access to services through diversified modes to access services (face-to-face, telehealth and mobile clinics);
- closer coordination and eventual integration of PHC services with public health and social care services through data-driven assessments of health needs and, subsequently, scaling community interventions for addressing the priority health needs identified;
- integrated care pathways through linkage with specialized outpatient and hospital services, supported by teleconsultation services; and
- the monitoring of PHC performance and feedback through local, tailored performance measurement efforts, supportive supervision, facilitating continuing professional development and introducing an internal quality improvement tool.

PHC management

- A networked approach to PHC services can increase the range and continuity of services through shared resources.
- Rural populations and PHC doctors and nurses working in the more than 1200 rural PHC centres in Georgia will benefit from establishing networks.
- Introducing a networked approach across the country has the potential to increase the range, continuity and overall quality of PHC services provided between rural and urban areas.

The Georgian Medical Holding can provide management and leadership for PHC, working with municipalities, regional branches of the National Center for Disease Control and Public Health, regional hospitals and other regional stakeholders. They can also serve an important function in planning services for the region, including identifying areas for investment, rehabilitating facilities (following approval in accordance with the standards of the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs) and developing diagnostics and other services within their PHC network.

PHC networks at the local level could also be established that would cover the territory of one municipality (for smaller municipalities, a few municipalities). By connecting rural PHC providers at the local level, PHC

networks could ensure that the population has better access to services, providing cover for leave, education and sickness between practices, sharing the use of telemedicine facilities to support outpatient consultation and education, sharing administrative tasks and introducing new PHC services (for example, rehabilitation services or social workers for addressing the social needs of patients within the local network).

The Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs has already initiated reforms to minimize fragmented care from small, stand-alone urban PHC providers to optimize the use of resources and increase the accessibility to a wider scope of services for the rural population. The refurbishment of rural PHC facilities is ongoing with support from the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs, and telemedicine capacity and capability is being developed through Georgian Medical Holding with support from a European Union–funded project. To improve the planning and implementation of the reform process, the Ministry established a PHC Coordinating Council. Investing in national capacity to manage the transformation of the urban and rural models of PHC through a dedicated PHC unit will be critical to the success of the reforms.

Priority actions

- **Years one and two.** Define key principles for establishing a multilevel network approach, including decisions on shared managerial and administrative functions, new shared PHC services within the networks and their respective catchment areas. Develop governance options for the networks, including for the role of Georgian Medical Holding to effectively manage the networks. Develop options for the financing and fund flows following the patient to and within the networks based on a recommended refined capitation-centric payment method *(8)*. Select at least two regions and municipalities within the regions that agree to accelerate the establishment of PHC networks and act as demonstration sites of a PHC network based on the redefined PHC model.

- Develop and approve minimum standards for rural PHC facilities, including requirements for diagnostic and laboratory equipment at PHC facilities, including: 1) a minimum set that should be available at all PHC facilities; and 2) a full set that should be easily accessible and affordable through the network of PHC facilities.

- **Year three.** Strengthen PHC networks in all regions and introduce new shared services at the local and regional levels. Introduce new functions for actors such as Georgian Medical Holding and its future regional branches (if they will be established as recommended), providing support in terms of resources to ensure high-quality management and a system for executing the following functions:

    - assessing needs and planning for rural PHC facilities;
    - collecting accurate data on service provision and utilization;
    - measuring and managing performance across regions;
    - developing a human resources strategy for recruitment, training and professional development;
    - implementing a digitalization strategy;
    - developing clinical pathways; and
    - allocating resources to regions based on assessing need and planning investment in and refurbishment of buildings.

- **Year four**. Roll out an extended range of functions for the established networks, including the use of mobile services within networks to bring high-quality services closer to all residents.

Monitoring and improvement

- Cycles of data analysis and use are needed to stimulate a culture of continual, locally led improvement as a true learning system.
- Data flows in Georgia at present predominately focus on input and output at the system level, with less well-established cycles of data feedback to PHC facilities.
- Data and feedback systems that provide performance intelligence at all levels are needed, together with mechanisms to ensure that it is used in decision-making.

7. Revise the PHC system for performance monitoring and quality improvement

Monitoring and evaluating the performance of PHC and communicating the results have critical uses for health policy-makers, facility managers and PHC providers *(33)*. These uses include improving clinical care at the practice level, such as managing noncommunicable diseases across patient panels, but also for managing facilities across networks and the system as a whole *(34)*. Cycles of data analysis and use are needed to stimulate a culture of continual, locally-led improvement as a true learning system *(35,36)*.

At present, there are vertical systems (mainly through the National Center for Disease Control and Public Health and its regional branches) for regularly monitoring input and output. Less well established is data analysis and feedback to inform PHC practices about their performance by the defined priority areas of the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs. Population-level data on key indicators, such as complications, avoidable hospitalizations and premature mortality are needed for practices to move to a model of care oriented towards performance and outcome.

Introducing PHC performance monitoring and management frameworks that provide feedback on performance data to each PHC practice would enable performance to be benchmarked and the frontline PHC providers to be engaged in supportive supervision. This might enable best practices to be identified that can act as demonstration sites and internal quality improvement circles to be introduced. This performance intelligence can also be used to support payment arrangements to incentivize PHC professionals and managers and, when reported publicly, facilitate user choice.

The Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs has initiated the development of a performance monitoring framework to monitor the impact of the implementation of the PHC Roadmap. The framework needs to be further refined to fully capture the implementation of transformations in both urban and rural areas. In parallel, the performance management system and mechanisms need to be strengthened locally. Currently, the information generated by the existing system is highly fragmented across numerous actors. The selection of key process and outcome indicators should be revisited based on their intended uses for ensuring effective primary care and chronic disease management.

Priority actions

- **Year one.** Establish a unified PHC performance monitoring framework that includes a plan for monitoring and evaluating implementation of the new PHC service model, with clear benchmarks and key performance indicators based on reviewing the existing system for data collection, reporting, analysis and feedback.

- **Year two.** Introduce feedback loops for continual learning and quality improvement at each level to support performance improvement, including within practices, such as quality committees, in alignment with the revised PHC performance framework. Remove unnecessary forms and reporting processes.

- **Year three.** Invest in successful change management by enhancing the capacity of managers, including their ability to use the established performance monitoring and management frameworks for managerial decisions and innovations.

- **Year four.** Further align motivational incentives, such as results-based payment for priority services and conditions (early childhood development and key noncommunicable diseases), to continually improve performance.

POLICY LEVERS TO SUPPORT THE TRANSFORMATION OF THE PHC MODEL

Governance

Strong leadership and governance are essential to lead the transformation of the PHC model of care from being reactive towards a more proactive model that addresses the health needs of the population. Acknowledgement of the benefits of multisectoral governance and collaborative leadership is growing *(4)*, with the engagement of committed stakeholders, including professional associations, providers, patient organizations and public administration, contributing to sustained political commitment.

Strong governance will also be needed to steer the development of an investment plan for PHC facilities, strengthening licensing requirements and selective contracting and managing the purchasing and setting up of information systems.

One important challenge that needs to be addressed is gauging the genuine interest and motivation of local governments to engage in the process. Currently, services are managed centrally, and horizontal and local coordination capacity is underdeveloped. The role of local governments remains limited, and requests from the central government are ad hoc rather than defined in clear mandates. These requests typically comprise support for disseminating information, gathering local stakeholders or collecting information from facilities.

At present, local governments do not have the formal responsibility to support improving the quality of PHC services. Therefore, if local authorities are not formally delegated the mandate to be part of this process, developing an arrangement that stimulates their motivation and interest to participate in this process will be crucial. In the absence of the decision to delegate more governance functions to local governments, and against the background of the PHC reform, using the networked approach suggested as a mechanism for bringing local governments as formal actors in the process would be practical (such as members of regional advisory boards).

Importantly, any changes to the model of care, specifically the intended first-contact points for the public to access services, new delivery modalities and scope of practice for PHC professionals, will require clear communication with the public. Informing the population about these changes and actively promoting the image and prominence of PHC in the health system are critical to support the changes proposed. Community awareness campaigns that include the dissemination of positive experiences of patients who benefit from advanced PHC practices could be used to promote PHC practices and the initial empanelment process as a first step in building relationships. Importantly, the implementation of a new model of care should be accompanied by a fully developed change management and communication strategy.

Financing

Adequate public funding is required to realize the vision of high-quality, evidence-informed, accessible and person-centred PHC. PHC financing in Georgia faces several challenges, such as a low level of public funding, a

complex co-payment system, fragmented financing, limited coverage for outpatient medicines and lack of financial incentives for PHC providers to deliver priority services to patients. Public spending on PHC is much lower in Georgia than in other countries in the WHO European Region. In 2018, it accounted for only 0.3% of gross domestic product. In 2019, only 7% of the overall health sector budget was spent on PHC, down from 12% in 2015 *(8)*. The government should substantially increase public investment in PHC, making PHC universally accessible and free at the point of use. Provider payments also need to be redesigned. For detailed analysis and policy recommendations on health financing for PHC, see the WHO policy brief *Rethinking primary health care financing in Georgia (8)*.

Health workforce

The current numbers and competencies of family doctors and general practice nurses in Georgia are insufficient to significantly expand the scope of PHC services for high-quality care over a sustained time period. The workforce has an ageing demographic profile, with many health-care workers within 15 years of the retirement age (60 years for women and 65 years for men), and some health-care workers are working well into retirement *(37)*. The requirement of at least one nurse per family doctor needs to be fulfilled immediately. The number of nurses remains very low in comparison to other countries in the WHO European Region, at just 542 per 100 000 population in 2019 *(1,38)*. The ratio of nurses to doctors has not exceeded 0.8 nurses to 1 doctor since 2014 *(1,38)*. The situation may be worse in primary care, especially in rural areas. Meanwhile, from 2012 to 2019, the reported number of family doctors increased from 1988 to 2578 (by 30%) *(37)*.

With support from WHO, Georgia has reviewed its health workforce planning and governance structures and assessed the health workforce. As part of recommendations from these reports, the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs is assigning a policy official to lead on human resources for health planning and governance and convening a multidisciplinary team representing ministries, agencies, educational institutions and other stakeholders to develop the capacity for health workforce planning.

Access to medicines

Efforts should be made to finalize and approve draft legislation governing medicines (the Law on Medicinal Products). Measures should also be taken to promote the cost-effective use of medicines, strengthen prescription enforcement and use of electronic prescriptions, establish good manufacturing practice through a certifying agency, revise the Essential Medicines List, address high markups of medicines and limit conflicts of interest. Introducing unified protocols and standards can also help to facilitate the development and implementation of cost–effectiveness guidelines. Finally, the outpatient medicines programme for people with chronic diseases should be expanded to cover more medicines and more people.

Health information system and telemedicine

A well-functioning health information system is essential to support the production, analysis, dissemination and use of reliable and timely information on determinants of health, health system performance and health status. To identify patient care gaps and assess the status of their panels, providers must be able to access key data about their empanelled populations. Health information system solutions are crucial to implementing, managing and delivering PHC services, including expanding

rural services and introducing the empanelment process (such as open enrolment registration and a system to maintain and update the individual enrolment database after each enrolment registration period). A well-functioning health information system is also needed to support data exchanges between PHC providers and the organizations responsible for population empanelment, performance monitoring and payment. PHC providers should be able to electronically report on patients in the target group and follow up patients not receiving care according to the guidelines. Depending on data availability, the platform should also support the monitoring of health outcomes and analysis of data for performance-based financing.

Telemedicine services are essential for bringing high-quality services closer to remote populations in rural areas. Telemedicine equipment has been procured for 50 rural PHC centres, and an additional 50 will be equipped in 2023. Centres receiving this equipment could serve as teleconsultation hubs for the provision of remote consultations for several rural practices in the district (within a local PHC network). In addition to remote consultations for patients, this equipment can also introduce a new working modality of remote provider-to-provider consultations, by which a family doctor connects with specialists in urban areas to discuss the clinical management plan for several patients who could benefit from the advice of a specialist. Designated telemedicine hubs can be also used for education and professional development.

In addition to the advanced equipment used at the rural telemedicine hubs, a lower cost and more portable option for telemedicine could be developed in parallel for wider use by family doctors and nurses. For example, PHC providers could receive advice and guidance through email or phone to support the management of noncommunicable diseases, triaging of patients and diagnostic decision-making. This has the advantage of lower costs and is also less logistically challenging since some or all of the consultations can be asynchronous, so that the family doctor and the specialist do not have to be available at the same time and in front of specialized equipment. The use of cell phones with peripherals would also allow telemedicine to be deployed in home visits and would enable nurses to be supported in very rural areas where a doctor may not always be available. Providing all family doctors and general practice nurses with a 4G smartphone would facilitate this and help to solve some of the connectivity problems experienced in using the electronic prescribing system. This could include free personal calls and data, which would be a significant employment benefit.

The payment mechanisms for providers and specialists need to be redesigned to ensure that the use of these digital service modalities is an attractive option or at least ensure that there is not any perverse incentive to avoid their use (or create overuse).

Priority actions within seven priority areas for strengthening PHC model in Georgia

	Year 1	Year 2	Year 3	Year 4
Redefine the PHC package of services, gradually expanding the scope of services provided				
Redefine the PHC services within the benefit package for defined priority noncommunicable diseases and mental health	●			
Clearly define scope of services provided for priority conditions by family doctors, general practice nurse and by narrow specialists	●			
Ensure access to diagnostic and affordable medicines in alignment with revised package of services		●		
Ensure access to a broader range of services, including antenatal care, TB, HIV, health education, further development of mental health services			●	
Activate measures for the continual review of the benefit package				●
Implement new clinical protocols and guidelines and patient pathways for priority conditions				
Implement revised clinical protocols for priority noncommunicable diseases and mental health	●	●		
Ensure that patients pathways align with the implementation of the new model of care, including referral system for priority conditions	●	●		
Establish a new process for routinely reviewing and updating clinical protocols and guidelines			●	●
Ensure the empanelment of the population that balances the community focus of PHC with the individual's right to choose a provider			●	●
Establish standards for optimal panel size for rural PHC	●			
Ensure that standards protect a patient's right to choose their PHC provider within administrative unit and freedom to change for free	●			
Establish governance mechanisms for the empanelment process		●		

	Year 1	Year 2	Year 3	Year 4
Invest in capacity building to support empanelment and panel management			●	
Invest in optimized tracking and assessment of population health metrics using electronic medical records			●	
Optimize the panels for urban population not to exceed 2000 patients per PHC team			●	
Ensure that panel management includes setting and working towards targets and assessing gaps in chronic disease management, immunization and treatment adherence				●
Reorient primary health care to better address community health needs and support population health management				
Study empaneled populations, create community profiles and leverage digital tools for risk stratification and monitoring population health outcomes	●			
Strengthen the capacity of PHC and public health professionals at the municipal public health centres and bridge them in assessing health needs, setting priorities and stratifying risk and developing population targets and systems		●		
Further expand the capacity of public health specialists by investing in training and introducing integrated approaches and tools for data gathering and analysis.			●	
Engage municipalities to give priority to health in the political agenda, to facilitate multisectoral action and to establish PHC accountability mechanisms for population health outcomes				●
Align the profile of PHC teams with population health needs and a revised package of services				
Establish a unit within the Ministry with the capacity and mandate to conduct health workforce assessments and strategic planning.	●			

	Year 1	Year 2	Year 3	Year 4
Develop a PHC workforce strategy that gives priority to the equal distribution of family doctors with family medicine competencies.	●			
Introduce a minimum requirement for PHC teams to have one general practice nurse per doctor	●			
Define clear roles and responsibilities of PHC providers, including laboratory and diagnostics, for most common conditions, and establish referral requirements.	●			
Establish the legal, educational, societal and organizational conditions for increasing the professional autonomy of general practice nurses.	●			
Develop requirements for competencies and responsibilities for social workers and nurse assistants to be introduced in PHC teams.	●			
Upgrade the competencies of general practice nurses in alignment with new services and tasks for priority clinical conditions.		●		
Invest in training family doctors in managing non-communicable diseases, early childhood development and mental health in alignment with the new PHC package of services and the expected new roles and responsibilities.		●		
Introduce a more systematic approach to continuing professional development for the PHC workforce to continually improve the quality of care provided and enhance patient experiences			●	
Establish a group of PHC professional development leaders within PHC networks to contribute to developing and implementing continuing medical education and other initiatives for innovative capacity building.			●	
Introduce multidisciplinary ways of working in a networked approach that includes sharing a broader range of human resources to expand teams				●

	Year 1	Year 2	Year 3	Year 4
Introduce new types of social workers that working with vulnerable patients in the network				●
Strengthen PHC management sub-nationally by introducing a networked approach				
Define key principles for establishing a multilevel network approach, including decisions on shared managerial and administrative functions, new shared PHC services within the networks and their respective catchment areas	●	●		
Develop governance options for the networks, including for the role of Georgian Medical Holding to effectively manage the networks.	●	●		
Develop options for the financing and fund flows following the patient to and within the networks based on a recommended refined capitation-centric payment method	●	●		
Select at least two regions and municipalities within the regions that agree to accelerate the establishment of PHC networks and act as demonstration sites of a PHC network based	●	●		
Develop and approve minimum standards for rural PHC facilities, including requirements for diagnostic and laboratory equipment at PHC facilities, including:	●	●		
Strengthen PHC networks in all regions and introduce new shared services at the local and regional levels.			●	
Roll out extended range of functions for the established networks, including the use of mobile services within networks				●
Revise the PHC system for performance monitoring and quality improvement				

	Year 1	Year 2	Year 3	Year 4
Establish a unified PHC performance monitoring framework that includes a plan for monitoring and evaluating implementation of the new PHC service model	●			
Introduce feedback loops for continual learning and quality improvement at each level to support performance improvement		●		
Invest in successful change management by enhancing the capacity of managers, including their ability to use the established performance monitoring and management frameworks for managerial decisions and innovations			●	
Further align motivational incentives, such as results-based payment for priority services and conditions to continually improve performance				●

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