

# Strategy for Development of Human Resource for Healthcare in Georgia 2016-2019 and Implimentation Plan



**Global Alliance  
for Health  
and Social Compact**

## Objectives covered

Elaboration of Human Resource Development Strategy for Healthcare and its Implementation Plan

## **CONSULTANCY ASSIGNMENT**

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

## **FINAL REPORT**

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| Implementation     | Global Alliance for Health and Social Compact   |
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for Health  
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# STRATEGY FOR DEVELOPMENT OF HUMAN RESOURCE FOR HEALTHCARE IN GEORGIA 2016-2019

## INTRODUCTION

1. The Strategy for Development of Human Resources for Healthcare for 2016-2020 is the main policy document in the area, which sets forth the priority intervention directions and mid-term objectives for ensuring the continuous development of human resources in the health system in Georgia. The implementation plan will underpin the Strategy for Development of Human Resources for Healthcare for 2016-2019 as a practical tool to implement in practice the mentioned policy document.
2. The development of the respective Strategy is well-reasoned by the importance of strategic planning of the human resources' development process, so as to ensure the efficient functioning of the health system. The Strategy was developed taken into account the following frameworks: the provisions of the existing legislative-normative framework and the national and international experience in the area. For the purpose of coordinating the development of human resources for health, the provisions of the given strategy were correlated with the relevant policy documents.
3. The Social-economic Development Strategy of Georgia "Georgia 2020" spotted specifically development human resources to ensure quality of the health care and the same priority is highlighted under a separate priority in the Georgian Healthcare System State Concept 2014-2020 "Universal Healthcare and Quality Management for Protection of Patient Rights" as *Development of human resources in the healthcare sector* "aimed to assess the needs and to plan the staffing with human resources in the health system; to ensure the staffing of the institutions from rural regions, near-border and high mountain regions; to motivate and foster the personnel in the health system; to improve the policies for training health workers in the medical and pharmaceutical education system. The following Implementation Plan will target at identifying existing priority challenges, drawing up methods of approach and intervention, which, in the context of a consistent implementation, will improve public access to high quality services and ultimately will translate into health gains for the overall Georgian population.
4. The Strategy translates into action the WHO policy initiatives and resolutions - WHO Global Code of Practice on the International Recruitment of Health Personnel (WHA63.16), Health

workforce strengthening (WHA64.6), Strengthening nursing and midwifery (WHA64.7), Transforming health workforce education in support of universal health coverage (WHA66.23), and Follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage (WHA67.24).

5. The Strategy shall come under the Association Agreement between the European Union and the European Atomic Energy Community and their Member States, of the one part, and Georgia, of the other part, and shall contribute to fulfilling the commitments of reducing poverty, improving living standards, as well as increasing the level of social protection in terms of quality, accessibility and financial sustainability in the field of health.
6. The implementation of the Strategy will be based on an Implementation Plan, which will specify the actions, deadlines, responsible people, and necessary resources.

## DESCRIPTION OF THE SITUATION

7. Human Resources for Health represent one of the fundamental components of the health system, without which the provision of healthcare and access to health services, the functioning of the medical institutions and of the system as a whole cannot be fulfilled.
8. A crisis in the area of the human resources for health is registered at the world and regional levels, which is manifested by insufficiency of medical workers, uneven geographical distribution of healthcare professionals, a level of qualification which does not meet the requirements, migration, etc.
9. The Georgian Healthcare System State Concept 2014-2020 “Universal Healthcare and Quality Management for Protection of Patient Rights” points out the need of “*Development of human resources in the healthcare sector – work on health sector human resource development policy and long-term plan will be started from 2015*” grounding the development of the present strategic policy document.
10. Strengthening the human resources component is a key area of the overall health reform agenda of the present Government at the national level. The Government acknowledges the importance of the human resources as a main driver of reforms and the most important input

into the health system to meet the population needs and to fit into the health system design to produce and deliver highest quality of care for Georgians.

11. The declared general main directions aim to develop continuously the human resources, to rationally use the existing personnel, to train adequately and in a diversified well-performing personnel for the health system via the following measures: a) assessing the needs and planning the staffing with human resources in the health system; b) ensuring the staffing with personnel in the institutions from remote regions; c) fostering and motivating the personnel in the health system; d) improving the policies for training personnel in the medical field, particularly focusing on nurses education system.
12. The Ministry of Labour, Health and Social Affairs of Georgia, as the central specialized body of public administration in the health area, has the role to ensure that the policy and regulatory environments support the Government's strategic objectives, and to provide leadership and support to the sector on workforce development. This role is expected to be through development and coordination of the implementation of public policies for professional training and development of the medical and pharmaceutical personnel; to ensure a balance in generating human resources in the health system by rationalizing the investments in training and distributing uniformly the medial workers, and to organize, together with the local public administration authorities and heads of institutions, activities for ensuring the necessary staffing of the institutions from the health system.
13. Health workforce have been traditionally higher in Georgia comparing to other CIS and EU since '90, however starting with 2005 the steady increase is observed to be over 10%. This is particularly the case the physicians. The number of pharmacists is dramatically low 7.64 per 100000 populations being situated close to the CIS average but incomparable with the EU average situated at 81.82 per 100000 populations. Although, the country has a large number of doctors they are unevenly distributed. Tbilisi benefits from the highest concentration of doctors being 4.5 times higher, than the regions with the lowest rate of physicians and twice higher than the Georgian average. This situation generates high inequity, limited access to healthcare services being applicable to the whole range starting with primary health care, hospital care, public health etc. the rural, cross-border, mountain regions found particularly difficult to recruit and to retain doctors. A completely reverse situation is for the middle qualified staff –

nurses, as since independence the trend was a steady decreasing one and being the lowest among CIS and EU countries and with 60% lower than the average for the EU countries. The mentioned facts lead as to observe a reverse balance between doctors and nurses in Georgia comparing to the Western region that will further on raise questions related to the human resources planning on the service provision range, professional skills, skill-mix, demography changes, nurse position in the society, team work.

14. The demographic situation in Georgia like in other post-soviet countries since independence has a steady declining trend. The causes are the sharp fall in the fertility rate and massive emigration flow, this phenomenon was spotted in the World Bank report of 2007, Georgia ranked among the highest-emigration countries in the world (with respect to population). At the same time aging population phenomenon as a general trend in the world is also another challenge Georgia will have to face in the coming years. All the mentioned general trends have huge impact on the health system and have to be taken into consideration while planning workforce according to the population needs and upcoming forecasts.
15. The liberalization and market approach applied in the mid 2000 to all the sectors in Georgia has led to massive increases in the number of private education institutions in Georgia translated in the already mentioned large number of doctors (73 higher education institutions with approximately 15 000 students). At the same time another adverse market behavior is generating less and less nurses, as the profession is not seen as a prestigious one in Georgia, the wages are extremely low. Another area that needs to be addressed is looking in-depth into the structure of the specialties as some of them encounter already shortfalls (nurses, long term care personnel, geriatricians) other producing overcapacity and ultimately generating brain drain and brain waste.
16. As the education is regulated in Georgia by the Ministry of Education (MoE), the MoLHSA has limited capacity and weak mechanisms to intervene and ensure policies, planning and management of the human resources for the health system. At the same time, there is lack of instruments to ensure quality of education at the undergraduate, postgraduate level, including lack of Continuous Medical Education (CME) system.



17. In Georgia the nurses are trained in vocational schools, which in the last decade have passed 100 and overlaps with some NGOs who provide also some training courses focused better on developing practical skills. Although, there is no standards or basic unified curricula to produce a standardize quality of training. In this context and overlapping with overproduction of doctors there is quite unusual phenomenon of doctors working as nurses.
18. MoLHSA have had over the last decade several attempts to provide high quality training courses with the support provided by different development partners. Those education initiatives have been in the PHC, public health etc. and need institutionalization and sustainability policy.
19. Registration and licensing are missing components in Georgian education system. The MoLHSA has delegated to a subordinated structure State Regulatory Agency of Medical Activities (SRAMA) the administration of a Unified State Certification Exam (USCE) The Agency is also formally responsible for the institutional accreditation of postgraduate programmes. The accreditation processes are generally based on the application procedure, although no monitoring and evaluation mechanisms are in place to ensure the proper implementation. Lack of mechanisms is complemented by reduced human resources capacities.
20. Medical education remains to be too theoretical with declarative practice, and after 10 years of university and post-university training, the young specialists have difficulties in individual practice. There is still a gap between the theoretical knowledge and the practical skills of the medical workers, which needs adjustments to the modern diagnostic requirements, treatment and prophylaxis of pathologies, so as to improve the quality of medical services and patient's security. Currently there are no occupational standards for the professions from the National Classifier of Occupations.
21. The retention of the personnel employed in the public medical-sanitary institutions needs a joint effort from the central specialized authorities, the management of the medical institutions, and the local public authorities. It is necessary to create attractive working conditions, especially in the context of the Government priority to carry out PHC reform and cost-containment measures to downsize the overproduction of certain highly rewarding health

services; good payroll conditions, personnel development to staff the medical institutions with qualified personnel and to maintain the high performance of the institution.

22. The whole-of-system approach places the Strategy for Development of Human Resources for Healthcare for 2016-2020 as a condition *sine qua non* for all other reform initiatives to be underpinned in a holistic and sustainable way creating a resilient health system. A strong health workforce is the part of the health system has a certain degree of flexibility and would respond to the Georgian population needs.
23. The Strategy will outline a new vision for human resources within the health system through a people-centeredness approach, acknowledging the multitude of actors: private, public, civil society and the high priority of the Government for involving development partners not limited to the European Union and Transatlantic partnerships.
24. For the first time health workforce in Georgia will be addressed in a comprehensive manner under a separate strategic policy document at the policy, financing, implementation levels accompanied by an Implementation Plan for the short and medium term prospective. The corner stone of the present document is that it should include and translate interlinked principles and actions and to correlate with all the healthcare reforms in an integrated approach.
25. This strategy has to generate actions as to ensure such principles as people-centeredness and continuum of care through interconnections at all levels of care, as: emergency care, primary health care, specialist care, hospital care sector, geriatric care, long-term and home based care services, rehabilitation and community based services. The Strategy also notes efficient skill-mix, professions balance, team oriented service provision to ensure and sustain effective patient pathways through the health system in Georgia.

## **CHALLENGES IN THE AREA OF HUMAN RESOURCES FOR HEALTH**

### **Governance**

26. The activity of the medical and pharmaceutical personnel is regulated via a number of legislative and normative acts (Law of Georgia on Health Care No. 1139 approved on 10.12.1997, Law of Georgia on Medical Activity No. 70290 approved on 8.06.2001, Law of Georgia on the Rights of Patients No. 283 approved on 05.05.2000, Law of Georgia on Public

Health No. 5069 approved on 27.06.2007), although it should be noted that nursing benefit from very limited regulation in the field. This legal framework is far from being comprehensive not specifying many important domains and does not allow an efficient implementation of all of them. The normative framework for certifying the professional activities of the medical and pharmaceutical workers is not sufficiently developed and regulated. The classifier of medical specializations is obsolete and contains approx. 26 specializations as compared to the average of 70 in EU, and this fact narrows and fragments the medical specialties and generates additional costs for training the specialists. Currently, the performance-based payroll mechanism that might be used for medical, nurses and pharmaceutical professionals is not used. The responsibilities of the public authorities for preparing and ensuring the conditions for employing medical workers in rural area are not regulated at the moment.

27. The stewardship function for caring out management of the human resources in the health area has been underestimated considering that free market will regulate. Although, the health sector has its own particularities and the situation allowed private bodies to develop adverse behaviors that negatively impacts the health sector. Thus, MoLHSA has a limited role in regulating mechanisms related to the health human resources on planning, education, continuous medical education, recruitment, motivation and retaining schemes, no particular plan or adjustments for the rural, cross-border, remote or mountainous regions related to all the mentioned components. There is no Division within MoLHSA responsible for the health human resources management implementation activities. At the same time, present Government have launched 2 years ago the Universal Healthcare Program aimed to ensure quality and access to health services for the entire population of Georgia. Thus there is a need for considering efficient use of resources developing delivery of the health care models: promoting diversified and skill-mix especially in PHC underpinned by sustainable referral system towards community or long term care or to the secondary care.
28. Many components of human resources' management, such as planning, recruitment, selection, integration and maintenance of specialists, motivation, development and evaluation, are totally missing or have a rudimentary development, being at the moment governed by the market rules, mostly realized by the private providers, disconnected with the planned reforms in the health system, respectively the management of the subordinated personnel is carried out spontaneously, limited to the scale of a health facility and mostly unprofessionally. There are

no specialized training courses tailored to the management staff of the medical institutions and the heads of the human resources services from the different levels of healthcare system.

29. The key principle of the Strategy is the responsibility of MoLHSA to provide national leadership and strategic direction for education, training and workforce development and to ensure a nationally coherent system is in place.

### **Human Resources Data Collection and Analysis**

30. There are substantial gaps and inconsistencies in the availability of national workforce data and consequently - gaps in the existing coverage of workforce planning with inadequate linkages between public and private sectors data.
31. The statistical reports under the current data collection mechanism is providing limited amount of data, which is not giving the necessary research level of details in order to underpin the evidence informed policy making process and design accordingly policy interventions. The current amount of data collection does not contain data regarding the age of the personnel from the health system and the gender distribution. It is difficult to report regarding the human resources for health to the international structures – WHO, OECD, EUROSTAT – because of the differences in the statistical forms and classifiers of medical specialties. At the same time, it is necessary to develop the capacities of analyzing the data on human resources, at the central level and at the level of the medical and pharmaceutical institutions. The streamlining of this process shall be ensured by implementing the Human Resources Information Systems - component of National Integrated eHealth System.

### **Human Resources Planning**

32. At this stage, there is not forecasting and planning policies for the human resources for the health system. There is a need for a methodology for planning, approved via normative acts, which would set forth the criteria and conditions of sustainable planning, and be based on the perspective needs of personnel in the health system, forecasting of population morbidity evolution, demographic trends in the country, number and quality of potential candidates for training in medical area, and the capacities of the education institutions.

33. The current and future needs of the public health and the care system will require a greater emphasis on primary and integrated health and long-term care than in the past. An understanding of working in cross-disciplinary teams and working to break down barriers between primary and secondary care is required and Strategy's focus is to ensure that it trains and develops a workforce with skills that are transferable between these different care settings.
34. The Ministry of Labour, Health and Social Affairs will need to take a strategic role in relation to those healthcare specialties where number controls are determined nationally. The MoLHSA policy interventions will address macro-level of HRH governance to enabling health facilities to design and implement meso- and micro-level governance interventions in the context of matching to their full scope of efficiency and performance.

### **Inter-sectorial Collaboration**

35. There is insufficient coordination of activities between the MoLHSA, Ministry of Education, private operators and Local Public Administration for staffing the medical, nurses and pharmaceutical institutions from rural, remote, cross-border and mountainous area with medical personnel and its retention. It is also necessary to improve collaboration between authorities regarding the change of the payroll system for medical and nursing personnel and financial retaining schemes for the rural, remote, cross-border and mountainous areas.

### **Human Resources Generation**

36. The medical education system is oversized driven by the market rules supply to the demand. At the opposite governed by the same rules the nursing education area is oversized in terms of institutions although there is a discrepancy in terms of volume. At the same time, taking into account the strange phenomenon of doctors working as nurses and NGOs providing nurses education courses these facts lead to ascertain low quality of medical, nurses education and urgently recognize the need for regulatory interventions.
37. In the context of current healthcare started reforms by the Government and particularly high priority to reform the Primary Health Care (PHC), there is revealed by the education institutions having no special training course tailored to the PHC workers.

38. Nurses is another area of black holes starting from the perceptual dimension not being seen in Georgia as a profession at all and continuing with the low quality and medium level studies which is not according to the European Standards aimed as a general approach for reforms.
39. After graduation there is no a genuine system of Continuous Medical Education nor for nurses nor for the medical staff which is a crucial mechanism to ensure quality of the health services provision and act as a retaining mechanism to some extent. As the global and local contexts change rapidly and the medical technologies develop quickly, it is necessary for the medical education to develop more dynamically, ensuring the shift towards competence-based education focused on pupil/student, meeting the needs of the medical system via a modern curriculum, concentrated on information and communication technologies, according to the European standards. The modernization of the post-secondary education system needs reconfiguration of the network of institutions to be in line with the regional and sector development of the country's economy and to increase the quality of education, including via adjustment of curricula, development of occupation standards and the National Framework of Qualifications, improvement of teaching staff quality, improvement of the technical-material basis, reform of the system for students' performance assessment. **The Strategy's interventions incorporate the responsibility on healthcare providers to deliver high quality education and training but for all their staff in order to ensure high quality and safe patient care.**
40. Investment in health care workforce will therefore need to reflect the changing needs of population, careers, and the local community with healthcare and health providers, from both public and private sectors, taking greater responsibility and accountability for the training, skills and competencies of the workforce they employ.

### **Health Education System Quality**

41. Poor quality of the medical acts, the large array of the medical education institutions and massive productions of physicians lead to raise questions on the quality of the education provided. As health is declared as a human right thus implicitly the State has the obligation to ensure and facilitate conditions that would contribute and foster population highest attainable level of health status. From this perspective regulation is limited to have a functional mechanism of accreditation of education institutions and raise the bar to the produced quality of education. There is no mechanism of assessment criteria, process for the education in the

health area that would establish a minimum of mandatory conditions to guarantee a minimum acceptable quality for the health system. The government through the establishment of such a mechanism would have also leverage to regulate the volume and have a mid to long term planning for the healthcare personnel.

### **Human Resources Financing**

42. The liberalization of the market has led to almost entire privatization of the health educational sector starting from pre-graduate, postgraduate and residency, nursing and pharmaceutical fields and rapidly proliferation of the number of institutions that overturned hundred in different areas. However, this fact as might have been expected did not influenced the optimization of costs and continuous increase in quality under the concurrence principle.
43. The system still preserves obsolete elements, sometimes doubling the taught material at different departments and different years of study. Training is focused on obtaining theoretical knowledge, and not on obtaining competences which are necessary for practical activity. In the training costs do not correlate with the obtained competences. The relations between the educational institutions and clinical basis are not defined clearly, as well as the remuneration of the personnel from the medical institutions involved in the teaching process is solely at the latitude of the private provider. Especially this is a problem for the nursing field as the colleges has fewer connections with the clinical basis.
44. The technical and material endowment of all health educational institutions is another unspotted challenge. As there are extremely high costs to fully equip, endow with manuals, training materials, dummies etc. a health education institutions the mentioned categories are those of cost cutting and generating profits instead. MoLHSA has limited power in regulation related to the private providers allowing them to pursue their ultimate goal as the profit although not at the expense of quality of educational service provision and the volume of the produced capacity.

### **New Technologies for Human Resources**

45. There is limited or almost not developed nation-wide and systemic approach towards promoting e-Learning programs at the different types and level of healthcare education. This systemic approach using National Integrated e-Health System would not only support cost-

containment measures within the education system on the long term, also would enable to develop sustainable continuous education system, reduce geographical inequalities, foster development and inclusiveness, empower people as users to actively participate and being responsible for their own health.

### **Payroll System**

46. The current payroll mechanism is not performance-based, does not focus on competence, personal skills, workload, etc. and does not contribute to motivating the personnel of the public health system. The private sector has its own payroll mechanism as per provider under the contract agreement with the person itself.
47. The complex of push factors (nontransparent recruitment mechanisms, unattractive salaries, deficient promotion methods, obsolete continuous medical education system, unsatisfactory working conditions, lack of clear professional development mechanisms) contribute more and more to increasing the outflow of qualified medical personnel from the public healthcare system to the private one, as well as to other areas of national economy or to migration out of the country. Not to mention some particular shortages within the health area as nurses, pharmacist, family doctors etc. Another aspect of complete ignorance although which has also its own part to play is the aspect of status and image that impacted so highly for example the nursing field that for the last decade encounter a continuous fall. The same situation is pictured for the PHC workers. This phenomenon might negatively influence and draw back the started Governmental reforms.

### **Professional Mobility**

48. Lack of accurate information on migration of medical personnel has left without attention the topic related to mobility of medical workers, as well as the development of policies for return and reintegration of migrant medical workers.
49. Mobility of medical workers remains untouched area until now and only adverse behaviors and current produced impact that distort and mutilate health system: dramatically decrease quality of care and access to the health care services, produce huge inequalities. Professional development is an important component for ensuring the quality of medical services,



maintaining the medical personnel, and the achieved performance. Nevertheless, no sufficient mechanisms are developed for ensuring career increase based on professionalism, knowledge, experience, which would have an important impact for motivating and maintaining the medical personnel.

## **NATIONAL VISION, GOALS AND INTERVENTIONS FOR HUMAN RESOURCES**

50. The Vision of the Strategy for Development of Human Resources for Healthcare is to achieve Universal Health Coverage and sustainable development goals by ensuring equitable access to a skilled and motivated health worker within a performing health system.
51. Realizing the Vision of Georgia's human resources for health requires firm, accountable and consultative leadership, well informed by information and planning capacity, processes and tools. Most important is MoLHSA leadership to drive the process of change.
52. The stated goal of the Strategy is the improvement of the quality and capacities of human resources for health for current and future needs of the health system. Effective and high quality education and training must ensure that health care personnel is available in the right numbers with the right skills, values and competencies to provide both excellent clinical outcomes together with patient-centered care.
53. In order to ensure the commitment to deliver high quality health and health services and a smooth transition for patients between care institutions, the Strategy's objectives are aligned with and reflective of the national health policies, declared reform priorities and public health outcomes frameworks.
54. The following three general objectives were identified from the problem and challenges overview, to form the framework for the human resources for health strategy:
- A. Establish a governance framework responsive to the needs in human resources for health
  - B. Generate adequate, qualitative and quantitative, human resources in line with the needs of the health system.
  - C. Ensure sustainable financing for training, maintaining and developing human resources for health and efficacy management of medical personnel mobility

## **NECESSARY MEASURES TO ATTAIN THE DECLARED OBJECTIVES AND EXPECTED RESULTS**

55. Health system sustainability requires re-balancing many current particularities and making decisions based on population needs and reflect the evidence of the most cost-effective, efficient workforce arrangements to provide care, including shifting to primary health care and develop long-term and rehabilitation care. It will mean re-configuring the workforce and the education and training programs that prepare and support them.

### **Establish a governance framework responsive to the needs in human resources for health**

56. For strengthening the role of the national authorities, involved in governing human resources for health, it is envisaged to:

- a) Develop the normative framework to increase the role of the MoLHSA in management of human resources in public sector (strategic planning, controlling access to and maintaining in the health sector);*
- b) Implement Human Resources Information System as part of the National Integrated eHealth System;*
- c) Enhance the capacities of the Agency for State Regulation of Medical Activities (ASRMA) in the field of accreditation of post-graduate medical education, accreditation of health care institutions, health personnel licensing, etc.*

57. For promoting international collaboration in the area of developing and implementing policies related to human resources for health, it is envisaged to:

- a) Coordinate the activities in the area of human resources for health with the WHO and EU policies;*
- b) Promote bilateral agreements in the area of human resources for health;*
- c) Develop partnerships with international institutions involved health care workforce professional development.*

### **Generate adequate, qualitative and quantitative, human resources in line with the needs of the health system**

58. For developing and implementing an efficient mechanism for planning personnel in the health system, it is envisaged to:

- a) Strengthen a national approach to human resources for planning and forecasting by developing consistent and standardized consumer and needs focused methodologies and tools that can be applied at national and regional levels;*
- b) Establish the offer for medical and pharmaceutical education in the public sector using the developed planning tools based on health profiles, request for health care, health policy targets and institutions' development perspectives.*

59. For aligning the normative and institutional framework in the area of human resources for health to the EU standards and WHO recommendations, it is envisaged to:

- a) Review the nomenclatures of professional training and medical specialties and adapt them to the requirements set in the European Directive 2005/36/EC on recognition of professional qualifications;*
- b) Develop the legislative and institutional framework, through enhancing ASRMA, for implementing the licensing (authorization) of health care personnel based on five-year cycles;*
- c) Standardization of medical education, through instituting common rules system conformable to EU standards, for higher and middle personnel at undergraduate, postgraduate and continuous medical education levels;*
- d) Accreditation of the capacities for medical and pharmaceutical education, undergraduate, graduate and postgraduate, and strengthening state's role to control the quality of medical education to ensuring the education process with professional, competent, competitive, professionally and pedagogically trained teaching personnel and managerial staff and standards-conformable;*
- e) Review university and post-university curricula and align to the EU standards, including the topics related to rural health for enhancing the competences of medical professionals working in rural areas so as to increase the retention level;*
- f) Development and implementation of the new concept for Continuous Medical Education, including diversifying of the financing mechanisms, training providers and education forms;*

- g) *Improvement of the normative framework in the field of medical and pharmaceutical practice, including the adoption of the legislation in the field of medical malpractice and defining the conditions of health personnel liability.*

60. For adapting the medical and pharmaceutical education to the reforms in the field and international requirements, it is envisaged to:

- a) *Cover immediate and short-term necessities in senior and medium qualified medical staff in primary health care by developing, authorization and implementing a system of certification in family medicine through re-specialization based on a six-month curriculum and two-month curriculum for nurses.*
- b) *Ensure a sufficient flow of family resident physicians and students in medical studies, so that a proper balance of inflow and outflow of professionals in family medicine ensure the existence of an adequate staffing.*
- c) *Review of education in family medicine, both for doctors and nurses, by increasing the share of family medicine within graduate medical education and medical residency education, respectively within nurse training studies, as well as by improving the quality of Continuing Medical Education in primary health care.*
- d) *Cover immediate and short-term necessities in senior and medium qualified medical staff in the field of long-term care and rehabilitation care;*
- e) *Improve the mechanism of collaboration between the medical education institutions and clinical training bases for a more efficient and increasing the practical training of medical personnel;*
- f) *Develop of the system of the residency by position as a policy intervention to covering the necessities in health personnel in rural area and/or other regions with imbalances in the distribution of health personnel;*
- g) *Design and implement human resources component in the accreditation of the medical and pharmaceutical institutions as a policy intervention (i.e. quality indicators in human resources, etc.) to ensuring adequate management and standards conformable at institutional level;*
- h) *Develop targets and action plans for the development of nursing and midwifery, as an integral part of national health policies (Framework Program on primary health care organization and development, Universal Health Coverage Program and implementation*

*acts, etc.) that are reviewed regularly in order to respond to population-health needs and health system priorities as appropriate;*

- i) Implement educational platform based on e-Learning as part of National Integrated eHealth System.*

**Ensure sustainable financing for training, maintaining and developing human resources for health and efficacy management of medical personnel mobility**

61. For improving the allocation mechanisms for medical education and the payroll system in the public sector for medical personnel based on activity results and performance, it is envisaged to:

- a) Design and implement a payroll mechanism of remuneration for the personnel employed in the public sector based on duty salary and individual performance (The monetary and non-monetary incentives should be part of the general financing mechanisms and to not create parallel or additional allocation systems);*
- b) Develop and implement innovative mechanisms and diversify financial sources for undergraduate and postgraduate medical/pharmaceutical education.*

62. For reviewing the allocation mechanism and the volume of incentives to creating a motivation environment to retain personnel in the health system, with a focus on public sector, it is envisaged to:

- a) Include in all policy documents on health financing and service delivery the interventions that support incentives for recruitment, retention and strategies for improving workforce issues, such as remuneration, conditions of employment, career development and advancement, and development of positive work environments.*

63. For improving continuously the conditions for professional activity at the level of health facilities, it is envisaged to:

- a) Develop the health facilities accreditation system to ensure the conformity to the service delivery quality and performance standards (including staff volume thresholds, etc.) thus creating adequate working conditions, endowed with necessary medical technologies so as to equalize the conditions between different geographic areas;*

*b) Stimulate participation of private sector, based on public-private partnerships, in provision of public services according to the designed standards in the field (allocation of transport units to the family doctors and primary care nurses, provision with IT equipment to access the National Integrated eHealth System, etc.).*

64. For realizing the actions for managing the mobility of medical personnel, it is envisaged to:

- a) Implement the provisions of the WHO Global Code of Practice on the International Recruitment of Health Personnel;*
- b) Develop bilateral agreements with other states for monitoring the flow of medical workers, their working conditions, and professional development;*
- c) Design mechanisms for recruiting emigrated medical workers, by informing them about the vacancies in the system, working conditions and provided facilities;*
- d) Develop and implement distance learning platforms for obtaining the necessary qualifications and knowledge before returning to country and the possibility to get employed immediately.*

## **IMPACT ASSESSMENT**

65. Globally, the estimated impact is represented by improving access to health care for all and health outcomes through generating the needed workforce to meet policy and health needs, increasing flexibility, improving ways of working and productivity of the existing workforce, improving retention and productivity, and revitalizing aspects of education, training and research.

66. The Strategy implementation relies on current or designed allocations mechanisms, self-financing interventions and on the results of the public-private collaboration and do not involves additional financing from the public budget.

67. The assessed financial impact is related to ensuring sustainable financing of human resources for health through diversifying sources of funding and utilization of cost-efficiency interventions. The assessed non-financial impact shall result in the following: a sustainable and affordable health system delivered by a committed and well supported workforce;

increased equality in access to services to support improved population and individual health outcomes; and a durable partnership between health service providers and educators in preparing and developing the high-quality health workforce.

68. The monitoring of the general objectives shall be conducted on the basis of the outcome indicators, and the attainment of the Strategy goals shall be centered on the following impact indicators:

- (a) The ratio of physicians to nurses will reach at least 1:2.5*
- (b) The gap in the distribution of health personnel between urban and rural areas will have been reduced by 2/3 in 2019;*
- (c) At least 85% coverage with the primary health care workers*
- (d) At least 75% of medical and pharmaceutical educational institutions will be accredited by a recognized accreditation authority*
- (e) At least 80% of medical educational institutions will have reoriented their education towards primary health care*
- (f) At least 85% of health workers professionally licensed*
- (g) At least 75% of health workers are using National Integrated eHealth System on a regular basis in their practice*
- (h) At least 85% of health facilities comply with standards issued by accreditation authority.*

69. The successful implementation of the Strategy presupposes a firm political commitment, efficient and visible stewardship, provision with the necessary resources, a good management and planning, an efficient system of monitoring and evaluation at each level, as well as skilled staff. The participation and support of the social partners, non-governmental organizations, interested associations and community groups are indispensable. A significant role is played by the cooperation with the international structures, both in the form of technical assistance and attraction of investments from donors.

## STAGES OF IMPLEMENTATION

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

Stage I (2016 – 2017), comprising the following:

- a) develop and improve the legal and regulatory framework and other implementation tools;
- b) accelerate structural and operational changes in human resources for healthcare management;
- c) diversify financing sources for human resources for health management.

Stage II (2018 – 2019), will make an emphasis on:

- a) use of all tools that ensure the implementation of the interventions necessary for achieving the declared general and specific objectives.

71. The Human Resources for Health Development Strategy implementation relies on integration and coordination of several programs and policy interventions centered on the main issues, identified and defined during the process of Strategy development and highlighted in the present document.

72. Health, education, regulatory and accrediting authorities, employers, health researchers, professional associations, health industry and not-for-profit sector, must collaborate in planning, implementation and evaluation of reforms that will result in a sustainable health workforce.

73. Cooperation agreements from all partners of the Georgia healthcare system represent the essence of the Strategy implementation success. During the process of implementation, the Ministry of Labour, Health and Social Affairs will cooperate with partners from inside and outside the healthcare system and with a particular focus on academic society and professional associations. The Strategy implementation will be largely disseminated in mass-media means so that the whole population and the professionals in this field are aware of its goals and contents.



## REPORTING AND MONITORING ACTIVITIES

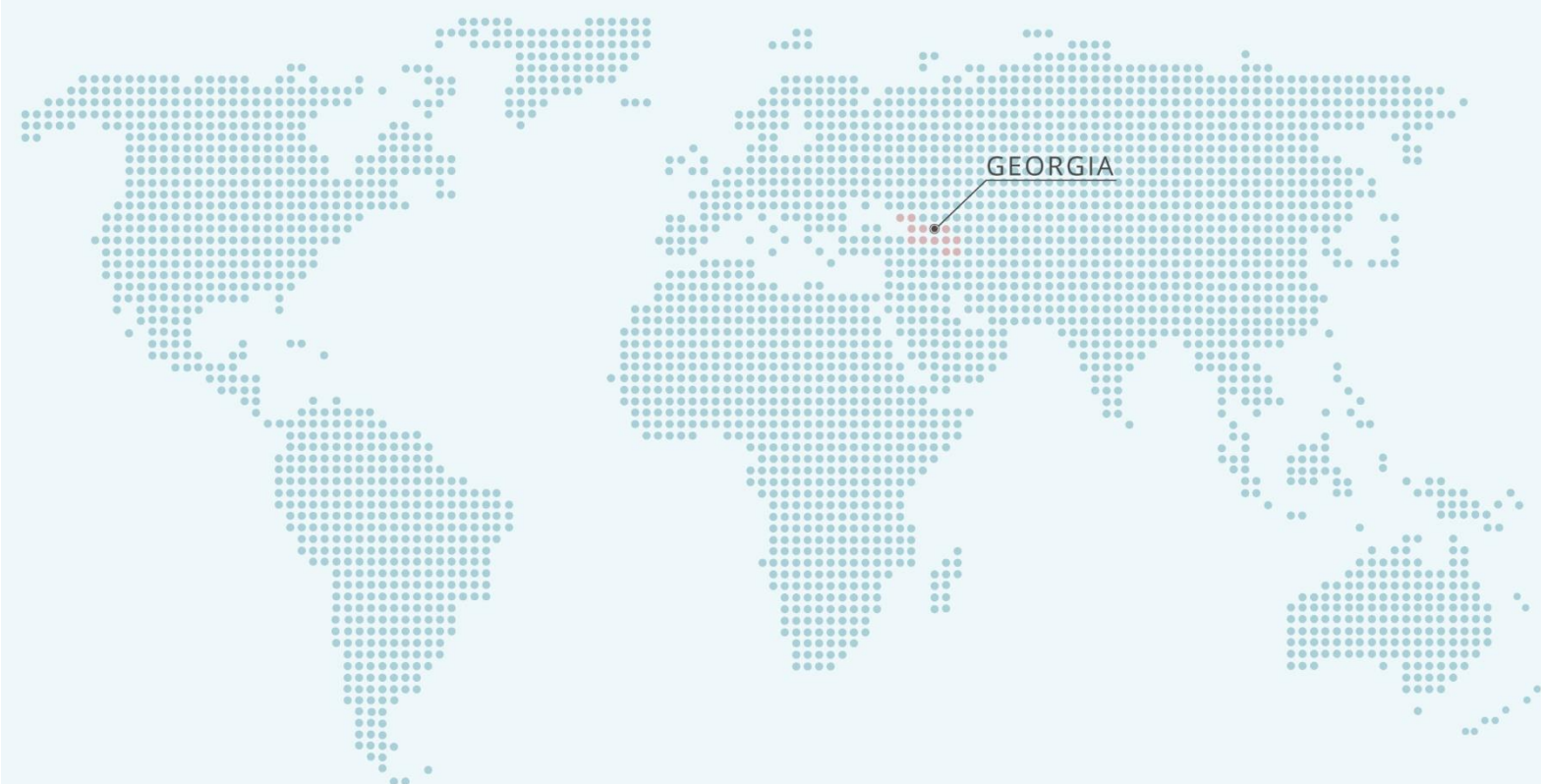
74. The Strategy monitoring activities shall be performed on a regular basis, conducted during the whole implementation period and shall include the collection, processing and analysis of monitoring data, identification of errors and/or collateral effects, as well as eventual corrections of content and form in the planned measures and activities. The monitoring shall be effected taking into account three sets of indicators (process, outcome and impact) that will allow supervising and assessing the achievement of the general objectives specified in the Strategy.
75. The process indicators will reflect the degree of completion of activities established in the Implementation Plan, outcome indicators will monitor the achievement of the specific objectives and applied measures, and the impact indicators will be used to evaluate the changes registered in the human resources management system.
76. The Strategy evaluation activity shall have a systematic character being carried out during the whole period of implementation and shall include the development of the annual progress reports, evaluation report after the first stage of implementation and the final evaluation report after the second stage of implementation all of them being based on monitoring indicators.
77. The progress reports shall refer to the outcomes registered at the respective stage of Strategy implementation – achievement of general and specific objectives, completion of planned activities, attainment of performance indicators specific for each type of activity and formulation of proposals for the improvement and correction of planned measures. The evaluation report after the first stage of implementation shall also contain the aspects of institutional, functional and structural improvements produced as a result of Strategy implementation, the impact on the health of the target groups referred to in the document, level of observing the implementation terms and content from the Implementation Plan by the responsible institution. In case of non-fulfilled activities, the reasons of non-fulfillment or partial fulfillment shall be specified and efficient measures for achieving the Strategy general objectives will be proposed.

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

## **Annex no.1 Implementation Plan of the Strategy for Development of Human Resources for Health 2016 – 2019**

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

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