DFID

PRIMARY HEALTH CARE DEVELOPMENT PROJECT

A. SUMMARY AND RECOMMENDATION

Background

1. DFID support for the development of Georgian Primary Health Care (PHC) began in 1997 and ended in August 1999. In conjunction with the National Health Management Centre (NHMC) in Tbilisi, the project developed a national Family Medicine (FM) speciality. (The NHMC was a branch of the Ministry of Labor, Health and Social Affairs, responsible for the development of Georgian PHC.) The end-of-project review in July 1999 concluded that the project had been successful. Achievements included**: (a) the establishment of capacity within the NHMC to train FM physicians; (b) the establishment of FM as a legally recognised speciality; (c) the development of training materials and curricula for the training of FM physicians; (d) the establishment of a licensing and accreditation system for FM training and FM physicians.**

2. The DFID project also formed an integral component of the World Bank Health Loan (Human Resource development) in Tbilisi, and enjoyed high levels of political support from both the Ministry of Labor, Health and Social Affairs and the Tbilisi Municipal Health Department (TMHD). In July 1999, the Georgian government approved a new National Health policy, which included an undertaking to improve the quality of primary health care services. The Minister of Health, Dr Jorbanadze, expressed his satisfaction with DFID support in this area, and requested further DFID technical assistance.

3. This project's purpose is to help the Government of Georgia develop a sustainable model of Primary Health Care based upon the principles of Family Medicine in order to improve the quality of, and access to, Georgian PHC. This will contribute to the project goal, which is to improve the health status of the Georgian population. The following outputs have been defined: (1) the establishment of family medicine demonstration sites; (2) the implementation of a sustainable and affordable financing model for primary health care; (3) increased MoH capacity to train PHC staff; (4) Development and implementation of population-based risk pooling in order to cover the costs of essential PHC drugs in the FM demonstration sites.

Recommendation

4. DFID should approve funding of £1.3million for a Primary Health Care Project in Georgia. The project is due to begin in August 2000 and continue for three years. The project will be implemented by consultants through competitive tender.

Justification

5. There is a clear need for support to the Georgian health system. The development of primary health care addresses this and fits into the Georgian government's strategy. It also links well with World Bank activities, and is an area in which the UK has a proven comparative advantage.

6. The break-up of the Soviet Union, a rapid transition to a "market economy", and the civil war have led to the virtual collapse of the Georgian economy. GDP per capita plummeted from about US$ 2,000 in 1990 to US$ 350 in 1994, with the subsequent rise (to US$ 984 in 1997) benefiting only a very small segment of society. World Bank projections show that economic growth would further benefit the same small segment of society and therefore have little effect on national health indicators. A recent survey showed that only 11 percent of the population are above the poverty line (now defined as US$ 23 per adult per month).

7. All key health indicators in Georgia have worsened. Thus, between 1990 and 1993, the Infant Mortality Rate (IMR) worsened by 13 percent to 21.4 per 1000 live births. The Maternal Mortality Rate (MMR) increased by 100 percent to 69 per 100,000 live births. The incidence of tuberculosis rose from 28.7 per 100,000 in 1998 to 105.2 per 100,000 in 1997. The number of diptheria cases also rose, from 28 in 1993 to 425 in 1995. For the period 1988-94, the overall age-adjusted mortality rate rose 18 percent. Note that this is also strongly linked to poverty (see table below).

Table showing morbidity and mortality rates for different income groups (1997)

Average income per month	Morbidity level per 1000	Mortality level per 1000
< 30 GeL	82	36
30 -50 GeL	27	27
> 50 GeL	8	2

8. The economic collapse also severely limited the government's capacity to respond to the population's needs. Since 1990, tax revenue has fallen by about 90%. Correspondingly, government expenditure on health fell to US$ 0.40 per capita in 1994. It was due to increase to US$ 16 in 1998, but has not done so and the level of government expenditure on health is a key condition of the World Bank's Health II Loan. In addition, health expenditure as a proportion of GDP was only 1% in 1997 (compared to an OECD average of 14%). This figure

includes central government transfers, local authority financing, and social insurance contributions, but not out-of-pocket payments.

9. There is also the very real issue of trust in, and access to, the Georgian health system. Low levels of trust in the system, have meant that people turn to privaet sources of health care supply. A recent UNICEF survey showed that 87% of total health system expenditure was out-of-pocket. This places the poor at a special disadvantage, adding to the vicious cycle of poverty and ill-health. This project aims to address the issue of access to the health systems by diverting resources into primary health care and away from expensive, specialised hospitals.

10. Indeed, the health sector in Georgia, as in other Former Soviet states, is characterised by severe disrepair, excess capacity (as reflected by occupancy levels of 28 percent with more than half the hospitals operating below 10 percent capacity utilisation level), and an emphasis on urban-based specialist care. The double impact of excess capacity and collapse in funding for this capacity make restructuring of the delivery system even more urgent in order to improve the quality and availability of the remaining, restructured services. The World Bank Health II Loan (due to begin in 2002) includes a radical hospital rationalisation programme. This project contributes towards that goal by establishing the foundations of a PHC system before the hospital rationalisation takes place.

11. The Georgian Strategic Health Plan has placed an emphasis on improving PHC and preventive health services, stating that “this will be achieved by shifting considerable resources to primary health care from hospital services”. The document identifies DFID as a partner in this process. The Georgian National Health Policy, approved by Parliament in July 1999, and an integral part of the Presidential Programme, identifies the development of PHC as a priority and the vehicle by which to improve equity, accessibility and affordability of health services for the population.

12. PHC also happens to be an area in which the UK has a comparative advantage. Firstly, the UK is well-regarded worldwide for its GP system. Secondly, DFID have and have had other PHC projects in the Transcaucasus region and in Central Asia.

B. PROJECT APPROACH

13. A logframe is attached.

Outline

14. This Project has been requested by the Georgian Ministry of Labor, Health and Social Affairs, and developed through collaboration with the Ministry of Labor, Health and Social Affairs, the World Bank, and the World Health Organisation. Note that the competence of the Georgian technical and official counterparts is very high, even if international experience of Primary Health Care (PHC) and health development is more limited. This Project Memorandum has been designed to incorporate comments and suggestions from the draft Project Memorandum.

15. The project will help to develop PHC through FM by implementing a new model of financing and provision in the four FM demonstration sites, evaluating the experience and the financial sustainability to enable a national roll out of the model through the WB Health II Loan.

16. The project's purpose is to help the Government of Georgia develop a sustainable model of Primary Health Care based upon the principles of Family Medicine in order to improve the quality of, and access to, Georgian PHC. This will contribute to the project goal, which is to improve the health status of the Georgian population. The following outputs have been defined: (1) the establishment of family medicine demonstration sites; (2) the implementation of a sustainable and affordable financing model for primary health care; (3) increased MoH capacity to train PHC staff; (4) Development and implementation of population-based risk pooling in order to cover the costs of essential PHC drugs in the FM demonstration sites.

17. The four outputs are explained briefly below:

(1) The establishment of family medicine demonstration sites

18. The five demonstration sites that have been selected are the five polyclinics in Tbilisi that took part in the first DFID project. They have been selected because they have the first cohort of trained Family Medicine physicians, and because of their strong orientation towards Family Medicine. Training at these demonstration sites will include rural physicians.

(2) The implementation of a sustainable and affordable financing model for primary health care

19. This component will explore the existing financing mechanisms in Georgia, especially those for PHC, and then examine further options for PHC financing. Issues addressed will include (a) possible roles for consumer contributions to health care, and (b) possible roles for public funds. It is likely that a compromise option of combined public and private funding will be examined. This component

ties in very tidily with the World Bank, who are studying options for financing of the health system as a whole.

(3) Increased MoH capacity to train PHC staff

20. The PHC team will be further strengthened through further training and development of the national FM training centre in Tbilisi and the Imereti, Kartli and Batumi regional centres. These regions were selected following discussions with the Government, an assessment of the regional poverty levels, and regional situational and institutional analyses by the project design team. Factors such as the presence of related DFID projects (such as good governance projects) and complementary donor activities (MSF, USAID) were also taken into account.

(4) Development and implementation of population-based risk pooling in order to cover the costs of essential PHC drugs at the four FM demonstration sites

21. A scheme to improve the availability of essential primary care drugs will be developed and implemented in the 5 FM demonstration sites through a reimbursement scheme. This builds on lessons learnt from the DFID financed, WHO drug reimbursement project in Kutaisi. The Kutaisi project showed how out-of-pocket payments can be harnessed to finance health services (and included a risk-pooling element to enable some redistribution from rich to poor). This component of the project will work very closely with the financing component. It will explore two key issues namely, (1) identifying the source of funds to be pooled to cover essential primary care drugs; and (2) how the providers (or drug suppliers) will be paid.

Other players

22. This project is intimately connected to the World Bank. Firstly, there are close ties with the World Bank loan on matters such as health finance where DFID and the World Bank are covering different sectors (the World Bank is working with the hospital sector, DFID with PHC). Secondly, it is intended that this project provides four PHC pilots which, when successful, can be rolled out under the World Bank Health II Loan due to begin in 2002. The Government of Georgia and the World Bank are both very keen that this should happen.

Beneficiaries

23. The expected beneficiaries from the project include:

- up to 2 million people in Tbilisi and the regions who will ultimately benefit from improved access to better quality Primary Health Care (PHC) once the primary care system is developed.
- the National Health Management Centre (NHMC) which will benefit from increased capacity to develop the Georgian health system, including PHC

- the National Family Medicine Training Centre (NFMTC) that will benefit from increased capacity to train PHC providers in both rural and urban areas
- Tbilisi Municipality Health Department (TMHD) which will be supported in its plans to strengthen PHC delivery in Tbilisi
- doctors from the regions and a further 24 from Tbilisi who will train as Family Medicine (FM) trainers
- up to 300 doctors who will train as FM physicians in the new PHC system
- the Government of Georgia who will benefit from popularity coming from PHC services that are free at point of delivery

Timing

24. The Project is planned to commence in August 2000 and will last for 3 years.