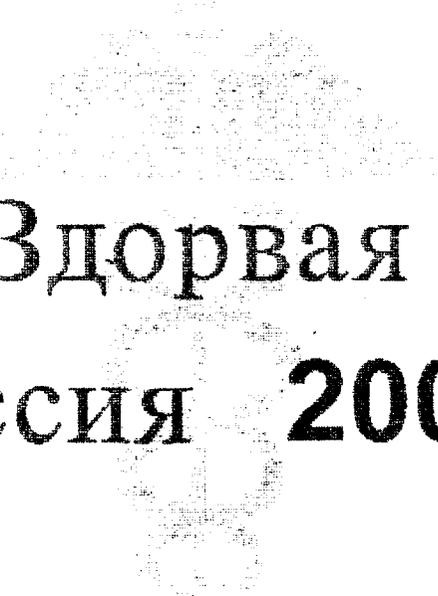


PD-ABP-264

TASK ORDER FOUR

FINAL REPORT



Здоровая Россия 2000

International Business & Technical Consultants, Inc.
45150 Russell Branch Parkway · Ashburn, VA 22011 · USA
Tel: 703-589-1900 · Fax: 703-729-2088 · Email: IBTCI@aol.com

February 28, 1995

A



International Business & Technical Consultants, Inc.

45150 RUSSELL BRANCH PKWY. ■ ASHBURN, VA 22011 ■ USA
TEL: 703-589-1900 ■ FAX: 703-729-2088 ■ EMAIL: IBTCI@AOL.COM

PO Box 16574
WASHINGTON, DC 20041

Mr. Terrance Tiffany
USAID/Moscow
Bolshoi Devyatinsky Per., 6
Moscow, Russia

Dear Mr Tiffany,

IBTCI is pleased to submit to you our draft final report on Task Order 4--Healthy Russia 2000 as per our terms of reference for this project. Attached are the report itself and supporting annexes including the deliverable report "Healthy Russia 2000". IBTCI is proud of its work on this task order and will be happy to answer any questions about the work or the report.

Sincerely,

Jayant S. Kalotra
President

cc: Mr. Walter Coles
Mr. Jonathon Hay

B

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HEALTHY RUSSIA 2000 FINAL REPORT

Executive Summary

The Healty Russia 2000 project, or Task Order Four, began in February 1994 to assist the Russian Privatization Center (GKI) in drafting a law on privatization of health-care institutions and pharmaceutical enterprises. It was to include: quick diagnoses of the current state of the Russian health-care system, and pilot privatizations of a local "pharmacy", wholesalers and pharmacies in two oblasts. The task order, however, evolved into different areas of emphasis at the specific requests of Mr. Jack LeSar of USAID and Mr. Jonathan Hay of GKI. After the submission of the report on Phase I on policy and privatization issues on the scheduled date of March 22, 1994, the direction of the Task Order was redefined. At the suggestion of IBTCI, AID/Moscow (Regional Office of Environment and Health) agreed with the Deputy Minister Dimitri Vasiliev that significant background information on the whole health-care institutions and pharmaceutical enterprises was needed before relevant and programatic policy and legal changes could be made. The Task Order was revised to include:

- a). Preparation of a white paper (subsequently entitled "Healthy Russian 2000") which was to serve as the platform for the executive branch of the Russian government to launch deliberations on health-care reform within the Duma. This initiative was to be a key political priority for the Presidency. As part of the white paper, a health-care financing model was to be created;
- b). a statistically relevant polling was to be undertaken for the first time in Russia to ascertain the opinions of health-care providers, consumers, administrators, employees and insurance companies;

c). projects were to begin to demonstrate the efficacy of the suggestions outlined in the policy paper and to form a basis for an anticipated major campaign to gain widespread public support for the reforms.

The three elements of the program were executed simultaneously in order to meet the stated needs of the GKI. The polling survey, completed in June provided a clear picture of the health-care opinions and priorities of the Russian people. This representative survey was the first to be used as a formulation for public policy. The health-care finance model provided new insight into the mechanisms of funding health care. This information provided valued inputs into the policy and legislative report (Health Russia 2000). The total report was presented in August 1994 to USAID/Moscow and GKI, it was widely praised as the most comprehensively prepared work for reform legislation that GKI had ever received.

The report was sent to the Duma for debate. Unfortunately, changes in the Duma's schedule delayed the consideration of health-reform legislation until early 1995. The impact of this delay, left the demonstrations on the pilot project out-of-phase with the earlier work, consequently the continuation of the pilot projects was tabled (while the Duma considered legislation).

In lieu of the demonstration program, a health-care administration training program was developed. This school was initially designed to teach a small group of twenty senior health-care administrators in the essentials of US health-care finance systems. Based on the response of participants and sponsors over 150 students attended these classes. Additional classes were therefore added to accommodate the request for more training and Russian health-care officials requested that the program be continued. A further shift in USAID programming priorities nonetheless resulted in a

lack of adequate US funding, and these classes became the last phase of the Healthy Russia Task Order.

SECTION ONE

Privatization Diagnostic Phase

Initial Assessment

The diagnostic phase for privatization of the health-care sector began in February 1994 with interviews conducted in the environs of Moscow and around the Russian Federation. Senior health-care officials, physicians, administrators and pharmacy operators were contacted in each survey area. IBTCI concentrated on investigating the organization and delivery of health-care services across the survey universe, including hospitals, pharmaceutical manufacturing, administration and retailing, insurance mechanisms, education and training for health-care providers, medical and pharmaceutical standards, and the potential for foreign sales and investment. Legal and regulatory frameworks were also analyzed and discussed with GKI officials and others, to lay an adequate basis for post privatization legal protection.

Phase One Report Findings

The diagnostic report was presented in March 22, 1994. The findings of the report can be found in Annex One. As requested by GKI, this report discussed the prospects for privatization across the spectrum of health care, including creation of not-for-profit trusts and direct private ownership of health-care assets by non-governmental organizations, and restructuring of nationally owned assets, into oblast and municipal corporations. The annexes to the diagnostic report included extensive interview notes, background discussions and recommendations on the hospital and pharmaceutical

sectors, as well as comprehensive supporting legal documents and a draft privatization law.

Transition

Based on the discussions of the diagnostic report, GKI decided to broaden the project considerably to include the restructuring of the entire health-care system. The Presidency, working with key health-care officials of the Duma, intended to make health-care reform a major political initiative in Russia's emerging democratic system. Accordingly, and unique to the USAID financed health-care project, GKI requested that massive public-opinion sampling be undertaken, including widespread polling of both consumers and providers, focus groups and media sampling, to determine the desire and support for health-care reform. This initial work was intended to form the basis for a campaign of public education to help gain widespread support for the potentially painful transition to a market-oriented health-care system. USAID/Moscow worked along with GKI in developing the broadened thinking embodied in the transitional phase. IBTCI participated as the implementing arm, and was made fully aware of the broad Russian political imperatives driving GKI's interest in health-care reform. GKI aimed for a completion date of the expanded project on September, 1994.

In carrying out the Phase I activities, IBTCI recognized that neither GKI, USAID/Moscow nor IBTCI had the complete knowledge and background of the Russian health-care and pharmaceutical sectors to prepare an exhaustive and authoritative draft privatization law. IBTCI requested USAID/Moscow to agree with GKI to the broadening of the scope of the task order.

SECTION TWO

The White Paper: Health Russia 2000

The Concept

The concept of "Healthy Russia 2000" was developed during April, 1994 by Dr. Jack LeSar, Regional Director of the Office of Environment and Health, of USAID/Moscow, working closely with GKI. The paper was to describe the current status of health care in the Russian Federation as well as recommend methods to improve these conditions to achieve a healthier population by the year 2000. GKI repeatedly emphasized the extremely high political importance which the Russian Presidency attached to "Healthy Russian 2000", and the expected schedule on which the project was to proceed.

The Process

The overall scope of this phase was to include three specific supporting tasks undertaken by IBTCI.

First, Boston Consulting Group (BCG) was contracted to study the health-care financing system of Russia and to develop a financing model. This descriptive model was to be used to study the current flows of funds for health care and changes for greater efficiency, effective care and broader financing options. New financing mechanisms were considered critical to the success of any substantial health-care reform.

Second, Young and Rubicam and Tarrance Group (YR/T) were contracted to conduct nationwide

public opinion sampling on the attitudes of both health-care providers and consumers. The findings of this sampling including polls, focus groups, and media analysis -- the first of its kind within the Russian Federation. This work would then be incorporated into the paper and used to develop the recommendations for future policy actions, reforms and public education. GKI especially wanted to know which segments of Russian opinion were likely to support health-care reform, and which were liable to oppose it. Decisions on future strategy in the reform effort could then be made on the basis of the unequaled public opinion information made available to the Russian Federation.

Third, privatization pilot projects were to be undertaken in carefully selected hospitals, polyclinics and pharmacies. These pilot projects were intended to demonstrate graphically, the practical real-world successes that would occur if the expected privatization reform recommendations of the project were implemented. GKI specifically indicated that it wanted pilot projects selected that could be used to help demonstrate to the Duma members of the advantages of the health-care reform program.

IBTCI, directed the program and integrated the input into the white paper. Additionally, IBTCI began the development of a nationwide public education campaign. Work proceeded at a fast-paced and highly accelerated rate in order to meet GKI's deadlines, which were, in turn driven by the expected Duma consideration of health-care reform in the Fall of 1994. The public education campaign, which was to begin in anticipation of the Fall Duma debates, would have been a nationwide project. The public education campaign would also be used to increase the general public's awareness of the state of their health-care system, and show that the simple market-oriented improvements and reforms could make for significantly improved health-care quality.

The process of writing the white paper was undertaken by a group of experts who researched and

wrote specific sections over the course of two months. Within this highly accelerated schedule, as noted above, both Russian and international Russian health-care experts wrote sections relevant to their respective areas of expertise. These sections were expanded with the findings and recommendations derived from the financing model and the public opinion surveys. The Task Manager, responsible for the white paper, unified and edited the entire document and its annexes. The paper was translated into Russian, and initial excerpts as well as verbal presentations of the findings, were presented to both USAID and GKI for comment in July. Based on the comments received, the paper was further revised and the final document with annexes was delivered ahead of schedule - August 1994.

Findings

Amidst the blizzard of policy papers descending on Moscow, "Healthy Russia 2000" was unique. It concluded that reform of the health-care system in Russia was already underway, however, with wide regional and sectoral differences both in the nature and progress of reforms. Accordingly, any policy discussions and recommendations could only be taken as part of an evolving, ongoing process. No single policy "prescription," no universal of public opinion and no single econometrics model could describe the ongoing health-care reform. Therefore, Healthy Russia 2000 was a working paper that presented clearly the reform that were already started in each region of the country, and how this process could be divided and amplified to provide universal health care for the Russian people.

In Section I: "Healthy Russia 2000" set forth a vision of the future of Russian health care: Today, there exists the possibility of achieving (1) meaningful universal access to health care; (2) enhanced, efficiently-provided health service in a cost-effective manner; (3) increased consumer choice and

competition among health-care providers leading to (4) better health and greater satisfaction for the people of Russia. These objectives could be realized while placing emphasis on the primary components of health care: prevention, early detection of disease, treatment and rehabilitation. Some aspects of health care, e.g., specific pharmaceutical manufacturing, distribution and retailing can be privatized entirely. Other aspects, such as hospitals and polyclinics, will have more diverse possibilities, including continued national ownership, transfer to local-municipal control, management by not-for-profit organizations or outright privatization.

Section II: This section described Russia's current state of health, which, in short, is not good. Compared to OECD countries, Russians have shorter life expectancies; higher illness and mortality rates among working age persons; higher infant mortality rates; and a general weakening of the population's immune system because of environmental pollution, alcohol abuse and allergies among youth. The birth rate has decreased, the general mortality rate has increased, and the population is aging. The young, women and the elderly are particularly vulnerable, and men have the lowest life expectancy in any European country.

In Section III: "Healthy Russia 2000" examined the current state of the health-care system, especially available resources, in light of the health problems previously described. Significantly, the causes of many of Russia's health-care problems are manifestations of the overall difficulty of the transition away from prior central control, structures and practices. Institutional resources, such as hospital facilities, are in relative over-supply, while their physical condition is poor. The numbers of physicians and nurses are high, but their talents are not well utilized often being spent on menial, non-medical tasks, and their pay and morale are low. Shortages of medical equipment are serious, aggravated by shortages of funding to purchase new, higher-quality equipment. The supply of pharmaceuticals is

far below essential levels. Plants are obsolete, production expertise for many drugs is lacking, and product ranges are outdated. The distribution of pharmaceuticals is one of the most serious problems in the entire health-care system, and will need significant restructuring.

Health care has been historically under funded, and national budget constraints have only grown worse. The Compulsory Medical Insurance law ("CMI") is in the early stages of implementation, and private payments are still a small percentage of the total expenditures for health care. As a result, real expenditures for health care are falling. Thus, the present system suffers from insufficient public funding, and yet also fails to attract private resources in sufficient quantities to meet aggregate needs. Brief analyses of the Dutch, German, British, Swedish and American health-care systems were provided to allow readers and decision makers to compare the existing Russian system to possible alternatives.

Section IV: This section described the results of the first systematic effort in Russia at consumer and provider polling on health care. Opinion is widely divided on the adequacy of existing health care and the need for reform. Younger, better-educated people tend to be more dissatisfied with the present system, and more ready to pay for increased care, compared to older, less-well-educated Russians who tend to prefer the system as it is. Wide regional variations also exist. Providers seem quite aware of the possibility of insurance, but consumers are far less informed. Despite existing public-information campaigns intended to improve lifestyles and thus health, very little real change in behavior has occurred. Nonetheless most Russians are optimistic about the future of health care, and there is a large, but still a minority that is supportive of major reforms in the system.

Section V: This section describes a new approach to Russian health care, stressing that increased

efficiency and competition can allocate scarce resources more effectively, especially since total resources available for health care are not likely to grow to any extent in the near future. Preventive medicine and increased consumer choice should be stressed. The pharmaceutical manufacturing, distribution and retailing industry should be privatized, and new local-government, not-for-profit and for-profit hospitals and polyclinics should be established. The CMI system must be made to work better, and sources of private financing need to be thoroughly explored.

Section VI: This section put forth concrete steps to implement the new approach, some of which are already underway. Additional steps can be undertaken immediately, and some others will have to await the outcome of the general debate on health care expected in the near future. Substantial new laws and regulations will be needed to shape the new private and local-government institutions that will be created, and prevent the creation of new monopolies. Financing remains difficult, but steps must be taken to preserve meaningful access to universal care. Increasing workforce training and maintaining the quality of care are critical. Major work is needed to reshape the pharmaceutical industry, especially distribution. More effective public-education campaigns, for both consumers and providers, are essential to the reform program's success. Finally, a Presidential Commission will create stronger public support for this major undertaking.

Reaction to "Healthy Russia 2000"

Both GKI and USAID/Moscow were strongly supportive of the conclusions and recommendations of "Healthy Russia 2000". The project was undertaken with the understanding that the urgent need for the work was to support the scheduled debate of health care in the Duma. This schedule was changed after the completion of the Healthy Russia 2000 report. Debate has now begun and this

report is the center-piece of those discussions.

However, nearly a year has passed since the work on the report was completed. In view of this delay, the demonstration of the pilot project was left unsupported, and consequently was changed. The following sections describe the work done in the pilot phase that supported the white paper. Section Four describes the health-care administration training program that replaced the pilot program.

SECTION THREE

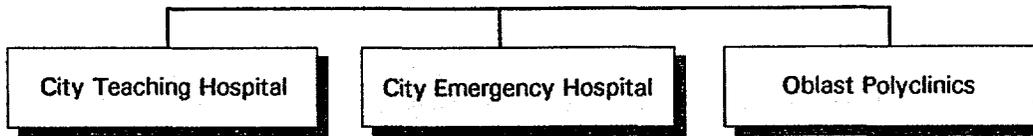
Pilot Projects

Pilot Site Selection

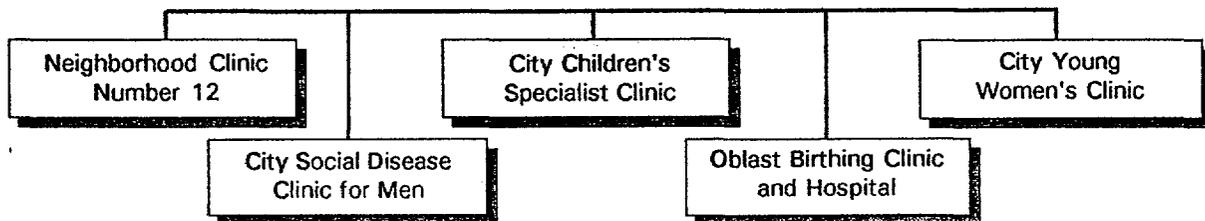
The selection of pilot project sites began simultaneously with the writing of the white paper at GKI's specific request. The pilots were chosen by IBTCI based on sites which could show the most improvement in the short period of time allotted. The instructions from AID were to choose two sites that a task order team could visibly improve to show reform to the public. This was found to be too expensive and time consuming. GKI then provided a new directive to demonstrate reform from within one institution through physical and procedural changes. The object was to get a positive reaction from health-care workers and health-care related bureaucrats. This was determined to be pilot project one. Another institution was to be chosen to show reform concerning environmental changes and increased patient comfort. This objective was to get positive responses from patients and visitors. This was determined to be pilot project two. Business education was to be coordinated with each project. This education and the work in the institutions were considered part of the reform program. One third of the proposed pilot project sites were chosen by AID, one third by GKI and one third were chosen based upon IBTCI's Dr. Robert Hay's site interview reports for the Healthy Russia 2000 paper. The sites visited were:

VISITED SITES:

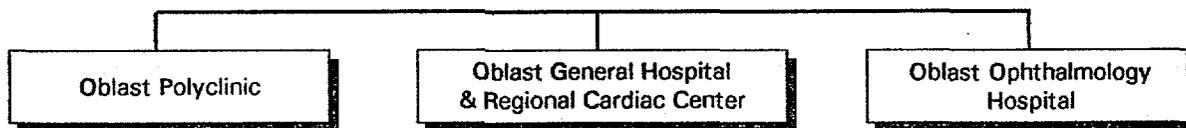
KEMEROVO:



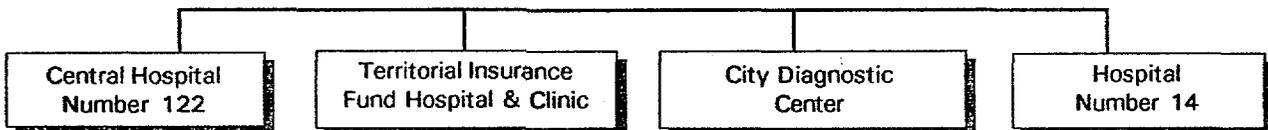
NOVOSIBIRSK:



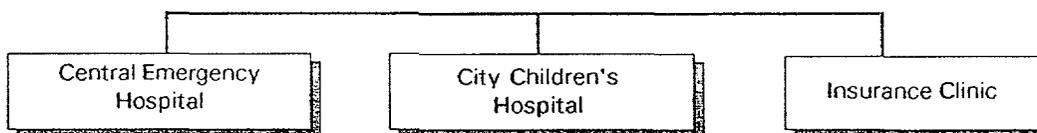
VLADIMIR:



ST. PETERSBURG:



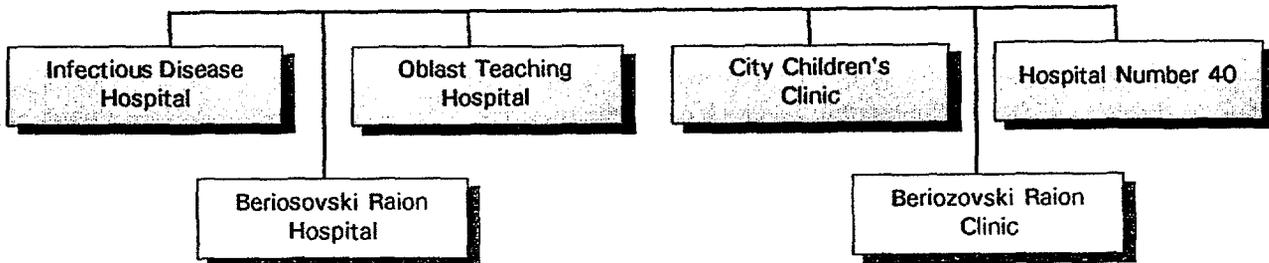
YAROSLAVL:



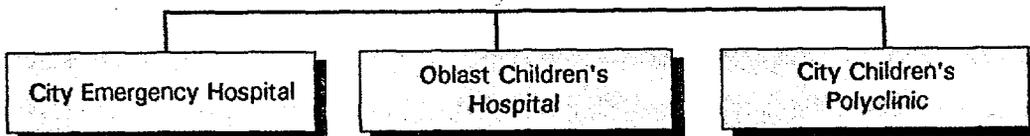
SAMARA:



EKATERINBERG:



TULA:



IBTCI examined **forty health-care institutions and insurance organizations**, and asked the administrator of each facility a specific set of questions. The basic health-care and facility structures were always reviewed.

QUESTIONS GENERALLY ASKED BY IBTCI INTERVIEWER:

- A. What is the average length of stay?
- B. What is your average census?
- C. What are your top three health-care problems?
- D. How do you purchase your consumables?
- E. Do you have a fully functioning pharmacy?
- F. Do you have a fully functioning warehouse?
- G. Please explain your table of organization.
- H. What relationship do you have to?
 1. Other clinics
 2. Other hospitals
 3. Diagnostic centers
 4. The Territorial Insurance Fund
 5. Insurance companies
 6. Health-Care Committees (City and Oblast)
 7. The Ministry of Health
- I. Please explain your cash flow.
- J. Do you need our help?

IBTCI always toured the facility, and always asked to see a ward, the operating room, the pharmacy, medical records, warehouse and outpatient clinics. The interviewer never made a negative comment while interviewing the officials or staff, or touring the institution, and there were never any promises or commitments. Usually refreshments or lunch were served, which gave time for the interviewer to

have informal talks with several key people of the institution.

VLADIMIR

One site chosen was the Vladimir Oblast Regional Hospital, which included polyclinics. With the collapse of the centralized Soviet system, the Vladimir hospital lost its pharmacy purchasing and storage system. The business system was left incomplete and the warehouse stopped functioning because purchasing and centralized materials management dissolved. A staff physician with no business experience was elected as head doctor, which is typical of most of the hospitals in Russia. The Oblast officials, the health-care committee members, the Head Doctor, and the senior staff of the hospital had a very positive and cooperative attitude. This positive attitude of the people, plus the condition of the pharmacy and the warehouse, made Vladimir a good choice for pilot project one. IBTCI believed that a positive response would be given by the people involved if they were shown physical and procedural reforms which had a visible impact on their work.

A memorandum of understanding was created between IBTCI experts, the Vladimir Hospital and the Oblast Health-Care Committee. This memorandum was written to provide common grounds and understanding, and it was reviewed and verbally approved by USAID/Moscow.

Nursing

The nursing service in the Vladimir Oblast Hospital was on the same standard as most Russian Hospitals. Nursing assumed housekeeping duties as well as general nursing responsibilities. Nursing services were substandard when compared to western standards, but do well with what they have. A significant amount of time was spent by an IBTCI nurse, evaluating the hospital nursing services.

She spent time in every nursing department of the hospital and attended various nursing meetings. A general feeling for what she would be able to contribute coupled with an evaluation of the potential resistance helped her form an opinion.

IBTCI decided to concentrate on the areas of sterility and basic education, because post-operative and post-maternal infection rates are quite high in Russian hospitals. Open windows and flies in the operating rooms could be an obvious source of infection. Any corrective action suggested, however, was not necessarily well received by hospital staff members. Operating rooms in Russian hospitals do not have forced ventilation, for example, and the operating room staff wants open window ventilation in the summer. The windows are closed in the winter to prevent heat loss. Suggestions to correct the situation were ignored. A new approach that did gain acceptance was in the area of general education by symposium and translated educational materials.

SYMPOSIUMS HELD AT THE VLADIMIR OBLAST HOSPITAL:

1. Aseptic Technique
2. Surgical Attire
3. Disinfection
4. Surgical Hand Scrubs
5. Sanitation in the Surgical Practice Setting
6. Sterilization, Steam and Ethylene Oxide
7. Universal Precautions in the Preoperative Practice Setting

Pharmacy

The pharmacy in the hospital did not function, although a small, private kiosk pharmacy did exist and partially provided outpatient needs. Before the start of Pilot Project One, pharmaceuticals were purchased on a daily basis by a nurse in each ward. The drugs were brought back to the hospital ward and placed in a common box. No records were kept except for controlled drugs, and there was no inventory, no real security, no usage figures and no system for expiring drugs. Drugs disappeared from the wards on a regular basis. With no systems or security in place, there was no way to control theft or spoilage. Without usage figures, bargaining with the drug supplier for better prices was impossible. Credit from the drug supplier was necessary and seemed to be the determining factor in purchasing.

IBTCI evaluated the situation, and decided that because of limited time and initial resistance, the central pharmacy would not be addressed. Each ward of the hospital would be approached as a separate unit, and pharmacy cabinets with additional storage area were designed. These cabinets are designed as stand-alone units, with special pharmacy inventory control. IBTCI designed the cabinets and had them approved by pertinent hospital staff. With the help of the hospital chief engineer, IBTCI drew up the plans for cabinets, and a local furniture factory was contracted to build them. A sample cabinet was produced and approved. Production lasted about one month. While the cabinets were under construction, an emergency box program was started.

The hospital was not equipped with emergency carts, because there was neither equipment nor funding for them. Emergency boxes were purchased for each ward. The boxes were created to be the best alternative to a crash cart. Each box was clearly labeled, and a drug inventory was kept in

each box with a few necessary medical items. Emergency procedure booklets were translated and kept in each box. A security clip was used to keep the contents of each box safe from pilferage.

To give the hospital and each ward a means of inventory control and a proper purchasing system, procedures for pharmaceutical purchasing were written. Time did not allow IBTCI to work directly in purchasing and inventory control. A counterpart from the hospital was hired and trained by IBTCI to maintain the system as it was created.

Materials Management

A materials management system has not existed at the Vladimir Oblast Hospital since the breakup of the Soviet central supply system. To create a materials management system a functioning warehouse must exist. IBTCI examined the existing warehouse on the Vladimir Oblast Hospital Compound. The warehouse was not adequate for storage of hospital supplies. The last repair work was completed in 1954. The roof leaked, windows were broken, doors were falling to the ground when opened, exterior plaster was in disrepair, lighting was inadequate, shelving was unsafe and insufficient, and the office consisted of one old table. The building was being used as a storage area for oversupplied goods and expired goods. The place had been broken into several times making security inadequate.

IBTCI evaluated the situation. How can a materials management system be initiated without a warehouse? The decision was made that it cannot. Meetings were held with the head doctor and the hospital chief engineer.

MATERIALS MANAGEMENT DECISIONS MADE & CARRIED OUT:

- A. The warehouse had to be refurbished.
- B. The pilot budget was not adequate for the estimated costs of repair. IBTCI will be responsible for some repairs but IBTCI will neither negotiate nor contract directly with the subcontractors. The hospital has that responsibility. IBTCI will fund directly to the hospital after evidence that work was completed.
- C. The chief engineer was hired as a counterpart. He is to oversee the project for both the task order and the hospital.
- D. Target dates were set for the completion of sub-projects.

The materials management program progressed, but much more slowly than expected. The warehouse modifications were constantly delayed because of problems with the subcontractors. The last project, creating new iron shelving and reinforcing the old shelving, was completed on September 30. Because of termination of the Task Order the inventory systems could not be overseen by IBTCI. IBTCI wrote policy and procedures for materials management and a manual bin card system. The warehouse lighting problems were personally fixed by IBTCI. It also placed a complete set of office furniture and filing cabinets in the warehouse office. The warehouse is now set for a complete inventory system.

A Counterpart Program was established for the Vladimir project. Three people were chosen to be trained in the reform programs. They also had the responsibility to help the team whenever possible. One person was chosen from the Engineering Department and two were chosen from the Nursing Department. Their salaries were supplemented by a small monthly stipend from Task Order funds. Hiring people from outside the hospital would have cost more. Hospital experience was needed

because the systems installed required certain basic health-care knowledge and experience.

Business Education

The Vladimir Oblast Hospital needed business education. The Head Doctor was competent but needed some basic hospital business education. The general budget for running the hospital was known, but the costing of designated areas or services was not known. Department Budgeting is almost unknown. Financial forecasting was impossible. Educating the staff in business systems for hospitals was difficult since some necessary positions were not planned and staffed. The hospital did not have a purchase officer, a materials manager, a centralized pharmacy, an office to handle insurance or a central sterilization and supply department. The best answer to all problems is a formal education system with follow up on site inspections. This will be addressed in the Yaroslavl section of this paper.

On June 17, 1994, IBTCI was a guest speaker at an education and appreciation seminar to three hundred oblast physicians. A brief talk was given on the USAID's sponsorship of Task Order Four and its purpose. Following the talk was a question and answer session on comparative western and Russian health-care organizations and types of western health-care financing. A dinner followed the meeting that included many discussions on health-care business systems.

All documents, labels, lists and reports in the nursing, pharmacy and materials management programs prepared by IBTCI for the Vladimir Oblast Regional Hospital are in Russian. Translators and interpreters were used in every meeting, class and seminar.

ST. PETERSBURG

The second site chosen was Hospital Number Fourteen in St. Petersburg. The hospital has a majority of geriatric patients and performs some heart surgery. The building is old and in poor condition. Patient comforts are grim at best. The Head Doctor and Head Nurse were very cooperative and appreciative of any assistance given. A proper pharmacy did exist, and the warehouse structure was basically sound. The lack of patient comfort and general condition of the hospital made it a good candidate for Pilot Project Two. IBTCI felt that this facility could show maximum results with minimum investment. It would be easy to show a change in physical appearance and easy to improve patient comfort.

The approach to Hospital Number Fourteen was different from Vladimir. The results of reforms at St. Petersburg were to be realized by the patients and their visitors. Physical changes in appearance and improvement in patient comfort in addition to the creation of business systems are the goals of the pilot project at this site.

The first part of the program was to address patient comfort. In the geriatric patient rooms reading lamps were purchased and placed. New long term mattresses were placed in some rooms. These mattresses reduced the bed sore problems common in the long term geriatric patients. Wheelchairs were purchased and assigned to certain rooms. Transport of non-ambulatory patients was a real problem. Patient care for them was constantly delayed because of lack of transport. Because patients did not have any form of diversion or entertainment, televisions of different sizes were purchased and placed in the common areas. Light bulbs of various sizes were bought and given to the engineer to place in the hospital to ensure that the hospital would have adequate lighting - over half of all the light

bulbs in the hospital were missing or burned out.

Nursing

IBTCI studied the hospital and decided that mutually agreed upon education and seminars mainly in the geriatric area should be given. One example of these seminars was a series of professional tasks given to the hospital fourteen nurses, as well as nurses from other area hospitals. Several professional booklets were translated, copied and distributed.

IN-SERVICE CLASSES TOPICS:

1. The process of aging
2. Nutrition
3. Medication
4. Diseases and conditions
5. Infections
6. Mobility and activities

(These classes were all oriented to the geriatric patient.)

Material Management

Creating a materials management system was not difficult a task as in Vladimir. The existing warehouse for Hospital Fourteen was structurally sound and in good repair. However, finishing work had to be done through the building of proper shelves. The warehouse was being used as a storage area for building supplies and trash. The needed work included floor leveling and

painting. Also, painting the inside walls needed to be done. Shelving was contracted separately. IBTCI drew the plans and installed proper location codes. The needed work was contracted through the hospital and completed on September 26.

Pharmacy

The Pharmacy in Hospital Fourteen is in good condition and functioning well using a manual system. IBTCI introduced and created an automated system. This included purchasing a computer, a printer and appropriate software. The software includes an inventory system which will help them identify fast moving drugs, monthly drug usage and other important line items of information. Purchasing can now be performed in a much more efficient manner. No such information was used before the installation of the system. Russian hospitals in general manually log all information into books or ledgers. They do not draw statistics or any useful information from these books. They seem to be kept just for some type of accountability. The new automated system is in Russian. The system was installed and running and the people were trained before the task order pharmacist left the site.

EKATERINBURG

Ekaterinburg was selected and approved by USAID to be the site for Pilot Project Two. A raion (region) in the Ekaterinburg Oblast was selected only twenty miles outside of the city of Ekaterinburg. The hospital was selected because of the recommendation of the Chairman of the oblast Health-Care Committee. He said that both the head doctor and the deputy were very progressive thinkers and would be cooperative. The hospital was ideal because it was the main hospital in this raion and has just over 200 beds. This is one satellite referral clinic and a one hundred bed pediatric hospital which are under supervision of the main hospital.

The idea of the Ekaterinburg pilot project was to create an actual working private system within the hospital. This system would contain the standard materials management system, accounting systems a centralized pharmacy with proper pharmaceutical storage, inventory control and purchasing procedures. The hospital is already working with the Territorial Insurance Fund and an individual insurance company. However, there are problems with reimbursement rates because the figures on some disease indexes cares are incorrect and under funded while others are incorrect and over funded. The health-care system located within this raion was ideal for major business experiments with overall system changes and systems management. The reason for these ideal conditions are:

- 1.) It is politically out of the way for both the oblast and federal governmental authorities.
- 2.) This system exists in a completely controlled environment.

Material Management

The materials management system overhaul was relatively easy. The storage areas already existed. A few minor modifications of the warehouse storage area was needed. Additional shelving, which allowed for a bin cart materials management system was created. This facility has a designated materials manager, even though he did not function as in the western world. When Task Order Four was shut down, the warehouse was complete with a shelving system and bin locator carts in place. It also had the policy procedures for materials management and partial education of the designated materials manager.

Pharmacy

The pharmaceutical department was only recently reviewed and there were no hands on consulting with the Task Order Four pharmacist. The Task Order Four obligation did not allow enough time for her to go there and set up a system. She remained working at both the St. Petersburg and the Vladimir sites. The hospital did have a centralized pharmacy with a pharmacist working in the pharmacy. Buying pharmaceuticals was a little more controlled than the other facilities, but a big gap in training and education in more efficient methods existed.

Nursing

The Task Order Four Nurse did work with the staff of both the main hospital and the children's hospital. The educational talks still centralized around sterile techniques in the birthing rooms and the operating rooms. Translated manuals were discussed in a seminar type setting with almost two

weeks of part time classroom training.

Business Education

The Task Order Four Team Leader met with the head doctor and his deputy several times both in Moscow and Ekaterinburg. Joint commission standards were discussed. The purpose of materials management was explained, as was financial management. Financial management was discussed in four sections. First, how to set up basic bookkeeping for a private hospital. Second, how to relate that bookkeeping into disease index pricing on a Diagnostic Related Groups (DRG) type system. The head doctor and his assistant were shown how to project and create annual budgets, what insurance was, and how to work with insurance companies and the Territorial Insurance Funds. There was an agreement to create a pharmaceutical company which was an example of true privatization in the pharmaceutical business. There was only one drug company supplying the hospital with drugs, and it was a company which was owned by the Ministry of Health. When this company learned of the possibility of a private pharmacy going up in the Ekaterinburg area, there was subtle hints that drugs, which the hospital needed, may not be offered to the hospital in the near future if competition was created.

The head doctor and his deputy are ready to not only overhaul the existing system, but also to experiment with true privatization, not just in the pharmaceutical area but also in patient care both at the clinic and hospital levels. The ideas discussed in reform and privatization will work when the timing is right. Unfortunately, right now the timing is not right. The funding for health care in that raion has been drastically reduced. More than half of the industries in the area have been closed, leaving unemployment at about sixty percent. The forty percent who are working are supporting not

only the sixty percent who are not working but could work but also every person in that raion. The income per patient day while Task Order Four was there working with the hospital was less than five dollars per day compared with seven dollars at other hospitals in other oblasts. This five to seven dollars covers all costs (labor, consumables, pharmaceuticals and some capital equipment). If there was a weakness in Task Order Four it had to be that there were limits of what could be done to health care with such limited funds. When the economy of Russia finally does start improving, then projects like Task Order Four could make dramatic changes in health care by working directly with chosen hospitals. With the current state of economy the best suggestion is the continuation of classroom education.

TULA

In July of 1994, IBTCI's entire pilot project team went to Tula. Tula is an industrial town about four hours drive south of Moscow. This visit was AID directed to study health-care institutions and specifically the Territorial Insurance Fund which was newly formed. This trip was unusual because the visits to the hospitals and clinics were through the Territorial Insurance Fund instead of the Health-Care Committee. An eleven hundred bed emergency hospital, which served the entire oblast, was toured. Extensive discussions were held with the hospital director about the hospital's responsibility and area of coverage. IBTCI decided not to consider the emergency hospital for Task Order Four because of its size, its complexity, and its very poor condition. It was apparent that some walls were on the brink of falling away from the building and even the operating rooms had cracks through which daylight seeped through. The medical practice was considered to be substandard because of lack of nurses and lack of proper equipment, drugs, etc.

The Pediatrics hospital and clinic was visited second. These institutions were the opposite of the last institution visited. They were extremely clean, in a very nice building, had up to date equipment, proper staffing, a very good patient flow layout, and seemingly competent physicians treating the children. The referral from outpatient clinic to inpatient was good. Supplies and pharmaceuticals were adequate, and the Head Doctor seemed to have a good grasp of hospital administration. IBTCI decided not to work with this hospital because of little possible impact it could make with the limited funds and time available.

IBTCI spent several hours with the Territorial Insurance Fund people studying structure, cash flows, sources of revenues, disbursement of revenues, conditions for disbursement of revenues, banking, and

oblast and federal regulations. Discussions on related computer hardware and the formal structure of the insurance companies and the Territorial Insurance Fund were held. A chart included in the report shows, in detail, the source of funds to health-care facilities in Russia, source of funds to health-care facilities in Russia, an outline of the composition of the Territorial Insurance Fund Board of Directors, and members. The Director and Assistant Director of the Tula Territorial Insurance Fund had already met with an HMO specialist in a previous meeting which was financed by another lender. They, like most of the insurance structures, specifically HMO's and PPO's, wanted further education in this area and requested that IBTCI bring in an HMO specialist from the United States to help them complete their project of creating an insurance organization. IBTCI did return to Moscow and submitted proper paperwork requesting an HMO specialist. Verbal approval was given but USAID did not extend the Task Order and the HMO specialist could not be provided.

SAMARA

IBTCI visited Samara to survey the health-care institutions in that oblast and met with the Head of the Health-Care Committee for the oblast. Upon arrival, statistics were reviewed, and two health-care institutions were visited. A women's and maternity hospital and an excellent diagnostic clinic were toured. As the visits went on, it was obvious that health care in Samara was supported by more revenues than in the other oblasts previously visited. Samara's institutions and their systems proved to be good. In a four hour session with the Oblast Health-Care Committee, it became obvious why they were so far ahead of the other oblasts. Samara, independently has created Diagnostic Related Groups (DRG's). Their reimbursement systems to the hospitals were based on these DRG's. The DRG's were not just general disease index DRG's, but were related specifically to neighborhoods of the oblast. Their pricing was unique and covered hospital neighborhoods. Samara is so far advanced in this DRG system that they have already closed five thousand beds because patient stay was shortened from twenty-two days to fourteen days. They were receiving the same amount of money as other oblasts, but since they reduced their number of beds it gave them more revenue per bed. The result was they had more supplies, higher wages, and a better supply of pharmaceuticals than the other oblasts visited. IBTCI was so impressed that it requested that the Head of the Health-Care Committee speak to the GKI and consider teaching the DRG pricing method to other oblasts.

Transitional Phase

Task Order Four pilot projects were very successful in achieving their limited objectives. IBTCI worked directly with health and insurance institutions and key people of those institutions. The program was one-on-one training on a per hospital basis. This personalized method made the

program successful. However, after reviewing the work between June and September of 1994, IBTCI re-evaluated what it had achieved. A considerable amount of time was needed to get the Russians adjusted and educated in the reform process. Those Russians who had worked with western contacts saw for themselves the benefits of reform. They still had to learn what the new procedures meant to them and their institutions. These people had to realize IBTCI's technical assistance was instructional, not a charity or a government hand out. The hardest part of the assignment was creating a trusting working relationship. The formation of this relationship took the longest period of time. The hands-on approach of introducing the client to new services and methods was positive, but not necessarily realistic. The only real way to approach such a wide and monumental program with a limited number of people is in classroom education. There are not enough people in any task order to work with every individual hospital in Russia on a one-on-one basis.

The transitional phase was between initiated pilot projects and the classroom education. During this transitional period, IBTCI held its final meetings with the Head Doctors of Vladimir, St. Petersburg, and Ekaterinburg. These meetings were one on one with a final, formal paper submitted followed by discussions. The Head Doctors were instructed on how to continue the pilot projects that were started in their hospitals. These discussions with the head doctors were long and complex and generally took eight to ten hours. It was more of an educational session. The Head Doctors were told how to continue with the pilot projects, and what to expect as the hospitals go through a transition from socialism to either private or insurance medicine. They were told that they would have to create new finance departments within the hospitals, that a formal warehouse staff would have to be hired to continue the materials management portion of the pilot projects.

The purchase and storage of pharmaceuticals was also discussed. Their methods of purchasing

pharmaceuticals needed to be changed dramatically. Before the pilot projects started, one nurse in every ward individually purchased drugs on a daily basis. IBTCI's pharmacist showed them proper procedures and methods of buying, especially in the generic area. She also showed them how to cross reference generic and trade names, and together with the materials manager, they reviewed purchasing procedures. In addition, IBTCI's materials manager and pharmacist educated the appropriate people within each hospital, including the Head Doctor, in the procedure.

The Head Doctor was also shown how important it was to have new accounting systems and how to be able to cost a patient index or treatment procedure. The head doctors and the oblast health-care committee members were very appreciative of IBTCI's assistance. They had learnt what was to be done, but they wanted more education in how to do it. The doctors were told that as the second part of the pilot project IBTCI would hold some educational classes. They were very enthusiastic about attending them and were also interested in creating an educational institution on a permanent basis.

The subject of nursing was not discussed in the final meetings, however, the directors of nursing of each facility each had a final meeting with the IBTCI nurse. The main emphasis was sterile techniques, how important it was and what can be done to improve their own situation. Several manuals in English and several manuals translated from English into Russian were left with the directors of nursing of each facility.

Every one of the recipients expressed deep appreciation of IBTCI, AID and the U.S. Government helping to improve their institutions. The Head Doctors said it gave them an insight that prepared them for the change that is coming. They were very pleased to be able to work with the Americans, although for an inadequate period of time.

SECTION FOUR

The Yaroslavl Training School

After the pilot projects described above were well-launched, AID decided to make a major change in the nature of the operational aspects of Task Order Four. AID decided that the pilot projects should be abandoned despite widespread praise for their efficacy by GKI and Russian health-care officials. Instead, AID decided to move to educational and training programs. At AID's request, therefore, IBTCI met with certain individuals in the city of Yaroslavl.

The purpose of the first visit by IBTCI was to examine and analyze an existing hospital orientation school supported by a non-profit insurance organization. This school was functioning as an educational facility to help process Russian students who were going to be working in the health insurance industry. The school is processing approximately twenty people per class, with at least eight classes per year. The insurance school has a collaboration with an existing business college in the city of Yaroslavl. The business college is a very successful private enterprise. The college is partially funded by the German Government to retrain Russian officers who were stationed in Germany. Originally, office space and teachers were rented from the business college to teach the insurance classes. Eventually the business school expanded to a point that it had to relocate its facilities because of the lack of teaching space. In 1994, the insurance school decided to separate from the business school; it remains associated, but physically independent.

IBTCI, with the cooperation and funding of AID, decided to try classroom teaching as an alternate way of implementing the objectives of Task Order Four.

AGREEMENTS BETWEEN INSURANCE SCHOOL & TASK ORDER FOUR:

1. The insurance school allowed IBTCI teachers to teach classes to students.
2. Specifically picked students by IBTCI will be allowed to attend lectures with the regular class.
3. If the extra students are allowed to attend, then IBTCI would purchase specific teaching aids and necessary classroom equipment.

The above agreement was reached and test classes were scheduled to start in November. First a series of test lectures were to be given at various conference and meetings in the Yaroslavl, Uglich, and Vologda areas. The purpose of these test classes was to see in what subjects the Russians had the most interest, to choose which people should attend additional classes, and to ensure that the subject matter was being learned by the individuals concerned.

First, a one-hour class was given to the Territorial Insurance Fund groups of the Yaroslavl Oblast. The second class was a defined lecture in specific subjects given in Uglich during a two day conference of key health-care and insurance people. Because of the unexpected interest in the subjects, the second lecture series was expanded from one four-and-one half-hour talk to two four-hour talks. The response from the people was tremendous, and it allowed IBTCI to go to the next stage, which was a formal lecture series given at the Insurance School in Yaroslavl. It was expected that the class size in Yaroslavl would be approximately twenty people, but the response was so strong that additional classes were added to teach over one hundred fifty-five people.

The first talk at Yaroslavl, which were one hour, basically highlighted materials management,

insurance organizations, and the structure of a private hospital. The second series of talks, given in Uglich, were on the same subjects but considerably broken down and focused on local issues and conditions. These classes are oriented for the head doctors and materials managers only. The formal classes that were given at the institute started with definitions of exactly what American insurance was and how it functioned. The lecture evaluated insurance policies, and defined limits, deductibles, co-payments, monthly fees and coverage. True life situations were demonstrated.

The types of insurance policies and the reasons for choosing them were discussed. The talks pointed out that the American system of medicine is not a single system -- it is many systems that somehow coordinate together to provide coverage. The structures of the insurance organizations was given keeping to the Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), and Physician Hospital Organization (PHO) structures. The seminars spent a large amount of time was spent on showing the relationship of the physician to the three insurance structures. Each insurance structure was drawn out on a diagram for the students showing the functions of each organization, the area of coverage of each organization, and the differences between the organizations. In addition, the financial organization as related to the patient was discussed and explained, as was the history of each of these three types.

The table of organization of a private hospital structure was discussed as well as the business functions in hospitals and clinics. Things that make private hospitals and clinics different from socialized institutions were also explained. The discussion also included an explanation of how the business systems relate to different types of physicians. The types of physicians and how they relate to private medicine was part of the lecture. Certain physicians in the class were asked to play roles. They became examples of how they fit into the system of private medicine. The discussion went into

detail about business office and computer systems in the hospitals and out-patient interact clinics. How to process the various types of patient payment that health-care institutions encounter was discussed. The costs of medical care by financial status and legal status were explained. An introduction, definition and function of the Joint Commission on Accreditation of Hospital Organizations (JCAHO) was defined. Patient rights, functions of the Medical Staff Committee, Executive Committee and Credentials Committee were expanded. Professional Staff discipline and several topics which could be related to Russian Hospitals were discussed in detail.

Under the Communist system, all people were educated and dropping out of the system was not allowed. Their education system in the early stages is similar to the United States educational system. As the education progresses, usually during the sixth year of education the government starts separating students, some towards the arts, some towards vocational education and some towards college education. Russian students are obsessed with taking notes, and this was the first problem. Because they take such intense notes, students really don't get to listen to actually what is being said and end up reviewing it at a later time so a period of questions and answers under this type system could only be held the next day, not at the end of the class period. IBTCI did not have the luxury of having the students come back for question and answer periods, so the lectures were prepared before class -- written in Russian and handed out typed, photocopied, stapled and given to each individual student. Diagrams were also made in Russian. Reference materials, such as the Joint Commission on Accreditation of Hospitals manual, was translated and also handed to the students after the classes. A PPO contract was translated and handed out to the students during the lecture when the subject was structures of PPO's and their relationships to physicians. In every class, a Russian text of Healthy Russia 2000 was given to each and every student that attended the classes. A brief reference to the material was made, mainly sighting its significance and its important statistics. The lecture

notes handed out to the students were not basic outlines, but very detailed papers going into all significant areas discussed in the classroom. Additional materials being used in the classroom were: a California drivers's license with a donor card on the back, a personal insurance card that is carried in the wallet and the business card of a primary physician in the United States.

The lecture series was given in English by IBTCI. It was translated into Russian by two interpreters. One interpreter was assigned for morning classes and the other was assigned afternoon classes. Both interpreters were in the room at all times, but when they were not in front of the class doing interpretations they were to sit and observe the students to see which part of the talk was of interest to the physicians, head doctors, university professors, or any other students who were in the classroom.

The talks were given in a Russian timing system, meaning for every forty five minutes of lecture there was a ten to fifteen minute break. A question-and-answer session was held at the end of each half-day of class. Because of IBTCI's knowledge of the U.S. health-care system and the Russian health-care system, it was easy for it to relate directly to the students the immediate history of Russian health care, the present status of Russian health care, and the direction in which it is going. The U.S., British, Canadian, and Dutch health-care systems were also discussed and compared. Middle Eastern health-care systems were discussed because of the recent transition from a socialized system to a semi-private subsidized system based on the petro-dollar.

The Uglich and Yaroslavl lecture series were so successful that the Dean of the Medical College, the Dean of the University of Higher Education and the Senior Oblast Official wrote letters to GKI and other various Russian officials and USAID personnel asking for the lecture series to be extended.

The Dean of the Medical University wanted to get the classes accredited so that his students and teachers that attend the classes would get formal Russian Educational credit.

SECTION FIVE

Conclusions

"Healthy Russia 2000" started out as a very ambitious, and potentially far-reaching project. Because of AID's changing priorities during the course of the project, however, its final scope was much narrower than originally intended. Our recommendations, therefore, reflect only the limited scope of the final objectives (Report - recommendation "HR 2000").

Ten years ago, for example, the Territorial Insurance Funds were created by law, shaping the future for at least the next ten years for Russian health care. To survive, Russian health care must begin to approach its many problems from two different directions. The first is to get the Russian public and providers oriented and educated in insurance systems. The second is to adopt appropriate business systems for hospitals to increase efficiencies and eliminate waste. It is not surprising that a great number of people were interested in insurance education. Within the next two years, virtually all health care will be on a reimbursement basis either through the Territorial Insurance Funds or the insurance companies.

Both of these groups are starting reimbursement systems and will probably change from straight reimbursement to something similar, such as a Diagnostic Related Group system (DRG). DRG systems already exist in certain oblasts in Russia, and the systems are working well. The result has been a substantial increase in bed closures, but there is great political fear in reducing beds. This fear can be eliminated through education in the DRG and insurance systems. In the near future, beds either have to be reduced or additional funding has to be procured. With the state of the Russian

economy at the present time, however, it is most unlikely there will be additional funding for health care. The history of funding for the last three years has been a steady decrease. The federal and oblast governments are receiving less and less in revenues, and, in turn therefore, have less and less to contribute to the hospitals.

IBTCI met with over four hundred Territorial Insurance Funds officials, head doctors, heads of hospital departments, senior health-care oblast officials, medical university officials, and federal government officials. No matter what the subject was, the objectives of Task Order Four were always discussed. The source of funding of Task Order Four was always explained to the key Russian people. The funding from the U.S. government, USAID and the Russian government involvement in providing IBTCI's seminars was always explained. IBTCI advised that it was funded by USAID based on a bi-lateral government to government agreement. It was clearly explained that USAID does not represent specific commercial companies involved with health care, health-care products or pharmaceuticals. The listeners were also made to understand that IBTCI was not a benevolent organization, but a group of professionals who were there to help the Russians adjust to their new economic system.

IBTCI's classroom education project was a complete successful and it will be sustained by the systems and trained personnel left behind. The insurance companies and the Territorial Insurance Funds whose representatives attended the lectures on structures and Joint Commission on Accreditation of Hospital Organizations have begun using the JCAHO manual. This manual was given to them in Russian to set standards for patient care and patient rights. The insurance officials in the Yaroslavl oblast have set basic standards for patient care for institutions which use their insurance. They have done this on their own, using IBTCI's classes and the related documents as a

basis. The classes given on different types of reimbursement -- especially in the diagnostic related group area -- have allowed the oblast health officials, the head doctors, and the insurance companies to begin working on different methods of reimbursement. They realize that the former Soviet system that most of them had been using will no longer work in their new economic system.

IBTCI has not solved Russia's health-care problems, but it has unquestionably **influenced the new direction in which Russian health care is going and in a small way reached over four hundred health-care providers, consumers, employers, administrators and insurance personnel to learn the benefits of reforms.** We cannot, however, predict what its ultimate impact might have been had AID's programming priorities not shifted from the broad restructuring of health care to the more familiar basic human needs approach. Future evaluations may wish to address this shift and its general implications in other sectors of the Russian economy.



International Business & Technical Consultants, Inc.
P.O. Box 16574 · Washington, D.C. 20041 · USA
Tel: (703) 589-1900 · Fax: (703) 729-2088 · Email: IBTCI@aol.com

other IBTCI offices:

Moscow · Bishkek · Cairo · Dhaka · Dublin